Citizenship, work, welfare, education and health in New Zealand

Des Gorman

Abstract

Access to excellent, unconstrained and timely health care is considered a birthright by most New Zealanders. However, there are shortcomings in some health services, especially in mental health and rehabilitation, and these not only have an adverse personal impact but also challenge the sustainability of the national welfare system. There are insufficient well-trained people who can manage ‘care’ in line with either generic best practice or Whānau Ora ideology. An important and core reform is for a coordination of relevant programmes in education, health, justice and welfare, and for both shared accountabilities and linked governance.

The Welfare Working Group

I recently had the privilege of being a member of Minister Bennett’s Welfare Working Group (WWG). The WWG, which was led by Ms Paula Rebstock, recommends substantive reform. This outcome arises from a recognition that our welfare system is often disabling and that it is neither sustainable nor fit-for-purpose. As an illustration of the cassis belli for reform, 31% of working age Māori are State welfare beneficiaries of one sort or another. There is no comfort for any New Zealander in such a rate of joblessness.

This essay is a personal review of the milieu of the WWG’s report and the knock-on implications for our health services.

Citizenship

In my opinion, New Zealanders have a sense of citizenship, which is in part based on a commonly held set of values. Ironically, those values are probably most appreciated by us when we are confronted by dissimilar viewpoints. For example, many New Zealanders were bemused by much of the argument against President Obama’s programme to increase health access in the USA. The concepts and values of mutuality, welfare and altruism were largely missing from the oppositional argument. It is hardly surprising that we have common values; after all, we are all ‘boat people’ who have come to New Zealand for a better way of life. Some of my ancestors (the Māori) arrived about 1000 years ago, whereas my father arrived on his boat from Australia in 1952. We also have defining legislation, such as the Social Security Act of 1938, and a unique treaty between the British colonisers of the nineteenth century and Māori (The Treaty of Waitangi).
The WWG was frequently told by commentators and those making submissions that social welfare was the centre-point of the national social contract. The more I thought about this, the more it seemed to me that this was not the case; surely the central social contract is that those of us who can work do so, for pay or not, and by way of this work we contribute both directly and indirectly to our society. In the absence of such a core commitment to work, our society cannot exist.

For reasons that are unclear, work and work-related schemes are often regarded pejoratively and both are frequently seen as being punitive in rehabilitation programmes. The sadly commonplace nature of these views and the resultant distortion of medical practice are such that the Royal Australasian College of Physicians has felt the need for a public campaign to argue that work is good for our spiritual, mental and physical health and that without work, people often experience consequent ill health. Indeed, positive vocational rehabilitation outcomes should become a key accountability for our health services. At present, they are not and the welfare system ‘inherits’ the poor outcomes of what are somewhat deficient rehabilitation and mental health services.

If work is at the core of our social contract, then the welfare system can be seen as consequential and to exist to support those who cannot work until they can do so. In this way, a sensible relationship between this analogous dog and its tail is affirmed. Some expectations inevitably arise from this citizenship. These include employment opportunities, which I will not discuss further, and unlimited access to education and health care, which will be the subject of the balance of this essay.

**Citizenship and education**

New Zealanders assume certain egalitarian birthrights: these include access to the highest quality of education; and, similarly, access to the health care that they need, when and where they need it, again of the highest quality, and without constraint. These expectations are essentially not negotiable, are passive (as compared to being consumer-owned and proactive in a health setting) and set a very high bar for service provision.

Despite considering themselves to being “Better British”, which is reasonably argued to have been a common feature of many early settlers from the UK, education is the basis of social mobility in New Zealand and the principal ‘vehicle’ used since European colonisation began in earnest here to prevent a repetition of the restrictive social classes of the immigrants’ countries of origin. Our Prime Minister is an example of such mobility. Similarly, I went to a lower socioeconomic (decile 1) secondary school and have not experienced any related externally-imposed limitations on my ambition and/or employment.

Educational equity has nevertheless been eroded since my school days, as evidenced by recent university-entrance attainment rates of only 13% for decile one, two and three secondary school students. This relative educational failure has self-evident and adverse employment, health and welfare, and justice-system impacts. Measures are in place to remedy the imbalance. The one that has the greatest appeal to those of us in the health system is the advent of health sciences academies at lower-decile and predominantly Polynesian (e.g. Otahuhu College) and Māori (e.g. James
Cook High School) secondary schools. Cohorts of students are admitted to the academy for the last three years of secondary schooling (years 11, 12 and 13). In addition to core academic subjects, such as English and Chemistry, students have work experience exposures through joint ventures with local providers and medical societies, and undertake programmes and courses that ensure they have (potential) access to the entire range of tertiary health worker education programmes. The direct benefits are three-fold by way of positive education, health and employment outcomes. First, the academies render education purposeful and are likely to increase student retention and to improve both attendance and performance. Second, the students’ health literacy is enhanced and these students will carry a health debate deep into their families and Whānau, and communities. Third, there can be few more guaranteed industries for employment than health.8,9

**Citizenship and health**

New Zealand shares a health service demand-supply-affordability mismatch with most of the industrialised World.8-10 Some of our health services are especially vulnerable and most of these are community- as compared to hospital-based. Those with the greatest adverse impact on the welfare system are the shortcomings in rehabilitation and mental health services, and the essential absence of a managed care (Whānau Ora) workforce. Treasury estimates that unmet mental health need is the single greatest contributor to long term injury- and illness-related disability and consequent welfare-dependency.11,12

Health Workforce New Zealand is well aware of these vulnerabilities and appropriate clinician-led service reviews are underway.13 These reviews are largely vignette-based and predicated to resolve the conundrum of meeting a significant growth in demand for health services (perhaps a doubling over the next decade) in a way that both maintains overall quality and access and closes access and outcome ’gaps’,14,15 and that slows the rate of increase in the costs of health care to something closer to the likely growth in wealth of our country over the same period (about 40%). A disruptively innovative reform of service configurations and models of care is necessary and will need to be underpinned by a similarly extensive reform of funding schema and rewards systems. The latter must include the consumer if there is to be a meaningful shift to patient-centred and -owned care. The landscape will inevitably involve both primary-secondary care and public-private partnerships and integration.

Funding, management, provider and education integrated models of care that include the health sciences academies cited above are also being developed in partnership with Māori (see Figure 1); this recognises and attends to current health outcome inequities. For example, the difference in life-expectancy between European New Zealanders/Pakeha (as well as other New Zealanders) compared to Māori is greater than the equivalent gap between North American Indians and the European colonisers of that continent.14
Across-sector alignment and governance

Education, health, welfare, along with the accident compensation and the justice systems are inexorably linked at a functional level and a failing in one has knock-on effects for most of the others; and yet, governance of these services is dislocated. If I were to select any aspects of the WWG’s recommendations for highlight here, it would be for a whole-of-sector conjoint governance, for aligned and long-term outcome accountabilities (e.g. positive employment outcomes as a headline health KPI) and for a consequential shift in the management of our rehabilitation system to the sort of long-term actuarial logic employed by the ACC. All are both overdue and necessary.

Figure 1. Schematic of Iwi Health Plan showing integration of secondary school health sciences academy

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<th>Health Science Academies at local secondary schools as joint venture:</th>
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<td>- Positive educational, health and employment outcomes</td>
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<th>Public-private mixed funding model:</th>
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<td>- Mutual and long-term actuarial logic</td>
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<th>Public (DHB and PHO)-private mixed provider model:</th>
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<td>- Scholarship and employment of local graduates through Health Science Academy scheme</td>
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