Improving New Zealand’s health system performance: Challenges for the way forward

Robin Gauld

Summary: This article discusses New Zealand’s present health system of publicly-funded District Health Boards, created in 2000. The system has a number of features that place it at the forefront of developed world nations. Yet, at the outset, there were suggestions that it could be too unwieldy for a country of four million people. Unfortunately, these suggestions have been borne out, with an increasingly complex set of structures that have failed to perform well. Compounding the complexity have been parallel developments such as introduction, from 2002, of new Primary Health Organisations. A new centre-right coalition government, elected in late-2008, faces several health policy challenges including health system performance, quality, information technology and workforce sustainability.

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New Zealand’s health care system has several commonalities with selected European and Organisation for Economic Co-operation and Development (OECD) countries. Access to most services is universal and underwritten by government funding drawn from general taxes. This funding contributes almost 80% of total health care expenditure. Public hospitals dominate and are free of any patient charges. Private hospitals provide mainly elective procedures, occasionally on contract to the public system. Public hospital specialists are salaried, but most also work in private practice. In contrast, general practitioners (GPs), who serve as gatekeepers within the system, are almost entirely in private practice. Since the 1930s, GPs have received substantial government subsidies to reduce direct patient charges. In 2008, health expenditure was around 9.2% of Gross Domestic Product (GDP). Over the past decade, real expenditure grew at 4.3% per annum, above the OECD average of 4%.

As discussed elsewhere, New Zealand’s health system endured a succession of reforms commencing in the late-1980s. An unsuccessful attempt in the early-1990s to create a market-based system of competing purchasers and providers was followed, after the 1996 election, by installation of a single national purchaser. In 1999, a new Labour-led coalition government sought to distance itself from the market and...
corporate hospital management structures of the 1990s. In 2000, it created twenty-one District Health Boards (DHBs), which are devolved planning and purchasing bodies and the nucleus of the present health system. Each is governed by seven elected and up to four appointed members and has a chief executive and supporting staff. DHB core funding is based on population characteristics with adjustments for age, ethnicity, disease prevalence and so forth. Within this funding, each DHB is responsible for planning and purchasing the full range of services for their respective local populations, from primary and disability support services through to hospital care (mostly from public hospitals which DHBs own). Thus, DHBs must prioritise expenditure. Underpinning DHB planning is a series of national health goals set out in the New Zealand Health Strategy.

The DHB system, in many ways, sets New Zealand apart from developed world counterparts. First, it represents a genuine attempt to plan and develop services aimed to improve population health and reduce inequalities in both service access and outcomes. Second, concepts of local participation and involvement are central to the system, from the predominantly elected boards through to requirements that DHB meetings are open to the public and that DHBs consult widely in planning and decision making. Third, DHBs are expected to collaborate with one other and other sectors to improve community health.

From the outset, there were questions about the design of the DHB system, particularly the large number, for a small country, of separate planning and purchasing bodies. To reduce the impact of restructuring, the DHBs were built around existing hospital governance structures. As such, they differ considerably in shape and size. The largest serve populations of over 350,000, the smallest 30,000. Yet each is required to maintain the same administrative structures, perform a common task set and respond to national policy goals. Due to this, and requirements for collaboration, the DHBs swiftly created four inter-regional ‘shared services’ agencies as well as a national coordinating organisation, District Health Boards New Zealand (DHBNZ).

In 2001, compounding questions about health system design, which are discussed below, the Labour-led government introduced its Primary Health Care Strategy. Key aims of this were to create new Primary Health Organisations (PHOs) designed to coordinate ongoing patient care, plan for population health care needs and reduce financial and other primary care access barriers, particularly for the most disadvantaged. Created between 2002–2006, and based on WHO Alma Ata principles of ‘comprehensive primary care’, PHOs are not-for-profit, multi-disciplinary organisations serving an enrolled population. Creation followed a ‘let all the flowers bloom’ model, whereby any entity that fulfilled a set of minimum standards was permitted to become a PHO. PHO funding is capitation-based, although many continue to reimburse general practitioners (GPs) on fee-for-service basis. Additional PHO funding is available for developing ‘care plus’ programmes for management of chronic disease patients, for ‘services to improve access’, and for health promotion. There are presently some eighty PHOs with 97% of New Zealanders enrolled.

