



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Research Commons

<http://researchcommons.waikato.ac.nz/>

Research Commons at the University of Waikato

Copyright Statement:

The digital copy of this thesis is protected by the Copyright Act 1994 (New Zealand).

The thesis may be consulted by you, provided you comply with the provisions of the Act and the following conditions of use:

- Any use you make of these documents or images must be for research or private study purposes only, and you may not make them available to any other person.
- Authors control the copyright of their thesis. You will recognise the author's right to be identified as the author of the thesis, and due acknowledgement will be made to the author where appropriate.
- You will obtain the author's permission before publishing any material from the thesis.

**INDIVIDUALISM AND THE PUBLIC GOOD:
A CASE STUDY IN CHILDHOOD IMMUNISATION**

Suzanne Elizabeth Gower

**A thesis submitted for the degree of
Doctor of Philosophy
at the University of Waikato, Hamilton,
New Zealand**

December 2000

ABSTRACT

The election of the Fourth Labour Government in July 1984 marked a turning point in New Zealand's political economic history, ushering in the rise of the individualism which was fundamental to the prevailing philosophy of neo-liberal rationalism. In addition, however, to the widely recognised individualism in the political economy there was also a rising attitude of individualism within New Zealand's civil society.

This thesis examines the development of New Zealand's childhood immunisation policy, the National Immunisation Strategy, as a case study in determining the impact both neo-liberal and civil individualism had on the development of a policy with implications for the public good.

The thesis describes the public policy environment in which the National Immunisation Strategy was developed, examining the changes individualism wrought in both New Zealand's political economy and in civil society. It traces the impact this had in turn on health sector reform, and later on the development of National Immunisation Strategy.

The research uses qualitative methods in the examination of the policy-making process. It examines the literature surrounding childhood immunisation policy in New Zealand, key documents related to the policy-making process and findings of interviews with key informants involved in the policy-making process variously as officials, expert participants, and interested observers.

The thesis concludes that both neo-liberal and civil individualism had a role in shaping not just the National Immunisation Strategy, but also the environment in which it was implemented. Furthermore, the failure of the strategy to improve childhood immunisation coverage rates and prevent epidemics of vaccine preventable diseases can be linked to the impact individualism had on both the policy development process and the National Immunisation Strategy.

ACKNOWLEDGMENTS

This has been a long and winding road along which there have been so many who have variously stimulated my thoughts, challenged my assumptions, distracted me, raised my spirits, argued the point and assured me both that this is possible and that there is life after the doctorate!

My deep appreciation to my chief supervisor, Dr Alan Simpson whose endurance, patience, inspiration and encouragement is monumental, and from whom I have learned so much. Thanks also to my co-supervisor Dr Mike Goldsmith for his encouragement and insights.

Very special thanks

- to all those who have generously shared with me their interest and expertise in childhood immunisation and public policy.
- to my fellow students and friends at the University of Waikato, for the friendship, support, encouragement, endless cups of coffee and the occasional glass of very good red wine: Dr Mary Finlayson, Raewyn Emmett, Jillene Bydder, Biddy Sharland, Kevin Churchill, Juay Lim, Tracey Bramwell-Cadman, Dr Craig Hight, John Hart and many others.
- to my colleagues and friends at the Christchurch School of Medicine, particularly in the Department of Public Health and General Practice, for their encouragement and support, stimulating corridor conversations and inspiring examples. Particular thanks to Gillian Abel – a demon proof reader and maker of graphs.

It is difficult to put into words the role of family in this process, but to my parents Bev and Roy, my sisters, Chris, Kath and Tarn, and my brothers-in-law, Dave, Bobby and Rob - who have always believed this was possible, but in the meantime have given me encouragement, support and a place to escape to. Thank you is not enough, but thanks.

To Holly, Sarah, Allias, Ash, Della, Jack, Max and Jonty,
and the children of the future; who constantly remind us what really matters.

Now, maybe, there will be time to smell the roses – and spray them!

TABLE OF CONTENTS

Abstract	ii
Preface - Acknowledgements	iii
Table of Contents	iv
List of Abbreviations	ix
Introduction	1
Chapter One: New Zealand's Shifting Paradigm	5
I: Introduction	5
II: Structural Adjustment in New Zealand	5
A – The New Zealand Economy	7
B – Corporatisation and Privatisation	12
C – Changes in the Public Sector	15
D – Social Policy	17
E – The Impact of Change	22
III: Pressure for Change	24
A – New Zealand in the International Community	24
B – Treasury's Solution - A Framework for the Way Forward	27
IV: Change in New Zealand Society	29
V: Conclusion	35
Chapter Two: Individualism	36
I: Introduction	36
II: The Discovery of the Individual	38
A – The Supreme and Intrinsic Value of Individual Human Beings	39
B – Autonomy	40
C – Privacy	40
D – Self-development	41
III: Individualism as the Foundation of the Modern State	41
A – Political and Economic Philosophy	42
B – The Late Twentieth Century Market Economy	50
C – Individuation and Personal Responsibility	55

IV: The Individual at the Turn of the Millennium	59
A – Individuals Seeking Happiness	60
B – Attitudes to Authority	66
V: Public Good	63
VI: Conclusion	65
Chapter Three: Health in New Zealand's Shifting Paradigm	66
I: Introduction	66
II: Health and Health Policy	68
A – The Nature of Health	69
B – The Nature of Health Policy	72
C – The Making of Health Policy	73
III: The Health Sector in New Zealand	75
A – History	75
B – Pressures on the Health Service	80
C – Health Sector Reviews	82
D – Health Sector Change	88
E – The Health Sector Reforms (1991)	91
IV: Conclusion	98
Chapter Four: Changing Attitudes Toward Health and Health Care	100
I: Introduction	100
II: Examples of Attitudinal Change	100
A – The Medical Model	101
B – Alternative Medicine	105
C – Parents Centre	109
D – The Cervical Cancer Inquiry	112
E – Discussion	115
III: Public Health	119
IV: Conclusion	123

Chapter Five: Methods	125
I: Introduction	125
II: Topic and Case Study Selection	125
III: Qualitative Research	126
IV: Methods	127
A – Literature	127
B – Document Review	128
C – Interviews	129
V: Health Policy Analysis	131
Chapter Six: Childhood Immunisation in New Zealand	132
I: Introduction	132
II: Immunisation	133
A – The History of Vaccines and Immunisation	133
B – International Immunisation Programmes	135
C – Economic and Political Influences	139
III: The New Zealand Situation	141
A – Policy and Practice	141
B – History	142
C – The Provision Structure	148
D – Monitoring	154
(1) Childhood Immunisation Coverage	154
(2) The Incidence of Vaccine Preventable Diseases	156
(3) Vaccine Related Adverse Events	157
(4) The Cold Chain	162
E – Barriers to Childhood Immunisation	162
(1) Contact with Health Care Providers	163
(2) Perception of Disease Risk	165
(3) Conscientious Objection	167
IV: Conclusion	170

Chapter Seven: Putting Childhood Immunisation on the Agenda	171
I: Introduction	171
II: New Vaccines and Changes in the Immunisation Schedule	173
A – Meningococcal Disease	173
B – Hepatitis B	174
C – <i>Haemophilus Influenzae</i> type b	175
D – MMR	175
III: Service Outcomes	176
A – Epidemics	177
B – Low Childhood Immunisation Coverage	182
IV: Structural and Organisational Change	190
A – The Public Health Commission	191
B – The Reform of Health Sector Funding and Service Provision	193
V: Political Issues	195
A – The Health Policy Environment	195
B – Media Attention	198
VI: Conclusion	201
Chapter Eight: Developing the National Immunisation Strategy	204
I: Introduction	204
II: The Expert Working Group	205
A – Membership	206
B – Background Papers	209
C – Members’ Perspectives	211
D – The Expert Working Group’s Report	218
E – Submissions on the Expert Working Group’s Report	223
III: The Public Health Commission’s Advice to the Minister of Health	225
A – Recommendations	225
B – Discussion	227
IV: Politics and Childhood Immunisation	228
A – The Political Processes	229
B – The National Immunisation Strategy and its Announcement	232
V: Commentary	233
VI: Conclusion	235

Chapter Nine: Discussion and Conclusions	237
I: Introduction	237
II: Childhood Immunisation: Public Good or Private Responsibility?	238
III: Individualism and the National Immunisation Strategy	240
A – The Process	240
B – Strategies	241
C – The Preceding Situation	242
D – Environment	243
E – Discussion	243
IV: Conclusions	250
Schedule of Interviews	255
List of References	256

List of Appendices

I - National Immunisation Strategy Working Group Background Papers, Volumes I & II, Tables of Contents only.

II – Graph of childhood immunisation related articles and letters published in the *NZMJ* 1985-1999.

LIST OF ABBREVIATIONS

AHB	Area Health Board
AMR	adverse medicine reaction
BMJ	British Medical Journal
CARM	Centre for Adverse Reaction Monitoring
CDC	Communicable Disease Centre
CDCAC	Communicable Disease Control Advisory Committee
CDNZ	Communicable Disease New Zealand
CEO	Chief Executive Officer
CHE	Crown Health Enterprise
CIS	Carcinoma in situ
CVI	Childhood Vaccine Initiative
DPT	Diphtheria, Pertussis and Tetanus
DRG	Diagnostic Related Group
EEC	European Economic Community
EEC	European Economic Community
EPI	Expanded Programme on Immunisation
ESR	Institute of Environmental Science and Research Limited
GATT	General Agreement on Tariffs and Trade
GDP	Gross Domestic Product
GMS	General Medical Services
GP	General Practitioner
GPV	Global Programme for Vaccines and Immunization
GST	Goods and Services Tax
HBL	Health Benefits Limited
HCNZ	Housing Corporation of New Zealand
HCP	Health Care Plan
HFA	Health Funding Authority
Hib	<i>Haemophilus influenzae</i> type b
HNZ	Housing New Zealand
HHS	Hospital and Health Services
IAS	Immunisation Awareness Society
IBRD	International Bank of Reconstruction and Development
IDAC	Infectious Diseases Advisory Committee

IMAC	Immunisation Advisory Centre
IMF	International Monetary Fund
IPAC	Immunisation Programme Advisory Committee
MARC	New Zealand Medicines Adverse Reactions Committee
NZCDC	New Zealand Communicable Disease Centre
NZMJ	New Zealand Medical Journal
PHC	Public Health Commission
PHN	Public Health Nurse
PMS	Post-marketing surveillance
RCSP	Royal Commission on Social Policy
RHA	Regional Health Authority
SIDS	Sudden Infant Death Syndrome
SOE	State Owned Enterprise
TCE	Transnational Corporate Enterprise
UNICEF	United Nations Children's Fund
VRD	Vaccine Research and Development
VSQ	Vaccine Supply and Quality
V&B	Department of Vaccines and Other Biologicals
WHO	World Health Organisation
WTO	World Trade Organisation

INTRODUCTION

James begins his book *New Territory: The Transformation of New Zealand 1984-92* with a short piece called 'The Far Country,' in which he outlines the differences between New Zealand in 1992 and another nation. The variations between the two societies are marked across a wide range of comparisons, some favouring New Zealand while others show the far country which, it becomes obvious, is New Zealand a decade earlier, in a better light.¹ The simple two page illustration is an edifying reminder of the nature and extent of change in New Zealand during an eight year period, a process of change which continued into the last years of the twentieth century.

The election of the Fourth Labour Government in July 1984 is frequently cited as the turning point in New Zealand politics, a watershed,² marking the beginning of a period during which a new orthodoxy was constructed in New Zealand.³ Indeed the events of the decade after 1984 have been labelled a revolution.⁴ The often repeated label for the condition emerging in New Zealand is that of individualism. Many commentators have used this term to indicate a shift in the state's basic philosophy, underpinned by its belief that the individual is in the best position to use their available resources in a way to maximise their well-being. According to Peters:

Since 1984 the New Right in New Zealand has been remarkably successful in advancing a foundationalist and universalist reason - the philosophy of a neo-liberal individualism - as the basis for a radical reconstruction of all aspects of society: a change in economic policy favouring supply-side economics and monetarism, a complete restructuring of the public sector, and a move away from the traditional welfare state to targeting social assistance.⁵

¹ Colin James, *New Territory: The Transformation of New Zealand 1984-92* (Wellington: Bridget Williams Books, 1992), pp.1-2.

² Jonathan Boston and Martin Holland, *The Fourth Labour Government: Radical Politics in New Zealand* (Auckland: Oxford University Press, 1987), p.2.

³ Andrew Heal, 'Jane Kelsey', *Metro*, June 1996, pp.94-97 (p.94).

⁴ Andrew Sharp, 'The Case for Politics and the State in New Zealand: An Introduction', in *Leap into the Dark: The Changing Role of the State in New Zealand Since 1984*, ed. by Andrew Sharp (Auckland: Auckland University Press, 1994), pp.1-18.

⁵ Michael Peters, 'Postmodernity and Neoliberalism: Restructuring Education in Aotearoa', *Delta*, 47 (1993), 47-62 (p.47). Others identifying aspects of individualism include Bill Willmott, 'Conclusion', in *New Zealand in Crisis*, ed. by David Novitz and Bill Willmott (Wellington: GP Publications, 1992), pp.245-250 (pp.247-248); Bruce Jesson, 'Politics: In Praise of Conservatism', *Metro*, October 1988, pp.198-201.

During the 1980s and 1990s individualism became an increasingly significant factor in New Zealand society. The political economic situation, influenced in part by the global economic factors, and changing attitudes among New Zealanders, combined with the changing composition of society, drew New Zealand away from the community focused welfare state which sustained it in the post war period. This was replaced by a system less concerned with community welfare and more focused on the rights and responsibilities of the individual. This argument is developed in Chapter One.

This thesis examines the introduction and impact of the structural changes emerging from a neo-liberal, individualist political economic philosophy, on which many commentators focus, but also explores other expressions of individualism, arguing that changing attitudes and behaviour in civil society also contributed to the increasing level of individualism in New Zealand.

Individualism will be discussed under two broad headings. On the one hand is neo-liberal individualism, a significant component of the political economic philosophy prevailing in the period under discussion. This is seen in the expectations the state has of individuals, the responsibilities it ascribes to them and the rights it acknowledges. On the other hand is the individualism evident in the attitudes and expectations of individual members of society and their behaviour in relation to each other and to the state. This will be called civil individualism.

While these two forms of individualism are considered distinct in the context of this thesis, they are not unrelated. The ideas about the individual, their capacities and the conditions under which they could function to the extent of their potential, are at the root of competing ideas about how society should be organised. Even in the pursuit of that organisation, however, society comes up against individuals, or groups of individuals, exercising those same capacities variously in support of, in opposition to, or refusing to take account of, the prevailing organising philosophy.

The last years of the twentieth century saw a shift away from the dominance of the neo-liberal political economic philosophy. Across the world dominance of the market was being challenged. In New Zealand the election of a centre-left

government in November 1999 saw, while not a whole sale rejection of the policies of the previous 16 years, at least a softening in the adherence to neo-liberal individualism. The Labour-Alliance Coalition Government must, however, deal with policies created in an individualist environment and a society some of whose members support and appreciate an individualist approach to public policy.

This thesis argues that both neo-liberal individualism and civil individualism have had a significant impact upon public policy formulated within this environment. Such a situation raises a number of questions. First, how, in a country widely concerned with the rights and responsibilities of the individual, were matters of public interest, the Public Good, secured? Second, given that individualism takes a number of forms, which manifestation had the greatest impact on public policy? Third, what can the public policy community learn about individualism in New Zealand which will assist it in implementing effective policy? Fourth, what is the role of the state within an individualist society?

This thesis approaches, and seeks to answer, these questions by examining the changes which took place both in the machinery of the state and in society. By focusing on the health sector and then on childhood immunisation as a case study, this thesis explores the variety of influences on an area of public policy which has ramifications for both an individual's rights and responsibilities, and the Public Good. This examination is placed within the context of the wider influences of public policy and the increasing impact of individualism in New Zealand.

Chapter One discusses the programme of structural adjustment implemented in New Zealand, the events which precipitated the changes and the foundations upon which those changes were based. It then examines the changing face of New Zealand society, discussing the links between the sets of changes which have rendered New Zealand increasingly individualist. Chapter Two examines the history and development of individualism, and explores the manifestations of both neo-liberal and civil individualism in the late twentieth century. Chapter Three discusses the issues behind health and health policy, before exploring the development of health services in New Zealand. The chapter then discusses how structural adjustment and a range of other factors have combined to modify the

health sector, introducing greater individualism. Chapter Four examines the shifting attitudes of New Zealanders toward health. Chapter Five discusses the methodology used to examine the substantive material. Chapter Six introduces the case study, childhood immunisation, and outlines policy and practice in New Zealand. Chapter Seven examines the factors which indicated a need for change and prompted the review of childhood immunisation policy. Chapter Eight examines the policy-making process that resulted in the National Immunisation Strategy, including the dynamics within that process. Chapter Nine links the changes in childhood immunisation policy to individualism and discusses the ramifications of individualism for public policy and the Public Good in New Zealand.

Chapter One

NEW ZEALAND'S SHIFTING PARADIGM

I: Introduction

The changes which took place in New Zealand in the years between the election of the Fourth Labour Government in 1984 and the formation of a Labour-Alliance Coalition following the 1999 election are a combination of structural and societal change. This chapter addresses each in turn.

II: Structural Adjustment in New Zealand

Many of the changes in New Zealand since 1984 were introduced by a raft of new government policy and legislative initiatives which substantially altered the nature of the relationships between the state, the community and the individual in New Zealand, relationships which had been relatively stable for 50 years. This process, largely begun when the Fourth Labour government assumed the Treasury benches in 1984, and continued by subsequent National, Coalition¹ and National Minority² governments, was driven by neo-liberalism.³ This was seen in the shift away from a welfare state with an interventionist government toward a greater reliance on market mechanisms to achieve policy goals.

The changes involved a combination of economic liberalisation and institutional change, altering both the role of the state within the economy and society,⁴ and the way the state sector itself operated. Looking back upon the period of change she has labelled *The New Zealand Experiment*, Kelsey identifies five key areas in New Zealand's programme of structural adjustment: market and trade

¹ The Coalition Government was formed by the National and New Zealand First Parties in December 1996, after New Zealand's first MMP election in October 1996.

² The National Minority government assumed power in New Zealand after the breakdown of the National - New Zealand First Coalition in August 1998.

³ Neo-liberalism favours the market model with a minimal role for the state, assuming that autonomous individuals, operating competitively in the free market result in the efficient allocation and distribution of goods and services. This is discussed further in Chapter Two.

⁴ Pat Walsh and Jonathan Boston, 'Introduction' in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston et al. (Auckland: Oxford University Press, 1991), pp.ix-xii (p.ix).

liberalisation, state sector reorganisation, monetary policy, labour market deregulation and fiscal restraint.⁵ Together they had an impact across the private and public sector economies and the welfare state. There was seldom a single motivating factor behind particular changes, but rather a complex combination of inter-related measures designed to achieve a range of goals, including price stability, economic growth, increased competition in the domestic market, improved competitiveness in the international market, efficient and equitable public services and a reduction in the balance of payments deficit.

New Zealand followed the example of other western democracies, including the United States and Britain, in adopting neo-liberal political economic strategies. While conforming to the Washington consensus⁶ New Zealand's political system, short electoral cycle and isolation allowed the changes to be made rapidly and to such a degree that New Zealand became the model for other countries wanting to achieve similar goals.⁷

The following section examines the formulation of New Zealand's changing political economy. The discussion of these changes is intended to provide an outline of the environment within which policy changes took place and the overall philosophy guiding New Zealand's decision makers. This section examines these changes under four separate headings: the New Zealand economy, corporatisation and privatisation, changes in the public sector and social policy. These headings are made to facilitate analysis, for it is not possible to consider these four areas in isolation. Each set of changes is inter-related, much as each section of the state and economy are interdependent.

⁵ Jane Kelsey, *The New Zealand Experiment: A World Model for Structural Adjustment* (Auckland: Bridget Williams Books, 1995), p.85.

⁶ The Washington consensus is the label given to the key elements in a structural adjustment programme. Cited in Kelsey, *The New Zealand Experiment*, p.18.

⁷ Jonathan Boston et al., *Public Management: The New Zealand Model* (Auckland: Oxford University Press, 1996) discusses the 'New Zealand Model', particularly in respect to public management, but also refers to other aspects of the reform process in New Zealand.

A: The New Zealand Economy

By the end of the twentieth century New Zealand's economy was operating under conditions very different to those which prevailed in the early 1980s. In line with the political philosophy dominant since the election of the Fourth Labour Government in 1984 there was an ongoing process of economic liberalisation. While the state retained a significant role in economic matters there was a shift to a more-market approach, tempered with a lower level of government intervention targeted at specific areas of social benefit. According to Dalziel, writing in 1992:

The paradigm driving macroeconomic policies since 1984 has been the view that the government's role is to create a stable environment of low inflation, fiscal balance, and external balance (i.e. in the balance of payments), within which the private sector can make the right decisions which will lead to economic recovery in deregulated markets.⁸

The New Zealand economy underwent a number of changes in order to create the environment within which business could flourish in both the domestic and the global economy. The floating of the New Zealand dollar, deregulation in various sectors, changes in monetary and fiscal policy were all aspects of the programme to reduce the level of state or political intervention in the economy, exposing it instead to the pressures and influences of the market, both domestic and international. The ultimate objective was to make New Zealand more competitive in the global economy in order to achieve the growth which would ensure economic security. The factors contributing to this process included low inflation, reduced interest rates, a realistically valued New Zealand dollar, tax reform, deregulation and lower government spending.

⁸ Paul Dalziel, 'Policies for a Just Society', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.208-223 (p.221).

The Reserve Bank Act (1989) illustrates two factors central to the changing relationship between the state and the economy in New Zealand. First, this legislation enabled the central bank to manage monetary policy independent of direct political control. Second, the Act simplified the objectives of monetary policy in New Zealand, moving away from the complex combinations of economic and social welfare objectives which had been included in Reserve Bank Acts since the central bank's inception in 1933.⁹ Under this new legislation the Governor of the Reserve Bank is contracted to achieve and then maintain the single target of low inflation through control of the money supply. The initial target of two percent was successfully achieved before the target was relaxed to three percent. While the Governor is responsible to Parliament and economic policy is set by the government, there was no political interference in the implementation of that policy. The use of contracts to define individual management responsibilities has been an increasing feature within the state sector, as is discussed below.¹⁰

Deregulation, begun during the Muldoon administration,¹¹ was a fundamental aspect of the change process. Regulation of business was refocused in order to remove structural restrictions on entry to sectors of the business community including the finance, telecommunications and transport industries.¹² Regulation continued with the focus shifting away from controls on entry to and exit from a sector and toward conduct regulations which set standards for behaviour within those sectors.¹³ Deregulation, or regulatory reform, broadened opportunities for participation in some previously restricted sectors of the economy, allowing for

⁹ For a discussion of the objectives set for the Reserve Bank see Paul Dalziel, 'The Reserve Bank Act: Reflecting Changing Relationships Between the State and the Economy in the Twentieth Century', in *State and Economy in New Zealand*, ed. by Brian Roper and Chris Rudd (Auckland: Oxford University Press, 1993), pp.74-90.

¹⁰ For further discussion of the Reserve Bank Act (1989) see Kelsey, *The New Zealand Experiment*, pp.159-172.

¹¹ Robert Muldoon, later Sir Robert, was Prime Minister at the head of a National Party government from 1975 to 1984. His administration's moves in deregulation are discussed in Brian Easton, *The Commercialisation of New Zealand* (Auckland: Auckland University Press, 1997), p.139.

¹² Chris Rudd, 'Politics and Markets: The Role of the State in the New Zealand Economy', in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.83-100 (p.92).

¹³ Rudd, 'Politics and Markets', p.92.

the expansion of private sector firms and providing the competition considered essential for efficiency across all sectors of the New Zealand economy, including the state's trading enterprises which are discussed further below.

The need to reform fiscal policy saw changes in two areas of major interest in the private sector economy. First, the need to reduce government spending was, in part, motivation for the withdrawal of the subsidies which were part of a system of measures which had encouraged and protected business in New Zealand. The second was in tax reform.

The dismantling of the system which had encouraged and protected business in New Zealand was in line with changes in international trade conventions established in the General Agreement on Tariffs and Trade (GATT) and the World Trade Organisation (WTO). The move also contributed to a reduction in government spending. Industry, most notably agriculture and manufacturing, had been protected from international competition through a programme of measures including subsidies, tariffs, export incentives and import licensing.¹⁴

The removal of import and export restrictions exposed New Zealand firms to international competition on very different terms to those they had previously faced. In the external market this required firms to compete in markets which were often subject to protection, thus forcing greater efficiency and innovation. In the domestic market New Zealand producers faced increased competition from imported goods. While this has been problematic for some firms it has provided increased choice for New Zealand consumers, sometimes lowering the price of goods. Examples of this include clothing, footwear and second hand cars.

In the short term these changes resulted in great hardship for some New Zealanders as businesses failed to survive the pressures of increased competition. In the long term, however, resources transferred into areas where New Zealand had a competitive advantage,¹⁵ thereby contributing to

¹⁴ Rudd, 'Politics and Markets', p.89.

¹⁵ Graham T. Crocombe, Michael J. Enright and Michael E. Porter, *Upgrading New Zealand's Competitive Advantage* (Auckland: Oxford University Press, 1991). Also known as the Porter project, this report discussed how New Zealand might improve its position in the international economy.

unemployment of unskilled workers as New Zealand increasingly focused its attention on value added markets. For example, New Zealand cannot successfully compete against off shore manufacturers of cheap clothing, but can compete in specialist, niche markets such as high quality fashion.

The second element of the reform of fiscal policy was reorganisation of the taxation system. On 1 October 1986 a package of tax reforms was introduced, including a 10 percent goods and services tax (GST), later increased to 12.5 percent, changes to personal income tax with some flattening and simplification of rates, reform of business taxes and the introduction of Family Support for families on low and middle incomes.¹⁶

The change from a system of progressive income and wholesale sales taxes, to a broad based consumption tax, considered by some to be more efficient and equitable,¹⁷ reflected the neo-liberal philosophy and the objectives of the more-market system. The rationale is that a consumption tax allows individuals more discretion in allocating their financial resources, choosing between consumption, saving and investment. In addition the shift away from income tax reduces the disincentives for work, investment and saving.¹⁸ For many New Zealanders, however, personal tax savings have been required to meet the costs which have arisen from cutbacks in government spending in areas including health, education and housing.

During this period of widespread deregulation, labour relations in New Zealand remained heavily controlled. The Fourth Labour Government avoided labour market deregulation, adopting instead industrial relations reform which was enshrined in the Labour Relations Act (1987).¹⁹ It was not until the National government came to power in 1990 that market principles came to dominate in the

¹⁶ Family Support, a targeted allowance, replaced the universal Family Benefit in 1991.

¹⁷ Claudia Scott, 'The 1985 Tax Reform Package', in *The Fourth Labour Government: Radical Politics in New Zealand*, ed. by Jonathan Boston and Martin Holland (Auckland: Oxford University Press, 1987), pp.184-197 (p.187).

¹⁸ For a discussion of the tax reforms see Scott, 'The 1985 Tax Reform Package'.

¹⁹ For a discussion of industrial relations reform under the Fourth Labour Government see Pat Walsh, 'A Family Fight? Industrial Relations Reform Under the Fourth Labour Government', in *The Making of Rogernomics*, ed. by Brian Easton (Auckland: Auckland University Press, 1989), pp.149-170.

area of employment. The Employment Contracts Act (1991) introduced labour market deregulation, providing a framework within which employers and their workforce were required to reach agreements or contracts without the regulations which previously influenced wages and conditions. Contracts, collective or individual, between employers and their workers replaced national agreements negotiated between unions and government representatives. The Act was designed to promote efficiency in the labour market, recognising the forces of supply and demand and allowing for the greater flexibility required for firms to compete in the prevailing economic conditions. Under the 1991 Act workers with certain skills were able to negotiate favourable contracts, while others were obliged to accept less favourable conditions. The reforms also changed the role of trade unions in industrial relations.²⁰

Other changes made those running both public and private companies more accountable to their shareholders and creditors. Under the Commerce Act (1986) directors must take personal responsibility for the decisions they make and the performance of the companies they run. These and others changes, discussed below, meant that there was more openness in the conduct of business than had previously been the case.

The changes introduced to the New Zealand economy were designed to provide an environment within which business could operate efficiently and competitively, maximising the return on available resources. The rationale behind these changes was that individual entities operating in the free market are likely to make more efficient decisions than are governments. The goal was to maximise the nation's standard of living by increasing New Zealand's competitiveness and that requires the efficient use of resources. Intervention from the state, designed to meet other goals, may interfere with the efficient allocation of resources.

²⁰ For a detailed discussion of the Employment Contracts Act (1991) see Pat Walsh and Peter Brosnan, 'Redesigning Industrial Relations: The Employment Contracts Act and its Consequences', in *Redesigning the Welfare State in New Zealand: Problems, Policies, Prospects*, ed. by Jonathan Boston, Paul Dalziel and Susan St John (Auckland: Oxford University Press, 1999), pp.117-133; Pat Walsh, 'The Employment Contracts Act', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.59-76.

This freedom from government intervention had a cost for some firms as the state decreased the level of support it once gave to the productive sector. Business was expected to make decisions based on market conditions and succeed or fail on the quality of those decisions. The government was less inclined than in the past to intervene politically in the conduct of business, relying instead on established procedures for the conduct of commerce.

In addition the government's focus on specific macroeconomic targets, as discussed above, emphasised the market's ability to allocate resources, ignoring, or tolerating the areas in which the market does not succeed alone, for example in ensuring full employment and equitable income distribution.²¹

Discussion in this section has focused on the private sector economy. At the beginning of this period of change in 1984, however, the public or state sector was approximately 25 percent of New Zealand's Gross Domestic Product (GDP).²² In its quest to improve the potential of the New Zealand economy the government could not afford to ignore the state sector. There is a complex inter-relationship between changes in each section of the economy as the government sought to provide incentives for the development of an efficient, competitive market economy which would maximise the standard of living for New Zealanders.

B: Corporatisation and Privatisation

The same rationale impelling the reduction of the state's role in private sector business also inspired changes in the public sector. Prior to 1984 the state was involved in a range of trading enterprises, but while some operated within a corporate structure most were run as government departments. The state's involvement in such enterprises stemmed from a belief that some services were of a strategic nature and that the private sector could not, or would not, provide particular goods and services necessary in the public and the nation's interest, for example, postal and telecommunication services. In addition the government used

²¹ Dalziel, 'Policies for a Just Society', p.221.

²² Treasury, *Economic Management* (Wellington: Treasury, 1984), p.275.

state trading enterprises as a tool to achieve social objectives, including, for example, affordable housing for low income New Zealanders and job creation to ensure low levels of unemployment.²³

In its advice to the incoming government in 1984 Treasury discussed the conflicts of interest it saw to be inherent in the state's operation of trading enterprises, and recommended changes which would require separation of the government's commercial and non-commercial objectives.²⁴ Treasury also suggested that in order to maximise efficiency it would be necessary to transfer ownership of state owned trading enterprises to the private sector.²⁵

The State Owned Enterprises Act (1986) provided the legislative framework for the corporatisation of a number of state owned trading enterprises. Corporatisation is the "process whereby government converts trading enterprises from a departmental form into a limited liability company, with performance criteria and a financial structure which seek to mirror those of equivalent private sector firms."²⁶ The resulting companies, known as State Owned Enterprises (SOEs), earned a dividend for their shareholder, the state.²⁷ If an SOE was to undertake non-commercial activities these were to be remunerated in a way which separated them from its commercial activities, making the division between the various roles of the SOE transparent.²⁸ State owned trading activities had been corporatised in the past, but the SOE Act made explicit the distinction between the management of an SOE and the associated Minister's political responsibilities.²⁹

²³ For a brief discussion of the state's involvement in trading enterprises and the rationale behind that involvement see R.C. Mascarenhas, 'State-owned Enterprises', in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston et al. (Auckland: Oxford University Press, 1991), pp.27-51 (pp.28-30 & 32).

²⁴ Treasury, *Economic Management*, pp.275-286.

²⁵ Treasury, *Economic Management*, pp.293-294.

²⁶ Peter McKinlay, *Corporatisation: The Solution for State Owned Enterprise?* 2nd edn. (Wellington: Victoria University Press for the Institute of Policy Studies, 1987), p.3.

²⁷ For a discussion of the SOE process see Mascarenhas, 'State-owned Enterprises'.

²⁸ Michael Williams, 'The Political Economy of Privatisation', in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.140-164 (p.141).

²⁹ John Martin, 'Remaking the State Services' in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.123-139 (p.125).

Corporatisation could have been the end stage of this process with the state retaining ownership of SOEs. Treasury's advice to the Labour government, after its re-election in 1987, was, however, that state ownership limited the impact of corporatisation.³⁰ Although the government had previously denied any intention to sell the SOEs, the Minister of Finance, Roger Douglas, announced a programme of privatisation in the 1988 Budget Speech. Privatisation can be defined in a number of ways, but in this context the ownership of assets was to be transferred from the state into the private sector, either in part or in their entirety.

The processes of corporatisation and privatisation, as defined above, were closely related to changes in the private sector. Each change was an integral part of the endeavours to increase competition and efficiency across the New Zealand economy. Deregulation was a closely related factor, both increasing the scope for expansion of private sector firms by allowing entry into industries previously limited to the state sector and providing competition for SOEs operating in those sectors, a necessary ingredient in the quest for efficiency.³¹ Privatisation also allowed private sector firms to invest in former SOEs, providing opportunities for New Zealand firms to expand and attract overseas investment. Furthermore, the sale of state assets involved in privatisation allowed for the retirement of public debt.³²

The corporatisation and later the privatisation of parts of the public sector was further confirmation of the government's belief that there are limitations on the role of the state in the allocation of resources and that the market has an important role in this process. Where the state did have a role in meeting social objectives and ensuring equity this was to be undertaken separately from commercial activities so as to ensure transparency in the division between fulfilment of social policy obligations and the conduct of trading activities. Again this indicates a

³⁰ Treasury, *Government Management: Brief to the Incoming Government 1987* (Wellington: Treasury, 1987), pp.112-113.

³¹ For a discussion of deregulation as a stage in the shift from corporatisation to privatisation see Mascarenhas, 'State-owned Enterprises', pp.39-43.

³² The reduction of debt was one of the reasons given for privatisation in the July 1988. See Mascarenhas, 'State-owned Enterprises', p.43. For further discussion of privatisation see Williams, 'The Political Economy of Privatisation'.

commitment to the individualism of economic liberalisation which is discussed further in Chapter Two.

The state owned trading enterprises were not the only part of the public sector to undergo change. The lessons of corporatisation were to be transferred into the remaining core public sector.

C: Changes in the Public Sector

The public sector has been defined as “those agencies which are established by the Executive to carry out the day-to-day administration of government.”³³ The process of corporatisation, institutionalised in the SOE Act (1986), reduced the size of the core public service and provided an alternative model for procedure in what was traditionally a non-political, hierarchical, career based service which provided free and frank advice to the New Zealand government. However, problems similar to those which had reduced efficiency in state owned trading enterprises also existed in the non-commercial and regulatory functions of the state sector.

Although changes in the management of the public service were discussed briefly in Treasury’s 1984 advice to the incoming government,³⁴ it was in 1987 that Treasury focused on the issue. Much as it had in the advice which underpinned the process of corporatisation, Treasury focused on the need to ensure greater efficiency in the use of resources, identifying five elements necessary to achieve improvement: “clarity of objectives; freedom to manage; accountability; effective assessment of performance; and adequate information flows.”³⁵

³³ Treasury, *Government Management*, p.51.

³⁴ Treasury, *Economic Management*, pp.286-293.

³⁵ Treasury, *Government Management*, p.55.

Restructuring of the state sector was mandated under two major pieces of legislation. The State Sector Act (1988) set out the procedures under which chief executives (CEOs) would be hired, on limited term, renewable, performance based contracts, to run government departments.³⁶ The Public Finance Act (1989) altered the focus of government departments from inputs to outputs and outcomes.³⁷ Together these two pieces of legislation gave CEOs the incentive and the autonomy to manage their responsibilities efficiently. Failure to do so would reduce the likelihood of contract renewal.

Reform of the state sector brought about a range of changes. Managerialism, which had begun to come into the public sector prior to the election of the Fourth Labour Government in 1984, became the norm in the public service.³⁸ There was a move to separate and make transparent the various roles of government departments, for example separating the policy advice and implementation roles. The reforms also altered conditions of employment and labour relations in the state sector, shifting away from the traditional values of the public service.

New Zealand's state sector reform had strong theoretical underpinnings in public choice theory, agency theory, transaction-cost analysis and managerialism. While the validity of these theoretical justifications is widely challenged they are consistent with the neo-liberal paradigm under which New Zealand has operated since 1984.³⁹ In addition, New Zealand is considered a model for the change process in other states, having achieved enormous change in such a short period of time.⁴⁰

³⁶ For a discussion of the State Sector Act (1988) see Kelsey, *The New Zealand Experiment*, pp.139-142; Martin, 'Remaking the State Services', pp.125-127; Pat Walsh, 'The State Sector Act 1988', in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston et al. (Auckland: Oxford University Press, 1991), pp.52-80.

³⁷ For a discussion of the Public Finance Act (1989) and related issues see Boston et al, *Public Management*, particularly pp. 260-279.

³⁸ Martin, 'Remaking the State Services', p.124.

³⁹ For a full discussion of these theories and their impact in New Zealand see Jonathan Boston, 'The Theoretical Underpinnings of Public Sector Restructuring in New Zealand', in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston et al. (Auckland: Oxford University Press, 1991); Boston et al., *Public Management*, pp.16-40; Allan Bollard, *New Zealand 1984 - 1991* (San Francisco: International Centre for Economic Growth, 1991), pp.7-11.

⁴⁰ Boston et al., *Public Management*.

Changes in the public service influenced and were influenced by changes in the wider operations of the machinery of state. Cabinet Secretary, Marie Shroff, has identified a culture change in the public service, citing three features; openness, participation and accountability.⁴¹ Much of this stems initially from the Official Information Act (1982). In Shroff's estimation the knowledge that potentially all advice is open to public scrutiny improves the quality of that advice, although she notes that extending openness still further does have the potential to restrict politicians and officials in committing matters to paper. In addition access to information increased the level of participation in the political process and making all participants in the process more accountable.

The increasing openness of government was further enhanced by the Fiscal Responsibility Act (1994) which enshrined in legislation a requirement for governments to comply with five principles of fiscal responsibility and also to report at particular intervals on fiscal matters.⁴² In addition to making fiscal management more transparent, the neo-liberal influences on New Zealand's fiscal policy are also embedded in legislation.⁴³

The combination of changes in the private sector economy and in the public sector have brought both the procedures and the philosophy of the two sectors closer together. The individualism inherent in the neo-liberal philosophy is now clearly apparent in the way in which business is conducted in New Zealand. Furthermore, it has influenced the way in which social policy has been both constructed and implemented in the post-1984 era, as is discussed in subsequent chapters.

D: Social Policy

Cheyne, O'Brien and Belgrave define social policy as "actions which affect the well-being of members of a society through shaping the distribution of and access to goods and resources in that society."⁴⁴ They include the actions, or inactions,

⁴¹ Marie Shroff, 'Supporting Central Government Through the Change', in *The Constitutional Implications of MMP*, ed. by Alan Simpson (Palmerston North: Dunmore Press, 1998), pp.14-26.

⁴² For a full discussion of the Fiscal Responsibility Act (1994) see Kelsey, *The New Zealand Experiment*, pp. 232-239; Boston et al., *Public Management*, pp.285-288.

⁴³ Kelsey, *The New Zealand Experiment*, p.239.

⁴⁴ Christine Cheyne, Mike O'Brien and Michael Belgrave, *Social Policy in Aotearoa New Zealand: A Critical Introduction* (Auckland: Oxford University Press, 1997), pp.2-3.

of the market place and voluntary associations alongside the actions of the state in this definition.⁴⁵ This is particularly appropriate in the New Zealand situation where the connections between the public sector, the private sector and the voluntary sector have been so important in shaping the process of change.

The impact of neo-liberal individualism on social policy in New Zealand was initially linked to wider changes in the public sector through reform of the organisational structures. However, the philosophical shift later influenced both the nature and level of services available to New Zealanders and the expectations about the financial contribution individuals would make for social services which had previously been state funded.

The Fourth Labour Government initiated service reviews in social policy areas including education, health and housing. In the education sector the foundations for change were laid by the Labour government and continued under the National government elected in 1990.⁴⁶ Changes in the health sector, begun by the Labour administration and continued by subsequent governments are discussed in detail in Chapter Three. The bulk of social policy reform, however, followed the 1990 election of a National government when the impact of change began to have a significant effect on consumers of social services.⁴⁷

Changes in social policy were foreshadowed in 1984 by Treasury which saw government's role in respect of social policy as limited to the provision of public goods, agency issues, merit goods and income redistribution.⁴⁸ These proposals suggested a redefinition of the role of the state, moving away from the universal provision of social services to a system of targeting which directed public resources toward those unable to provide for themselves, while those with private resources were expected to assume a greater share of the burden. The Minister of

⁴⁵ Cheyne et al., *Social Policy in Aotearoa New Zealand*, p.3.

⁴⁶ Michael Peters and James Marshall, *Individualism and the Community: Education and Social Policy in the Postmodern Condition* (London: Falmer Press, 1996), p.66.

⁴⁷ Finance Minister Roger Douglas did intend to extend market reforms to social policy in 1988, but the move was vetoed by Prime Minister, David Lange. For a discussion of this see Bruce Jesson, *Fragments of Labour: The Story Behind the Labour Government* (Auckland: Penguin, 1989), p.8.

⁴⁸ Treasury, *Economic Management*, pp.252-254. This material is analysed in Peters and Marshall, *Individualism and the Community*, pp.7-9.

Finance in the 1990 National Government, Ruth Richardson, stated that “in general, those individuals and families with reasonable means should attend to their own needs. As a broad principle, the top third of all income earners can be expected to meet most of the cost of their social services.”⁴⁹

Successive governments moved to institutionalise the concept of individual responsibility, both by targeting resources and by shifting away from the provision of services, limiting its role to that of funder, while other agencies, either state owned or private sector agencies, operated as service providers, often contracting in a competitive environment. In this way market mechanisms became increasingly involved in matters of social policy. Peters and Marshall describe this shift as a commodification of social policy, particularly apparent in education and health.⁵⁰

An early sign that the National government would extend neo-liberal individualism into social policy came with the reduction in the levels of transfer payments or income support. In addition the changes introduced restrictions on benefits including the Domestic Purposes Benefit for mothers under 18 years, student allowances for those under 25 years and the unemployment benefit for those recently out of work.⁵¹ The assumption supporting this change was that individual families, and not the state, should take responsibility for the care and welfare of their members.

⁴⁹ Ruth Richardson, cited in Jonathan Boston, ‘Redesigning New Zealand's Welfare State’, in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland Oxford University Press, 1992), pp.1-18 (p.1).

⁵⁰ Peters and Marshall, *Individualism and the Community*, p.99.

⁵¹ For discussion of changes to the benefits regime see Bob Stephens, ‘Budgeting with the Benefit Cuts’, in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.100-125; Kelsey, *The New Zealand Experiment*, pp.276-83; Cheyne et al., *Social Policy in Aotearoa New Zealand*, pp.187-188.

User part-charges were introduced, or increased, in areas ranging from pharmaceutical prescriptions to tertiary education. The targeting of health care assistance, in both the primary and secondary sectors, resulted in the introduction of the Community Services Card to differentiate between various income groups which the state funded at different levels. Another example of targeting was the means testing of elderly New Zealanders who require long term residential or hospital care. Once again those considered to have the resources were required to contribute financially.

This financial contribution toward the services they accessed was supposed to provide consumers with an incentive to analyse whether they required the service or if their preference was to spend that money elsewhere. When, in July 1997, the National - New Zealand First Coalition government introduced free GP care for children under six years of age, some, including Members of Parliament, expressed concern that the policy was resulting in unnecessary visits to the doctor. It was suggested that parents had no incentive to ration their visits because there was not a financial disincentive. This perspective assumes that only financial incentives are effective, discounting time and other indirect financial costs of taking a child to the GP.

Changes in the state's involvement in the provision of housing to low income New Zealanders is an illustration of the way in which the government's guiding philosophy has moved into the area of social policy, separating the commercial and social goals of the state. Prior to 1990 the state, through the Housing Corporation (HCNZ), assisted low income New Zealanders with housing through two main mechanisms; first, it maintained a stock of residential properties which it rented to low income earners, second, it assisted low income New Zealanders into house ownership through its mortgage scheme. HCNZ also provided policy advice to the government and undertook regulatory and other responsibilities.

Changes to these arrangements were announced in the 1991 budget. HCNZ was to be commercialised, becoming Housing New Zealand (HNZ). HCNZ mortgages were to be subject to market interest rates and sold to the private sector. Market rentals were to be introduced over four years and responsibility for providing low income New Zealanders with housing assistance was to be taken up through an Accommodation Supplement managed by the Department of Social Welfare.

Changes in housing policy reflected both the state's desire to separate its commercial and social goals and its faith in the allocative efficiency of market mechanisms. However, HNZ was not created as an SOE, but as a Crown entity under the Housing Restructuring Act (1992).⁵² New Zealand's housing policy was clearly individualist in that it was motivated by the economics of neo-liberalism. Furthermore, it was justified by the rhetoric of individualism in that a tenant gained the choice to rent where they pleased in either the public or the private sector, with support from the state through the housing supplement. However, this took little account of the factors which interfered with the tenants' options, including security and cultural needs.⁵³

As in housing the state retained an involvement in many social services. The introduction of a more-market, often competitive approach to the provision of social services has been justified on the twin premises of improving efficiency and increasing consumer choice. Both are central aspects of individualism. However, another aspect of the changes was the increased emphasis, enforced through regulation, on individuals fulfilling their responsibilities. An example of this is the way in which non-custodial parents were compelled to contribute to their children's financial support. Systems were established to ensure that all parents fulfilled their financial obligations in respect of dependent children, including

⁵² A Crown entity differs from an SOE in that the later is, as discussed above, set up under the State Owned Enterprises Act (1986) to act competitively as would any privately owned business. A Crown entity, also known as a state owned company or a Crown owned company, is established under its own legislation with social, cultural or public policy goals.

⁵³ For a discussion of the changes in housing policy and their impact see Eric Pawson, 'The State and Social Policy', in *Changing Places: New Zealand in the Nineties*, ed. by Richard Le Heron and Eric Pawson (Auckland: Longman Paul, 1996), pp.210-246; Laurence Murphy, 'Housing Policy,' in *Redesigning the Welfare State in New Zealand: Problems, Policies and Prospects*, ed.

legislation and inter-country agreements which allow monies owed to be deducted from income, both in New Zealand and abroad.

E: The Impact of Change

In combination the changes that took place in the private sector, together with those in the public sector and in social policy in the period between 1984 and the end of the century denote a significant shift in successive governments' views as to the appropriate role for the state in providing for the well-being of all New Zealanders. Examination of changes in government policy reveal a trend away from the state as a universal provider and protector of the community, toward a greater emphasis on the individual's role in assuring both their own welfare and the welfare of the wider community. Business was expected to operate profitably in the market with minimal state support, or shift its resources to an activity where it would do so. Individuals were expected to accept a greater role in providing for the welfare of themselves and their families, although the state retained a level of interest as provider in areas such as housing, education and health.

Measures introduced by successive governments in the period 1984-1999 significantly altered an approach to governance which had been accepted and acted upon by governments of both political parties since the 1930s. There was, as is often stated, and is discussed above, a shift in the orthodoxy, a revolution altering the relationship between the state, the community and the individual across all sections of New Zealand society. This has been described as a shift from *welfare* capitalism, where the state had an active role in ensuring community welfare, to *welfare capitalism* where the greater emphasis is given to providing the conditions under which individual citizens can provide for their own welfare.⁵⁴

by Jonathan Boston, Paul Dalziel and Susan St John (Auckland: Oxford University Press, 1999), pp.218-237.

⁵⁴ Peggy Koopman-Boyden, 'Social Policy: Has There Been One?' in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.213-231 (p.213).

For many New Zealanders this situation is considered to have increased opportunities and promoted individual welfare, but for others the opposite has been the case.

Among middle and high income groups the reforms were generally popular, the dominant view being that the reforms were both inevitable and beneficial. Among low income groups it was more difficult to know, since these groups were less articulate at expressing their views. But it is certain that the negative effects of the reforms bore more heavily on the poor than on the rich – Labour’s policies reducing the supply and security of jobs on which semi and unskilled workers depended, and National’s policies increasing the financial hardships associated with low pay and unemployment.⁵⁵

Indicators commonly accepted as a measure of welfare provide conflicting information. While economic growth increased after 1984, an increasing number of New Zealanders lived in poverty.⁵⁶ During the 1980s the gap between the wealthy and the poor increased faster in New Zealand than in any other member of the OECD.⁵⁷ The number of New Zealanders dependent on benefits rose, during a time when, with the state benefit cuts, the standard of living of beneficiaries was falling.⁵⁸

Particular groups of New Zealanders were over represented among those living in poverty.⁵⁹ For example single parent families, 73 percent of whom were, in 1996, living below the so-called poverty line, made up 21 percent of those who were poor in New Zealand.⁶⁰ Māori were also over represented among low income groups, and among the unemployed. In 1995 the unemployment rate for Māori

⁵⁵ M.C.Brown, ‘Policy-induced Changes in Māori Mortality Patterns in the New Zealand Economic Reform Period’, *Health Economics*, 8 (1999), 127-136 (p.128).

⁵⁶ For a discussion of the impact the economic reforms have had on poverty in New Zealand see Cheyne et al., *Social Policy in Aotearoa New Zealand*, pp.184-19; Brian Roper, ‘The Changing Class Structure’, in *The Political Economy of New Zealand*, ed. by Chris Rudd and Brian Roper (Auckland: Oxford University Press, 1997), pp.79-99.

⁵⁷ ‘For Richer, For Poorer’, *Economist* 5 November 1994; Joseph Rowntree Foundation, *Inquiry into Income and Wealth* (London: Joseph Rowntree Foundation, 1995), cited in Cheyne et al., *Social Policy in Aotearoa New Zealand*, p.185.

⁵⁸ Stephens, ‘Budgeting with the Benefit Cuts’; C. Waldegrave, B. Stephens and P. Frater, ‘Most Recent Findings in the New Zealand Poverty Measurement Project’, *Social Work Review*, 8 (1996), 22-24.

⁵⁹ Poverty is identified and defined in a range of different ways. For a discussion of ways of measuring poverty in New Zealand see Robert Stephens, Charles Waldegrave, and Paul Frater, ‘Measuring Poverty in New Zealand’, *Social Policy Journal of New Zealand*, Issue 5 (1995), pp.88-111.

was three and a half times higher than that for Pakeha.⁶¹ However, as Poata-Smith points out, for Māori, deprivation is indicated in a range measures, including poor educational outcomes, poor health, high rates of imprisonment and dependency on the state.⁶² While there may have been some improvement in these indicators for Māori, the inequalities between Māori and non-Māori have not decreased.⁶³

This section has discussed some of the changes in New Zealand's public policy. However, the state does not operate in isolation from the community, nor does New Zealand operate in isolation within the international community. The following sections will explore the influences for change, political, economic and social, within New Zealand and in the international arena which sparked a radical shift after 50 years of relative stability.

III: Pressure for Change

The developments in New Zealand since 1984 reflect changes evident in other western democracies. That these changes have taken place rapidly and to such an extent is in part due to the crisis situation in which New Zealand found itself in 1984. This section will examine the events which contributed to that crisis and the solution adopted.

A: New Zealand in the International Community

New Zealand was not alone in experiencing a period of economic and political turmoil in the final two decades of the millennium. Around the world states with various political systems and at all stages of development confronted upheavals unprecedented since the end of the Second World War. For developed democracies in the Western world the changes came on the heels of the extended period of economic stability and prosperity which followed World War II.

⁶⁰ C. Waldegrave et al., 'Most Recent Findings in the New Zealand Poverty Measurement Project'.

⁶¹ Evan Te Ahu Poata-Smith, 'The Political Economy of Inequality Between Māori and Pakeha', in *The Political Economy of New Zealand*, ed. by Chris Rudd and Brian Roper (Auckland: Oxford University Press, 1997), pp.166-179 (p.161).

⁶² Poata-Smith, 'The Political Economy of Inequality Between Māori and Pakeha', p.164.

⁶³ Ministry of Māori Development, *Progress Towards Closing the Social and Economic Gaps Between Māori and Non-Māori* (Wellington: Te Puni Kokiri, 2000), p.6.

During World War II a determination emerged to avoid the economic mistakes perceived to have contributed to the Great Depression and the war itself. International agreements arising out of the 1944 conference at Bretton Woods introduced a range of strategies designed to ensure stability in the international financial sector and promote international trade. While these measures may not always have worked perfectly the machinery existed to assist in the development of the international economy. Institutions including the International Monetary Fund (IMF) and the International Bank for Reconstruction and Development (IBRD or World Bank), and later the General Agreement on Tariffs and Trade (GATT), encouraged movement toward the liberalisation of world trade, a move which it was believed would advance international co-operation and peace. In the post-war years the international economy experienced a period of prosperity and growth which was to last through the 1950s and 1960s.

This international prosperity both contributed to and was reflected in the New Zealand situation. As a small state with an economy reliant on export income, participation in the international community has always been important to New Zealand. Security - economic, political and military - has been pursued through good relations with other states. New Zealand depended upon stable overseas markets for its commodity exports, suppliers for imported goods and international investment to promote economic growth.

New Zealand benefited from its traditional close links with the United Kingdom, still considered by many at the time to be the mother country. This relationship, both with the domestic community,⁶⁴ and in terms of foreign policy, security and trade was deemed to be an important component of the country's prosperity and stability.

During the post-war period New Zealand's economic growth was fuelled by international trade in commodities for which prices were good and demand was high. However, realising that commodity producers were vulnerable to fluctuations in the international market, New Zealand moved at various times to

safeguard the domestic economy with a range of protective measures.⁶⁵ In addition the New Zealand government, like other Western democracies, followed Keynesian economic recommendations, using demand management to ensure macroeconomic goals including employment.

In 1973 a series of incidents was to end the economic prosperity both for New Zealand and around the world. Britain joined the European Economic Community (EEC), changing Britain's status as a virtually guaranteed market for New Zealand's agricultural produce and forcing New Zealand to diversify its markets. Commodity prices, which had boomed in the early 1970s, collapsed in 1973. The first of the oil shocks raised the price of both fuel and transport, on which New Zealand's export industries relied.

The year 1974 was the beginning of an international recession. Attempting to reverse the economic downturn, which caused a slow down in economic growth and a rise in unemployment, other states embarked upon economic restructuring processes, labelled Reaganomics in the United States and Thatcherism in the United Kingdom. Furthermore, the international economy changed in ways which made it difficult for a state to maintain domestic sovereignty in economic matters. The rise of Transnational Corporate Enterprises (TCEs), changing technology and the rise of the New Right as an economic philosophy in the world's major economies forced states to come to terms with the international market economy. In addition the international institutions which provided liquidity were based on the ideals of the free market.⁶⁶

New Zealand, meanwhile, responded to changes in the international economy by borrowing in the international finance markets and increasing the level of trade protection. While its dependence on the international economy remained high New Zealand became increasingly isolated from it and the lessons it had to offer.

⁶⁴ John Gould, 'Past and Present in New Zealand's Economic Dependence', in *New Zealand in the World Economy*, ed. by Hyam Gold (The Papers of the Nineteenth Foreign Policy School 1984, University of Otago, 1984), pp.8-16 (p.11).

⁶⁵ For a discussion of these and other responses to the international economic situation see Paul Wooding, 'New Zealand in the International Economy', in *State and Economy in New Zealand*, ed. by Brian Roper and Chris Rudd (Auckland: Oxford University Press, 1993), pp.91-107.

⁶⁶ Kelsey, *The New Zealand Experiment*, pp.16-17.

The country was living beyond its means to preserve a way of life it had built during more prosperous times. The failure of the Muldoon government to recognise and adjust to the imperatives of the international economy took New Zealand deeper into economic crisis. Inflation rates were high, unemployment grew, economic growth was stagnant and the New Zealand dollar was overvalued.

In July 1984, New Zealand's economic situation had reached a critical point, emphasised by the foreign exchange crisis that developed as New Zealand speculators bought foreign currency in anticipation that the dollar would be devalued after a Labour party election victory.⁶⁷ This, combined with the ongoing economic decline, provided a climate within which a radical programme of change could be introduced. There was wide acceptance that it was vital a way be found to improve New Zealand's economic performance and restore the nation's credibility in the international economy. Sharp wrote in 1994:

By the time the Fourth Labour Government set in train the multiple challenges to state and nation required by a neo-liberal model, New Zealand's underdeveloped state was in crisis. The rationale upon which it had been based had collapsed in the 1960s and 1970s, in part because of the defection of the imperial power, in part because the domestic accommodation overseen by the state was in disarray. Unable to take the opportunities proposed by the import-substitution model ... the state drifted into a policy limbo.⁶⁸

B: Treasury's Solution - A Framework for the Way Forward

It is widely accepted that before the 1984 election the electorate was not aware of the direction the Fourth Labour Government's economic policy would take. It has also been suggested that the government's economic direction differed from Labour Party policy before the election.⁶⁹ Minister of Finance, Roger Douglas, had given some indication of his intention to follow a more-market direction in

⁶⁷ It was known that Roger Douglas, who it was expected would be Finance Minister in the Labour Government, favoured devaluation of the New Zealand dollar. Devaluation had been an aspect of his Economic Policy Package. See Jesson, *Fragments of Labour*, pp.63-64.

⁶⁸ Nigel Haworth, 'Neo-liberalism, Economic Internationalism and the Contemporary State in New Zealand', in *Leap into the Dark: The Changing Role of the State in New Zealand Since 1984*, ed. by Andrew Sharp (Auckland: Auckland University Press, 1994), pp.19-40 (p.22).

⁶⁹ For a discussion of the formulation of the Labour Party's economic policy prior to the 1984 election see Jesson, *Fragments of Labour*, pp.55-62.

economic policy, but the consistent adherence to a philosophy of neo-liberalism by the Fourth Labour Government can, at least in part, be credited to the advice of public service officials, particularly those in the Treasury.

Treasury and its officials enjoyed a high level of influence in most areas of public policy.⁷⁰ Goldfinch and Roper outline four sources of Treasury's power. First, it sets the agenda which determines the policy alternatives to be considered. Second, its role as financial controller requires it to comment on all matters before Cabinet with economic implications. Third, Treasury has a dominant position and reputation within both the bureaucracy and in the private sector, and fourth, because of its links with the business community "a government which consistently ignored Treasury advice would risk losing business confidence."⁷¹

Treasury's advice reflected the economic philosophy prevailing in the international community; neo-liberalism. However, Treasury's policy advice went further than neo-liberal economics to the ideas of New Right neoclassicism.

According to Goldfinch and Roper:

Treasury has indeed adopted New Right neoclassicism in relation to both its broad philosophical conception of the State in society and to its specifically economic framework....[*Economic Management* (1984), *Government Management* (1987) and *The Brief to the Incoming Government* (1990)] extensively borrow from the writers of the New Right, often verbatim and without due consideration of the limitations of their theoretical arguments and empirical findings, nor of the appropriateness of applying them in New Zealand's specific social and economic context.⁷²

The material in the government briefing papers represented a particular ideological perspective. However, according to Bunkle:

[T]he market policies set out in the briefing papers *Economic Management*, were not presented as political ideology. The

⁷⁰ Jonathan Boston and Fiona Cooper, 'The Treasury: Advice, Coordination, and Control', in *New Zealand Politics in Perspective*, ed. by Hyam Gold, 2nd edn (Auckland: Longman Paul, 1989), pp.123-144 (p.123).

⁷¹ Shaun Goldfinch, and Brian Roper, 'Treasury's Role in State Policy Formulation During the Post-War Era', in *State and Economy in New Zealand*, ed. by Brian Roper and Chris Rudd (Auckland: Oxford University Press, 1993), pp.50-73 (p.52).

⁷² Goldfinch and Roper, 'Treasury's Role in State Policy Formulation during the Post-War Era', pp.55-56.

government would have had difficulty getting them accepted in that form. Instead, they were presented as scientific and natural truth, and this illusion of scientific objectivity was an important reason for the early acceptance of laissez faire dogma by the National and Labour cabinets, caucuses and party organisations.⁷³

In prescribing a neo-liberal economic framework as the way forward Treasury had support in international institutions, including the IMF and the World Bank.

The power of Treasury's advice to politicians since 1984 and the paradigm in which that advice was situated have made a major contribution to the shape of public policy in the period since. The role of individualism in the philosophies of neo-liberalism and the New Right is discussed in detail in Chapter Two. However, while the degree of its influence was very considerable, Treasury was not alone in pushing New Zealand away from the community orientated, greater-good focus of the post-war, welfare state years. The next section examines the social changes which also influenced the shift.

IV: Change in New Zealand Society

In the 1950s and 1960s New Zealand society enjoyed a period of stability and prosperity after the uncertainty and deprivation of the Great Depression and World War II. New Zealand society during this time has been described as homogeneous, both in social and political terms. Supported by a developing welfare state, initiated by the first Labour government in the 1930s, and dominated by the majority British culture, New Zealand society was egalitarian and conformist. New Zealanders saw themselves as individualist, but believed that everyone had the right to a 'fair go' in terms of opportunities and access to social services which would protect them from the shifting fortunes of life.

⁷³ Phillida Bunkle, 'The Economy: Restructuring and Growth', in *New Zealand in Crisis*, ed. by David Novitz and Bill Willmott (Wellington: GP Publications, 1992), pp.72-80 (p.73). See also cited material in Bruce Jesson, 'The Almost Uncontested Victory of the Libertarian Right', *The Republican* (July 1988), 7-14 (p.9).

A number of writers have described a consensus within New Zealand during these years.⁷⁴ Such a consensus view is also noted to have been present in other countries which adhered to values centred around the needs of the entire community, and accepted the welfare state and the Keynesian economics which made it possible.⁷⁵ Not all New Zealanders fitted neatly into this strongly British, male view of New Zealand society, but the pressures to conform made opposition difficult for groups, including Māori and women, who did not reap the benefits of the so-called egalitarian society.⁷⁶ There were issues of conflict during this time and groups did challenge the status quo, but for the most part New Zealand society fitted within very narrow boundaries, accepting the services provided by the welfare state and conforming within a range of norms acceptable to society.⁷⁷

During this period there was little to differentiate the two major political parties operating in New Zealand.⁷⁸ While the National Party and the Labour Party represented different constituencies, each saw the welfare state, albeit managed differently, as the conduit through which their aims for New Zealand could be achieved. As noted earlier, both parties followed Keynesian economics and saw an interventionist role for government in the pursuit of New Zealand's prosperity.

The shape of New Zealand society was, however, changing. Population growth in the post-war years was rapid, averaging over two percent.⁷⁹ Immigration made a significant contribution to the rising population with immigrants coming from Britain, Europe and later the Pacific Islands and Asia. As a consequence the ethnic make up of New Zealand society was changing. According to census data the percentage of the population identified as European fell from 93.6 percent in

⁷⁴ Writers discussing the consensus which existed in New Zealand during this period include James, *New Territory*, pp.9-35; Robert Chapman, 'Political Culture: The Purpose of Party and the Current Challenge' in *New Zealand Politics in Perspective*, ed. by Hyam Gold, 2nd edn (Auckland: Longman Paul, 1989), pp.14-32; Bruce Jesson, Allanah Ryan and Paul Spoonley, *Revival of the Right: New Zealand Politics in the 1980s* (Auckland: Heinemann Reid, 1988), pp.26-28.

