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Questions about New Zealand's health system in 2013, its 75th anniversary year

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Abstract

New Zealand's health system turns 75 in September, 2013. This article suggests that it is a time for celebration but also reflection on whether we have achieved the aims of the 1938 Social Security Act which laid out a set of principles for health care delivery. The article looks at questions of access, equity and service integration. It outlines why the health system we have today is shaped the way it is, and asks whether we should recommit to the original 1938 aims or develop a new set of principles for our health system.

This year, 2013, is a significant occasion for the New Zealand health system for it marks the 75th anniversary of the laying of its contemporary foundations. Such an anniversary is a time for celebration but also for reflection on whether we have achieved the goals sought in the passage, on 14 September 1938, of the Social Security Act under the government of Michael Joseph Savage.

It is also a time for debate around how well our present health system functions and performs in the light of the 1938 Act's aims. This article, therefore, reflects on the goals of the Social Security Act for health care, whether we have achieved them and what the key barriers to this have been. It also asks whether we should recommit to the original 1938 aims for health care, or develop a new set of principles that reflect how the New Zealand health system is presently structured and performs.

What the Savage Government aimed for

When the Savage Government presided over the 1938 Social Security Act (SSA), for health care, they did so with an intention of creating universal access to a comprehensive national health service. New Zealand was, thus, the first democratic capitalist country in the world to attempt this. Indeed, the National Health Service in the United Kingdom was not enabled until a decade later.

The intent of the Savage Government was laudable, given the pre-existing circumstances: health care was not a right, its delivery was highly variable, access depended to a great degree on ability to pay and whether services were even available, and the provision of public services was limited.[1–3]

The goals of the SSA were visionary, including that:

- Health care should be universally available and a fundamental right without barriers to access;
- all New Zealanders should have equal access to the same standard of treatment;

- the health system should have a preventive rather than curative focus; and
- services should be integrated not fragmented between primary and hospital-based care.[3]

These goals, in many ways, align closely with international thinking today – from agencies such as the World Health Organization – around what health systems should aim for in terms of overall design.[4,5] This makes it all the more important that we ponder whether, 75 years on, we have achieved the SSA aims. The next section takes up this question.

Have we achieved the aims of the Social Security Act?

Over time, we have built a New Zealand health care system that performs anywhere from poorly to superbly depending on which of the many indicators one looks at. Health system performance measurement is complex and it is often difficult to get a clear picture of performance across an entire system.[6]

In 2011, in an attempt to provide an overall performance rating for the New Zealand health system, a group of medical students and I developed a scorecard which rated New Zealand against 64 international and national benchmark indicators using routinely-collected data. This allowed us to compare New Zealand's performance with the best across a range of different dimensions. The method for this and findings are presented in more detail elsewhere.[7]

In brief, we selected indicators across a series of performance categories (healthy lives, efficiency, quality, access and equity). Where international data were used, benchmarks were set by averaging performances for the three highest-performing systems with the New Zealand score rated against the benchmark in a simple numerator-denominator calculation. For local data, the same process was employed with the three top-performing DHBs used for establishing the benchmark.

The result was a reasonable 71%, but a notably poor 57% for equity and only 64% for access raising serious questions about achievement of at least two of the four SSA goals listed above, discussed in further detail below.

Universality, access and equity—In terms of universality, New Zealand has performed reasonably well in the broadest sense. All permanent residents, regardless of socio-economic status or tax-contributions, are entitled to a range of health and disability services that are largely government-funded through general taxes. This places New Zealand alongside other developed nations that consider health care to be a fundamental right.