The primary care reforms were, in many ways, a lost opportunity. They were an attempt by a government, suspicious of private medicine and medical dominance of primary care, to subsume GPs and their Independent Practitioner Associations (IPAs) under PHOs rather than to work with them. IPAs are GP groups that developed through the 1990s and achieved considerable clinical and organisational gains. The IPAs vowed not to be undone, but also had the infrastructural capacity required by many PHOs and so grew in power. Consequently, rather than resulting in a uniform set of organisations, the primary care landscape has become increasingly complex. Like the DHB sector there are large and small PHOs with varying capacity, each required to fulfill the same administrative and service development functions. Reflecting this, and again requirements for collaboration, at least a half-dozen ‘representative’ bodies have emerged in addition to sixteen IPAs that provide management support services.

Performance of the health system

With the DHB system and PHO structures now well-established, questions are mounting about how well the New Zealand health system is functioning and whether it is capable of performing at a higher level.

The core planning, purchasing and service delivery structures have failed to perform well. Despite considerable funding increases through the 2000s (70% in real terms), the DHBs continue to struggle. Deficits (or insufficient funding for services delivered) have been an ongoing problem for various DHBs, creating considerable challenges during funding negotiations with the government. Some DHBs have been placed under ‘intensive monitoring’ by the government while they have worked to reduce expenditure and balance their budgets. This, of course, has meant government intervention in DHB activities. A cost control ethos has surrounded the DHBs, restricting potential for broadening the scope of activities to include other sectors or new services; they have remained mostly focused on maintaining crucial hospital services. Some DHBs have sought to contract out services such as laboratory testing, or revoked a tradition of providing free laboratory services for private patients.

The funding problems have been reflected in elective service waiting lists. New Zealand was among the first to implement a scoring and booking system for non-urgent treatments, which has remained troubled. Elective service access has been static since 2000 in spite of funding and staff increases. Under government pressure to meet treatment time targets, DHBs have resorted to ‘dumping’ booked patients from their lists. A 2008 investigation found that eight patients had died due to ‘avoidable delays’ in heart surgery at one DHB. Another showed vast regional inequities in cardiac service access, declining rates of intervention (37% below England, 75% below Canada and 85% below Australia) and inconsistent use of prioritisation assessment tools and the booking system.

A 2005 Treasury analysis indicated that DHB hospital efficiency had declined by 2.6% per annum from 2000/01 to 2003/04 but had increased by 1.1% percent per annum in the prior three years when the single purchasing agency (the former Health Funding Authority) was in place. In its 2008 brief to the new government, the Ministry of Health gave little reason to believe DHB efficiency had improved. Indeed, its advice was that better integration and planning of services was needed, especially across the ‘four regions’ that represent the purchasing districts in place in the early-1990s.

The DHBs have produced mixed performances in other areas. Performance, as measured against population health targets introduced in 2007, has improved. Life expectancy, infant and cardiovascular mor-
tality rates have improved in the 2000s, although economic advancement may have contributed to this. Inequalities between Maori and other New Zealanders are reducing, along with smoking rates and incidence of obesity. This said, several DHBs have failed to perform across various population health indicators.13

As already indicated, PHOs were something of an afterthought. PHO implementation was hasty and driven largely by financial incentives, with detail worked out through the implementation process. The arrival of PHOs means there are now two sets of organisations – PHOs and DHBs – at different levels within the New Zealand health system planning for a common population. Probably only a third of DHBs appreciate the potential contribution of primary care to health systems and public health and so in many regions PHOs lack crucial support from their funders.

Patient fees have come down and access to GPs has improved,5 although a quarter of New Zealanders continue to experience cost-related access difficulties.14 Furthermore, it remains unclear how much the government expects patients to pay to see a GP (ideally, there should be no fee as with public hospitals) or how it intends to regulate fees in the longer-term. Similarly, there is no clarity over whether PHOs should manage extended patient care and budgets; whether they might take on some DHB purchasing functions; whether there should be fewer, larger PHOs; and whether or not these should be territorial monopolies.

The DHB performances point to questions about whether the governance model is adequate. As noted, public involvement was one of the rationales for the present structures. Yet voter turnout at DHB elections has routinely been under 50%, while the quality of elected board members has sometimes been questionable.15 Furthermore, DHB boards are required under legislation to be accountable not to voters but to the Minister of Health.

Issues for the new government
Late-2008 saw the election of a new centre-right National–Party led coalition government, which faces multiple health policy challenges. The new government has shifted the political focus from population health to hospital waiting lists, ‘value for money’, and clinical leadership concepts as outlined in England’s ‘Darzi report’.16 At the time of writing (August 2009), there have been a number of post-election developments.