⁷⁵ Koopman-Boyden, 'Social Policy', p.213.

⁷⁶ Cheyne et al., *Social Policy in Aotearoa New Zealand*, p.21.

⁷⁷ One such issue was the watersiders strike of 1951.

⁷⁸ Austin Mitchell, *Politics and People in New Zealand* (Christchurch: Whitcombe and Tombs, 1969), p.140.

⁷⁹ Royal Commission on Social Policy, *The April Report: Report of the Royal Commission on Social Policy*, Vol.1 (Wellington: The Commission, 1988), p.49.

1945 to 88.1 percent in 1976 while the Māori population grew from 5.8 to 8.8 percent and other races from 0.6 to 3.1 percent.⁸⁰ While in the post-war years the census records divided all residents into either European, Māori or other races, specifying only four races in that category, by 1991 the ethnic origins of 31 groups were identified specifically and this number does not include combinations of those groups. Reducing the 1991 figures back into the original categories identifies 79.5 percent European, 9.7 percent New Zealand Māori, 6.6 percent other races, while 4.3 percent are ethnic combinations.⁸¹

Despite its distance from the major influences of western society, New Zealand followed many of the trends seen in other nations as, in the late 1960s and 1970s, signs of social change began to emerge. Accepted patterns of gender roles, sexuality and racial norms were challenged by the women's movement, gay liberation and a wave of Māori nationalism.

No longer was it possible to describe New Zealand as the homogenous society whose members were willing to conform in order to improve the welfare of the whole community. Differentiated factions within society began to demand social services designed to meet their members' individualised needs. A one-size-fits-all service was no longer acceptable.⁸² Human Rights legislation and attention to the rights of minority groups within society supported a more individualised approach to the needs of New Zealanders. These changes, in combination with the increasingly heterogeneous nature of New Zealand society, made previous service delivery styles inappropriate in the 1980s and 1990s.⁸³

Changes in society were reflected in the way New Zealanders choose their political representatives. Where as at one time voting patterns had been stable and electoral results relatively predictable, this has become increasingly less the case, with people changing their voting habits. Jack Vowles and others discuss

⁸⁰ Department of Statistics, *1976 Census of Population and Dwellings*, Vol.7 (Wellington: Statistics New Zealand, 1976), p.8.

⁸¹ Department of Statistics, *1991 Census of Population and Dwellings* (Wellington: Statistics New Zealand, 1991), p.31.

⁸² Health Benefits Review, *Choices for Health Care: Report of the Health Benefits Review* (Wellington: The Review, 1986), p.1.

⁸³ Koopman-Boyden, 'Social Policy', p.216.

New Zealanders' increasing volatility rate,⁸⁴ speculating on the reasons behind it.⁸⁵ While increasing electoral volatility reflects, to a certain extent, the international trend, the New Zealand rate has been higher than European averages from 1970 onward.⁸⁶

The changes in New Zealand society can be explained in a number of different ways, but it is likely that the explanation is to be found in a combination of factors. One explanation is in the postmodernist rejection of the dominance of the expert, and the move away from an unquestioning adherence to the scientific explanation which had motivated citizens to follow the dictates of the state and its institutions.

Another explanation is found in the generational change.⁸⁷ The generations emerging to test their ideas in the late 1960s and 1970s did not remember well the deprivations of the Great Depression and World War II, so they were less influenced by the factors which had motivated their parents to conform in order to ensure security. Furthermore, they had benefited from the provisions of the welfare state, enjoying a higher level of education, health and welfare than any previous generation. This was also the generation for whom travel became common, and young New Zealanders returned with experience of life in cultures less conformist than their homeland. A rebellion against the constraints of New Zealand society began to emerge.

⁸⁴ The volatility rate is defined as “[measuring] the net percentage of voters switching parties and moving into and out of nonvoting” Jack Vowles and Peter Aimer, *Voters Vengeance: The 1990 Election in New Zealand and the Fate of the Fourth Labour Government* (Auckland: Auckland University Press, 1993), p.247.

⁸⁵ For a full discussion of electoral volatility see Vowles and Aimer, *Voters Vengeance*, pp.14-15; Jack Vowles, Peter Aimer, Helena Catt, Jim Lamare and Raymond Miller, *Toward Consensus: The 1993 Election in New Zealand and the Transition to Proportional Representation* (Auckland: Auckland University Press, 1995), pp.41-60; Jack Vowles and James Lamare, ‘Party Interests, Public Opinion and Institutional Preferences: Electoral System Change in New Zealand’, *Australian Journal of Political Science*, 31 (1996), 321-345. (p.323); Jack Vowles, ‘Aspects of Electoral Studies, Present and Past: New Zealand Voters and ‘the System’, 1949-1996, *Political Science*, 50 (1998), 90-110 (pp.99-101).

⁸⁶ Vowles et al., ‘Aspects of Electoral Studies, Present and Past’, p.43.

⁸⁷ Colin James points out that major change in New Zealand has come with each second generation, suggesting that it is a reaction against the stability of the preceding generation. Colin James, *The Quiet Revolution: Turbulence and Transition in Contemporary New Zealand* (Wellington: Allen & Unwin / Port Nicholson Press, 1986), pp.9-10.

New Zealand during the Muldoon years was a nation whose powerful elite were attempting to deny the changes taking place in the outside world, particularly in the international economy. This had a potent impact on some New Zealanders who were forced to wait for change, knowing that there was another way, but compelled to tolerate the regulation and protectionism which was the government's attempt to maintain an earlier standard of living despite changes in international economic conditions.

When economic change did take place its guiding philosophy was another influence in the shifting nature of New Zealand society. As has been discussed above, individualism is at the foundation of neo-liberal political economy adopted by the Fourth Labour Government after its election in 1984. Individual New Zealanders were forced to come to terms with the withdrawal of the state from the economy and business. As the programme of structural adjustment progressed into the welfare state New Zealanders were subject to the expectation that they would take a higher level of responsibility for their own welfare and that of their family. While that has been problematic for some sections of society, others have embraced the challenge. The idea that they had choices motivated many New Zealanders to give more consideration to their decisions. In seeking information on which to base their decisions many have become aware of the entire range of alternatives. Some have thus rejected practices previously endorsed by both the state and society. It is not possible to conclude that this reaction to neo-liberalism is responsible for the increasing diversity among New Zealand society, but it must be considered along with the postmodern explanation and generational differences.

In part because of the role individual citizens are now expected to take and in part because of moves to protect and maintain existing levels of service a level of consumerism has emerged with the result that New Zealanders are no longer unquestioningly grateful for a beneficent welfare state. They now want to ensure that they are getting what they are entitled to and that what is being provided is safe.

Individualism has long been considered a characteristic of New Zealanders. There is disagreement, however, as to whether European immigrants settling in New Zealand were the rugged individualist types widely considered to have settled America, or if they were more concerned with creating a society in which co-operation would ensure security.⁸⁸ The emergence of the contemporary New Zealander has been a long process and the factors that have contributed to individualism in late twentieth century New Zealand society are many, as are expressions of that individualism.

Many New Zealanders have welcomed individualism because it allows them to follow personal value choices free from state interference. This is expressed both within conservative and liberal sections of society. Others have accepted the demands of neo-liberal individualism and now pursue their rights and responsibilities in line with expectations prevailing in the public sector. For yet another group, however, the rising level of individualism has imposed a strain on their personal and financial resources with negative outcomes. One of the central issues for this group is increasing poverty. This matter has been introduced above and is discussed further in Chapter Four.

The understanding and expression of individualism takes a variety of forms. Some people recognise individualism as an extreme adherence to the rights of the individual alone. Others see in individualism those rights, but combined with responsibility both to themselves and to other individuals. Some see individualism as a particular brand of community while others see individualism as something entirely apart from community, if they recognise the existence of such an entity. The variety of expressions of individualism are examined in Chapter Two.

⁸⁸ Mary Boyd, 'Australia-New Zealand Relations', in *Australia, New Zealand and the Pacific Islands Since the First World War*, ed. by William S. Livingstone and W. Roger Louis (Canberra: Australia National Press, 1979), p.48, cited in James, *The Quiet Revolution*, p.11.

V: Conclusion

The period between the election of the Fourth Labour Government in 1984 and the Labour-Alliance Coalition's assumption of the Treasury benches in the closing weeks of the twentieth century saw a progressive, but fundamental transformation in the relationships between the state, the community and the individual in New Zealand. The influence of neo-liberal individualism has been a significant, if not the dominant factor in New Zealand's progress away from its history as a welfare state, toward a situation where market mechanisms have a leading role not only in the private sector, but also in the public sector and in the implementation of social policy.

While neo-liberal individualism has a particular understanding of the role and responsibilities of the individual, there has also been a change in individual New Zealander's behaviour and expectations within society. As individuals are increasingly expected to assume personal responsibility for aspects of their lives in which the state would previously have had a significant role, individual New Zealanders have focused on and taken up their right to control and make choices in their lives. Many New Zealanders have become less concerned with the impact of their choices on society as a whole, and more concerned with the options open to them and their families.

There are, however, conflicts, both within the application of neo-liberal individualism and between neo-liberal individualism and what this thesis will refer to as civil individualism. Thus the achievement of some policy goals has been hampered. This thesis will explore this conflict using childhood immunisation policy as a case study. First it is important to explore the development of the concept of individualism in more detail, examining its various expressions and interpretations. This is addressed in Chapter Two.

Chapter Two

INDIVIDUALISM

I: Introduction

The individual was one of the significant elements in the building of modern western civilisation, with much discussion about the attributes and capacities of the individual human person. This focus on the individual has been the starting point for attempts both to describe how the world of human interaction works, and to prescribe how it might work better. Although the idea, or, more accurately, the set of ideas about the place, role and potential of the individual preceded the term by many centuries, this train of scholarship has been labelled *individualism*.¹

Individualism is, however, a term used with notorious lack of precision. Certainly over the centuries various scholars have contributed to the understanding of what an individual is and how they fit in, both with other individuals and within society. Furthermore, this understanding has, according to Steven Lukes, informed the development of six doctrines of individualism; political, economic, religious, ethical, epistemological and methodological.² Individualism has been used both as a favourable and a pejorative term, although not always describing the same condition, illustrating the variations in the understanding of the term and the assumptions behind its use.

In addition, given that the state of society and the place of the individual within it has not remained static, the term individualism is used to describe a particular attitude and set of behaviours evident in Western capitalist society as it moved into the new millennium.

¹ The origins of the term individualism are uncertain, but it seems likely to be in the French critique of particular understandings which give more credence to pre-social explanations of the individual. According to Friedrich A. Hayek, *Individualism and Economic Order* (London: Routledge and Kegan Paul, 1949), fn 3, and Steven Lukes, *Individualism* (Oxford: Basil Blackwell, 1973) p.6, the term originated with the Saint Simonians who used it to describe a competitive society. Others have attributed its origins to de Tocqueville.

² Steven Lukes, *Individualism*.

In these circumstances, setting out a comprehensive description of the development and boundaries of individualism, as it can be viewed from the beginning of the twenty-first century, is beyond the scope of this thesis. In order to facilitate the descriptive process some limitations must be acknowledged. First, this chapter does not attempt to provide a comprehensive or exhaustive description of all aspects of individualism, but instead focuses on the theoretical background of expressions of individualism evident in the New Zealand situation and as reflected, to varying degrees, in other western capitalist democracies.

Notably, a significant section of the discussion of individualism takes place within the debate between individualism and communitarianism. While some of that material informs the discussion in this chapter, this thesis will not extend the debate in that context. Another significant body of literature on individualism is in the discipline of psychology, a discussion of which, while important in the understanding of individual and group behaviour, is beyond the scope of this thesis.

Second, in order to do justice to the material to be covered it is necessary to develop an approach which allows the complexities of individualism, complicated by the various usages of the term, to be examined in a logical format, making the important connections between various aspects of the material. To this end Turner's method of distinguishing between the various expressions of individualism has been adapted to provide an appropriate framework.³ The boundaries of this adapted framework are, of necessity, somewhat arbitrary.

Turner first identifies an historical process as "the discovery of the individual." This development of the ideas about the capacity and responsibilities of the individual and their place in society is discussed in Section II of this chapter.

³ Bryan Turner, 'Individualism, Capitalism and the Dominant Culture: A Note on the Debate', *The Australian and New Zealand Journal of Sociology*, 24 (1988), 47-64 (p.56).

Turner's second distinction encompasses the issues at the foundation of Western democratic government in the twentieth century. Turner has labelled this as "a doctrine called individualism which emerged in the seventeenth century in response to the problems associated with individual changes in religion, political behaviour and in property rights."⁴ Section III of this chapter will focus on individualism as the foundation of the modern state in an examination of first, the philosophical foundations of individualism in the political economy and second, its influence in the processes and structures of government and the state at the end of the twentieth century. Attention will also be given to Turner's fourth distinction, that of individuation - "the identification of individuals for the purposes of taxation, surveillance and regulation by the state", alongside the associated concept of personal responsibility.

Section IV departs from Turner's categories in an examination of the individual in the late twentieth century. While it does include discussion of Turner's third distinction, aesthetic individualism, the focus is on what has been introduced above as civil individualism; the expectations individuals have of life, the way they relate to each other within society and react to the institutional arrangements of the state structure.

Section V briefly examines the idea of public good, both as an economic term and in its broader social interpretation.

II: The Discovery of the Individual

The individual human being has long been recognised in the very early ideas of Greek society and Christianity.⁵ They were normally perceived, however, as utilising their individual capacities in the pursuit of the good of their community or society. In the period of the Middle Ages the individual was subsumed to the interests of the society.

⁴ Turner, 'Individualism, Capitalism and the Dominant Culture', p.56.

⁵ Christian Lalive d'Epinay, 'Individualism and Solidarity Today', *Theory, Culture and Society* (1991), 57-74 (p. 55).

It was during the great upheavals of the Reformation, the Renaissance and the Enlightenment that new ideas began to emerge about the place, capacity and potential of the individual and their relationship with and place within society. From this period emerged a number of ideas considered fundamental to western twentieth century understanding of the individual. Lukes's discussion of the basic ideas of individualism isolates the concepts while acknowledging that the ideas "are either mutually exclusive or jointly exhaustive."⁶

These basic ideas, each of which have made a contribution to fundamental principals on which western civilisation was built, indicate the value society attaches to individual human beings. These ideas are often the common thread in otherwise variant philosophies.

These ideas have been seen as a positive individualism, a moral individualism which was not anti-social, indeed was necessary for the building of a strong society.⁷ In contrast are the competitive, egoistic expressions of individualism which will be discussed in a later section.

A: The Supreme and Intrinsic Value of Individual Human Beings

That the individual human being has worth as and of themselves is a fundamental assumption of individualism. Although the New Testament is interpreted as recognising an individual's unique purpose under God, during the Middle Ages, when the society was supreme, the individual was regarded as a building block with a specific purpose, but was dispensable in the interests of the public good.⁸

With the Renaissance came the proclamation that individuals were an end in themselves, a thought to be reiterated by Rousseau, Paine and Kant in various ways.

The many documents which repeat this sentiment include the preamble to the Universal Declaration of Human Rights adopted by the General Assembly of the

⁶ Lukes, *Individualism*, p.44.

⁷ Turner, 'Individualism, Capitalism and the Dominant Culture', p.48, discussing the attitudes Alexis de Tocqueville expressed in *Democracy in America*.

⁸ Ullman, 1901, cited in Lukes, *Individualism*, pp.46-47.

United Nations in 1948 which declares its “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family.”

B: Autonomy

Significant in the understanding of individualism is the idea that individuals are autonomous, capable of thinking for themselves and reaching independent decisions.

That each individual should follow the dictates of their conscience was again a departure from the dictates of the Middle Ages, when one was required to obey the order of a superior. For Spinoza the exercise of thinking for one’s self was central to freedom - in line with Descartes’s consideration “*cogito, ergo sum*”.⁹ Kant, too, linked autonomy to freedom and to morality.

Hobbes identified two forms of autonomy. First, is an intellectual autonomy; a self-reliance in the gathering of information. Second is a moral autonomy; that is the individual has the right to make their own decisions.¹⁰

C: Privacy

The third idea is that each individual has the right to a private existence in a public world. Such a private life was originally perceived as a deprivation, but the right to private reflection expanded to J.S.Mill’s opinion that the individual had the right to control all things which did not have direct concern to others.¹¹

For example de Tocqueville, who was concerned that individuals in a democratic system would isolate themselves from public life, believed that negative liberty, a freedom from interference, was important.¹² There are, of course, various interpretations as to just what should be the private sphere.

⁹ d’Epinay, ‘Individualism and Solidarity Today’, pp.58-59 examines Descartes “first principle of philosophy”.

¹⁰ A.Ryan, ‘Hobbes and Individualism’, in *Perspectives on Thomas Hobbes*, ed. by G.A.J.Rogers and A.Ryan (Oxford: Clarendon Press, 1988), pp.81-105 (p.81).

¹¹ J.S.Mill, *On Liberty* (London: David Campbell, 1972).

¹² Alexis de Tocqueville, *Democracy in America*, rev. edn (London: David Campbell Publishers, 1994).

D: Self-development

This relates to uniqueness, individuality and, as Mills proclaims, the allowance for and tolerance of difference in individuals within society.

The characteristics of individualism were not automatic, but required effort on the part of the individual. This could be tied to individual responsibility.

The development of this set of ideas about the potential of the individual human being, and thus the capacity each has for directing their own lives, led philosophers both to use those ideas in an attempt to explain how the world worked and to speculate on how society might be better organised so as to make the most of that potential.

The theory that society was ordered by and around individual human beings in a series of voluntary relationships and exchanges did, however, form the foundation of a series of prescriptions as to how the world should be organised. It is in these ways of ordering relationships and exchanges between individuals that we find the foundations of western, democratic capitalist society.

The following section examines the influence of individualism, or particular interpretations of it, on the development of the modern state.

III: Individualism as the Foundation of the Modern State

At the turn of the twenty-first century the capitalist democracies of the western world all follow, to a greater or less degree, the practices of neo-liberal political economics. Market mechanisms are employed to facilitate the distribution of goods and services and, while the state provides a safety net for those unable to take care of themselves, there has been a move away from the universal provision of welfare. According to Alain Touraine the focus has moved away from political and social actors toward economic actors, with a dismantling of political and

social controls over economic activity. Touraine contends, as have others, that this contributes to a triumph of individualism.¹³

The foundations of individualism are to be found intertwined with the foundations of the political and economic philosophies which underpin the contemporary system Touraine attacks. This section will trace the origins of this connection between individualism and the contemporary political economy.

A: Political and Economic Philosophy

[T]he individualist view of the purpose of government as protecting individuals' rights and allowing them maximum scope to pursue their interests owes much to Locke, on the one hand, and to the Utilitarians on the other. Lockean liberalism stresses a view of government's role as *protector* of the life, liberty and property of its citizens – above all their property. The Utilitarians on the other hand, provided the rationale for the liberal view of government as holding the ring, as referee, nightwatchman or traffic-policeman, while individuals pursue, in harmonious competition, their several interests.¹⁴

The foundations of the political theory around which the contemporary liberal, democratic states have been built are to be found in the turmoil of the 17th century. It was in this time, a period of significant conflict between various interests in society, religious and secular, that individualism emerged as thinkers of the time attempted to determine what it was that lay behind the successful establishment of a system of political authority. Individualism, however, is recognised as having a much longer history with its roots in the Judeo-Christian tradition.¹⁵ Certainly some of the ideas of individualism discussed in the last section have their origins in times prior to the emergence of seventeenth century liberal political philosophy.

¹³ Alain Touraine, 'Social Transformations of the Twentieth Century', *International Social Science Journal*, 50 (1998), 165-171.

¹⁴ Lukes, *Individualism*, p.84. [emphasis in the original]

¹⁵ See Turner, 'Individualism, Capitalism and the Dominant Culture', p.56.

Any understanding of how a society might be successfully governed is based on assumptions about human nature. The individualist tradition owes its roots to those philosophers who formulated their world views in the light of certain assumptions about the nature, capacities and rights of the individual, the basis on which they might form associations with other individuals and ultimately to the conclusion that the legitimate authority of the state comes from the consent of individuals.¹⁶

Writing in 1962 Macpherson was critical of the political theory that he saw as having emerged from English utilitarian tradition, essentially the theory of Hobbes as amended by Locke and identified as *possessive individualism*.¹⁷ He puts forward seven propositions as underpinning *possessive individualism*.

- (1) What makes a man human is freedom from dependence on the will of others.
- (2) Freedom from dependence on others means freedom from any relations with others except those relations which the individual enters voluntarily with a view to his own interest.
- (3) The individual is essentially the proprietor of his own person and capacities, for which he owes nothing to society.
- (4) Although the individual cannot alienate the whole of his property in his own person, he may alienate his capacity to labour.
- (5) Human society consists of a series of market relations.
- (6) Since freedom from the wills of others is what makes a man human, each individual's freedom can rightfully be limited only by such obligations and rules as are necessary to secure the same freedom for others.
- (7) Political society is a human contrivance for the protection of the individual's property in his person and goods, and (therefore) for the maintenance of orderly relations of exchange between individuals regarded as proprietors of themselves.¹⁸

¹⁶ Lukes, *Individualism*, p.79.

¹⁷ C.B.Macpherson, *The Political Theory of Possessive Individualism: Hobbes to Locke* (London: Oxford University Press, 1962), p.272.

¹⁸ Macpherson, *The Political Theory of Possessive Individualism*, pp.263-264.

Macpherson and other critics maintain that *possessive individualism* and the scholars who contributed to this theory ignored the social nature of humans, both in their creation and situations of living. The early foundations of this theory are to be found, as noted briefly above, in the work of scholars who sought solutions to England's seventeenth century political turmoil, particularly Thomas Hobbes (1588-1679) and John Locke (1632-1704).¹⁹ While individualism is an acknowledged feature of their own and their successors' work, there was also an acceptance of the social influences on individuals.

Hobbes perceived individuals as equals, living in a state of nature, motivated by a drive to avoid death. Their lives were "solitary, poor, nasty, brutish and short". In matters of government he considered that absolute sovereignty would give human beings the best possible chance of living peacefully together. The precondition for this was the consent of individual members of society.²⁰

Jean Hampton, in her analysis of Hobbes' theories confirmed that he was heavily individualist. She states that Hobbes' individualism "regards individual human beings as conceptually prior not only to political society but also to all social interactions. In fact his method of argument relies on and reveals his view that human beings are individuals first and social beings second."²¹ So it seems that Hobbes did not dismiss human's social capacities entirely.

Locke also held individuals to be equal, living in a state of nature. He did not favour absolute sovereign rule, but saw that government should be with the consent of the majority and had a role in the protection of individuals' rights. Locke considered that individuals had property rights, although these were not unlimited, but tied to a share of the commons which would prevent the individual starving. The individual also had the right to the product of his labour – a form of property. Locke was also very keen to ensure that individuals were suspicious of

¹⁹ A brief outline on the early lives of these two scholars and the times in which they lived can be found for Hobbes in Jean Hampton, *Hobbes and the Social Contract Tradition* (Cambridge; Cambridge University Press, 1986), p.5; and for Locke in John W. Yolton, *The Locke Reader* (Cambridge: Cambridge University Press, 1977), pp.1-9.

²⁰ Hampton, *Hobbes and the Social Contract Tradition*, p.105.

²¹ Hampton, *Hobbes and the Social Contract Tradition*, p.7.

authority and he saw that individuals had a responsibility to be on their guard against its dictates.

Among his critics there is a belief that Locke's view of society is atomistic, with individuals living in a state of nature, and that he ignored the social tendencies of human beings. Ruth Grant claims, however, that:

[Locke] recognised the social character of human life and the extent to which individuals develop beliefs, ideas and interests in a social context ... Locke's political argument – that men are born free – is not a sociological claim, but a moral one.²²

Out of their conception of the individual in the state of nature the social contractarians understood government in a specific and limited way. First, political representation was based on the consent of individuals. Second, representation was of the interests of individuals, not of classes or of interest groups, and third, government limited its role to that of protector, creating the conditions under which individuals might pursue their interests.

Although there was a move away from the social contract, the idea that methods and systems which focus on the individual are the best way of arranging society have persisted in some perspectives. In political theory individual consent to government is based on free elections, but the role and operation of the state has also been influenced by individualism which emerges from the ideas and theories of liberal economics.

Liberal political theory and the various assumptions about the role, capacity and responsibilities of the individual have continued to develop, being interpreted in various ways down the years. Tucker explores the role individualism has had in the various liberal traditions in political theory. He identifies a number of assumptions about the individual which have combined in various ways to underpin varieties of liberalism:

- (1) The resources of the world, including the person and talents of all individuals, are initially unowned and available to all; [Hobbesian anarchy]

²² Ruth W. Grant, 'Locke's Political Anthropology and Lockean Individualism', *Journal of Politics*, 50 (February 1988), 42-63 (p.43).

- (2) Persons own and have a right to control their own talents and body. They may do what they like with themselves provided they do not harm others; [possessive individualism]
- (3) Self-owning persons can acquire moral rights to unequal amounts of external resources; [possessive individualism]
- (4) Raw, external resources should be regarded as initially jointly or collectively owned - they are not available to private appropriation; [egalitarian individualism]
- (5) All the resources of the world, including the person and talents of all individuals, are initially collectively owned; [Rawlesian collectivism]
- (6) Only individual persons enjoy rights; there are things no person or group may do to them.²³

Examination of Tucker's analysis reveals the impact the understanding of the individual has had on political theory and political systems through time. He has used Macpherson's label of possessive individualism to describe two characteristics attributed to individualism, points 2 and 3, which, he theorises, when used in combination indicate a commitment to neo-liberal individualism.

Tucker variously attributes other characteristics assigned to individuals as indicating the various levels of adherence to individualism within a range of liberal political philosophies advocated by scholars including Rawls, Buchanan, and Hayek. As Tucker's work suggests, philosophers have built on, or departed from the work of Hobbes and Locke, developing various understandings of how individuals function and prescriptions for the shape of the environment in which they would function best, both for their own benefit and for the good of society as a whole. These understandings include components relating to the capacities and requirements of individuals, individuals' rights, and the role of government in the lives of individuals. In economic terms these assumptions formed the basis of understandings about how wealth could be maximised. Fundamental to expressions of individualism is the relationship between the individual, the society they live in and the agent of that society - the state.

²³ David F.B. Tucker, *Essay on Liberalism: Looking Left and Right* (Dordrecht: Kluwer Academic Publishers, 1994), p.141.

There is a great deal of debate about the selfishness, or inward regarding nature of individualism. On the one hand is the interpretation recognised as *atomism*, whereby the individual exists outside of society, making choices with no regard for other individuals, as though their actions do not have consequences for others.²⁴ On the other hand there is *moral individualism* whereby the individual has the right to make decisions for themselves, although not without regard for others.

John Stuart Mill, in *On Liberty*, discusses what he saw to be a balance of authority between the individual and society. He saw individuals as having sovereignty in all things that concerned themselves alone, but as having an obligation to the society of which they are a member in respect of matters which would have an impact on others. He said:

It would be a great misunderstanding of this doctrine to suppose that it is one of selfish indifference, which pretends that human beings have no business with each other's conduct in life, and that they should not concern themselves about the well-doing or well-being of one another, unless their own interest is involved.²⁵

There were those, however, who were concerned that the pursuit of individual rights would prevent persons from recognising their role and responsibility in society. Alexis de Tocqueville, in his examination of the emerging American democratic society, feared that individualism born of democracy would see the retreat of individuals into the realm of privacy, with a consequential decline in the very public institutions that would sustain the democratic system. It was participation in those local voluntary institutions that he saw as the value of the democratic system.²⁶

Thus there was a tension between the fear that democracy would lead to the collapse of social connections, and the value put on the idea that participation in a democracy is voluntary and would free the individual from obligations to which

²⁴ Some, with a pejorative view of individualism use the terms inter-changeably; for example Crittenden.

²⁵ Mill, *On Liberty*, p.144.

²⁶ de Tocqueville, *Democracy in America*, Vol.II, pp.98-105. Many writers have discussed the paradox in de Tocqueville's attitude toward individualism. These include Turner, 'Individualism, Capitalism and the Dominant Culture', p.48-49.

they did not consent. Manent points out that neither the fears of the first group nor the hopes of the second have been fully realised.²⁷

A great deal of both praise and vitriol has been directed toward those early economic philosophers who advocated individualism and the superiority of the market. It is to these scholars that the idea of economic rationalism has been attributed. Adam Smith (1723-1790) considered that the wealth of a nation was the outcome of the efforts of all its members pursuing their own individual self-interests. Smith had great faith in the market, unfettered by government interference. He considered that there was a hidden or invisible hand operating to ensure that the market cleared. He opposed the mercantilist tendency for tariffs on trade, favouring free trade between nations, so that each might pursue its comparative advantage. Smith was not, however, without respect for the value of society or recognition of the responsibility individuals had to one another, a position often overlooked by neo-liberals using his name to support an unfettered market.²⁸

Friedrich Hayek, widely identified as one of the founders of the neo-liberal individualist political economy, has drawn a line between those who he sees as having contributed to a positive individualism and those who formulated a negative, or rationalist individualism. The first he labelled true individualism, and included the following writers in this group; John Locke, Bernard Mandeville, David Hume, Josiah Tucker, Adam Ferguson, Adam Smith, Edmund Burke, de Tocqueville and Lord Acton. Hayek was a great supporter of Adam Smith, believing there to be much more to his understanding of human nature and behaviour than just the economic rationalism he has been credited with following, particularly by his detractors.

Those labelled as presenting a negative, or rationalist individualism were the French and those in the Cartesian tradition. Hayek was concerned that the Benthamites were more influenced by this second meaning of individualism. He

²⁷ Pierre Manent, 'On Modern Individualism', *Journal of Democracy*, 7 (1996), 3-10 (p.3).

²⁸ Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations, and The Theory of Moral Sentiments*.

included Rousseau and the social contractarians in this description.²⁹ It is this narrow Cartesian rationalist individualism which Hayek deplors, believing it “has persistently proved a grave obstacle to an understanding of historical phenomena”.³⁰

According to Hayek, individualism “is primarily a *theory* of society, an attempt to understand the forces which determine the social life of man, and only in the second instance a set of political maxims derived from this view of society.”³¹

However, he also wrote that:

The chief concern of the great individualist writers was indeed to find a set of institutions by which man could be induced, by his own choice and from the motives which determined his ordinary conduct, to contribute as much as possible to the needs of all others: and their discovery was that the system of private property did provide such inducements to a much greater extent than had yet been understood.³²

It is not, Hayek states, that true individualism is about selfish interests and desires, but rather that it allows each individual to follow the course they consider to be desirable. Nor is it that all men are equal, but rather “that no man is qualified to pass final judgement on the capacities which another possesses or is be allowed to exercise.”³³ Hayek notes that the inequalities of man allow for such a system because “we can allow each individual to find his own level.”³⁴

Individualism, in Hayek’s interpretation, does not prevent association, but rather it is opposed to coercion to bring about association. “True individualism is, of course, not anarchism, which is but another product of the rationalistic pseudo-individualism to which it is opposed. It does not deny the necessity of coercive power but wishes to limit it - to limit it to those fields where it is indispensable to prevent coercion by others and in order to reduce the total of coercion to a minimum.”³⁵

²⁹ Friedrich A Hayek, *Individualism and Economic Order* (London: Routledge and Kegan Paul, 1949), pp.4-5.

³⁰ Hayek, *Individualism and Economic Order*, p.10.

³¹ Hayek, *Individualism and Economic Order*, p.6. [emphasis in the original]

³² Hayek, *Individualism and Economic Order*, pp.12-13.

³³ Hayek, *Individualism and Economic Order*, p.15.

³⁴ Hayek, *Individualism and Economic Order*, p.16.

³⁵ Hayek, *Individualism and Economic Order*, pp.16-17.

There is a close and contributory relationship between individualist political philosophy and the economics of capitalism.³⁶ The rise of private property, competition and individual effort as part of the move into the industrial age was related to the recognition of the individual's role in and contribution to society. Significant in these conditions were economic freedom and private property so the individual might seek to maximise his self development.³⁷

There is on the one hand a view of individualism which is positive and allows for the participation of the individual in society and, on the other, a view which is atomistic and isolates the individual in a realm of personal responsibility, unsupported by the state or society. Which perspective was it then that dominated at the end of the twentieth century and why?

B: The Late Twentieth Century Market Economy

The liberal or individualist³⁸ view of the relationship between individuals, civil society and the state emerged over a long period and reflects a very complex development of ideas. While certain capacities have been attributed to the individual and other moral rights similarly assigned, there was an acknowledgement that the individual had a place in society, owing and owed certain obligations in that realm

In the years during which theories of political and economic individualism developed the balance between the individual and the society of which they were a member, and between the state and the market, varied depending upon the degree to which those in power adhered to, or whose circumstances allowed them to adhere to, the philosophy of individualism.

³⁶ Turner, 'Individualism, Capitalism and the Dominant Culture', p.55.

³⁷ Robertson, 1933, cited in Lukes, *Individualism*, p.89.

³⁸ These terms are not intended to be interchangeable.

There was long period in the middle years of the twentieth century during which governments and society accepted a particularly active role for the state. This saw the state grow in size, provide many services which had previously been accessed in the private sector, for example health and education, and participate in commercial activities as a means of achieving their social policy objectives.

In the 1970s and 1980s the search for economic growth and increased efficiency in the state sector prompted a return to the doctrine of individualism. Governments around the world adopted a more liberal understanding of the role of the state, emphasising both the role of the market, and individuals' rights and responsibilities. What emerged in the late twentieth century was, however, built on a very selective reading of those scholars who had contributed to the liberal tradition and individualism. It concentrated, almost to the exclusion of all else on the economic nature of life and the economic factors which motivate individuals.

When, nearly three centuries ago (1714), Bernard Mandeville offered the paradoxical maxim, "private vice: public virtue", the touchstone for an elegant analysis of the then-burgeoning commercial capitalism of western Europe, he provoked praise or scorn in his readers not because he had *discovered* or *revealed* the pervasive selfishness and competitiveness of human nature (these were ancient, often-elaborated facts of life), but because he saw that they might be *welcomed* and *celebrated*. He drew together and expressed forthrightly the steadily more insistent argument of the seventeenth-century economic theorists that the release and encouragement of human competitiveness and self-seeking energies resulted in both a rising material prosperity for individuals and an irresistible growth in national wealth and power. Mandeville thus asked mankind to confront a fateful moral revolution.³⁹

The focus shifted onto the very elements that Mandeville had identified, but to the almost total exclusion of any modifying factors. In the search for prosperity, wealth and power, political leaders denied all but the very strictest individualistic interpretation – as in Margaret Thatcher's denial of the existence of society.

The political economy was dominated by the philosophy of neo-liberalism, with its ideas of individualism, limited government and free market forces. This has

³⁹ Ralph Ketcham, *Individualism and Public Life: A Modern Dilemma* (New York: Basil Blackwell, 1987), p.136. [emphasis in the original]

also been labelled the New Right, although this term combines neo-liberalism with social conservatism, which aims to use government to establish societal order and authority based on social, moral and religious conservatism.⁴⁰ While there are aspects of contradiction between its two strands, they are linked in that social conservatism provides the justifications for the adoption of policies called for by neo-liberal political economic perspectives.

Of neo-liberalism Peters and Marshall say:

On the assumptions of a 'negative' conception of freedom and of market capitalism as the basis for a free society, neo-liberalism favours a minimal or residual state, arguing both that social needs are best met by allowing the market to allocate public goods and that the bureaucratic State is an impediment to smooth resource allocation. This ideology postulates an intimate connection between capitalism and individualism, championing the economic and political freedom of the individual against the State and, indeed against all forces of collectivism.⁴¹

Coburn sets out his assumptions about neo-liberalism thus:

[N]eo-liberalism refers to the dominance of markets and the market model. Though composed of a complex combination of characteristics the basic assumptions of neo-liberalism, the 'philosophy' of the new right are:

1. That markets are the best and most efficient allocators of resources in production and distribution;
2. That societies are composed of autonomous individuals (producers and consumers) motivated chiefly or entirely by material or economic considerations;
3. That competition is the major market vehicle for innovations.⁴²

Neo-liberalism is, to a degree, a restatement of classical liberal ideas. It adopts monetarism which sees a very limited role for government in economic policy - that is the control of the money supply.⁴³ Furthermore there is a belief that the market is a more efficient mechanism for the production and allocation of goods

⁴⁰ Desmond S. King, *The New Right: Politics Markets and Citizenship* (London: Macmillan, 1987), p.2.

⁴¹ Michael Peters and James Marshall, *Individualism and the Community: Education and Social Policy in the Postmodern Condition* (London: Falmer Press, 1996), pp.52-53.

⁴² David Coburn, 'Income Inequality, Social Cohesion and the Health Status of Populations: The Role of Neo-liberalism', *Social Science and Medicine*, 51 (2000), 135-146 (p.138).

⁴³ King, *The New Right*, p.10.

and services than the state, with the consequential belief that the state should be limited in its role, allowing individuals to provide for themselves.

The economic aspects of neo-liberalism are related to a moral individualism, or the conservative belief that state interference in the lives of individuals and the individual family places a limitation on individual autonomy and an individual's right to make choices for themselves. The New Right promotes the idea of self-reliance supported by a successful market economy based on individual effort and competition in order to avoid state intervention and welfare dependency. Nigel Ashford states "I would now favour the market even if it was less productive and efficient, because it is the only *moral* system based on a voluntary choice of individuals and therefore based on the dignity of the individual."⁴⁴

This adherence to the doctrine of individual rights takes moral individualism a great deal further than some of the interpretations discussed above. Some individuals, often called libertarians, claim a very wide private realm, desiring that society and the state allow them to make choices for themselves and their families, while not forcing them to fund the choices other individuals are making in their own private realms. Libertarians are accepting of the emphasis neo-liberal individualism puts on personal responsibility, although there is a demand for protection in the form of strong law and order policies. There is little, if any, acknowledgement in this interpretation, of the impact individual actions and decisions have on society as a whole.

For others this shift to increased levels of personal responsibility has been an unwelcome consequence of changes in the way services are provided. Increasing individualism, with associated increases in personal responsibility were influenced by a particular way of understanding decision making and individual choice; public choice theory.

Public choice theory has been described as "the economic study of non-market decision making."⁴⁵ Alternatively labelled social choice theory, rational choice

⁴⁴ Nigel Ashford, 'The Bankruptcy of Collectivism', in *The 'New Right' Enlightenment*, ed. by Arthur Seldon (London: Economic and Literary Books, 1985), p.45. [my emphasis]

⁴⁵ Dennis C. Mueller, *Public Choice* (Cambridge: Cambridge University Press, 1979), p.1.

theory, the economics of politics and the Virginia School, it emerged from the disciplines of economics and mathematics, using the tools of those disciplines to examine issues within the political realm, including the behaviour of voters, politicians and the bureaucracy.⁴⁶ Its central tenet is the assumption that human individuals are “egoistic, rational, utility maximiser[s]”⁴⁷ so that each will make a series of rational decisions in order to utilise their available resources in a way which will maximise their welfare.

According to public choice theory, however, the tendency to maximise utility is not limited to private individuals in the pursuit of their own and their families’ welfare, but also applies to politicians and bureaucrats in the performance of their elected or appointed positions. Where a private individual’s rationality motivates decisions which will maximise their own utility, a politician operates in a way which will maximise their electoral votes, and a bureaucrat seeks to maximise both their own employment conditions and, more importantly in the public sector, the prestige, power and budget of their department. Such motivation among those responsible for the allocation of public funds leaves them open to capture by interest or pressure groups.

Having accepted this analysis of the behaviour of politicians and bureaucrats, public choice theorists moved to consider ways in which the public interest could be maximised without the burden of an oversized government. The literature has focused on the problems of aggregating individual preferences to maximise a social welfare function. Public choice theory looks at the issues of collective choice and the protection of the public good and liberty.

Public choice theory does not argue against the idea of government entirely, but sees as its role the guarantee of national security, the maintenance of law and order and the satisfaction of voter preferences. This is a minimalist role for the state which limits the discretionary power of politicians through the use of constitutional tools. James Buchanan considers that “Institutions must be

⁴⁶ Iain McLean, *Public Choice: An Introduction* (Oxford: Basil Blackwell, 1987), p.1.

⁴⁷ Mueller, *Public Choice*, p.1.

designed so that individual behaviour will further the interest of the group, small or large, local or national.”⁴⁸

In the New Zealand situation, Treasury, whose significant influence on New Zealand's economic restructuring is discussed above, is in accordance with the public choice theory view of the state sector.⁴⁹ Thus, the reorganisation of the public sector in New Zealand attempted to put in place mechanisms which would constrain the “rent seeking elites.” To achieve this, the reorganisation, as much as possible, separated the functions of policy making, purchasing and service provision in an attempt to improve efficiency in the public sector. “Public choice theory provides support for the privatisation of State enterprises and publicly provided social services.”⁵⁰

There is a strong link between the impact of neo-liberal individualism on the mechanisms of the state and the role each individual member of society is expected to fulfil in assuring their own welfare and that of those who have a legal claim upon them. The next section discusses these expectations.

C: Individuation and Personal Responsibility

Alongside the push for individual rights and individual choice in the neo-liberal paradigm, there are two further, but associated, assumptions: first, that individuals have and will fulfil certain responsibilities; second, that the individual will be subject to surveillance and regulation. This section discusses the place of these two assumptions and the way in which they apparently conflict with other features of modern individualism.

The expectation that as citizens, individuals have a role to play in ensuring their own welfare is behind the catch cry of *personal responsibility*.⁵¹ As has been

⁴⁸ James Buchanan, ‘The Economic Theory of Politics Reborn’, *Challenge: Magazine of Economic Affairs*, 31 (March/April 1988), 4-10 (p.10).

⁴⁹ For a discussion of Treasury’s acceptance of public choice theory see Shaun Goldfinch ‘Treasury and Public Policy Formation’, in *The Political Economy of New Zealand*, ed. by Chris Rudd and Brian Roper (Auckland: Oxford University Press, 1997), pp.60-76.

⁵⁰ Shaun Goldfinch and Brian Roper, ‘Treasury’s Role in State Policy Formulation During the Post-War Era’, in *State and Economy in New Zealand*, ed. by Brian Roper and Chris Rudd (Auckland: Oxford University Press, 1993), pp.50-73 (p.61).

⁵¹ This is sometimes called individual responsibility.

discussed, neo-liberal individualism considers that the most efficient allocation of resources is achieved by the rational individual, making decisions for themselves in a state of freedom. This has been expanded into a maxim of the paradigm in that individuals are expected to take personal responsibility in a range of areas.

In their published debate on the subject of personal responsibility versus social responsibility Schmidtz and Goodin examine the merits of two, not always opposing, views on the best way to ensure the welfare of the citizenry.⁵² Schmidtz puts the case for a society in which individuals take responsibility for their own actions. This is not an argument for atomism or isolation, nor does Schmidtz support the public choice theory perspective of individuals as rational utility maximisers operating in a perfectly competitive market.⁵³ Instead he favours a society in which responsibility is internalised.⁵⁴ Goodin, however, while acknowledging the desirability of individuals taking responsibility for themselves and their families, suggests that a wide range of social, economic and cultural factors act as barriers to this goal.⁵⁵

This debate is extended, with reference to welfare policy, by Deacon and Mann.⁵⁶ On the one hand they identify a group of moralists who perceive a need to restructure welfare policy in a way which encourages responsible behaviour. On the other hand are a group of sociologists who identify barriers to responsible behaviour in the structures of the wider environment.

The central issue is the creation of an environment in which individuals do well. On the one hand are Schmidtz and the moralists saying there is a need for a society in which individuals get the message that there is a way to do things which is best for society as a whole, and part of getting that message across is ensuring that individuals are internalizing their responsibilities, rather than passing them on to others who had no role in creating the situation in the first place. On the other

⁵² David Schmidtz and Robert Goodin, *Social Welfare and Individual Responsibility: For and Against* (Cambridge: Cambridge University Press, 1998).

⁵³ Schmidtz and Goodin, *Social Welfare and Individual Responsibility*, p.5.

⁵⁴ Schmidtz and Goodin, *Social Welfare and Individual Responsibility*, p.8.

⁵⁵ Schmidtz and Goodin, *Social Welfare and Individual Responsibility*, p.99.

⁵⁶ Alan Deacon and Kirk Mann, 'Agency, Modernity and Social Policy', *Journal of Social Policy*, 28 (1999), 413-435.

hand are Goodin, and Deacon and Mann who posit that society is much too complex for individuals to be expected to take personal responsibility for everything. There are too many factors shaping behaviour which are beyond the control of the individual.

In the area of health status and determinants of health there is an ever expanding body of scholarship examining the social, economic and cultural factors which contribute to health or act as barriers to individual control of, or personal responsibility for, health status. The Whitehall Study has found, for example, that in the British public service health status is related to an individual's position in the hierarchy.⁵⁷ Wilkinson has found that in developed nations the aggregate health status is related to their degree of income inequality.⁵⁸ This is related to other scholarship on social capital which suggests a connection between health status and social cohesion.⁵⁹

While there are those who debate whether or not personal responsibility is a productive route in the search for the welfare of individuals and society, others are examining the contested meaning of the term itself. In her discussion of the arguments surrounding the topic Minkler provides Dworkin's typology on the meanings of the term:

role responsibility (one's body belongs to oneself), *causal responsibility* (one's health status is in large part determined by personal behavioral choices), and *responsibility based on liability* for costs and other undesirable consequences of one's illness.⁶⁰

⁵⁷Eric Brunner and Michael Marmot, 'Social Organization, Stress, and Health', in *Social Determinants of Health*, ed. by Michael Marmot and Richard G. Wilkinson (London: Oxford University Press, 1999), pp.17-43 (p.17).

⁵⁸Richard Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996).

⁵⁹Richard Putnam, *Making Democracy Work: Civic Traditions in Modern Italy* (Princeton: Princeton University Press, 1993); I. Kawachi and B.P.Kennedy, 'Socio-economic Determinants of Health: Health and Social Cohesion: Why Care About Income Inequality?' *BMJ*, 314 (1997), 1037. For a discussion of this and related work see Coburn, 'Income Inequality, Social Cohesion and the Health Status of Populations', pp.135-137.

⁶⁰Cited in Meredith Minkler, 'Personal Responsibility for Health? A Review of the Arguments and Evidence at Century's End,' *Health Education & Behavior*, 26 (1999), 121-140 (p.122).

These understandings of personal responsibility each have their corollary in the various expressions of individualism. That one's body belongs to oneself suggests that an individual may do with that as they will, having moral rights over health related choices. However, the second interpretation suggests that in doing so one is expected to make positive health behaviour choices, or, as ties in with the third meaning, accept the consequences of one's actions, both financially and otherwise. The contradiction here is that an individual can be forced to bear, at least in part, the financial cost of their illness, whether or not their behaviour contributed to its occurrence.

The imposition of neo-liberal individualism has shifted the way in which health care priorities and policies are determined. For example, in health promotion there is the potential to justify a shift from an environmental approach which acknowledges the multitude of factors involved in disease causation, to a individualist model which focuses on individual health behaviour and the potential for individual behaviour change.⁶¹ The imposition of neo-liberal principals in health sector policy is discussed in Chapter Three.

Personal responsibility can further be viewed in two ways. On the one hand is the view that individuals must take responsibility for certain obligations they have, either as a result of their position as citizens, or as a result of their own actions and choices. On the other hand this can be viewed as protecting other citizens from the responsibility for the choices or actions of others.

The second point this section will address is the related assumption that individuals are subject to increasing levels of regulation. According to Turner "[a]s the demands for individual rights grow on an equal basis, there is correspondingly an increase in state surveillance. The more individual rights expand, the more the individual becomes subject to centralised control and regulation." This has been described as the Foucault Paradox.⁶²

⁶¹ Arum Midha and Michael Sullivan, 'The Need to Redefine the Practice of Health Promotion in the United Kingdom', 44 (1998), 19-30.

⁶² Turner, 'Individualism, Capitalism and the Dominant Culture', p.60.

In one interpretation individuation runs contrary to individualism in that it imposes upon an individual's private realm. It is in line, however, with the expectation that individuals will take personal responsibility for their actions, not impose the costs of that action on others.

The rise of neo-liberal individualism in the last quarter of the twentieth century has forced a range of changes upon individuals in western society. For some this has, as is discussed further in Chapter Four, been welcomed, but others have been disadvantaged by the shift in the organisation and expectations of the state. Separate from, but not unrelated to neo-liberal individualism is what this thesis has called civil individualism; the individualism evident in the attitudes and expectations of individual members of society and their behaviour in relation to each other and to the state.

IV: The Individual at the Turn of the Millennium

While some forms of individualism are imposed by the institutional structures of society, as discussed above, others are intrinsic to individuals. There is further evidence of individualism in the way each individual citizen lives within the society of which they are a member.

The term individualism is also used to describe the attitudes evident among the members of western societies in the late twentieth century. It cannot be considered as entirely separate from the forms or expressions of individualism discussed above, but relates to an individual's values and expectations. Furthermore, western society at the beginning of the twenty-first century is considered increasingly individualist, with its members displaying attitudes which are more concerned with their own personal happiness and less concerned with society as a whole.

Geert Hofstede writes about individualist societies as those “in which the interests of the individual prevail over the interests of the group,”⁶³ and “*Individualism pertains to societies in which the ties between individuals are loose: everyone is expected to look after himself or herself and his or her immediate family.*”⁶⁴ Hofstede discusses a number of characteristics which he considers identify societies as individualist and has, through the use of a questionnaire to employees of IBM throughout the world, ranked 50 countries and three regions according to their degree of individualism. Those achieving the highest individualism index are countries considered to be western capitalist and democratic.⁶⁵

An attempt to examine how individuals behave within society and how the shape of that society influences, and is influenced by, individuals’ behaviour could be interpreted as methodological individualism, in that it assumes that we can reduce analysis to statements about individuals. However, it is not intended to imply that individuals are not influenced by other individuals, social groups, the state or by society as a whole, but that the reverse is true. This section investigates some of the expressions of individualism within society, examining how and why individual citizens react as they do.

A: Individuals Seeking Happiness

The end of the twentieth century saw an increase in the diversity of the population and a decline in the level of control society had over its members. While, as has been discussed above, there has been a correlation between the increasing rights and individuation, within society increasing rights have been associated with individuals giving less regard to the constraining social mores, seeking happiness in ways which had previously been frowned upon.

In seeking rights under the law, or in seeking the right to make choices for their own happiness without suffering the disapproval of society, individuals have pushed boundaries that had previously seemed unmoveable. They have

⁶³ Geert Hofstede, *Cultures and Organisations: Software of the Mind* (London: Harper Collins, 1991), p.50.

⁶⁴ Hofstede, *Cultures and Organisations*, p.51. [emphasis in the original]

⁶⁵ Hofstede, *Cultures and Organisations*, p.53.

demonstrated a willingness to seek happiness, less concerned with those who may oppose them.⁶⁶ Areas in which individuals and groups have challenged accepted social norms and changed them, to a greater or lesser extent, include; race relations, homosexuality, divorce, and single parenting.

That individuals seek happiness is not a new concept, but where once this was sought within society, there is now more concern with self-fulfilment, while social good makes less contribution to individual happiness.⁶⁷ Christian Lalive d'Épinay considers “the hedonistic or eudaemonist individualism, which characterises the contemporary ethos, is the perfectly logical, if not absolutely necessary, consequence of the process which has characterised Western civilisation since the Renaissance.”⁶⁸

Individuals are not seeking happiness in isolation from that bastion of neo-liberal individualism – the market. Consumerism is a significant component of individual expression as individuals pursue the good life and the right to be free of the restrictions of society. However, as John Ralston Saul points out, this individualism has the appearance of conformity. In addition this option was available only to those with resources.⁶⁹

The individualist's consumerism goes much further than just the purchasing of material goods. The individual's willingness to challenge the status quo in search of happiness or satisfaction has had an impact on the public provision of services. Where once individuals accepted the one-size-fits-all service of the health sector or the education sector, a shift in attitudes has seen groups and individuals demanding an individualised service, or at least one more in tune with the needs of groups within society, for example, women, Māori and hospitalised children. This is discussed further in Chapter Four.

⁶⁶ Manent, 'On Modern Individualism', p.4; d'Épinay, 'Individualism and Solidarity Today'.

⁶⁷ d'Épinay, 'Individualism and Solidarity Today', p.65.

⁶⁸ d'Épinay, 'Individualism and Solidarity Today', p.57.

⁶⁹ John Ralston Saul, *Voltaire's Bastards: The Dictatorship of Reason in the West* (Ontario: Penguin Books, 1993). This is discussed in a number of places, not least in relation to what Saul sees as an overwhelming conformism in modern society – see p.12.

B: Attitudes to Authority

The inhabitants of Western democracies have become ever more autonomous, ever more equal, and have felt themselves progressively less defined by the family or social class to which they belong.⁷⁰

The pursuit of individual happiness is also relevant in the discussion of individuals' shifting attitudes toward the state and those with authority, either real or implied. Individualism suggests that individuals have the capacity and the right to make decisions for themselves. In the original idea of autonomy the ability to think for oneself was one of the criteria which defined the individual. In that the thought that individuals are in no way socially constructed has been discarded, how then does the individual regard his or her decision-making processes?

Ruth Grant considers, in a way that is not undisputed, that Locke was not individualist in an anti-social way, but that he did expect individuals to be on their guard against the dictates of authority:

Locke's individualism is to be found in his assertion of individual natural rights and his encouragement of independent individual thought. His object in both cases is to combat authoritarianism, to combat the subjection of any man to the will of another politically or intellectually, and particularly where intellectual oppression is a tool of political oppression. Locke means to make men independent judges of the truth and watchful guardians of their rights.⁷¹

This ties back to the role of the individual in consenting to be governed. As such the idea could apply to both government, in the sense of running the state, and in the smaller ways that govern and guide individuals' lives. Vickers was also concerned that without the participation of the individual then we end up with totalitarian systems which are even less cognisant of the public good than are the exponents of the New Right.⁷²

Individuals have been delegated more responsibility in ensuring both their own welfare and that of their families at a time when they are also subject to increasing

⁷⁰ Pierre Manent, *An Intellectual History of Liberalism* (Princeton: Princeton University Press, 1994), p.xvi.

⁷¹ Ruth W. Grant, 'Locke's Political Anthropology and Lockean Individualism', p.61.

⁷² Geoffrey Vickers, *Freedom in a Rocking Boat: Changing Values in an Unstable Society* (Harmondsworth: Penguin, 1972).

levels of surveillance. In addition the level of social conformity has declined, at least in as much as individuals may express an opinion which opposes the power of the state.

There has been a shift from achieving happiness within society to a mood in which less attention is given to what society thinks. Many members of society are, however, still concerned with the impact individual actions and decisions have on others and society as a whole. So where once an individual might have been reigned back from opposition to the state by the mood of community tolerance for a particular position, that restraint may not be the force it once was. It is difficult to determine if collective opposition to state activities are motivated by consideration of the public good, or if such action is only the product of coinciding individual interests.

V: Public Good

Despite the tendency toward individualism in both the operations of the state and in the behaviour of individuals within civil society there remain actions, either performed or demanded, which are justified in the public good. The shift to individualism achieving the public good is often less about what the state does and more about what the state demands that individuals do, either voluntarily, with coercion or under duress. Thus requests or requirements of individuals are often justified as a matter of public good.

Public good, like individualism, is a term used to describe more than one state, both of which are relevant to the topic of this thesis. On the one hand is the accepted definition of *a public good*, while on the other hand there is a separate meaning attributable to *the public good*. This section will define and discuss each separately.

The first expression - *a public good* – is most accurately described as an economic term. It is generally accepted to be a commodity which is non-excludable and non-rivalous, thus, if provided is universally available to all who wish to partake

of it, at no direct cost.⁷³ This aspect of direct cost is important, because due to its other two characteristics it is not possible to levy a charge on those who use a public good. While this understanding of a public good is relatively straight forward, particularly when considering physical goods, it may become complex when making decisions about services or situations. Later in the text this thesis will discuss childhood immunisation, or more accurately the protection against vaccine preventable diseases offered by childhood immunisation, as a public good.

The second expression – *the public good* – is, however, much more difficult to define. This concept, otherwise variously labelled as the public interest or the common good, is not static. It implies a moral, political or philosophical judgement which will be influenced by a multitude of factors and vary across time.⁷⁴

The public good is in some interpretations in opposition to some interpretations of individualism. Plato said “What knits a community together is not private interest, but the common good.”⁷⁵ However the public good has the potential to undermine our civil liberties and human rights.⁷⁶

An explanation of the public good which is consistent with the neo-liberal interpretation of individualism, is identified by Minkler: “Public or common good, in short is defined as my right not to pay for your foolish or risky behavior.”⁷⁷ So the public good is an activity or strategy that when followed ensures that the public, or the public purse, will not have to fit the bill for the consequences of not doing it. These costs need not be financial, but they are costs.

It is this aspect of public good that contrasts most significantly with individualism and will be examined further with respect to childhood immunisation.

⁷³ For a basic explanation of public goods see John Horsman and Susan St John, *Economic Concepts: An Introduction* (Auckland: Longman Paul, 1992), pp.202-205.

⁷⁴ Francis Kane, *Neither Beasts nor Gods: Civic Life and the Public Good* (Dallas: Southern Methodist University Press, 1998), p.40.

⁷⁵ Kane, *Neither Beasts nor Gods*, p.1.

⁷⁶ Bill Willmott, ‘Conclusion’, in *New Zealand in Crisis: A Debate About Today's Critical Issues*, ed. by David Novitz and Bill Willmott (Wellington: GP Publications, 1992), pp.245-250 (p.249).

⁷⁷ Minkler, ‘Personal Responsibility for Health?’ p.135.

VI: Conclusion

Individualism is a way of looking at the foundations and assumptions upon which an individual's relationships and interactions are built. The development of ideas about the individual, their capacities and the environment in which they function most effectively has a long and variable history. At the beginning of the twenty-first century individualism remains a complex notion and although it has been overtaken in more recent times by the emphasis on economic liberalism and the particular understandings of an individual that that entails, there can be no single definition or view of individualism. That it is a complex mixture of perspectives must be kept in mind in attempting to understand both the development of public policy and reactions to it.

This thesis concentrates on two broad perspectives in examining the impact of individualism in the late twentieth century; *civil individualism* describing relationships individuals initiate with other individuals and society as a whole, and *neo-liberal individualism* describing the relationship between the state, society and the individual which originates in the mechanisms of the state.

These ideas will be discussed in respect of the development of public good policies, specifically health policy and childhood immunisation policy.

Chapter Three

HEALTH IN NEW ZEALAND'S SHIFTING PARADIGM

I: Introduction

Health is a matter of concern to both the individual and the society of which they are a member, having ramifications for the welfare of each. Because of this universal concern governments throughout the world are involved, albeit via differing arrangements, in the provision of health services.

One of the main reasons for [governments' participation in the health sector] is that individuals cannot look after all aspects of their own health. They may not have the financial means and knowledge to do so and rarely are they in a position to exercise full control over those aspects of their lives known to affect health such as where they work and live, the air they breathe and the food they eat. Moreover, it is in the interests not only of the individuals themselves, but also of the community at large, to maintain the health of all its members. In other words health carries external benefits. Therefore it falls to government to ensure that all citizens have access to a reasonable standard of care.¹

As in many previous elections health was one of the issues of greatest concern to electors in the lead up to New Zealand's general election in October 1996. Many concerns arose from issues that had or were thought to have had their roots in the health reform process instituted by the National government in 1991.² However, while health is an issue that is increasingly to the fore in the interests of individuals and communities throughout the Western world, not all the concerns about health and health services can be traced to the health sector reform process.

The whole area of health service provision has been undergoing a series of transformations as a result of shifting influences both within the health sector and in the wider community. These factors are, in turn, part of the motivation for change in the organisation of the health sector. The demographic characteristics of New Zealand's population have been subject to ongoing change, shifting the

¹ Ann Wall, 'Conclusion', in *Health Care Systems in Liberal Democracies*, ed. by Ann Wall (London: Routledge, 1996), pp.183-199 (p.186).

² David McLoughlin, 'How Bad is Our Health?' *North and South* (September 1996), 68-82 (p.68).

demand for many services, including health. Technology is enhancing the capacity to intervene in many sectors of life, including health. Attitudes within society are changing, and health is only one area in which individuals and society as a whole are challenging the way decisions are made and actions taken.

This thesis argues that, although it is not possible to see all the changes in the health sector as the result of an increasing individualism within New Zealand, the focus on the rights and responsibilities of the individual, from within both the state infrastructure and civil society, was a significant influence on the way in which New Zealand's health sector changed, particularly from the late 1980s.

In discussing New Zealand's health reforms Blank identifies the debate as between two roles for government.

These health reforms raise a set of very fundamental philosophical questions concerning what functions government ought to fulfil in New Zealand society. At the base of much of the debate over health reform is a vehement disagreement over the legitimate purpose of government. Often this is cast as a matter of ideological conflict between traditional notions of the welfare state, where the government has a responsibility to provide a broad range of essential services to all citizens, and a more individualistic, market-orientated model of democracy, wherein many of these traditional public functions are assigned to the private sector.³

Blank focuses on the role of the state, whereas this thesis argues that the philosophical debate in health, as in other areas of public policy, includes much more complex considerations of the inter-relationship between the state, society and the individual and the roles of each. By tending toward a more-market model, especially in the reforms introduced from 1991, the New Zealand government identified a preference for a more individualist model of health and health care. This preference, the antecedents of which are discussed in Chapter One, has been institutionalised in a manner that reflects changes that have taken place in other sectors of the New Zealand economy. However, other factors influencing the shape of health and health policy in New Zealand are also of an individualist nature. Individuals have become more involved in the issue of health, both on a

³ Robert Blank, *New Zealand Health Policy: A Comparative Study* (Auckland: Oxford University Press, 1994), p.121.

personal basis and politically, as attitudes move away from the widespread, but never universal, acceptance that health was the business of medical science and professional practitioners of that discipline.⁴

In combination these factors provide an illustration of how the increasing individualism introduced in Chapter One and discussed in Chapter Two is shaping a particular area of public policy, that of health. This chapter begins by examining what health and health policy are, before looking briefly at the factors thought to influence the formulation of policy. Section III examines the development of New Zealand's health sector, focusing on the way it has been influenced by the neo-liberal philosophy of political economy. Chapter Four will continue the examination, discussing some of the other factors which have contributed to the shape of the health sector in the 1990s.

II: Health and Health Policy

A number of terms recur frequently throughout this chapter, and for clarity it is important to explain their usage within the context of this thesis.

Health sector refers to all entities contributing to the provision of health services, including funding, policy and service provision in the public, private and voluntary sectors.

State funded health sector is that part of the health sector that exists within the public sector. This includes services purchased by the state funded health sector from private or voluntary service providers.

Health services are those services provided within all levels of the health sector, whether funded by the state or by the private sector.

Health care refers to services directly targeted toward maintaining or improving the health of individuals and populations.

⁴ For a discussion of medical dominance and changes in the New Zealand context see Elizabeth Tully and Belinda Mortlock, 'Professionals and Practices', in *Health and Society in Aotearoa New Zealand*, ed. by Peter Davis and Kevin Dew (Auckland: Oxford University Press, 1999), pp.165-180.

There are, however, two particular terms that, because of the level of discussion and debate about their meanings, require closer examination. These are health and health policy. This is followed by a brief discussion of how health policy is formulated.

