Progressive Thinking:

Ten Possible Futures for Public & Community Services

Our health system and services: A best possible future[1]?

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Aotearoa New Zealand has a health system that is the envy of many other countries. It delivers high quality care at a reasonable cost; has an approach to financing that enables all residents and citizens to be covered for most health care costs; has a highly skilled and dedicated workforce; is able, through predominant public funding, to direct funding to key priorities; and has a structure that is relatively straight-forward compared to many other systems. In spite of a number of changes over time in how the system is organised, there remain a number of long-standing problems that need major attention over the next two decades. (For background on the Aotearoa New Zealand health system see Gauld, 2009 and Cumming *et al,* 2014.)

Significant changes and transitions are being observed in the health systems of most developed countries, and New Zealand is no exception. Health systems are rarely static. Less the result of conscious design, health systems tend rather to be the product of history and cultures with a steady interest in how best to reorient the health system to meet a series of challenges within a fiscally constrained environment. In thinking about change, it is often easy to imagine an inevitable and smooth forward trend. In practice, change is much more likely to be a meandering river with slack water, pools, dams as well as disruptive rapids (Hickson, 2020).

This brief considers the history of organisational change in the provision of health services in Aotearoa New Zealand, the rapids endured, the tributaries followed and the potential paths ahead. We draw on past futures thinking, current assessments of the state of health services and the disruptive potential of Covid-19. In the light of the recent recommendations of the Health and Disability System Review (Health and Disability System Review, 2020) (aka The Simpson Report), we are entering a period where we are pinning our hopes on a new health structure to deliver better outcomes, including reduced inequities. As the complex task of implementation begins, we consider the potential for the health system to enter an eddy of change characterised by a swirl of debate over structures and the sequencing of reform.

Issues with the health system

The key ongoing concerns over health care in Aotearoa New Zealand include:

- Major inequities in health and access – Not all those in Aotearoa New Zealand have the best health and wellbeing they can have. While both length of life and quality of life have been increasing in Aotearoa New Zealand, Māori, Pacific, and low income New Zealanders, alongside those with disabilities, continue to have significantly poorer health status, and inequities have not been reducing in recent years.

[1] This paper focuses on health services. Although the system also delivers disability support services, these are not covered in this paper.

- Major inequities between ACC and Health – Not only do those on ACC get earnings-related compensation while others must rely on far less generous social welfare benefits, but the services available, and access to them, is poorer for those relying on the health system.
- A narrow concept of health and health services – The system does not always deliver better health through a determined focus on the key determinants of health, such as housing, employment, education and so on, and focuses too much on treatment as opposed to health promotion and illness prevention.
- Complex funding rules that differ across services and programmes - Making it difficult for people to get the best mix of services they need.
- Significant barriers to access to primary care – Through user charges at the point of service user.
- Inequitable funding in primary care – The capitation funding formula has long been argued to not adequately reflect the higher needs, and hence costs, of delivering services to key groups of New Zealanders.
- Poor cousins – Primary mental health, disability support, and dental care are not well supported by the system.
- Fragmentation of services – People see a range of different health professionals across a wide range of service delivery organisations, but information does not always follow them, they may get different advice from different providers, or they may receive duplicate services or fall through gaps. Too often, too, services are regarded as being organised around those delivering care rather than the needs of those receiving services.
- Lack of community and service user roles in decision-making.

Historical Overview

Through to the rapid-filled 1990s

Aotearoa New Zealand has been aiming to have a free, integrated health service focused on prevention since a national health service was first proposed in the 1930s. We were, however, not able to achieve this, but we did get full government funding and ownership of hospitals with free hospital care, along with government subsidies to support primary care delivered by independent professionals, albeit with user charges for many services.

Many reviews since the 1930s have supported the original aims and have suggested significant reforms, but in practice governments here tend to change structures, focusing on the parts of the system that they run. Reforms in the 1960s and 1970s amalgamated hospitals, while those in the 1980s linked public health with hospital care to encourage a focus on health promotion and disease prevention. The 1990s involved a complete overhaul of the system, separating roles in policy, purchasing and provision and emphasising contracting and competition to improve efficiency and responsiveness. Those 1990 reforms cost a considerable amount of money, as well as angst, and were never fully able to be fully implemented – resulting in many changes to the original plans. Emerging from these rapids of the 1990s was a single health funding authority to ensure consistency and reduce contracting costs, and an emphasis on provider co-operation rather than competition.

