Are the government’s intended health indicators the accountability measures the New Zealand health system urgently needs?

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We have embarked on another expensive and disruptive reform of our health system. The government’s 12 Health System Indicators are intended to “measure and report how well our health and disability system is doing for New Zealanders.” If so, they will measure any benefits that the reforms generate and will be a useful input into the accountability framework required to produce these benefits. Indeed, in his announcement on 6 August 2021, Minister of Health Andrew Little said the Health System Indicators would be used to hold government to account and ensure it delivers more equitable healthcare for all New Zealanders.

An effective accountability framework is necessary for successful reform

Ensuring delivery of the government’s priorities will also require those responsible for managing and providing care to be similarly accountable. Health spending represents a large and growing share of public expenditure, so there must be some assurance that the money is spent on what the government and ultimately Parliament intended. However, the health system is populated with people who have considerable discretion and who are likely to be more concerned about their accountability to peers, patients and communities than some remote official or minister.

Part of the answer is striking the right balance between top-down accountability to Parliament, horizontal accountability between decision-makers and their peers and bottom-up accountability to the people and communities the system serves. We have not got this balance right yet and are lurching from the extensive decentralisation of the 2000 reforms to an almost complete recentralisation. Having abolished the Health Funding Authority in 2000, the proposal now is to re-establish a similar organisation with even greater scope and powers.

The proposed Health System Indicators essentially attend to top-down accountability. In this case, they need to be measures of progress that have the greatest impact on prioritised ambitions; the degree of progress required to achieve the desired impact need to be identified; and there must be clarity about the consequences of under- or over-achievement.

Delivering benefits from health system reforms is difficult, as our history demonstrates. The underlying “political economy” of healthcare helps ensure that providers of existing services delivered in existing ways are in a strong position to protect themselves if funding becomes tight and to capture new funding. Simply delivering “more of the same” is not going to result in more equitable or affordable healthcare or significant improvements in the government’s six priorities. However, this is likely unless providers have a strong incentive to change the way services are designed and delivered and believe these changes are consistent with their professional obligations.
Using indicators as goals to drive accountability is risky but manageable and the alternative is likely to be worse

Using indicators as goals to drive accountability has obvious risks, like unintended consequences and crowding out what is valuable but hard to measure. For example, planned-care waitlists can be manipulated at the expense of both healthcare quality and cost. Consequently, we are also interested in how an indicator was met. The stronger the incentive to deliver the required goal, the higher the risk.

These risks can be minimised. The answer is in adopting measures to reduce the scope for manipulation and in the application of judgement in making an assessment and, when the risk is hard to control, in using “lower powered” incentives, such as earned autonomy.

Moreover, the alternative is neither attractive nor risk free. Ineffective accountability will inevitably result in yet another failed reform and generate additional risks to healthcare quality and cost.

The introduction of a primary care capitation in 2001, without any accountability for better outcomes, is illustrative. Capitation creates a financial incentive to both enrol as many patients as possible in a practice and reduce the cost to serve them. New Zealand Medical Council data show that the average general practitioner (GP) has given up almost a day per week in their usual practice since then and has reduced their after-hours and on-call commitments from an average of ten to four hours per week. Subsequent national health surveys have shown that the single biggest cause of unmet need in primary care is now the availability of the GP that the person wants to see. The reduction in after-hours care from GPs is associated with a subsequent proliferation of urgent care clinics, fragmenting primary care and increasing demands on emergency departments. Although the causal relationship between capitation and these effects is conjectural, the association is predictable given the financial incentive that capitation without accountability creates.

A shift to indicators is a deliberate departure from the past

Helen Clark’s government introduced ten “health targets” with accompanying “goals” and a quarterly assessment of district health board (DHB) achievement on the Ministry of Health website. Performance against goals was decidedly mixed during a period of increased health expenditure relative to GDP and, by different measures, reduced health system productivity.

John Key’s government sought to strengthen accountability by reducing the number of targets to six and increasing public transparency by publishing DHB performance quarterly in the mainstream media. Within six years, all four non-process outcomes were at least within one percentage point of target at the national level. Progress against the two process targets (smoking advice and CVD/diabetes checks) was not as strong. The track record of process measures (activity or outputs versus valuable outcomes) in health system funding innovations is generally poor.

The current government’s 12 high-level indicators have no goals, and the Minister of Health has made it clear that “they are not about incentivising with funding or pointing the finger if targets are not met – they are neither a carrot nor a stick.”

If there is no sense of what is required and no consequence for lack of measured progress, then the future will not differ much from the past given the strong incentives in the system to deliver more of the same.

Indefinite, indicators that lack goals and consequence suggest that reformers have yet to work out how accountability will meaningfully work down, across and up the large and complex public health and disability system.

The six government priorities

Electoral competition is partially based on what different parties promise to deliver once in power. It is, therefore, not surprising that different governments have different health priorities and seek to convince voters that healthcare will actually improve under their watch.

However, improving total health system performance should be a common objective
because it allows more of any government's priorities to be delivered for a given budget. This suggests that government priorities are best grounded in something like the widely accepted “Triple Aim” (as recommended by the government's relevant expert working group). Without this or another holistic perspective, it is not clear that these high-level indicators are either necessary or sufficient for total system performance improvement. Chasing a changing list of targets will likely pull resources from neglected but equally important outcomes. For example, the current indicators do not address outcomes for those with disabilities.

