The challenges of long-range planning for healthcare funding, performance and outcomes

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Two articles in this issue of the *New Zealand Medical Journal* highlight critical challenges that have faced our healthcare system and affected health behaviour and outcomes over the generations. Previous articles in the *Journal* have noted some of the issues raised as a result of the historic compromise made between the government and the medical profession following the passage of the Social Security Act in 1938. This affected the intent of the legislation and how our health system functions, with consequences for patient care and outcomes.[1,2]

The original legislation aimed to create a health system in which all services were to be integrated as part of a National Health Service; all health professionals were to be employees of that service; there would be no access barriers—financial or otherwise; and the focus would be on public health and community services. Horn and Gorman[3] re-emphasise the consequences of the events that followed and, using the lens of economics, focus on why creating effective change seems such a difficult task. Greenaway-McGrevy[4] presents New Zealand research that corroborates findings elsewhere. These are that economic cycles impact on labour supply which, in turn, has profound impacts on mortality and other health-related behaviours. In this case, the research points to the conclusion that a buoyant economy, with increased work opportunities, negatively impacts the aged-care sector, and that economic downturns and unemployment are associated with self-harm and assaults.

There can be no denying that our health system has failed multiple populations on multiple accounts over the years in terms of delivering on the original goals of the Social Security Act.[1,5,6] If it had not, access to care would be equitable, and so would outcomes. Similar could be said of macroeconomic performance—there would be close links between macroeconomic activity and the healthcare system with a strong population-health focus and active interlinking between the activities of different arms of government and the various public and social services. There would be considerably more focus on planning, including for workforce needs, but also in terms of ironing-out longstanding inadequacies in the funding model for health.[7] Such issues have, again, been highlighted in the 2020 Health and Disability System Review.[8] The Minister of Health has suggested that implementation of this review will focus on some key areas, such as, importantly, developing a Māori Health Authority—some three decades after the idea was originally floated as part of the ill-fated 'health reforms' of the early-1990s.[9] Implementation will also focus on supporting people to stay well in the community; high-quality emergency and specialist care when it is needed; digital services and technology to provide more care in communities; and valuing and training a sufficient healthcare workforce.

There is little new in the Minister's implementation points; perhaps the detail, when released, will provide some fresh thinking on these. It is possible we will see only incremental change and quite a lot of reinforcement of the status quo. The Māori Health Authority could provide crucial assistance with difficult conversations. If we think about the health workforce and access to specialist care, which remains deeply problematic, fundamental change is needed.

Around the country, people with non-urgent demands often only receive timely and needed care if they can pay for private service. This area of our health system has its roots in the historic compromise. Yet the user-pay element of the system would not exist without considerable public sector support and backing, which includes picking up the costs of patients who have had complications following private treatment and then need to be cared for in the public sector—paid for, of course, by the majority of taxpayers who cannot afford to access the private sector they are supporting.[10] This issue has sat outside of policy conversations over the years, possibly because it is in the too-hard basket and too provocative to raise. Yet some of the deepest inequities in our society lie between those who can access services privately and those who cannot. These services are frequently provided privately by the very same practitioners it is impossible to access in the public sector unless for urgent and acute care. It is hard to imagine teachers or police working in the same way, or that New Zealanders would accept these professionals straddling both the public and private sectors with service access based on ability to pay. The parallel ACC system, with its different co-payment rates and levels of service access covered through a variant of social insurance, adds a further dimension of inequity.

What kinds of structures and incentives are required in order to traverse the situation? Important research into this question is needed, as well as a very open public conversation around how to get our health workforce working for public rather than private interests. We may well have the complement of health workforce needed to deliver on all healthcare needs in New Zealand, but the economic incentives are misaligned. What sorts of macroeconomic structures within the healthcare system would be needed to ensure that public demands are delivered on? Is there a way of regulating private activity when public demands are unable to be met? Is there a way to implement social-insurance-style funding across the full spectrum of healthcare? Evidence suggests that, without such regulation or a different funding model, the public sector will be worse off.[11] Interminable questions also abound around how to fund and deliver on demands for new therapies and technologies, and how to make these available to all New Zealanders.[12]

How do we create incentives within our healthcare system to draw upon other industries? There is solid evidence showing sectors, including health, that focus on 'operational excellence' do produce superior performance, experiences and outcomes.[13] We continue to be in denial about this across the New Zealand healthcare system. We need to also look at how industries such as airlines have drawn together complex logistics through a consolidated focus on operational excellence along with information technology. Imagine having an 'Aotearoa health app' designed by Air New Zealand; this is entirely doable but requires our healthcare professionals—from primary through to hospital care and the private sector, along with managers—to have the will to work collaboratively on behalf of patients to iron out the logistical challenges of care coordination and channel this through an app. This would bring a new level of transparency to the system and patient friendliness. There is no reason it can't be done. If there is, let us hear why.

Horn and Gorman's and Greenaway-McGrevy's articles highlight issues of inequity and economic performance as fundamental to how our healthcare system functions, as well as what we desire from it and the impacts on outcomes. These issues are not going to be solved by once again 'tinkering' with the healthcare system. What is needed is fundamental redesign based on the 1938 principles and investment in a new model of care. Courageous steps and challenging conversations will be necessary. In New Zealand, we are now in a position to take bold steps in new directions and build a new compact. Will interests stymie our boldness? Let's see.

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