A: The Nature of Health

The way in which the concept of health is understood influences how health policy is formulated and what health services are provided. This understanding is in turn influenced by a number of factors including the ideological stance of the policy makers and the scientific understanding of matters relating to health and disease. In addition to discussing the evolving understanding of health this section will briefly examine both why health is desirable and why government is involved in the process.

In 1946 the World Health Organization (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁵ While this definition was an improvement on the earlier understanding of health as the absence of disease, it was considered to be unrealistic in that it described an ideal and often unattainable outcome.⁶ In its place emerged a range of more flexible definitions that acknowledged that health may be a process, existing in different levels over time. More recent interpretations are along the lines that health is “[a]n important resource for living; physical abilities and social and psychological capacities to achieve one’s potential and respond positively to the challenges of the environment.”⁷

The links to the physical and social environment are important. “The foundations of health are common to all and include basic requirements such as adequate food, safe water, shelter, safety and hope. In addition, information, education and a

⁵ *World Health Organization Constitution*, Geneva, WHO, 1946, cited in Robert Beaglehole and Ruth Bonita, *Public Health at the Crossroads: Achievements and Prospects* (Cambridge: Cambridge University Press, 1997), p.1.

⁶ Fritjof Capra, *The Turning Point: Science Society and the Rising Culture* (New York: Simon and Schuster, 1982), p.124.

⁷ Penelope Hawe, Deirdre Degeling and Jane Hall, *Evaluating Health Promotion* (Sydney: MacLennan and Petty, 1990), p.206.

sense of community are essential if people are to develop their potential.”⁸ Furthermore, the breadth of the term health is confirmed by the observation that increases in the level of health within a community owe more to improvements in the social environment than they do to advances in medical techniques.⁹

Seedhouse makes the point that health is understood very differently by different disciplines involved in health care and health services more generally. It is his contention that health is the foundation for achievement.¹⁰

Māori have a more complex understanding of health. The Whare Tapu Wha model acknowledges four aspects of health: the spiritual, thoughts and feeling, the physical side, and family.¹¹ Other models for well-being include Te Wheki or the octopus model.¹²

Health can be understood in a number of different ways, but for an individual the possession of health contributes to maximisation of their personal welfare. In this way health could be understood as a private good which, in combination with their other personal attributes, determines an individual’s quality of life.

The health of an individual citizen is not, however, an entirely private matter as it has ramifications for the society of which they are a member. A democratic society requires a fully participatory citizenry, and good health contributes to an individual’s ability to participate fully in society.¹³ Should an individual's state of health prevent them from contributing to society at their full potential then society must bear the loss of that potential contribution in addition to the direct cost

⁸ Beaglehole and Bonita, *Public Health at the Crossroads*, p.4.

⁹ Valerie Brown, ‘Health Care Policies, Health Policies or Policies for Health?’ in *Health Policy: Development, Implementation, and Evaluation in Australia*, ed. by Heather Gardner (Edinburgh: Churchill Livingstone, 1992), pp.91-118 (p.94).

¹⁰ David Seedhouse, *Health: The Foundations for Achievement* (Chichester: John Wiley and Sons, 1986).

¹¹ Mason Durie, *Whaiora: Māori Health Development* (Auckland: Oxford University Press, 1994), p.70.

¹² For discussion of models of health in keeping with a Māori perspective, and other related issues see Papaarangi Reid, ‘Te pupuri i te ao o te tangata whenua’, in *Health and Society in Aotearoa New Zealand*, ed. by Peter Davis and Kevin Dew (Auckland: Oxford University Press, 1999), pp.51-62.

¹³ Philippa Howden-Chapman and Fiona Cram, *Social, Economic and Cultural Determinants of Health*, Health Determinants Programme Background Paper 1 (Wellington: National Health Committee, 1998), p.4.

imposed by the state of health. In a society which maintains a state funded health service this may include a charge on the public purse for their health care, but there may be other costs, for example the spread of infectious diseases. Issues relating to infectious diseases, their control and the responsibilities of individuals in respect of this control are discussed in Chapters Six, Seven and Eight.

The interest of society in both the health of the individual and in the factors which influence the health of society as a whole suggest that there is a role for government in health if for no other reason than the public interest. However, in many countries there is an acceptance that the government has a wider role in contributing to the personal welfare of its citizens in order to maintain a just society.

How a government chooses to participate in ensuring the health of its citizens is influenced in part by its understanding of the causes of disease. There are differing interpretations as to how a state of health is achieved, where the responsibility for achieving health lies and how government policy on these matters should be formulated. One interpretation is that health is beyond the control of individuals because illness is caused by entirely external influences. Another interpretation is that individuals have choices, some of which may contribute to lesser levels of health. A number of theories have developed over the years to explain the causes of disease. While some of these have been discarded with time and scientific knowledge, three theories remain popular explanations for poor health.

The first is germ theory wherein disease is caused by the action of micro-organisms. The second is the life style theory whereby disease is caused by behaviours that are unhealthy. This is also called *blame-the-victim* because it assumes the individual has control over various factors that contribute to their health. The third is the environmental theory that assumes that diseases are caused by factors in the environment, for example in the work environment. The assumption linked to this theory is that the causes of disease are beyond the control of the individual and require control by collective action. While no single theory provides the complete explanation for disease causality, and the

explanation lies in a combination of each, it is useful to keep these theories in mind when examining health policy as assumptions about disease causality can inform the direction of particular policies.¹⁴

B: The Nature of Health Policy

The achievement and maintenance of health involves a great deal more than just the services provided under the rubric of health care. Health policy is therefore about more than just the services provided in the health sector, but rather about all the factors that impact upon the health of the population or individuals within the population.

According to Palmer and Short:

Generally, the term ‘health policy’ embraces courses of action that affect that set of institutions, organisations, services and funding arrangements that we have called the health care system. It includes actions or intended actions, by public, private and voluntary organisations that have an impact on health.¹⁵

Recalling the definitions of health discussed above suggests that the relevant set of institutions, organisations, services and funding arrangements should include some which exist outside the health care system. In that vein Brown sees health policy as a part of all social policy.¹⁶

Walt notes that health policy is interpreted differently depending on one’s perspective both in terms of involvement and culture.¹⁷

Health policy embraces courses of action that affect the set of institutions, organizations, services, and funding arrangements of the health care system. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organizations that have an impact on health. This means that health

¹⁴ For discussion of the theories of disease causality and the links between the prevailing assumptions about disease causality and public policy see Sylvia Noble Tesh, *Hidden Arguments: Political Ideology and Disease Prevention Policy* (New Brunswick: Rutgers University Press, 1988), pp.33-57.

¹⁵ George R. Palmer and Stephanie D. Short, *Health Care and Public Policy: An Australian Analysis*, 2nd edn (Melbourne: Macmillan, 1994), p.23.

¹⁶ Brown, ‘Health Care Policies, Health Policies or Policies for Health?’ p.91.

¹⁷ Gill Walt, *Health Policy: An Introduction to Process and Power* (Johannesburg: Witwatersrand, 1994), p.1.

policy is concerned with environmental and socio-economic effects on health as well as with health care provision.¹⁸

Walt further comments that much of the attention to health policy is devoted narrowly to the health care system alone and suggests the term *healthy public policy* to indicate a wider focus which includes environmental and socio-economic matters.¹⁹

Blank concentrates on health policy as an aspect of public policy that concerns the intentions of government.

Health policy [includes] ... those courses of action proposed or taken by a government which affect health care institutions, organizations, service and finance [and] although health policy can be conceptually distinguished from other areas of public policy, it is in reality closely related to social and economic policy in general [H]ealth and health policy cannot be understood in isolation from social welfare, unemployment, poverty, housing, and general economic policies.²⁰

Thus, while what is often meant when health policy is discussed would more accurately be called health services or health care policy, it must be remembered that health is significantly affected by policies outside the health sector.

C: The Making of Health Policy

Health policy, as with all public policy, is shaped within the structure of the modern democratic state. There is debate as to just how that process takes place and what factors influence policy outcomes. Policy options are constrained or directed by factors existing in the state and society. The availability of resources, the priorities of the government and society and the values prevailing within society at the time, all have an impact on emerging public policy.

The often technical nature of health policy, and the existence of a number of expert groups within the health sector, mean that there are additional constraints on health policy formulation. In addition, the direct impact health policy has, or will have in the future, on the lives of all citizens makes this area of policy subject

¹⁸ Walt, *Health Policy*, p.41.

¹⁹ Walt, *Health Policy*, pp.41-42.

²⁰ Blank, *New Zealand Health Policy*, p.1.

to a high level of lay public interest. Because of these often competing interests the determination of health policy is a highly political process.²¹

Public policy decisions are the responsibility of the government, but they are advised and influenced by a range of groups. There are a number of theories as to who has influence and how that works. The pluralist view suggests that all interest groups can organise themselves to influence policy. While the levels of power may vary, each group is able to compete to achieve their aims. The elite view, however, suggests that there are those whose position or knowledge gives them an advantage in influencing policy. The structural perspective suggests that the structure of society protects and furthers the interests of particular groups within society. A Marxist perspective suggests that power is in the hands of the few, but that it is linked to economic matters. Corporatism as a theory sees centralised interest groups as having the power to deal with government.²²

Short discusses four models of influence on the development of health policy. First, the engineering model concentrates on the role of scientific knowledge. Second, the enlightenment model suggests that rather than a single study or set of findings influencing policy it is new ways of thinking which emerge over time to have an impact on policy through an enlightenment process. Third, the materialist model which, linked to the Marxist approach above, suggests that economic matters are the main force behind health policy development. Fourth, the elective affinity model which considers the values and beliefs of the policy makers – a position which relates to Weber's position that individual's choices are not determined solely by their economic interests.²³

Chapter One discusses some of the manifestations of the philosophy that has dominated the political process in New Zealand since 1984. While the public service has traditionally been thought to provide non-partisan and neutral advice

²¹ Heather Gardner and Simon Barraclough, 'The Policy Process', in *Health Policy: Development, Implementation, and Evaluation in Australia*, ed. by Heather Gardner (Edinburgh: Churchill Livingstone, 1992), pp.3-28 (p.7).

²² For further discussion of these perspectives see Gardner and Barraclough, 'The Policy Process', pp.11-14.

²³ Stephanie Short, 'Elective Affinities: Research and Health Policy Development', in *Health Policy in Australia*, ed. by Heather Gardiner (Melbourne: Oxford University Press, 1997), pp.65-82.

to government it is clear that many officials have particular notions as to the direction policy should take. This is also the case for many elected members of the government. These two groups could be considered elite in that their place in the policy making process gives them an advantage in influencing policy. In addition the medical profession have had a role in the formulation of health policy which, according to Palmer and Short, is not reflected in any other area of public policy.²⁴ The reform of the health sector in New Zealand since 1991 has altered the way in which health policy is determined and has attempted to shift the power in that process. The following sections will trace the changes in New Zealand's health sector, exploring, among other things, the way in which power relationships have changed.²⁵

III: The Health Sector in New Zealand

As in other sectors of the economy New Zealand's state funded health sector has been subject to influences similar to those which have shaped and changed the health sector in other developed, capitalist states. However, as Hay states, “the nature of health care in New Zealand has emerged as the result of a conjunction of broad social processes with local characteristics.”²⁶ New Zealand's health sector has developed in a unique way, and while it can be seen to share characteristics with other states it can only be accurately discussed with an understanding of the influences which have shaped both its structure and the attitudes existing within it, including the political system, the national economy, national values and attitudes. This section explores the way in which New Zealand's health sector has evolved, examining the structural influences.

A: History

The emergence of health services during the early period of settlement in New Zealand closely followed the model in place in Britain at that time. As in Victorian Britain there was an acceptance that individuals would be self-reliant,

²⁴ Palmer and Short, *Health Care and Public Policy*, p.25.

²⁵ For further discussion of the influences on health policy see Walt, *Health Policy*, pp.73-121 and Blank, *New Zealand Health Policy*, pp.1-23.

²⁶ Iain Hay, *The Caring Commodity: The Provision of Health Care in New Zealand* (Auckland: Oxford University Press, 1989), p.1.

taking care of themselves and their families, with health care services provided by the private sector. Society, however, recognised its responsibility to those of its members with less resources, providing, through charitable efforts, for those who were unable to provide for themselves.²⁷ This situation proved to be unsustainable, because the colony was without the wealthy classes who provided the bulk of charitable contributions in Britain, a factor that, combined with the scattered nature of settlement in New Zealand and the colonialists' obligations to Maori under the Treaty of Waitangi, forced the provincial governments, and later central government, to make provision for hospital services.²⁸

Initially state funded hospitals, established by Governor George Grey, were for Maori and those unable to fund their health care in the private sector.²⁹ However, as medical technology advanced and hospital care became more sophisticated, public hospitals began to accommodate both fee paying patients and those who had traditionally been their clientele at no direct cost.³⁰ This change was accompanied by a shift in perceptions about standards in public hospitals and an acceptance that these were suitable places for all classes of New Zealanders to receive health care.³¹

To provide some measure of protection against the cost of health care in either the public or the private sector Friendly Societies or Lodges set up schemes which, for a set fee, ensured members and their families affordable medical care in the fee-for-service health care system.³²

The urbanisation of the New Zealand society and the economic depression of the late 1920s and early 1930s contributed to a shift in the orthodoxy of New Zealand's society, moving, as it did, toward the Left with the election of a Labour administration and the adoption of many of the Party's socialist values.

²⁷ Graeme Fraser, 'An Examination of Factors in the Development of New Zealand's Health System', in *In the Public Interest: Health, Work and Housing in New Zealand*, ed. by Chris Wilkes and Ian Shirley (Auckland: Benton Ross, 1984), pp.53-75 (p.54).

²⁸ Fraser, p.56; Miriam Laugesen and George Salmond, 'New Zealand Health Care: A Background', *Health Policy*, 29 (July/August, 1994), 11-23 (p.14).

²⁹ Hay, *The Caring Commodity*, p.18.

³⁰ Laugesen and Salmond, 'New Zealand Health Care', p.14.

³¹ Fraser, 'An Examination of Factors in the Development of New Zealand's Health System', p.60.

³² Hay, *The Caring Commodity*, p.17; Laugesen and Salmond, 'New Zealand Health Care', p.14.

The First Labour Government of Michael Joseph Savage was elected to the Treasury benches in November 1935 promising, among other things, a free medical service. Public pressure for the introduction of some form of collective health care system was high at this time, having forced the previously incumbent Coalition government to investigate health insurance options in the period prior to the elections.³³ The contributory style of health care system received some attention from the new Labour Government, but was eventually rejected by the full Cabinet in favour of a health service fully funded from tax revenue.

New Zealand's state funded health service was introduced as part of the wide ranging legislation in the Social Security Act (1938). This Act provided the legislative base for the Welfare State with provisions for a "comprehensive system of public health, pensions and superannuation" and was designed to fulfil in part the Labour Government's election promise of a decent standard of living for New Zealanders. The Social Security Act, which provided for monetary support and health, was introduced alongside provisions for state housing and a minimum wage.³⁴ The intention of the legislation in respect of health was to establish a tax funded health service which would provide all New Zealanders with free medical and hospital care.³⁵

The news that medical care was to be provided free to consumers received a largely positive reception in the general community, although the financial feasibility of the scheme was questioned in some quarters.³⁶ However, the medical fraternity, represented by the New Zealand branch of the British Medical Association, was united in its opposition to parts of the scheme relating to free General Practice (GP) care.³⁷

The medical profession favoured changes to the financing of health care which would have made expensive medical technology more accessible, while also

³³ Hay, *The Caring Commodity*, p.84.

³⁴ For detail of the Welfare State see B. Gustafson, *From the Cradle to the Grave: A Biography of Michael Joseph Savage* (Auckland: Penguin, 1988).

³⁵ Hay, *The Caring Commodity*, p.86.

³⁶ Hay, *The Caring Commodity*, p.86.

³⁷ For a discussion of the medical profession's involvement in the political processes surrounding the development of the health services components of the Social Security Bill see Hay, *The Caring Commodity*, pp.84-125.

ensuring the maintenance of doctors' incomes.³⁸ However, the profession was concerned that the state's proposed role as third party funder, paying for primary medical services on a capitation basis, would interfere in what it considered to be the sacred relationship between a doctor and their patient. Doctors wanted to preserve the market aspect of the relationship, with the patient paying for the service, rather than the state taking over the funding role entirely.

On this basis the medical community refused to co-operate with the introduction of the free GP care under the Social Security Act (1938). Medical opposition has, however, been interpreted as an attempt to protect the profession's power in the health sector.³⁹ The doctors' refusal to support and co-operate with the provisions of the Social Security Act (1938) relating to General Practice forced the government to amend the provisions of the legislation, with the Social Security Amendment Act (1941) allowing doctors to make a financial charge direct to their patients in addition to receiving a fee-for-service from the government.⁴⁰ This change is, in itself, testament to the power of the medical profession in New Zealand society during that period.

What did eventually emerge was a health system that saw patients pay a portion of the cost of visiting their General Practitioner, while the remainder of that cost and prescription charges were met by the state. Hospital care was free, New Zealand being the first country in the world to establish this service.⁴¹ This attempt to maintain the market aspect in the relationship between doctor and patient was, however, the beginning of the New Zealand's use of a system of user part-charges. It established the basic structure which, although it saw little substantive change in the succeeding fifty years, was adjusted to meet changing funding arrangements in the health sector.

³⁸ Hay, *The Caring Commodity*, p.95.

³⁹ Tony Simpson, *A Vision Betrayed: The Decline of Democracy in New Zealand* (Auckland: Hodder and Stoughton, 1984), p.188.

⁴⁰ Hay, *The Caring Commodity*, pp.121-22.

⁴¹ Blank, *New Zealand Health Policy*, p.123.

Despite the establishment of a universal state funded health service New Zealand has always retained the provisions for private sector medicine to exist alongside the state funded system. This has allowed consumers choice to make alternative arrangements for themselves as was provided for by the recommendations of a committee examining policy in the lead up to the Social Security Act (1938).⁴²

In the years following the introduction of the state funded health sector the existence of a parallel private hospital system and the provisions for user part-charges were to influence developments in the state funded health sector. As the pressure increased on public hospitals, especially for surgical services, waiting lists were employed as a rationing mechanism, encouraging those who were able to opt for private hospital care. With the introduction of private medical insurance in 1961 this option was extended to more New Zealanders.⁴³

The availability of a hedge against GPs' fees and an alternative to state funded health care saw an increasing number of New Zealanders taking up the option of private medical insurance. The proportion of New Zealanders holding private medical insurance grew steadily until the early 1990s when changes in the state funded health sector increased demand on medical insurers, driving up premiums and reducing the numbers taking out medical insurance. In 1999 less than 37 percent of New Zealanders had private medical insurance compared with 50 percent of the population in 1990.⁴⁴ However, looking at the long term view the general trend has been for increasing numbers of New Zealanders to have private medical insurance.

The increased uptake of private medical insurance is considered to indicate a number of factors, including dissatisfaction with the state funded health sector, the wish to avoid waiting lists and increased choice.⁴⁵ In 1989 Chetwynd reported

⁴² T. McGuigan, *A Health Service for New Zealand* (Wellington Government Printer, 1974), p.45.

⁴³ Hay, *The Caring Commodity*, pp.153-163.

⁴⁴ Richard Braddell, 'Healthcare at the Crossroads', *New Zealand Herald*, Monday 5 April 1999, Section D, p.2.

⁴⁵ Hay, *The Caring Commodity*, p.159.

that the growth in the numbers of New Zealanders taking private medical insurance was uneven between genders, occupational groups and geographically.⁴⁶

This ability to exit from the state funded health service is considered to have contributed to the rundown of the service. New Zealanders who were unhappy with standards or service in the state funded health sector had the option of moving into the private sector, thereby lessening any motivation to influence policy in the public sector through political action.⁴⁷

Alongside the shift to private medicine, user part-charges were also employed to limited public expenditure in the health sector. The state subsidy for General Practice visits did not rise to cover the increasing charges so the patient faced increased costs. In the 1980s this mechanism was extended to prescription charges in order to reduce the cost of pharmaceuticals to the state. In the 1990s hospital stays and outpatient visits also attracted a user part-charge.

Since the early 1940s, when the health services most New Zealanders were familiar with in the 1980s emerged as part of the welfare state, the state funded health sector had grown and changed incrementally to meet the nation's changing needs. However, since the early 1980s the health sector has undergone significant structural alterations that reflect changes in other areas of both the private and public sector economies. Chapter One discussed both the political economic environment during this period and the specific changes in various sectors, many of which have had an impact on the health sector. However, the health sector has also been subject to specific influences which, combined with external factors, have shaped the nature of its change.

B: Pressures on the Health Service

By the 1980s it was apparent that the state funded health sector in New Zealand was no longer delivering a universal health service according to need. The cost of the service was increasing and attempts to reduce the burden on the public purse

⁴⁶ Jane Chetwynd, 'Trends in Private Medical Insurance Ownership: Lessons for the Public Sector', *NZMJ*, 102 (1989), 107-109 (p.108).

⁴⁷ Geoffrey M. Fougere, 'Exit and Voice and the Decay of the Welfare State Provision of Hospital Care' (unpublished master's thesis, University of Canterbury, 1974).

were resulting in hardship for many people. Three factors in particular are recognised as contributing to the failure of New Zealand's state funded health services to meet the original intentions, a situation which required reform in the state funded health sector: an ageing population, advances in medical technology and constraints on the funds available for the health sector.

First, in common with many other Western countries New Zealand has an ageing population which puts more pressure on the health service. As a result of declining fertility and increasing life expectancy the proportion of the population over the age of 65 years is increasing, a trend which will continue into the middle years of the twenty-first century. This age group is known to be a high user of health care services, thus putting an ever increasing pressure on the health care budget.⁴⁸ It must be noted that this conclusion is disputed.⁴⁹

Second, advances in medical technology are also increasing the pressure on the health sector. While some of these advances increase efficiency, most innovations increase financial demands on the health sector. Furthermore, these advances are not only replacing existing procedures, but also providing options where once the health sector had nothing to offer, increasing not only budgetary pressures, but also the demands on staffing expertise, treatment space and equipment.⁵⁰

Third, as New Zealand's economy has become tighter constraints on resources available to the health sector are subject to greater pressure. While expenditure in the health sector may be growing, demands are not met automatically as they once appeared to be. Cumming and Salmond identify the influence of wider economic and social policy reform as an important external pressure for health sector reform.⁵¹

⁴⁸ For discussion of the impact of the ageing population see Blank, *New Zealand Health Policy*, pp.26-34; Grant Johnston and Audrey Teasdale, *Population Ageing and Health Spending: 50-year Projections*, Occasional Paper No.2 (Wellington: Ministry of Health, 1999).

⁴⁹ P. Zweifel, S. Felder and M. Meier, 'Ageing of the Population and Health Care Expenditure: A Red Herring?' *Health Economics*, 8 (1999), 485-496.

⁵⁰ For discussion of the impact of advancing medical technology see Blank, pp.34-41.

⁵¹ Jacqueline Cumming and George Salmond, 'Reforming New Zealand Health Care', in *Markets and Health Care: A Comparative Analysis*, ed. by Wendy Ranade (New York: Addison Wesley Longman, 1998), pp.122-146 (p.125).

In combination these three factors are increasing the pressure on New Zealand's health sector budget, the first two by increasing the demand for services and the third by constraining the amount by which health spending can, or is allowed to, grow. However, the pressure is more than budgetary. The availability of new technologies raises important ethical questions about their use. For example, should new developments in neonatal care be used in the attempt to save infants born at ever earlier stages of gestation when the surviving child may be left with a persistent disability which will compromise their quality of life? At the other end of the age spectrum the scarcity of financial resources raise questions about making expensive surgical techniques or pharmaceuticals available to the elderly, who may only benefit for a short time.⁵² To answer these questions is well beyond the scope of this thesis, but it is vital to keep in mind that the pressures cannot be defined in financial terms alone.

C: Health Sector Reviews

The factors which contributed to the pressure for change in New Zealand's state funded health sector built gradually over a period of years. However, during this time the awareness that change would be necessary lead to the commissioning of a number of reports on New Zealand's health service. This section will concentrate on four major reviews, although other reports were undertaken, particularly in specific areas of the health service.

The first of these was the White Paper, *A Health Service for New Zealand*, produced in 1974.⁵³ This was a major document which attempted to map the future direction of the health services at a time when it was only just becoming apparent that changes in the international economy would change New Zealand's ability to provide welfare services as it had done in the post war years.

⁵² An example of the discussion on this topic is D.G. Jones, 'Aging, Dementia and Care: Setting Limits on the Allocation of Health Care Resources to the Aged', *NZMJ*, 110 (1997), 466-468.

⁵³ McGuigan, *A Health Services for New Zealand*.

The White Paper discussed perceived deficiencies in New Zealand's health service and the country's failure to maintain its position of international leadership in health care.⁵⁴ Changes in health care, financial arrangements and administrative structures were identified as contributing to the need for change. The paper then set out its proposal for changes at both national and local levels of the health service. The plan was to establish a New Zealand Health Authority and 14 Regional Health Authorities (RHAs) to replace the Department of Health and the existing Hospital Boards respectively.

Included in the paper were details of changes in funding arrangements, membership of the RHAs - a mix of elected and government appointed members - and responsibilities for staff at various levels of the health services. It is interesting to note that the White Paper rejected what was later to be known as general management, considering it to be inappropriate for any one official to take responsibility for staff operating outside their area of professional expertise. Recommended was a multi-disciplinary, team consensus approach.⁵⁵

The next major report took place in 1986, by which time the government was attempting to meet the challenges of economic and social change in New Zealand. The Health Benefits Review produced the report *Choices for Health Care (1986)*.⁵⁶ The review team, convened in February 1986, was required to "report upon the underlying rationale for state involvement in health and to recommend broad principles and directions for reform."⁵⁷ Although the review and report touched on aspects of the secondary health care sector, its major focus was on primary health services. In fulfilment of their responsibilities the review team produced a document designed to promote informed debate among New Zealanders as to the future role for government in the provision, financing and regulation of the nation's health services.

⁵⁴ McGuigan, *A Health Services for New Zealand*, p.75.

⁵⁵ McGuigan, *A Health Services for New Zealand*, pp.142-143.

⁵⁶ Health Benefits Review, *Choices for Health Care: Report of the Health Benefits Review* (Wellington, The Review, 1986).

⁵⁷ Health Benefits Review, *Choices for Health Care*, p.1.

The report initially outlined two opposing ideological positions on the provision of health care services. One view was that the community should share the cost of illness. Such a position requires the state to take a major role in ensuring the funding of a universal health care system which provides equal access for all. The alternative position requires individuals to take responsibility for their own welfare, assigning the state a role as the residual provider of health care for those who could not provide for themselves.⁵⁸

In attempting to make recommendations on the mix of these ideologies the review team accepted public submissions, investigated health benefits, looked at the costs of health care and researched international alternatives.

The review team outlined five options for the future of the state's involvement in health, ranging between the two major ideological positions outlined above. They also outlined specific strategies for change, both in the short and the long term.

The report did not offer specific recommendations for changing the state's role in the health sector, believing that it would be more constructive to initiate and inform public debate on the issues involved. However, the review team did support a major role for the state in funding, regulation and priority determination in the health sector, but believed that there was scope for other agencies, including the private and voluntary sectors, to have a role in the provision of health care services.⁵⁹

The next major government initiated review of New Zealand's state funded health services was the Hospital and Related Services Taskforce. Set up in March 1987 by the Ministers of Health and Finance, under the chairmanship of businessman Alan Gibbs, the Taskforce produced the report *Unshackling the Hospitals (1988)*,⁶⁰ commonly referred to as the Gibbs Report.

⁵⁸ Health Benefits Review, *Choices for Health Care*, p.2.

⁵⁹ Health Benefits Review, *Choices for Health Care*, pp.129-30.

⁶⁰ Hospital and Related Services Taskforce, *Unshackling the Hospitals: Report of the Hospital and Related Services Taskforce* (Wellington: The Taskforce, 1988).

Its terms of reference required the Taskforce to recommend a structure which would ensure that hospital and related services would “contribute to the Government’s broad health goals, and in particular assist in the achievement of improved health status for all New Zealanders.”⁶¹ This review concentrated on the secondary sector of the health services, examining the realities of New Zealand’s state funded hospital system, the options provided by the experience of other states and improvements which might be made through the introduction of a more business orientated management system.

The Gibbs Report expressed the Taskforce’s concern with issues of equity, efficiency and morale, but concluded that the main problem in the public hospital sector was poor management.⁶² The report criticised the practice of using triumvirate or consensus management as “highly inefficient.”⁶³ It was also unhappy about the use of staff, both as a result of the consensus management style and because of the lack of autonomy in employment practices. However, the Taskforce appeared to be most concerned about the lack of management information available in the hospital sector, especially the almost total absence of information related to costs and productivity.

Unlike the Health Benefits Review, the Hospital and Related Services Taskforce had very specific recommendations to make to government. It proposed that while the government remain the dominant funder and provider of hospital and related services, the two roles should be separated. Furthermore, hospitals, as service providers, should be paid for the services they delivered instead of for the costs they incurred in doing so. Under a system that combined these two innovations, the Taskforce believed that hospitals would have the autonomy to operate in the most efficient and competitive way possible within a limited market, from which they would receive accurate information about the value of their services.

⁶¹ Hospital and Related Services Taskforce, *Unshackling the Hospitals*, p.4.

⁶² Hospital and Related Services Taskforce, *Unshackling the Hospitals*, p.26.

⁶³ Hospital and Related Services Taskforce, *Unshackling the Hospitals*, p.19.

Hospital and related services would be purchased or funded by six Regional Health Authorities, acting on behalf of those living within their areas. The RHAs, controlled by elected boards, would not own or control service providers, but would instead contract with service providers in the public, private and voluntary sectors.

The Taskforce report provided detailed descriptions of a proposed structure for this system, including the roles of all the parties it saw as being involved. It also recommended that general management be introduced to replace consensus management, that management information systems were urgently required and that diagnosis related groups (DRGs) be considered as a basis for payment for services provided. The report acknowledged that research projects were already established to investigate many of the areas it had criticised.

While the government was looking for new ways to develop the health sector the new political economic environment encouraged private enterprise to participate more fully in the policy development process. In 1991 the New Zealand Business Roundtable commissioned CS First Boston NZ Limited to undertake a study of the delivery and financing of health care in New Zealand. The report, *Options for Health Care in New Zealand (1991)*,⁶⁴ presented options for the finance and delivery of health care in New Zealand. The report cited the increasing number of persons purchasing private health insurance and the length of public hospital waiting lists as indicators of the problems in the state funded health sector in the absence of adequate performance data on which to base an assessment of the sector.

⁶⁴ Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand: Report for the New Zealand Business Roundtable* (Wellington: The Roundtable, 1991).

The authors of the report identified what they saw as the major problems of the sector in economic terms. First, the inability of consumers to influence funding allocation through purchasing decisions meant that resource allocation decisions might not deliver maximum value to consumers. Furthermore, this contributed to poor information links between the consumer and the provider, resulting in little incentive for service providers to operate efficiently.

In making its recommendations for change the report accepted that the government might want to retain the dominant role in the funding and delivery of health services, but recommended that the two functions be separated. Moreover, it recommended that services be purchased from competing, commercially operated organisations.

In addition the authors proposed that individual consumers could have greater influence on the service, and greater efficiency would be achieved, if they had the option to take their share of state funding out of the state sector and contract with an alternative health care provider.

While making recommendations on health sector improvement for a state funded and provided health service, the authors considered that greater advantages were possible in a fully privatised system believing that it could “achieve significant efficiency benefits without compromising equity objectives.”⁶⁵

The authors offered three options for a fully privatised health system. The first was a purely voluntary system under which individuals would decide for themselves about the purchase of health insurance. All services would be privatised and the government would have no role in the subsidisation of insurance. The government would retain a role in the provision of those public health functions that contribute to the public good, but are not voluntarily supported.

The second option was for a system that included voluntary insurance and a publicly funded safety net. This would modify the previous scheme by

⁶⁵ Danzon and Begg, *Options for Health Care in New Zealand*, p.59.

government provision of a level of health care for those who had not provided for themselves through health insurance. The third option was for compulsory health insurance supported by targeted subsidies for those for whom the cost of private insurance is a problem, either because of low income or high risk.

The report discussed the problems of the three options offered, but the broad recommendation was for a move toward corporatisation of health services and the use of private insurance to fund health services, supported by a government provided safety net.

In retrospect the reviews discussed and their recommendations appeared to have little immediate impact on the state funded health sector. However, the following sections will demonstrate that they indicated a trend in the ideas and thoughts of those advising government. Many of the ideas discussed in this section reappear in the changes initiated by the Labour Government in the late 1980s, discussed in Section D, and in the National Government's health reforms of the early 1990s, discussed in Section E.

D: Health Sector Change

By the early 1980s there was recognition that change had to take place in New Zealand's health sector. The Area Health Board Act (1983) was introduced by a National Government to rationalise the structure of health service provision in New Zealand along the lines recommended in the 1974 White Paper. Under this legislation the 29 Hospital Boards, which provided personal health services, and the 18 district offices of the Department of Health, which provided public health services, were to be amalgamated into 14 Area Health Boards (AHBs) initially responsible for the purchasing and provision of hospital and public health services. However, it was anticipated that their role would later be extended to include primary health care.⁶⁶ The establishment of this structure was a complex process that was not completed until 1989.

⁶⁶ Laugesen and Salmond, 'New Zealand Health Care', p.15.

During this period the Fourth Labour Government came to power, introducing, as is discussed in Chapter One, a new political economic philosophy across both the private and the public sectors. However, in the area of social services, including health, the Government remained committed to the egalitarian approach that had received bipartisan support since the emergence of the Welfare State in the late 1930s and early 1940s.⁶⁷

The Labour Government commissioned The Health Benefits Review and The Hospital and Related Services Taskforce and, while very few of their recommendations were immediately implemented, these two reports contributed to and influenced the debate on the future of New Zealand's health sector.⁶⁸ However, there was some movement, including the introduction of general management in 1988 to replace the complex management triumvirate of a nurse, a doctor and an administrator that had been criticised by the Gibbs Report. Furthermore, accountability for the range of services provided was established through annual contracts between the AHBs and the Minister of Health based on the New Zealand Health Charter.⁶⁹

These organisational changes reflected those taking place in the wider public sector in an attempt to increase efficiency and make transparent the operation of publicly funded services. In the health sector there was an improvement in productivity levels with an increase in the number of surgical procedures being undertaken and a decrease in the average stay in hospital.⁷⁰ However, despite increased efficiency, pressure to reduce expenditure on health services continued.⁷¹

⁶⁷ For discussion of the term egalitarian and this concept in the New Zealand context see Toni Ashton, 'Reform of the Health Services: Weighing up the Costs and Benefits', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), 146-168 (pp.147-148).

⁶⁸ Ashton, 'Reform of the Health Services', pp.149-150.

⁶⁹ Ashton, 'Reform of the Health Services', p.150.

⁷⁰ Treasury, *Briefing to the Incoming Government* (Wellington: Treasury, 1990). See also Brian Easton, 'How did the Health Reforms Blitzkrieg Fail?' *Political Science*, 46 (1994), 215-233.

⁷¹ For discussion of health expenditure in New Zealand during this period see D. Muthmala and C.G. McKendry, *Health Expenditure Trends in New Zealand: 1980-1991* (Wellington: Department of Health, 1992).

The need to reduce expenditure resulted in pressure to cut back services. However, the multiple roles of the AHBs made this difficult. On the one hand, control of both personal and public health resulted in the less demanding public health services being cut back to meet the growing demands of the hospital sector.⁷² On the other hand the AHBs' role as a service provider, and thus owner of the provision infrastructure, was in conflict with their responsibility as purchaser to select the most efficient service. Their ownership role promoted continuation of the status quo, inhibiting their flexibility to respond to the community's changing needs through use of services in the private sector or by moving from the centralised hospital based services into the community.⁷³

During the 1980s New Zealand's health sector began to introduce some of the features of market individualism which were having such an impact in the wider economy. However, these were limited to the organisational and structural aspects of the service, requiring the system, and individuals working in the service, to take responsibility for decisions through increased accountability. Availability of health services remained within the realm of positive individualism, whereby individuals are able to maximise their potential with the support of a universal entitlement to health care as a right attached to citizenship. Individualism was also to be a feature of the reforms which were to follow in the 1990s when there was a move away from the positive individualism toward so-called negative individualism whereby individuals are forced to make choices based on their own resources. This shift has not been clear-cut, however, and New Zealanders' health needs are met in a system which balances between positive and negative individualism.⁷⁴

⁷² Ashton, 'Reform of the Health Services', p.151.

⁷³ Ashton, 'Reform of the Health Services', p.151. This was a reason given by Upton for the structural changes which were part of the 1991 health sector reforms.

⁷⁴ The concepts of positive and negative individualism are discussed further in Chapter Two.

In 1990 the National Party came to power on an election promise to continue to provide health services in line with the long standing egalitarian model. However, in December 1990 an economic statement introduced changes which indicated a shift to a more-market approach in social assistance policy. In the area of health services this included the introduction of user part-charges based on income levels.⁷⁵ Also announced was a Ministerial Committee on the Funding and Provision of Health Services, which was to become known as the Health Services Taskforce.⁷⁶ Although this committee did not release a final report its findings contributed to the shape of major reform in New Zealand's health sector announced in 1991. The next section examines the resulting reform of the health sector.

E: The Health Sector Reforms (1991)

In July 1991 the Minister of Health, Simon Upton, released the Green and White Paper *Your Health and the Public Health: A Statement of Government Health Policy*.⁷⁷ This document announced the Government's intentions for reform of the health sector and proposed options for related policy to stimulate public debate. In his introductory statement Upton declared that "[t]he primary objective of this reform process must be to secure, for everyone, access to an equitable level of health care. Low income should not create a barrier to quality care."⁷⁸ To achieve this end New Zealand's state funded health sector was to be reformed in line with changes which had taken place in other sectors of the New Zealand economy. The health sector reforms were based on the prevailing neo-liberal philosophy, discussed in Chapter One, which supported the separation of roles,⁷⁹ an emphasis on business like practices and the introduction of competition.

⁷⁵ For a discussion of user part-charges and their impact see Blank, *New Zealand Health Policy*, pp.140-141.

⁷⁶ For a discussion of the Taskforce and its operation see Pauline Barnett and Kerry Jacobs, 'Policy-making in a Restructured State: The Case of the 1991 Health Reform Policy in New Zealand', *Australian Journal of Public Administration*, 59 (2000), 73-86.

⁷⁷ Simon Upton, *Your Health and the Public Health: A Statement of Government Health Policy*, Minister of Health (Wellington: Minister of Health, 1991).

⁷⁸ Upton, *Your Health and the Public Health*, p.1.

⁷⁹ The roles separated out under the neo-liberal political economic philosophy included those of policy advice, service purchasing or funding and service provision.

To establish a split between the purchasers and the providers of health services four Regional Health Authorities (RHAs) were to be established. RHAs would purchase health services for their community from service providers in the public, private and voluntary sectors. They would be funded on a population basis from government and guided in their purchasing decisions by the needs of the community they served and by guidelines and priorities set in the Ministry of Health.⁸⁰ RHAs were to be run by Boards appointed by the Minister of Health.

Business like practices were to be adopted by publicly owned health care providers through the creation of 23 Crown Health Enterprises (CHEs) which would be required to return a profit to the Crown. The CHEs would subsume existing publicly funded facilities and were to be based around major public hospitals. CHEs would be run by Boards appointed by the Minister of Crown Health Enterprises, a position created to ensure the split between the funding and provision of health services went right through to the Ministerial level. RHAs and CHEs would eventually take up the roles of the AHBs, which were immediately disbanded, but in the interim Commissioners were appointed to take over the running of the AHB facilities. RHAs and CHEs were established under the Health and Disability Services Act (1993) and began to operate officially in July 1993.

In order to provide consumers with choice and to ensure competition in the health sector the Green and White Paper proposed that individuals have the option of taking their funding entitlement from the RHA to a Health Care Plan (HCP). HCPs would be obliged, under statute, to provide a given level of services to its members. This would enable individual New Zealanders to choose a health services purchaser which would be obliged to provide a specified range of services, but which would have a focus suited to their health needs, for example women, young families or Maori.⁸¹ However, in June 1992 Upton announced that the Government would not proceed with HCPs because the information needed to

⁸⁰ See for example Ministry of Health, *Policy Guidelines for Regional Health Authorities 1995/96* (Wellington: Ministry of Health, 1995).

⁸¹ Upton, *Your Health and the Public Health*, p.61.

implement them fairly did not exist.⁸² This removed the element of individual choice in selecting purchasers of health care.⁸³

The reforms also provided for the establishment of the Public Health Commission (PHC) to be the part of the state funded health sector infrastructure dedicated to public health matters. It was to manage the budget for public health activities, advise the government on issues of public health, purchase public health services and advise “the Government, RHAs and health care plans on personal health care services required to meet public health type objectives, for example, immunisation.”⁸⁴

The establishment of the PHC was a staged process. The Public Health Commission Implementation Group was appointed in November 1991, an Establishment Board was appointed in July 1992 and the PHC came into formal existence, under the Health and Disability Act, on 21 June 1993. However, work had already begun on achieving the PHC’s pilot health goals announced by the then Minister of Health, Simon Upton, in November 1992.⁸⁵

The PHC operated until 1995 when it was disbanded, its purchasing roles absorbed by the RHAs and its advisory role moving into the Ministry of Health. The end of the PHC is still shrouded in rumour, but it is suggested that the philosophy of the Commission was at odds with the neo-liberal philosophy of the government and met with opposition from other government departments and business interests whose practices were called into question by the PHC.⁸⁶

⁸² *New Zealand Parliamentary Debates*, Vol. 528 (1992), p.10776.

⁸³ For a full discussion of the rationale behind HCPs and their abandonment see Mary Finlayson, *An Analysis of the Implementation of Health Policy in New Zealand, 1991-1996* (unpublished doctoral thesis, University of Waikato, 1996), pp.114-117 and pp.198-226.

⁸⁴ Upton, *Your Health and the Public Health*, p.111.

⁸⁵ Minister of Health ‘Press Release: Policy Guidelines to the Public Health Commission’, 25 November 1992.

⁸⁶ For a discussion of the dis-establishment of the PHC see Marten Hutt and Philippa Howden-Chapman, *Old Wine in New Bottles: The Public Health Commission and the Making of New Zealand Alcohol Policy* (Wellington: Institute of Policy Studies for the Dept. of Public Health, Wellington School of Medicine in conjunction with the Health Services Research Centre, 1998), p.142; Todd Kriebel, ‘The Rise and Fall of the Crown Entity: A Case Study of the Public Health Commission’, *Public Sector*, 20 (1997), 19-22; Linda Goodwin, ‘The Rise and Fall of the Public Health Commission’ (unpublished master’s thesis, University of Waikato, 1997).

Hutt and Howden-Chapman, in their examination of the development of New Zealand's alcohol policy, identify three main reasons for the demise of the PHC. First, the government's objectives had changed, second, there was a high level of rivalry between the PHC and others in the bureaucracy, including the Ministry of Health, and third, pressure from groups with a vested interest in matters of public health.⁸⁷ Barnett and Malcolm also discuss the political unacceptability of the PHC.⁸⁸

The PHC was established as a Crown entity.⁸⁹ As such it had a degree of independence and accountability which is consistent with the neo-liberal approach to the conduct of policy advice. However, it apparently interpreted its brief in a way inconsistent with the prevailing individualist philosophy of government, business and society. Hutt and Howden-Chapman discuss a document which illustrates the PHC's attitude. A submission from the Beer, Wine and Spirits Council asserted that "You cannot coerce people into good health." However, annotations on this document suggest that the PHC thought it could use coercive methods to achieve an improvement in the health of New Zealanders. The comments were, first, "The PHC has been set up to improve and protect the public health" and second, "We have legislation for this purpose."⁹⁰

In addition to its prescriptive elements the Green and White Paper identified issues for further public debate. The National Advisory Committee on Core Health Services, known as the Core Services Committee, was established in 1992 to define a core of health services which would be available to New Zealanders within the state funded health sector. However, the Committee was not able to establish an explicitly defined list of services, and within its first year of operation shifted its focus to determining the circumstances under which services should be available in the state funded health sector.⁹¹ The government later changed the

⁸⁷ Hutt and Howden-Chapman, *Old Wine in New Bottles*, pp.19-22.

⁸⁸ P. Barnett and L.A. Malcom, 'To Integrate or Disintegrate?: Fitting Public Health into New Zealand's Reforming Health System', *European Journal of Public Health*, 8 (1998), 79-86 (p.83).

⁸⁹ For discussion of this see Hutt and Howden-Chapman, *Old Wine in New Bottles*, pp.14-20.

⁹⁰ Cited in Hutt and Howden-Chapman, *Old Wine in New Bottles*, p.27.

⁹¹ For a discussion of the Core Services Committee and its changing role see Jacqueline Cumming, 'Core Services and Priority Setting: The New Zealand Experience', *Health Policy*, 29 (1994), 41-60.

Committee's name and Terms of Reference. It became the National Health Committee, with responsibility for providing the Minister of Health with independent advice on the kinds of, and priorities for, health services that should be available in the state funded health sector.⁹²

The other matter proposed for discussion in the Green and White Paper was the way in which health services would be funded in New Zealand. The alternatives included funding health care from general tax revenue, a continuation of the existing system, a system of social insurance payments, a tax dedicated to health care, compulsory health insurance in the public sector and private health insurance with a safety net for those unable to obtain cover in the private sector.⁹³ The Green and White Paper set out the alternatives, indicating the government's preferences, and invited submissions on options for the funding of health care. Cumming and Salmond suggest that the government's retreat from change in this area, with the retention of a tax-based system of funding health services, was a response to their declining popularity.⁹⁴

The health sector changes proposed in the Green and White Paper sought to achieve a number of things. Upton's explicit objectives, set out above, were supported by a number of others. The funder-provider split, more accurately the funder-purchaser-provider split, divided the roles in order to clarify the objectives of the various institutions. It was Upton's contention that the range of responsibilities held by AHBs had confused their decision making.

The move away from elected Boards was another component of the reforms. There had long been concern that AHBs did not have enough business expertise and in 1988 this problem prompted the Labour Minister of Health to reduce the number of elected members and make up the numbers with government appointed persons with relevant business expertise.⁹⁵ However, as discussed above, the 1991 reforms replaced elected Boards, initially with Commissioners and later with

⁹² For the National Health Committee's Terms of Reference see their web site at <http://www.nhc.govt.nz>

⁹³ Upton, *Your Health and the Public Health*, pp.89-103.

⁹⁴ Cumming and Salmond, 'Core Services and Priority Setting', p.129.

⁹⁵ Claudia D.Scott, 'Reform of the New Zealand Health Care System', *Health Policy*, 29 (1994), 25-40 (p.28).

appointed Boards. The rationale behind this was that elected Boards were subject to capture by interests in the health sector, for example by doctors, nurses or by other community interest groups.

Reducing the power of professional groups within the health sector was also a motivation for the introduction or extension of managerialism. Upton stated that clinicians were to be allowed to concentrate on their areas of expertise while the running of institutions was to be handled by managers. This also facilitated the move into more business like practices, for example contracting.

Economic incentives were introduced into decision making at all levels of the process. Competition between both purchasers and providers was intended to increase efficiency. The financial contribution consumers were required to make to both hospital and outpatient services was intended to promote resource utilisation assessment.

Throughout the change process, the rhetoric of positive individualism was used to justify changes motivated by neo-liberal individualism that can be perceived as negative. New Zealanders were told that the health reforms would give them more choices and make more explicit what they could expect from the state funded health sector and what they could expect to have to fund themselves. This thesis will argue that while the changes are related to individualism, the focus is on the type of individualism which allows a reduction in the state's role in funding services for individuals - that is neo-liberal individualism. The changes in the health sector were motivated by the need to reduce state spending on health, and transferring responsibility for both choice and funding from the state to the individual was a strategy employed in this process.⁹⁶

⁹⁶ State spending on health has continued to increase across the period of health reform. Although there have been changes in the way funding is allocated and in the services provided for under the health budget, spending on health has increased both in real and nominal terms, and as a percentage of GDP. See Chandra Galapitige, *Health Expenditure Trends in New Zealand 1980-1998* (Wellington: Ministry of Health, 1999).

An example of this is in the adoption of user part-charges for hospital care, putting it on a par with primary health care. The suggestion was that individual New Zealanders were not giving due consideration to their choices in health care because hospital services were free. User part-charges are designed to make health care consumers aware of the cost of health care, thus reducing demand for services.⁹⁷ The introduction of a part-charge was supposed to prompt consumers to consider how they would prefer to spend their money. This suggests that individuals consume health care, not by necessity, but by choice, much as they would choose to purchase entertainment or clothing. It also assumes that they have choices from which to select service providers.

In part because the reform process was not implemented as first promulgated New Zealanders were not provided with increased choice, nor were their entitlements to state funded health sector care made explicit. Because HCPs were not established individuals could not take their entitlement to state funding to another purchaser. This removed the availability of choice to those who could not afford to purchase private medical insurance. The Core Services Committee failure to determine a core of services to which New Zealanders would be entitled as of right meant that uncertainty remained in this area and waiting lists were used to ration services, particularly in the area of surgical services. Changes in the area of public health will be discussed later in the chapter

There have been positive outcomes from the reform process, for example as it provided scope for the introduction of special initiatives in response to particular problems. Innovative approaches in respect of childhood immunisation are discussed in later in the thesis. There was, however, increasing disquiet about the state of the health sector in New Zealand and it was a major issue in the 1996 General Election with particular attention to waiting lists and the withdrawal of hospital services from rural communities.

⁹⁷ Blank, *New Zealand Health Policy*, p.77.

The December 1996 agreement between the National Party and New Zealand First to establish a Coalition Government prescribed a number of changes which altered the structure of the state funded health sector and its objectives. The profit motive was removed. Ministerial lines of responsibility for purchasing and provision, previously divided between the Minister of Health and the Minister of Crown Health Enterprises, were united in one Minister and an Associate Minister. Increased funding was made available to reduce waiting lists and improve health services.⁹⁸

In 1999 a change of government preceded another series of major changes in the health sector. These are taking place at the time of writing, but Annette King, Minister of Health in the Labour Alliance Coalition government has already indicated the future shape of the health sector in a return to elected District Health Boards. A plethora of documents are being produced as strategy in the health sector is reassessed.⁹⁹ As has been discussed previously health is a political issue and the change of government saw changes in the way policy was shaped. The political issues involved in childhood immunisation policy will be discussed in Chapters Six, Seven, Eight and Nine.

IV: Conclusion

New Zealand's health sector has always, to a greater or lesser degree, reflected the political economic philosophy dominant in wider society and government. In the early post-colonial era the emphasis on market exchange and an individualist focus on caring for one's self and one's own family was reflected in the private sector, market exchange nature of health care services. In the post-war years health care services were provided on the basis of universal entitlement within the welfare state, although those who were able could avail themselves of the private sector alternative. In the last decade of the twentieth century the health sector

⁹⁸ Toni Ashton, 'The Health Reforms: To Market and Back?' in *Redesigning the Welfare State in New Zealand: Problems, Policies, Prospects*, ed. by Jonathan Boston et al. (Auckland: Oxford University Press, 1999), pp.134-153 (pp.139-140).

⁹⁹ These include; Annette King, *The Future Shape of Primary Health Care: A Discussion Document* (Wellington: Ministry of Health, 2000); Annette King, *The Health Strategy: A Discussion Document* (Wellington: Ministry of Health, 2000).

came increasingly to reflect the political economic philosophy of neo-liberalism and the expressions of individualism encompassed in that world view.

The health sector was initially cushioned from the impact of post-1984 neo-liberalism by Labour's wish to protect social policy. Even since 1991, when the more-market approach began to impact on the health sector, it was still not subject to the potential extremes of privatisation. It did, however, have to adjust to a more business like approach, including aspects of competition, contracting, rationing and the profit motive. In this way neo-liberal individualism has had a direct impact on health sector policy and the provision of health services in New Zealand.

There are, however, aspects of civil individualism in the introduction of health sector reforms, reflecting the situation evident in wider political economic reform. For example in the matter of choice discussed in respect of the Green and White paper, *Your Health and the Public Health*. This may be interpreted as an aspect of civil individualism in that it indicates an intention to create a situation whereby the consumer of health services had some control in choosing their service provider or the mode of service delivery. While this was to be the case in some situations, rather than being the desired result, consumer choice was a by-product of the drive to ensure competition in the health market. This is an example of the use of the rhetoric of, or appeal, to civil individualism to justify or disguise a change introduced to further neo-liberalism.

Despite the impact of neo-liberal individualism on official mechanisms, economic policy was not the only influence shaping health service provision in New Zealand. While it is not possible to determine whether it is as a reaction to changes in health policy, the general political mood of New Zealand or to other factors, attitudes toward and within the health sector have been changing. Chapter Four examines some of the factors which indicate changing attitudes as well as events which have themselves motivated changes in attitude.

Chapter Four

CHANGING ATTITUDES TOWARD HEALTH AND HEALTH CARE

I: Introduction

While our understanding of health is changing and the health sector reforms are altering the way health care is delivered in New Zealand, other factors are also influencing both the structure and function of the health sector and the way in which society interacts with the health sector. Chapter One introduced a number of the changes taking place in New Zealand society. Some of those changes have a particular impact in the area of health and health care. While it is possible to identify some of these changes independently, they interact in various ways to have an important impact on the health sector. Some are universal, reflecting the situation found in other countries of similar circumstances, but others relate to, or are illustrated by, particular events in the New Zealand situation.

II: Examples of Attitudinal Change

Western society has begun to shift away from its modern acceptance of the dictates of science, a factor which in the health sector is illustrated by the decline of what has been called the medical model.¹ The resulting change in the relationship between medicine and the community has seen a decline in the professional dominance the traditional medical establishment once had in the health sector. There are a number of symptoms of this, one of which is recognised as the rise of alternative medicine. In the New Zealand context there are specific examples which illustrate this, ranging from consumer based movements like Parents Centre, to official investigations like the Cervical Cancer Inquiry.

¹ The term 'medical model' will be discussed later in this section.

The issues discussed in this section are indicative of attitudes shaping the health sector both in terms of the reform process and as the community's reaction to the reform process. While equal weight has been given to each issue they are interdependent, having an influence upon each other and therefore cannot be considered in isolation.

A: The Medical Model

Western society has experienced a long period during which orthodox medicine has dominated the health sector. Doctors have exercised significant power in defining illness and health, when those conditions exist, how they should be treated and who should have the right to practice the science of medicine.² The power of the medical profession has been supported and legitimised by both society and the state as each turned to doctors for assistance and followed their advice, endorsing medical science and its practitioners as the authority in matters of health and health care.

Although medicine remains powerful, in the late twentieth century there are a number of challenges to its dominance. The doctor's skills continue to be important and in demand as much of society still looks to medicine for help when they are ill.³ However, society, or at least parts of it, is rejecting the paternalism of the medical profession, and espousing an interpretation of health which allows individuals greater self-determination. To understand why this is happening it is necessary to realise the basis on which medicine's legitimacy was established and the changes within society which render such a situation no longer universally acceptable.

² These points are discussed by Fritjof Capra, *The Turning Point: Science, Society and the Rising Culture* (New York: Simon and Schuster, 1982); and Ian Kennedy, *The Unmasking of Medicine* (London: George Allen and Unwin, 1981).

³ Simon J. Williams and Michael Calnan, 'Conclusions: Modern Medicine and the Lay Populace in Late Modernity', in *Modern Medicine: Lay Perspectives and Experiences*, ed. by Simon J. Williams and Michael Calnan (London: UCL Press, 1996), pp.256-264 (p.256).

Medicine is based on positivist science and, at the turn of the millennium, was practised according to what has been labelled the medical or biomedical model.⁴ Capra discusses the development of the biomedical model under the influence of Descarte's idea of the separation of mind and body. Medicine emerged from a mechanistic view of the human body, reducing everything to its constituent parts. Illness was assumed to be a breakdown in the human machinery which required fixing. Thus medicine had a very narrow view of health and illness, excluding consideration of factors other than the physical. Little attention was given to the role of environmental or attitudinal factors in disease causation. Because doctors alone were considered competent to determine when an individual is ill, individuals' responsibility and liberty was lessened.⁵

Capra questions the role of medicine, given the gaps in its understanding of illness and the wide range of influences on health and illness. The legitimacy of medicine's dominance in the health area and its role in general society have been challenged by a number of writers on the basis that it excludes significant portions of the human experience, and robs individuals of their autonomy.⁶

Williams and Calnan suggest that the widening gap between medicine and the lay population is linked to the broader changes taking place in Western society.⁷ Chapter One discussed the move away from the faith in science and expertise which grew out of the Enlightenment, and how it has contributed to changing attitudes to medicine. Williams and Calnan argue:

[I]ncreasing lay knowledge about modern medicine, declining deference to experts in society at large, changing attitudes of doctors, and changing patterns of morbidity are modifying social expectations concerning the doctor-patient relationship in the direction of mutual participation.⁸

⁴ Capra, *The Turning Point*, pp.123-163.

⁵ Kennedy, *The Unmasking of Medicine*, pp.7-8.

⁶ Kennedy *The Unmasking of Medicine*; and Ivan Illich, *Limits to Medicine* (New York: Penguin, 1977).

⁷ Williams and Calnan, 'Conclusions', pp.261-262.

⁸ Simon J. Williams and Michael Calnan, 'Modern Medicine and the Lay Populace: Theoretical Perspectives and Methodological Issues', in *Modern Medicine: Lay Perspectives and Experiences*, ed. by Simon J. Williams and Michael Calnan (London: UCL Press, 1996), pp.2-25 (p.9).

Gabe, Kelleher and Williams suggest that challenges to the dominance of medicine have come from a number of sources including management, nursing, alternative medicine, the legal profession, journalists, lay consumers and social movements.⁹ While each of these are important and have an influence on the way in which medicine is perceived, this section will concentrate on exploring the reasons medicine is understood differently in general society, in the eyes of actual and would-be consumers of health services.

Risk has become an important issue in the judgement of medicine by health consumers. According to Williams and Calnan:

Widespread lay knowledge of modern risk environments serves to expose the 'limits' of so-called 'expertise', thus serving to weaken or further undermine people's faith and confidence in official pronouncements, including those of the medical establishment, concerning public safety and danger.¹⁰

The impact of risk assessment on the gap between the medical profession and lay consumers of health services is exacerbated by the different ways in which scientists and members of the lay population assess risk.

The management of risk traditionally has relied on calculations of predicted physical harm that reflect the probability and magnitude of an event's consequences to human health. Only recently have researchers begun to analyse the ways in which the public intuitively understands risks and makes judgements concerning the comparative dangers of different technologies. One important finding is that experts and laypersons often disagree about the meaning of risk: the qualities of the hazard can matter as much as the quantity of the risk faced by the public.¹¹

⁹ David Kelleher, Jonathan Gabe and Gareth Williams, 'Understanding Medical Dominance in the Modern World', in *Challenging Medicine*, ed. by Jonathan Gabe, David Kelleher and Gareth Williams (London: Routledge, 1994), pp.xi-xxix (p.xiii-xix).

¹⁰ Williams and Calnan, 'Conclusions', p.262.

¹¹ Robin Gregory, Paul Slovic and James Flynn, 'Risk Perceptions, Stigma, and Health Policy', *Health and Place*, 2 (1996), 213-220 (p.213).

Thus, as awareness of the limits to and uncertainty of medicine spreads, the lay population is using their new knowledge to measure the risks and benefits of medical treatment on their own scale. This provides another challenge to the position of medical practitioners in the health environment. Chapter Six will explore this issue with specific reference to childhood immunisation.

Whether it is because of the attitudes encountered in society, or because doctors are beginning to recognise the limits imposed on their practice by traditional medicine, even within the medical profession there is recognition that change must take place. Ian Stanley, Professor of General Practice at the University of Liverpool, has noted that society has changed in ways that have rendered medical paternalism an unacceptable basis for the doctor patient relationship.¹² This is just one indication of the recognition of a need for change, but there are alternative routes via which this change could be achieved. One involves doctors recreating their role, but an alternative involves the wider population in this transformation.

Kennedy considers that change lies in a form of consumerism. He suggests that it is necessary for health services consumers to be more informed about their health and their rights. Furthermore, he believes those rights should be protected by the state, arguing that the medical profession should not be left to make all the decisions in the health area, that standards for medicine should not be set by medicine. Kennedy's solution lies in the development of a new relationship between the doctor and the patient, one which alters the balance of power.¹³

¹² Ian Stanley, 'Foreword', in David Seedhouse, *Liberating Medicine* (Chichester: John Wiley and Sons, 1990), pp.xi-xii (p.xi).

¹³ Kennedy, *The Unmasking of Medicine*, p.167.

Seedhouse, on the other hand, suggests that the changes must come from within the medical establishment. In *Liberating Medicine* he discusses the need to free medicine from the constraints which limit the alternatives for its practitioners.¹⁴ This would appear to reinforce the power of medicine. It also acknowledges, however, society's high expectations of medicine in the past and infers a future in which that situation will continue. Seedhouse suggests that doctors should be trained for the roles society expects them to fulfil.

It is desirable that the medical profession and consumers of medical services work in tandem, because challenges to the medical profession's established practices are a reality. The next three sections examine briefly situations in which a challenge to the dominance of medicine is or was perceived even if it was not explicit.

B: Alternative Medicine

One indication of the changing way in which health is understood is in the rising popularity of alternative or complementary medicine, or alternative therapies.¹⁵ The situation in New Zealand reflects similar trends apparent in countries with a comparable profile; that is Western, liberal democracies with a state funded health sector. There is a growing body of literature which examines aspects of alternative medicine, including why more people are consulting alternative therapists, either as an adjunct to or instead of conventional medicine, and how the alternative medicine sector is responding to that growth.¹⁶

¹⁴ Seedhouse, *Liberating Medicine*, p.xiv.

¹⁵ This thesis will use both the terms alternative medicine and alternative therapies.

¹⁶ This literature includes items examining the New Zealand situation, including; Nevill Drury, *The Healing Power: A Handbook of Alternative Medicine and Natural Health in Australia and New Zealand* (Sydney: Australia & New Zealand Book Co., 1981); Julie Leibrich, Janet Hickling, and George Pitt, *In Search of Well-being: Exploratory Research into Complementary Therapies* (Wellington: Department of Health, 1987); Kevin Dew, 'Borderland Practices: Validating and Regulating Alternative Therapies in New Zealand' (unpublished doctoral thesis, Victoria University of Wellington, 1998).

Alternative medicine describes a wide range of treatments including acupuncture, hypnotherapy, homoeopathy, chiropractic, osteopathy, naturopathy, iridology and colour therapy. While some of these therapies have the support of the conventional medical establishment, being considered almost orthodox, others are dismissed as quackery.¹⁷

The increase in demand for alternative therapies became apparent in the 1980s.¹⁸ During that time there was a demand for accreditation of practitioners to give the public some indication of those therapists who were trained to a specified standard. In 1987 the Nationwide Register of Natural Therapists was set up to recognise therapists in a range of disciplines including classical homeopathy, medical herbalist, naturopathy, remedial body therapists and osteopathy. This organisation requires that members practice in accordance with a Code of Ethics and Rules of Practice. The Board established a complaints procedure.¹⁹

The increasing popularity of alternative medicine is further confirmed by a proliferation of training courses and qualifications in alternative therapies. Courses are available through a number of training institutions, including Polytechnics. Some of these courses are accredited with the New Zealand Qualifications Authority. Some courses attract state funding, student allowances and student loans.

Another sign of the shift to alternative medicine is the increased demand for the medicines and herbs which these practitioners prescribe, or which some individuals are purchasing in place of, or in addition to, traditional pharmaceuticals.²⁰ This has prompted an increase in the number of retail outlets and an increase in the production and range of products manufactured or imported.