Yet the 64% for access given in our scorecard highlights a range of problem areas. While no-one will be turned away from a hospital emergency department when in need of health care, and which is free, access to services across the spectrum of care in New Zealand remains problematic. As ours and many other studies consistently highlight, it is patchy, far from universal, and varies by socioeconomic status, service, ethnicity and region.[8]

Perhaps most problematic are the fees charged to see a general practitioner (GP) or allied primary care provider such as a practice nurse. Data variously show a proportion of New Zealanders avoid seeing the doctor or filling a prescription due to

cost barriers. For example, some 26% of patients in poor health surveyed in 2011 by the Commonwealth Fund had cost-related barriers to health care.[9]

Jatrana and Crampton's analyses of Statistics New Zealand data collected in 2004–05 show 15.5% of the population avoided seeing a doctor due to cost.[10] The subsequent 2006–07 New Zealand Health Survey suggested only 1.7% of respondents (but 4.1% of Māori) fell into this category.[11]

While the last two of these studies have different findings, one interpretation may be that increased subsidies introduced through the 2000s aimed at removing financial barriers have been effective and demonstrate progress toward removing cost barriers. On other measures, such as physical access to a GP, New Zealand performs comparatively well with Commonwealth Fund data showing three-quarters of patients in poor health able to get a same or next day appointment.[9]

When it comes to hospital and specialist care, questions also abound around universality, equity and access. Waiting lists for non-urgent services, as we know, have long been a feature of our health system which successive governments have worked to improve the management of.[12]

Certainly, there is more transparency now with the use of scoring and booking systems than two decades ago. The electives target in place since 2009 has also driven a renewed government and DHB commitment to improving public service access and waiting times.

Yet access continues to vary by DHB and specialty,[13,14] while periodic media reports suggest it could be becoming increasingly difficult to access public hospital specialist services despite the influence of a national target for improving elective services access.[15] Certainly, access remains problematic from the perspective of doctors as shown in a 2012 Commonwealth Fund survey in which 75% expressed concerns about the length of time their patients were waiting to see a specialist.[16]

The implication is that those who can pay privately or have health insurance will receive the care they need, while those unable often suffer until they become unwell enough to reach the threshold over which they may be seen and treated. It is difficult to believe this scenario was an intent of the original SSA, nor what most New Zealanders want today.

Preventive not curative focus—To be fair, successive governments have worked to build a preventive focus for the New Zealand health system.[12] Indeed, the guiding legislation for the present DHB system requires a focus on inter-sectoral planning, health needs assessments and health promotion. However, over the years the best of policy intentions have often failed due to the powers of particular interest groups, an over-riding focus in the health system on personal health and institutional arrangements discussed in more detail below that work against good cross-sectoral planning which prevention requires.

Integration—Integration is an area of considerable concern, given the potential we have for this in New Zealand and a history of attempting to better integrate services.[17,18] In practical terms, integration means that patients perceive the health professionals they see—whether primary care or hospital based—as all working for the same system as you would expect at different branches of your bank. In this sense, most

patients with multiple health care encounters would probably suggest there is limited integration, although we lack good data about this based on patient experiences.[18] Again, Commonwealth Fund surveys indicate that some 30% of patients with chronic care needs experience problems with care coordination.[9] Other studies into care coordination and integration have revealed similar challenges.[18]

In New Zealand, we have the essential ingredients for integration. We have a single-payer health system in that the government pays for most health care and most social services are centrally-funded. Health funding incorporates disability support services funding, unlike many other countries where this is by a separate agency. We also have CEOs in each DHB, with ultimate responsibility for the organisation of care in their region.

The money and, very importantly, lines of authority are therefore linear. In contrast, many countries have multi-payer systems meaning health care providers receive their income from many different sources, complicating attempts to run a single system.[19] The most prominent example is the USA. Why then have we failed after 75 years to achieve an integrated health care system; and how do we make sense of the various other shortcomings touched upon above? We need to go back to the late-1930s.

Compromise and consequent institutional foundations—Others have documented the political bargain struck between the government and the then very powerful medical profession, represented through the New Zealand Branch of the British Medical Association (NZBMA) as it was called, required as it would have been almost impossible to implement the SSA otherwise.[1 20]

The NZBMA opposed the government's proposals for funding doctors, which was likely to be some form of government-funded 'national insurance' that could come via a capitation model that would pay a fixed sum per annum per patient enrolled with a doctor and mean no direct patient charges to see a doctor. The NZBMA was of the view that such a model would undermine the doctor-patient relationship as it would interrupt the 'personal arrangements' between the two parties if a third payer – the government—became involved.[1]

Yet this view flew in the face of advice received from Sir Henry Brackenbury, vice-president of the British Medical Association (UK), who visited New Zealand in 1937. Brackenbury was a firm believer that national health insurance was the best method for funding. Fee for service medicine, he said, effectively reduced medical practice to the status of selling goods over the counter instead of fostering the principle of the doctor being the professional health advisor to the individual.

