How our health system evolved up to the restructuring in 2022

Alternative heading: How did we get into this crap?

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Aotearoa New Zealand's adoption of a universal health system occurred as a result of the adoption of the first Labour government's Social Security Act 1938.

For context it took another decade until the National Health Service in the United Kingdom was founded while Australia did not get its Medicare based universal coverage until 1984. The United States is still waiting!

Healthcare in Aotearoa before universal coverage

Prior to colonisation the health system for Māori was based on hapu, their basic economic unit. It was largely self-sufficient coping with its own resources and supporting those in need, the elderly, sick and disabled.

As primarily British migration took off there were none of the support institutions (charity and the infamous 'poor houses' of their 'home country') to call upon.

Instead migrants had to make do. It was not until the early 1880s with the introduction of refrigeration that New Zealand was to become an export as well as domestic consumption economy.

In 1882 one Harry Atkinson (at different times premier and colonial treasurer) argued that private charity would not meet the needs of the sick and indigent. Instead he advocated that it was the state's responsibility to care for them.

Perhaps influenced by Bismarck in Germany, he called for a shift from "private thrift or saving" to "cooperative thrift or insurance" which, he stressed, must be "national and compulsory." Atkinson was farsighted for his era and at the conservative end of the political spectrum.

Unfortunately he failed to get enough parliamentary support, including from those who were to make up and lead the reforming Liberal government of the 1890s and 1900s.

Instead, in 1885, the Hospitals and Charitable Aids Act established a national system under the jurisdiction of specially constituted boards. This system continued with various refinements until 1938.

Universal coverage

The small rural town of Kurow in the Waitaki district is famous for two things. One was being the home of the exceptional All Black captain Ritchie McCaw. The other, and with all due respect to the remarkable McCaw, was much more significant. Kurow was the genesis of New Zealand's universal health system.

Kurow had two outstanding individuals who were subsequently to become instrumental in establishing the new system. One was general practitioner Dr David McMillan and the other was Presbyterian minister Arnold Nordmeyer.

They collaborated with workers in the nearby Waitaki hydroelectric dam construction site who had formed an association. The association deducted a monthly subscription from wages to cover doctors' and hospital fees.

Following Labour's success in the 1935 election, both McMillian and Nordmeyer went on to play critical roles in the development of the 1938 Social Security Act as it affected the health system.

The Act introduced what became known as the 'welfare state'. In respect of health, in broad terms, it universalised and enhanced existing measures and ensured that payments were not required for public hospital care.

After a bitter battle with the medical profession (in those days led by the British Medical Association), a compromise was reached. General practitioners were able to charge fees for service co-payments in return for receiving a government funded general medical services benefit (this continued although, in the 2000s, the benefit was changed to capitation based on patient enrolments with co-payments regulated).

This provided the foundation of the health system up to the adoption of the Pae Ora Act last year. There was a structural separation between community-based and hospital-based healthcare. Public hospitals were run by statutory hospital boards.

Responsibility for population health and primary care (including directly employing GPs and nurses in designated 'special areas' which could not attract for-profit general practices) resided with the then Department of Health.

Evolution of health system until Pae Ora 2022

This structure developed and continued until the 1980s with the arrival of area health boards. Its genesis, in part at least, was an initiative developed but not legislated for under the third Labour government (1972-75).

However, the idea behind it morphed into a bipartisan initiative. Implementation began under a National government and was completed by a Labour government.

Area health boards were trialled first in two regions in 1983 and then gradually implemented across the country over the following six years.

By 1989 14 area health boards had both replaced the much more numerous hospital boards and also incorporated the responsibilities of population health and 'special areas' providing

primary care that had previously resided with the health department (soon to be redesignated a ministry).

To a degree area health boards also represented a loosening of the structural boundaries between primary and hospital provided healthcare. Had they been able to continue longer, it most likely would have assumed some responsibility for all of primary care.

In 1993 the National government introduced a new system based on competitive market forces as its drivers instead of cooperation, which had underpinned healthcare delivery since 1938. The structural divide between primary and hospital care was restored.

Public hospitals were run by crown health enterprises (changed to hospital and health services after the 1996 election and the formation of the National-New Zealand First government).

They were state-owned companies covered by both the Commerce and Companies Acts. Consequently they were required to compete with both each other and the private sector.

Largely due to the fundamental contradictions of using a competitive market to provide a public good (with no ability to control demand) and increasing public unpopularity, this system was abandoned by the Labour-Alliance government elected in late 1999.

On 1 January 2001 the Public Health and Disability Services Act came into force. Competition was out the door and cooperation returned.

Twenty-two district health boards (DHBs) were established (subsequently reduced to 21). Like the preceding area health boards and hospital boards they were statutory authorities.

To some extent DHBs were a return to the thinking behind the establishment of area health boards. Arguably they were similar to what area health boards may have evolved into had they been allowed to continue. But DHBs went further.

