

Reform
① Structure → DHB - HFA *
② service delivery → Health
HHS*

new developments *Restructuring, Reform and More Change: Recent Developments in New Zealand Health Policy*

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Good introduction

Over the last two decades, New Zealand's public health sector has undergone what might be described as incessant reforms and changes. The changes have occurred at two levels, propelled by differing factors. Changes to the *structure* of the health sector have been politically imposed by reform-minded governments. Changes in *service delivery* arrangements have been required by structural changes, but also driven from within the health sector itself. Changes have also, of course, been propelled by the 'health reform' movement: in parallel with New Zealand, and feeding off one another, almost every developed country in the world has embarked upon major health sector restructuring and rationalisation.

Since the 1980s, the New Zealand health sector has been subjected to four major restructurings:

1. The formation of the area health board (AHB) system (1983-1991). This established 14 centrally funded, regionally based boards responsible for health planning, purchasing and provision;
2. The 'health reforms', unveiled in 1991 by the National Government, commencing operation in 1993. The planning and purchase of services was assigned to four new regional health authorities (RHAs); provision functions to 23 new crown health enterprises and any other providers (private and third sector) who were successful in the process of tendering for services provision. The links between the purchaser and provider levels were to be maintained through a system of individualised service contracts;
3. The health 're-reforms', prompted by problems with the health reforms and the founding of the National-led coalition government in 1996. These amalgamated the four RHAs into the central Health Funding Authority (HFA).

4. The development of the present district health board (DHB) system (1999-), imposed by the Labour-led coalition government.

Each of these policy shifts spelled significant changes in the organisation and functioning of the sector. Behind each of the four structures, micro-changes in management systems and service delivery continued to be implemented. For example, the *State Sector Act 1988* necessitated the introduction of new management approaches in hospitals, while the *Public Finance Act 1989* required of area health boards new financial practices and accountabilities. Through the 1990s, general practitioners self-organised into contracting and service delivery networks, new methods emerged for purchasing pharmaceuticals and for prioritising of funding and patients, and 'by Maori, for Maori' health care continued to progress, subject to setbacks resulting from the sector restructurings.

The New District Health Board System

The incipient DHB system sees the sector move 'full circle', for it rehearses fundamental features of the earlier AHB structures. These include devolution of varying degrees of power and responsibility to a local level, community involvement in service planning and purchasing, a focus on service and inter-sectoral integration and development of a series of population based strategies and targets (King, 2000).²

There are a number of potential gains offered by the new structures. However, many of the aims of the DHB system could have been achieved within the prior health structures, alleviating the need for further disruption to a reform-wary sector. For example, it would have been possible to have added elected representatives to existing hospital boards,

and to have devolved greater numbers of staff, levels of funding and responsibility for service planning to HFA locality offices to achieve the 'closeness' to local populations and providers intended of the DHB system. In support of moves in this direction, more locality offices could have been established. The HFA could have been required to initiate more involved consultation processes to enhance community input, perhaps through citizens' juries or by increasing the range of issues over which public input was sought. Hospitals could have been required to shift their focus beyond their traditional borders through increased attention to service integration strategies and collaboration with other providers and policy sectors on initiatives aimed at improving health status. Legislative amendments could have removed hospitals from the Companies Act, setting them up as statutory bodies and enabling the health sector to focus on the principle of public service and 'patients not profit'. Some of Labour's policies were already beginning to emerge under the aegis of the previous National Government and the HFA, such as increasing moves toward using a population based funding formula sensitive to local circumstance, longer-term contracting and strategic planning, and a focus on the determinants of health and reducing health inequalities (see Creech, 1999).

Step One: Establishing New Structures

At an analytical level, development of the DHB system can be seen as occurring in two steps. The reforms enacted in 1993 and 1996 only just managed to work through the first of the two steps before they were again restructured. Step one entails structural adjustment: the basic reshaping of the health sector. Well established administrative and technical systems, relationships between agencies and individuals, and institutional knowledge are crucial to the effective delivery of health care. Yet, structural adjustment by its very nature undermines these. New Zealand's experiences with health reforms through the 1990s suggest that it takes at least two years, possibly much longer, for the sector to recover from a bout of change and adjust to the demands of new structures. This is because each time reforms are enacted, the work of existing agencies is assumed by new ones. RHAs had to learn a new purchasing task, this was handed on to the HFA and is now being distributed across the Ministry of Health, 21 DHBs and five inter-district shared services bureaus. While individual members of

agencies take their knowledge of, say, the purchase or planning of health care with them, systemic change means that the sum total of knowledge that may have built up is dispersed. Some is scattered across new agencies as people are relocated; other knowledge disappears with the departure of staff from the health sector. The process of 're-learning', or building from scratch, takes considerable time.