¹⁷ D.W. Beaven, 'Alternative Medicine a Cruel Hoax - Your Money or Your Life', *NZMJ*, 102 (1989), 416-417 (p.416).

¹⁸ Jan Raymond, 'Homeopathy: Examining the Evidence', *New Ethicals*, 30 (1993), 36-49 (p.36).

¹⁹ New Zealand Natural Health Practitioners Accreditation Board, *Nationwide Register of Natural Therapists* (Auckland, 1997).

²⁰ M. Saks, 'The Alternatives to Medicine', in *Challenging Medicine*, ed. by Jonathan Gabe, David Kelleher and Gareth Williams (London: Routledge, 1994), 84-103 (p.85).

Attitudes to alternative medicine among members of the medical establishment are varied. Writing in the *New Zealand Medical Journal*, Professor Beaven, then of the Department of Medicine at the Christchurch School of Medicine, University of Otago, questioned the safety of alternative therapies, labelling some as exploitative, while others he described as quackery.²¹ However, some medical practitioners will refer patients to alternative therapists and some GPs practice alternative therapies.²²

Medical registration and disciplinary authorities in countries around the world treat the use of alternative therapies in different ways, but in New Zealand there is a degree of tolerance for medical practitioners employing unorthodox practices with good intentions.²³

Acceptance that there has been an increase in the practice of alternative therapies has prompted investigation into the reasons behind this shift. Various scholars have examined a range of rationales. The shifting attitude to medicine and the way doctors are perceived by some individuals is seen to be contributing to the rise of alternative therapies providing, as it does, an alternative to the traditional practices of the medical establishment. This is an indication of dissatisfaction, at least in some sections of society, with what are perceived to be the failures of the medical establishment. Another contributing factor is the wish of an increasing number of individuals to participate in their own health care and receive individualised treatment. In addition, alternative therapists give their clients more time than do medical practitioners.²⁴

An increased awareness of health and a desire to participate more fully in the process than is encouraged by the conventional medical establishment is another reason for consulting alternative medicine therapists who tend to use an holistic approach in place of traditional medicine's often mechanistic and partial approach.

²¹ Beaven, 'Alternative Medicine a Cruel Hoax', pp.416-417.

²² Tony Helman, 'Young Doctors Welcome Alternative Treatments', *New Zealand Doctor* (15 July 1991), p.25; Raymond, 'Homeopathy', pp. 37-38.

²³ David Cole and Ian St George, 'Medicine at the Fringes', *NZMJ*, 106 (14 April 1993), 130-133.

²⁴ These motivations for a shift to alternative medicine are discussed in Kelleher, et al., 'Understanding Medical Dominance in the Modern World', p.xv.

Sharma quotes Coward as suggesting that the use of alternative medicine ties in with the individualist idea of responsibility for oneself and the idea encouraged by alternative therapies that perfection is achievable. Coward is saying that this is part of a cultural shift, that an holistic approach to health is individualistic.²⁵ This ties in with notions of lifestyle and victim blaming in that it assumes that individuals make choices about the level of health each will pursue.

Gabe and Bury suggest that the rejection of pharmaceuticals by some is in part attributable to a more conservative moral order which values autonomy and personal freedom.²⁶ Again this suggests that Gabe and Bury, like Coward, are discussing individualists who adhere to a negative form of individualism within which they value freedom and resist the dictates of outsiders, even those who may do them good.

Alternative medicine is individualist, as is all conventional Western medicine. However, it requires a greater personal commitment to health than traditional medicine for a number of reasons. First, it is without financial subsidisation so the client must assume responsibility for the full cost of the consultation and prescribed treatment. Second, the holistic approach taken by many alternative medicine practitioners requires attention to many aspects of the client's life which require greater participation in the treatment than simple compliance with prescribed treatment.

It is possible, however, to participate at an individual level without rejecting the assistance of those who have greater expertise than ones-self in specialist areas, including medicine.

²⁵ Ursula Sharma, *Complementary Medicine Today: Practitioners and Patients* (London: Routledge, 1992), p.248.

²⁶ Jonathan Gabe and Michael Bury, 'Risking Tranquillizer Use: Cultural and Lay Dimensions', in *Modern Medicine: Lay Perspectives and Experiences*, ed. by Simon J. Williams and Michael Calnan (London: Routledge, 1996), pp.74-94 (p.90).

The willingness of an increased number of New Zealanders to make these commitments signifies changing attitudes, not only toward the medical establishment, but also toward the contribution individuals can make to their own health and that of their families. This commitment has also been seen in organisations which have emerged in response to particular issues. One such movement is Parents Centre.

C: Parents Centre

Parents Centre²⁷ was established in 1952 to “[promote] ... those practices which have beneficial effects upon early parent-child relationships such as education for childbirth, rooming-in, breastfeeding, *home confinement*, and permissive methods of child care.”²⁸ Its founders were inspired by the teaching of Grantley Dick-Read and Maurice Bevan-Brown, both medical practitioners with progressive ideas at variance with normal practice among their colleagues in the medical establishment at the time. Although the organisation did have the support of some doctors, its members encountered a high level of resistance from the medical establishment in its attempts to, first, change obstetric practice and later to introduce more parental involvement with children in hospital.²⁹

In the 1950s birth in New Zealand was dominated by the needs of the hospital and its staff. Hospital routine was rooted in the need for the hygienic and professional practice of obstetrics and midwifery which had helped to overcome New Zealand's earlier extremely high rate of post-partum infection. However, the resulting regimentation of many if not most maternity hospitals allowed parents little control in the birth process. Sedating pain relief during childbirth was routine and

²⁷ Parents Centre was initially called the Natural Childbirth Association, but the practice of natural childbirth was so opposed by those established in orthodox obstetric practice that the name itself encouraged antipathy. From Mary Dobbie, *The Trouble With Women: The Story of Parents Centre New Zealand* (Whatamonga Bay: Cape Catley, 1990), p.21.

²⁸ The aim of Parents Centre as recorded in the draft constitution developed at a general meeting, 25 June 1952, cited in Dobbie, *The Trouble With Women*, p.21. [emphasis in original]

²⁹ Dobbie, *The Trouble With Women*. There is also a brief discussion of the friction between Parents Centre and the medical establishment in Derek A. Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington: Victoria University Press, 1995), pp.165-166.

babies were removed to a central nursery, only brought to their mothers for four hourly feeding.

These examples illustrate the power the medical establishment had in dictating parents' roles in the birth of their children and, later, in the way they were cared for should they require hospitalisation. Attempts to introduce changes in line with recent research on the benefit of parent's early and ongoing continuous contact with their infants met with rejection from obstetricians, GPs, hospital administrators and the Plunket Society. However, Parents Centre persisted and as the organisation spread throughout the country greater pressure was brought to bear on the medical establishment forcing a process of gradual change.

Parents Centre is one of New Zealand's earlier examples of lay or consumer opposition to the dominance and dictatorial position of the medical establishment. The changes required confrontation and were achieved as public awareness of the situation grew. Initially the campaigns for change were met with resistance from the medical establishment, along with resentment that anyone would presume to criticise the work of experts. This was a time when the professionals dominated in matters of health. "[The] public [was] accustomed to accepting the opinions handed down from a professional level far above them."³⁰

Other organisations also working to support parents in areas where the medical establishment was dominant include La Leche League and the Home Birth Movement. In the desire to affect change in the health care they and their families received some parents sought help to avoid the institutions and processes of the medical establishment, while others worked to change the existing system from within. As in the area of alternative medicine these organisations represent a rejection, at least in part, of established practices in the health area, a rejection of the professional dominance in aspects of life over which individuals would wish to have more control.

³⁰ Dobbie, *The Trouble With Women*, p.2.

In 1988 the Royal Commission on Social Policy noted that, in submissions to the Commission:

There was a considerable lobby of women wanting better access to home birth facilities and more education about this birthing choice. These women also wanted birth in hospitals to become more responsive to the women's wishes so that women had control of their birthing experiences.³¹

In addition submissions to the Commission had criticised the attitudes of doctors and specialists toward women.³²

Parents Centre is an example of lay consumers who, armed with knowledge on a topic that was of interest to them, challenged the existing practices in that area. Because this was an area which fell within the domain of the medical profession, was in fact an area that had been medicalised, this brought Parents Centre into confrontation with the medical profession. That there was active resistance to these individuals getting what they wanted for themselves illustrates the power the medical establishment had to decide what was best for individuals even against their own wishes.

That such a body emerged was a generational rebellion against a situation which had previously been accepted. Kedgley states that many women, discussing their birthing experiences and hospitalisation in the 1950s, report handing responsibility to the experts because they had no knowledge of childbirth themselves, and felt isolated and frightened in a strange environment where the midwives and nurses were in control.³³

³¹ Royal Commission on Social Policy, *The April Report: Report of the Royal Commission on Social Policy* (Wellington: The Commission, 1988), Vol.1, p.226.

³² Royal Commission on Social Policy, *The April Report*, Vol.1, p.227.

³³ Sue Kedgley, *Mum's the Word: The Untold Story of Motherhood in New Zealand* (Auckland: Random House, 1996).

The presence of such a body of thought suggests that government's attempts, during the reform process begun in 1991, to block the power of medicine and the traditional medical establishment institutions had support within the community. Whether the outcomes of the reform process have advantaged these groups is an area for further examination which is beyond the scope of this thesis.

The Parents Centre example illustrates a gradual process of incrementalism pursued by consumers of a health sector service, gradually expanding the group of parents who demanded, although did not always get, the changes they wanted in the health care available to themselves and their children. However, the Cervical Cancer Inquiry influenced a broader constituency, shifting the way in which many New Zealanders related to the health sector and the medical establishment in particular.

D: The Cervical Cancer Inquiry

The Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and the crisis which motivated it are seen by OECD reviewers as one of the two major factors contributing to the rise of health consumerism in New Zealand.³⁴ The Cervical Cancer Inquiry was initiated after an article in *Metro* magazine detailed the experimental nature of treatment for cervical cancer at New Zealand's major women's hospital, alerting public attention not only to this specific issue, but also to relationships within the medical establishment.³⁵ While it addressed specific concerns about the ethics of research and informed consent to medical treatment the Inquiry also raised in the public consciousness questions about the way in which the medical profession related to their patients, the level of information given to patients and patients' right to have information on and be involved in treatment related decisions.

³⁴ Discussed in OECD, 'New Zealand', *The Reform of Health Care Systems: A Review of Seventeen OECD Countries* (Paris: OECD, 1994), pp.227-242 (p.233). The other factor was the crisis in New Zealand's psychiatric services, an issue which is beyond the scope of this thesis.

³⁵ Sandra Coney and Phillida Bunkle, 'The Unfortunate Experiment at National Women's Hospital', *Metro*, June 1987, 46-65.

The central issue before the Cervical Cancer Inquiry was a research project, initiated in 1966 by Dr Herbert Green and continued into the 1980s, designed to test the hypothesis that a particular pre-cancerous state, carcinoma in situ (CIS), did not develop into an invasive malignancy. The course of treatment, or lack of treatment, employed in this trial was contrary to normal practice in gynaecology around the world and had been criticised in academic fora. Peripheral, but no less important, issues included why the women included in this study were not aware they were subjects in a research trial, why other medical practitioners were unable to challenge Green's methods and why the ethics committee had approved a research project, the aims of which had been dismissed by other experts in the field. The Inquiry was to uncover a large number of issues of concern in the relationship between the medical establishment and lay consumers of health services.³⁶

The Report of the Cervical Cancer Inquiry, also known as the Cartwright Report, commented on and made recommendations in respect of a number of matters, including the detection and treatment of CIS, research protocols, patients' rights, informed consent and the role of teaching in clinical practice.³⁷ After the publication of the Report in 1988 there was a political commitment to carry out its recommendations.

While the recommendations of the Cervical Cancer Inquiry and their implementation are important, it is this situation's contribution to a change in the relationship between the medical establishment and lay health services consumers which is central to this thesis. On one level the Inquiry's recommendations required changes in policy and procedure, but on another level the fact of the Inquiry itself, the events that led up to it and the publicity which surrounded the

³⁶ For detailed discussion of and comment on the issues discussed at the Cervical Cancer Inquiry see Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters, *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (Auckland: The Committee, 1988); Sandra Coney, *The Unfortunate Experiment* (Auckland: Penguin, 1988); Clare Matheson, *Fate Cries Enough* (Auckland: Spectre, 1989).

³⁷ Committee of Inquiry, *The Report of the Committee of Inquiry*.

process raised the profile of an individual's knowledge about and responsibility for their own health in the public consciousness.

Even before the Cartwright Report was published Coney noted a shift in attitudes:

Consumers wanted a new relationship with doctors, one where there was an equal partnership, a collaborative relationship where the consumers could have real choices and exercise real control over their bodies and health care. The medical profession, ... 'is trying to come to grips' with the changes in public attitude, but currently 'there is a bit of a mismatch.'³⁸

The Cervical Cancer Inquiry revealed that the medical establishment was not always driven by the same factors that motivated lay consumers. This realisation forced individuals and groups to realise that they had to take responsibility for their own health and safety, even within the health sector. However, the Cartwright Report recommended that guidelines for informed consent be set in place to ensure that all individuals undergoing medical or surgical procedures were informed about the procedure, its side effects and the alternatives available to them. There was wide debate on the matter of informed consent, including documents from the Department of Health.³⁹

The major impact of the Inquiry and the publicity which had surrounded it was the attention it focused on rights, responsibilities and attitudes within the health sector. While it is not possible to quantify the changes that have taken place in this area, there is a belief that the consequences of the process have been significant. According to a survey undertaken by the Federation of Women's Health Councils in 1993 the findings of the Cartwright Report were being implemented in a very patchy way:

It is clear that the flurry of activity in response to the [Cartwright] Report has not been sustained and that knowledge of the recommendations has become blurred and less familiar to people over time. Medical practitioners in particular continue to distance themselves from the Cartwright Report dismissing it as a 'thing of the past'. For women, the Report continues to be a cornerstone for their rights as health consumers.⁴⁰

³⁸ Coney, *The Unfortunate Experiment*, p.263.

³⁹ Department of Health, *Principles and Guidelines for Informed Choice and Consent for all Health Care Providers and Planners* (Wellington: Department of Health, 1991).

⁴⁰ Federation of Women's Health Councils Aotearoa-New Zealand, *Is Cartwright Still an Issue?* (Auckland: A Federation of Women's Health Councils Discussion Document, 1993), p.22.

This position is endorsed by Coney who, while detailing the way in which the inquiry's recommendations have been derailed, applauds attitudinal changes within the health sector:

Health care consumers have become more assertive and aware of their rights, and health professionals' awareness of issues such as informed consent has been heightened. Patients are more likely to be offered information to make decisions, and they feel more able to ask questions, and have them answered.⁴¹

It cannot be assumed that this attitude is universal, but it is indicative of a change. Considered along-side other indications of attitudinal change discussed above, it provides some evidence of the issues the New Zealand community consider important in the formulation of health policy and the delivery of health care.

The period since the Cartwright Report has seen significant changes in the relationship between health care providers and consumers. This has been attributed to a combination of the health reforms and the implementation of Judge Cartwright's recommendations, including the Code of Consumer Rights. Townshend, Sellman and Haines suggest that aspects of each have impacted upon the concept of partnership in health care.⁴² These matters clearly need regular and ongoing attention as the context of health and the shape of the health sector changes.

E: Discussion

In concluding an examination of the relationship between the medical establishment and lay society Williams and Calnan note that it is difficult to frame simple answers to questions about individuals' involvement in their own health and health care:

[L]ay people are not simply passive or active, dependent or independent, believers or sceptics. Rather they are a complex mixture of these things (and much more besides)... social reality, in truth, is

⁴¹ Sandra Coney, 'Unfinished Business: The Cartwright Report Five Years On', in *Unfinished Business: What Happened to the Cartwright Report?* ed. by Sandra Coney (Auckland: Women's Health Action, 1993), pp.19-49 (p.48).

⁴² Philip L. Townshend, J. Douglas Sellman and Rodney Haines, 'The Cartwright Report Ten Years On: The Obligations and Rights of Health Consumers and Providers', *NZMJ*, 111 (1988), 390-393.

both complex and contradictory, and we would do well to remember this as we edge ever closer to the twenty-first century.⁴³

In examining the attitudinal changes affecting New Zealand's health sector this observation is important. Any change in the health sector both influences and is influenced by other changes. While the process of structural change in the health sector has been significant, so too have attitudes within both the medical establishment and lay society. While individuals and society continue to appreciate and utilise the advantages of modern scientific medicine there has been a move away from the wholesale adherence to the dictates of the medical establishment. That individuals are taking a greater role in their own health can be explained in a number of different ways.

First, a higher level of participation is required by changing patterns of service provision which require individuals to have a greater input into their health care. No longer, if it was ever wholly the case, are services provided automatically, so the individual is required to take a greater part in initiating and organising their own health care. One of the consequences of this is that some individuals are more likely to question that which they once took for granted.⁴⁴

Second, individuals in the lay population have greater access to health information than ever before. Health promotion programmes, the requirements of informed consent and access to technology have all contributed to this position. So too has the attitude that knowledge about an individual's health is no longer the prerogative of trained health workers.

Third, individuals are prompted to take greater control over their own health as part of the wish to have greater autonomy in all facets of their lives. The Parents Centre example suggests that there have always been those in New Zealand society prepared to work for the right to determine their own health care choices. The issues Parents Centre fought for in the 1950s and 1960s are now taken for granted in maternity and child care. It is possible there are other areas of health

⁴³ Williams and Calnan, 'Conclusions', p.264.

⁴⁴ It is suggested that in order for health sector reforms like those which took place in New Zealand to work it is necessary to have an empowered consumerate. L. Segal, 'The Importance of Patient Empowerment in Health System Reform', *Health Policy*, 44 (1998), 31-44.

care where what we now consider normal will, in the future, be considered oppressive medicalisation.

It is unlikely that these explanations exist as discrete entities, but rather that it is a combination of these and other factors which motivate individuals. There is a fourth group, however, for whom the three explanations discussed above have little meaning. This is a group of New Zealanders for whom changes in the infrastructure of the welfare state, including health, housing, employment and income support, reduced any ability they had to participate effectively in the maintenance of their own health and that of their families.

Poverty has increased in the years since the Fourth Labour Government was elected in 1984.⁴⁵ This change has not been even across New Zealand society. “The incidence of poverty is more that 2 ½ times greater among Māori and more than 3 ½ times greater among Pacific Island families, than it is among Pakeha families”.⁴⁶

It is well recognised that social, cultural and economic factors have an impact on health. Those New Zealanders living in poverty are disadvantaged on two levels. On the one hand poverty reduces an individual’s ability to participate in society. On the other hand their disadvantage in the areas including education, employment, income and housing, the factors which contribute to, or are the results of their poverty, have a strong correlation with health status.⁴⁷ Poor health further limits their ability to participate fully in society. Without intervention this will contribute to a downward spiralling of both health and social participation for this group of New Zealanders.

⁴⁵ Robert Stephens, Charles Waldegrave, and Paul Frater, 'Measuring Poverty in New Zealand', *Social Policy Journal of New Zealand* (1995), 88-111 (pp.104-107).

⁴⁶ Charles Waldegrave, Robert Stephens, and Paul Frater, 'Most Recent Findings in the New Zealand Poverty Measurement Project', *Social Work Review*, 8 (1996), 22-24 (p.22).

⁴⁷ Philippa Howden-Chapman and Fiona Cram, *Social, Economic and Cultural Determinants of Health*, Health Determinants Programme Background Paper 1 (Wellington: National Health Committee, 1998), pp.18-28.

Poverty was increasing at a time when there was an expectation that New Zealanders would take an increasing level of responsibility for their health. However, for many New Zealanders poverty and poor health are dis-empowering, reducing their ability to fulfil this emerging expectation. In addition, some aspects of those health and social services which may in the past have supported New Zealanders in navigating the health system and taking care of their own health have been lost in the competitive and contractual health services environment.

The changing face of health care in New Zealand has been illustrated by the shifting patterns in relationships between the lay population and those who they consult on matters of health. Some of the factors which contributed to these changes have also been discussed. These changes do not, however, represent a rejection of the latest medical technology. According to Blank there remains an expectation, both within the health care community and among the public, that should it be required the full extent of advanced medical technology will be available to all.⁴⁸

Changing attitudes in relation to health and health care practices can be seen to have links to the rising level of individualism in New Zealand at the end of the twentieth century. New Zealanders now feel able to challenge what was once unarguable and to look for alternatives where once none were available. Where once members of New Zealand society conformed within a narrow band of normality they now seek out options which satisfy their own individual needs.

While this has positive effects for society there are also potential negative ramifications. Consideration must be given as to how, in a society increasingly guided by the needs and aspirations of individuals, the welfare of the population is ensured. There are areas where maximising the utility of society's individual members does not automatically ensure the maximum utility for society as a whole.

⁴⁸ Robert Blank, *New Zealand Health Policy: A Comparative Study* (Auckland: Oxford University Press, 1994), pp.38-41.

One particular area of health policy which illustrates a number of the contradictions of individualism is public health. How does an area of public policy so concerned with populations fare in an individualist society? The following section will examine what public health means at the turn of the millennium and its attractions in an increasingly individualist New Zealand.

III: Public Health

This chapter has discussed the impact of rising individualism, both at the state level and within society, on New Zealand's health sector. There are links between the individualism, both neo-liberal and civil, which underpin health sector reform and individuals' desire for autonomy and greater control in matters of health. However, these links are not always direct and other factors, including those which have increased demand within the health sector, are mediating the relationship between the individual and the state in the health sector. It is not always immediately clear why a particular course is followed and different groups may have different reasons for following the same course. One area of health that illustrates this is public health.

Public health as a discipline has a different focus to that of the orthodox personal health services of the medical establishment, although it does include medical practitioners. Rather than the mechanistic focus on fixing the component which fails to function correctly in the individual human being, public health is concerned with preventing disease on a population basis. A popular definition of public health is the "art and the science of preventing disease, promoting health, and prolonging life through the organised efforts of society."⁴⁹

Beaglehole and Bonita provide a concise description of the elements of modern public health theory and practice:

- its emphasis on collective responsibility for health and the prime role of the state in protecting and promoting the public's health;
- a focus on whole populations;

⁴⁹ Acheson, 1987, cited in Robert Beaglehole and Ruth Bonita, *Public Health at the Crossroads: Achievements and Prospects* (Cambridge: Cambridge University Press, 1997), p.146.

- an emphasis on prevention, especially the population strategy for primary prevention;
- a concern for the underlying socioeconomic determinants of health and disease, as well as the more proximal risk factors;
- a multi-disciplinary basis which incorporates quantitative and qualitative methods as appropriate; and
- partnership with the populations served.⁵⁰

Public health has a long history during which, although the full potential of the approach to health has been identified, it has seldom been achieved. Returning to the earlier discussion of what health is and what factors determine the health status of a population reveals the areas in which a programme designed to maximise the health of a population might operate. If poverty makes people sick, then alleviating poverty will improve health. However, although the link between poverty and poor health was made early, public health programmes have traditionally focused on symptoms rather than the real problem. Despite this, public health has made a number of important contributions to the improvement of health status.

Over the years the mechanisms by which public health has worked to improve health have changed. The earliest phase of public health was concerned with preventing the spread of infectious disease. Public health was originally concerned with quarantine and sanitary reform.⁵¹ Later this expanded to be concerned with health protection. In the late twentieth century the Ottawa Charter focused attention on health promotion and the so-called new public health. Throughout this time there has been a pull between the mechanistic focus on the purely limited causes of disease and the wider underlying social and economic causes of disease.

Public health and the strategies it employs gained increased attention in the final years of the twentieth century for a number of disparate reasons. While public health with its population approach might not immediately appear attractive from an individualist perspective there were elements which appealed to both neo-liberal individualism and civil individualism.

⁵⁰ Beaglehole and Bonita, *Public Health at the Crossroads*, p.147.

⁵¹ This was the case in New Zealand as in other countries. For further discussion see Dow, *Safeguarding the Public Health*, pp.15-19.

The public health approach was committed to preventing disease through the organised efforts of society. Public health research began to offer knowledge which could help prevent disease. On the one hand this appealed to civil individualism in that it gave individuals choices and options. They could make changes in their behaviour which would reduce the likelihood they would contract what came to be known as lifestyle diseases. This knowledge gave them a degree of control which they had not previously had. On the other hand this same option appealed to the cost containing intentions of the neo-liberal individualist. At a time when the treatment of lifestyle diseases, or diseases of wealth, was becoming increasingly expensive as people lived long enough to contract them and new technology emerged to treat them, the prospect of preventing disease was attractive.

There were, however, conflicts between these two positions. While the neo-liberal state funding disease prevention strategies may have been interpreted as a positive move in public health terms the very individualist nature of the strategy had other ramifications. For the neo-liberal individualist the appeal was not only in the potential for cost containment, but also in the potential to shift at least a portion of the responsibility from the collective onto the individual. In some states, including New Zealand, disease prevention strategies are provided in the state funded health sector, but there is an expectation that it is an individual's responsibility to accept the services and follow the advice provided on a population basis. This expectation does not rest solely with politicians and economists, but also with health care providers who consider individuals have a responsibility to follow what are scientifically proven disease prevention strategies.

This situation presents at least two potential problems. Some individuals consider that such provision of services with attached expectations removes their freedom to choose, although there are few, if any such services offered in New Zealand where individuals rejecting the service are subject to sanctions. The other problem relates to the lack of recognition, at least in some circles, that there are barriers other than cost to individuals accessing services provided on a population basis, and that health is about more than just accessing health care.

There are other problems and tensions in the rising profile of public health. A recurring theme is the battle for funds between the preventive and curative sections of the health sector. Primary and preventive health care have received a declining share of health care resources over the last three decades. The reallocation of resources is problematic because of perceptions about what health care is and the profitability of the technological imperative which prevails.⁵²

The appeal of public health to individualism, especially neo-liberal individualism, must be mitigated by its concern with the wider factors contributing to health, specifically socio-economic determinants of health and illness. The neo-liberal political economy separated out the various sectors of the economy. Public health, however, includes a focus on a wide range of policy areas, including employment, education and housing, as contributing to health. This perspective, with its emphasis on healthy public policy across this range of policy areas, is contrary to the individualist, market philosophy of a neo-liberal state.

It is this conflict between the paradigms of public health and neo-liberal political economics that provide at least part of the explanation as to why the Public Health Commission, a component of the health sector reform process, could not survive in New Zealand's political economy. As was discussed above the PHC's recommendations to government were in conflict with the emerging relationship between the state and business interests which underpinned the reform of the private sector economy.

Given the hypothesis that New Zealand is becoming more individualist, more concerned with rights and individual responsibilities, a public health approach appeals to aspects of both neo-liberal and civil individualism. On the one hand the state is saying individuals are in the best position to maximise resources, but to do that they should follow a particular line. The motivation behind this approach is to preserve resources, not to increase choice. On the other hand we have individual New Zealanders, concerned with taking control in their own lives who want an environment in which to maximise their opportunities. The state has a role, even under an individualist philosophy, to do this. This could be another

⁵² Blank, *New Zealand Health Policy*, p.119.

support for the state pushing public health measures in a coercive manner. The third point is that in an individualist society individuals have the right to choose for themselves. They have the right to do good or do harm to themselves.

Here then is a conflict between the state's role to provide a health promoting environment, the state's desire to save resources, and the citizen's right to choose their own course. This is further complicated by the possibility that the rights of one individual may impose on the rights of another. What of the state's role when its actions can be interpreted to follow a number of motivations? What is it that really motivates a particular policy direction?

This thesis will explore these questions by examining an area which has links to both public health and personal health. Childhood immunisation policy is, in part, a health policy which crosses these boundaries. It is a disease prevention strategy designed to reduce the incidence of infectious diseases in populations, but it is delivered to individuals. Consideration must be given to how an individualist society deals with an issue of such a Public Good nature.

IV: Conclusion

The impact of increasing individualism in New Zealand is apparent in a range of areas across the health sector. While the health sector reform process was in line with neo-liberal changes in the wider political economy, other changes reflected a shift in society's attitudes and expectations.

In combination these expressions of individualism have been significant in shaping the direction of New Zealand's health sector. The neo-liberal individualism fundamental to the political economic changes has been significant in public policy reform, but so too has been the increasing level of individualism within society.

The move away from the welfare state and universal provision of a one-size-fits-all health service is the result of a number of different pressures for change. The dominant understanding is that the pressure of the neo-liberal agenda has driven this process faster and further than other individualist pressures. However, New Zealanders, normally in groups, have also worked in an attempt ensure that

individuals have access to health care which is appropriate to their needs and that in all matters relating to health individuals can make an informed choice between options.

There is, however, tension on a number of levels within the process of determining procedure within the health sector. One is between neo-liberal individualism and the demand for a more individualised health care system. Another is between the moves toward individualism and the role of the government, through its public health structures, to ensure that in the communal life of society individuals do not harm each other. This is an area where the choices made by individuals can have a direct impact on the health of the wider population, even to the extent where one individual's choice may limit the choices available to others.

These issues will be further examined in the context of childhood immunisation. This thesis will examine practice and public opinion around childhood immunisation, before looking at the development of a National Immunisation Strategy for New Zealand.

Chapter Five

METHODOLOGY

I: Introduction

This research explores the process of and influences on public policy-making during a time when the prevailing philosophy was one of individualism, both neo-liberal individualism and civil individualism. This chapter examines the methods used both in research and in policy analysis.

II: Topic and Case Study Selection

In the early stages of this research, when the broad intention was to examine the impact of the 1991 health sector reforms on child health, it became apparent that to look at child health as a product of the health sector reforms alone ignored the effect a whole range of changes in public policy were having in New Zealand. The foundation of these changes was clearly in the paradigm shift discussed in Chapter One.

This thesis, therefore, examines the wider public policy environment before focusing on health policy and then on childhood immunisation policy as a case study of the impact individualism had on public policy-making in New Zealand.

Childhood immunisation policy was selected as a case study for number of reasons. First, it is a health strategy which has an impact on child health - the original area of interest. Second, when this research started there was a high level of interest in and concern about childhood immunisation. Work to establish a National Immunisation Strategy, a new childhood immunisation policy, was ongoing at the time. Because of the currency of the topic it should have been fresh in the minds of those who were involved, an advantage in finding out the detail of the process. This was particularly important at a time when rapid changes in the health sector reduced the institutional memory.¹ Third, childhood immunisation is

¹ Poor institutional memory in the health sector is often discussed as a by-product of the departure of long serving staff and the rapid turnover of staff which were part of the reform process.

a health strategy which has aspects of both public good and individual good, an interesting comparison, particularly when exploring the impact of individualism on emerging policy.

III: Qualitative Research

The task here is not to quantify trends in the area of childhood immunisation, although there will be an element of this in the background information. Rather it is to identify and analyse the variety of influences which shaped both the policy-making process and the resulting policy. It was therefore appropriate to use a qualitative methodology to both examine the policy development process and to explore whether or not the resultant policy was consistent with the philosophy prevailing in New Zealand's political economy.

Leininger states:

The qualitative type of research refers to the methods and techniques of observing, documenting, analysing and interpreting attributes, patterns, characteristics, and meanings of specific, contextual or gestaltic features of phenomena under study. Essentially the goal of qualitative research is to document and interpret as fully as possible the totality of whatever is being studied in particular contexts from the people's viewpoint or frame of reference. This includes the identification, study, and analysis of subjective and objective data in order to know and understand the internal and external world of people. These dimensions of knowing are essential to ascertain quality features of the informant's feelings views and patterns of action (or lack of action) and their interpretations or explanations.²

While individuals and their attitudes and opinions are important in this research so too are the ways in which they relate to each other and to the wider influences of the various organisations with which they interact. This aspect of qualitative research is acknowledged by Strauss and Corbin:

Qualitative research is any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification. It can refer to research about persons' lives, stories,

² M. Leininger, 'Nature, Rationale and Importance of Qualitative Research Methods', in *Qualitative Methods in Nursing*, ed by M. Leininger (Philadelphia: W.B.Saunders, 1985), pp.1-25 cited in Jo Ann Walton, 'Qualitative Health Research Methods', in *SocialDimensions of Health and Disease: New Zealand Perspectives*, ed. by John Spicer, Andrew Trlin and Jo Ann Walton (Palmerston North: Dunmore Press, 1994), pp.276-294 (p.281).

behaviour, but also about organisational functioning, social movements, or interactional relationships.³

IV: Methods

A range of information sources were used in obtaining the detail of this topic. This started with a review of literature and moved on to examine more specific material through examination of documents and interviews with key informants.

A: Literature

The literature used in this research falls into three main categories. First, a great deal had been written, both in a scholarly fashion and in the popular press about the changes in New Zealand's political economy following the election of the Fourth Labour Government. This was readily accessible in both university and public libraries. There are also a large number of Ministerial briefing papers available in the public domain which indicate the theoretical underpinnings of advice in the public policy community.

Second, an enormous literature examines both the development and impact of individualism, and the suitability of the doctrine or paradigm as an organising force in the western world. Related to this is material on neo-liberalism and individualism among individuals – what this thesis has called civil individualism. While some of this was readily available some journal articles and books were more difficult to acquire.

Third, there is a very broad literature on childhood immunisation. The focus has been on the historical development of immunisation, and both the international and New Zealand's experience of childhood immunisation. What has not been explored in any more than a very superficial way is the science of vaccines except in reference to specific matters which impact on service provision.

³ A.L. Strauss and J. Corbin, *Basics of Quantitative Research: Grounded Theory Procedures and Techniques* (Newbury, CA: Sage, 1990) cited in Kath Ryan and Harriet Denz Penhey, 'Qualitative Research in Medical Practice,' *NZMJ*, 109 (1996), 87-88.

B: Document Review

A range of documents contributed to both the background material on this topic and to the substantive material. These included:

- National Immunisation Strategy Working Group Background Papers, which provided both published material on childhood immunisation and unpublished material given to members of the Expert Working Group;
- Published reports which emerged from the review of childhood immunisation;
- Cabinet papers;
- Select Committee Reports;
- Ministerial and Ministry of Health press releases on matters relating to childhood immunisation;

Some of this material was readily available in the public domain, but others items, specifically Cabinet Papers, were obtained under the Official Information Act.

Documents have been analysed, along-side interview findings, for indications of individualism, both civil and neo-liberal.

In accessing a number of sources of documentary material the situation has changed significantly over the course of this research. The use of the internet and the emerging practice of making documents available in a read only format through Adobe Acrobat Reader has facilitated improved access to previously difficult to access material.

C: Interviews

The purpose of conducting interviews as part of this research was to gain an insight into the attitudes within and pressures on the childhood immunisation policy development process. Initial discussions with various individuals involved in the implementation of childhood immunisation policy at a regional level indicated who the key personnel were in the national policy development process.

These officials in the public policy community in Wellington, identified as key informants, were in most cases very helpful and interested in the examination of the process. It was clear, however, that while these individuals were not attempting to conceal what really went on, they were so steeped in the culture of policy-making that the range of insights they would provide would be very limited. They did however, have some interesting comments on the role of the Minister of Health, and were able to facilitate access to some of the documentation involved in the Expert Working Group process.

Discussion with these officials and review of the documents produced in developing the PHC's advice on immunisation to the Minister of Health suggested that the Expert Working Group on immunisation would be a relatively accessible group whose involvement both in matters related to childhood immunisation generally and in respect of the Expert Working Group would give them a unique perspective on the process. Membership of the group fell into two broad categories. First, the group included a number of individuals who were very familiar with issues in childhood immunisation, having been involved in the policy development level in the past. These were recognised experts in various fields related to the provision of childhood immunisation. Second, were a group of people who, while they were very involved in childhood immunisation, were not directly involved in the development of policy or immersed in the policy-making culture. The membership of the group included a range of occupational and organisational affiliations, as is discussed in detail in Chapter Eight.

Members of the Expert Working Group interviewed not only provided information about that process, but also on other matters related to childhood immunisation procedure and practice.

The intention in interviewing members of the Expert Working Group was to explore these individuals' views on the process and the influences they saw as shaping both the group's recommendations and the National Immunisation Strategy as announced in 1995. Interviews with Expert Working Group members took place after the National Immunisation Strategy was announced.

It was not intended to interview all the members of the group, but to meet with a number of individuals who represented interests within the group. In the event, selection of interviewees was determined by availability and convenience. Members of this group were not as readily accessible as was originally anticipated. A list of the members' names and employment was included in the *Report of the Expert Working Group*, but attempting to contact some members, through their recorded place of work, three years after the Expert Working Group had met, proved difficult in some cases, with a number having changed jobs.

The lay members of the committee and one of the Plunket Nurses were located using the electoral roles. In one case an interviewed member of the group was able to provide an introduction to another member of the group.

Interviewees were initially contacted by letter, with a follow-up phone call to arrange an interview. Some of those contacted did not reply to the letter and were not contactable by telephone. These non-responders were health professionals holding senior positions in their organisations. One person in the Ministry of Health did not accept the invitation to an interview, indicating in a telephone conversation his feeling that such a meeting would be in conflict with the role he had taken in the Expert Working Group process. Another senior member of the group had moved overseas. However, others contacted, including nurses and lay representatives responded to the letter and were eager to share their experiences and perspectives.

Eventually seven members of the Expert Working Group were interviewed. These individuals represented a range of organisational and occupational affiliations and included one lay person.

A semi-structured, depth interviewing⁴ format was used, allowing the interview to follow various lines in which the interviewee had particular expertise or insight. The interviews were audio taped and transcribed, although in one interview by telephone this proved unsuccessful. Short form notes were also taken during the interview as a back up for the audio-taping.

V: Health Policy Analysis

While this research addresses a range of issues surrounding childhood immunisation, the central material addresses the development of the policy. In this it has been useful to follow Palmer and Short's discussion of Ham and Hill's three broad levels of analysis: the decision making level, the health-policy-making process and the structural level.⁵

This thesis concentrates on the process of policy determination, rather than policy implementation, although this will be touched on. The major areas of focus are: identifying the process drivers, determining how childhood immunisation got on the policy agenda; the process through which policy was developed; and ultimately assessing the influence individualism had in this process.

⁴ Sue Jones, 'Depth Interviewing,' in *Applied Qualitative Research*, ed. by Robert Walker (Aldershot: Dartmouth, 1993), pp.45-55.

⁵ George R. Palmer and Stephanie D. Short, *Health Care and Public Policy: An Australian Analysis*, 2nd edn (Melbourne: Macmillian, 1994), pp.23-37.

Chapter Six

CHILDHOOD IMMUNISATION

I: Introduction

New Zealand has failed to achieve immunisation coverage targets and prevent recurring epidemics of vaccine-preventable diseases, such as measles and pertussis. Available estimates suggest that there has been no improvement in coverage since 1996 despite at least partial implementation ... of the 1995 National Immunisation Strategy (Immunisation 2000).¹

Writing in early 2000 Nikki Turner, Director of the Immunisation Advisory Centre, and others indicate New Zealand's failure in childhood immunisation, considered internationally to be an important part of both public health and child health strategies. This is despite a great deal of attention directed to this area over the 1990s.

Childhood immunisation is the case study in this thesis, and the next three chapters will explore what has contributed to this perceived failure. This chapter will examine the background of childhood immunisation, the National Immunisation Strategy and childhood immunisation policy and practice in New Zealand as established by that strategy. Chapter Seven will examine the factors that put childhood immunisation on the policy agenda for consideration, while Chapter Eight will examine the policy-making process which produced the National Immunisation Strategy.

¹ Nikki Turner et al., 'Improving Immunisation Coverage: What Needs to be Done?' *New Zealand Public Health Report*, 7 (2000), 11-14 (p.11).

II: Immunisation

Immunization is the act of artificially inducing immunity or providing protection from disease; it can be active or passive. Active immunization consists of inducing the body to develop defenses against disease. This is usually accomplished by the administration of vaccines or toxoids that stimulate the body's immune system to produce antibodies and/or cell-mediated immunity that protects against the infectious agent. Passive immunization consists of providing temporary protection through the administration of exogenously produced antibody.²

At the beginning of the twenty-first century the medical establishment³ and public policy-makers throughout the world consider immunisation to be a proven strategy for ensuring both individual and public health, providing protection against a range of infectious diseases. Plotkin and Plotkin state “[t]he impact of vaccination on the health of the world’s peoples is hard to exaggerate. With the exception of safe water, no other modality, not even antibiotics, has had such a major effect on mortality reduction and population growth.”⁴

A: The History of Vaccines and Immunisation

Immunisation as a means of protecting human beings against disease has a long history. There are records of early attempts to provide protection against disease, particularly smallpox dating back as far as the sixth century.⁵ The first recognised scientific work in this area was Edward Jenner’s use of cowpox serum to vaccinate individuals against smallpox. Jenner began in 1796 by vaccinating James Phipps with material from Cowpox lesions, a process which subsequently protected the boy against smallpox. This result was repeated in other children.⁶

² Walter A. Orenstein et al., ‘Immunization’ in *Mandell, Douglas and Bennett’s Principles and Practice of Infectious Disease*, ed. by Gerald L. Mandell, John E. Bennett and Raphael Dolin, 4th ed. Vol.2 (New York: Churchill Livingstone, 1995), pp.2770-2790 (p.2770).

³ The term *medical establishment* is used here to refer to the mainstream health care system in New Zealand, based largely around the medical profession, but including nurses and other health workers who practice within the conventions of traditional western medicine.

⁴ Susan L. Plotkin and Stanley A. Plotkin, ‘A Short History of Vaccination’, in *Vaccines*, ed. by Stanley A. Plotkin and Edward A. Mortimer, Jr. (Philadelphia: W.B.Saunders, 1988), pp.1-7 (p.1).

⁵ For discussion of early attempts to induce protection against smallpox see Plotkin and Plotkin, ‘A Short History of Vaccination’, pp.1-2; and F. Fenner et al., *Smallpox and its Eradication* (Geneva: World Health Organisation, 1988), pp.245-258.

⁶ Edward Jenner, *The Origin of the Vaccine Inoculation*, London, 1801 reproduced in Fenner et al., *Smallpox and its Eradication*, pp.258-261.

Jennerian vaccination was rapidly accepted, but the man and his work were not without their critics. Although other scientists extended the work on vaccines and vaccination, Jenner's work is considered to have been a turning point in the control of smallpox.⁷

Research continued until Louis Pasteur developed the first manmade vaccines; first against anthrax in 1881, and in 1885 successfully protecting humans against rabies. Again these discoveries were surrounded by controversy, particularly in respect of testing on human subjects.⁸

In the 200 years since the first scientific advances in immunisation, the work of scientists in research programmes around the world has produced significant progress in the field. Improved understanding of infectious diseases and human immune responses, along with advances in the technology of vaccine production, have resulted in increasing numbers of ever safer vaccines. Furthermore, research among immunised populations is constantly improving understanding of the timing and spacing of vaccination.⁹

In the last decade of the twentieth century scientific understanding of vaccines and immunisation continued to grow. Researchers continued working to develop vaccines against a range of infectious and non-infectious diseases, including HIV. Work is also continuing on combining a greater number of vaccines while reducing the number of vaccination events required to provide an individual with protection against the diseases.¹⁰

⁷ For discussion of Jenner's work on vaccination see Plotkin and Plotkin, 'A Short History of Vaccination', pp.1-2; Fenner et al., *Smallpox and its Eradication*, p.258-273.

⁸ For a brief summary of Pasteur's work on vaccines see Plotkin and Plotkin, 'A Short History of Vaccination', pp.2-3. A recent review of Pasteur's work and his attitudes to his research, informed by private papers previously unavailable is provided by Gerald L. Geison, *The Private Science of Lois Pasteur* (New Jersey: Princeton University Press, 1995).

⁹ For discussion of the historical course of vaccine development see Plotkin and Plotkin, 'A Short History of Vaccination'.

¹⁰ For discussion of current advances in vaccines and the associated technology see *The Jordan Report: Accelerated Development of Vaccines* (Bethesda MD: National Institute of Allergy and Infectious Diseases, 1994); Stanley A. Plotkin and Walter A. Orenstein, eds., *Vaccines*, 3rd ed. (Philadelphia: W.B. Saunders Company, 1999).

In addition, knowledge and experience about the delivery of vaccines and the management of vaccination programmes is growing both in the western world and in developing countries.

B: International Immunisation Programmes

The prevention of infectious diseases in children by immunization is one of the outstanding accomplishments of medical science. Children enjoy better health today because of effective immunization programs that in many countries have diminished markedly the morbidity and mortality of once-common contagious diseases.¹¹

While immunisation of adults has been required in respect of some diseases, by far the largest effort has been directed to immunising children. Childhood immunisation is credited with being a significant factor in the improvement of children's health, and in reducing disease and death as a result of infectious diseases. As vaccines became available they were introduced to those communities that could afford them, successfully reducing the incidence of diseases including diphtheria, polio and whooping cough.

By the early 1970s many previously common childhood diseases were rarely seen and their effects largely forgotten in the developed nations of the western world. However, in the developing world vaccine preventable diseases were causing millions of child deaths each year and leaving many other children with permanent disabilities.

A significant factor in the establishment of a global approach to immunisation was the progress made in the eradication of smallpox. Through the combined efforts of international agencies and governments an international programme of surveillance, quarantine and immunisation led to the total eradication, by 1979, of a disease that had previously caused 10 million cases and 2 million deaths each year, demonstrating what could be achieved with a co-ordinated international campaign.¹²

¹¹ Penelope H. Dennehy, Erica E. Jost and Georges Peter, 'Active Immunizing Agents' in *Textbook of Pediatric Infectious Diseases*, ed. by Ralph D. Feigin and James D. Cherry, 4th ed., Vol.2 (Philadelphia: W.B. Saunders Company, 1998), pp.2731-2795 (p.2731).

¹² For a detailed discussion of the eradication of smallpox see F. Fenner et al., *Smallpox and its Eradication*.

In 1974 the World Health Organisation (WHO) established the Expanded Programme for Immunisation (EPI) to extend the protection of vaccines to the children of the developing world.¹³ Built on the success of the smallpox eradication programme the EPI set out to provide protection against six common causes of child mortality and morbidity against which only five percent of the world's children were then protected; diphtheria, tetanus, whooping cough, polio, measles and tuberculosis.¹⁴

The EPI utilised the skills and resources of a number of international and bilateral aid and development agencies to establish and fund immunisation programmes in developing states. In addition, the programme worked with each state's government and Ministry of Health to establish a programme which would be sustainable within the state's own resources.

The EPI participated in the establishment of an infrastructure to deliver immunisation safely, including the development of immunisation protocols, sourcing of safe supplies of vaccine, the establishment of the "cold chain" so that vaccines remain potent and the training of staff to manage and provide the immunisation service.

Initially the EPI made only slow gains, increasing coverage against the six target diseases to 20 percent by 1980.¹⁵ Further progress was motivated by a series of initiatives which mobilised both governmental and non-governmental organisations within the international community. Not only did this international interest assist in the organisation and funding of childhood immunisation programmes, it also motivated political support within developing states.¹⁶

¹³ For discussion of the EPI see Terrel Hill, Robert Kim-Farley and Jon Rohde, 'Expanded Programme on Immunization: A Goal Achieved Toward Health for All', in *Reaching Health for All*, ed. by Jon Rohde, Meera Chatterjee and David Morley (Delhi: Oxford University Press, 1993), pp.402-422; World Health Organization and UNICEF, *The State of the World's Vaccines and Immunization* (Geneva: World Health Organization and UNICEF, 1996), p.11; Peter F. Wright, 'Global Immunisation - A Medical Perspective', *Social Science and Medicine*, 41 (1995), 609-116; R.H. Henderson, 'Vaccination: Successes and Challenges', in *Vaccination and World Health*, ed. by Felicity T. Cutts and Peter G. Smith (Chichester: John Wiley and Sons, 1994), pp.3-16.

¹⁴ Vaccines against these six diseases make up the EPI schedule, thus they will be referred to as the EPI diseases.

¹⁵ Hill et al., 'Expanded Programme on Immunization', p.404.

¹⁶ Hill et al., 'Expanded Programme on Immunization', p.413.

In 1977 the World Health Assembly set a target of Universal Childhood Immunisation by the year 1990. This was defined as 80 percent coverage of children by their first birthday with the EPI schedule.¹⁷ In 1981, when the WHO developed its strategy to achieve “Health for all by the year 2000”, one of the targets was that “all children be immunised against the major infectious diseases of childhood.”¹⁸

In 1990 the World Summit for Children set up the Childhood Vaccine Initiative (CVI) to improve the supply and quality of vaccines available. This coalition of international organisations and donor agencies included the WHO, UNICEF, the World Bank and the Rockefeller Foundation.

In 1994 the WHO set up the Global Programme for Vaccines and Immunisation (GPV) as an umbrella for the three units working on improving immunisation; the EPI, Vaccine Research and Development (VRD) and Vaccine Supply and Quality (VSQ). The GPV worked closely with the CVI and other agencies working in the same areas. Restructuring of the WHO in 1998 saw the GPV become the Department of Vaccines and Other Biologicals (V&B), which absorbed the GPV’s functions and other responsibilities.¹⁹

Since the EPI was established considerable progress has been made in Third World childhood immunisation. In 1996 almost 80 percent of the world’s children were fully immunised according to the EPI schedule at their first birthday,²⁰ with immunisation estimated to save 3 million lives every year.²¹

¹⁷ Hill et al., ‘Expanded Programme on Immunization’, p.404.

¹⁸ ‘Health for All by the Year 2000’, *UN Chronicle*, September 1992, p.45.

¹⁹ Department of Vaccines and Other Biologicals, *Report of the First Meeting of Interested Partners to the Health Technology and Pharmaceuticals Cluster* (Geneva: World Health Organization, 1999), pp.7-10. For more recent and comprehensive information on the structure, aims and intentions of the renamed Department of Vaccines and Biologicals see Department of Vaccines and Biologicals, *Vaccines, Immunisation and Biologicals: 2000-2003 Strategy* (Geneva: World Health Organization, 2000).

²⁰ WHO/UNICEF, *The State of the World’s Vaccines and Immunization*, p.11.

²¹ World Bank, *World Development Report 1993: Investing in Health* (New York: Oxford University Press, 1993), p.8; Hill et al., ‘Expanded Programme on Immunization’, p.407; WHO/UNICEF, *The State of the World’s Vaccines and Immunization*, p.11.

Immunisation coverage in the Third World is considered to be on a par with that achieved in developed states.²²

Significant progress has been made in efforts to eradicate polio by the year 2000. The number of cases reported globally have fallen from 350,000 in 125 countries in 1988 to 7,012 in 30 countries in 1999. Efforts continue to aim at eradicating polio by the end year 2000.²³

The EPI is also involved in other areas of child health as, in common with some industrialised countries, the immunisation schedule forms the framework for other aspects of well-child care. This is particularly important in less developed countries where non-immunisation services include health promotion and education activities. The EPI has been an important building block in the quest to improve public health in developing states. Its success has encouraged both international organisations and state governments to set other and more ambitious goals in the health area. The EPI has also set up the infrastructure and the precedents to success in responding to other immunisation programmes and in other health issues.²⁴

The international efforts to widen the impact of childhood immunisation have had impressive results. However, the programme faces a number of problems. In 1995, when considerable progress had been made, 2.4 million children under 5 years of age still died each year as a result of vaccine preventable diseases. It was feared that economic and social conditions were eroding gains made in the area of childhood immunisation.²⁵ Evidence of this can be seen in the recurrence of vaccine preventable diseases in Eastern Europe in the wake of the collapse of communist governments and the infrastructure they supported. For example, in the Russian Federation an epidemic of diphtheria followed a drop in immunisation

²² Wright, 'Global Immunisation - A Medical Perspective'.

²³ World Health Organization, *Global Polio Eradication: Progress 1999* (Geneva: World Health Organization, 2000).

²⁴ WHO/UNICEF, *The State of the World's Vaccines and Immunization*, p.13.

²⁵ World Health Organisation, 'The State of World Health, 1995', *Journal of Public Health Policy*, 16 (1995), 440-451 (p.443).

coverage for diphtheria, tetanus and pertussis from 90 percent in 1980 to 43 percent in 1992.²⁶

Other problems also threaten the future of the global childhood immunisation effort. While research by CVI and other organisations may produce vaccines against a wider range of diseases, and, it is feasible, a super vaccine to reduce the number of vaccination events required to provide adequate protection against a range of communicable diseases, these will almost certainly be more expensive than the EPI schedule. In addition the successes so far may fuel donor fatigue. The programmes are heavily dependent on outside assistance.

That dependence on international leadership and outside assistance gives further grounds for criticism. Banerji considers the EPI to be the imposition of the health values of international aid agencies on communities within developing countries. He considers this, achieved by a combination of international pressure on state governments and social marketing, to violate the principles of Primary Health Care outlined in the Alma Ata Declaration, which state that health initiatives should come in response to an internal demand.²⁷

C: Economic and Political Influences

Paul Greenough notes that the success of immunisation programmes, both in terms of coverage and sustainability, is heavily dependent on a combination of public demand and political will.²⁸ This is no less the case in the West than in countries of the developing world. Issues of economics, technology, social structure and political culture all influence the way an immunisation policy is

²⁶ S. Dittmann, *The Diphtheria Situation in the Newly Independent States and the WHO/Unicef Strategy to Control Diphtheria* (Geneva: World Health Organisation, 1995), cited in John Howarth, 'Global Eradication of Polio by 2000 is not a Realistic Goal', *BMJ*, 313 (1996), p.627.

²⁷ Debabar Banerji, 'Hidden Menace in the Universal Child Immunisation Programme', *IFDA DOSSIER 61* (Sept/Oct 1987), 55-61; Debabar Banerji, 'Crash of the Immunisation Program: Consequences of a Totalitarian Approach', *International Journal of Health Services*, 20 (1990), 501-510; Debabar Banerji, 'A Fundamental Shift in the Approach to International Health by WHO, UNICEF, and the World Bank: Instances of the Practice of "Intellectual Facism" and Totalitarianism in Some Asian Countries', *International Journal of Health Services*, 29 (1999), 227-259.

²⁸ Paul Greenough, 'Global Immunisation and Culture: Compliance and Resistance in Large-Scale Public Health Campaigns - Introduction', *Social Science and Medicine*, 41(1995), 605-607 (p.605).

determined and the measures that can or will be employed to ensure immunisation targets are achieved.

Immunisation, supported as an effective health strategy, is also considered economically sound. Donald Henderson notes “that of all procedures known to medicine, [immunisation] is the single most cost-beneficial and, certainly by far the simplest to perform.”²⁹ Analysis of the cost-benefit ratios of immunisation reveal that an effective immunisation programme can save the curative health services many times the cost of the immunisation programme.³⁰ In 1993 the World Bank considered immunisation to be one of the most effective public health programmes available, and an EPI Plus package to have the highest cost effectiveness of any health measure available at that time.³¹

There continue, however, to be tensions in the allocation of resources between preventive and curative strategies in the health area. In both the developing and the developed worlds there has been evidence of investment in specialist tertiary services at the expense of public health services. This includes investment in infrastructure and in human resources. Where there is a willingness to spend heavily to cure a disease, or correct its effects surgically, there is a reluctance to spend the often lesser amounts of money on preventing the disease in the first place.³²

Maximising the impact of limited financial resources is an issue for health policy-makers throughout the world. In developing states there is pressure on policy-makers and donor agencies to concentrate resources in the development of preventive health care strategies like immunisation in preference to centralised high tech services.³³

²⁹ Donald A. Henderson, ‘Vaccination Policies and Practices’, *Australian Journal of Public Health*, 19 (1995), 634-638 (p.635).

³⁰ See for example Henderson, ‘Vaccination Policies and Practices’, p.634.

³¹ World Bank, *World Development Report 1993*, pp.72-74; WHO/UNICEF, *The State of the World’s Vaccines and Immunization*, p.14.

³² World Bank, *World Development Report 1993*, pp.134-139.

³³ World Bank, *World Development Report 1993*, p.156-160.

In OECD countries governments are reforming long established health services in the face of increasing economic pressure. New Zealand's efforts in pursuit of an efficient, equitable and sustainable health system are discussed in Chapter Three. Section III of this chapter discusses how a proven health strategy, in this case childhood immunisation, endorsed by the World Bank for its qualities of efficiency and effectiveness, has been dealt with in New Zealand.

III: The New Zealand Situation

Childhood immunisation in New Zealand has tended to follow trends established in other states of the developed world. Over the years, however, a range of social, political and health sector factors have influenced the evolution of a childhood immunisation policy, reflecting the particular character of the New Zealand social and political economic situation. At the time of writing childhood immunisation is given according to the National Immunisation Strategy promulgated in 1995, with minor amendments.

The state's commitment to support the vaccination of children against a range of communicable diseases is generally accepted as an important component of the strategy to protect the health of both individual New Zealanders and the New Zealand population as a whole. Nevertheless, the ultimate responsibility for childhood immunisation is considered to be with the parent or caregiver.³⁴ As such the practice of childhood immunisation in New Zealand is a combination of the political will and public demand suggested by Greenhough and discussed in the previous section.

A: Policy and Practice

In her speech to the Royal New Zealand Plunket Society in March 1995 the Minister of Health, Jenny Shipley, announced the National Immunisation Strategy. This was to form the basis of the New Zealand government's policy on childhood immunisation. The Minister stated "[the] National Immunisation Strategy ... has a

³⁴ Ministry of Health, *National Immunisation Strategy 1995* (Wellington: Ministry of Health, 1995), p.1.

clear target to achieve a 95 percent full immunisation coverage of all children at the age of two by the year 2000.”³⁵

The Minister discussed five initiatives included in the strategy, including:

- a new immunisation schedule involving fewer visits to the vaccinator, but designed to aid the improvement of coverage and to provide a greater protection against disease;
- the introduction of standards designed to improve the quality of vaccines and vaccination;
- the setting up of local immunisation co-ordination within each of the four RHAs;
- the improvement of surveillance and immunisation coverage information;
- the introduction of immunisation certificates as a way of ensuring parents would make a positive choice either to accept or reject immunisation for their child. This certificate was to be presented when a child enrolled at a school or early childhood care centre, providing an opportunity to check and record immunisation status for use in offering catch up immunisation or in the event of an outbreak of disease when unimmunised children can be excluded on the advice of the Medical Officer of Health.

Since 26 February 1996 childhood immunisation in New Zealand has been undertaken largely according to details set out in the *National Immunisation Strategy 1995*.³⁶ This includes the initiatives announced by the Minister in 1995 and set out above, but retains a number of other features carried over from practice prior to that date.

The immunisation schedule includes nine vaccines: diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, measles, mumps, rubella, hepatitis B, and *haemophilus influenzae* type b (Hib). These vaccines are given over a course of five visits to the vaccinator, four of which are between the ages of six weeks and 15 months, with a subsequent vaccination episode undertaken at the age of eleven years.

³⁵ Jenny Shipley, *Immunisation 2000*, Address to Royal New Zealand Plunket Society’s Annual General Meeting, Christchurch Town Hall, 29 March 1995, p.2.

³⁶ Ministry of Health, *National Immunisation Strategy 1995* (Wellington: Ministry of Health and Public Health Commission, 1995). In August 2000 there were some minor changes in the vaccination schedule. These are set out in *Vaccine Changes August 2000: Information for Vaccinators and Administrators* (Wellington: Health Funding Authority/Ministry of Health, 2000).

The entire childhood immunisation schedule is provided free to all New Zealand children, although the decision as to whether a child will be immunised remains the prerogative of the child's parents or guardians. No measures are employed which compel parents or caregivers to have their child immunised, or reward them for doing so. Nor are there sanctions upon those parents who choose not to have their children immunised. Neither welfare benefit entitlements nor school entry eligibility are tagged to completion of all or any part of the immunisation schedule. However, some early childhood day-care providers require that a child be up to date with the recommended immunisation schedule before they will be accepted for enrolment.³⁷ In addition, the National Immunisation Strategy does make provision for non-immunised children to be excluded from school during an epidemic of a vaccine preventable disease.³⁸

Although the childhood immunisation schedule includes nine vaccines there are other licensed vaccines available at full cost to the consumer. An example of this is the vaccine against Chicken Pox, Varilrix, which is actively marketed in New Zealand by the pharmaceutical company which manufactures it. Although Varilrix was registered in New Zealand in December 1996, the Ministry of Health had, at that time, no plans to add the vaccine to the immunisation schedule,³⁹ nor has it done so since.

As discussed above the current practice of childhood immunisation had evolved slowly in New Zealand in response to changes in the availability of vaccines and scientific understanding of their actions. It is therefore important to review the history of childhood immunisation in New Zealand.

B: History

The origins of childhood immunisation in New Zealand can be traced back to efforts to combat smallpox in the 1860s. Since that time the introduction of

³⁷ There has been some media attention to children refused entry to child-care centres because of their lack of immunisation.

³⁸ Ministry of Health, *National Immunisation Strategy 1995*, p.10.

³⁹ Ministry of Health, 'Press Release: Ministry of Health does not Recommend Routine Use of Chicken Pox Vaccine', 31 January 1997. For further discussion see M.Tobias, 'Chickenpox Immunisation in New Zealand', *NZMJ*, 111 (1998), 274-281.

vaccines has been gradual, influenced by a range of factors including vaccine availability and safety, public demand, the will of health professionals and the co-operation of health bureaucrats and policy makers. It was not until the 1960s that New Zealand had a national childhood immunisation schedule.

Over the years vaccines were introduced to the schedule as they became available, often attracting public funding after a period on the private market. With progress in research and development vaccines have in many cases been replaced with safer or combined vaccines. With the exception of the cessation of smallpox vaccination with the eradication of that disease, the immunisation schedule has continued to increase since it began in 1960.⁴⁰

New Zealand's earliest childhood immunisation programmes began in response to the threat of smallpox in the 1860s. A mandatory smallpox vaccination programme for children was introduced in the 1860s, but was considered unsuccessful, with compulsory vaccination being very unpopular. Subsequent modifications to the programme abandoned compulsion and introduced education programmes to encourage compliance, although school entry still depended upon successful protection against smallpox.⁴¹

Initially immunisation was the responsibility of the Department of Public Health, but the 1920 Health Act transferred public health matters, including immunisation, to the Department of Health. Childhood immunisation was then promoted by the School Medical Service, with early efforts focused on the introduction of a diphtheria vaccine available from 1922 onwards. However, public opposition and lack of political will⁴² combined with the death of children in Bundaberg, Queensland, after they received faulty diphtheria serum⁴³ served to keep the

⁴⁰ A brief overview of childhood immunisation schedules in New Zealand is provided by Derek A. Dow and Ossi Mansoor, 'New Zealand Immunisation Schedule History', *NZMJ*, 109 (1996), 209-212.

⁴¹ For a full discussion of immunisation of children against smallpox in New Zealand see F.S. McLean, *Challenge for Health* (Wellington: Government Printer, 1964), pp.237-245.

⁴² Derek A. Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington: Victoria University Press, 1995), p.108.

⁴³ Dow, *Safeguarding the Public Health*, p.109.

number of children protected against diphtheria low. It was not until 1941 that there was a nation-wide immunisation strategy for diphtheria.⁴⁴

By 1945 a vaccine against pertussis (whooping cough) was available from either the Health Department or a medical practitioner who received vaccine supplies from the Health Department at no charge. In 1953 this was replaced by a double vaccine which combined diphtheria and pertussis.⁴⁵ Tetanus immunisation began in the 1950s with the introduction of the triple vaccine which included vaccines for diphtheria, pertussis and tetanus (DPT). Initially this was available only at full cost from some medical practitioners. It was not until 1960 that DPT replaced the double vaccine supplied free of charge by the Health Department.⁴⁶

The introduction of DPT, a WHO approved triple antigen, was combined with the introduction of an immunisation schedule which has been modified in the years since as both new information about the appropriate timing of vaccines and new vaccines have become available. New vaccines have included both those against diseases which had not previously been covered by the schedule and improved vaccines to replace those previously available.⁴⁷

The epidemics of poliomyelitis in the 1940s and 1950s contributed to the acceptance of immunisation against this disease when it became available.⁴⁸ The Salk vaccine was available in 1956, but introduction of the safer, oral Sabine vaccine in 1961 was more widely accepted. At first it was given to infants, but in April 1962 it was made available to all school children. Initially high immunisation coverage was achieved, but with no confirmed cases of polio in

⁴⁴ Diphtheria immunisation is discussed in McLean, *Challenge for Health*, pp.356-357; Dow and Mansoor, 'New Zealand Immunisation Schedule History', p.210.