The way such priorities are defined is important. Ideally these should be priority outcomes a government seeks to deliver expressed in measurable terms. The critical requirement is to assess the efficacy of measures/indicators by reference back to these priority outcomes to identify which are having the greatest impact.

“Improving wellbeing” is cited in three of the six priorities. Wellbeing might be best seen as keeping more people healthier for longer, which enhances their participation and independence. Participation and independence are quantifiable and particularly important for assessing the performance of the disability system.

Taking this view, “improving child wellbeing” would be more about ensuring children’s health leaves them well placed to participate fully at school. The before-school check programme was structured to assess this fitness and so could be used as a success measure. That would show which high-level indicators make the most sense. Many indicators seem too narrow to reflect the desired outcome for the associated demographic (eg, the proposed ambulatory-sensitive hospitalisation (ASH) indicator seems to be about just keeping children out of hospital).

The most notable departure from previous governments' targets is the inattention to wait-times, both for cancer treatment (both Clark and Key) and shorter stays in emergency departments (Key). The proposed elective (or planned care) indicator is the closest the intended indicators come, and that falls back to a comparison with “the agreed number of events in the delivery plan.” Whether that means shorter wait times for electives depends on the delivery plan, which is likely to be set with some confidence that whatever number is “agreed” will be achieved. For a system that requires rationing, reducing wait times for treatment is a priority for the public, so this omission is surprising.

The twelve high-level indicators

Turning to the indicators, the two ASH rate indicators are interesting because recent and yet to be published analysis of this measure in two patient cohorts in Auckland shows that avoidable hospital admissions are more closely related to social deprivation factors than they are to the number of GPs per capita. Wider social determinants are also likely to be important to the achievement of most of the other government priorities. This suggests that the government should be looking to managers of the health system to identify actions within their plans to work with other agencies to address these upstream factors (as Canterbury’s System Level Measure Improvement Plan currently does). This is inherently transformative and will require more effective collaboration across agencies, with the budgeting, commissioning and funding plans and accountability arrangements necessary to support and incentivise such collaboration.

The “strong and equitable public health system” indicators are “number of days spent in hospital for unplanned care” and “people who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the delivery plan.” Neither indicator really focuses on equity. Given the Minister’s emphasis on improving equity, it would have been better if an equity lens was applied generically (eg, by requiring a reduction in the variability of outcomes across population groups).

The “financially sustainable health system” indicators are “net surplus/deficit as a percentage of revenue” and “budget versus actuals variance as a percentage of budget.” Financial sustainability has little to do with any single year’s budgetary outcome. This was a chance to significantly lengthen the financial horizon of health managers and better align their financial incentives with the desire to strengthen prevention as well as the role of primary care (and hopefully to work with others to...
modify the important social determinants of wellbeing). The indicators that really matter for financial sustainability are more like those that drive decisions at ACC. Their focus on controlling their future claims liability gives them a strong financial incentive to invest in prevention, early treatment and rehabilitation back to work or independence. Contrast that with the health system where the focus is to manage this year’s health costs within this year’s health budget, something these intended indicators only reinforce.

Balancing centralised and distributed accountability

Our final observation is that the publication of the indicators is premature. The government is yet to design the institutional arrangements beyond the broad brushstrokes of abolishing DHBs, public health organisations (PHOs) and alliances and creating Health New Zealand. Those arrangements will determine what system of accountability will operate in detail and how goals are best expressed, developed and assessed.

Designing effective accountability processes will be largely about the allocation of decision rights, funding models and flows of information. The contribution of any particular indicators will depend on how these arrangements work within the context of the total system architecture and whether they are co-created with clinicians and consumers who accept the resulting measures as meaningful and legitimate.

The latter is essential in the design of locality networks within the current reforms. These will only succeed if the initiative lies with professionals and community groups to agree on the contribution they will make to improve local service design and delivery. Central agencies will have to provide the infrastructure, support and models of funding that promote and support innovative “local solutions to meet local need.” Voluntary organisations, iwi providers and others are not going to be commissioned by a middle manager from a government agency.

The way forward

The New Zealand health system is reasonably characterised as being increasingly unaffordable and unfair. Reform is needed, and that must include meaningful accountability measures, supported by the right incentives, to encourage the changes in service design and delivery necessary for a fairer and more financially sustainable system.

The government intends that their new indicator framework can be used to hold itself, and presumably those who provide health and disability services, to account for making progress towards achieving its six system priorities. However, an over-reliance on a centralised and top-down approach—especially one with the current definition of priorities and associated indicators, a lack of goals or targets to define what degree of progress is expected or required and the consequence-free nature of its application—means it is unlikely we will get the accountability so badly needed to really shift the dial on the issues of equity and affordability.

Finally, reformers first need to develop system architecture that will facilitate desirable, enduring and comprehensive improvements in the health and disability system and only come back to target and indicator settings when they have built such a system.
Competing interests:
Nil.

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REFERENCES
5. Gorman D, Horn M. Purchasing better, innovative and integrated health services. Internal Medicine Journal 45 (2015); doi:1111/imj.12929