In tandem with this, those at the front-line of health care delivery face significant uncertainty as they wait for new systems to form and attain a level of functionality so they can begin again the process of relationship building and getting on with the task of delivering health services.

During step one of the current round of changes, the health sector faced a number of other challenges, in addition to the basic re-building process. First, there was an early lack of information and policy detail available to those charged with enacting change. In part, this was because central policymakers launched the process of change in advance of producing necessary plans and details. For many, particularly those responsible for forming DHBs, planning for change was undertaken in an informational void, where information about the road ahead simply did not exist. This meant substantial second-guessing of yet-to-be taken government decisions.

Second, the change process was a mix of top-down Ministerial prescription and bottom-up provider description. Quite who was driving the process of change was not entirely clear, and there remains a lack of sector confidence in the capacity of the centre to provide necessary leadership. Policy was initially produced in haste and much of this was 'made up' as required. In keeping with the policy to devolve functions from the centre, the government also sought designs for the DHBs from respective host regions, although the tendering of designs occurred within a tight centrally-prescribed framework. For instance, DHB designates were required to provide estimates of the costs and demands of change and human resource requirements in an apparent absence of central government analysis.

Third, the change process threw the sector into a heightened state of uncertainty. Few officials, managers or providers were unaffected by the changes and, for many, the future remains unclear. In a long and drawn out process, HFA officials spent most of 2000 uncertain whether their jobs

would be redundant, retained within a MOH directorate, or transferred to a DHB or one of their shared services bureaus. Many non-government providers were unclear about whom they would need to forge relationships with: the MOH or DHB? For some national or cross-border providers, such as Iwi-based providers and agencies like Plunket and the Family Planning Association, relationships would need to be developed with many DHBs.

Fourth, there were doubts about whether the system would produce intended results. Improvements in health status take many years to emerge and are often affected by factors beyond the borders of the health sector. Before DHBs can even begin to focus on mechanisms to deliver health gain, they need to be fully functional. It will be at least mid-2002 before this will occur. For some, full devolution of funding and service delivery responsibility may be withheld by the Minister for an extended period. There are also concerns that DHBs will be dominated by hospitals, which historically overshadow the health system. A further concern is that 'bureaucracy' will proliferate. The absorption of HFA functions into the MOH required an expansion in the central agency. New inter-regional 'shared services' agencies are being created by the DHBs to bring economies of scale to many of their purchasing and planning tasks. The DHBs are acquiring an average of around 16 staff each. Board members will all require payment, and statutory obligations will mean the creation of a list of around 66 'responsible' bodies, including the DHBs themselves and their respective sub-committees.

Fifth, in a sector jaded by change, there has been considerable concern about 'yet another round of changes'. There is also concern that gains achieved with the step two consolidation of the health system through 1999 are being lost, as is the institutional knowledge and national overview provided by the central HFA.

Finally, and as a consequence of these points, support for the new policy directions remains questionable both within and beyond core government agencies. For some, it is not the policies themselves that are deficient, but the fact that further change and disruption is being introduced and the method of its introduction. Others simply do not see the merits of creating at least 20 separate local purchasing agencies. They view DHBs as potentially recalcitrant and

politically motivated, incapable of delivering on policy intentions and likely to drive up costs (e.g. Treasury, 2000). It has been widely suggested that if the RHA system was confusing and administratively burdensome, then worse can be expected of an increased number of purchasers.

Step Two: Beyond Structural Change

Step two commences once the establishment of the DHB system has traversed the process of structural adjustment, and entails focusing on the delivery of services and building upon a maturing structure. Instead of concentrating on becoming functional, the sector is able to focus on advancement. New Zealand is now very accustomed to going through step one, but through each of the last two rounds of change we have had only around a year of step two before the structures have been brought to a halt by a change of government and health policy directions. This means that none of the structures listed above has been left to function for long enough for us to be able to tell with any certainty how well they performed. It may be that each would have performed at least as well as the next if given the chance to do so.

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Step one in the creation of the DHB system should be nearing completion by around the end of 2001, although many of the purchasing functions DHBs are to be responsible for will not be devolved from the Ministry of Health until mid-2002. In the case of disability support, service planning will be a joint DHB-Ministry activity, with the Ministry retaining funding responsibilities. Moreover, DHBs will continue to work through various policy and operational details. As DHBs move into step two, they face a new round of challenges which could lead to questions over their adequacy.