⁴⁵ Diana Lennon et al., 'Control of Whooping Cough in New Zealand; Slow Progress', *NZMJ*, 108 (1995), 495-497 (p.495); Dow and Mansoor, 'New Zealand Immunisation Schedule History', p.210.

⁴⁶ S. Hickling, 'Tetanus Immunisation', *NZMJ*, 86 (1977), 529-530 (p.529).

⁴⁷ A full discussion of the various vaccines and their origins is beyond the scope of this thesis, but such information is provided in Dow and Mansoor, 'New Zealand Immunisation Schedule History'.

⁴⁸ For a discussion of the debate surrounding the introduction of polio vaccination in New Zealand see Jean C. Ross, 'A History of Poliomyelitis in New Zealand' (unpublished masters thesis, University of Canterbury, 1993), pp.81-95.

New Zealand after 1962 compliance soon dropped away.⁴⁹ Early problems with vaccine storage meant polio vaccine was given by staff of the Department of Health, but in 1967 it was included in the schedule of childhood immunisations given by GPs.⁵⁰

Measles vaccine was introduced to the immunisation schedule in February 1969, but withdrawn late in that year because of side effects reported in Britain. A new vaccine was introduced in February 1970. The age at which it is recommended measles vaccines be given has altered over the years with knowledge of the impact the vaccine has in conferring immunity at different ages.⁵¹ In November 1990 the vaccine MMR was included in the immunisation schedule to replace separate vaccines for measles and rubella and introduce a vaccine for mumps.⁵²

In September 1985 the Department of Health began offering Hepatitis B vaccine to the babies of women who were Hepatitis B carriers. In March 1987 this provision was extended to all neonates in seven areas of the country; Northland, Takapuna, Auckland, South Auckland, Rotorua, Gisborne and Napier. The childhood immunisation programme was extended in 1988 to include all neonates and children under five years of age as at the 29 February 1988.⁵³ The introduction of Hepatitis B to the vaccine schedule is discussed further in Chapter Seven.

In 1994 the vaccine against *haemophilus influenzae* type b (Hib) was included in the immunisation schedule. The tetravalent DPTH replaced the triple vaccine DPT so as to include the new vaccine without adding an additional injection to the schedule.⁵⁴ This vaccine's introduction was supported by consideration of the economic benefits, as well as by the wish to prevent child deaths and permanent damage occurring regularly into the 1990s as a result of this preventable disease.

⁴⁹ Poliomyelitis immunisation is discussed in McLean, *Challenge for Health*, p.325; Dow, *Safeguarding the Public Health*, p.194.

⁵⁰ Dow and Mansoor, 'New Zealand Immunisation Schedule History', p.211.

⁵¹ Dow and Mansoor, 'New Zealand Immunisation Schedule History', p.211.

⁵² Dow and Mansoor, 'New Zealand Immunisation Schedule History', p.211.

⁵³ George Salmond, 'Circular Letter: Hepatitis B Immunisation Programme', 9 February 1988.

⁵⁴ Dow and Mansoor, 'New Zealand Immunisation Schedule History', p.211.

There was a marked decline in mortality and morbidity after the introduction of the vaccine.⁵⁵

There are also vaccines given which are not part of the immunisation schedule. The BCG against tuberculosis was introduced in 1948.⁵⁶ This vaccine has never been part of the childhood immunisation schedule, but was routinely given to children starting at secondary school. This was dependent, however, on the decision of the various health districts and, in consideration of lowered incidence of tuberculosis, effective available treatment and improved living conditions, the vaccine is rarely given to children now. However, BCG vaccine is offered to neonates who may be considered at increased risk of contracting the disease.⁵⁷

From time to time non-schedule vaccines have been given in campaigns as a response to disease epidemics. In 1987 such a campaign was undertaken in Auckland during an epidemic of group A meningococcal disease. This campaign, which is considered further in Chapter Seven, was considered to have successfully protected vaccinated children against the disease and controlled the epidemic.⁵⁸ This has not been possible, however, in respect of an epidemic of group B meningococcal disease ongoing in New Zealand at the time of writing. There is as yet no commercially available group B vaccine, but work in this area is ongoing.⁵⁹ The Ministry of Health has been working with three vaccine manufacturers to develop a vaccine for New Zealand, although at the time of writing consideration was being given to concentrating that effort with one preferred manufacturer.⁶⁰

⁵⁵ Michael Baker and Diana Martin, 'Hib Disease Rate Plummets Following Immunisation Programme', *The New Zealand Public Health Report*, 2 (1995), 13-14.

⁵⁶ Dow, *Safeguarding the Public Health*, p.193.

⁵⁷ Lesley Voss, 'Neonatal BCG Vaccine', *NZMJ*, 108 (1995), 373-374 (p.373)

⁵⁸ Diana Lennon et al., 'Successful Intervention in a Group A Meningococcal Outbreak in Auckland, New Zealand', *Pediatric Infectious Disease Journal*, 11 (1992), 617-23; Diana Lennon et al., 'Control of Epidemic Group A Meningococcal Disease in Auckland', *NZMJ*, 106 (1993), 3-6.

⁵⁹ C.Bremner et al., 'Epidemic Meningococcal Disease in New Zealand: Epidemiology and Potential for Prevention by Vaccine', *NZMJ*, 112 (1999), 257-259.

⁶⁰ Ministry of Health, 'Press Release: Cuban Vaccine Development Experts Visit New Zealand', 13 October 2000; Ministry of Health, 'Press Release: Progress Continues Toward Development of Meningococcal Vaccine', 10 November 2000.

Throughout the period in which vaccines have been available there have been periodic changes in the timing and combination of vaccines in response to new scientific information. The latest alteration, at the time of writing, has been in August 2000, with changes in the vaccine combinations to accommodate the introduction of an acellular pertussis vaccine which will reduce the number of side effects, and a Hib vaccine that will give earlier protection with one less dose.⁶¹ Although undertaken in response to advances in technology and knowledge these changes have sometimes been perceived as indicating uncertainty in the ranks of health professionals who some sections of the community considered should show no doubts.

In June 1998 the Ministry of Health convened a workshop on the future of the immunisation schedule. Its recommendations, published in the *New Zealand Medical Journal*, included the introduction of an acellular pertussis vaccine, as was done in August 2000, and other changes in vaccine timing and frequency.⁶²

The introduction of the National Immunisation Strategy in 1995 and the associated changes in the immunisation schedule was only one change in the evolution of childhood immunisation in New Zealand. This was, however, an attempt to introduce a comprehensive package of measures which addressed issues right across the childhood immunisation provision structure. The following sections will discuss the mechanisms involved in the provision, management and monitoring of New Zealand's childhood immunisation programme.

C: The Provision Structure

As with all state funded health services provision of childhood immunisation is purchased for the community by the Health Funding Authority (HFA). Childhood immunisation is provided as a personal health service through primary health care providers working within the community. The predominant providers are GPs, although some childhood immunisations are given by other health workers

⁶¹ *Vaccine Changes August 2000: Information for Vaccinators and Administrators* (Wellington: Health Funding Authority /Ministry of Health, 2000).

⁶² Osman Mansoor and Stewart Reid, 'The Future of the Immunisation Schedule: Recommendations of a Workshop', *NZMJ*, 112 (1999), 52-55.

including Plunket and public health nurses in some areas.⁶³ Others, including Tipu Ora and the Māori Women's Welfare League are contracted to promote immunisation.

Immunisations are given in accordance with the current immunisation schedule and the Immunisation Standards 1996.⁶⁴ Thus a parent will take the child to the GP or other vaccinator when immunisations are due. Although it is considered a parental responsibility to present a child for their immunisations, it is also expected that the immunisation provider will operate a recall system to remind families when immunisations are due. However, this is more likely to be a reminder of missed vaccinations than a warning in advance of the event.

The immunisation event is free to the consumer. Vaccines for the immunisation schedule are purchased and stored on behalf of the HFA by the National Vaccine Store at the Communicable Disease Centre in Porirua. Vaccines are then distributed to vaccinators under contract by Zuellig Pharma Limited's facilities in the main centres around the country. This system of distribution has been introduced gradually to replace the previous systems under which hospitals were involved in the distribution of vaccines. There are a limited number of exceptions to this system, where hospitals continue to distribute vaccines.⁶⁵ The distribution of vaccines will be discussed further in Section III: D in respect of monitoring of the cold chain.

⁶³ The HFA immunisation strategy is set out in National Health Committee, *Review of the Wisdom and Fairness of the Health Funding Authority Strategy for Immunisation of 'Hard to Reach' Children* (Wellington: National Health Committee, 1999), pp.11-25.

⁶⁴ The Immunisation Standards 1996 appear as an appendix in the *Immunisation Handbook 1996*, 2nd edn. (Wellington: Ministry of Health, 1996), pp.160-166.

⁶⁵ Personal communication with staff in the National Vaccine Store and with Ann Shaw, regional immunisation co-ordinator.

Immunisation providers are remunerated for each immunisation event, at the rate of \$11.00 per event, by the HFA through Health Benefits Limited (HBL)⁶⁶ in a similar way to claiming the General Medical Services Benefit (GMS). In some cases, where they have seen the child for a consultation as well as an immunisation, a GP may claim the GMS and the vaccine benefit. The exception is in capitated primary health care providers who do not claim benefits, but are funded to provide primary health care, including childhood immunisation to a given population.

The 11 year old vaccine event is managed differently in different regions. In the South Island children go to their GP as they would for an early childhood vaccination. In the North Island the vaccination is provided, under contract to the HFA, by the HHS as a school based programme. Parents are required to provide written consent and the vaccinations are undertaken at school in a mass approach. If a parent wishes this vaccine event can be undertaken by the child's usual primary health care provider. Immunisation education, for both providers and consumers is purchased by the HFA.

On occasion immunisation is provided outside the primary health care setting. Some hospitals provide an opportunistic immunisation catch up programme. This is where children who present at hospital, for whatever reason, with incomplete immunisations are offered education on immunisation and the missed vaccines. It can be difficult to determine what vaccines the child has received in this situation.

While most vaccinators are registered nurses working under the auspices of a medical practitioner, or medical practitioners themselves, there is provision under the law for independent non-medical vaccinators. According to the Medicine Regulations 1984, Amendment No. 5, which came into force in April 1992, persons who satisfy the Director General of Health or a Medical Officer of Health as to their competency may legally conduct immunisation programmes. The intention of this legislative change was to facilitate increased options in the

⁶⁶ Health Benefits Limited was set up and owned by the four RHAs, although this ownership has been transferred to the HFA. Its role is to handle GMS and other financial claims from health care providers.

provision of immunisation. The change had the backing of Treasury and health service providers including the Plunket Society, but was opposed by the New Zealand Medical Association.⁶⁷

The Medical Association supported vaccination remaining with GPs. It opposed the initiative to introduce non-medical vaccinators for a number of reasons. First, stand-alone vaccination programmes would not improve immunisation coverage unless targeted at children who were not being vaccinated. Second, stand-alone vaccination programmes would be an inefficient use of resources when GP facilities already existed. Third, the association was concerned about standards of care citing non-medical vaccinations lack of training limiting their ability to provide either informed consent or emergency care if required. Fourth, stand-alone vaccination would divide immunisation from routine well child health care, when many unvaccinated children would benefit from a general health review.⁶⁸

In the 1990s a child's immunisation was effectively the combined responsibility of parents and primary health care providers. New Zealand, as has already been noted, does not employ incentives for either providers or consumers to increase the immunisation coverage rates. This strategy has been used in other countries with positive impact on immunisation uptake statistics. In Austria childhood immunisation was one of the requirements women needed to meet to attain a financial incentive payment in a scheme designed to improve ante-natal and early child care. France has also employed a similar scheme.⁶⁹ In New Zealand the government considers childhood immunisation to be a parental responsibility and is not in the business of paying people to do what it considers they should be doing anyway.⁷⁰

⁶⁷ Memorandum to Cabinet, The Medicines Regulations CAB (92) 138 (13 March 1992).

⁶⁸ Alister Scott, Letter to John Eastwood, Department of Health, 28 August 1991, printed in full in the Background Papers for the Expert Working Group on Childhood Immunisation.

⁶⁹ David Hemenway, 'Financial Incentives for Childhood Immunisation', *Journal of Policy Analysis and Management*, 14 (1995), 133-139 (p.136)

⁷⁰ This was a view expressed by Katherine O'Reagan, then Associate Minister of Health in the National Government, at interview with the author, Cambridge, 10 November 1995.

An alternative to incentives for consumers of immunisation is incentives for immunisation providers. In the United Kingdom financial bonuses⁷¹ for general practices achieving given immunisation coverage rates among the population registered with the practice have been significant in raising national immunisation coverage rates.⁷² The positive response to financial incentives for service providers is an indication of the importance of provider commitment in childhood immunisation.⁷³

Providing incentives to childhood immunisation providers in the New Zealand situation faces both structural and attitudinal barriers. The British system provides incentives to GPs based on coverage rates achieved within a defined population. New Zealand does not have the system of total patient registration used in Britain, although there have been some moves to introduce it.⁷⁴ Furthermore, as discussed previously, childhood immunisation provision is not limited to GPs.

While paying patients to comply with any health strategy may work, it would have been contrary to the individualist direction of government policy in New Zealand where the expectation was that individuals would take responsibility for themselves. However, it is a little at odds with the movement which enforces a particular code of behaviour which does not interfere with the freedom of others in that there is no direct cost to non-compliant behaviour.⁷⁵

In considering alternatives for inclusion in the National Immunisation Strategy incentives for providers and consumers were not put forward or investigated in any detail, although there was mention of the option in the *National Immunisation Strategy Working Group Background Papers*. The report of the Department of

⁷¹ These payments are known as target payments. See David K. Whynes and Darrin L. Bains, 'Income-based Incentives in UK General Practice', *Health Policy*, 43 (1998), 15-31 (pp.16-17); Anne Rogers and David Pilgrim, 'The Risk of Resistance: Perspectives on the Mass Childhood Immunisation Programme', in *Medicine Health and Risk: Sociological Approaches*, ed. by Jonathan Gabe (Oxford: Blackwell Publishers, 1995), pp.73-90.

⁷² Hemenway, 'Financial Incentives for Childhood Immunisation', pp.136-167; Henderson, 'Vaccination Policies and Practices', p.363.

⁷³ Henderson, 'Vaccination Policies and Practices', p.637.

⁷⁴ Total patient registration requires that all people wishing to use the state funded health sector must be registered with a particular General Practice. The Northern RHA was investigating the introduction of a similar scheme.

⁷⁵ For an economic analysis of financial incentives see A. Giuffrida and H. Gravelle, 'Paying Patients to Comply: An Economic Analysis', *Health Economics*, 7 (1998), 569-579.

Health Immunisation Working Group (1991), recommended that “[t]he Department of Health explore the options for immunisation incentives for both providers and parents/caregivers.”⁷⁶ Also included were a number of journal articles discussing the British experience which incorporates incentives for providers.

It is clear, however, that this was never given a great deal of consideration in New Zealand because of philosophical objections at the government level. Failure to undertake cost-benefit analysis supports the premise that this policy development phase was heavily influenced by the prevailing philosophy and less about a rational consideration of all the issues and alternative courses of action. Instead ideological considerations were paramount. The health bureaucracy, under the direction of the politicians understood that there was to be no radical change in this area.

The level of the vaccine benefit may also be a barrier to raising immunisation coverage rates. Research carried out in Wellington in 1996 found that the cost of maintaining immunisation services and related recall systems was \$15.15 per vaccine event, that is an \$8.51 cost to the general practice.⁷⁷ Harry Pert, GP of Rotorua indicated at interview that were the vaccine benefit to be higher GPs would find it economically viable to put into place systems which would increase immunisation coverage.⁷⁸ Dell Hood, the Medical Officer of Health for Hamilton, reported that her discussions with GPs indicated that it was not cost effective for GPs, who are running private businesses, to do more than send a reminder letter and make a few phone calls.⁷⁹

The attitude of policy-makers and service funders is, however, that childhood immunisation is part of the total service primary health care providers should be delivering to their patients. The move is toward establishing contracts between

⁷⁶ Department of Health, *Immunisation Strategic Options: Report of the Department of Health Immunisation Working Group* (unpublished, 1991) pp.15-16.

⁷⁷ Deborah McLeod, Robert Bowie and Marjan Kljakovic, ‘The Cost of Childhood Immunisation in General Practice’, *NZMJ*, 111 (1998), 73-76.

⁷⁸ Harry Pert, Interview with the Author, Rotorua, 23 January 1997.

⁷⁹ Dell Hood, Interview with the Author, Hamilton, 9 April 1996.

the HFA and primary health care providers, which include childhood immunisation coverage targets, for example, in capitated practices.

D: Monitoring

To ensure the maintenance of standards in the delivery of childhood immunisation and to determine areas in which further assistance may be needed it is necessary to maintain surveillance over aspects of process and procedure. Improved monitoring and surveillance of immunisation was one of the National Immunisation Strategy's approaches to improving immunisation coverage.⁸⁰ The major foci in this task are immunisation coverage, the incidence of vaccine preventable diseases, vaccine adverse events and the efficiency of the cold chain.

(1) Childhood Immunisation Coverage

The establishment of an immunisation coverage surveillance system was one of the five elements in the National Immunisation Strategy. In the year 2000 Turner et al. identify that this has not been achieved.⁸¹

Immunisation coverage, or the proportion of a population which has been immunised, is an indication both of the success of immunisation delivery programmes and of the likelihood of a population being at risk from a given disease.

Michael Baker, Public Health Medicine Specialist at the Communicable Disease Centre, considers the ideal immunisation surveillance system should provide a range of information:

- coverage at the national, regional and health district levels;
- coverage at the provider level;
- characteristics of non-recipients (by age, ethnicity, location, vaccination session, timeliness);
- identification of non-recipients for reminder-recall purposes.⁸²

⁸⁰ Ministry of Health, *National Immunisation Strategy 1995*, p.8.

⁸¹ Turner et al., 'Improving Immunisation Coverage.'

⁸² Anne McNicholas and Michael Baker, 'Immunisation Coverage in New Zealand: Ongoing Surveillance Using Benefit Claim Data', *The New Zealand Public Health Report*, 2 (1995), 3.

New Zealand has a poor record in providing accurate immunisation coverage information. The most reliable data recognised has been that from the 1992 National Immunisation Coverage Survey. This random study of 706 two and three year olds was undertaken by Communicable Disease New Zealand (CDNZ) and published as *Immunisation Coverage in New Zealand*.⁸³ The results of this survey are discussed in Chapter Seven.

This intermittent survey approach to immunisation surveillance is expensive to undertake and provides only a snap shot of immunisation coverage at a particular time. While the data reflects the coverage situation at national and regional level and indicates the characteristics of non-recipients it does not provide information on non-recipients which would enable them to be offered reminders or catch up immunisation. Therefore it does not meet all Baker's criteria for the ideal surveillance system.⁸⁴

A second source of immunisation coverage information is available in the records General Practices keep of their clients' immunisation status, often in age-sex registers which may be either computerised or manual.⁸⁵ This data can form the basis of surveillance information useful in identifying both specific non-recipients and the characteristics of the group, measuring provider success and, through aggregation, reflecting regional and national coverage levels. Ossi Mansoor, a public health medicine specialist with the Ministry of Health investigated the potential of this option and considered it to be promising.⁸⁶ A version of this system is used in Britain, providing up to date and useful immunisation coverage information.

The potential benefits of provider based surveillance may, however, be limited by a number of factors in the New Zealand situation. First, not all general practices operate age-sex registers, either computerised or manual. Second, although it is

⁸³ Communicable Disease New Zealand, *Immunisation Coverage in New Zealand*, 92: Suppl 2 (Porirua: Communicable Disease New Zealand, 1992).

⁸⁴ A more detailed examination of the 1992 survey and other measurements of New Zealand's immunisation coverage is in Chapter Seven.

⁸⁵ Family Health Unit, *A Health Professional's Guide to Age-Sex Registers and Privacy in Primary Care Services* (Hamilton: Midland RHA, 1995).

⁸⁶ Ossi Mansoor, 'Ask and You Shall be Given: Practice Based Immunisation Coverage Information', *NZMJ*, 106 (1993), 504-505.

being considered in some regions, New Zealand does not have a system of universal patient registration, so not all children will be represented in a general practice age-sex register. Third, as not all children receive their immunisations in the general practice setting the information may not be kept up to date even were all children registered with a particular practice.

A third source of information on immunisation coverage is available from the vaccine benefit returns. As discussed above most immunisation providers claim remuneration for each vaccination event from HBL. Using the data provided to estimate immunisation coverage has in the past been found to be inconsistent with other methods.⁸⁷ However, updating of the claim form in 1994 has resulted in more useful information. McNicholas and Baker suggested that with further amendments to the claim form its usefulness as a source of information could be maximised.⁸⁸

At the time of writing the most recent available information on immunisation coverage comes from two sources. First, North Health's 1996 Immunisation Coverage Survey which used the methodology of the 1992 immunisation coverage survey in the North Health region. This indicated that immunisation coverage in the region, that is full immunisation coverage at age two years, had improved since the 1992 survey. Coverage rates overall had risen from 55.4 percent to 63.1 percent. Coverage for Māori was 44.6 percent.⁸⁹

Second, is a national estimate based health benefit data. According to McNicholas, Garret and Perks this indicates that in 1998 immunisation coverage levels were approximately ten percent lower than in 1996.⁹⁰

(2) The Incidence of Vaccine Preventable Diseases

Prior to 1996 there were problems estimating the impact of vaccines and the magnitude of epidemics of vaccine preventable diseases because many were not

⁸⁷ Murray Malcolm, 'Immunisation Surveillance: A Comparison of Four Methods in Canterbury', *NZMJ*, 106 (1993), 221-223.

⁸⁸ McNicholas and Baker, 'Immunisation Coverage in New Zealand', p.3.

⁸⁹ North Health, *Immunisation Coverage in North Health* (Auckland: North Health, 1997).

⁹⁰ Ann McNicholas, Nick Garrett and Melissa Perks, *Immunisation Coverage Surveillance Using Benefit Data* (Wellington: Ministry of Health, 1999).

notifiable. This was discussed in a paper submitted to the Expert Working Group.⁹¹ The National Immunisation Strategy moved to correct this, stating:

The effectiveness of immunisation programmes will continue to be monitored through the analysis of disease outcomes. The Ministry of Health will amend the notifiable diseases schedule to include all of the vaccine-preventable diseases.⁹²

In June 1996 a new notifiable diseases schedule came into effect. It included all diseases for which there were vaccines on the childhood immunisation schedule. Under the Health Act (1956) medical practitioners are obliged to notify the Medical Officer of Health when they suspect or diagnose a notifiable disease. This data is collated and analysed by the Institute of Environmental Science and Research Limited (ESR) on behalf of the Ministry of Health.⁹³ Surveillance data is published in *The New Zealand Public Health Report*.

(3) Vaccine Related Adverse Events

It has been established that childhood immunisation is considered to be an effective strategy in maintaining both individual and the public health. However, it is acknowledged that vaccines do have unwanted side effects.⁹⁴ Vaccine related adverse events reported in children include relatively minor events like raised temperature and painful swelling at the injection site, through to more serious events including high pitched crying, seizures and encephalopathy. Vaccine related adverse events are predominantly of a minor nature and have no lasting effect on the child.⁹⁵ Furthermore, it is considered that the risk of a child suffering a severe vaccine reaction, resulting in long term vaccine damage is lower than the risk of similar side effects as a result of contracting the vaccine preventable disease.⁹⁶

⁹¹ Yvonne Galloway, 'Briefing Papers from the New Zealand Communicable Disease Centre: Surveillance of Vaccine-Preventable Diseases', *National Immunisation Strategy Working Group Background Papers Volume II* (Wellington: Public Health Commission, 1993).

⁹² Ministry of Health, *National Immunisation Strategy 1995*, p.8.

⁹³ Michael Baker and Alison Roberts, 'A New Schedule of Notifiable Diseases for New Zealand', *The New Zealand Public Health Report*, 3 (1996), 33-37.

⁹⁴ Philippe Duclos and Adwoa Bensti-Enchill, 'Risks and Benefits of Immunisation', *Current Therapeutics*, 34 (1994), 17-27 (p.17)

⁹⁵ Duclos and Bentsi-Enchill, 'Risks and Benefits of Immunisation', p.28.

⁹⁶ For a discussion of this point based on Third World experience see Duclos and Bentsi-Enchill, 'Risks and Benefits of Immunisation', p.25.

Any adverse event occurring in the wake of vaccination of a child should be dealt with immediately as would any other incident in which a child requires medical attention - initially by the family GP, with assistance from emergency and specialist services as required. However, the population-based nature of childhood immunisation programmes means that it is important that there is additional monitoring of such events for planning, information and statistical purposes.

Much attention is given to minimising the chance of vaccine related adverse events occurring. The first focus of attention is the vaccine itself. Before a vaccine is marketed it is extensively tested, then trialled on small groups to ensure its safety. However, the value of small pre-market trials is limited, as they are likely to reveal patterns related only to the most serious and common of side effects. Once the vaccine is being used in a larger population group, patterns of adverse events which have not been seen before may become apparent. For this reason it is important to continue to collect information on adverse events in a strategy of post-marketing surveillance (PMS).

In New Zealand all vaccines must meet this country's specifications for safety and vaccines arriving in the country are monitored by the Institute of Environmental Science and Research: Communicable Disease Centre (CDC), which is also responsible for operating the National Vaccine Stores.

The second consideration in minimising the possibility of side effects from immunisation is the conditions under which the vaccine is administered. Immunisation schedules are developed and regularly updated so as to avoid circumstances which may have been observed to increase the risk of adverse events. Factors which contraindicate immunisation, because they carry with them an increased risk of side effects, are acknowledged in immunisation guidelines. These factors may include previous vaccine reactions, a family history of vaccine related adverse events, fever, or a history of convulsions.⁹⁷

⁹⁷ Contraindications to immunisation are discussed in the *Immunisation Handbook*.

There is, however, concern that rather than alerting parents and vaccinators to situations in which vaccination should be avoided, certain circumstances are being inappropriately considered to be contraindications for immunisation causing immunisations to be delayed or omitted unnecessarily.⁹⁸ In order to minimise this situation specialist services have been established to advise GPs and parents on situations which may or may not contraindicate immunisation.⁹⁹ In New Zealand this role is assumed by the Immunisation Advisory Centre (IMAC) which is attached to the Auckland School of Medicine.

New Zealand data on the occurrence of vaccine side effects is collected by the Centre for Adverse Reactions Monitoring (CARM) under contract to the Ministry of Health.¹⁰⁰ CARM is a research group within the Department of Social and Preventive Medicine at the University of Otago Medical School. It was set up in 1965 by the Royal New Zealand College of General Practitioners, the Royal Australasian College of Physicians, the New Zealand Dental Association and the University of Otago Medical School's Department of Pharmacology. CARM operates independently of the Ministry of Health and has no regulatory responsibility.

CARM collects information on adverse medicine reactions (AMR) which it conveys to the New Zealand Medicines Adverse Reactions Committee (MARC) which advises the Minister of Health about matters relating to medicine safety.¹⁰¹ CARM also provides information to medical practitioners through publications in the *New Zealand Medical Journal* and publication of the *Prescriber Update* which provides information on drugs which have been reported as having related side effects.

⁹⁸ For further discussion of the misuse of contraindications to immunisation see Norman Begg and Angus Nicoll, 'Myths in Medicine: Immunisation', *BMJ*, 309 (1994), 1073-1075.

⁹⁹ For details see R. Hall and A.L.J. Williams, 'Special Advisory Service for Immunisation', *Archives of Disease in Childhood*, 63 (1988), 1498-1500; M.J. Newport and S.P. Conway, 'Experience of a Specialist Service for Advice on Childhood Immunisation', *Journal of Infection*, 26 (1993), 295-300.

¹⁰⁰ Ministry of Health, *National Immunisation Strategy 1995*, p.17.

¹⁰¹ For details of MARCs responsibilities see Peter Pillans, 'Post-Marketing Surveillance: The Role of the GP', *New Ethicals*, October 1994, 9-15 (p.13).

CARM obtains its information on AMRs through voluntary reports from health professionals who believe that there is a causal relationship between a drug, vaccine, blood product or therapeutic device and an adverse event. It is left to the clinical judgement of the reporting physician to determine whether or not there is a causal relationship, but CARM will accept reports where that link is in doubt.¹⁰² While the centre will accept any report of any adverse event, it encourages reporting of serious events.

In respect of vaccine related adverse events CARM provides the following guidelines as to what should be reported:

- occurring within three days of vaccination: anaphylaxis, persistent screaming (for more than three hours), collapse or shock-like state, hypotonic/hypertonic episodes;
- occurring within 15 days of vaccination: convulsions, encephalopathy;
- occurring within 30 days of vaccination: meningitis (unless aetiology unrelated);
- occurring within three months of vaccination: acute flaccid paralysis.¹⁰³

Despite the recommendations, examination of CARM's 1995 annual report in the *New Zealand Medical Journal* reveals that of the 333 reports received most are of less serious side effects, including inflammation at the injection site, fever, irritability, rash and urticaria. However, there were also reports of convulsions and inconsolable crying.¹⁰⁴

Under the Immunisation Standards 1996 vaccinators are required to report adverse events promptly.¹⁰⁵ However, in New Zealand, in common with other countries, reporting is essentially voluntary.¹⁰⁶ In the United States reporting of specified vaccine related adverse events is mandatory under the National Vaccine Injury

¹⁰² Pillans, 'Post-Marketing Surveillance', p.14.

¹⁰³ Pillans, 'Post-Marketing Surveillance', p.14.

¹⁰⁴ P.I. Pillans and D.M. Coulter, 'Centre for Adverse Reactions Monitoring Report for the Year Ending June, 1994', *NZMJ*, 108 (1995), 488-491 (p.490).

¹⁰⁵ *Immunisation Handbook*, p.165.

¹⁰⁶ Osman Masoor, 'Vaccine Adverse Events in New Zealand 1990-5', *NZMJ*, 110 (1997), 270-272 (p.271); Pillans, 'Post Marketing Surveillance', p.10.

Act.¹⁰⁷ Voluntary reporting makes it almost impossible to judge whether or not the existing impression as to the occurrence of vaccine related adverse events is accurate. If any part of the picture is an accurate reflection of the reality it is more likely to be in relation to serious events as it is those which CARM focuses on in its recommendations for reporting.

Although less serious side effects are acknowledged in the Centre's reports it is possible that these figures are a gross under estimation of that type of side effect. First, side effects may not be reported because the child does not require medical attention. Second, the doctor may not report the event, either because of doubts as to the causal relationship between the vaccine and the adverse event or because it is not perceived to meet the criteria for a serious event. Thus, there could be a high level of less than serious side effects in the community undetected. Anything which may be learnt from this information about the timing, safety and contraindications for immunisation is being lost.

In a limited number of cases vaccine related adverse events result in significant, severe or permanent damage to the child. In New Zealand compensation in such cases is the responsibility of the Accident Rehabilitation and Compensation Insurance Corporation. The Medical Misadventure Unit of the Corporation receives many claims for compensation, most in respect of minor damage related to vaccination. However, only a small number of these are approved, usually under the Medical Mishap provisions of the Accident, Rehabilitation and Compensation Insurance Act (1992).¹⁰⁸ Compensation is then paid out by local branches of the Corporation, making estimation of the cost of compensation difficult to assess.

¹⁰⁷ For details of the requirements of the United State's National Vaccine Injury Act see Dennehy et al., pp.2733-4.

¹⁰⁸ Medical Mishap is where there are untoward consequences of treatment properly given, as opposed to Medical Misadventure, the term given to personal injury as a result of medical error. These terms are defined under Section 5 of the Accident, Rehabilitation and Compensation Insurance Act (1992).

(4) The Cold Chain

To ensure that vaccines maintain their efficacy it is necessary to provide storage and transport at the correct temperature. Vaccine inefficacy in the past has been attributed to inadequate vaccine storage and transportation control, prompting the inclusion in the National Immunisation Strategy of standards for the care of vaccines. The responsibility for this lies with a number of different personnel in the chain of purchasing, storing, transporting and using vaccines.

As discussed above the National Vaccine Store purchases and stores vaccines and then distributes them to the company contracted to undertake local distribution. The National Vaccine Store contracts with a courier company to transport the vaccines to the regional distribution points, with conditions which ensure the timeliness of deliveries. Zuellig Pharma Limited and other distributors are then responsible for distribution of vaccines to vaccinators.

Guidelines for vaccinators on maintaining the cold chain are contained in the *Immunisation Handbook*.¹⁰⁹ Monitoring of adherence to these guidelines and maintenance of appropriate storage temperatures are undertaken by local immunisation co-ordinators.

Matheson and Bolotovskiy reported in 1993 that “a number of studies of vaccine storage conditions in general practices (GP) have indicated that inadequate storage conditions may also contribute to vaccine failure.” Although there are no more recent published studies about vaccine storage, anecdotal reports suggest that most problems with the cold chain are encountered at the vaccinator level.¹¹⁰

E: Barriers to Childhood Immunisation

Concerns about low levels of immunisation coverage in New Zealand raise questions about why it is that children do not receive the recommended immunisations. A range of factors have been identified as increasing the risk that children will not complete the immunisation schedule. These include factors

¹⁰⁹ *Immunisation Handbook*, pp.26-28.

¹¹⁰ Personal Communication with Ann Shaw, regional immunisation co-ordinator.

which reduce a family's mobility, access to health care and low socio-economic status.¹¹¹

Chapter Seven discusses immunisation coverage information and specific risk factors identified in the New Zealand situation in greater detail, but this section will concentrate on three areas in which the rise of individualism can be seen to have had a particular impact: contact with health care providers; perception of disease risk; and conscientious objection to childhood immunisation.

(1) Contact with Health Care Providers

Many GPs challenged the findings of the 1992 survey on immunisation coverage in New Zealand, because coverage rates among the children registered in their practices were much higher than those identified by the survey. This is likely to be correct, but it is those children who are not on a GP's register who are most likely to be at risk of not completing the immunisation schedule.¹¹²

In New Zealand some sections of the population are less likely to have an ongoing relationship with a primary health care provider, particularly Māori and low income New Zealanders.¹¹³ Cost sharing, or user part-charges have been found to be a barrier to access to primary care in New Zealand.¹¹⁴

That such a situation contributes to low immunisation rates is consistent with literature which suggests both that poverty is a barrier to immunisation and that children of families who do not have an ongoing relationship with a regular primary health care provider are at risk of poor health outcomes.¹¹⁵

¹¹¹ For discussion of factors identified as increasing the risk that New Zealand children will not be immunised see National Health Committee, *Review of the Wisdom and Fairness of the Health Funding Authority Strategy for Immunisation of 'Hard to Reach' Children* (Wellington: National Health Committee, 1999), pp.6-7.

¹¹² This point was made by Ruth Rhodes, Manger of Child Health Services for the Midland RHA, at interview with the author, Hamilton, 19 June 1995.

¹¹³ Laurence Malcolm, 'Inequities in Access to and Utilisation of Primary Medical Care Services for Māori and Low Income New Zealanders', *NZMJ*, 109 (1996), 356-358.

¹¹⁴ Cameron Grant, Christopher Forrest and Barbara Starfield, 'Primary Care and Health Reform in New Zealand', *NZMJ*, 110 (1997), 35-39 (p.38).

¹¹⁵ National Health Committee, *Review of the Wisdom and Fairness*, pp.42-44.

Lack of an ongoing relationship with a primary health care provider acts as a barrier to children receiving the childhood immunisation schedule on time. They may not be registered with a General Practice or see a Plunket Nurse or other Child Health worker regularly. This situation may arise for a number of reasons, for example because of a family's mobility or because of existing debt with a GP. Although attempts were made by the RHAs, and later by the HFA to overcome such a situation by purchasing culturally and geographically appropriate services, there are still children who fall through the gaps.

Pamela Williams, a member of the Expert Working Group on childhood immunisation who was at that time a senior Plunket Nurse in South Auckland, indicated that existing debt with a GP can be a barrier to immunisation.

[I]n areas like South Auckland, low socio-economic areas, ... although immunisation is free, the family owe their GP money for the adults visiting. They don't want to front up to the GP because they are going to be asked about bills.¹¹⁶

As a result families may visit a GP only on a casual basis or present at after-hours medical services, emergency centres or the Emergency Department of a hospital.¹¹⁷ Families in this situation, without an ongoing relationship with a health care provider, may not receive information about childhood immunisation, nor will they be reminded if they have not presented for immunisations on time. When they do seek medical attention personnel treating the child do not have access to medical records and the parents may not recall the child's immunisation status.

In some cases the child comes into contact with a health service provider who will offer immunisation catch up. This situation can be problematic when the immunisation status is unknown, but it does provide an opportunity for education and immunisation. However, not all health service providers offer opportunistic immunisation catch-up services.

¹¹⁶ Pamela Williams, interview.

¹¹⁷ Ruth Rhodes, interview.

The link between poverty, poor health and neo-liberal political economic policies are discussed in Chapter Four. That some children do not have an ongoing relationship with a GP or other primary health care provider, and thus do not have the opportunity to complete the recommended immunisation schedule, suggests that the institutionalisation of neo-liberal philosophy in economic and social policies has made a contribution to low immunisation uptake in this country.

(2) Perception of Disease Risk

New Zealand has had a regular childhood immunisation schedule for more than 35 years, with new vaccines being introduced as they have become available. This is considered to be the significant contributing factor to the rarity in the 1990s of diseases which once occurred regularly and were recognised as a serious danger to children's health. New Zealand has not had a reported case of wild polio since April 1962,¹¹⁸ and although there was a case of diphtheria reported in 1998,¹¹⁹ that disease has been extremely rare since the 1960s.¹²⁰ The common occurrence, or epidemics of these diseases is beyond the memory of most parents of young children and has little if any impact on their decision to immunise their children.

This position is reinforced by the opposite situation. Discussion with health workers and parents suggests that those parents who do come into contact with, or have personal knowledge of, life threatening cases of vaccine preventable disease are often more willing, or more motivated, to vaccinate their children. Furthermore, when Hib vaccine was introduced, immunisation coverage across the entire schedule improved because parents had heard of the serious sequelae associated with contracting Hib disease and were eager to ensure their children were protected against the disease.

¹¹⁸ Dow, *Safeguarding the Public Health*, p.194.

¹¹⁹ Anonymous, 'A Case of Diphtheria in New Zealand', *Communicable Disease Intelligence*, 22 (1998), 188.

¹²⁰ Dow, *Safeguarding the Public Health*, p.193.

However, many parents are more familiar with the side effects of vaccines than they are with the side effects of vaccine preventable diseases. Thus when making their decisions they consider the risk of the vaccine more important than the risk of the disease. This is an important point. Diana Lennon, Professor of Paediatrics at the Auckland School of Medicine has suggested that the decision about whether or not to immunise one's child should be a simple exercise in risk analysis.¹²¹ However, while Lennon's opinion on this matter is influenced by her scientific training and her experience, parents making the decision to immunise will be subject to other influences.¹²² Gregory et al note:

The management of risk traditionally has relied on calculations of predicted physical harm that reflect the probability and magnitude of an event's consequences to human health. Only recently have researchers begun to analyse the ways in which the public intuitively understands risks and makes judgements concerning the comparative dangers of different technologies. One important finding is that experts and laypersons often disagree about the meaning of risk: the qualities of the hazard can matter as much as the quantity of the risk faced by the public.¹²³

In discussing childhood immunisation specifically White and Thomson note that:

Immunization and the effects of childhood diseases have been promoted within a biomedical perspective but concepts of health and illness have socio-cultural perspectives based on folk medicine knowledge, experiences and attitudes. Thus, it is a narrow view that immunization is a parent's responsibility, and that what is required to increase immunization rates is parent education ... Indeed that parental decisions are based at all on theoretical knowledge is itself an assumption.¹²⁴

¹²¹ Diana Lennon, 'Immunisation: Where's the Controversy?', *Patient Management*, December 1992, 33-37.

¹²² For a discussion of the assessment of risk in relation to childhood immunisation see Anne Rogers and David Pilgrim, 'The Risk of Resistance: Perspectives on the Mass Childhood Immunisation Programme', in *Medicine, Health and Risk*, ed. by Jonathan Gabe (Oxford: Blackwell, 1995), pp.73-90.

¹²³ Robin Gregory, Paul Slovic and James Flynn, 'Risk Perceptions, Stigma, and Health Policy', *Health and Place*, 2 (1996), 213-220 (p.213).

¹²⁴ Gillian Eyres White and Alex N. Thomson, 'As Every Good Mother Should'. Childhood Immunization in New Zealand: A qualitative Study', *Health and Social Care*, 3 (1995) 73-82 (p.80).

In the case of childhood immunisation in the 1990s parents were being asked to follow the recommendations of medical science and the state, rather than their own assessment of the situation. For some people this is an enormous leap of faith, especially at a time when they are subject to very real pressures to take more responsibility for the welfare of their families. In this situation some parents go looking for other opinions and find an organised effort to provide an alternative view in the Immunisation Awareness Society (IAS). Although this organisation offers a broad range of information, it also acts as a support network for those who make a decision to refuse immunisation for their children.

(3) Conscientious Objection

Parental non-consent accounts for only a small percentage of those children who do not complete the recommended childhood immunisation schedule. In the 1992 survey they were noted to be between one and six percent.¹²⁵ In New Zealand the focus of feelings in opposition to routine childhood immunisation is the IAS, an active group with a growing membership and a number of branches throughout the country.

While the medical establishment exercises its concerns about poor immunisation coverage and attempts to institute policy which will improve the situation, there are those who refuse to accept without question the prevailing position on immunisation. An apparently growing group of parents, health workers, medical practitioners and researchers from a number of different disciplines challenge the current orthodoxy on childhood immunisation policy and practice.

Opposition to the orthodox position on immunisation is not however homogenous. Rather it espouses a variety of positions ranging from those which are ardently anti-immunisation through to a group which seeks a balance of information on which to base an informed choice in the matter of childhood immunisation. A growing body of writing by professionals from various disciplines and concerned parents raises a number of issues in relation to all or parts of the practice of

¹²⁵ Communicable Disease New Zealand, *Immunisation Coverage in New Zealand*, Vol. 92: Suppl 2 (Porirua: New Zealand Communicable Disease Centre, 1992).

immunisation, challenging it over a number of different matters. The issues raised in this writing fall into three broad categories. The first challenges the need for immunisation, questioning the part immunisation has played in the eradication of disease. The second focuses on the safety and efficacy of vaccines, while the third challenges the quality of information the medical establishment makes available about vaccination.

The first group rejects the orthodox conclusion that immunisation has had a role in reducing the incidence of infectious diseases. This includes those who believe that, rather than immunisation being responsible for the eradication or reduction of diseases like polio and smallpox, these diseases were declining anyway and, allowed to follow their natural course, would have died out as other diseases have died out in the past. There is further contention that the practice of immunisation has interfered with the natural course of diseases, serving only to shift the focus of disease into later life, or to contribute to the rise of other diseases. In addition to attacking the use of immunisation in light of this information, they are also critical of those who use incomplete data to support the thesis that immunisation has caused the decline of particular diseases. This school of thought supports the belief that, instead of concentrating on immunisation, the focus of efforts to raise the standard of child and general health should be on such factors as nutrition, housing, safety and education.

The second category of issues is related to the safety and efficacy of vaccines. The most prominent of these is the issue of vaccine side effects. There is concern that although, as discussed above, the occurrence of side effects is acknowledged by those who support immunisation, they may occur more often than is recognised. Reporting of side effects is not mandatory and accurate identification of vaccine damage can be difficult because of the possibility of coincidental events. Furthermore, parents report that vaccinators do not always warn of the likelihood of side effects or what they may mean. Another concern is that vaccines are given in solutions which contain other substances, including antibiotics and chemical stabilisers. There have also been concerns that instances where vaccines have contained infective material.

Concern has also been expressed about children who have been vaccinated according to the schedule, but contract a disease against which they should have been protected. Vaccination is known to be only about 95 percent effective, but once again this is not always explained to parents. In some cases failure of a vaccine to confer immunity is considered to be as a result of a failure in the so-called "cold chain". The danger in this situation is seen as believing a child has protection against a disease when in fact they have none. There are further concerns that immunisation may interfere with the natural development of the human body's own immune system. The body's reaction to immunisation has been linked, by those questioning its safety, to the development of asthma and eczema and in the occurrence of Sudden Infant Death Syndrome (SIDS).

The third category of concern relates to the information available about immunisation and the way in which this is presented to parents and the community in general. In seeking to make an informed choice about immunising their child many parents find it difficult to obtain a balance of information on which to make their decision. There are reports that health professionals appear to consider immunisation the only alternative and that parents wanting more information are made to feel that they are considering a dangerous and irresponsible alternative. Parents who delay immunisation, or decline to consent to immunisation for their child report they are sometimes harassed by phone calls from child health workers reminding them that their child's immunisations are not up to date, or having to justify their decision every time they see a doctor with their child.

Many parents, seeking only to make an informed choice for their child, are dissatisfied with the information they receive from the medical establishment, so pursue alternative sources of information. In New Zealand this information is available from the IAS, which is the organisational focus of the challenge to the orthodox position on childhood immunisation in this country.

IAS is a group of parents who wish to inform other parents, health professionals and politicians about vaccination issues. They endeavour to make information on these issues available to those who need it and to encourage debate on these

issues. The IAS is part of a growing international network of organisations which aim to increase awareness of the issues which relate to immunisation.¹²⁶ While these organisations claim to be interested in the dissemination of information on immunisation and not a lobby against immunisation, it would appear that they are perceived in the medical and health policy establishment as being anti-immunisation.

IV: Conclusion

New Zealand's experience of childhood immunisation has long illustrated an incrementalist approach to policy-making. Advances in the science of vaccines and vaccination have traditionally driven policy change. Implicit in this process, however, have been assumptions about what is acceptable in New Zealand society and to the mechanisms of the state, particularly in the provision of health services.

The National Immunisation Strategy, announced in 1995, was developed and implemented during a time when the emphasis of public policy was on shifting away from the universal provision of social services toward greater levels of personal responsibility. Childhood immunisation, however, is accepted as a public good and regarded as a significant part of the state's responsibility in maintaining the public health.

The strategies announcement followed a review of a wide range of possible options in the provision of childhood immunisation, including a number of alternatives which have proved successful in raising immunisation coverage in other developed countries. Why is it then that New Zealand continued to pursue incrementalist change in childhood immunisation policy and that there has been no significant improvement in immunisation coverage at age two years?

The following chapters will examine what it was that put childhood immunisation on the public policy agenda, how the process was handled and the limitations placed on the available alternatives by factors in New Zealand's political, economic and social environment.

¹²⁶ Other organisations similar to the IAS operate in Australia, Britain, the United States, Belgium, Canada, France, Germany, Finland, Italy, the Netherlands, Spain and Switzerland.

Chapter Seven

PUTTING CHILDHOOD IMMUNISATION ON THE AGENDA

I: Introduction

The announcement of a national immunisation strategy in March 1995 marked the culmination of a process which had been ongoing since 1992, when the protection of children from preventable infectious diseases was announced as one of the Public Health Commission's (PHC's) pilot health goals.¹ During that time childhood immunisation policy and practice in New Zealand were reviewed, and options for the future were considered. This process had the potential to introduce a new approach to the development of childhood immunisation policy and procedure in New Zealand. It could have marked a shift away from the incrementalist approach of the past, adopting instead a co-ordinated, intersectoral and well-publicised approach.² The potential of the national immunisation strategy was, however, limited, as is any policy initiative, by the environment in which it was created, and the priorities and limitations of the interests which drove the process.

The practice of childhood immunisation in New Zealand has been subject to intermittent change since the introduction of the smallpox vaccination programme in the 1860s, but particularly in the period since the childhood immunisation schedule was regularised by the Health Department in 1960. As is discussed in Chapter Six, changes were made from time to time in order to accommodate advances in vaccine development, the growing body of knowledge about vaccines and the conditions which maximised their impact, and new knowledge about which diseases were a threat to New Zealand's children. Hence the incrementalist label.

¹ This thesis will refer to this process as a review, although no part of the process was officially referred to as such.

² "Incrementalism is recognised as being descriptive of how policy makers actually make decisions ... Incrementalism, or muddling through, involves making small adjustments to existing policies, rather than reviewing all alternative strategies for achieving policy objectives." From George R. Palmer and Stephanie D. Short, *Health Care and Public Policy: An Australian Analysis*, 2nd edn (Melbourne: Macmillan, 1994), p.30.

In the late 1980s a number of childhood immunisation related events combined to raise the profile of childhood immunisation among health professionals, politicians and the public. This attention continued into the early 1990s as information about immunisation coverage and epidemics of vaccine preventable disease added to earlier concerns and combined with structural and attitudinal change in the health sector to put childhood immunisation firmly on the public policy agenda. The process attracted a broad spectrum of views from New Zealand society and the public policy community, but when this issue is discussed two views tend to dominate. The first perspective, and the principal driver in this process of change, was the medical establishment, particularly the sections of it concerned with child health and the control of infectious diseases. The second perspective was the political economic philosophy dominant in New Zealand at that time. Neo-liberal individualism shaped the environment from which all public policy emerged at that time, but emerging policy reinforced the environment, so that preceding policy and structural changes had a role in shaping childhood immunisation policy and practice.

A number of factors were involved in putting the issue of childhood immunisation policy on the agenda for attention and review. These related to introducing new vaccines to New Zealand's children and concern about the country's record in protecting its children against vaccine preventable diseases, while others were founded in the changes in the structure and philosophy of the health sector as a result of the 1993 health sector reforms discussed in Chapter Three. Other factors relate to aspects of the political process. As in the past the medical establishment took a central role in driving childhood immunisation policy change. However, in the early 1990s, other elements of the political process were also involved, both in putting the issues of childhood immunisation on the agenda and in driving the policy determination process.

Because of the diverse range of factors motivating the review, this chapter outlines and discusses these factors under four headings: first, the introduction of four new vaccines for use with children; second, service outcomes, which examines indications that existing policy was producing poor outcomes; third, structural and organisational change, which examines issues related to change in the wider health

sector; fourth political issues, which examines the creation of a particular climate of attention to childhood immunisation and the political response to that climate.

II: New Vaccines and Changes in the Immunisation Schedule

Developments in the science of vaccines means that new vaccines are regularly available, either to improve the protection offered or to increase the range of diseases for which there is protection. In the late 1980s New Zealand saw a great deal of work done in a number of areas related to vaccine development, with new vaccines, either introduced or demanded, and changes in the childhood immunisation schedule, as had previously happened, to improve the safety and effect of vaccine protection. Changes in the vaccine schedule, however, attract public attention and raise the profile of immunisation. This section will briefly examine four events that contributed to the heightened profile of childhood immunisation in the late 1980s. First, the outbreak of meningococcal disease in Auckland and the introduction of a vaccine which successfully controlled the outbreak. Second, the work on Hepatitis B and the introduction of that vaccine to the immunisation schedule. Third, the increased incidence of *Haemophilus Influenzae* type b and the introduction of that vaccine to the immunisation schedule. Fourth, the introduction of MMR vaccine to the schedule.

A: Meningococcal Disease

Meningococcal disease causes serious illness, having high mortality rates. In 1985/86 an outbreak of meningococcal disease, serogroup A, in Auckland was successfully controlled using vaccine.³ This outbreak and subsequent high rates of meningococcal disease in New Zealand are discussed in Chapter Six. The disease is included here because the disease outbreak and the vaccination campaign which was undertaken to control it were instrumental in raising the profile of vaccination and the occurrence of vaccine preventable diseases.⁴

³ N. Wilson et al., 'Meningococcal Disease Epidemiology and Control in New Zealand', *NZMJ*, 108 (1995), 437-443 (p.438).

⁴ Dell Hood, who was involved in the vaccination campaign during the outbreak, discussed the high level of public interest in this campaign and concerns about vaccine safety.

B: Hepatitis B

New Zealand was at the forefront in the development of vaccine for hepatitis B.⁵ This was the result of a long campaign of work in the Eastern Bay of Plenty, led by Alexander Milne, on the incidence of, and vaccination against Hepatitis B.⁶ Milne and colleagues also undertook research which led them to trial immunisation against hepatitis B using lower than the manufacturer's recommended doses of vaccine, beginning in 1983.⁷

Initially vaccination against hepatitis B was available to the infants of HbsAg positive mothers. In February 1988 the Department of Health began a campaign to immunise children under 4 years against hepatitis B. In February 1990 the vaccine was made available to all children under 16 years of age.⁸

Throughout the campaign there was public discussion not only of the merits of the vaccine and its possible side effects, but also criticising the way the Health Department handled the campaign. There were rumours of Aids contamination of the vaccine and the IAS sought to give parents a more complete picture of possible side effects than was available from officials. Much of this was documented in the press, further fuelling the debate.

The incidence of hepatitis B was high in some sections of the community, including Māori. For this reason interest groups, including the Māori Women's Welfare League and the Hepatitis B Foundation were actively lobbying government for funding of further research and appropriate immunisation programmes. This contributed to raising the profile of this disease and vaccine preventable disease as a whole.

⁵ Diana Lennon and Stewart Reid, 'Childhood Immunisation in New Zealand', *NZMJ*, 107 (1994), 171-172 (p.171).

⁶ For a discussion of the events that led to the inclusion of a Hepatitis B vaccine into the immunisation schedule see P.N. Goldwater, 'History of Hepatitis B Vaccination in New Zealand: Lessons for Australia?' *Australian Journal of Public Health*, 17 (1993), 221-225; W. Muraskin, 'Bucking the Health Establishment: Alexander Milne and the Fight for a New Zealand Hepatitis B Immunization Program', *Social Science & Medicine*, 41 (1995), 211-225.

⁷ A. Milne et al., 'Mass Vaccination Against Hepatitis B in Preschool Children: Immunogenicity After Three Reduced Doses', *NZMJ*, 102 (1989), 429-430; A. Milne et al., 'Hepatitis B Vaccine boosters: Further Studies In Children', *NZMJ*, 103 (1990), 539-541.

⁸ Derek A. Dow and Ossi Mansoor, 'New Zealand Immunisation Schedule History', *NZMJ*, 109 (1996), 209-212 (p.211).

C: *Haemophilus Influenzae* type b (Hib)

As discussed in Chapter Six, *Haemophilus Influenzae* type b (Hib) causes serious morbidity and mortality in small children. A vaccine against this disease was introduced to the schedule in 1994. CDCAC had been discussing the introduction of a vaccine against Hib into the free schedule since 1989 and in 1992 recommended that as soon as a new tetravalent vaccine, which combined a Hib vaccine with Diphtheria-Tetanus-Polio (DPT), was registered in New Zealand it be included in the immunisation schedule.⁹ This move was supported by an analysis examining the economic benefits of the vaccine's introduction.¹⁰ The official processes required were undertaken in September 1993 and the Hib vaccine was introduced to the schedule in January 1994.¹¹

The delay in introducing a vaccine against this disease was a factor in raising the profile of vaccine preventable disease and the governments role in funding immunisation programmes.

D: Measles Mumps Rubella (MMR)

In November 1990 the vaccine MMR was included in the immunisation schedule to replace separate vaccines for measles and rubella and introduce a vaccine for mumps.¹²

As is the case with changes in the vaccine schedule this attracted comment, including negative comment on the campaign instigated at the launch of this vaccine.¹³

⁹ Minister of Health, Memorandum to the Chairman of the Cabinet Committee on the Implementation of Social Assistance Reforms, in SAR (93) 167, 14 September 1993; Stewart Reid, Letter to the Minister of Health, 30 October 1992, printed in full as Appendix 1 to these Papers.

¹⁰ D. Lennon et al., 'The Case for *Haemophilus Influenzae* type b Vaccination in New Zealand', *Communicable Disease New Zealand*, 92 (1992), 89-95.

¹¹ Shanthi N. Ameratunga, Diana R. Lennon and Diana Martin, 'Haemophilus Influenzae type b Disease: Prospects for Prevention in New Zealand', *NZMJ*, 107 (1994), 193-194.

¹² Dow and Mansoor, 'New Zealand Immunisation Schedule History', p.211.

¹³ H. Butler, 'Hepatitis B Immunisation [letter]', *NZMJ*, 101 (1988), 464

This and other work on childhood immunisation often involved the Communicable Disease Control Advisory Committee (CDCAC). This Committee had a statutory role to advise the Minister of Health on matters relating to communicable disease. CDCAC became the Infectious Diseases Advisory Committee (IDAC)¹⁴. Individuals including Diana Lennon, Professor of Paediatrics at the Auckland Medical School and Dr Stewart Reid, a GP who was chair of the CDCAC, were working through this mechanism to bring about improvement in childhood immunisation in New Zealand.

The events surrounding the use of these four vaccines were instrumental in raising public and health professional consciousness about vaccines and vaccine preventable disease. This heightened profile contributed to putting childhood immunisation on the public policy agenda. Unlike low immunisation coverage and epidemics of vaccine preventable disease these issues related to getting new vaccines in – and the problems with that. However, these initiatives also represent work that was ongoing in the area, with the Ministry of Health and CDCAC working together in a rational and considered way to ensure that there was sufficient evidence of an acceptable standard to ensure that introducing these vaccines was the safe and responsible course to take.

III: Service Outcomes

The standards achieved across a range of childhood immunisation service issues in the early 1990s were of concern to health professionals and policy officials involved in the delivery and monitoring of childhood immunisation in New Zealand. Two particular issues focused attention on negative outcomes from the provision of childhood immunisation services: the occurrence of epidemics of vaccine preventable diseases and the related issue of low vaccine coverage rates in New Zealand.

¹⁴ The Immunisation Practices Advisory Committee (IPAC) was established to take care of such matters..

A: Epidemics

In the Foreword to the 1993 *Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy* David Skegg noted:

New Zealanders have recently suffered epidemics of two vaccine-preventable diseases, measles and pertussis (whooping cough). These epidemics not only caused much suffering, but also resulted in at least four deaths from measles amongst unimmunised children. The challenge for personal health care providers, the regional health authorities and the Public Health Commission is to improve immunisation coverage from the current levels.¹⁵

Epidemics of vaccine preventable disease in a country where the vaccine is freely available, at no direct financial cost to the consumer, indicate a failure at some level. At one level of analysis, the focus would be on the failure of individuals, either at the provider level or by the individual responsible for accessing the service, which in the case of childhood immunisation is the parent or guardian.¹⁶ Another level of analysis, however, would examine the structures put in place to deliver childhood immunisation. This section will discuss epidemics and their impact on the debate about childhood immunisation in the early 1990s. Factors contributing to this situation will be discussed further in the section on immunisation coverage.

Epidemics of measles and whooping cough have tended to occur in New Zealand in approximately four-year cycles. This had always been of concern to members of the medical establishment involved in communicable disease prevention, but the measles epidemics of 1985 and 1991 and the whooping cough epidemics of 1986 and 1991 had a wider audience. The medical establishment worked successfully with the media to alert the attention of others interested in child

¹⁵ David Skegg, 'Foreword', in *Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy*, compiled by the Public Health Commission (Wellington: Public Health Commission, 1993).

¹⁶ Various documents refer to parents, guardians and/or caregivers as the person responsible for accessing childhood immunisation services. This thesis will use the term parent to include all these groups.

health, initiating a debate on childhood immunisation in which the medical establishment, parents and the wider community participated.¹⁷

This debate coincided with widespread public concern about changes in the state funded health sector and the philosophy guiding those changes. Childhood immunisation appealed to that public concern as yet another area in which the health sector was seen to be failing the people of New Zealand. Therefore, although it was the medical establishment that initially drove the debate, public concern about the impact of neo-liberal individualism on the country's health services carried the debate along, possibly much further than it would have travelled had New Zealanders been content with the direction of health policy and the organisation of the state funded health sector.¹⁸

Measles has traditionally been considered a relatively benign disease which was contracted almost as a matter of course during childhood. Children would be nursed at home and recover with a life long protection against the disease. Contrary to this belief, research suggests that 10 percent of those who contract measles will suffer complications at some level, including middle ear infections, pneumonia and encephalitis.¹⁹ While pneumonia can be serious in infants and young children, the most serious threat is from encephalitis, a side effect of measles in 1:1000 cases.²⁰

Statistics on the measles epidemic in the second half of 1991 vary between sources. Galloway and Stehr-Green's survey of notifications to AHBs states that 9,239 cases of the disease were reported in the 6 months July – December 1991.²¹ Other sources suggest that some 560 children were admitted to hospital, and four

¹⁷ The role of the media in the debate on childhood immunisation and epidemics will be discussed later in this chapter.

¹⁸ There is a full discussion of the health sector reforms in Chapter Three.

¹⁹ Paul Stehr-Green of the Communicable Disease Centre in Porirua, quoted in Nicola Legat, 'Measles on Elm Street', *Metro*, December 1991, 92-101 (p.96).

²⁰ A concise discussion of the side effects of measles is available in Ministry of Health, *Immunisation Handbook* (Wellington: Ministry of Health, 1996), p.90.

²¹ Y. Galloway and P. Stehr-Green, 'Surveillance for Measles – New Zealand, 1991', *Morbidity & Mortality Weekly Report. CDC Surveillance Summaries*, 41 (1992), 13-17.

un-immunised children died of measles during the epidemic.²² In a leading article in the *New Zealand Medical Journal* in 1997 Mansoor, Durham and Tobias of the Ministry of Health wrote that the 1991 measles epidemic had resulted in seven deaths and 629 hospitalisations.²³

Accepting the differences in these numbers, they still may not reflect the magnitude of the epidemic. First, measles was not a notifiable disease at the time, so even if a medical practitioner saw an individual with measles they were not obliged to report the case to health authorities.²⁴ In addition, many families would treat measles at home without ever consulting a health professional. It is therefore estimated that the number who had contracted measles was much higher. A school survey undertaken by Dr Lester Calder in Auckland indicated that actual numbers were likely to be 5-10 times greater than official notifications suggested.²⁵ Another source stated that the number of cases was approximately 15,000.²⁶

A number of specific service issues related to measles, and measles immunisation, were highlighted by the 1991 epidemic. In what was then the Wellington Area Health Board region, analysis of information collected during the epidemic revealed two major areas of failure with the immunisation programme. The first was within the Pacific Island community. While the Pacific Island population in the Wellington area was seven percent of the total, 36 percent of the children admitted to hospital with measles in the early stages of the epidemic were from that community. By developing links with local Pacific Island churches the Area Health Board was able to initiate a programme which successfully provided immunisation to Pacific Island children.²⁷

²² Ministry of Health, *Immunisation Handbook*, p.91.

²³ Osman Mansoor, Gillian Durham and Martin Tobias, 'Can New Zealand Eliminate Measles?' *NZMJ*, 110 (1997), 387-388 (p.387).

²⁴ Early in the epidemic the Wellington Area Health Board made measles a reportable disease. In 1996 measles was included on the schedule of notifiable diseases as is discussed in Chapter Six.

²⁵ Legat, 'Measles on Elm Street', p.93.

²⁶ Juliet Ashton, 'Measles: Fighting the Epidemic', *Health*, 40 (1991), 4-6 (p.4).