2020 tributaries: Alternatives mapped out in 1997

In 1997, as the health sector was coming to the end of a decade of radical organisational change, a futures project set out to develop scenarios for the New Zealand health sector in 2020. Scenarios offer potential possibilities, rather than firm predictions (Krieble & Middleton, 1997). They are focused descriptions of fundamentally different futures presented in a coherent script-like or narrative fashion (Schoemaker, 1993). The expectation is that they enable decision makers to constructively discuss challenging conditions and options in more open ways.

Looking back at the five scenarios developed in 1997, early signals of the importance of concepts of well-being rather than illness and the importance of consumer empowerment were outlined in one scenario entitled Power to the People.

Another scenario – "Two tiers" – presented a health sector in 2020 where New Zealanders had given away any desire to have a universally accessible publicly funded and owned health system, with the state providing only an inadequate safety net for the uninsured. In this scenario, public confidence in the publicly funded and owned health system fades and a focus on individual rights and entitlements prevents progress towards more collective goals and an emphasis on social and economic determinants of health. The arc of health policy change since 1997 has avoided this scenario; however, one can point to the more nuanced ways in which the private sector has made inroads into health delivery, such as in aged residential care and the more recent corporatisation of primary health care.

The titles of the final three scenarios sum up further possible futures and these centred on: a technically highly tuned and less politicised version of the present system (A Technocrat's Dream); a system driven by the introduction of private health care plans similar to the original 1990s plans (Positively Private and Global); and *ad hoc* adjustments to current challenges (Muddling Through). In the latter scenario, steady economic growth has fuelled advances in health provision but the gap between available resources and consumer expectations has grown. New approaches to delivering health services co-exist with traditional structures.

When those who had a hand in shaping these scenarios were recently interviewed (Menzies & Middleton, 2020), they were struck by the ongoing relevance of the underpinning drivers and values that had shaped each scenario. For example, the long run interest in the gains expected from new digital ways of working are evident in a number of scenarios, but interviewees pointed out how much of the potential is still unrealised. To carry forward the metaphor of a river of change, the much-heralded changes from new technologies and research and development has met a certain amount of slack water over the last two decades.

The calmer 2000s and 2010s

A combination of Power to the People and Muddling Through would be the best way to describe what has happened in Aotearoa New Zealand in recent years. In part to avoid the turmoil of the 1990s, there has been a period of relative organisational stability from 2000 onwards: for the past 20 years, policy change has relied on a sequence of strategic directions urging more attention towards the health needs of populations, stronger collaboration between different parts of the system, and managing within the resources available. In the early 2000s, we re-established a population health focus through (now) 20 local District Health Boards (DHBs) (with elected Board members) and worked to strengthen primary care, including through the establishment of new

Primary Health Organisations (PHOs) which aimed to enhance community and consumer engagement. The result has been expansions in the role of primary care, including a wider range of health professionals, and a recent introduction of better primary mental health services. There have also been some improvements in consumer and community engagement in this setting, but not as far as originally envisaged. The introduction of Whānau Ora as a philosophy of holistic health and development operationalised by Māori and Pacific providers is one obvious example of the ways in which ideas around well-being have received health policy attention since 1997 (Smith *et al*, 2019).

2020

The Health and Disability System Review

Signalled as a once in a generation opportunity, for the past two years a Health and Disability System Review (the Review) has been taking stock of our health system. In an Interim Report (Health and Disability System Review, 2019), the Review both recognised the strengths of the system but also pointed to a number of key problems – most particularly the lack of progress in reducing inequities in health. It also pointed to poor long-term planning; a lack of certainty for key planning, funding and delivery organisations over future funding flows; a lack of clarity around the roles and responsibilities of key organisations (e.g., DHBs and PHOs); as well as to poor integration and a limited role for consumers and communities in decision-making.

The Final Report of the Ministerial review recommended a series of new structures as important to achieving key policy goals. The report particularly emphasised the lack of attention to and accountability for reducing inequalities in health. It recommended the establishment of a new agency – Health NZ – to enhance planning and commissioning, to more clearly set priorities, to support DHBs in their work, and to strengthen accountability for achieving key goals such as reductions in inequities. DHBs would be reduced in number to between 8 and 10 but would also emphasise a locality approach in the planning for and delivery of services, especially primary care services. PHOs would no longer formally exist. It also recommended the establishment of a new Māori Health Authority to work at all levels of the health care system to plan and prioritise Māori health. An alternative view recommended going further than this by giving the Authority significant funding to support Māori health as having the biggest potential to improve the health outcomes of Māori.