First, there are inevitable tensions in the delivery of health care stemming from an expectation that services should be of high quality and access, yet low cost. Previously the central HFA was responsible for performing the 'balancing act' between these three factors. In the future this will be a DHB task. With the 'closeness' to the affected population embedded in the DHB decisionmaking structures, the balancing act could become a tension infused process. DHBs are intended to be responsive entities answerable to their populations. The addition of elected members after the 2001 local government elections with a heightened sense of

local affinity may increase tensions. The tensions will only be exacerbated by the funding shortfalls DHBs are facing in the 2001/02 financial year. Some may become 'more efficient' by finding new ways of arranging their affairs, which is the desire of the government; others may attempt to cut back services in order to stay in budget. Whatever the scenario, these 'micro' decisions are local responsibilities and likely to be politicised.

Second, and related to the previous point, DHBs will eventually be funded using a weighted population based formula. Currently, services are largely funded on an individual volume and output basis. The population formula is to be 'phased in' from the 2002 financial year yet, as above, this is likely to be a protracted and tension-infused process. This is because some regions, for instance South Auckland (Counties Manakau DHB), have been seriously underfunded while others (e.g. Otago and Southland) have been funded above the level calculated using the population formula. The problem is not recent, dating back to at least the AHB era. What is different today is that there is more accurate data about funding levels and little justification, other than the crucial social and political ramifications, for inequitable funding distribution. There will be tensions around the reallocation of funds from those likely to gain and those likely to lose. Whether central funders have the political and technical ability to reallocate funds (or allow some regions to grow more than others), and how much pressure from the DHBs is faced in the process, remains to be seen.

Third, it is government policy to enhance primary care and create links with other policy sectors with an influence on health — housing, education, local government, welfare, etc. Underpinning this is a belief that robust primary care, population health strategies and intersectoral planning will create healthier communities, alleviate health inequalities and reduce secondary and tertiary care costs. However, if greater primary care access and coverage is achieved this could have a flow on effect of increasing secondary care costs. It may be that many previously undetected health needs will be uncovered, with more referrals resulting. A major impediment to exploring new ways of providing services and building intersectoral relationships will be funding and performance appraisal mechanisms. What the government seems to want is closer integration of service

levels within the health sector, for services to be delivered in the most appropriate settings, and for policy sectors to be aware of their impacts on one another. The current focus on the outputs of individual agencies and policy sectors will only work against new patterns of organisation. It is foreseeable that the divide between primary and secondary care and between policy sectors will persist.

Fourth, the 'national' perspective of some policies could be in conflict with the local focus of DHBs. This may be particularly the case with regard to service 'prioritisation', which commenced under the HFA, and consistency in areas such as the management of elective surgery patients. The government has placed considerable emphasis on ensuring that DHB plans are comparable with one another. Any DHB that fails to team up with the centre faces any number of sanctions, from the withholding or withdrawal of funds through to takeover by the Minister of Health. As such, most DHBs are limited in the extent to which they can make 'local decisions to suit local circumstance'.

Finally, A Fundamental Question

As this fourth set of structural changes progresses, it is important to consider some broader issues surrounding health sector policy design. We need to ask what the ultimate intention of structural change is. Arguably, in the New Zealand environment, there are two motivating factors: the desire for cost reduction (or at least containment); and the assessment of what a 'good' structure for the sector is.

With regard to the first, none of our recent reforms has been in place long enough to know which was the more 'efficient'. However, it is highly likely that, if politicians and their advisers were looking for substantial efficiency gains, it would have been much more efficient to have left structures alone and simply asked agencies and individuals to look for better ways of doing things. We do not know, but we may well have been 15 percent better off if we had committed to any one of the recent systems. Structural changes have created substantial costs from staff disillusionment and related inefficiencies and the amount of work which goes into planning and implementing change, through to the dollars required to drive change. There is no 'perfect' health system in the world; each has its shortcomings. What there is, and New Zealand is probably more experienced than any other country in this, is simply different ways of 'cutting' the system.

Regarding the second point, what is considered to be a 'good' structure for the health system is influenced by context. Political tides change, and with these, so do objectives and structures set down for the delivery of health services. As such, what was considered to be a 'good' structure in the early 1990s (one that stimulated competition and private management practices), differs substantially from that in the early 2000s (where collaboration, community participation and population health are the norm). Who knows what future arrangements await the health system?

Notes

1. This article contains some revised and abridged material from the author's forthcoming book (Gauld, 2001)

2. Further information on the new structures is contained in a variety of policy papers and newsletters posted on the Minister of Health's website (www.executive.govt.nz/minister/king). The Ministry of Health website is also a useful source of information (www.moh.govt.nz).

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