²⁷ 'Epidemic Unmasks at-risk Group', *Health*, 40 (1991), 7-8.

The second group over-represented among those contracting measles was older children and adolescents, some of whom had been immunised as infants. This indicated waning protection against measles in this age group, promoting consideration of the addition of a second dose of the measles vaccine to the immunisation schedule.²⁸

The measles epidemic also threatened to spread internationally when three New Zealand gymnasts competing in Indiana developed measles after contact with a case in New Zealand. United States public health officials reacted with a vaccination programme for those who may have come into contact with the infected New Zealanders.²⁹

In responding to issues emerging during the measles epidemic, both at the time and later, health service providers employed structural initiatives to improve immunisation coverage and protection against vaccine preventable disease. Although there was a significant appeal to individuals through the media and other disseminators of information, including the churches, there were also programme and organisational changes made, including taking immunisation to the children, instead of expecting families to seek out vaccinators, and changes to the immunisation schedule.

While the epidemic of measles provided an opportunity for the medical establishment to assess gaps in the immunisation programme, at a more general level it raised the public profile of vaccine preventable diseases and the process of immunisation. The topic was widely discussed in the print media, on television and on radio. Publicity was given to attempts to control the epidemic, but there was also discussion of why the epidemic had occurred in the first place and of the way in which the epidemic and problems with the vaccine had been handled. Nicola Legat, writing in *Metro*, noted:

Officials have certainly not earned parents' trust by their failure to date to discuss openly that they still have problems with measles, quite apart from the fact that so many children are still getting it.³⁰

²⁸ 'Epidemic Unmasks at-risk Group.'

²⁹ F. Johnson et al., 'Measles at an International Gymnastics Competition: Indiana, 1991', *Mortality and Morbidity Weekly Report*, 41 (1992), 109-111.

³⁰ Legat, 'Measles on Elm Street', p.100.

The other vaccine preventable disease to have occurred in epidemic proportions in New Zealand was whooping cough. Despite the availability of an effective vaccine, epidemics of this disease continue to occur at varying levels of severity.³¹ As was the case with measles the actual dimensions of the whooping cough epidemic of 1991 were unknown because the disease did not become notifiable until the schedule of notifiable diseases was amended in 1996. The best available information, extrapolated from hospital discharge information, suggested that 1 in 100 children under one year of age will have whooping cough during an epidemic, with 25–50 percent of those children admitted to hospital.³²

These epidemics, and the increased demands on health services which were their consequence, took place at a time when the health sector, embarking on a process of change, was very concerned with cost containment. The visit to a GP, or admission to hospital, of a child with a vaccine preventable disease could be viewed as avoidable, and therefore an unnecessary charge on the state funded health sector. In purely financial terms the cost-effective nature of childhood immunisation made it an attractive health strategy.

Not all those who were concerned about epidemics of vaccine preventable disease considered the matter in purely financial terms. Many expressed concerns about children's misery as a result of having measles or whooping cough, while others were concerned about the possible side effects of these diseases. However, the two perspectives are related. A child who suffers severe complications as a result of contracting a vaccine preventable disease, for example measles encephalitis, would be subject to pain and suffering. In addition the child and their family may, if they survived the initial episode, live with the long-term sequelae of the disease, including a lower than might have been expected quality of life, for the rest of the child's life. Their long-term care could involve intensive health care and special education services.

³¹ Diana Lennon et al., 'Control of Whooping Cough in New Zealand: Slow Progress', *NZMJ*, 108 (1995), 495-497 (p.495); Stewart Reid et al., 'Pertussis Control in New Zealand', *NZMJ*, 107 (1994), 460-466 (p.460).

³² Lennon et al., 'Control of Whooping Cough in New Zealand', p.495.

Epidemics of vaccine preventable diseases illustrate in a tangible way a failure to protect children against these diseases. The medical establishment and others involved in the provision of health services clearly used these epidemics to raise the profile of vaccine preventable disease and of immunisation, taking the debate into both the public and the political arena. However, epidemics were only one of a number of factors motivating the review of the way in which New Zealand provides childhood immunisation.

B: Low Childhood Immunisation Coverage

Epidemics of vaccine preventable disease are a symptom of problems in the immunisation service. Failure to achieve rates of immunisation coverage which will halt the spread of disease is a major contributor to this problem.³³ In May 1992 Communicable Disease New Zealand (CDNZ) released a special report, *Immunisation Coverage in New Zealand*,³⁴ revealing that less than 60 percent of all New Zealand children were fully immunised at the age of two years.³⁵

These findings of low national immunisation coverage are frequently quoted in discussion about childhood immunisation in New Zealand. This was particularly so in the documents generated by the review of childhood immunisation and the policy determination process.³⁶ While there have been other surveys of immunisation coverage undertaken, the 1992 CDNZ survey is considered the most accurate and provides information about the attitudes and expectations of caregivers toward immunisation.

³³ Galloway and Stehr-Green, 'Surveillance for Measles – New Zealand, 1991'.

³⁴ Communicable Disease New Zealand, *Immunisation Coverage in New Zealand*, Vol. 92: Suppl 2 (Porirua: New Zealand Communicable Disease Centre, 1992).

³⁵ CDNZ, *Immunisation Coverage in New Zealand*, p.7.

³⁶ The results of the 1992 survey are cited in speeches and documents including *Report of the Expert Working Group*, 1993, p.3; Public Health Commission, *Immunisation: The Public Health Commission's Advice to the Minister of Health* (Wellington: Public Health Commission, 1994), p.7; Jenny Shipley, 'Immunisation 2000: Address to the Royal New Zealand Plunket Society's Annual General Meeting', Christchurch Town Hall, 29 March 1995, p.2.

The CDNZ survey was undertaken through a single interview with the caregivers of a representative sample of 706 two and three year old children. The sample was divided into four, with equal numbers being selected from each of the then proposed RHA regions; North, Central-North, Central-South and South. Demographic patterns within the sample were consistent with those indicated by census data.³⁷ Data on immunisations were taken from the records in the Health and Development Record Book or, if this was not available, from General Practitioner's records. Parental recall of the immunisation event was not relied upon.

The survey studied the attitudes of caregivers to childhood immunisation. It revealed that between 88.8 percent and 97.6 percent of caregivers considered that immunisation was important, although this varied between regions and depending on which disease was in consideration. Only a very small number of caregivers had not had their children immunised because they opposed immunisation as a practice.³⁸ While individual commitment to childhood immunisation was high, final immunisation coverage statistics indicated that this commitment did not translate into full immunisation for a corresponding proportion of children.

The observation of a gap between parents' intentions and their actions indicates that a link was missing in the chain between decision making and action. Two thirds of caregivers wanted more information from immunisation providers and more than 87 percent of caregivers considered that a reminder of when vaccines were due would be helpful in ensuring that children received their vaccines on time.³⁹ This desire to be reminded of the forthcoming immunisation event indicated that parents would have welcomed, and were conscious that they needed, support in fulfilling their stated intentions in the area of childhood immunisation. This then is one explanation for the missing link referred to above.

Parents' wish for a reminder was a reality at odds with the individualist expectation that individuals are rational utility maximisers, who will pursue their

³⁷ CDNZ, *Immunisation Coverage in New Zealand*, p.4.

³⁸ CDNZ, *Immunisation Coverage in New Zealand*, p.9.

³⁹ CDNZ, *Immunisation Coverage in New Zealand*, p.6.

own interests independently. Even when an action is considered to be desirable for the individual involved, or to maximise their utility, those claiming to desire it still required a reminder. This need for support in the pursuit of individual interests had ramifications for the development of childhood immunisation policy and practice.

The CDNZ survey revealed declining levels in immunisation coverage as the child grew older. Ninety percent of children had received their first post-neonatal vaccines, those due at the age of six weeks, an event which coincides with the post-natal check-up for both mother and child. Eighty percent of children had received the other vaccinations due in the first year of life, but only 70 percent had received vaccines due in the second year of life.⁴⁰ This finding supports earlier discussion about parents' need for support in following through on their intention to have their child immunised. It suggests that health professional assistance played a role in ensuring children were immunised. Families were likely to have more contact with health professionals when an infant was very young, with less contact as the child grew older. As a consequence they were less likely to be reminded about forthcoming immunisation events as the child got older, explaining at least in part, the lower rates of immunisation in the second year of life. This supports the claim that reminders to parents that an immunisation event is due would assist in increasing immunisation coverage.

In addition, vaccines were less likely to be given on time in the second year of life than during the first year.⁴¹ The first post-neonatal vaccine event was given on time to around 80 percent of children, but only around 70 percent of children got other vaccines due before 12 months of age on time. In the second year of life only 50 percent of children were immunised on time. This finding also supports the comment in the previous paragraph about the role contact with health professionals had in reminding parents of immunisation events, suggesting that structural factors, as in the availability and accessibility of health professionals, have a significant impact on immunisation coverage.

⁴⁰ CDNZ, *Immunisation Coverage in New Zealand*, p.7.

⁴¹ CDNZ, *Immunisation Coverage in New Zealand*, p.7.

Over all, by the time parents were interviewed, when the children were an average age of three years, just over 60 percent of children had been fully immunised.⁴²

The most common reason given by caregivers for non-immunisation of a child was the presence of a medical contra-indication.⁴³ However, the CDNZ survey did not gather information on which the validity of reported contra-indications could be judged. The second most common reason for non-immunisation was that parents had “not got around to it”. That the caregiver held anti-vaccination sentiments was the third reason for non-immunisation, while the least common reason was financial concerns.⁴⁴

The explanation of reasons for non-immunisation link back to the earlier discussion about parents’ wish to have more information about immunisation and reminders as to when immunisation events are due. It is possible that more information about immunisation could include information about when a child could or could not be immunised. This may lead to a decline in the number of children whose immunisations are delayed by inappropriate medical contra-indications.

This, however, assumes that only a lack of accurate information is preventing parents having a child immunised when they are unwell. It may be that even knowing that a child can be safely immunised when unwell, a parent would not want to do so. It is not possible to know from the survey information available what parents actually meant when the survey recorded medical contra-indication as a reason for not immunising. Even with more information some parents are still going to disagree with medical advice, and thus may refrain from immunising a child when they have a condition which medical science would not consider a contra-indication to immunisation. A full exploration of the variance between medical advice and parental decisions is beyond the scope of this thesis, but there

⁴² CDNZ, *Immunisation Coverage in New Zealand*, p.7.

⁴³ CDNZ, *Immunisation Coverage in New Zealand*, p.6. Medical contraindications are where a child is considered to be in poor health and thus unfit for vaccination. However, this is used as justification in many cases where the child could safely have the vaccination. This is discussed briefly in Chapter Six in the section on vaccine adverse events.

⁴⁴ CDNZ, *Immunisation Coverage in New Zealand*, p.9.

are a variety of perspectives from which this matter can be viewed. This relates back to the discussion of perceptions of risk and decision making in Chapter Four.

On the matter of parents having not got around to immunising their child then it would appear that the earlier stated need for reminders could be useful in avoiding this reason for non-immunisation.

The CDNZ survey also revealed a number of risk factors for low uptake of immunisation, although not all of these were common to all regions, or considered statistically significant in the context of this survey. These factors included children living in households where the main source of income was from benefits, children whose caregiver identified themselves as Maori or part-Maori, children whose families had moved frequently, and children whose caregiver had not attained School Certificate.⁴⁵ This is in line with later and international research on the factors which make children 'hard to reach' for immunisation.⁴⁶

Those families in which a risk factor for low immunisation uptake was present were a group similar to those identified as having been disadvantaged by the neo-liberal policies of governments since 1984. Chapters One and Four discuss the impact neo-liberal policies had on increasing the numbers of New Zealanders living in poverty and the disproportionate representation of Maori in this group. They also discuss issues related to educational attainment and benefit dependence. The social and economic policies of neo-liberalism, again discussed in Chapter One, increased the circumstances considered to contribute to low rates of childhood immunisation coverage. This suggests that New Zealand's poor immunisation coverage may be related to changes in the political economy. However, because New Zealand's immunisation coverage data is very poor, it is not possible to trace links between the pattern of immunisation coverage and the emergence of the neo-liberal economic and social policies. This will be discussed further in Chapter Nine.

⁴⁵ CDNZ, *Immunisation Coverage in New Zealand*, pp.9-10.

⁴⁶ National Health Committee, *Review of Wisdom and Fairness of the Health Funding Authority Strategy for Immunisation of 'Hard to Reach' Children* (Wellington: National Health Committee, 1999), p.6.

Given that the individualist model considers that individuals' own actions are responsible for their circumstances, and thus the solutions,⁴⁷ it might have been expected that under a purely individualist approach to childhood immunisation policy, these factors would not receive attention. This is discussed further in Chapter Eight.

The CDNZ results contrast with those produced by a survey of immunisation coverage undertaken by the Royal New Zealand Plunket Society as a part of its wider study of child health indicators: the Plunket National Child Health Study.⁴⁸ The Plunket survey concluded that 92.5 percent of children were fully immunised at age one year and 83.3 percent fully immunised at age two years.⁴⁹

The Plunket National Child Health Study was a longitudinal study of 4286 randomly chosen New Zealand babies born between 2 July 1990 and 30 June 1991.⁵⁰ The demographic characteristics of this group closely match those indicated by the census. These children were followed over four years, tracking data on a number of different topics, including immunisation.

Data was collected by the child health nurse, usually the Plunket Nurse, at set regular intervals. Immunisation information was collected from the Nurse's records, the Health and Development Record Book and parental interviews at age six weeks, three months, six months, nine months, 12 months, 18 months and two years of age.⁵¹

Reasons for non-completion of the immunisation schedule were similar to those found by the CDNZ survey. Only 1.4 percent of the children had had no immunisations at all at age two years, with the parents of 1.1 percent of the total sample not wanting their children to have any immunisations at all.⁵² This survey

⁴⁷ Christine Cheyne, Mike O'Brien, and Michael Belgrave, *Social Policy in Aotearoa New Zealand: A Critical Introduction* (Auckland: Oxford University Press, 1997), p.176.

⁴⁸ Charles Essex, Paul Smale and David Geddes, 'Immunisation Status and Demographic Characteristics of New Zealand Infants at 1 Year and 2 Years of Age', *NZMJ*, 108 (1995), 244-246.

⁴⁹ Essex et al., 'Immunisation Status and Demographic Characteristics ...', p.246.

⁵⁰ Essex et al., 'Immunisation Status and Demographic Characteristics ...', p.244.

⁵¹ Essex et al., 'Immunisation Status and Demographic Characteristics ...', p.244.

⁵² Essex et al., 'Immunisation Status and Demographic Characteristics ...', p.245.

also found that incomplete immunisation increased with the child's position in the family.⁵³

In common with the CDNZ study the Plunket study indicated that the most common reason for a child to have had their immunisations delayed was because of the child's ill health. As with the CDNZ survey this study did not have the information to judge the nature of those health events or their validity in delaying the immunisation event. However, a previous study had revealed that between 69 percent and 79 percent of health events considered to contra-indicate childhood immunisation need not have done so.⁵⁴ This conclusion assumes, as has been discussed above, that the reason children are not immunised is because parents do not have enough information on which to judge when a child who is unwell could be safely immunised.

Although the Plunket survey revealed much higher immunisation coverage rates than did the CDNZ study, the validity of the findings have been disputed, given the numbers of children lost to follow-up. Although the survey results did acknowledge this situation, the assumption was made that children no longer under child health nurse supervision were as likely to maintain the immunisation schedule as were children who remained under supervision. However, child health nurse supervision was considered a significant factor in children receiving immunisation according to the recommended schedule,⁵⁵ which puts this study's conclusions in doubt. If the children who dropped out of the survey were assumed to have had no further immunisation then, according to one commentator, the immunisation rate dropped to 78 percent at one year of age and 55 percent at two years of age.⁵⁶ It is likely, however, that the true situation falls somewhere between the claimed level and that which could be assumed if the lost participants were included in the final data.⁵⁷

⁵³ Essex et al., 'Immunisation Status and Demographic Characteristics ...', p.245.

⁵⁴ Essex et al., 'Immunisation Status and Demographic Characteristics ...', p.245.

⁵⁵ Ben Grey, 'Immunisation Rates of Infants [letter]', *NZMJ*, 108 (1995), p.369.

⁵⁶ Grey, 'Immunisation Rates of Infants [letter]', p.369.

⁵⁷ Grey, 'Immunisation Rates of Infants [letter]', p.369.

A number of other documented studies suggest that immunisation coverage was much higher than these two national surveys suggested, including surveys which used methodology similar to the CDNZ study.⁵⁸ However, these were geographically limited. Other studies did not use a statistically representative child population, often drawing the sample from all or part of a General Practice patient list. It is acknowledged that there is a group of children who do not have any contact with a General Practice or other primary health care provider except in an emergency situation, making such surveys open to the criticism that they are not an accurate reflection of the total population.⁵⁹

The results of these surveys, particularly the CDNZ survey, attracted a great deal of attention and caused concern within the community. While clearly this concern was not entirely misplaced, the immunisation coverage statistics have been used to their maximum effect. Politicians, public health officials and health professionals repeatedly made the point that only about 60 percent of children were fully immunised, to reinforce the existence of a problem. While true, this is also misleading in that a much higher number of children have all immunisations recommended in the first year of life. It is the later immunisation events which lead to the lower statistics. Therefore the problem may not be as large as the attention to immunisation coverage statistics would suggest. Many children could have their immunisations brought up to date with just one visit to the vaccinator.

In addition to alerting attention to purely numerical considerations, these immunisation coverage surveys focused attention on factors which were contributing to low immunisation coverage. For example, the impression common among both parents and professionals was that children had to be in perfect health to be vaccinated. Knowledge of this situation allowed remedial action to be directed at the factors which contributed to low immunisation coverage. However, as is discussed above, that particular issue is wider than just a matter of poor information.

⁵⁸ Included in this group; Paul Stehr-Green et al., 'How Well are We Protecting Our Children? An Immunisation Coverage Survey in Hawkes Bay', *NZMJ*, 105 (1992), 277-279.

⁵⁹ This group includes; Dharmalingam Ramadas, Christopher Moyes and Gnani Ramadas, 'Immunisation Status of Children in the Eastern Bay of Plenty', *NZMJ*, 105 (1992), 378-379.

The studies discussed, and other studies undertaken within more limited populations, indicated variation in childhood immunisation coverage in New Zealand. However, taking into account the limitations of studies which indicated higher levels of coverage, New Zealand's immunisation coverage rates were inadequate. They did not meet World Health Organization (WHO) targets, as outlined in Chapter Six, or the levels required to halt the transmission of the target vaccine preventable diseases. As such, low rates of immunisation coverage were a significant factor in prompting attention to the way in which New Zealand's childhood immunisation programme was managed.

Epidemics of vaccine preventable diseases and the identification of low immunisation coverage rates, which contributed to their occurrence, served as a powerful tool in the medical establishment's drive to raise the issue of childhood immunisation in New Zealand. However, this debate took place at a time when the infrastructure supporting the delivery of health services, including childhood immunisation, was undergoing major change. Therefore other factors, outside the interests of the scientific medical community, could also be seen to be instrumental in putting childhood immunisation on the agenda in the early 1990s.

IV: Structural and Organisational Change

Change in the organisation and management of New Zealand's health sector had been ongoing, particularly during the late 1980s. But, as is discussed in Chapter Three, health sector reform, in line with the neo-liberal programme of structural adjustment in other sectors of the New Zealand economy, was introduced in 1991. Emerging changes in the structure and organisation of the health sector were significant in the review of childhood immunisation.

A: The Public Health Commission

The Public Health Commission (PHC), the establishment, operation and disbanding of which is discussed in Chapter Three, had a central role in the review of childhood immunisation policy and practice. This role can be viewed in two ways. First, the establishment of the PHC both symbolised and created an environment which was supportive of initiatives in the area of public health. Second, the PHC created the infrastructure within which public health issues could be examined.

The establishment of the PHC indicated a commitment by the National government to public health issues. That commitment was, however, consistent with, and an expression of, the neo-liberal political economic philosophy prevailing at the time. The Green and White Paper was explicit about this interest. “The Government, as principal funder of health services, has an interest in effective public health activities because they reduce publicly-funded treatment costs.”⁶⁰ In a speech to the Health Promotion Forum in 1991 Upton reiterated that this drive for cost containment was part of the attraction of attention to public health. “[P]ublic health services, if they are successful, will reduce the use of personal health services”.⁶¹ Childhood immunisation fitted within the Minister’s intentions for the PHC. It was a public health issue which, although subject to problems, had the potential to reduce the cost of personal health services in the state funded health sector.

The PHC’s six pilot health goals, announced by the Minister in November 1992, included “to protect children from preventable infectious diseases by improving immunisation.”⁶² These goals were established at a time when the failures of New Zealand’s childhood immunisation programme were fresh in the minds of the medical establishment, the public and politicians. The evidence of those failures,

⁶⁰ Simon Upton, *Your Health and the Public Health: A Statement of Government Health Policy*, (Wellington, Minister of Health, 1991), p.107.

⁶¹ Simon Upton, ‘Address to the Health Promotion Forum’, Auckland, 24 October 1991, cited in Mary Finlayson, ‘An Analysis of the Implementation of Health Policy in New Zealand, 1991-1996’ (unpublished doctoral thesis, University of Waikato, 1996)

⁶² Minister of Health, ‘Press Release: Policy Guidelines to the Public Health Commission’, 25 November 1992.

epidemics of vaccine preventable disease and low immunisation coverage rates, are discussed in the previous section.

In the late 1980s and the early 1990s the issues discussed in Sections II and III of this chapter raised the profile of childhood immunisation as a health strategy, putting it on the political agenda. The epidemic of meningococcal disease in Auckland and the immunisation campaign organised in response attracted both support and opposition for immunisation. The work being done on Hepatitis B and the introduction of Hepatitis B vaccine to the national immunisation schedule attracted a high level of attention both within the medical and lay communities. The Māori Women's Welfare League and the Hepatitis B Foundation, both lobbied effectively in political circles. Professional organisations were also talking to the health policy-makers about improving the delivery of childhood immunisation.⁶³ These issues and others, including concern about low immunisation coverage and vaccine safety, promoted public debate about, and political attention to childhood immunisation in the late 1980s.⁶⁴ In the early 1990s epidemics of vaccine preventable diseases and low immunisation coverage statistics cemented the issue as ripe for the attention of the PHC in its infancy.

The establishment of the PHC provided an infrastructure within which work could be done on improving public health services for New Zealanders. Having been given a place on the PHC's agenda, the issue of childhood immunisation was then addressed within the emerging processes of the Commission. This is discussed in detail in Chapter Eight.

There is some doubt that the PHC was important in the attention given to childhood immunisation at this time. Dell Hood was convinced that had the PHC not been established, some other part of the health policy establishment would

⁶³ In August 1988 the Paediatric Society was talking to the government about improving immunisation in New Zealand.

⁶⁴ Nemu Lallu, then a Senior Advisor in the Aids and Communicable Disease Unit of the Ministry of Health recalls that a range of interests were raising the profile of childhood immunisation in the late 1980s. Lallu, who has been with the Ministry of Health for 13 years has institutional memory which is rare in the reformed health sector.

have addressed the problems of childhood immunisation at this time.⁶⁵ Stewart Reid expressed a similar view at interview, indicating that some individuals had been working on this issue for many years.⁶⁶ However, in 1994 Reid and Diana Lennon stated that “the restructured New Zealand health system with the creation of the Public Health Commission is well placed to take full advantage of the impact of childhood immunisation.”⁶⁷

It may well be that, even without the establishment of the PHC, the work required to develop a national strategy for childhood immunisation would have been undertaken. However, it is impossible to avoid the parallels between the intentions of the government in establishing the PHC and the unfulfilled potential of childhood immunisation. This was undoubtedly an attractive issue considering the government’s neo-liberal individualist intentions for the health sector; primarily increased personal responsibility and cost containment. Those motivations worked in combination with other factors, including the events which brought the issue of childhood immunisation into the public and political consciousness at that particular time.

B: The Reform of Health Sector Funding and Service Provision

The health sector reforms, announced in the 1991 Green and White Paper, *Your Health and the Public Health*,⁶⁸ allocated various responsibilities within the health sector in a way consistent with new public management systems. As discussed in Chapter Three, this required separation of policy advice, purchasing of services and the provision of services. The government as funder provided instructions to the purchasers, for example in the *Policy Guidelines for Regional Health Authorities*.⁶⁹ Purchasers were then responsible for exploring the health service

⁶⁵ Dr Dell Hood, Interview with the author, Hamilton, 9 April 1996. Hood was the Medical Officer of Health for Hamilton. She was not a member of the PHC’s Expert Working Group on childhood immunisation.

⁶⁶ Dr Stewart Reid, Interview with the author, Lower Hutt, 5 March 1997. Reid, a GP and Chair of CDCAC, had a long involvement with matters relating to childhood immunisation.

⁶⁷ Diana Lennon and Stewart Reid, ‘Childhood Immunisation in New Zealand’, *NZMJ*, 107 (1994), 171-172 (p.172).

⁶⁸ Upton, *Your Health and the Public Health*.

⁶⁹ Ministry of Health, *Policy Guidelines for Regional Health Authorities* (Wellington: Ministry of Health, 1994/95, 1996/97).

needs of the community they served and then contracting with providers to deliver health services at an appropriate level.

Childhood immunisation, an aspect of health care which crossed the boundaries between public health and personal health, involved both areas in the funding and purchasing of childhood immunisation services. The provision of childhood immunisation also involved a number of different agencies in the health sector. Having the policy clarified, with expectations and responsibilities clearly delineated, was both consistent with updates of documentation taking place throughout the health sector at that time and essential to facilitate a co-ordinated team approach to childhood immunisation.

The funder/purchaser/provider split, and the separation between public health and personal health services, changed the established relationships between agencies, wiping out an element of flexibility which had been present prior to the health sector reforms. Where once the staff of two agencies may have worked together or shared information on an informal basis, for the benefit of an individual client, this was no longer to be promoted. The market model, under which the health sector was expected to operate, encouraged competition between agencies in place of the earlier spirit of co-operation. Furthermore, once a strategy was put in place, under contract to the funding organisation, the course of action was set. If the strategy was achieving its objectives all was well, but if not there was little room for reworking, or correcting the problem. Health service providers could do only what they were contracted to do, thus it was important to set out the various responsibilities ahead of time.

The introduction of the competitive market model, separation of roles and service contracts to the health sector was consistent with the neo-liberal individualism prevailing in New Zealand's wider economy. At this level the drive for attention to childhood immunisation came from the health sector bureaucracy, motivated by the need to put in place parameters for the provision of childhood immunisation under the reformed health sector. It is likely, however, that had other interests, particularly those of the medical establishment, not pushed for change in childhood immunisation policy and practice at this time then the documentation

required to facilitate the contracting process would have been undertaken during the transition stage of the health sector reform process.

V: Political Issues

The issue of childhood immunisation did not inspire political conflict. There was a level of inter-party agreement on the desirability and acceptability of childhood immunisation as a health strategy. The issue was, however, politicised to some extent as the National government used the issue, first, to demonstrate that it was taking action on an issue of child health at a time when the electorate was concerned about health service cuts. Second, it was an issue that lent itself to promoting personal responsibility, as is discussed further below.

A: The Health Policy Environment

The review and reorganisation of childhood immunisation policy came at a time when a process of reform in the health sector was underway, having been signalled in the Green and White Paper.⁷⁰ Attention to childhood immunisation was consistent with both the health policy directions indicated in that document and the philosophy guiding public policy in general during the late 1980s and early 1990s. Childhood immunisation was not, however, an area of health policy attracting any significant political debate, receiving bi-partisan support in what was, in the early 1990s, basically a two party political system.

Upon its election in 1990 the incoming National government received two briefing documents particularly significant for health policy. Treasury's *Briefing to the Incoming Government 1990*⁷¹ discussed the need for fiscal restraint in order to maintain the economic recovery which had begun slowly.⁷² It included recommendations for radical change in the health sector. As a means of controlling spending on health Treasury indicated support for disease prevention and health promotion policies which had proven to be effective.⁷³ Although the document did not indicate particular examples, immunisation was considered both

⁷⁰ Upton, *Your Health and the Public Health*.

⁷¹ Treasury, *Briefing to the Incoming Government 1990* (Wellington: Treasury, 1990).

⁷² Treasury, *Briefing to the Incoming Government 1990*, p.2.

⁷³ Treasury, *Briefing to the Incoming Government 1990*, pp.118-119.

cost effective and to have made a significant contribution to the improvement of health. The emphasis of this document appeared, however, to be on changes that individuals could make in their lifestyles which would, in turn, reduce the cost of health care. The document was consistent with the prevailing Treasury ethos which had guided the changes, discussed in Chapter One, that took place initially in the financial and business sectors and later in the public sector, during the two terms of the Fourth Labour Government.

The second briefing document was *Health in the 1990s: Issues, Options and Opportunities* from the Department of Health.⁷⁴ This document defined health very broadly and, in contrast to the Treasury document, focused on the determinants of health strongly influenced by government policies in areas including housing and employment.⁷⁵ This paper proposed improvements to existing arrangements in the health sector rather than radical change.⁷⁶

The two papers shared a number of overlapping themes. However, the general tone of the Treasury document emphasised health care policy and radical change, while the Department of Health document had a broader focus on health policy and recommended the avoidance of radical change.⁷⁷ The incoming Minister of Health, Simon Upton, informed the Director-General of Health, George Salmond, that the departmental briefing paper did not reflect the intentions of the government.⁷⁸ This was a critical turning point in the direction of health policy making in New Zealand as the balance of influence shifted away from those within the health sector and toward Treasury and other proponents of a neo-liberal perspective on public policy.

Within a year of its election the National Government embarked upon the health sector reforms set out in the Green and White Paper, discussed in Chapter Three.

⁷⁴ Department of Health, *Health in the 1990s: Issues, Options and Opportunities* (Wellington: Department of Health, 1990).

⁷⁵ Department of Health, *Health in the 1990s*, p.3.

⁷⁶ Department of Health, *Health in the 1990s*, p.1.

⁷⁷ The difference between health policy and health care policy is discussed in Chapter Three.

⁷⁸ George Salmond, then Director of the Health Services Research Centre, but previously Director General of Health, made this point in a presentation 'The Role of Health Outcomes in Health Sector Reforms', to the Health Development and Policy Programme Conversation/Seminar Series, University of Waikato, 28 September 1995.

The paper indicated that there was to be a focus on public health in the new structure with the establishment of the PHC. Immunisation was repeatedly cited, including as an example of the Commission's role in liaising with purchasers and providers of personal health services.⁷⁹ This focus on immunisation was carried through to the inclusion of childhood immunisation as one of the PHC's pilot goals.

The technical work that would improve childhood immunisation was already being done within the ongoing, official processes of the health sector, but in the early 1990s childhood immunisation was frequently raised in official policy-related documents. Political attention to childhood immunisation was expedient on a number of fronts. First, the recent epidemics of vaccine preventable diseases and low rates of immunisation coverage had attracted negative public attention. Directing resources toward the improvement of childhood immunisation was a positive move at a time when public attention was focused on the government's perceived reduction of health services for all New Zealanders. Improvements in childhood immunisation would have been simple to prove and quantify. Such improvements could have been used, as they have been in other countries, to show the performance of the health system in a good light. Childhood immunisation coverage has been used as an indicator of success in Britain's National Health Service.⁸⁰

Second, childhood immunisation fitted within the underlying philosophy guiding public policy in the early 1990s, as is discussed in Chapter One. A successful childhood immunisation strategy would have reduced admissions to hospital and financial expenditure on caring for children with vaccine preventable diseases. In addition childhood immunisation was a health strategy which, while it enjoyed a high level of public support, allowed parents a choice. Related to this, however, was a significant degree of personal responsibility delegated to parent's in respect of childhood immunisation.

⁷⁹ Upton, *Your Health and the Public Health*, pp.105-115.

⁸⁰ Radical Statistics Group, 'NHS "Indicators of Success": What Do They Tell Us?' *BMJ*, 310 (1995), 1045-1050.

International influences were a third factor in making attention to childhood immunisation policy expedient. Other developed countries had also found it necessary to review policy in light of declining childhood immunisation coverage rates. Examples from both the United Kingdom and Australia's were used in New Zealand's review process, as each country had undertaken reorganisation of their childhood immunisation services shortly ahead of New Zealand.

Meanwhile, as is discussed in Chapter Six, in developing states the WHO and a number of non-governmental aid organisations had been working to improve immunisation, and raising the possibility that developed nations would fall behind their less affluent neighbours in this indicator of child health. The early progress of developed nations in the area of immunisation had motivated a degree of complacency among health policy makers, no-longer warranted, motivating remedial action.

B: Media Attention

In the matter of childhood immunisation as in all matters of public interest the media has a role in both informing and influencing public opinion. During the late 1980s and early 1990s television, radio, newspapers, popular magazines and professional periodicals all devoted attention to issues relating to childhood immunisation. The issue continues to be regularly attended to both in news coverage and in commentary.

In the period under study childhood immunisation received television air time both as a news item and in documentary. Radio covered material which both supported childhood immunisation and challenged its value as a health strategy. Newspapers addressed the issue both in news reports and in editorial. Magazines were able to devote more space to examinations of the issues involved.

Kevin Dew, a sociologist then at Victoria University of Wellington, examined the media response during the measles epidemics of 1985 and 1991, noting that there

was a much higher media concern with measles in the 1991 epidemic than there had been during the 1985 epidemic.⁸¹

Dew concludes that the focus of media coverage was on reporting the number of cases of measles and on emphasising the desirability of vaccination and the contribution the un-vaccinated were making to the growth of the epidemic. He also comments on the discussion of and support for the concept of mandatory choice.⁸² It was not until later in the course of the epidemic that he identified a retreat from the support for the medical establishment's position, when the media drew attention to the failure to confer immunity resulting from the use of vaccines which had not been stored at the correct temperature.

It is Dew's contention that the media were in alliance with the medical establishment in raising issues indicated by them rather than highlighting new concerns or those of other sectors of the community. In as much as media attention raised the public profile of an issue, Dew argues that it did so in line with the medical establishment's position on the issue. "By the very nature of its operation the media is much more likely to reinforce existing attitudes than to change them....the *Evening Post* on only two occasions reported alternative views."⁸³

Newspapers, in editorials, articles and letters to the editor, sometimes published strident attacks on parents who did not immunise their children. On one occasion the *Sunday Star-Times* published a story about the experiences of a family whose child had reacted badly to an immunisation event.⁸⁴ It later published a letter from a paediatrician and childhood immunisation researcher rebuking them for attracting attention to issues which may discourage parents immunising their children.⁸⁵ It is not uncommon for those who support the value of immunisation

⁸¹ Kevin Dew, *The Measles Vaccination Campaigns in New Zealand, 1985 and 1991: The Issues Behind the Panic*, Victoria University of Wellington, Dept. of Sociology and Social Work Working Papers, No.10 (Wellington: Victoria University of Wellington, 1995), p.20.

⁸² Mandatory choice is the term used to describe a situation whereby parents, while not compelled to immunise their children, must make a conscious choice one way or the other.

⁸³ Dew, *The Measles Vaccination Campaigns in New Zealand, 1985 and 1991*, p.21.

⁸⁴ Donna Chisholm, 'Vaccine Boy's Mum Angry at Ban', *Sunday Star-Times*, Sunday 2 April 1995, A2.

⁸⁵ Ed. Mitchell, 'Letter to the Editor', *Sunday Star-Times or New Zealand Herald* (1995).

to attempt to suppress or censor any debate which acknowledges other than the positivist line on immunisation. Such a position should be regarded with concern in a democratic society where all aspects of this issue should be debated openly.⁸⁶

If newspapers tended to support the medical establishment's perspective on childhood immunisation, articles in popular New Zealand magazines gave a more balanced discussion of the issues concerning childhood immunisation. This included discussion of problems with the strategy, including storage problems and difficulties communicating to parents the risks and benefits of childhood immunisation. In December 1991 *Metro* published an eight page examination of childhood immunisation in New Zealand, prompted by the measles epidemic. This article gave more attention to the variety of views on the issue. Other popular magazines also contributed to the discussion, often providing both professional and lay views on childhood immunisation, including parent's experiences and opinions.⁸⁷

Radio New Zealand was also giving a range of perspectives on immunisation related issues. Investigation of the Sound Archives' holdings reveal attention to both events in the childhood immunisation programme, and to controversies surrounding immunisation. For example: the controversy surrounding meningitis vaccination during the 1987 epidemic in Auckland; the launch of the Hepatitis B immunisation programme and related concerns; concerns about the effectiveness of New Zealand's approach to childhood immunisation; the introduction of MMR in 1990.⁸⁸ The format varied from short news items through to longer interviews, ranging in length from one minute, seventeen seconds through to eight minutes, forty-six seconds. Most items were between two and four minutes long. Interviews were frequently with senior medical personal with an interest in

⁸⁶ Stephanie Short, 'On the Tension Between Individual Health Rights and Public Health Responsibilities', *Australian and New Zealand Journal of Public Health*, 21 (1997), pp.245-246.

⁸⁷ Judy Gilbert, 'Vaccination: Professional Issue, Personal Dilemma', *Health and Living*, February/March 1991, 30-33; Pam Neville, 'Measles Shock', *New Zealand Woman's Weekly*, 2 September 1991, 39; Annette Taylor, 'A Shot in the Dark?', *Next*, February 1992, 102-107.

⁸⁸ The Sound Archives do not collect all material played on Radio New Zealand Stations, but a search using the keyword immunisation identified 25 items with specific attention to childhood immunisation. The abstracts indicated that between 1987 and 1994 a range of childhood immunisation related topics were addressed on public radio in New Zealand.

childhood immunisation, senior policy staff in the Ministry of Health or with the Minister of Health.

Media attention to issues of immunisation, vaccination and vaccine preventable diseases may have increased over this time period, but this reflects increased attention to the topics within New Zealand's medical establishment. Review of fifteen years of the *New Zealand Medical Journal* indicates an increasing level of attention to immunisation, especially childhood immunisation, in the years between 1984 and 1999. The number of articles or letters on childhood immunisation per year peaked in 1989, but has levelled out over subsequent years.⁸⁹

The media had an important role in informing New Zealanders about childhood immunisation issues. Media coverage reflected the range of opinions on childhood immunisation, although as Dew points out, there were times when they appeared to be the mouthpiece for public health strategies to increase immunisation coverage.

Regardless of bias, media attention to childhood immunisation was a vital ingredient in promoting public debate about the desirability of childhood immunisation.

VI: Conclusion

The thesis of this study is that individualism has had a significant role in shaping childhood immunisation policy in New Zealand. In examining the factors that put childhood immunisation on the agenda for the attention of the policy community, there are findings which both support and refute this thesis.

⁸⁹Using Medline and Endnote four searches were made of entries for the NZMJ in the years 1985-1999 using the keyword combinations child and vaccine, child and immunization, infant and vaccine, infant and immunization. Duplications were discarded. The number of articles or letters fitting this profile varied between zero and fifteen over the period. There were zero in 1985 and 1986 before rising sharply to peak at fifteen in 1989. They fell away to four in 1990, but then rose again to sit between seven and twelve from 1992 until 1999. The results of this exercise are tabled and graphed in Appendix Two.

It is clear that the primary driver in getting childhood immunisation on the policy agenda was the medical establishment. It was both motivated by, and used, epidemics of vaccine preventable disease and the CDNZ 1992 survey's demonstration of low immunisation coverage to draw attention to the need for change in the provision of childhood immunisation. Despite the involvement of individuals and groups from outside the medical establishment, it was predominantly those from within who attracted attention to the issues through their use of the media.

The medical establishment has traditionally been guided by the medical model, which is considered individualist. However, public health practitioners, very involved in this issue, have a wider, community based perspective on health and health policy. In addition there is recognition of the population or community factors significant in the spread of infectious disease, forestalling a purely individualist approach to their prevention and treatment. So while there was concern about individuals and their suffering as a result of contracting vaccine preventable disease, there was also concern about the level of population health and transmission of vaccine preventable disease in the community.

The role of the medical establishment in promoting childhood immunisation for consideration by the public policy community cannot therefore be seen as individualist in that individualism was not a motivating factor for this group. That the issue got onto the agenda at the time it did and was addressed in the manner it was, however, suggests that other factors were also important. Had it been only a case of addressing the concerns of the medical establishment, there were already mechanisms in place to do so. The nature of the attention to childhood immunisation policy was significantly influenced by the individualist motivations of the government and its wider policy agenda.

The changing structure of the health sector and the reorganisation of procedural and funding matters were also material in bringing childhood immunisation up for review. Because of the underlying philosophy of neo-liberal individualism which supported the health sector reforms, it is possible to identify the significant

influence of individualism, but the changes required could have been handled within the normal processes of the health bureaucracy.

So while it can be argued that individualism was significant in relation to structural and organisational change, the dominant role of individualism in this matter was in the way in which childhood immunisation fitted within the government's wider philosophical agenda. Childhood immunisation lent itself to the promotion of two important facets of the government's philosophy; individual choice and personal responsibility. Combined with the cost containing potential of a successful childhood immunisation policy, these two ideas meant that the government could implement neo-liberal ideas in respect of individualism and sell it to the electorate using the increasingly familiar rhetoric of neo-liberal social policy.

The attraction of promoting childhood immunisation as part of the government's individualist health policy required that changes in the policy be confined within fairly narrow parameters. It was necessary to ignore the contribution wider government policy was making to increasing problems for a section of the population in areas that had been identified as determinants of health and which were furthermore risk factors for incomplete immunisation; poverty, housing, education and employment. Other policy options not available to the framers of the childhood immunisation policy included financial incentives. These limitations were naturally not made explicit.

Therefore this thesis argues that individualism was significant in putting childhood immunisation on the public policy agenda in the early 1990s. Although there were other, non-individualist influences involved, in poor service outcomes and the medical establishment's interest in those, it was the combination of those matters with structural changes and the government's political economic philosophy that ensured the issue of childhood immunisation received the attention that it did at the time that it did.

Chapter Eight

DEVELOPING THE NATIONAL IMMUNISATION STRATEGY

I: Introduction

Being required by one of its pilot goals to improve childhood immunisation, in 1993 the Public Health Commission (PHC) undertook a review of policy and practice options in this area of child and public health. The review, built on existing initiatives to improve childhood immunisation practice in New Zealand, was part of the early work of the PHC, the establishment of which is discussed in both Chapter Three and Chapter Seven. This review was effectively the beginning point for the policy-making process in respect of childhood immunisation.

The immunisation objectives were:

*To increase to 80% by the year 1995, and to 90% by the year 2000, the proportion of New Zealand children with completed early childhood immunisation by the time they are two years old.*¹

In making recommendations for the development of a National Immunisation Strategy the PHC, and the Expert Working Group which it convened to assist in the process, addressed a wider range of issues as is discussed in the next section. Using the *Report of the Expert Working Group* and public submissions on that report the PHC made its recommendations on immunisation to the Minister of Health in 1994.

In 1996 the Minister of Health announced the National Immunisation Strategy with significant fanfare. The strategy followed some, but not all of the Expert Working Group and PHC's advice, in establishing what is effectively New Zealand's policy on childhood immunisation. The strategy did not, however, mark a significant departure from existing policy, representing instead an incremental approach to change in childhood immunisation practice.

¹ Public Health Commission and the Expert Working Group, *Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy* (Wellington: Public Health Commission, 1993), p.3. [italics in original]

This chapter examines the influences which ensured that the changes were limited, basically incremental, and fitted within a narrow band of options acceptable in the prevailing political economic climate. It will examine, in turn, the Expert Working Group's resources, process and recommendations, public submissions on those recommendations, the PHC's role in shaping the review process and its advice to the Minister of Health, and the National Immunisation Strategy announced in 1996.

II: The Expert Working Group

The background section of the *Report of the Expert Working Group* stated:

As well as the need to improve the coverage, other issues that need to be addressed include information systems, changes to the immunisation schedule, notification of vaccine preventable diseases and vaccine adverse events, and the management of the cold chain Therefore the Public Health Commission convened an expert working group to assist in the development of a national immunisation strategy. The members of the expert working group, [were] chosen for their wide range of expertise and experience²

The Expert Working Group convened for a two-day workshop in February 1993. The group was supplied with a range of information and opinion on childhood immunisation gathered by the PHC, and worked with PHC staff and Dr Norman Begg, a British consultant with expertise in raising childhood immunisation coverage. The Expert Working Group made recommendations which the PHC used, in conjunction with public submissions on those recommendations, in formulating its advice to the Minister of Health on childhood immunisation.

The Expert Working Group had no formal terms of reference,³ but its purpose, as stated above was to “assist in the development of a national immunisation strategy.” According to the *Report of the Expert Working Group* it considered:

- the positive and negative aspects of the current immunisation situation;
- where we would like to be in three years time;
- the strategies that should be implemented in the 1993/94 year and the following years to achieve the aims for 1996.⁴

² *Report of the Expert Working Group*, p.3.

³ Dr Ossi Mansoor, personal communication with the author, 17 December 1999.

⁴ *Report of the Expert Working Group*, p.4.

Given these parameters the Expert Working Group could have considered a very wide range of options in the development of the National Immunisation Strategy. That their recommendations remained confined to a relatively narrow band of basically incremental change indicates that there were constraints in the process, the environment or intrinsic to the members of the Expert Working Group. These constraints will be discussed further in the following sections which examine the membership of the Expert Working Group, the background papers supplied to the group's members and the experiences and impressions of some members.

A: Membership

The Expert Working Group on childhood immunisation was made up of 21 individuals including a range of personnel from various areas of the health sector and consumer representatives interested and involved in childhood immunisation. Seven members of this group had previously been involved in the Consensus Development Conference which produced *Tamariki Ora*, the paper on Well Child Care.⁵

The group's 21 members represented a variety of occupational groups and organisations. Of these, nine were medical practitioners, four were practising nurses, six had management and advisory roles in the health sector and two were caregivers.

Of the doctors, two were GPs, and two were hospital physicians with joint academic appointments; one in infectious diseases and the other in paediatrics. Three were public health / community health medicine specialists; one employed in the Ministry of Health, one working as a Medical Officer of Health, and the third working in an academic position. Of the remaining doctors, one was an epidemiologist and the other worked as a paediatrician for the Plunket Society. The doctors included the chair and four members of CDCAC.

⁵ National Advisory Committee on Core Health and Disability Support Services / Public Health Commission, *Tamariki Ora: A Consensus Development Conference Report on Well Child Care to the National Advisory Committee on Core Health and Disability Support Services and the Public Health Commission* (Wellington: The Committee, 1993).

Of the nurses, two were employed as Plunket Nurses, one was a PHN and one worked as a Practice Nurse.

Membership of the Expert Working Group was as follows;

Ms Anna Bailey: Plunket Nurse, South Auckland [Tamariki Ora]

Dr Michael Baker: Medical Epidemiologist, NZ Communicable Disease Centre

Dr Don Bandaranayake: Senior Lecturer in the Department of Community Health, Wellington School of Medicine, Member of CDCAC

Mr Peter Burton: Manager, Population Health, Southern RHA

Dr Gabrielle Collison: Medical Officer of Health, Northland AHB

Ms Barbara Docherty: Senior Practice Nurse, Christchurch [Tamariki Ora]

Ms Linda Thompson Erihe: Director of Maori Health, Manawatu-Wanganui AHB

Ms Cathy Holland: Programme Manager, Health and Planning Development, Midland RHA

Associate Professor Diana Lennon: Infectious Disease Paediatrician and Epidemiologist, Auckland, Member of CDCAC

Dr John Mcleod: General Manger, Planning, North Health

Ms Moe Milne: Formerly Maori Health Service Adviser to the Northland AHB. Locality Projects Manager, Needs Assessment for North Health [Tamariki Ora]

Dr Avind Patel: Senior Adviser (Community Medicine) Department of Health, Member of CDCAC

Dr Harry Pert: General Practitioner, Rotorua [Tamariki Ora]

Ms Jacqui Quinn: Public Health Nurse Adviser, Manawatu-Wanganui AHB

Dr Stewart Reid: General Practitioner, Lower Hutt, Chair of CDCAC

Dr Mark Thomas: Infectious Diseases Physician and Senior Lecturer in Molecular Medicine, Auckland, Member of CDCAC

Dr Pat Tuohy: Regional Paediatrician for the Plunket Society [Tamariki Ora]

Ms June Robinson: caregiver [Tamariki Ora]

Ms Henriette Rawlings: Mother, involved in Plunket, Parents Centre and the Guide Association [Tamariki Ora]

Ms Pam Williams: Plunket Nurse, South Auckland

Ms Lyn Wright: Health Services Analyst with Central RHA

Table 1 in the *Report of the Expert Working Group*⁶ indicated that the membership selection was based around occupational groups and organisations:

OCCUPATIONAL GROUP	ORGANISATION
<ul style="list-style-type: none"> • Caregiver • Practice nurse • Plunket nurse • Public health nurse • General practitioner • Paediatrician • Infectious Diseases Physician • Community Medicine Physician • Medical Officer of Health 	<ul style="list-style-type: none"> • Royal NZ Plunket Society • NZ Communicable Diseases Centre • Communicable Diseases Control Advisory Committee (CDCAC) • Area Health Board • Northland register • Department of Health • Each Regional Health Authority

The Expert Working Group members represented two broad groups. The first included individuals who were actively involved in the determination of childhood immunisation policy and practice at a national level. These include three specific, but overlapping, groups: first are the members of CDCAC; Dr Stewart Reid, Associate Professor Diana Lennon, Dr Mark Thomas and Dr Avind Patel. These are all names that come up regularly in discussion with others in the health policy sector about the development of childhood immunisation policy, both prior to the Expert Working Group process and subsequently. Second are staff from the Department of Health; Dr Avind Patel, both a member of CDCAC and a Senior Advisor in the Department of Health and later in the Ministry of Health, provided a link between the two which was important in the work on childhood immunisation before, during and subsequent to the Expert Working Group process.⁷ Third, those working in national agencies; Dr Michael Baker, Medical Epidemiologist, NZ Communicable Disease Centre was involved in the surveillance of childhood immunisation coverage, Dr Pat Tuohy represented the Plunket Society which is a prominent provider of child health services in New Zealand.

⁶ *Report of the Expert Working Group*, p.3.

⁷ Personal communication with Nemu Lallu in the Ministry of Health, 29 November 2000.

The second group of Expert Working Group members were involved in childhood immunisation at a regional or local level. They represented both a range of occupations and geographical locations. For example; Pam Williams a senior Plunket Nurse from Auckland, had been involved in the Hepatitis B programme, including on a national committee; Lyn Wright, a Health Services Analyst with the Central RHA considered that her inclusion in the Expert Working Group reflected her public health role in the organisation; Dr Harry Pert, GP, had been active in raising immunisation coverage in Rotorua.

In addition the Expert Working Group included two lay members who represented parents' and caregivers' experience.

Notable by its omission was the Immunisation Awareness Society or any other representative of a perspective that challenged the acceptability of universal childhood immunisation. That was, however, consistent with the group's purpose, that is to assist in the development of a national immunisation strategy, not to challenge childhood immunisation as an effective child health and public health strategy. The impact of the anti-immunisation perspective was, however, evident in the Expert Working Group process. This is discussed further in Section II: C.

B: Background Papers⁸

Each member of the Expert Working Group was initially given a volume titled *National Immunisation Strategy Working Group Background Papers* and a copy of the 1992 immunisation coverage survey, *Immunisation Coverage in New Zealand*.⁹ According to the letter, which accompanied the posting, these were dispatched on 5 February 1993, 12 days before the Working Group's meeting.¹⁰

Volume I contained 58 items, 12 of these being comments from interested individuals which were appended to this volume, but not listed in the table of

⁸ Public Health Commission, ed., *National Immunisation Strategy Working Group Background Papers*, Vols I&II (unpublished, 1993). A list of these papers is included as Appendix I.

⁹ Communicable Disease New Zealand, *Immunisation Coverage in New Zealand*, 92:Suppl 2 (Porirua, Communicable Disease New Zealand, 1992).

¹⁰ Ossi Mansoor, Letter to Expert Working Group participants, Ref. PHC 14/3, 5 February 1993.

contents. Of the main body of material, the items were numbered 1-45 and listed in a table of contents.¹¹

The 46 items in the main body of the volume can be categorised as follows:

- twenty-nine had previously been published and were reprinted from periodicals/journals;
- five were unpublished articles - some of which were subsequently published;
- seven items were of an official nature, including national and international immunisation schedules, policy and procedure and reports from official bodies. One of these items was a group of immunisation schedules;
- three were taken from the published proceedings of a conference;
- one was the report of a Plunket Nurses working group;
- one, a schematic on attitudes and behaviour related to immunisation, was not attributed in any way.

The 29 items previously published had appeared in the years from 1983 to 1992, 17 focused on New Zealand experience, nine on the United Kingdom, and one each on Canada, Scandinavia and the international situation. Four of these were letters, one an editorial and one a short report. Of the 23 articles, all were authored by individuals or groups with a medical or related scientific focus. One article had an economic component. All articles were published in one of 11 journals, all of a health, medicine or public health medicine orientation, all but three of which were peer reviewed.

All of the articles dealt with an aspect of childhood immunisation policy or practice from a stance which accepted universal childhood immunisation as the goal. Only one published letter challenged this perspective, being from a researcher and activist known for her anti-immunisation stance.¹²

The background papers did not include any published articles from outside the medical scientific field, with the possible exception being a conference paper on social marketing written by an Australian academic well known in health

¹¹ There were three exceptions to this. Items number 1 and 45 were not included in the contents and an item which came between items 33 and 34 was neither numbered nor listed in the table of contents. This may be significant only in that it indicates the speed with which this process was put together.

¹² Hilary Butler, 'Hepatitis B Immunisation', *NZMJ*, 101 (1988), 464.

promotion circles.¹³ This indicates the medical, scientific focus of the background material supplied to the Expert Working Group.

The Expert Working Group members received a second volume of background papers in February 1993.¹⁴ This volume, *National Immunisation Strategy Working Group Background Papers Volume II*, contained briefing material from NZCDC, summaries of aspects of immunisation practice, a letter from a working group participant, Dr Harry Pert, and two letters from the New Zealand Medical Association.

According to the *Report of the Expert Working Group* the PHC sought input from 50 organisations involved in childhood immunisation and included these responses in the Background Papers. There are many names on the list of contributors, Appendix B in the *Report of the Expert Working Group*,¹⁵ from whom contributions do not appear in the Background Papers. This does not, however, indicate that responses were not passed on to the Expert Working Group because in a number of cases the submission was of material of local interest or on local procedure, for example, a paper on Wellington's vaccine distribution network.

In addition, two letters from Alistair Scott, NZMA, printed in the Background Papers, indicate he received approaches first from John Eastwood, Department of Health, 14 August 1991, and later from Gillian Durham, PHC, 21 January 1992. These indicate that the letters made specific proposals, one of which was the introduction of non-medical vaccinators.

C: Members' Perspectives

There was significant diversity within the membership of the Expert Working Group. Members represented not just a number of organisations and occupational groups, as discussed above, but also various levels of education, differing world-

¹³ Don Nutbeam, 'Consumers not Patients: The Application of Social Marketing Principles to the Improvement of Immunisation Uptake', in *Immunisation: the Old and the New*, Proceedings of the PHAA Conference (1991), pp.12-16.

¹⁴ It is not known when the Expert Working Group received the second volume, although participants were asked to send contributions for this volume to Ossi Mansoor at the PHC by 9 February 1993.

¹⁵ *Report of the Expert Working Group*, p.17.

views and different levels of experience of, and familiarity with, the policy-making process. All these factors combined to produce a range of expectations of the Expert Working Group process.

Those members of the Expert Working Group who had an ongoing involvement in the official processes which shaped immunisation practice felt that the Expert Working Group process had limited significance in the determination of the National Immunisation Strategy. According to Stewart Reid, a GP who was chair of CDCAC, the Expert Working Group process had to be undertaken, but the real decisions had already been made.

I [had] spent a lot of time talking over what was regarded as the National Immunisation Strategy ... since about 1985-86....[T]he new schedule that's in place has been in gestation for many years. The structures that have been put in have absolutely nothing to do with that. The ... Expert Working Group - I guess that had to be gone through, but there were only three or four or five people there who were really influencing it in my view.

There was Norman Begg from the UK, Harry Pert from Rotorua, myself and [Diana] Lennon. I think they were the main people who pushed the thing through. I suspect others would not have the same view, but essentially that was where the knowledge and the experience came from, because no-one else, or very few others, had done any detailed work in the field.¹⁶

In fact others did support Reid's perspective, even if they did not like it. Pamela Williams, at the time a senior Plunket Nurse in South Auckland, shared Reid's view that the process was pushed by a limited number of individuals, considering that the doctors dominated the proceedings.¹⁷

Members of the group were influenced by the role they had in respect of childhood immunisation. The indication is that some participants felt that the decisions had been made elsewhere and they had little impact on outcomes. Williams reported that "there was an agenda that didn't really have to do with great radical change."¹⁸ Lyn Wright, who had worked in the health policy area for a number of years, agreed that there was resistance to radical change. With her experience of policy-making, Wright felt that she and others with similar

¹⁶ Stewart Reid, interview with the author, Lower Hutt, 5 March 1997.

¹⁷ Pamela Williams, interview with the author, Auckland, 19 December 1996.

¹⁸ Pamela Williams, interview.

experience understood that there would have been no point introducing radical suggestions in the prevailing political climate.¹⁹

In analysing the lack of radical change in the National Immunisation Strategy it is apparent that some members of the Expert Working Group were aware of the factors which created an environment which others, for example Williams, as discussed above, felt constrained by the process. These members considered it necessary to develop recommendations which were acceptable within the prevailing policy environment. It is significant that while other groups making recommendations on public health issues were ignored or had their suggestions rejected, the Expert Working Group on childhood immunisation was self-censoring, thus fitting into the desired mould at an earlier stage than did the processes in other areas, for example the PHC's recommendations on the alcohol policy.²⁰

As is discussed in Chapter Six there were a number of alternative courses available in developing the National Immunisation Strategy. The Expert Working Group recommendations were limited to basically incremental changes in existing policy and practice. Anything that challenged the fundamental basis of the existing practice, or was outside the bounds acceptable in a neo-liberal political economy was couched as a recommendation for further investigation. One area in which the Expert Working Group followed this course was in respect of incentives for immunisation providers. Another was so-called mandatory choice which the Expert Working Group recommended be investigated further.

There was a dichotomy between those group members familiar with the political economic realities of policy-making, and those more accustomed to working with the practical applications of the policy that caused a tension in the group. To a degree this was inevitable in bringing a range of perspectives together in a relatively small group. Some members of the group considered the range of

¹⁹ Personal communication with Lyn Wright, 29 November 2000. Wright, then employed as a health services analyst and with a background in public health was a member of the Expert Working Group.

²⁰ For detail on this process see Marten Hutt and Philippa Howden-Chapman, *Old Wine in New Bottles: The Public Health Commission and the Making of New Zealand Alcohol Policy* (Wellington: Institute of Policy Studies for the Dept. of Public Health, Wellington School of Medicine in conjunction with the Health Services Research Centre, 1998).

experiences and involvement in childhood immunisation was to a degree counter-productive.²¹

The diversity within the group was also perceived as having potential advantages. Dr Michael Baker, from the Communicable Disease Centre, felt that there could have been value in the broad range of individuals included in the Expert Working Group. He had particular expectations of the process.

I was principally hoping that we would get a more intersectoral approach.... [S]uccessful vaccination requires a whole lot of things to go right....So what I wanted to see was some more rational policies, particularly in the areas that I was involved in - that is disease surveillance, and particularly immunisation surveillance....I was really hoping we would come up with some overall framework ... so we would move in a direction of having an immunisation surveillance system that met all those criteria of giving good population data for policy purposes, and also dealing with unimmunised children for an operational response to each child.²²

Although the National Immunisation Strategy did include the intention to develop and improve immunisation coverage surveillance, this is an area of the strategy that has not been well developed, and there continue to be problems with immunisation coverage surveillance.²³

Members of the Expert Working Group spoken to appeared not to link events in the wider political economy with the development of childhood immunisation policy. The exception was Michael Baker who raised this point:

I think the timing of this was such that because of the ... Green and White paper and the whole [way] centralised solutions were not [acceptable] at that point. People were looking for approaches which ... could use contracting methods, ... multiple providers and you therefore need to accept that reality.²⁴

Dr Baker's awareness of the issues involved in the health sector reforms may be explained by his position in a national facility and his ongoing involvement in government policy.²⁵ His use of the word 'reality' mirrors Wright's

²¹ This point was made by both Pamela Williams and Harry Pert at interview.

²² Michael Baker, interview with the author, Porirua, 11 December 1996.

²³ Nikki Turner et al., 'Improving Immunisation Coverage: What Needs to be Done?' *New Zealand Public Health Report*, 7 (2000), 11-14.

²⁴ Michael Baker, interview.

²⁵ Michael Baker was Medical Epidemiologist at the New Zealand Communicable Disease Centre.

understanding of the need to work realistically within the constraints of government policy and the public policy-making environment.²⁶

The desire to have multiple providers of childhood immunisation helps to explain why Harry Pert's idea about GP registers was not popular. Dr Pert discussed his impression that there was an intention to move childhood immunisation away from general practice. "[T]here was a perception ... that general practice has failed to deliver [good immunisation coverage] therefore somebody else has a turn."²⁷ However, he had definite reservations about this, considering that the people involved in the delivery of childhood immunisation were not being consulted about appropriate solutions to the problem.

Like it or not the vast majority of immunisations are done in general practice, general practice owns the problem and I think what should have happened is people come to us and say "What is the problem? Why are children not immunised? What are the reasons for it? What are the possible solutions?" Instead it was almost "Let's start again, we'll have a different strategy with different problems."²⁸

Dr Pert's impression that the Expert Working Group was expected to come up with something completely new is at odds with the impression of other members of the expert group, for example Williams and Wright, discussed above, who perceived that radical change was not what the PHC was seeking. This impression was borne out by the eventual recommendations and the National Immunisation Strategy which did not initiate any significant innovations in the provision of childhood immunisation. Wright commented that rather than seeing Pert's solution as building on existing processes, his suggestions were for too radical a change.²⁹

Dr Pert went to the Expert Working Group meeting to propose that the system which had proved successful in Rotorua be extended on a national basis.³⁰ However, he found there to be resistance to such a strategy.

[M]y ideal would have been for people to have recognised the kind of solution that we [in Rotorua] had, to have endorsed it, resourced it to

²⁶ Lyn Wright, personal communication.

²⁷ Harry Pert, interview with the author, Rotorua, 23 January 1997.

²⁸ Harry Pert, interview.

²⁹ Lyn Wright, personal communication.

³⁰ H.Pert, 'Immunisation Strategies', *NZMJ*, 106 (1993), 262.

have helped extend it. But I think it was a very general practice centred approach and I think [the Expert Working Group] were uncomfortable with that. I think they want[ed] choice, [but] the downside of increased choice is decreased accountability.³¹

Dr Pert's impression of a desire for choice is consistent with the expectations of health service provision under the regime of economic individualism. Putting all a health strategy's resources with one provider, or one class of provider was contrary to the general direction of government policy at that time. This requirement for choice of provider was not explicitly acknowledged in the *Report of the Expert Working Group*, but neither was there an assumption that GPs would be the primary provider of immunisations. Choice is a pre-requisite for competition, another central tenet in neo-liberalism and specifically in the health system which was still under construction when the Expert Working Group met in 1992.

In examining Dr Pert's comments on the matter of choice and decreased accountability, while there was no acknowledgement in the *Report of the Expert Working Group* that parents had a choice as to whether or not to have their child immunised, accountability in this situation is seen, at least by some, to be with parents, rather than with providers, although this is inconsistently applied. This will be discussed further below.