Having pointed out problems with system complexity and fragmentation, suggesting there should be new agencies is remarkable. As time is absorbed in setting these up and working out the various relationships between them, as well as developing new plans to guide the system, the potential is high that we enter an eddy of change with the opportunity to bring decision making and services closer to communities further and further away. Another risk, given the lack of detail on what these various new agencies will do, is that they suffer the fate of previous organisations. For example, a major issue with the 1990s reforms was a double-up in policy making roles across the Ministry of Health and Health Funding Authority; while twenty years on from the implementation of the Primary Health Care strategy that set up PHOs, we were still debating what the roles of PHOs are or should be.

The impact of Covid-19 – how slow or fast might be the eddy we end up in?

Health policy is always difficult for governments, as many different needs compete for scarce resources, including funding. Just to keep up with current service delivery costs significant amounts of money and aiming to fill key gaps in service delivery could chew up even more resource.

In the Covid-19 era, it is harder, however, to spot what the limits to state spending actually are. Economic orthodoxy is not as strong as it has been, as governments demonstrate little difficulty (or opposition) to financing significant government action. The health sector is but one area crying out for new funding – particularly in public health as well as in aiming to catch up in areas where we have fallen behind as a result of covid-19, such as in elective surgery and cancer screening and treatment. Nonetheless, we can imagine that financial pressures will re-emerge in the not-too-distant future.

Contemporary scholarship on health system reform emphasises experimentation and relational ways of driving change. While planning-based rationalist tools and accountability mechanisms loom large in the final recommendations of the Review, the learning from the responses to Covid has centred on the speed of reaction and system learning. That said, there is no doubt there is much to be learned from the co-ordination required to have not only the health sector but different sectors (such as defence; business, innovation and employment) working well together. Internationally, it is interesting to see the risks of centralised over-planning as the Nightingale hospitals in England put up in a flurry of centralised planning, have been found to be not needed as much as anticipated as rapid learning happened across intensive care units on how to treat the virus (Pawson, 2020).

During the pandemic in Aotearoa New Zealand, some previous barriers between secondary and primary care dissolved, and the role of communities in supporting the response and the consequences was highlighted. But gaps were also exposed in terms of public health planning and resourcing, in service providers' connections with community health providers, in the ability of privately owned providers to support a collective interest with programmatic funding, and in connections with Māori and Pacific communities. The voice of unions, such as the PSA, also seemed to be missed in formal deliberations. How different parts of the sector have stronger input into regular and emergency decision-making is a key issue for the future.

Conclusions

Internationally, Covid-19 has starkly exposed deep similar health inequities and underlined structural disadvantage. While Aotearoa New Zealand has yet to see a death toll that directly reflects this, the second wave of cases has shown that the potential is there for some of our least well off populations to suffer more from the virus, while the economic impact of the pandemic will also impact hard on less financially well-off communities. The potential is there for a redoubling of the debate of how we should best work to reduce inequities in health, and where to spend our scarce resources to best improve health and wellbeing. The Aotearoa New Zealand response to Covid-19 has shown, however, that when governments really want to achieve things, they can move quickly and fund accordingly – we would love to see such a determined approach to reducing inequities in coming years.

Our focus must turn to the broader determinants of health, health promotion and disease prevention, with an enhanced and well-integrated primary care sector with global funding (as opposed to programmatic funding) and fewer barriers (including financial) to access to services.

Community and consumer engagement must increase to build on the knowledge of local needs and what works to improve health in those communities. There must be greater ethnic diversity in health personnel, to match current and future population demographics. Finally, equity needs to be front and centre, with a stronger, independent, well-resourced leadership and funding role for Māori and Pacific populations, including more equitable funding arrangements that better ensure greater needs are funded concomitantly.

Whilst none of these issues are ignored in the recent Review, details on how to get there are sketchy. Best practice in policymaking involves targeting the right intervention in the right context, rather than a broad scattergun approach. With governments eager to demonstrate they are taking action, structural changes launched under the guise of fixing the system are tempting. However, without sufficient attention to the implementation details we are at risk of entering an eddy of change and miss spotting the existing key points of community leverage that will improve the system.

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