DHBs were characterised by being responsible for the whole of community and hospital based healthcare for geographically defined populations. This included undertaking health needs analyses for their populations.

The most common structural feature of a DHB was one or two acute base hospitals and the primary and other community care providers within its geographic boundary.

This structural feature was directly relevant to a specific legislative function. DHBs were to focus on the integration of care between community and hospital.

Canterbury was the DHB that pioneered this focus the most and became a recognised world leader because of its success.

Primacy of cultural change

It is a no-brainer to those with experience in and of health systems that, if the objective is to achieve change that is sustainable, it must be driven by a clear explicit culture change.

It is a mantra for those with this experience that culture change always trumps structural change for effectiveness.

Unfortunately this wisdom was not a no-brainer for those responsible for the design and implementation of the Pae Ora Act (healthy futures) 2022 and the entities it created.

There is a lot of academic literature on cultural change in respect of organisations. In the context of health systems, broadly speaking culture change is a means to achieving

healthcare ends. It comprises a range of activities directed at 'overhauling' or 're-engineering' a health system or entity's value system.

This does not mean that culture change precludes a role for structural change. In each of the four culture changes discussed earlier, they were supported by structural changes that were consistent with and enabling of them.

In 1938 the culture change was to put in place a universal health system which encompassed community, hospital and population health. Based on a cooperative ethos, it marked a departure from reliance on charitable health.

The roles of boards to run public hospitals and the health department for primary care and population health were consequential to and supportive of this culture change.

From 1983 to 1988, the culture change was to establish new statutory bodies to assume responsibility for both hospitals and population health as well as the potential to move into primary care. The structural change was to enable the creation of the 14 area health boards.

In 1993 there was a radical departure from culture based on cooperation to culture based on competition. Structural change was put in place to enable this culture change.

This included the formation of state-owned companies to run public hospitals and new purchasing authorities (regional health authorities) to construct a competitive market by establishing structures for a purchaser-provider split.

This commercial competition based culture proved to be both controversial and inconsistent with the public good values of a universal health system. However, while the culture change was seriously flawed, the structural change put in place to implement was consistent with its objective.

In 2001 there was a major culture change, in the first instance returning to the cooperative ethos. It went further, however, by bringing community and hospital healthcare under the same local statutory body, an explicit responsibility of these bodies for geographically defined populations, and promoting integration between primary and hospital care.

The structural change was the establishment of DHBs responsible for base (and other) hospitals and connected communities, including primary care, rest homes and non-government organisations.

As with the earlier culture changes, forming DHBs was consistent with the new change.

All these four culture changes from 1938 contrasted with the Pae Ora Act where structural change came first.

Principle of Subsidiarity

There has been a largely unacknowledged principle which had underpinned our health system since 1938 when the Social Security Act made it universal.

Arguably the principle went back to the 1885 Hospitals and Charitable Aids Act with its specially constituted boards operating within a national system, albeit it charity dependent.

The principle is called subsidiarity. It has historical ecclesiastical origins, not always the best. More important, for around a century, it has been the foundation of the relationship between local and central government internationally. This includes New Zealand at least since the provincial system of government came to an end under the Abolition of Provinces Act 1875.

The underlying premise is that things should be done locally (or regionally) except when it is best done centrally. But, in this relationship, central government is the 'higher authority' (just as the church was to families in the principle's early ecclesiastical history).

Subsidiarity is also the principle that governs the relationship between the European Union and its member states.

Overwhelmingly healthcare is provided locally through general practices, non-government organisations, and hospitals. Since the 1938 legislation, from hospital boards to DHBs, there has always been an influential level of statutory authority located closer to where most healthcare is provided.

Abolishing subsidiarity

To understand the Pae Ora Act it is necessary to recognise its most important, but less discussed, feature: it brought to an end basing the health system on the principle of subsidiarity.

It did this first by abolishing DHBs without any localised statutory alternative. This meant the loss of a statutory local voice, at least behind closed doors, on behalf of geographically defined populations that DHBs were responsible for.

New Zealand already had, before their abolition, one of the most centralised health systems in economically developed economies. Central government:

- appointed the chairs and deputy chairs;
- approved (or rejected) district annual plans that DHBs were required to submit;
- issued letters of expectations (aka instructions) to DHBs;
- set policies which DHBs were required to follow; and

- controlled (and obstructed) major capital works projects.

It became even more centralised by becoming more vertical through abolishing DHBs and transferring decision-making further upstairs and far away from where most healthcare is provided.

The new entity Health New Zealand (Te Whatu Ora) was established in part to replace DHBs and to assume their roles for the provision of healthcare to their communities. It also had transferred to it the funding and planning responsibilities of the Ministry of Health.