Another aspect of the discussion was the question of making childhood immunisation compulsory. Henriette Rawlings reported raising this in the working group. In response one of the senior medics, possibly Diana Lennon, carefully explained to her why this would not work, indicating that there was an understanding among those involved in childhood immunisation that New Zealand society would not tolerate compulsion in this matter.³²

³¹ Harry Pert, interview.

³² Henriette Rawlings, telephone interview with the author, 25 January 1997.

This acceptance that compulsion was not an acceptable option was approached on two fronts. First, as introduced above was the belief that New Zealand society would not tolerate compulsory immunisation. This is a belief which has its roots in the rejection of compulsory smallpox vaccination in the 1800s, as is discussed in Chapter Six.

Second, at interview Stewart Reid expressed the opinion that to make childhood immunisation compulsory would be to admit that it does not recommend itself strongly enough or stand on its own merits. “[A]s a strong advocate of immunisation I weaken my position by saying it should be mandatory. Because if the arguments for it are sufficiently compelling you don’t need to make it mandatory.”³³

The Expert Working Group did not include any representation from those often labelled the anti immunisation lobby. However, it was clear from comments made by participants that the perspective was familiar to many of those working in childhood immunisation.

I think Hilary Butler actually had a huge influence [on the Expert Working Group], although she actually wasn’t there. That whole anti-immunisation lobby made people feel very nervous. Avind Patel has, used to have, an absolute paranoia about upsetting Hilary Butler.³⁴

Dr Dell Hood, Medical Officer of Health for Hamilton, but not an Expert Working Group member, also commented that options for change were constrained by what was acceptable to New Zealand society and the anti-immunisation lobby. For example she felt that introducing provider incentives was not an option given the potential reaction from both New Zealand society in general and the anti-immunisation lobby in particular.³⁵ Stewart Reid also noted that in discussion with a Minister of Health during the 1980s he had raised the possibility of introducing sanctions on those who did not immunise their children. The Minister responded that this would be political suicide!³⁶

³³ Stewart Reid, interview.

³⁴ Pam Williams, interview.

³⁵ Dell Hood, interview with the author, Hamilton, 9 April 1996.

³⁶ Stewart Reid, interview.

This perceived constraint on available options again links back to civil individualism and an understanding, at least among some members of the Expert Working Group, that New Zealanders desire the freedom to make decisions for themselves. As such this suggests that New Zealanders are individualist to a degree that rejects compulsion in the matter of childhood immunisation, rejects the state imposing in a matter that is considered to be a private decision. This is however, at odds with the tolerance for compulsion in other public health strategies, for example cycle helmets, suggesting that childhood immunisation may be a special case. This will be discussed further in Chapter Nine.

That childhood immunisation is considered in a different light from other public health strategies relates at least in part to perceptions about disease risk and side effects discussed in Chapter Six. While recognition of these factors was clearly present in the Expert Working Group and the wider community of those involved in childhood immunisation, this was only one of the factors constraining the Expert Working Group in making its recommendations for a National Immunisation Strategy.

On the one hand the Expert Working Group was constrained by the understanding its members had of what was acceptable to New Zealanders, at least in terms of immunisation; civil individualism. On the other hand some members of the group were aware of the constraints imposed by the prevailing political economic philosophy; neo-liberal individualism. The next section will discuss the recommendations the group produced under these twin constraints.

D: The Expert Working Group's Report

The Expert Working Group's recommendations to the PHC were clearly founded in the belief that childhood immunisation was a good and desirable course to follow. This is in line with the prevailing belief among both conventional health providers and health policy-makers around the western world. As is discussed in the section on the background papers there was only one inclusion that represented the challenge to universal childhood immunisation as a desirable public health strategy.

The aim of the group's process was to improve childhood immunisation in New Zealand, not to debate the merits of immunisation as a health strategy. The perspective taken on this issue was, however, entirely mechanistic in that it entertained no solutions which were not embedded in the process and practice of childhood immunisation. It did not take a wider view of factors which may influence the uptake of childhood immunisation and thus childhood immunisation coverage in New Zealand. Given that a range of factors, known to contribute to low uptake, had been identified, this may be indicative of either a particular perspective on childhood immunisation within the group, or the degree of control exerted over the working group process and its report. As discussed above some members of the Expert Working Group, and certainly those who worked in public policy-making, were aware of the futility of making recommendations which ran contrary to the government's prevailing philosophy, at that time neo-liberalism.

The Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy identified what it considered to be the principles of immunisation service delivery. Many of these reinforced standard practice or usual medical establishment rhetoric in the contemporary environment, for example; that immunisation service delivery be supported by scientific data, and that immunisation service delivery include Maori providers.

The report then went on to recommend that certain strategies be implemented in the following financial year, that is 1993/94. These initiatives, later to be reflected in the National Immunisation Strategy, included

- appointing local, regional and national immunisation co-ordinators
- improving the infrastructure for the provision of immunisation
- improving the quality of immunisation service delivery
- developing information systems and information resources.³⁷

These were enlarged upon and included more detailed recommendations as to implementation.³⁸

³⁷ *Report of the Expert Working Group*, p.2

³⁸ *Report of the Expert Working Group*, pp.6-12.

In the medium term, that is the following two financial years, 1994/95 and 1995/96, the Expert Working Group recommended attention to a number of issues. These included assessment of the National Immunisation Strategy, accreditation of all vaccinators, a national population register, a social marketing strategy for immunisation, development of information resources for providers and consumers, and linking immunisation to well child care. They also recommended further exploration of incentives to providers and or consumers to improve immunisation coverage, and the concept of mandatory choice.³⁹

The *Report of the Expert Working Group* took a narrowly focused approach to childhood immunisation, almost entirely ignoring the environment within which childhood immunisation took place. There is reference to the cultural environment, which is acknowledged in terms of Maori and Pacific Island peoples, and to the problem of families living distant from vaccination services. There is, however, no explicit recognition of the impact of social or economic factors on immunisation coverage.

This report accepted without question that immunisation was the right thing to do. It did not acknowledge that parents had a choice as to whether or not they immunised their child, nor did it delegate primary responsibility to parents as did later documents. It concentrated solely on strategies for improving childhood immunisation rates, with little reference to related issues. For example, although it was stated in the principles of immunisation service delivery that immunisation services should be integrated into comprehensive primary health care,⁴⁰ the report made no recommendations as to how this integration was to be achieved. Instead it indicated that while the Expert Working Group supported linking of childhood immunisation with well child checks it had reservations about combining the two events if any charge made with well child checks acted as a deterrent to those who associated the financial cost with the immunisation event.⁴¹

The report took a very isolationist approach to the issue of childhood immunisation. It examined one aspect of the health services, almost without

³⁹ *Report of the Expert Working Group*, pp.13-15.

⁴⁰ *Report of the Expert Working Group*, p.5.

⁴¹ *Report of the Expert Working Group*, p.14.

reference to other health services, or to wider societal issues. It concentrated on correcting what were perceived to be shortcomings in the system which delivered childhood immunisation. In the tradition of a mechanistic approach to health, the focus was on finding the very small part of the system that was broken so as to improve childhood immunisation coverage by fixing that one bit. It did not directly address other factors which have been linked with low rates of childhood immunisation achieved in New Zealand. The 1992 survey indicated, as is discussed in Chapter Seven, that children were less likely to be immunised if they lived in a household where the main source of income was from benefits, if their caregiver identified themselves as Maori or part-Maori, if their family had moved frequently, or if their caregiver had not attained School Certificate.⁴²

Two particular strategies are of particular interest, illustrating as they do attitudes toward childhood immunisation policy and practice both at the Expert Working Group stage and later in the development of the National Immunisation Strategy. The first of these is the concept of mandatory choice. The report states:

The expert working group did not consider that mandatory choice, requiring documentation of immunisation or the lack of it on school entry, was an appropriate way of increasing immunisation in pre-school children. However, the expert working group felt that an informed debate on mandatory choice should take place.⁴³

Mandatory choice is a concept imported from Australia, where the term is used to describe a situation whereby parents, while not compelled to immunise their children, must make a conscious choice one way or the other. It is clear from the above quote that the Expert Working Group did not recommend following this course. First, the idea of mandatory choice was to be adopted in the National Immunisation Strategy, but not the name, which has, however, been used to describe the concept by external critics of the strategy.⁴⁴ Second, the obligation on parents to make a conscious choice to immunise or not became linked to school entry checking of immunisation status through the vehicle of immunisation certificates.

⁴² CDNZ, *Immunisation Coverage in New Zealand*, pp.9-10.

⁴³ *Report of the Expert Working Group*, p.15.

⁴⁴ Kevin Dew, 'Epidemics, Panic and Power: Representations of Measles and Measles Vaccines', *Health*, 4 (1999), 379-398.

The second strategy which illustrates attitudes to childhood immunisation policy concerns incentives for providers and consumers. “The possibility of using incentives to improve immunisation coverage would require further work before considering any scheme. These possibilities should be explored by the Public Health Commission.”⁴⁵

The Expert Working Group had been given information on the successful use of provider and consumer incentives in other countries. However, constrained by its prevailing desire to recommend politically acceptable options which had a chance of being implemented, it avoided any specific recommendations in this area, indicating instead a need for more work in this area. Consumer and provider incentives ran contrary to the guiding philosophy of government, which was based on the premise, as has been discussed earlier, that individuals would do what was in their own best interests, and that the state should not interfere in that process.

That the state had a wider interest in ensuring a level of immunisation coverage that would prevent the spread of vaccine preventable disease, and therefore forestall both the misery involved and the financial cost of the health care infected children would require, does not seem to be an argument that swayed the neo-liberal government. Instead it was their belief that ensuring children were immunised was a parental responsibility. This adherence to the tenets of personal responsibility, discussed in Chapter Two, follows both the ideas that first, an individual’s body is their own and second, that the individual’s health is at least in part a product of their own choices.

Recommending further investigation of incentives indicated that the Expert Working Group thought them to be a good idea, without making statements which may have been controversial, not just in the prevailing philosophical climate, but also with those who opposed coercive methods in the promotion of childhood immunisation. The National Immunisation Strategy did not include any incentives for either providers or consumers. This is in line with the expectation, a component of the neo-liberal economic individualism, that individuals would take responsibility for their own welfare.

⁴⁵ *Report of the Expert Working Group*, p.15.

The *Report of the Expert Working Group* did not recommend compulsion, nor did it address the multitude of non-immunisation related social and economic issues which are recognised as contributing to low immunisation coverage rates. As was discussed in the previous section the Expert Working Group confined itself to a very narrow reading of the situation which was acceptable within the bounds of both the neo-liberal individualism prevailing in the political economy and the civil individualism shaping New Zealanders' expectations of their rights and responsibilities in respect of their health.

E: Submissions on the Expert Working Group's Report

The *Report of the Expert Working Group* was distributed by the PHC to those organisations and institutions with an interest in child health and public health as a discussion document. In response to the PHC's invitation 87 submissions were received from individuals, interest groups, professional organisations and health sector organisations. An analysis of these submissions was prepared by Dialogue Consultants.⁴⁶ The document contained an analysis of submissions, with footnotes, which sometimes contained comments on the content or accuracy of the submissions.

The submissions reflected a wide range of views on childhood immunisation. There were those who supported the tone of the document and the attention to childhood immunisation that it signalled. Others attacked what they believed to be the pro-immunisation bias of the report, with some of the submissions suggesting that individuals with neutral or anti-immunisation views should have been invited to take part.

One submission was reported as expressing concern about the "Pilot Health Goal 'to increase to 80% by 1995, and 90% by 2000, the proportion of NZ children with completed early childhood immunisation by the time they are two years old' It was considered the methods used to achieve this goal will inevitably bring unacceptable pressure to bear on parents'/caregivers' rights ("their freedom of

⁴⁶ Dialogue Consultants, *Analysis of Submissions on the Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy* (Wellington: Public Health Commission, July 1993).

choice”).⁴⁷ A footnote to this item notes that “The intentions of the Working Party are considered by the PHC to be expressly non-coercive and the opposition to ‘mandatory choice [item] 6.8 is cited as an example of this.’”⁴⁸ While the Report does not recommend coercion, neither does it indicate a tolerance for failure to meet the pilot health goal if coercion of parents is the cost of success. In addition the Report does not dwell on parents’ right to choose in the area of childhood immunisation. The submission’s concern that such a cost would be inevitable may be valid.

There was no direct reference to the very narrow, service focused perspective taken by the report, although some submissions commented on the basic philosophy of the document which did not question the desirability of universal childhood immunisation and thus issues integral to this perspective. Although there was support for the philosophy there were challenges based on first the “very desirability and efficacy of vaccination,”⁴⁹ and second, “the apparent treatment of immunisation in isolation.”⁵⁰

Footnote 2, following the first item noted “Several submissions went so far as to say that the funds spent on NIS goals would be better spent in providing better support services in homes, and more education about diet and good mothering, to raise children’s standard of health and hence their natural immunity.”⁵¹

Footnote 3, following the second item identified notes “This matter is, in fact covered in the third principle of the strategy.”⁵² This is the case, but taken as a whole the tone of the Report does not give a feeling that the suggested strategy will be integral to existing well child or primary care practices. As has been discussed in Section II: D, the Expert Working Group had reservations about integrating immunisation events with well child care events.

The analysis then went on to discuss submissions on each aspect of the report. They continued to cover the range of opinions on the report, reflecting opinion on

⁴⁷ Dialogue Consultants, *Analysis of Submissions* p.3.

⁴⁸ Dialogue Consultants, *Analysis of Submissions* p.3, f/n 5.

⁴⁹ Dialogue Consultants, *Analysis of Submissions* p.3.

⁵⁰ Dialogue Consultants, *Analysis of Submissions* p.3.

⁵¹ Dialogue Consultants, *Analysis of Submissions* p.3, f/n 2.

⁵² Dialogue Consultants, *Analysis of Submissions* p.3, f/n 3.

both childhood immunisation and the approach the Expert Working Group had taken.

III: The Public Health Commission's Advice to the Minister of Health

One of the functions of the PHC was to advise the Minister of Health on matters relating to public health. Using a framework developed in the document *A Strategic Direction to Improve and Protect the Public Health*,⁵³ the PHC provided advice on a wide range of issues central to the public health, one of which was childhood immunisation.

*Immunisation: The Public Health Commission's Advice to the Minister of Health*⁵⁴ was published in March 1994. It identified and discussed what the PHC perceived to be the major problems with childhood immunisation: low immunisation coverage rates, a lack of information and problems with the cold chain.⁵⁵ It also identified its objective "To protect children from preventable infectious diseases by improving immunisation."⁵⁶

A: Recommendations

Immunisation made recommendations under the following headings; setting outcome targets, setting health public policy targets, setting public health programme targets and setting research and information targets.

Policy Targets

- That a national immunisation co-ordinator be appointed.
- That further work be done on linking immunisation with well child care.
- That a discussion paper be written on school and early childhood centre entry policies immunisation policies.
- That options for increasing provider commitment be investigated.

⁵³ Public Health Commission, *A Strategic Direction to Improve and Protect the Public Health: The Public Health Commission's Advice to the Minister of Health 1993-1994* (Wellington: Public Health Commission, 1994).

⁵⁴ Public Health Commission, *Immunisation: The Public Health Commission's Advice to the Minister of Health* (Wellington: Public Health Commission, 1994).

⁵⁵ Public Health Commission, *Immunisation*, p.6.

⁵⁶ Public Health Commission, *Immunisation*, p.6.

- Consideration be given to accreditation of all vaccinators
- That indirect cost barriers to immunisation be investigated.
- That mechanisms for changing the immunisation schedule be investigated.
- That vaccine storage and distribution be reviewed.
- That vaccine preventable diseases and vaccine adverse events be included in the notifiable disease schedule.

Programme Targets

- That the PHC purchase the services required to support effective national co-ordination of the immunisation programme.
- That the PHC further develops the concept of healthy schools.
- That RHAs purchase local co-ordination of immunisation services.
- That RHAs develop systems to improve the quality of immunisation service delivery.
- That RHAs continue to purchase culturally-appropriate (including iwi-based) primary care services, which improve immunisation coverage for Maori.
- That RHAs continue to purchase culturally-appropriate (including iwi-based) primary care services, which improve immunisation coverage for Pacific Island peoples and other ethnic groups.

Research and Information Targets

- That a national information system for immunisation is developed which provides information, on coverage and which enables the identification of children missing out and comparison of provider performance.
- That the national immunisation co-ordinator has established procedures and a system for reporting and analysing vaccine adverse events and vaccine-preventable diseases.
- To conduct research to assess the need for the 18-month immunisation episode.

B: Discussion

Unlike the *Report of the Expert Working Group*, the PHC did acknowledge the wider context within which childhood immunisation fits, in terms of disease causality, parental choice and service provision. This addressed concerns expressed in submissions on the *Report of the Expert Working Group*, as discussed above, including safety of childhood immunisation, informed consent and the consideration of immunisation in isolation. *Immunisation* notes that:

While the focus of this paper is on immunisation, it must be stressed that it is just one component of primary health care. There are other means of preventing disease, for example with good nutrition, housing and lifestyle. However, immunisation remains an effective means of preventing disease.⁵⁷

The paper did point out that, based on the British experience, it was known to be possible to increase immunisation coverage without either addressing socio-economic status or employing coercive policies. *Immunisation* states that this was achieved by “improving the infrastructure of immunisation service delivery and encouraging GPs.”⁵⁸ While this is correct, it does not reflect the complexities involved in New Zealand replicating Britain’s achievements.

The British system of general practice requires that patients be enrolled with a given practice. The system also has a sophisticated, computerised information system which allows for central tracking of both patient and provider behaviour. In addition, the encouragement took the form of financial incentives for general practices achieving particular levels of immunisation coverage. Certainly the policy itself is not overtly coercive, and the model has been successful, but this does not guarantee that coercive tactics have not be employed within individual general practices. In addition, as is discussed in Chapter Six, it is widely held that it was financial incentives which produced the improvement in coverage rates.

⁵⁷ Public Health Commission, *Immunisation*, p.6.

⁵⁸ Public Health Commission, *Immunisation*, p.8.

While the PHC did recommend improved information systems it did not spell out the implications of this for what is, in New Zealand, a private sector business. Neither did the PHC recommend incentives, financial or otherwise for immunisation providers. This was despite acknowledging Nicoll, Elliman and Begg's finding "that immunisation provider commitment is the single most important factor in determining coverage."⁵⁹

Both the Expert Working Group and the PHC, in its advice to the Minister of Health appeared to accept that there were parameters outside which advice would not be taken. This is in conflict with the wide spread discussion of the PHC's refusal to tailor, or moderate its advice to fit with the more market, individualist philosophy guiding the government and its policies, its advice on childhood immunisation is reasonably accommodating. The PHC did recommend strategies that would have been in conflict with the government's philosophical position, but limited the impact of such advice by suggesting them as areas for further discussion.

IV: Politics and Childhood Immunisation

The determination of health policy is, as discussed in Chapter Three, a highly political process. Because childhood immunisation was, particularly in the late 1980s and early 1990s, receiving high levels of professional, media and public attention it had high political appeal.⁶⁰ Universal childhood immunisation, however, received bipartisan support with little, if any, debate about the desirability of moves to improve immunisation coverage rates in New Zealand or what strategies might be used to achieve this objective. This section will examine the attention issues of childhood immunisation received in the political realm, the factors which drove the establishment of the National Immunisation Strategy at this level and the way in which it was launched.

⁵⁹ A. Nicoll, D. Elliman and N.T. Begg, 'Immunisation: Causes of Failure and Strategies and Tactics for Success', *BMJ*, 299 (1989), 808-812.

⁶⁰ This point is discussed in Chapter Seven and was reinforced by Osman Mansoor, interview with the author, Wellington, 25 October 1995. Mansoor, a Public Health Medicine Specialist worked in the PHC and organised the Expert Working Group process.

A: The Political Processes

Childhood immunisation did receive attention in Parliament during this time, with limited discussion in Select Committees and in the debating chamber, and more attention in Cabinet. During the development of a National Immunisation Strategy the Social Services Committee, concerned about childhood immunisation in New Zealand, challenged the PHC as to its actions in respect of improving this area of child health. The PHC reported that work was being done to improve GP recall systems and the information on which parents could make an informed choice.⁶¹ Both of these matters were to be addressed in the National Immunisation Strategy.

The second mention of childhood immunisation in the Select Committee process came in the wake of the public announcement of the National Immunisation Strategy and concerned Immunisation Certificates. This came after the dissolution of the PHC so it was the Ministry of Health addressing the Committee on childhood immunisation matters.⁶²

Immunisation did not get sustained attention in the debating chamber, however, it was raised during the debate on the Appropriations Bill as will be discussed further below, and in question time at the time of the announcement of the National Immunisation Strategy. Both of these items indicate that the Minister of Health had a personal commitment to childhood immunisation.

Discussion with officials in the policy community indicate that Jenny Shipley, Minister of Health at the time, took a significant role in driving the establishment of the National Immunisation Strategy.⁶³ Her interest in and commitment to childhood immunisation preceded her appointment as Minister of Health, but

⁶¹ Social Services Select Committee, 'Vote Health,' *The Report of the Select Committees on the 1994/95 Estimates and Supplementary Estimates*, New Zealand House of Representatives, I.19B (Wellington, 1995), p.92.

⁶² Report of the Social Services Committee, '1994/95 Financial Review - Ministry of Health,' in the *Reports of Select Committees on the 1994/95 Financial Reviews of Government Departments and Offices of Parliament*, New Zealand House of Representatives, I.23C (Wellington, 1996), p.66.

⁶³ This point was reinforced by a number of officials involved in the process including Ossi Mansoor; Sally Stewart, Ministry of Health, interview with the author, Wellington, 25 October 1995; Rosemary Simpson, Health Policy Analyst, Ministry of Women's Affairs, interview with the author 25 October 1995.

there are indications that her views were modified over the period of her attention to the issue.

That Shipley's commitment to childhood immunisation predated her incumbency in the health portfolio is indicated by her support, as Minister of Social Welfare, for vaccination in a disease outbreak situation. In a letter dated 5 July 1993 the Minister of Social Welfare informed her colleague, the Minister of Health, that she had instructed her Ministry to ensure there was financial support for meningitis vaccination during an outbreak of the disease.⁶⁴ The letter stated:

Had I not taken this interim action the Government and your department in particular would have almost certainly been the subject of adverse media attention and political embarrassment. I am requesting that you urgently address this issue, and suggest that vaccinations for meningitis and other life threatening illness be included in the schedule for free vaccinations forthwith.⁶⁵

Although Shipley may have been concerned with the health of New Zealand's children, the consideration of potential political embarrassment was clearly an additional motivating factor in determining the response to a given situation. It is also clear that Shipley did not recognise limitations which were at that time preventing vaccines being added to the schedule, namely the non-availability of the four-in-one vaccine which was to be included in the immunisation schedule in 1994.

It is reported that when she was Minister of Health Shipley was known to have particular, individualist attitudes to immunisation. Officials report that, given that childhood immunisation was free to families, she did not recognise barriers to childhood immunisation and saw childhood immunisation as a parental responsibility.⁶⁶ This was reflected in the attitudes of Katherine O'Reagan, Associate Minister of Health, who at interview, expressed the opinion that low immunisation coverage indicated that parents were forgetting their

⁶⁴ This letter, obtained under the Official Information Act, was introduced into the parliamentary debate on the Appropriation (Financial Review) Bill (No.2), 2 March 1995 by Opposition Member Martin Gallagher, cited in *New Zealand Parliamentary Debates*, Vol.546 (2 March 1995), p.5784.

⁶⁵ Letter from the Minister of Social Welfare to the Minister of Health, 5 July 1993, cited in *New Zealand Parliamentary Debates*, Vol.546 (2 March 1995), p.5784.

⁶⁶ Discussion with officials involved in the development of the National Immunisation Strategy.

responsibilities.⁶⁷ Furthermore O'Reagan indicated that the government was not in the business of paying people to do what they should do.⁶⁸ These attitudes are in line with neo-liberal individualism and related understandings of personal responsibility. However, both Shipley and O'Reagan saw that there was a partnership in this matter, with the state providing vaccination services and parents presenting their children at the appropriate times for vaccination.

Shipley's understanding of a workable approach to improving immunisation coverage apparently shifted during the development of the National Immunisation Strategy. Officials report that early in the process she was very interested in introducing incentives and disincentives, with a leaning toward compulsion. However, she listened to opinion in this area and moved away from that view, concentrating instead on the wider systems issues indicated by the Expert Working Group and the PHC.

Shipley did however, retain a preference for measures which reinforced parental responsibility for childhood immunisation. Although the Expert Working Group and the PHC had recommended further discussion on so-called mandatory choice, the Minister took the issue up in Cabinet and it went ahead without the discussion.⁶⁹ This is an illustration of the power of ministerial commitment. Although the PHC had prepared a discussion paper on this topic it was never distributed. What is in Australia called mandatory choice was effectively established in New Zealand by the introduction of a requirement that children starting early childhood education or at school are required to present immunisation certificates. The required regulations for this were promulgated in The Health (Immunisation) Regulations 1995.

Other aspects of the National Immunisation Strategy were set out in the *National Immunisation Strategy 1995*, although not all of these expectations were implemented immediately.

⁶⁷ Katherine O'Reagan, Associate Minister of Health, interview with the author, Cambridge, 10 November, 1995.

⁶⁸ Katherine O'Reagan, interview.

⁶⁹ Osman Mansoor, interview; Sally Stewart, Ministry of Health, interview with the author, Wellington, 25 October 1995.

In establishing the National Immunisation Strategy, and supposedly changing immunisation policy, Mrs Shipley did not take any political risks. She followed the example of predecessors in avoiding the introduction of measures which may have promoted childhood immunisation, but would have been unpalatable to the electorate. That she avoided the risks was in part due to the advice she received, but it also reflected a neo-liberal understanding of the state's role and personal responsibility.

B: The National Immunisation Strategy and its Announcement

The National Immunisation Strategy was announced at the Royal New Zealand Plunket Society's Annual General Meeting on the 29 March 1995. The National Immunisation Strategy is discussed fully in Chapter Six, but briefly it included:

- a new immunisation schedule;
- standards designed to improve the quality of vaccines and vaccination;
- local immunisation co-ordination within each of the four RHAs;
- the improvement of surveillance and immunisation coverage information;
- the introduction of immunisation certificates.

The National Immunisation Strategy basically followed the recommendations of the Expert Working Group and the PHC, excepting in the matter of immunisation certificates as discussed in the previous section. It was a relatively simple and uncontroversial strategy which addressed many of the concerns parents and health professionals had about childhood immunisation. Dissemination of information about the National Immunisation Strategy was facilitated by its simple structure.

With the possible exception of immunisation certificates the National Immunisation Strategy was simply the packaging of a collection of measures which could or should have been introduced as part of the normal updating and improvement of childhood immunisation practice. This signified an incremental approach to childhood immunisation policy, building on established practices, not the product of a radical or even rational reconsideration of available options to improve immunisation coverage in New Zealand. For example, although the new immunisation schedule was included in the National Immunisation Strategy, work on complying with the latest scientific knowledge had been ongoing and would

have been introduced anyway, as had other changes in the immunisation schedule over the years.

That the measures were packaged together as the National Immunisation Strategy reflects two requirements. First, that there was need to have the process and procedures for childhood immunisation clearly set out. The *National Immunisation Strategy 1995* clearly documented the lines of responsibility in achieving goals and targets for childhood immunisation. Second, that there was the political requirement for a response to the relatively high level of public, health professional and political attention childhood immunisation and its associated problems had been receiving since the late 1980s. There was an unwillingness to introduce a fundamentally different approach to childhood immunisation, by introducing one of a number of alternative approaches including compulsion or incentives or a new delivery system. So instead the National Immunisation Strategy comprised a range of measures that, while all laudable and required, should have been introduced as a matter of course in the normal processes of quality improvement.

The National Immunisation Strategy could then be interpreted as a public relations exercise rather than a genuine release of new policy initiatives. This may be an uncharitable or cynical interpretation, because given the level of concern that had been expressed about vaccine safety and efficacy it was important that parents and health professionals were informed about the changes being introduced. The high profile of the launch of the National Immunisation Strategy may have been justified by the importance of childhood immunisation as a health strategy and by the high profile the original problems had received. Full advantage was taken of the opportunity to publicise the National Immunisation Strategy was part of the campaign to achieve the new targets and address the undoubted problems existing in this area of child health.

V: Commentary

The development of New Zealand's policy on childhood immunisation involved individuals and groups from within a number of sectors in the health and public policy establishments. This alone introduced a range of professional and organisational perspectives and understandings into the discussion. However,

there is an additional layer in this process because of the participants' various personal understandings of, or philosophies on, the role an individual can or should take in promoting their own, or their family's welfare.

Therefore a participant's understanding of the individual's role in society would have had an impact on their perceptions of what was possible and desirable in developing childhood immunisation policy. Their professional training, professional and personal experiences, and political inclinations would have influenced this understanding. The strength of each would have varied according to the individual's position in the process. A number of intersecting groups stand out in this process.

First, medical science was driving this process with its practitioners' understanding that childhood immunisation was a desirable and necessary health strategy. In this group there was an understanding that it was important to get the science of vaccines and vaccination right, and to educate parents so that the number of children protected from vaccine preventable disease increased and the rates of vaccine preventable disease dropped. As has been noted in earlier sections even within this group there was variation in the understanding of how this could be achieved. For example, whether the focus should be on GP provision or on multiple providers.

Second, those involved in the policy-making process who, either influenced by Treasury or aware of the power of the neo-liberal paradigm, saw childhood immunisation as a cost effective health strategy that included a component of personal responsibility in ensuring the health of New Zealanders. Although, as is discussed in Chapter One, in other sectors Treasury's recommendations included private provision of services and user pays, this was not the course in the health sector, although competition was encouraged, hence the apparent preference for multiple providers.

Third, elected politicians, a group that may intersect with the second group, who were under pressure to respond on an issue that left unattended could have left the government open to criticism and embarrassment. In addition, each came from a particular philosophical position, with understandings of what was acceptable to

the electorate, either from their own experience, or informed by policy advisors. So that where their personal preference may have been along a particular line, it was possible that politicians would be swayed by advice. It would seem that this was the case with Jenny Shipley, but while she was advised away from compulsions and punitive measures, she was still determined that parents would be forced to make decisions about, and take personal responsibility for, their children's immunisation.

Fourth, was a group who saw childhood immunisation as having practical problems for which they sought practical solutions. They had given little if any thought to the factors which shaped individual response to policy, or the philosophical understandings which shaped that policy. They did, however, become aware that the perspectives of the first three groups, discussed above, acted to constrain policy options.

This childhood immunisation policy emerged as a combination of influences, more than one of which can be attributed to varying interpretations of individualism.

VI: Conclusion

The National Immunisation Strategy, which stands as New Zealand's childhood immunisation policy, introduced only incremental change to the procedures and practices that were in place before the PHC launched into its review of childhood immunisation in 1992. That New Zealand did not take up options which have improved immunisation coverage in other developed countries is due in large part to the significant influence of individualism.

The Expert Working Group on childhood immunisation and the PHC were self-censoring in the lines of enquiry they pursued and in the advice they gave the Minister of Health. This differs from other areas of public health where working parties have made recommendations which have been subject to opposition from conflicting interests, or later come into conflict with the intentions of government.

This outcome was a function of two facets of individualism. First, an understanding at least among those dominant in the Expert Working Group that

New Zealanders would not tolerate compulsion in respect of childhood immunisation, that is an aspect of civil individualism. Second, that guided by a neo-liberal political economic philosophy the government had a preference for an immunisation strategy which retained an element of personal responsibility in childhood immunisation at both consumer and provider level.

Chapter Nine will draw together the various threads of individualism in respect of childhood immunisation policy and public policy in general.

Chapter Nine

DISCUSSION AND CONCLUSION

I: Introduction

The debate about where the line falls between those responsibilities and decisions which fall to individuals, and those which are the prerogative of the community as a whole, has long been a question central to the organisation of society. In attempting to determine the proper role for the state as the agent of society philosophers and politicians have presented a plethora of models, each prescribing alternative roles for the state in the lives of its citizens while, at the same time, largely determining the role of the individual.

This thesis has focused on two expressions of individualism; neo-liberal individualism and civil individualism, which have been significant in the development of the National Immunisation Strategy, New Zealand's childhood immunisation policy.

Individualism is relatively simple to identify in the policies of successive governments since 1984, in constructing a political economy based on neo-liberal rationalism. It is, however, less straightforward to categorise the changes that have taken place in New Zealand society generally. At this level individualism stems from a number of sources and takes a number of forms. On the one hand there are the ways in which individuals have reacted to, or felt the impact of, economic rationalism. Some New Zealanders have embraced the changes it has introduced, while at the other end of the scale many have been severely disadvantaged by the same changes. In between these two points is a continuum along which sit a range of reactions varying from positive benefits through to extreme hardship.

On the other hand are the various behaviours and attitudes of individuals in respect of their place in society and their responsibilities to other members of society. The perspective which expounds modern society to be a hedonistic, consumer-orientated, anti-authoritarian collection of beings in which individuals

are less concerned with society and more concerned with the private realm, cannot be viewed as describing a single set of beliefs or behaviours. There are, once again, a range of positions within this view. Furthermore, not everyone living in an individualist society subscribes to the doctrine of individualism, or would accept that they were individualist.

The case study in this thesis examines the development of New Zealand's childhood immunisation policy, the National Immunisation Strategy, a public good health policy developed during the period when neo-liberalism was the prevailing philosophy in the New Zealand political economy.

This chapter draws together the various matters raised in this thesis. It will first discuss whether childhood immunisation is a public good or a private responsibility. Second, it will discuss the impact of individualism on the National Immunisation Strategy. It will then draw together some conclusions based on the propositions raised in the introduction to the thesis.

II: Childhood Immunisation: Public Good or Private Responsibility?

Immunisation is a health strategy delivered to individuals. In the majority of cases receipt of the vaccine will confer on the individual immunity to a specific disease, or group of diseases, depending on the vaccine. Any undesirable side effects also accrue to the individual. However, a small number of individuals who are immunised will not be conferred with protection against the relevant disease. In addition there are a small number of individuals who, for medical reasons, cannot be immunised.

On a population health level vaccine preventable diseases can be spread among those who do not have immunity to a disease. This group includes those who cannot be immunised, those who were immunised but did not acquire protection against the disease, and those who have not been immunised either by reason of deliberate choice or unplanned omission. The larger this group of people is, the more a disease is likely to spread.

When considering the influence of individualism on the shape of public policy in a matter with implications for the public good, childhood immunisation is an

instructive case study. On the one hand immunisation might be considered a private matter, and thus within the prerogative of the individual. If a parent or guardian chooses to have their child immunised then the child will have protection against the relevant vaccine preventable diseases. If not, then the parent is accepting, for their child, the risk of contracting those vaccine preventable diseases.

This would be simple if all children immunised developed immunity to the relevant diseases. As has been discussed above, this is not, however, the case. Some immunised children do not develop immunity and thus are also at risk of contracting vaccine preventable diseases. This matter is further complicated because some children, whose parents plan to have them immunised, do not complete the programme of immunisations. As discussed in Chapters Six and Seven failure to complete the immunisation schedule has been linked to particular features in the family's circumstances, including poverty, unemployment and poor housing. These features have links to other aspects of public policy and are thus conceivably beyond the control of the individual parent. These children, too, are at risk of contracting vaccine preventable diseases. In addition there is a group of children who cannot, because of pre-existing physical conditions, be immunised.

Protection against vaccine preventable disease is not, therefore, entirely a matter of choice. For some children there is an element of chance involved. There is however, an additional matter to consider in terms of protection against vaccine preventable disease. If the pool of vaccinated children is large enough then those children who, for whatever reason, do not have immunity are protected. Because children cannot be excluded from the benefits of low rates of disease transmission conferred by a high level of immunisation coverage, childhood immunisation is *a public good*. That childhood immunisation is considered to be in *the public good* is a moral judgement, as is discussed in Chapter Two. That judgement is, however, related to society's assessment that childhood immunisation is a desirable course to take given that it reduces the incidence of potentially serious and life threatening vaccine preventable diseases.

Childhood immunisation is neither a purely private, nor a purely public matter. The potential side effects, both beneficial and damaging, have implications for

both the individual child and their family, and for the wider community of which they are a members. While parents' retain the final say in whether or not, and when, a child is immunised, society retains a degree of protection against any possible tendency society may have to act as though the end justifies the means in achieving high immunisation coverage rates. The success of this aspect of childhood immunisation policy in maintaining childhood immunisation as an effective individual and population health strategy rests on parents continuing to see either the individual utility or the social utility of childhood immunisation.

The next section will examine the impact individualism had in the development of the National Immunisation Strategy.

III: Individualism and the National Immunisation Strategy

In developing the National Immunisation Strategy the process, the options considered and other factors were significantly influenced by individualism.

A: The Process

The review of childhood immunisation took place during a time when the neo-liberal individualist policies initiated by the Fourth Labour Government in 1984 were beginning to have an impact of New Zealand's social policy. It was part of a process of review established by the PHC to examine policy and practice in a number of areas of public health.

The process, discussed in Chapter Seven, included the gathering of background information and opinion, the convening of an Expert Working Group on childhood immunisation, and public submissions on the Expert Working Group's findings. The findings from this process consolidated in the PHC's advice to the Minister of Health.

Much of the process is based on expert advice from the medical establishment. Although some of health professionals involved had a public health perspective, the biomedical model had a strong influence. This in part explains the reductionist approach, which emerged particularly during the Expert Working Group process, and discussed in Chapter Eight.

B: Strategies

In developing the National Immunisation Strategy New Zealand's health policy makers had, theoretically at least, a number of options available to them. Various strategies had been employed in other developed western democracies, either over the long term as the customary approach to childhood immunisation in that country, or more recently in response to persistently low immunisation coverage rates.

It is a telling indication of the level and interpretations of individualism in New Zealand that some of these strategies were not available for inclusion in the National Immunisation Strategy, either because they ran contrary to the government's philosophical persuasion, or because they cut across norms accepted by the population generally. However, other strategies were attractive in the New Zealand situation. This section will briefly outline these strategies and discuss why such approaches were, or were not, available to New Zealand's health policy makers.

As noted in Chapter Six, in the United States of America children must be immunised before they can enrol in the state school system. It is difficult to gain exemption from this ruling. The exception is for individuals affiliated to certain religious organisations recognised as preaching conscientious objection to the practice of immunisation. New Zealand, however, has traditionally avoided making immunisation compulsory since a brief period in the early days of smallpox vaccination.

Britain established a complex system of provider incentives for childhood immunisation. Immunisation is part of the system of primary care provided through general practices. The special arrangements of primary care facilitate such a system. First, all persons must be enrolled with a GP, and second, each practice is linked to a complex computerised information system which allows health workers in the practice access to information about, among other things immunisation records. In addition the system enables the funding organisation to track the immunisation coverage rate within the practice. GPs achieving certain immunisation coverage rates are rewarded with financial bonuses.

This is an option, which includes components promoted by certain interests in New Zealand, but was never considered a viable option for inclusion in the National Immunisation Strategy. Although work is being done on total patient registration for primary care, this is a long way from being a national system. The computerised recall and tracking system used in the UK was not available in New Zealand. New Zealand's general practice system was essentially private sector with some public subsidisation. Politicians have frequently expressed the opinion that they were not going to pay people to do what they should be doing anyway.

In France parents are given a financial bonus if they have a prescribed schedule of antenatal and well child care events including immunisation. As is discussed in Chapter Eight it was considered that New Zealand society would not tolerate the introduction of such a policy.

Other options open to New Zealand's health policy makers include linking childhood immunisation to benefit payments. Parents who did not have their children immunised on time would not receive their full amount of the transfer payment in respect of their child's maintenance. This may well have been included in the National Immunisation Strategy, emphasising as it does the personal responsibility aspect of health. However, politicians were made aware that it would further disadvantage children and families already disadvantaged by poor circumstances and would be unlikely to improve immunisation coverage rates. This does indicate that the government was willing to take advice in certain areas.

An option that is included in the childhood immunisation policy, although not announced as part of the National Immunisation Strategy is the recognition of non-medical vaccinators. This allowed for an element of competition to be included in the area of childhood immunisation. This ran contrary to advice from the medical profession, but was in line with the government's political economic philosophy.

C: The Preceding Situation

Despite the attention given to childhood immunisation policy and practice, and the range of options available for consideration in the development of the National

Immunisation Strategy, what emerged was not substantively different from the policy in place prior to the review of childhood immunisation begun in 1993.

There were clearly some modifications, with the adoption of new strategies, including immunisation certificates, but the substantive details were unchanged. Childhood immunisation remained free to all children and was a matter of parental choice. In effect what was presented to the public was basically a repackaging of the old procedures with a few ends tidied up. These changes were in line with the demands for greater accountability inherent in the service provision environment engendered by the health reforms as part of the reorganisation of the public sector.

The National Immunisation Strategy was consistent with the individualist climate prevailing in the health sector and in wider society.

D: Environment

The National Immunisation Strategy may have brought little new in the way of policy to the area of childhood immunisation, but the environment which had shaped both the policy determination process and the policy itself also influenced the way in which the strategy was implemented, albeit in rather different ways.

The individualism expressed as economic rationalism in the political arena was expressed as a rejection of authority's power in the public arena. What was responsibility devolving for government was welcomed as increased personal responsibility by some New Zealanders. What was cost containing for the state meant that many New Zealanders lost the advice and support which had once sustained them and allowed them to participate more fully in society.

E: Discussion

Greenhough suggests, as noted in Chapter Six, that maintaining immunisation coverage at appropriate levels, and in a sustainable manner, requires a combination of political will and public demand.¹ The availability of the technology does not alone make immunisation an acceptable or successful health strategy. Other issues including culture, politics and economics also have an

¹ Paul Greenough, 'Global Immunisation and Culture: Compliance and Resistance in Large-Scale Health Campaigns - Introduction', *Social Science and Medicine*, 41 (1995), 605-607.

impact. This thesis argues that the various expressions and effects of individualism in New Zealand's government and society mediate the impact of both political will and public demand in respect of childhood immunisation.

Furthermore, this thesis argues that the acceptance, by the medical establishment, the public and politicians, that childhood immunisation is both a public good and in the public good has mediated the impact of both neo-liberal and civil individualism on the National Immunisation Strategy.

The political will to support universal childhood immunisation has long been established in New Zealand. A regularly updated schedule of vaccines has been available to children since the 1960s, with some vaccines available prior to that date. So when, in the late 1980s and early 1990s, it became clear that there were problems with childhood immunisation, it was expected that changes would be made to improve the situation.

To improve childhood immunisation was one of the PHC's pilot health goals when it was set up in 1992. As such policy and practice were examined and recommendations for modification were made to the Minister of Health. The actions of politicians appeared to support the rhetoric, confirming the presence of political support for childhood immunisation. There were, however, a number of options that could have been adopted in the quest to improve immunisation coverage and reduce the rates of vaccine preventable disease. What was delivered was not a wide ranging reconsideration of the various options available, but instead a continuation of the previous incremental approach to change in the area of childhood immunisation.

As is discussed in Chapter Seven the medical establishment were the principal drivers in putting childhood immunisation on the agenda for review. They were also strongly represented in the review process itself, advocating for process developments which would ensure that the correct vaccines would be delivered to children in a safe and effective way. They did not, however, encourage any but an incremental approach to childhood immunisation policy.

The theory of neo-liberal individualism is predicated on the concept that individuals are rational utility maximisers, that is they are in the best position to

allocate their resources in a manner which produces the greatest benefit, both for themselves and for wider society. Childhood immunisation, however, demonstrates some of the flaws in this argument. Science declares that immunisation prevents potentially serious diseases safely. Although acknowledging that vaccines do have side effects, science indicates that the risk to an individual from vaccine side effects is less than the risk of that individual getting the disease and suffering its side effects. Furthermore, the vaccination of individuals would provide protection for the whole population by preventing the transmission of the disease, thus producing benefits both for individuals and the society of which they are members.

If it is assumed that because science is promoting the course of action, in respect of childhood immunisation, that would produce the greatest utility, then individual's actions in respect of immunisation suggest that the theory of rational utility maximisation is not well founded. A number of factors contribute to individuals assessing their utility differently than would science. First, they may not have access to the information upon which science makes its assessments. Second, they assess risk differently than do scientists. Third, they may rank other preferences ahead of childhood immunisation for these or other unrelated reasons.

The neo-liberal political economic philosophy, however, builds on the rationalist theory and its understanding that individuals make the most efficient use of their resources if they are allowed to make decisions for themselves. From this stance it recommends that the state should, first, not limit individuals' freedom to act according to their own preferences except when their actions would be harmful to others, and second, expect individuals to take personal responsibility for maximising their own welfare. Personal responsibility, as identified by Dworkin and discussed by Minkler,² and discussed in Chapter Two, can be understood in a range of ways, but while this is often promoted as a desire to give individuals the freedom to make their own choices, there is also an element of transferring the cost from the state to the individual.

² Meredith Minkler, 'Personal Responsibility for Health? A Review of the Arguments and Evidence at Century's End,' *Health Education & Behavior*, 26 (1999), 121-140 (p.122).

The state's actions do, however, indicate that it recognises that the rationalist project is flawed. States are involved in the provision of health and other social services, because without state intervention individuals would not have access to certain alternatives which promote individual welfare and also have ramifications for the public good. Childhood immunisation is an example of this.

In New Zealand vaccines and vaccination are provided at no direct cost to the family. There is, however, an expectation that parents have a responsibility to access childhood immunisation services for their child. What is not so clearly acknowledged is that there are factors other than the cost of vaccines and vaccination which act as a barrier to parents fulfilling this perceived responsibility.

So in the development of the National Immunisation Strategy there was a group of participants who considered that individual parents should be expected to take personal responsibility for ensuring that children received vaccinations at the appropriate times. There is no evidence that the government even considered making parents responsible for the direct cost of vaccination. This is in line with the understanding that childhood immunisation is a public good and that the state has a role in providing health services.

There was discussion of enforcing the element of personal responsibility by making childhood immunisation compulsory or introducing punitive measures in situations where children were not being immunised. This suggestion was, however, countered by aspects of civil individualism, there being an understanding among many involved in childhood immunisation that New Zealanders would not tolerate compulsion in respect of childhood immunisation.

This point illustrates that the matter of childhood immunisation is clearly a special case. New Zealanders tolerated compulsion in other public health matters, for example, the wearing of cycle helmets and the banning of certain types of fireworks. However, in the case of childhood immunisation, individual children are being vaccinated and although some of the potential benefits accrue to the child, immunisation is also of benefit to the wider community in contributing to

the so-called herd immunity. More important, however, in contributing to the rejection of compulsion, is the risk of vaccine related side effects, which will impact upon the individual child.

Civil individualism, as discussed in Chapter Two, suggests that at the turn of the millennium individuals are, first, happiness seeking, and second, less accepting of the dictates of authority than they may have been in earlier times. While these aspects of civil individualism were not explicitly recognised in the development of the National Immunisation Strategy, they did have an impact on the environment into which the strategy was implemented.

The two aspects of civil individualism are linked in respect of childhood immunisation. On the one hand individuals are seeking to maximise their happiness or benefit. In doing this they are more concerned with their individual personal benefit from an action, while the effects of these actions on society or the impact of society's benefit upon their happiness is less important than it was in the past. On the other hand individuals are less tolerant than in the past of the dictates of authority. In the case of childhood immunisation this authority may be perceived as the state and/or the medical establishment.

In maximising their happiness individuals are less constrained by scientific or expert opinion than was previously the case. As discussed in Chapter Six lay individuals assess risk in different ways than do scientists, and they are now prepared to act on their own beliefs. They may follow the recommendation of the state and medical science, but many individuals resist efforts to compel them along this line. Hence the rejection of compulsion is related to acknowledged strength of aspects of civil individualism.

The 1992 survey on immunisation coverage, discussed in Chapter Seven, found that 82 percent of parents consider childhood immunisation a good thing. In addition, most New Zealand children begin to have the immunisations recommended. These factors indicate a significant level of public demand for childhood immunisation. However, still New Zealand cannot achieve immunisation coverage rates to halt the transmission of some vaccine preventable diseases and prevent epidemics, for example, of measles and whooping cough.

What then are the factors mediating the impact of Greenhough's requirements for an effective and sustainable immunisation programme? Clearly given the declining number of children completing the immunisation schedule on time, the combination of political will and public demand is not enough. In addition there must be a synergy between what the public demand and what the politicians are willing, or able to provide. There must be a meshing of service provision and consumer need.

It is not so much that neo-liberal individualism had an impact on the National Immunisation Strategy, although that was significant, but rather that neo-liberalism was shaping the environment into which the National Immunisation Strategy was implemented, precipitating the rise of a number of factors which increase the risk that a child will not complete the recommended immunisation schedule.

Individualism was a factor in a range of areas, several of which are significant in this discussion: first, in the provision of health care services; second, the impact of other changes in public policy; third, in the attitudes and expectations of politicians and officialdom as expressed in the rhetoric of childhood immunisation promotion; and fourth, in the assessment of political support.

First, in the provision of health services, the cutting back of services which once provided the support for childhood immunisation had an enormous influence on the viability of the National Immunisation Strategy. Where once families would have ongoing and regular contact with a health care professional, many families no longer have contact with a person who will both inform them about immunisations and its risks and benefits, and remind them when vaccinations are due.

Second, regarding the wider aspects of public policy, which had an impact on individuals' ability to access services for their children, the social and economic determinants of health, are becoming increasingly recognised in public health circles, and link various factors which have changed for some in society as a result of New Zealand's economic reforms, with lower levels of health.

Third, in the changing of public expectations and attitudes, some parents are more aware of their options and alternatives than previously. As a consequence they seek more information upon which to make an informed choice for their child. Part of this is a degree of distrust of the medical establishment, which is linked to the rejection of authority, discussed in Chapter Two and related to civil individualism.

Fourth, childhood immunisation had political support. This health strategy was thought important enough for the government to make improving childhood immunisation coverage a priority. There is no evidence that free immunisation at point of vaccination was ever under threat. In line with neo-liberal economic rationalism political attitudes were that parents should do the right thing and that the government was not in the business of paying people to do the right thing.

There was an emphasis among politicians on parents doing the right thing. That parents have a choice is acknowledged, but the rhetoric used to discuss immunisation indicates that there is a right way and a wrong way to exercise that choice. Punitive actions against those who do not immunise their children have not been introduced, but in their place has been an attempt to create an attitude toward immunisation which replicates a situation where individuals considered the impact their decisions would have on wider society – a tactic which is less likely to find support in increasingly individualist times.

This could be interpreted as the government attempting to manufacture in modern individualist society the behaviour of a society whose members saw within their private responsibilities a duty to the wider society of which they were a member. This is a positive personal individualism. This is a society of which John Ralston Saul, among others, writes. The philosopher d'Epinau makes the point that contemporary individuals are seeking happiness less within society and more in a private realm than did their predecessors. If we accept that interpretation to be accurate, then the political rhetoric is not going to shame parents into immunising their children because their happiness is not dependant on society's approval of their behaviour.

In addition to the direct impact individualism had on the development of childhood immunisation policy, it also had a wider impact on the environment in which that policy was implemented. Neo-liberal individualism and the changes the associated political economic philosophy has introduced to New Zealand have contributed to the factors which are known to increase the risk that children will not complete the recommended immunisations. Some of these factors are perceived to be directly related to low immunisation uptake while other factors are less directly related. These include poverty, benefits as the main household income, poor housing and lack of an ongoing relationship with a health care provider.

The impact that individualism has had on public policy, and consequently on the wider environment, means that it is not possible to consider the failure of the National Immunisation Strategy to achieve its targets to be a result of childhood immunisation policy alone.

IV: Conclusions

This thesis argues that the failure of the National Immunisation Strategy to increase immunisation coverage rates can be explained by the influence individualism has had, not only on the process of the childhood immunisation review and the development of the National Immunisation Strategy, but also on wider political economic environment in which the policy was implemented.

The impact of political will has been mediated by the philosophy guiding the overarching direction of the government's actions and public policy. Furthermore, the adoption of coercive or punitive measures in relation to childhood immunisation would not only run contrary to the political economic philosophy, they would also meet resistance from society as a whole, although for different reasons.

Therefore, in a time of individualism, both political economic and social, the reversal of current trends in immunisation coverage would come at a cost. Such an achievement would require either the sacrifice of some of what a society holds dear in terms of freedom, or major changes in the political economic structure widely vaunted as the preferred approach to political economics.

The first option would involve the loss of the freedom to make choices and/or the freedom from the coercive tactics which characterise childhood immunisation policy in countries which enjoy higher immunisation coverage rates than does New Zealand. The second option is in changing the political economic foundations of what has been labelled the New Zealand way.

The introduction to this thesis identified four issues. First, in a country widely concerned with the rights and responsibilities of the individual, it is of considerable importance to understand how matters of public interest, and the public good, were secured. While it is clear that the state continued to see itself as having a role in securing the public good, it is also apparent that a significant responsibility was implicitly, if not explicitly, devolved to individuals and their families.

The second issue identified in the introduction was to identify which manifestation of individualism had the greatest impact on public policy. It is clear that that the two forms of individualism on which this thesis has focused, neo-liberal and civil individualism, each had a role, in limiting policy options and so in guiding the course of the National Immunisation Strategy. Neo-liberal individualism was the force that drove the government in seeking to promote personal responsibility, but there was also recognition of the limitations civil individualism put on policy options.

The third issues relates to what the public policy community can learn about individualism in New Zealand which will assist it in implementing effective policy. Examination of development of the National Immunisation Strategy suggests that officials in the public policy community were very aware of the limitations civil individualism place on policy options for childhood immunisation. Whether this is, however, a broad understanding of the individualist motivations of New Zealand society, or limited to a specific awareness of New Zealander's preferences in the matter of childhood immunisation is beyond the scope of this thesis to determine.

The fourth issue concerns the role of the state within an individualist society. An examination of childhood immunisation policy suggests that the existence of a

combination of neo-liberal and civil individualism does not preclude the state taking an active roll in regulating activity in the state. What is limited is the impact such regulation can have.

In the period when the National Immunisation Strategy was being developed there was little, if any, attention given to the interactions between aspects of public policy. Policies were developed in isolation, with no regard for the impact they might have on other areas of public policy. Therefore what was produced was an *ad hoc* series of measures, which while they had a philosophical underpinning of neo-liberal individualism, did not have an overarching synthesis which produced a unified approach to how issues of personal responsibility and public good were dealt with.

Neither form of individualism is slavishly followed. There is a balance between the public good aspect of childhood immunisation and the matter of personal responsibility. Childhood immunisation fits into the Treasury's understanding, as set out in its *Briefing to the Incoming Government 1990*, of a desirable health strategy that recognises the need to reduce the pressure on the health sector by having individuals take personal responsibility for maintaining their health, but it also recognises the contribution immunisation makes to public good and consequently, that in view of its dependence on health services the state should take a role in providing immunisation services. This is discussed in Chapter Seven.

In terms of civil individualism, as discussed in Chapter Two, individuals may be less concerned with their responsibilities to wider society, but that aspect does still exist. While parents are likely to be thinking about considering immunisation in terms of protecting their own child, their responsibility to prevent the spread of vaccine preventable diseases is a factor for some parents. Certainly they want other parents to be thinking of this. As for the rejection of authority, as noted in Chapter Two, there are certainly indications that parents want more information, not just that what they have been told is the correct thing to do, but that they want an opportunity to weigh the options and explore the possible sequelae for themselves.

It is here that we see that, in a time of civil individualism, individuals recognise a wider range of influences on their decisions than just those medical science considers to be good.

Here there are a number of limitations. First, there is medical science saying that childhood immunisation is a safe and desirable thing to do. Weighing the benefits and the risks in scientific terms they consider immunisation contributes greatly to the public good. However, if the premise of civil individualism is accepted, the tendency to challenge authority means that many parents are not going to follow the recommendations of science or government without question. In addition their own weighing up of the options is going to include other factors, as has been discussed in terms of lay attitudes to risk.

Second, civil individualism suggests that in making a decision about immunisation parents are going to concentrate on the impact this will, or may, have on their own child, giving less attention to the impact any decision they make may have on other members of society.

Despite the rhetoric about personal responsibility and the role parents should take in ensuring the health of their children, neo-liberal political economic policies made it very difficult to develop and implement a more developed childhood immunisation policy. In addition, the process was driven, as health policy typically is, by the medical establishment who, while bringing scientific logic to the process, are not necessarily reflective of, or incorporating, the political and the social realities of the day.

So New Zealand's childhood immunisation policy, the National Immunisation Strategy, was very much in keeping with the medical model, putting better and safer processes in place. Any deficiencies contained in the policy were, however, exacerbated by the impact of neo-liberal public policy in related social and economic areas, which resulted in reduced levels of support for many New Zealanders and increasing hardship and poverty for a significant number.

It is not that New Zealand needs to adopt compulsion or introduce coercive measures to increase immunisation levels. It is feasible that the medical model approach to childhood immunisation might work in a political economic

environment less focused on economic rationalism. A further alternative would be if New Zealanders were more tolerant of alternative models, a situation which would require a shift in the assumptions which stem from civil individualism.

The lack of resolution between the competing pressures on childhood immunisation is extracting a cost from New Zealanders. The policy developed in a time when neo-liberalism was the prevailing paradigm, affirmed established practices, rather than tackling the serious challenge to develop a rational approach to this very real problem. New Zealanders must, however, decide where it is that they see the best balance lying between individual rights and responsibilities as influenced by both neo-liberal and civil individualism.

Failure to address this balance has had costs in a number of areas of life. In terms of childhood immunisation there are already clear indications that the National Immunisation Strategy, introduced into a neo-liberal political economic environment, is not achieving its target to improve immunisation coverage. As a consequence children will continue to contract vaccine preventable diseases in epidemic proportions.