Most importantly, the financial situation for DHBs has deteriorated with only six not in deficit. A third are considered ‘at risk’, meaning remedial action has been required to justify continued deficit financing. This, of course, has added to suspicions that the DHB system is unwieldy, and underscores suggestions that the DHBs might be more efficient if some functions were centralised.17 The new government’s initial response has not only been to allocate to health an additional $750 million per annum (an extra 6% or so to the health budget) for the next three years,18 but also to ask serious questions about the health system, with a Ministerial Review Group commissioned for this task. Other developments include a pledge to build twenty elective surgery ‘super centres’, intended specifically to improve access; suggestions that DHBs could be sacked if they fail to improve cancer waiting times; and that they should work more closely together, e.g. for ‘back office’ functions such as information technology and with shared clinical services, especially in regions where access to specialist services is problematic. Many DHBs had already been pursuing shared arrangements.

Beyond this, various other challenges, sidelined over the years by the focus on structural change, demand the new government’s attention. First, there has been inadequate attention to quality, problems with which are estimated to account for around 30% of expenditure.19 A 2007 study highlighted widespread variations in DHB capacity to ensure safe services and a lack of a quality focus across public hospitals.20 In 2007, the government created a Quality Improvement Committee which has since produced two sentinel event reports. However, there remains no national infrastructure for quality improvement and a dire need for the government to bolster efforts.

Second, there is a need to sort out electronic information systems, the foundations of which were developed in the 1990s in the era of competition. While New Zealand has comparatively high levels of computerisation,21 PHO and DHB systems lack interoperability. Similarly, electronic patient records are widely used by GPs, but portability is limited. In late-2008, seven DHBs announced a joint initiative to develop an ‘integrated, person-centred’ system. Such developments need to be emulated across the health sector and there is a demand for central leadership in this.

Third, New Zealand has a workforce crisis induced partially by neglect for workforce development in the 1990s and insufficient attention since. Understaffing and the requirement for hospitals to hire locums is frequently cited as a reason for DHB overspending. New Zealand has the highest proportion of foreign-born and foreign-trained doctors in the OECD, similarly high levels of nurses and some of the highest expatriation rates. Meanwhile, New Zealand is below the OECD average when it comes to producing medical and nursing graduates,22 and comparatively low pay rates mean it is difficult to compete in the international labour market. The situation has not been assisted by the fact that salary arrangements are an individual DHB responsibility. Under financial duress, they have routinely resisted health professional requests for salary increases, leading to a series of unprecedented strikes. To be fair, public hospital nurses received a 19% salary increase in 2006 (supplied by additional government funding). There has been a gradual increase in the intake of medical students, and a Medical Training Board has been created to address shortages of senior and junior doctors.23 The new government has introduced a voluntary ‘bonding’ scheme for a range of health professionals, with student loan write-offs for those agreeing to work in under-served locations. There is a strong argument that public hospital employees should be treated in the same way as New Zealand’s police and teachers, with national pay scales and negotiations under direct central government responsibility.

Finally, there is the question of whether New Zealand’s present devolved health system structures have the capacity to deliver coordinated care. Efforts to improve efficiency, quality and electronic systems could alleviate some of the long-standing gaps between primary and hospital-based care, and public and private providers. Building clinical networks that traverse institutional boundaries could also help.

Each of these issues was canvassed by the Ministerial Review Group.24 Their report is likely to induce a range of new structural changes to the New Zealand health system. Recommendations include:

- Creating a new independent National
Health Board to take over various DHB and Ministry of Health purchasing responsibilities, monitor the performance of DHBs and PHOs, and drive national approaches to issues such as information technology development.

- Transforming the Quality Improvement Committee into a new national quality agency with increased capacity.

- Creating a new health technology assessment agency (possibly out of the long-lived National Health Committee).

- Promoting a higher-level regional approach to DHB planning, and reducing the number of PHOs.

These recommendations are not, in themselves, unreasonable. Yet, if implemented, they could be just as unwieldy as the present situation: a smaller number of regional planning bodies and PHOs could be interacting with a larger number of central agencies. The challenge for the government is to look beyond the one-agency, one-function model that has dominated contemporary administrative thought and seek to integrate the inevitably intertwined functions of finance, quality and health technology assessment within a single body.

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