Brackenbury believed doctors should be able to give full attention to patients without having to worry about presenting them with a bill.[1] In sum, there was something of a conflict of views between BMA leadership and the New Zealand Branch.

The bargain eventually struck between the government and NZBMA in order to get the 1938 reforms implemented was as follows:

- GPs would maintain their independence and private business ownership model, and their ability to directly charge each patient for services provided. They would also receive a subsidy per visit from the government, meaning patients directly paid around a third of the cost.[20]

- Doctors would be permitted to work part-time in public hospitals for which they would be paid a salary, while maintaining their capacity to also work in the private sector. Hospitals would have no patient fees.[1]

In this bargain, we had the establishment of institutional arrangements that remain in place today. These foundations have led to a health system with quite separate service delivery compartments and methods of funding: GPs and specialists in private practice serve largely their own and their patients' interests, not those of the whole health system or public; public hospitals, similarly, function independently, despite employing the same specialists working privately.

In primary care, various attempts over the years to alter fee structures or integrate with hospital services have been troubled by a mix of resistance and substandard policy.[21] However, recent trends suggest a closer alignment of GPs and primary care within the broader health system, while raising questions around how they might be further advanced. These include the increasing involvement of GPs and Primary Health Organisations (PHOs) in DHB activities and the gradual building of integrated local health systems, which should be propelled by the 2013 'New PHO Services Agreement' and Alliancing arrangements being implemented in each DHB region.

There has also been a gradual shift in recent years in some areas toward salaried general practice with capitation funding under PHOs, and GPs do play a crucial 'gatekeeping' role in the health system which is absent in many countries. This role could be given increasing prominence with the post-2008 policy emphasis on 'better, sooner, more convenient' and its implications for moving more services, and enhancing their coordination, under the umbrella of primary care.

When it comes to hospital care, debating the dual system goes to the heart of how some 40% of our medical specialists practice. That is, with both a public and a private hat on. Some say the dual system gives patients choice, but it also drives inequities in access through charges that are prohibitive to many. New Zealand is unusual in having no method for setting private fees which, in many EU and Asian countries, are often exactly the same as in public and, in this regard, a driver of equitable access which is an explicit aim of their health systems.[2223]

We need debate around private fees in which there is little transparency, especially when New Zealand's private specialists rely on publicly-subsidised systems – the GP gatekeepers—for patient referrals and public hospitals for crucial backup and support when patients have complications. And if private practice is quicky accessible what is hindering similarly timely access in public hospitals?

The embedded nature of our health system described above has meant an almost inevitable path dependency that seems difficult to shift from.[24] This path is largely due to resistance of the NZBMA and policy compromises made in the short period after 1938.

We need to ask, 75 years on, whether it was appropriate for one group to dominate so strongly in the policy process over 70 years ago, whose interests have best been served, and what public value and good the resulting system has brought long-term to the New Zealand public and to the development of our health care delivery arrangements?

We need to ask, also, whether we should we accept for our health system what has become status quo for its foundations? We know why the health system we have today is structured the way it is, but we need more debate and research into how well it performs.

We need to involve the public in this debate, and our health professionals. We need to ask whether we should recommit to the 1938 principles, as outlined above, and aim to achieve these; or whether we need a new set of principles that more accurately reflects the status quo.

If the latter, should we expect some patients to face access barriers, especially fees for primary care services; should we be resigned to compartmentalisation in our health system and the complexity this creates, particularly for developing strategies aimed at integration and at preventive approaches to health care delivery; and should we accept that those who can pay get swifter access to non-urgent services. This is the year for debating such questions and thinking about the design of our health system for the years to come.

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