SCHEDULE OF INTERVIEWS

Baker, Dr Michael, Interview with the author, Porirua, 11 December 1996

Hood, Dell, Interview with the author, Hamilton, 9 April 1996

Mansoor, Osman, Interview with the author, Wellington, 25 October 1995

O'Reagan, Katherine, Interview with the author, Cambridge, 10 November 1995

Pert, Harry, Interview with the author, Rotorua, 23 January 1997

Rawlings, Henriette, Interview with the author, 25 January 1997

Reid, Stewart, Interview with the author, Lower Hutt, 5 March 1997

Rhodes, Ruth, Interview with the author, Hamilton, 19 June 1995

Stewart, Sally, Interview with the author, Wellington, 25 October 1995

Williams, Pamela, Interview with the author, Auckland, 19 December 1996

Wright, Lyn, Interview with the author, 29 November 2000

LIST OF REFERENCES

- Abbott, G., et al., 'Childhood Immunisation in Rotorua [letter]', *NZMJ*, 112 (1999), 454-455
- Ameratunga, S. N., D. R. Lennon, and D. Martin, 'Haemophilus Influenzae type b Disease: Prospects for Prevention in New Zealand', *NZMJ*, 107 (1994), 193-194
- Ameratunga, S. N., et al., 'The Immunogenicity of Haemophilus Influenzae: Meningococcal Protein Conjugate Vaccine in Polynesian and non-Polynesian New Zealand infants', *Journal of Paediatrics & Child Health*, 33 (1997), 138-141
- Anonymous, 'Epidemic Unmasks at-Risk Group', *Health*, 40 (1991), 7-8
- Anonymous, 'Health for All by the Year 2000', *UN Chronicle*, September 1992, 43-58
- Anonymous, 'For Richer, For Poorer', *Economist*, 5 November 1994, 19-23
- Anonymous, 'A Case of Diphtheria in New Zealand', *Communicable Diseases Intelligence*, 22 (1998), 188
- Apperley, Alan, 'Hobbes on Democracy', *Politics*, 19 (1999), 165-171
- Ardern-Holmes, S. L., et al., 'Trends in Hospitalization and Mortality from Rotavirus Disease in New Zealand Infants', *Pediatric Infectious Disease Journal*, 18 (1999), 614-619
- Ashford, Douglas Elliott, *The Emergence of the Welfare States* (Oxford: Blackwell, 1886)
- Ashford, Nigel, 'The Bankruptcy of Collectivism', in *The 'New Right' Enlightenment*, ed. by Arthur Seldon (London: Economic and Literary Books, 1985), pp.33-45
- Ashton, Juliet, 'Measles: Fighting the Epidemic', *Health*, 40 (1991), 4-6
- Ashton, Toni, 'Reform of the Health Services: Weighing up the Costs and Benefits', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.146-168
- Ashton, Toni, 'The Health Reforms: To Market and Back?', in *Redesigning the Welfare State in New Zealand: Problems, Policies, Prospects*, ed. by Johnathan Boston, Paul Dalziel and Susan St John (Auckland: Oxford University Press, 1999), pp.134-153
- Baker, Michael, and Diana Martin, 'Hib Disease Rate Plummet Following Immunisation Programme', *The New Zealand Public Health Report*, 2 (1995), 13-14
- Baker, Michael, and Alison Roberts, 'A New Schedule of Notifiable Diseases for New Zealand', *The New Zealand Public Health Report*, 3 (1996), 33-37
- Banerji, Debabar, 'Hidden Menace in the Universal Childhood Immunisation Programme', *IFDA Dossier 61*, (1987), 55-61

- Banerji, Debabar, 'A Fundamental Shift in the Approach to International Health by WHO, UNICEF, and the World Bank: Instances of the Practice of "Intellectual Facism" and Totalitarianism in Some Asian Countries', *International Journal of Health Services*, 29 (1999), 227-259
- Barnett, P., and L.A. Malcom, 'To Integrate or Disintegrate?: Fitting Public Health into New Zealand's Reforming Health System', *European Journal of Public Health*, 8 (1998), 79-86
- Barnett, J. R., and P. Coyle, 'Social Inequality and General Practitioner Utilisation: Assessing the Effects of Financial Barriers on the Use of Care by Low Income Groups', *NZMJ*, 111 (1998), 66-70
- Barnett, Pauline, and Kerry Jacobs, 'Policy-making in a Restructured State: The Case of the 1991 Health Reform Policy in New Zealand', *Australian Journal of Public Administration*, 59 (2000), 73-86
- Beaglehole, Robert, and Ruth Bonita, *Public Health at the Crossroads: Achievements and Prospects* (Cambridge: Cambridge University Press, 1997)
- Beauchamp, J., and O. Mansoor, 'Temperature and the Storage of Vaccines [letter]', *NZMJ*, 105 (1992), 135
- Beaven, D. W., 'Alternative Medicine a Cruel Hoax--Your Money and Your Life?', *NZMJ*, 102 (1989), 416-417
- Bedford, H., and D. Elliman, 'Concerns About Immunisation', *BMJ*, 320 (2000), 240-243
- Begg, Norman, and Angus Nicoll, 'Myths in Medicine: Immunisation', *BMJ*, 309 (1994), 1073-1075
- Blakely, T., O. Mansoor, and M. Baker, 'The 1996 Pertussis Epidemic in New Zealand: Descriptive Epidemiology', *NZMJ*, 112 (1999), 30-33
- Blakely, T. A., O. Mansoor, and M. Baker, 'The 1996 Pertussis Epidemic in New Zealand: Vaccine Effectiveness', *NZMJ*, 112 (1999), 118-120
- Blank, Robert H., *New Zealand Health Policy: A Comparative Study* (Auckland: Oxford University Press, 1994)
- Bollard, A., and R. Buckle, *Economic Liberalisation in New Zealand* (Wellington: Allen & Unwin/Port Nicholson Press, 1987)
- Bollard, Allan, *New Zealand 1984 - 1991* (San Francisco: International Centre for Economic Growth, 1991)
- Boston, Jonathan, and Martin Holland, *The Fourth Labour Government: Radical Politics in New Zealand* (Auckland: Oxford University Press, 1987)
- Boston, Jonathan, and Fiona Cooper, 'The Treasury: Advice, Coordination, and Control', in *New Zealand Politics in Perspective*, ed. by Hyam Gold, 2nd edn (Auckland: Longman Paul, 1989), pp.123-144
- Boston, Jonathan, 'The Theoretical Underpinnings of Public Sector Restructuring in New Zealand', in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston, et al. (Auckland: Oxford University Press, 1991), pp.1-26

- Boston, Jonathan, 'Redesigning New Zealand's Welfare State', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.1-18
- Boston, Jonathan, et al., *Public Management: The New Zealand Model* (Auckland: Oxford University Press, 1996)
- Braddell, Richard, 'Healthcare at the Crossroads', *New Zealand Herald*, Monday 5 April 1999, D2
- Bradley, P., 'Should Childhood Immunisation be Compulsory?', *Journal of Medical Ethics*, 25 (1999), 330-334
- Bremner, C., et al., 'Epidemic Meningococcal Disease in New Zealand: Epidemiology and Potential for Prevention by Vaccine', *NZMJ*, 112 (1999), 257-259
- Brown, V.A., 'Health Care Policies, Health Policies or Policies for Health', in *Health Policy Development, Implementation and Evaluation in Australia*, ed. by Heather Gardner (Melbourne: Churchill Livingstone, 1992), pp.91-118
- Brown, M. C., 'Policy-induced Changes in Maori Mortality Patterns in the New Zealand Economic Reform Period', *Health Economics*, 8 (1999), 127-136
- Brunner, Eric, and Michael Marmot, 'Social Organization, Stress, and Health', in *Social Determinants of Health*, ed. by Michael Marmot and Richard G. Wilkinson (Oxford: Oxford University Press, 1999), pp.17-43
- Buchanan, James, 'The Economic Theory of Politics Reborn', *Challenge: Magazine of Economic Affairs*, 31 (1988), 4-10
- Bunkle, Phillida, 'The Economy: Restructuring and Growth', in *New Zealand in Crisis: A Debate About Today's Critical Issues*, ed. by David Novitz and Bill Willmott (Wellington: GP Publications, 1992), pp.72-80
- Butler, H., 'Hepatitis B Immunisation [letter]', *NZMJ*, 101 (1988), 464
- Capra, Fritjof, *The Turning Point: Science, Society and the Rising Culture* (New York: Simon and Schuster, 1982)
- Chapman, Robert, 'Political Culture: The Purpose of Party and the Current Challenge', in *New Zealand Politics in Perspective*, ed. by Hyam Gold, 2nd edn (Auckland: Longman Paul, 1989), pp.14-32
- Chetwynd, J., 'Trends in Private Medical Insurance Ownership: Lessons for the Public Sector', *NZMJ*, 102 (1989), 107-109
- Cheyne, Christine, Mike O'Brien, and Michael Belgrave, *Social Policy in Aotearoa New Zealand: A Critical Introduction* (Auckland: Oxford University Press, 1997)
- Chisholm, Donna, 'Vaccine Boy's Mum Angry at Ban', *Sunday Star-Times*, Sunday 2 April 1995, A2
- Coburn, David, 'Income Inequality, Social Cohesion and the Health Status of Populations: The Role of Neo-liberalism', *Social Science and Medicine*, 51 (2000), 135-146

- Cole, D., and I. St George, 'Medicine at the Fringes', *NZMJ*, 106 (1993), 130-133
- Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters, *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (Auckland: The Committee, 1988)
- Commonwealth Department of Health and Family Services, *The Australian Immunisation Handbook*, 6th edn (Canberra: Commonwealth Department of Health and Family Services, 1997)
- Communicable Disease New Zealand, *Immunisation Coverage in New Zealand*. Vol. 92: Suppl 2 (Porirua: New Zealand Communicable Disease Centre, 1992)
- Coney, Sandra, and Phillida Bunkle, 'The Unfortunate Experiment at National Women's Hospital', *Metro*, June 1987, 46-54
- Coney, Sandra, *The Unfortunate Experiment* (Auckland: Penguin, 1988)
- Coney, Sandra, 'Unfinished Business: The Cartwright Report Five Years On', in *Unfinished Business: What Happened to the Cartwright Report*, ed. by Sandra Coney (Auckland: Women's Health Action, 1993), pp.19-49
- Crittenden, Jack, *Beyond Individualism: Reconstituting the Liberal Self* (New York: Oxford University Press, 1992)
- Crocombe, Graham T., Michael J. Enright, and Michael E. Porter, *Upgrading New Zealand's Competitive Advantage* (Auckland: Oxford University Press, 1991)
- Cumming, Jacqueline, 'Core Services and Priority Setting: The New Zealand Experience', *Health Policy*, 29 (1994), 41-60
- Cumming, Jacqueline, and George Salmond, 'Reforming New Zealand Health Care', in *Markets and Health Care: A Comparative Analysis*, ed. by Wendy Ranade (New York: Addison Wesley Longman, 1998), pp.122-146
- d'Epinay, Christian Lalive, 'Individualism and Solidarity Today: Twelve Thesis', *Theory Culture and Society*, 8 (1991), 57-74
- Dalziel, Paul, 'Policies for a Just Society', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.208-223
- Dalziel, Paul, 'The Reserve Bank Act: Reflecting Changing Relationships Between the State and the Economy in the Twentieth Century', in *State and Economy in New Zealand*, ed. by Brian Roper and Chris Rudd (Auckland: Oxford University Press, 1993), pp.74-90
- Danzon, Patricia, and Susan Begg, *Options for Health Care in New Zealand: Report for the New Zealand Business Roundtable* (Wellington: The Roundtable, 1991)
- Dare, Tim, 'Immunisation Free-riders Take Health Benefits Without Paying', *New Zealand Herald*, Monday 22 September 1997, A13
- Davey, Sheila, *State of the World's Vaccines and Immunization* (Geneva: World Health Organization and UNICEF, 1996)

Deacon, Alan, and Kirk Mann, 'Agency, Modernity and Social Policy', *Journal of Social Policy*, 28 (1999), 413-435

Dennehy, Penelope H., Erica E. Jost, and Georges Peter, 'Active Immunizing Agents', in *Textbook of Pediatric Infectious Diseases*, ed. by Ralph D. Feigin and James D. Cherry, 4th edn. Vol. 2 (Philadelphia: W.B. Saunders Company, 1998), pp.2731-2795

Department of Health, *Health in the 1990s: Issues, Options and Opportunities* (Wellington: Department of Health, 1990)

Department of Health, *Principles and Guidelines for Informed Choice and Consent for all Health Care Providers and Planners* (Wellington: Department of Health, 1991)

Department of Health, *Immunisation Strategic Options: Report of the Department of Health Immunisation Working Group* (unpublished, 1991)

Department of Statistics, *1976 Census of Population and Dwellings*. Vol. 7 (Wellington: New Zealand Department of Statistics, 1976)

Department of Statistics, *1991 Census of Population and Dwellings* (Wellington: New Zealand Department of Statistics, 1992)

Department of Vaccines and Biologicals, *Vaccines, Immunization and Biologicals: 2000-2003 Strategy* (Geneva: World Health Organization, 2000)

Department of Vaccines and Other Biologicals, *Report of the First Meeting of Interested Partners to the Health Technology and Pharmaceuticals Cluster* (Geneva: World Health Organization, 1999)

Dew, Kevin, *The Measles Vaccination Campaigns in New Zealand, 1985 and 1991: The Issues Behind the Panic*, Victoria University of Wellington, Department of Sociology and Social Work Working Papers No. 10. (Wellington: Victoria University of Wellington, 1995)

Dew, Kevin, *Borderland Practices : Validating and Regulating Alternative Therapies in New Zealand* (unpublished doctoral thesis, Victoria University Of Wellington, 1998)

Dew, Kevin, 'Epidemics, Panic and Power: Representations of Measles and Measles Vaccines', *Health*, 4 (1999), 379-398

Dialogue Consultants, *Analysis of Submissions on the Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy* (Wellington, 1993)

Dobbie, Mary, *The Trouble With Women: The Story of Parents Centre New Zealand* (Whatamongo Bay: Cape Catley, 1990)

Dow, Derek A., *Annotated Bibliography for the History of Health and Medicine in New Zealand* (Dunedin: University of Otago, 1994)

Dow, Derek A., *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington: Victoria University Press, 1995)

Dow, D. A., and O. Mansoor, 'New Zealand Immunisation Schedule History', *NZMJ*, 109 (1996), 209-212

- Duclos, Philippe, and Adwoa Bensti-Enchill, 'Risks and Benefits of Immunisation', *Current Therapeutics*, 34 (1994), 17-27
- Durie, Mason, *Whaiora: Māori Health Development* (Auckland: Oxford University Press, 1994)
- Easton, Brian, 'How did the Health Reforms Blitzkrieg Fail?', *Political Science*, 46 (1994), 215-233
- Easton, Brian, *The Commercialisation of New Zealand* (Auckland: Auckland University Press, 1997)
- Essex, Charles, Paul Smale, and David Geddes, 'Immunisation Status and Demographic Characteristics of New Zealand Infants at 1 Year and 2 Years of Age', *NZMJ*, 108 (1995), 244-246
- Essex, C., P. Tuohy, and M. Hunter, 'Non-immunisation of Children: Book Dispelling Immunisation Myths is Available [letter]', *BMJ*, 310 (1995), 940
- Essex, Charles, and Patrick G. Tuohy, *Immunisation: Questions and Answers* (Dunedin: The Royal New Zealand Plunket Society, 1996)
- Family Health Unit, *A Health Professional's Guide to Age-Sex Registers and Privacy in Primary Care Services* (Hamilton: Midland RHA, 1995)
- Fancourt, R., 'Child Health in Times of Social and Economic Change', *NZMJ*, 110 (1997), 95-97
- Farmer, K., et al., 'Measles Control [letter]', *NZMJ*, 110 (1997), 195
- Federation of Women's Health Councils Aotearoa-New Zealand, *Is Cartwright Still an Issue?* (Auckland: A Federation of Women's Health Councils Discussion Document, 1993)
- Fenner, F., et al., *Smallpox and its Eradication* (Geneva: World Health Organisation, 1988)
- Finlayson, Mary, *An Analysis of the Implementation of Health Policy in New Zealand, 1991-1996* (unpublished doctoral thesis, University of Waikato, 1996)
- Fougere, Geoffrey M., *Exit and Voice and the Decay of the Welfare State: Provision of Hospital Care* (unpublished master's thesis, University of Canterbury, 1974)
- Fraser, Graeme, 'An Examination of Factors in the Development of New Zealand's Health System', in *In the Public Interest: Health, Work and Housing in New Zealand*, ed. by Chris Wilkes and Ian Shirley (Auckland: Benton Ross, 1984), pp.53-75
- Gabe, Jonathan, David Kelleher, and Gareth Williams, *Challenging Medicine* (London: Routledge, 1994)
- Gabe, Jonathan, and Michael Bury, 'Risking Tranquilizer Use: Cultural and Lay Dimensions', in *Modern Medicine: Lay Perspectives and Experiences*, ed. by Simon J. Williams and Michael Calnan (London: UCL Press, 1996), pp.74-94
- Galapitage, Chandra, *Health Expenditure Trends in New Zealand 1980-1998* (Wellington: Ministry of Health, 1999)

- Galloway, Y., and P. Stehr-Green, 'Measles in New Zealand', *Communicable Disease NZ*, (1991), 107-109
- Galloway, Y., and P. Stehr-Green, 'Surveillance for Measles--New Zealand, 1991', *Morbidity & Mortality Weekly Report. CDC Surveillance Summaries*, 41 (1992), 13-17
- Galloway, Yvonne, 'Briefing Papers from the New Zealand Communicable Disease Centre: Surveillance of Vaccine-Preventable Diseases', in *National Immunisation Strategy Working Group Background Papers Volume II*, ed. (Wellington: Public Health Commission, 1993), pp.
- Gardner, Heather, and Simon Barraclough, 'The Policy Process', in *Health Policy: Development, Implementation, and Evaluation in Australia*, ed. by Heather Gardner (Edinburgh: Churchill Livingstone, 1992), pp.3-28
- Geison, Gerald L., *The Private Science of Lois Pasteur* (New Jersey: Princeton University Press, 1995)
- Gilbert, Judy, 'Vaccination: Professional Issue, Personal Dilemma', *Health and Living*, February/March 1991 1991, 30-33
- Giuffrida, A., and H. Gravelle, 'Paying Patients to Comply: An Economic Analysis', *Health Economics*, 7 (1998), 569-579
- Goldfinch, Shaun, and Brian Roper, 'Treasury's Role in State Policy Formulation During the Post-War Era', in *State and Economy in New Zealand*, ed. by Brian Roper and Chris Rudd (Auckland: Oxford University Press, 1993), pp.50-73
- Goldfinch, Shaun, 'Treasury and Public Policy Formation', in *The Political Economy of New Zealand*, ed. by Chris Rudd and Brian Roper (Auckland: Oxford University Press, 1997), pp.60-76
- Goldwater, P. N., 'History of Hepatitis B Vaccination in New Zealand: Lessons for Australia?', *Australian Journal of Public Health*, 17 (1993), 221-225
- Goodwin, Linda, *The Rise and Fall of the Public Health Commission* (unpublished master's thesis, University of Waikato, 1997)
- Gould, John, 'Past and Present in New Zealand's Economic Dependence', in *New Zealand in the World Economy*, ed. by Hyam Gold (Dunedin: The Papers of the Nineteenth Foreign Policy School 1984, University of Otago, 1985), pp.8-16
- Grant, Ruth W., 'Locke's Political Anthropology and Lockean Individualism', *Journal of Politics*, 50 (1988), 42-63
- Grant, C. C., et al., 'A Comparison of Two Pertussis Epidemics in Auckland', *NZMJ*, 110 (1997), 182-184
- Grant, C. C., C. B. Forrest, and B. Starfield, 'Primary Care and Health Reform in New Zealand', *NZMJ*, 110 (1997), 35-39
- Greenough, Paul, 'Global Immunisation and Culture: Compliance and Resistance in Large-Scale Health Campaigns - Introduction', *Social Science and Medicine*, 41 (1995), 605-607
- Gregory, Robin, Paul Slovic, and James Flynn, 'Risk Perceptions, Stigma, and Health Policy', *Health and Place*, 2 (1996), 213-220

- Gustafson, B., *From the Cradle to the Grave: A Biography of Michael Joseph Savage* (Auckland: Penguin, 1988)
- Hall, R., and A.L.J. Williams, 'Special Advisory Service for Immunisation', *Archives of Disease in Childhood*, 63 (1988), 1498-1500
- Hall, Robert, and Eddie O'Brien, *Immunisation Myths and Realities: Responding to Arguments Against Immunisation*, 2nd edn (Canberra: Commonwealth Department of Health and Family Services, 1998)
- Hampton, Jean, *Hobbes and the Social Contract Tradition* (Cambridge: Cambridge University Press, 1986)
- Hardy, I. R., D. R. Lennon, and E. A. Mitchell, 'Measles Epidemic in Auckland 1984-85', *NZMJ*, 100 (1987), 273-275
- Hawe, Penelope, Deirdre Degeling, and Jane Hall, *Evaluating Health Promotion* (Sydney: MacLennan and Petty, 1990)
- Haworth, Nigel, 'Neo-liberalism, Economic Internationalism and the Contemporary State in New Zealand', in *Leap into the Dark: The Changing Role of the State in New Zealand Since 1984*, ed. by Andrew Sharp (Auckland: Auckland University Press, 1994), pp.19-40
- Hay, Iain, *The Caring Commodity: The Provision of Health Care in New Zealand* (Auckland: Oxford University Press, 1989)
- Hayek, Friedrich A., *Individualism and Economic Order* (London: Routledge and Kegan Paul, 1948)
- Heal, Andrew, 'Jane Kelsey', *Metro*, June 1996, 94-97
- Health Benefits Review, *Choices for Health Care: Report of the Health Benefits Review* (Wellington: The Review, 1986)
- Health Funding Authority / Ministry of Health, *Vaccine Changes August 2000: Information for Vaccinators and Administrators* (Wellington: Health Funding Authority /Ministry of Health, 2000)
- Heisler, M. B., and J. B. Richmond, 'Lessons from Finland's Successful Immunization Program', *New England Journal of Medicine*, 331 (1994), 1446-1447
- Helman, Tony, 'Young Doctors Welcome Alternative Treatments', *New Zealand Doctor*, 15 July 1991, 25
- Hemenway, David, 'Economics of Childhood Immunization', *Economic Inquiry*, 32 (1994), 519-523
- Hemenway, David, 'Financial Incentives for Childhood Immunisation', *Journal of Policy Analysis and Management*, 14 (1995), 133-139
- Henderson, R.H, 'Vaccination: Successes and Challenges', in *Vaccination and World Health*, ed. by Felicity T. Cutts and Peter G. Smith (Chichester: John Wiley and Sons, 1994), pp.3-16
- Henderson, D. A., 'Vaccination Policies and Practices', *Australian Journal of Public Health*, 19 (1995), 634-638
- Hickling, S., 'Tetanus Immunisation', *NZMJ*, 86 (1977), 529-530

- Hill, Terrel, Robert Kim-Farley, and Jon Rohde, 'Expanded Programme on Immunization: A Goal Achieved Toward Health for All', in *Reaching Health for All*, ed. by Jon Rohde, Meera Chatterjee and David Morley (Delhi: Oxford University Press, 1993), pp.402-422
- Hofstede, Geert, *Cultures and Organisations: Software of the Mind* (London: Harper Collins, 1991)
- Hood, Dell, 'The National Hepatitis B Immunisation Working Party', *Seminar Presented in the Department of Community Health, School of Medicine, University of Auckland*, (1988)
- Horsman, John, and Susan St John, *Economic Concepts: An Introduction* (Auckland: Longman Paul, 1992)
- Hospital and Related Services Taskforce, *Unshackling the Hospitals: Report of the Hospital and Related Services Taskforce* (Wellington: The Taskforce, 1988)
- Howarth, J., 'Global Eradication of Polio by 2000 is not a Realistic Goal', *BMJ*, 313 (1996), 627
- Howden-Chapman, Philippa, and Fiona Cram, *Social, Economic and Cultural Determinants of Health* (Wellington: National Health Committee, 1998)
- Hutt, Marten, and Philippa Howden-Chapman, *Old Wine in New Bottles: The Public Health Commission and the Making of New Zealand Alcohol Policy* (Wellington: Institute of Policy Studies for the Dept. of Public Health, Wellington School of Medicine in conjunction with the Health Services Research Centre, 1998)
- Illich, Ivan, *Limits to Medicine* (New York: Penguin, 1977)
- Jackson, G., et al., 'Severe Outbreak of Meningococcal Disease in Auckland [letter]', *NZMJ*, 100 (1987), 226
- James, Colin, *The Quiet Revolution: Turbulence and Transition in Contemporary New Zealand* (Wellington: Allen & Unwin / Port Nicholson Press, 1986)
- James, Colin, *New Territory: The Transformation of New Zealand 1984-92* (Wellington: Bridget Williams Books, 1992)
- Jefferies, C., et al., 'Meningococcal Disease in Auckland, July 1992 - June 1994', *NZMJ*, 112 (1999), 115-117
- Jesson, Bruce, 'Politics: In Praise of Conservatism', *Metro*, October 1988, 198-201
- Jesson, Bruce, Allanah Ryan, and Paul Spoonley, *Revival of the Right: New Zealand Politics in the 1980s* (Auckland: Heinemann Reed, 1988)
- Jesson, Bruce, 'The Almost Uncontested Victory of the Libertarian Right', *The Republican*, July 1988, 7-14
- Jesson, Bruce, *Fragments of Labour: The Story Behind the Labour Government* (Auckland: Penguin, 1989)
- Johnson, F., et al., 'Measles at an International Gymnastics Competition: Indiana, 1991', *Mortality and Morbidity Weekly Report*, 41 (1992), 109-111

- Johnston, Grant, and Audrey Teasdale, *Population Ageing and Health Spending: 50-year Projections, Occasional Paper No.2* (Wellington: Ministry of Health, 1999)
- Jones, Sue, 'Depth Interviewing', in *Applied Qualitative Research*, ed. by Robert Walker (Aldershot: Dartmouth, 1993), pp.45-55
- Jones, D. G., 'Aging, Dementia and Care: Setting Limits on the Allocation of Health Care Resources to the Aged', *NZMJ*, 110 (1997), 466-468
- Kane, Francis, *Neither Beasts nor Gods: Civic Life and the Public Good* (Dallas: Southern Methodist University Press, 1988)
- Kawachi, I., and B.P. Kennedy, 'Socio-economic Determinants of Health: Health and Social Cohesion: Why Care About Income Inequality?', *BMJ*, 314 (1997), 1037
- Kedgley, Sue, *Mum's the Word: The Untold Story of Motherhood in New Zealand* (Auckland: Random House, 1996)
- Kelleher, David, Jonathan Gabe, and Gareth Williams, 'Understanding Medical Dominance in the Modern World', in *Challenging Medicine*, ed. by Jonathan Gabe, David Kelleher and Gareth Williams (London: Routledge, 1994), pp.xi-xxix
- Kelsey, Jane, *Rolling Back the State: Privatisation of Power in Aotearoa/New Zealand* (Wellington: Bridget Williams Books, 1993)
- Kelsey, Jane, *The New Zealand Experiment: A World Model for Structural Adjustment* (Auckland: Auckland University Press & Bridget Williams Books, 1995)
- Kennedy, Ian, *The Unmasking of Medicine* (London: George Allen and Unwin, 1981)
- Ketcham, Ralph, *Individualism and Public Life: A Modern Dilemma* (New York: Basil Blackwell, 1987)
- King, Desmond S., *The New Right: Politics, Markets and Citizenship* (London: Macmillan, 1987)
- King, Annette, *The Future Shape of Primary Health Care: A Discussion Document* (Wellington: Ministry of Health, 2000)
- King, Annette, *The New Zealand Health Strategy: A Discussion Document* (Wellington: Ministry of Health, 2000)
- Koopman-Boyden, Peggy, and Claudia Scott, *The Family and Government Policy in New Zealand* (Sydney: George Allen & Unwin, 1984)
- Koopman-Boyden, Peggy, 'Social Policy: Has There Been One?', in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.213-231
- Krieble, Todd, 'The Rise and Fall of the Crown Entity: A Case Study of the Public Health Commission', *Public Sector*, 20 (1997), 19-22
- Laugesen, Miriam and George Salmond, 'New Zealand Health Care: A Background', *Health Policy*, 29 (1994), 11-23

- Le Grand, Julian, 'Knights, Knaves or Pawns?: Human Behaviour and Social Policy', *Journal of Social Policy*, 26 (1997), 149-169
- Legat, Nicola, 'Measles on Elm Street', *Metro*, December 1991, 92-101
- Leibrich, Julie, Janet Hickling, and George Pitt, *In Search of Well-being: Exploratory Research into Complementary Therapies* (Wellington: Department of Health, 1987)
- Lennon, D., et al., 'An Outbreak of Meningococcal Disease in Auckland, New Zealand', *Pediatric Infectious Disease Journal*, 8 (1989), 11-15
- Lennon, D., et al., 'The Case for Haemophilus Influenzae type b Vaccination in New Zealand', *Communicable Disease New Zealand* 1992, 92 (1992), 89-96
- Lennon, D., et al., 'Successful Intervention in a Group A Meningococcal Outbreak in Auckland, New Zealand', *Pediatric Infectious Disease Journal*, 11 (1992), 617-623
- Lennon, Diana, 'Immunisation: Where's the Controversy', *Patient Management*, December 1992, 33-37
- Lennon, D., et al., 'Control of Epidemic Group A Meningococcal Disease in Auckland', *NZMJ*, 106 (1993), 3-6
- Lennon, Diana, and Stewart Reid, 'Childhood Immunisation in New Zealand', *NZMJ*, 107 (1994), 171-172
- Lennon, D., et al., 'Control of Whooping Cough in New Zealand; Slow Progress', *NZMJ*, 108 (1995), 495-497
- Lennon, D., and S. Reid, 'Control of Pertussis', *NZMJ*, 109 (1996), 283-284
- Lukes, Steven, *Individualism* (Oxford: Basil Blackwell, 1973)
- Lukes, Steven, *Essays in Social Theory* (London: Macmillan Press, 1977)
- Macpherson, C.B., *The Political Theory of Possessive Individualism: Hobbes to Locke* (London: Oxford University Press, 1962)
- Malcolm, Murray, 'Immunisation Surveillance: A Comparison of Four Methods in Canterbury', *NZMJ*, 106 (1993), 221-223
- Malcolm, Laurence, 'Inequities in Access to and Utilisation of Primary Medical Care Services for Māori and Low Income New Zealanders', *NZMJ*, 109 (1996), 356-358
- Manent, Pierre, *An Intellectual History of Liberalism* (Princeton: Princeton University Press, 1994)
- Manent, Pierre, 'On Modern Individualism', *Journal of Democracy*, 7 (1996), 3-10
- Manoor, Ossi, Personal communication with the author, 17 December 1999
- Mansoor, O. D., 'Ask and You Shall be Given: Practice Based Immunisation Coverage Information', *NZMJ*, 106 (1993), 504-505
- Mansoor, Ossi, Letter to Expert Working Group Participants, 5 February 1993
- Mansoor, O., 'DTPH vaccine', *NZMJ*, 107 (1994), 382
- Mansoor, O. D., 'Immunisation: Sacred Cow or Evidence Based Medicine?', *NZMJ*, 109 (1996), 171-172

- Mansoor, O., and P. I. Pillans, 'Vaccine Adverse Events Reported in New Zealand 1990-5', *NZMJ*, 110 (1997), 270-272
- Mansoor, O., G. Durham, and M. Tobias, 'Can New Zealand Eliminate Measles?', *NZMJ*, 110 (1997), 387-388
- Mansoor, O., D. Sarfati, and G. Durham, 'Is Confidence in Immunisation Declining?', *NZMJ*, 111 (1998), 300
- Mansoor, O., et al., 'A Measles Epidemic Controlled by Immunisation', *NZMJ*, 111 (1998), 467-471
- Mansoor, O. D., 'Selective Evidence was used to Support Link Between Immunisation and Asthma', *BMJ*, 318 (1999), 193
- Mansoor, O., and S. Reid, 'The Future of the Immunisation Schedule: Recommendations of a Workshop', *NZMJ*, 112 (1999), 52-55
- Martin, John, 'Remaking the State Services', in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.123-139
- Mascarenhas, R.C., 'State-owned Enterprises', in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston and et.al. (Auckland: Oxford University Press, 1991), pp.27-51
- Matheson, Clare, *Fate Cries Enough* (Auckland: Sceptre, 1989)
- McGuigan, T., *A Health Service for New Zealand* (Wellington: Government Printer, 1975)
- McKinlay, Peter, *Corporatisation: The Solution for State Owned Enterprise?*, 2nd edn (Wellington: Victoria University Press for the Institute of Policy Studies, 1987)
- McLean, F.S., *Challenge for Health* (Wellington: Government Printer, 1964)
- McLean, Iain, *Public Choice: An Introduction* (Oxford: Basil Blackwell, 1987)
- McLeod, D., R.D. Bowie, and M. Kljakovic, 'The Cost of Childhood Immunisation in General Practice', *NZMJ*, 111 (1998), 73-76
- McLoughlin, David, 'How Bad is Our Health?', *North and South*, September 1996, 68-82
- McMurrin, Sterling M., 'Ideas and the Processes of History', in *The Abdication of Philosophy: Philosophy and the Public Good*, ed. by Eugene Freeman (Illinois: Open Court, 1976), pp.109-128
- McNicholas, Anne, and Michael Baker, 'Immunisation Coverage in New Zealand: Ongoing Surveillance Using Benefit Claim Data', *The New Zealand Public Health Report*, 2 (1995), 3
- McNicholas, Anne, Nick Garrett, and Melissa Perks, *Immunisation Coverage Surveillance Using Benefit Claim Data* (Wellington: Ministry of Health, 1999)
- Midha, Arun, and Michael Sullivan, 'The Need to Redefine the Practice of Health Promotion in the United Kingdom', *Health Policy*, 44 (1998), 19-30
- Mill, J.S., *On Liberty* (London: David Campbell, 1972)

Milne, A., et al., 'Mass Vaccination Against Hepatitis B in Preschool Children: Immunogenicity After Three Reduced Doses', *NZMJ*, 102 (1989), 429-430

Milne, A., et al., 'Hepatitis B Vaccine boosters: Further Studies In Children', *NZMJ*, 103 (1990), 539-541

Minister of Health, 'Press Release: Policy Guidelines to the Public Health Commission', 25 November 1992

Ministry of Health, *Guidelines to Regional Health Authorities* (Wellington: Ministry of Health, 1994/95, 1996/97)

Ministry of Health, *National Immunisation Strategy 1995* (Wellington: Ministry of Health and the Public Health Commission, 1995)

Ministry of Health, *Policy Guidelines for Regional Health Authorities* (Wellington: Ministry of Health, 1995/96)

Ministry of Health, *Immunisation Handbook*, 2nd edn (Wellington: Ministry of Health, 1996)

Ministry of Health, 'Press Release: Ministry of Health does not Recommend the Routine Uses of Chicken Pox Vaccine', 31 January 1997

Ministry of Health, 'Press Release: Cuban Vaccine Development Experts Visit New Zealand', 13 October 2000

Ministry of Health, 'Press Release: Progress Continues Toward Development of Meningococcal Vaccine', 10 November 2000

Ministry of Maori Development, *Progress Towards Closing Social and Economic Gaps Between Maori and Non-Maori: A Report to the Minister of Maori Affairs* (Wellington: Te Puni Kokiri, 1998)

Ministry of Maori Development, *Progress Towards Closing Social and Economic Gaps between Maori and Non-Maori: A Report to the Minister of Maori Affairs*. (Wellington: Te Puni Kokiri, 2000)

Minkler, Meredith, 'Personal Responsibility for Health? A Review of the Arguments and Evidence at Century's End', *Health Education & Behavior*, 26 (1999), 121-140

Mitchell, Austin, *Politics and People in New Zealand* (Christchurch: Whitcombe and Tombs, 1969)

Mueller, Dennis C., *Public Choice* (Cambridge: Cambridge University Press, 1979)

Muraskin, W., 'Bucking the Health Establishment: Alexander Milne and the Fight for a New Zealand Hepatitis B Immunization Program', *Social Science & Medicine*, 41 (1995), 211-225

Murphy, Laurence, 'Housing Policy', in *Redesigning the Welfare State in New Zealand: Problems, Policies and Prospects*, ed. by Jonathan Boston, Paul Dalziel and Susan St John (Auckland: Oxford University Press, 1999), pp.218-237

Muthmala, D., and C.G. McKendry, *Health Expenditure Trends in New Zealand: 1980-1991* (Wellington: Department of Health, 1992)

National Advisory Committee on Core Health and Disability Support Services / Public Health Commission, *Tamariki Ora: A Consensus Development Conference Report on Well Child Care to the National Advisory Committee on Core Health and Disability Support Services and the Public Health Commission* (Wellington: The Committee, 1993)

National Health Committee. Terms of Reference. 1998. Available: <http://www.nhc.govt.nz/about/terms.htm>.

National Health Committee, *Review of the Wisdom and Fairness of the Health Funding Authority Strategy for Immunisation of 'Hard to Reach' Children* (Wellington: National Health Committee, 1999)

Neville, Pam, 'Measles Shock', *New Zealand Woman's Weekly*, 2 September 1991 1991, 39

New Zealand Natural Health Practitioners Accreditation Board, *Nationwide Register of Natural Therapists* (Auckland, 1997)

New Zealand Parliamentary Debates, 1992

Newport, M.J., and S.P. Conway, 'Experience of a Specialist Service for Advice on Childhood Immunisation', *Journal of Infection*, 26 (1993), 295-300

Nichter, Mark, 'Vaccinations in the Third World: A Consideration of Community Demand', *Social Science & Medicine*, 41 (1995)

Nicoll, A., D. Elliman, and N. T. Begg, 'Immunisation: Causes of Failure and Strategies and Tactics for Success', *BMJ*, 299 (1989), 808-812

North Health, *Immunisation Coverage in North Health* (Auckland: North Health, 1997)

Nutbeam, Don, 'Consumers not Patients: The Application of Social Marketing Principles to the Improvement of Immunisation Uptake', *Immunisation: The Old and the New* (Canberra: PHAA, 1991), pp.12-16

OECD, 'New Zealand', in *The Reform of Health Care Systems: A Review of Seventeen OECD Countries*, ed. (Paris: OECD, 1994), pp.227-242

Orenstein, Walter A., et al., 'Immunization', in *Mandell, Douglas and Bennett's Principles and Practice of Infectious Disease*, ed. by Gerald L. Mandell, John E. Bennett and Raphael Dolin, 4th edn. Vol. 2 (New York: Churchill Livingstone, 1995), pp.2770-2790

Palmer, George R., and Stephanie D. Short, *Health Care and Public Policy: An Australian Analysis*, 2nd edn (Melbourne: Macmillan, 1994)

Patten, Dean, Sandy Brinsdon, and Ray Kirk, *Increasing Childhood Immunisation Coverage: An Investigation of Strategies for Improving Delivery to Specific Population Groups* (Wellington: Department of Health, 1993)

Pawson, Eric, 'The State and Social Policy', in *Changing Places: New Zealand in the Nineties*, ed. by Richard Le Heron and Eric Pawson (Auckland: Longman Paul, 1996), pp.210-246

Pert, H., 'Immunisation Strategies [letter]', *NZMJ*, 106 (1993), 262

Pert, H., 'An Immunisation Success Story', *NZMJ*, 112 (1999), 327

- Peters, Michael, 'Postmodernity and Neo-liberalism: Restructuring Education in Aotearoa', *Delta*, 47 (1993), 47-62
- Peters, Michael, and James Marshall, *Individualism and the Community: Education and Social Policy in the Postmodern Condition* (London: Falmer Press, 1996)
- Pillans, Peter, 'Post-Marketing Surveillance: The Role of the GP', *New Ethicals*, October 1994, 9-15
- Pillans, P. I., and D. M. Coulter, 'Centre for Adverse Reactions Monitoring report for the year ending 30 June, 1993', *NZMJ*, 107 (1994), 490-493
- Pillans, P. I., and D. M. Coulter, 'Centre for Adverse Reactions Monitoring report for the year ending 30 June, 1994', *NZMJ*, 108 (1995), 488-491
- Pillans, P., 'National Centre for Adverse Reactions Monitoring report for the period 1 July, 1994 to 3 June, 1996', *NZMJ*, 110 (1997), 383-385
- Plotkin, Stanley A., and Edward A. Mortimer, *Vaccines* (Philadelphia: W.B.Saunders, 1988)
- Plotkin, Susan L., and Stanley A. Plotkin, 'A Short History of Vaccination', in *Vaccines*, ed. by Stanley A. Plotkin and Edward A. Mortimer (Philadelphia: W.B.Saunders, 1988), pp.1-7
- Plotkin, Stanley A., and Walter A. Orenstein, eds., *Vaccines*, 3rd edn (Philadelphia: W.B. Saunders Company, 1999)
- Poata-Smith, Evan Te Ahu, 'The Political Economy of Inequality Between Maori and Pakeha', in *The Political Economy of New Zealand*, ed. by Chris Rudd and Brian Roper (Auckland: Oxford University Press, 1997), pp.166-179
- Public Health Commission, ed., *National Immunisation Strategy Working Group Background Papers*, Vol. I, 1993)
- Public Health Commission, ed., *National Immunisation Strategy Working Group Background Papers*, Vol. II, 1993)
- Public Health Commission, *A Strategic Direction to Improve and Protect the Public Health: The Public Health Commission's Advice to the Minister of Health, 1993-1994* (Wellington: Public Health Commission, 1994)
- Public Health Commission, *Immunisation: The Public Health Commission's Advice to the Minister of Health* (Wellington: Public Health Commission, 1994)
- Public Health Commission and the Expert Working Group, *Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy: Recommendations of a Workshop Held on 17 and 18 February 1993* (Wellington: Public Health Commission, 1993)
- Putnam, Richard, *Making Democracy Work: Civic Traditions in Modern Italy* (Princeton: Princeton University Press, 1993)
- Radical Statistics Group, 'NHS "Indicators of Success": What Do They Tell Us?', *BMJ*, 310 (1995), 1045-1050
- Ramadas, Dharmalingam, Christopher Moyes, and Gnani Ramadas, 'Immunisation Status of Children in the Eastern Bay of Plenty', *NZMJ*, 105 (1992), 378-379

- Raymond, Jan, 'Homeopathy: Examining the Evidence', *New Ethicals*, 30 (1993), 36-49
- Richardson, J., and I. Robertson, *Ageing and the Cost of Health Services*, Working Paper 90 (Melbourne: Centre for Health Program Evaluation, 1999)
- Rogers, Anne, and David Pilgrim, 'The Risk of Resistance: Perspectives on the Mass Childhood Immunisation Programme', in *Medicine, Health and Risk*, ed. by Jonathan Gabe (Oxford: Basil Blackwell, 1995), pp.73-90
- Roper, Brian, 'The Changing Class Structure', in *The Political Economy of New Zealand*, ed. by Chris Rudd and Brian Roper (Auckland: Oxford University Press, 1997), pp.79-99
- Ross, Jean C., A History of Poliomyelitis in New Zealand (unpublished masters thesis, University of Canterbury, 1993)
- Royal Commission on Social Policy, *The April Report: Report of the Royal Commission on Social Policy*. Vol. 1-5 (Wellington: The Commission, 1988)
- Rudd, Chris, 'Politics and Markets: The Role of the State in the New Zealand Economy', in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.83-100
- Ryan, A., 'Hobbes and Individualism', in *Perspectives on Thomas Hobbes*, ed. by G.A.J. Rogers and A. Ryan (Oxford: Clarendon Press, 1988), pp.81-105
- Ryan, Kath, and Harriet Denz Penhey, 'Qualitative Research in Medical Practice', *NZMJ*, 109 (1996), 87-88
- Saks, M., 'The Alternatives to Medicine', in *Challenging Medicine*, ed. by Jonathan Gabe, David Kelleher and Gareth Williams (London: Routledge, 1994), pp.84-103
- Salmond, George, 'Circular Letter: Hepatitis B Immunisation Programme', 9 February 1988
- Salmond, George, 'The Role of Health Outcomes in Health Sector Reforms', *Health Development and Policy Programme Conversation/Seminar Series*, University of Waikato, 28 September 1995
- Salmond, C., P. Crampton, and F. Sutton, 'NZDep91: A New Zealand Index of Deprivation', *Australian & New Zealand Journal of Public Health*, 22 (1998), 835-837
- Saul, John Ralston, *Voltaire's Bastards: The Dictatorship of Reason in the West* (Ontario: Penguin Books, 1993)
- Saul, John Ralston, *The Unconscious Civilization* (New York: Free Press, 1997)
- Schmidtz, David, and Robert Goodin, *Social Welfare and Individual Responsibility: For and Against* (Cambridge: Cambridge University Press, 1998)
- Scott, Claudia, 'The 1985 Tax Reform Package', in *The Fourth Labour Government: Radical Politics in New Zealand*, ed. by Jonathan Boston and Martin Holland (Auckland: Oxford University Press, 1987), pp.184-197

- Scott, Alister, Letter to John Eastwood, Department of Health, printed in full in the Background Papers for the Expert Working Group on Childhood Immunisation, 28 August 1991
- Scott, Claudia D., 'Reform of the New Zealand Health Care System', *Health Policy*, 29 (1994), 25-40
- Seedhouse, David, *Health: The Foundations for Achievement* (Chichester: John Wiley and Sons, 1986)
- Segal, L., 'The Importance of Patient Empowerment in Health System Reform', *Health Policy*, 44 (1998), 31-44
- Sharma, Ursula, *Complementary Medicine Today: Practitioners and Patients* (London: Routledge, 1992)
- Sharp, Andrew, 'The Case for Politics and the State in New Zealand: An Introduction', in *Leap into the Dark: The Changing Role of the State in New Zealand Since 1984*, ed. by Andrew Sharp (Auckland: Auckland University Press, 1994), pp.1-18
- Sheldon, T., 'Netherlands Faces Measles Epidemic', *BMJ*, 320 (2000), 76
- Shipley, Jenny, Immunisation 2000: Address to the Royal New Zealand Plunket Society's Annual General Meeting, Christchurch Town Hall, 29 March 1995
- Short, Stephanie, 'Elective Affinities: Research and Health Policy Development', in *Health Policy in Australia*, ed. by Heather Gardner (Melbourne: Oxford University Press, 1997), pp.65-82
- Short, Stephanie, 'Editorial: On the Tension Between Individual Health Rights and Public Health Responsibilities', *Australian and New Zealand Journal of Public Health*, 21 (1997), 245-246.
- Shroff, Marie, 'Supporting Central Government Through the Change', in *The Constitutional Implications of MMP*, ed. by Alan Simpson (Palmerston North: Dunmore Press, 1998), pp.14-26
- Simpson, Tony, *A Vision Betrayed: The Decline of Democracy in New Zealand* (Auckland: Hodder and Stroughton, 1984)
- Simpson, N., S. Lenton, and R. Randall, 'Parental Refusal to have Children Immunised: Extent and Reasons', *BMJ*, 310 (1995), 227
- Skegg, David, 'Foreword', in *Report of the Expert Working Group to the Public Health Commission on the National Immunisation Strategy*, ed. (Wellington: Public Health Commission, 1993)
- Smith, Adam, *An Inquiry into the Nature and Causes of the Wealth of Nations*
- Smith, Adam, *The Theory of Moral Sentiments*
- Social Services Committee, '1994/95 Financial Review - Ministry of Health', in *Reports of Select Committees on the 1994/95 Financial Reviews of Government Departments and Offices of Parliament, I.23C*, ed. (Wellington: New Zealand House of Representatives, 1996), pp.
- Stanley, Ian, 'Foreword', in *Liberating Medicine*, ed. by David Seedhouse (Chichester: Wiley and Sons, 1990), pp.xi-xii

- Stehr-Green, Paul, et al., 'How Well are We Protecting Our Children? An Immunisation Coverage Survey in Hawkes Bay', *NZMJ*, 105 (1992), 277-279
- Stephens, Bob, 'Budgeting with the Benefit Cuts', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.100-125
- Stephens, Robert, Charles Waldegrave, and Paul Frater, 'Measuring Poverty in New Zealand', *Social Policy Journal of New Zealand*, (1995), 88-111
- Stephens, Robert, Charles Waldegrave, and Paul Frater, 'Measuring Poverty: Some Rebuttals of Easton', *Social Policy of New Zealand*, (1997), 181-185
- Streeflanda, Pieter, A.M.R. Chowdhuryb, and Pilar Ramos-Jimenezc, 'Patterns of Vaccination Acceptance', *Social Science & Medicine*, 49 (1999), 1705-1716
- Taylor, Annette, 'A Shot in the Dark?', *Next*, 1992, 102-107
- Tesh, Sylvia Noble, *Hidden Arguments: Political Ideology and Disease Prevention Policy* (New Brunswick: Rutgers University Press, 1988)
- Tobias, M., et al., 'Chickenpox Immunisation in New Zealand', *NZMJ*, 111 (1998), 274-281
- Tocqueville, Alexis de, *Democracy in America*, rev. edn (London: David Campbell Publishers, 1994)
- Touraine, Alain, 'Social Transformations of the Twentieth Century', *International Social Science Journal*, 50 (1998), 165-171
- Townshend, P. L., J. D. Sellman, and R. Haines, 'The Cartwright Report Ten Years On: The Obligations and Rights of Health Consumers and Providers', *NZMJ*, 111 (1998), 390-393
- Treasury, *Economic Management* (Wellington: Treasury, 1984)
- Treasury, *Government Management: Brief to the Incoming Government 1987* (Wellington: Treasury, 1987)
- Treasury, *Briefing to the Incoming Government* (Wellington: Treasury, 1990)
- Tucker, David F.B., *Essay on Liberalism: Looking Left and Right* (Dordrecht: Kluwer Academic Publishers, 1994)
- Tully, Elizabeth, and Belinda Mortlock, 'Professionals and Practices', in *Health and Society in Aotearoa New Zealand*, ed. by Peter Davis and Kevin Dew (Auckland: Oxford University Press, 1999), pp.165-180
- Turner, Bryan, 'Individualism, Capitalism and the Dominant Culture: A Note on the Debate', *The Australian and New Zealand Journal of Sociology*, 24 (1988), 47-64
- Turner, Nikki, et al., 'Improving Immunisation Coverage: What Needs to be Done?', *New Zealand Public Health Report*, 7 (2000), 11-14
- Upton, Simon, *Your Health and the Public Health: A Statement of Government Health Policy* (Wellington: Minister of Health, 1991)

Upton, Simon, Address to the Health Promotion Forum, Auckland, 24 October 1991

Upton, Simon, 'Memorandum to Cabinet: The Medicines Regulations 1984, Amendment No. 5', March 1992

Vickers, Geoffrey, *Freedom in a Rocking Boat: Changing Values in an Unstable Society* (Harmondsworth: Penguin Books, 1972)

Voss, L., D. Lennon, and M. Gillies, 'Haemophilus Influenzae type b Disease in Auckland Children 1981-87', *NZMJ*, 102 (1989), 149-151

Voss, Lesley, 'Neonatal BCG Vaccine', *NZMJ*, 108 (1995), 373-374

Vowles, Jack, and Peter Aimer, *Voters Vengeance: The 1990 Election in New Zealand and the Fate of the Fourth Labour Government* (Auckland: Auckland University Press, 1993)

Vowles, Jack, et al., *Toward Consensus: The 1993 Election in New Zealand and the Transition to Proportional Representation* (Auckland: Auckland University Press, 1995)

Vowles, Jack, and James Lamare, 'Party Interests, Public Opinion and Institutional Preferences: Electoral System Change in New Zealand', *Australian Journal of Political Science*, 31 (1996), 321-345

Vowles, Jack, 'Aspects of Electoral Studies, Present and Past: New Zealand Voters and "the System"', *Political Science*, 50 (1998), 90-110

Waldegrave, Charles, Robert Stephens, and Paul Frater, 'Most Recent Findings in the New Zealand Poverty Measurement Project', *Social Work Review*, 8 (1996), 22-24

Wall, Ann, 'Conclusion', in *Health Care Systems in Liberal Democracies*, ed. by Ann Wall (London: Routledge, 1996), pp.183-199

Walsh, Pat, 'A Family Fight? Industrial Relations Reform Under the Fourth Labour Government', in *The Making of Rogernomics*, ed. by Brian Easton (Auckland: Auckland University Press, 1989), pp.149-170

Walsh, Pat, 'The State Sector Act 1988', in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston, et al. (Auckland: Oxford University Press, 1991), pp.52-80

Walsh, Pat, and Jonathan Boston, 'Introduction', in *Reshaping the State: New Zealand's Bureaucratic Revolution*, ed. by Jonathan Boston, et al. (Auckland: Oxford University Press, 1991), pp.ix-xii

Walsh, Pat, 'The Employment Contracts Act', in *The Decent Society?: Essays in Response to National's Economic and Social Policies*, ed. by Jonathan Boston and Paul Dalziel (Auckland: Oxford University Press, 1992), pp.59-76

Walsh, Pat, and Peter Brosnan, 'Redesigning Industrial Relations: The Employment Contracts Act and its Consequences', in *Redesigning the Welfare State in New Zealand: Problems, Policies, Prospects*, ed. by Jonathan Boston, Paul Dalziel and Susan St John (Auckland: Oxford University Press, 1999), pp.117-133

- Walt, Gill, *Health Policy: An Introduction to Process and Power* (Johannesburg: Witwatersrand University Press, 1994)
- Walton, Jo Ann, 'Qualitative Health Research Methods', in *Social Dimensions of Health and Disease: New Zealand Perspectives*, ed. by John Spicer, Andrew Trlin and Jo Ann Walton (Palmerston North: Dunmore Press, 1994), pp.276-294
- White, Gillian Eyres, and Alex N. Thomson, 'As Every Good Mother Should'. Childhood Immunization in New Zealand: A Qualitative Study', *Health and Social Care*, 3 (1995), 73-82
- Whynes, David K., and Darrin L. Bains, 'Income-based Incentives in UK General Practice', *Health Policy*, 43 (1998), 15-31
- Wilkinson, Richard, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996)
- Williams, Michael, 'The Political Economy of Privatisation', in *The Fourth Labour Government: Politics and Policy in New Zealand*, ed. by Martin Holland and Jonathan Boston (Auckland: Oxford University Press, 1990), pp.140-164
- Williams, Simon J., and Michael Calnan, 'Modern Medicine and the Lay Populace: Theoretical Perspectives and Methodological Issues', in *Modern Medicine: Lay Perspectives and Experiences*, ed. by Simon J. Williams and Michael Calnan (London: UCL Press, 1996), pp.2-25
- Williams, Simon J., and Michael Calnan, 'Conclusions: Modern Medicine and the Lay Populace in Late Modernity', in *Modern Medicine: Lay Perspectives and Experiences*, ed. by Simon J. Williams and Michael Calnan (London: UCL Press, 1996), pp.256-264
- Willmott, Bill, 'Conclusion', in *New Zealand in Crisis: A Debate About Today's Critical Issues*, ed. by David Novitz and Bill Willmott (Wellington: GP Publications, 1992), pp.245-250
- Wilson, Nicholas, et al., 'Meningococcal Disease Epidemiology and Control in New Zealand', *NZMJ*, 108 (1995), 437-442
- Wood, Ellen Meiksins, *Mind and Politics: An Approach to the Meaning of Liberal and Socialist Individualism* (Berkeley: University of California Press, 1972)
- Wooding, Paul, 'New Zealand in the International Economy', in *State and Economy in New Zealand*, ed. by Brian Roper and Chris Rudd (Auckland: Oxford University Press, 1993), pp.91-107
- World Bank, *World Development Report 1993: Investing in Health* (New York: Oxford University Press, 1993)
- World Health Organization, 'The State of World Health, 1995', *Journal of Public Health Policy*, 16 (1995), 440-451
- World Health Organization, *Global Polio Eradication: Progress 2000* (Geneva: World Health Organization, 2000)
- World Health Organization / UNICEF, *State of the World's Vaccines and Immunization* (Geneva: WHO/UNICEF, 1996)

Wright, Peter F., 'Global Immunisation - A Medical Perspective', *Social Science and Medicine*, 41 (1995), 609-616

Yolton, John W., *The Locke Reader* (Cambridge: Cambridge University Press, 1977)

Zweifel, P., S. Felder, and M. Meier, 'Aging of the Population and Health Care Expenditure: A Red Herring?', *Health Economics*, 8 (1999), 485-496

APPENDIX I

National Immunisation Strategy Working Group Background Papers

Volumes I & II, Tables of Contents only.

National Immunisation Strategy Working Group

Background Papers Volume I

1. 'Schematic: Four Major Groups Identified on the Basis of their Attitudes and Behaviour about Immunisation'
2. Lennon, Diana, 'Immunisation: Where's the Controversy?', *Patient Management*, December 1992, 33-37
3. Department of Health Immunisation Working Group, *Immunisation Strategic Options: Report of the Department of Health Immunisation Working Group* (Wellington: Department of Health, 1991)
4. Harrison, G. P., and G. A. Durham, 'The 1991 Measles Epidemic: How Effective is the Vaccine?', *NZMJ*, 105 (1992), 280-282
5. Action Report 1989 (UK), 'Conclusions and Recommendations', in *National Immunisation Study* (1989), pp.39-43
6. 'Standards for Pediatric Immunization Practices (USA)', pp.4 & 7-15.
7. Rabo, Erik, and John Taranger, 'Scandinavian Model for Eliminating Measles, Mumps, and Rubella', *British Medical Journal*, 289 (1984), 1402-1404
8. Jarman, J. N., 'Children Hospitalised with Pertussis in the Bay of Plenty', *NZMJ*, 105 (1992), 340
9. 'Immunisation by Plunket Nurses'
10. Essex, C., A. M. Counsell, and D. C. Geddis, 'Immunization Status and Demographic Characteristics of New Zealand Infants in the First 6 Months of Life', *Journal of Paediatrics & Child Health*, 29 (1993), 379-383
11. Graham, David, 'Well-Child Care and the Health Reforms' (unpublished, 1993)
12. Editorial, 'Immunisation policy: recipes for success', *Lancet*, 2 (1987), 78-80
13. Nicoll, A., D. Elliman, and N. T. Begg, 'Immunisation: Causes of Failure and Strategies and Tactics for Success', *BMJ*, 299 (1989), 808-812
14. White, J. M., et al., 'Vaccine Coverage: Recent Trends and Future Prospects', *BMJ*, 304 (1992), 682-684
15. Jarman, B., et al., 'Uptake of Immunisation in District Health Authorities in England', *British Medical Journal Clinical Research Ed.*, 296 (1988), 1775-1778
16. Begg, N. T., and J. M. White, 'A Survey of Pre-school Vaccination Programmes in England and Wales', *Community Medicine*, 10 (1988), 344-350

17. Carrangis, John, 'The Development of the South Australian Immunisation Campaign From its Origins to 1990', *Immunisation: The Old and the New, Second National Immunisation Conference* (Canberra: Public Health Association of Australia, 1991), pp.25-26
18. Nutbeam, Don, 'Consumers not Patients: The Application of Social Marketing Principles to the Improvement of Immunisation Uptake', *Immunisation: The Old and the New, Second National Immunisation Conference* (Canberra: Public Health Association of Australia, 1991), pp.12-16
19. Victorian Health Department, *The Victorian School Entry Immunisation Scheme* (Victoria: Health Department, year unknown)
20. Doherty, Glenn, 'Executive Summary', in *Programme Evaluation: Final Report on the Department of Health and the Maori Women's Welfare League South Auckland Immunisation Promotion Pilot Programme*, ed. (Wellington: Department of Health, 1992), pp.2
21. Vimpani, Graham, 'Computer-assisted Immunisation Registries: The British Experience', *Immunisation: The Old and the New, Second National Immunisation Conference* (Canberra: Public Health Association of Australia, 1991), pp.38-41
22. Ross, E., and N. Begg, 'Child Health Computing [editorial]', *BMJ*, 302 (1991), 5-6
23. Begg, N. T., O. N. Gill, and J. M. White, 'COVER (Cover of Vaccination Evaluated Rapidly): Description of the England and Wales Scheme', *Public Health*, 103 (1989), 81-89
24. Jefferies, S., et al., 'Low Immunization Uptake Rates in an Inner-city Health District: Fact or Fiction?', *Journal of Public Health Medicine*, 13 (1991), 312-317
25. Loeser, H., et al., 'The Organization and Evaluation of a Computer-assisted, Centralized Immunization Registry', *American Journal of Public Health*, 73 (1983), 1298-1301
26. Soljak, M. A., and S. Handford, 'Early Results from the Northland Immunisation Register', *NZMJ*, 100 (1987), 244-246
27. Soljak, M. A., 'Immunisation Registration [letter]', *NZMJ*, 100 (1987), 666
28. Soljak, M. A., 'How Many Children are Fully Immunised?', *NZMJ*, 97 (1984), 37-39
29. Mansoor, O.D., *Practice Based Immunisation Coverage Information* (Unpublished, 1992)
30. Colver, A., 'Immunisation and General Practice [letter]', *Lancet*, 1 (1989), 906
31. Reid, J. S., and H. J. Graham-Smith, 'Childhood Immunisations: A Recall System is Worthwhile', *NZMJ*, 97 (1984), 688-689
32. Scott, David J, O. Ralph Wiles, and Ian D. Kirkby, 'A General Practice Audit of Childhood Morbilli Vaccination', *The New Zealand Family Physician*, (1987), 126-127

- Berridge, Paul, 'Wanganui Immunisations for 1987', *The New Zealand Family Physician*, 15 (1988), 147 [not numbered or included in the Table of Contents]
33. Carson, Selwyn, 'Routine, Opportunistic Health Surveillance of Infants and Children in General Practice', *The New Zealand Family Physician*, (1992), 127-129
 34. 'Immunisation Schedules from England and Wales, WHO, Australia, Netherlands and USA
 35. Ellis-Pegler, R. B., 'Vaccination for Children: So Many Changes', *NZMJ*, 102 (1989), 342-344
 36. Lennon, Diana, et al., 'The Case for Haemophilus Influenzae Type b Vaccination in New Zealand', *Communicable Disease New Zealand*, 92 (1992), 89-97
 37. Mansoor, Ossi, and Gillian Durham, 'Does Control of Pertussis Need Rethinking?', *Communicable Disease New Zealand*, 91 (1991), 43-48
 38. Hood, D. A., and I. R. Edwards, 'Meningococcal Vaccine--Do Some Children Experience Side Effects?', *NZMJ*, 102 (1989), 65-67
 39. Tuohy, P. G., 'Guillain-Barre Syndrome Following Immunisation with Synthetic Hepatitis B Vaccine [letter]', *NZMJ*, 102 (1989), 114-115
 40. Butler, H., 'Hepatitis B Immunisation [letter]', *NZMJ*, 101 (1988), 464
 41. Reid, Stewart, 'Surveillance of Adverse Reactions to Vaccination', (1993)
 42. Beauchamp, J., and O. Mansoor, 'Temperature and the Storage of Vaccines [letter]', *NZMJ*, 105 (1992), 135
 43. Wellington Area Health Board, *The Transport and Storage of Vaccines in the Wellington Region*
 44. Expanded Programme on Immunization, 'Contraindications for Vaccines used in EPI', *Weekly Epidem.Rec.*, (1988), 279-281
 45. Levy's Report on Measles, pp.2-3.

Notes and Comments from

Dr P.G. Tuohy,
B. Docherty
Dr Don Bandaranayake
June Robinson
Dr Gabrielle Collison
Dr Jonathan Jarman
Dr Chris Moyes
Phil Shoemack
Elaine Boyd
Dr Charlotte Paul
Dr Nigel Dickson
Gay Williams

National Immunisation Strategy Working Group

Background Papers Volume II

Briefing Papers from the New Zealand Communicable Disease Centre:

Baker, Michael, *A Framework for Immunisation Surveillance*, January 1993

Matheson, Don, and Alexander Bolotovskiy, *Investigation of the New Zealand Cold Chain: Preliminary Report*, February 1993.

Baker, Michael, *Further Analysis from the National Immunisation Coverage Survey: Preliminary Report*, February 1993.

Baker, Michael, *Use of Immunisation Benefit Claims Data for Immunisation Coverage Surveillance: Preliminary Report*, February 1993.

Reid, Stewart, *Surveillance of Adverse Reactions to Vaccination*, January 1993

Galloway, Yvonne, *Surveillance of Vaccine-Preventable Diseases*, February 1993.

National Advisory Committee on Core Health and Disability Support Services / Public Health Commission, *Tamariki Ora: A Consensus Development Conference Report on Well Child Care to the National Advisory Committee on Core Health and Disability Support Services and the Public Health Commission - Draft only*, (Wellington: The Committee, 1993), pp.14-23

Collison, Gabrielle, 'Northland Area Health Board Immunisation Register', (1993)

Salmond, Clare, and Don Bandaranayake, 'Memorandum to the Immunisation Workshop on Hepatitis B Immunisation Coverage in New Zealand.',

Bandaranayake, Don, 'The Case for a National Immunisation Register', in *Discussion Paper for the Public Health Commission*, ed. , 1992), pp.

'Immunisation Delivery Mechanisms: Tirohanga Hauora', in *The Department of Health and the Maori Women's Welfare League South Auckland Immunisation Promotion Pilot Programme Report*, pp.86-91

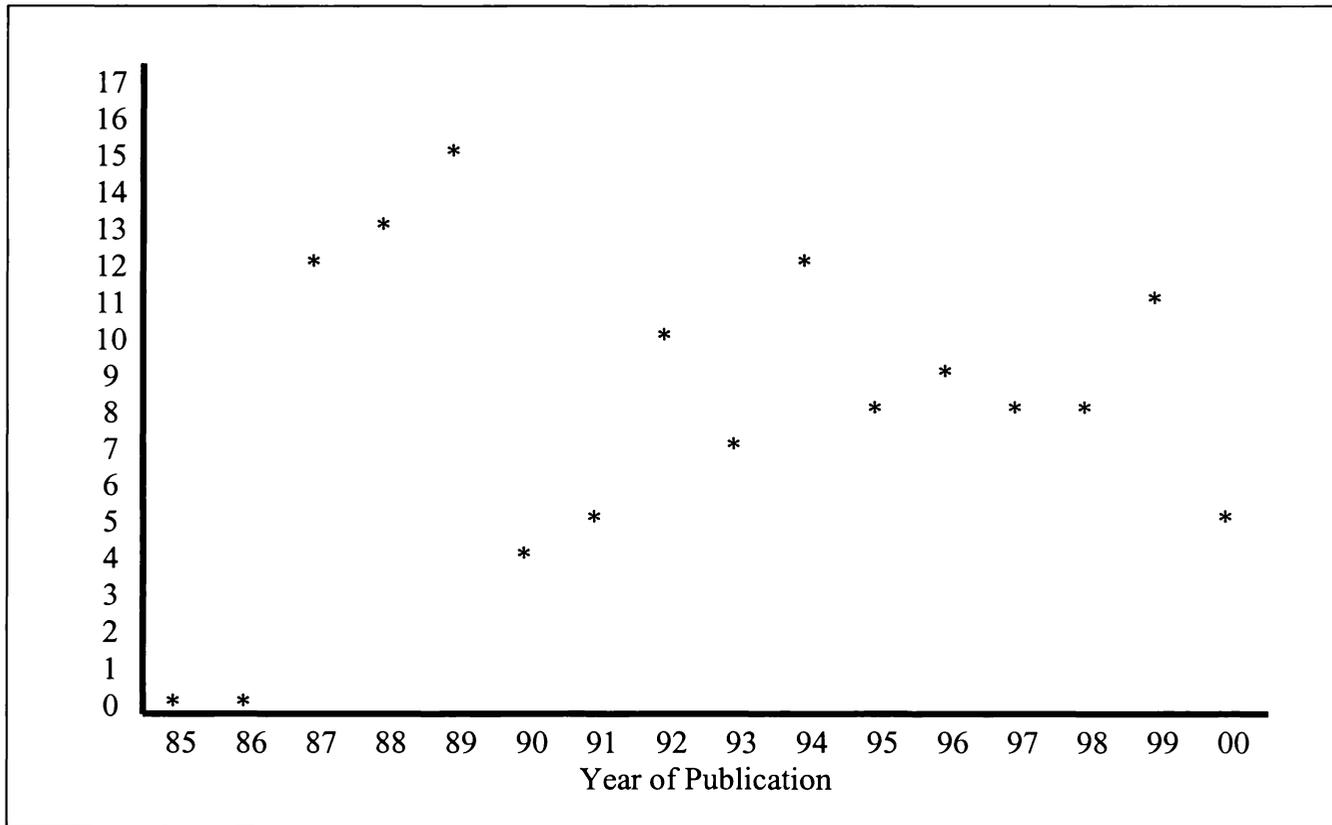
Letters from Dr Harry Pert

Dr Alister Scott x 2

APPENDIX II

Table and Graph of childhood immunisation related articles and letters published in the *NZMJ* 1985-1999.

year	letters	articles	total
1985	-	-	0
1986	-	-	0
1987	7	5	12
1988	7	6	13
1989	5	10	15
1990	3	1	4
1991	1	4	5
1992	3	7	10
1993	3	4	7
1994	6	6	12
1995	3	5	8
1996	6	3	9
1997	2	6	8
1998	0	8	8
1999	4	7	11



Childhood Immunisation Related Articles and Letters Published in the *NZMJ* 1985-1999.