From Heather Simpson to Andrew Little: from one 'c' word to another 'c' word

After taking office in October 2017 the Labour-led coalition government, with David Clark the new health minister, established a panel to review the health and disability system. Its chair was Heather Simpson.

There was logic behind this appointment. As a former chief of staff for Prime Minister Helen Clark, she was intimately familiar with the construction of the Public Health and Disability Services Act which established the DHBs. Simpson well understood the thinking behind and intentions of this transformational change and its cultural underpinning.

The review, which inevitably became known by the name of its chair, published an interim report in August 2019. It provided a good summary of the pressures on the system.

The final report was submitted to the health minister in March 2020 but, owing to the pandemic, was not published until June that year. The government endorsed it in principle but held over finalising a position until after the forthcoming election.

The government narrative is that the April 2021 announcement of the abolition of DHBs by then health minister Andrew Little was consistent with the principles of the Simpson review.

Not so! The difference between the two can be summarised by two ‘c’ words – cohesion and control.

The Simpson review saw DHBs continuing as the critical statutory bodies for the delivery of healthcare services to their populations (a reduced number but continuing nevertheless).

It also identified a serious problem with the health system; lack of cohesion. The review got this right. Its solution was first to transfer the funding and planning responsibilities from the health ministry to a new national body, Health New Zealand.

Second, it would provide a transparent structural connection between this new body and DHBs, both nationally and regionally. But there was no suggestion of removing the existing statutory role of DHBs.

The review was not the first time cohesion had been raised as an issue. David Cunliffe was health minister for less than a year before the Labour-led government lost the 2008 election.

But he was worried about the lack of cohesion and worked with his health ministry to explore ways of addressing it. This was interesting work but lack of time meant it could not come to fruition.

His successor, Tony Ryall, established a review of the health system chaired by former Treasury head and Business Roundtable (now the New Zealand Initiative) leader Murray Horn. It too recognised the cohesion deficit.

One of its main recommendations was to establish a National Health Board (NHB) very similar to the Health New Zealand recommended by the Simpson review. DHBs would remain central to the health system.

The Association of Salaried Medical Specialists argued that the functions proposed for the NHB should in the main be supported but it was unnecessary and unwise to create a new national organisation to achieve it. Instead the health ministry should establish the capabilities necessary to perform this function.

Director-General of Health Stephen McKernan argued similarly but also produced convincing data of how much more expensive creating an additional national bureaucracy would be. Ironically McKernan subsequently became a business consultant who headed up the Government's transition unit to implement the establishment of the new current entities, including Te Whatu Ora.

Minister Ryall's resolution of the issue was not to establish a new national organisation but rather require the health ministry to perform its functions. A ministerially appointed committee called the National Health Board was also set up.

Ryall's successor, Jonathan Coleman subsequently disestablished the ministerial committee. The functions recommended by the Horn review remained with the health ministry but, largely due to its leadership culture, it failed to provide the capabilities necessary to make the health system more cohesive.

This failure may have influenced the Simpson review to recommend forming Health New Zealand in the way it did.

Following the public release of the Simpson review, I questioned both the need to establish a new national body (why not strengthen the capabilities of the Ministry and change the culture of its top leadership to relational base on engagement) <u>and</u> the logic behind reducing the number of DHBs.

While I still hold this view, this new structural connection between the 'centre' and DHBs had merit in itself. Subject to the right culture, it could help enable better cohesion.

An interesting part of the Simpson review was the establishment of smaller population-based localities. It was impressed by a promising initiative of MidCentral DHB. Over time localities would, the review recommended, replace the primary care organisations (PHOs).

DHBs would then take over the transaction cost roles of PHOs (including management, funding allocation, data analysis and administrative) rather like had already successfully occurred in South Canterbury DHB.

Localities then would be like networks resourced and supported by their DHBs. This would be a horizontal-relational rather than vertical-structural relationship. They would work together developing locality plans for the health needs of their populations. I thought this initiative had merit.

Enter Andrew Little and a new 'c' word

So how did Minister Little's announcement depart from the Simpson review. First, it overturned the review's support for continuing with DHBs (ie, it abandoned the principle of subsidiarity which had been the cornerstone of our universal health system for 84 years).

Second, it radically changed the role of the proposed Health New Zealand by taking the huge additional operational responsibility for the provision, configuration and delivery of local healthcare that had previously been undertaken by locally based DHBs.

Third, with the absence of a cultural change to underpin this structural overhaul (other than a nebulous reference to health inequities), it allowed the restructuring to establish its

culture. The restructuring was to make an already centralised system even more vertically centralised

In other words, a culture of control. The Simpson review was about cohesion. The restructuring has proven to be about control.

This change explains so much of the current precarious position the wider health system now finds itself and the risks it, patients and their close ones face. You will have to wait until tomorrow to learn what might be done by Te Whatu Ora to make things better for patient care.