

The rocky road to health reform: some lessons from New Zealand

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Abstract

Ongoing structural change has been a feature of the New Zealand health system throughout the 1990s. As we enter the new millennium a new government is now embarking upon yet another round of reform. I look back on the past few years and consider what lessons might be learned about the process of health policy-making in New Zealand. They include the need for a clear vision about the goals of health policy, the importance of consulting with key stakeholders at an early stage, the problems of implementing change too speedily, and the need to allow sufficient time for systems to mature before replacing them with new structures.

Introduction

The New Zealand public health system has recently undergone a decade of radical and ongoing reform. The changes have often been controversial and have created an environment of instability and uncertainty. As we enter the new millennium a new government is now embarking upon yet another round of major reform. It is timely to look back upon the past few years and consider what lessons might be learned from the rocky road to health reform in New Zealand. The focus here is on the process of policy-making rather than on the content of health policy, the objective being to consider how the policy-making process might be improved.

A decade of change

After 50 years of relative stability in the health sector, in November 1990 an incoming National (i.e. conservative) government stated its intention to reform the public health system. It appointed a five-member Ministerial Committee on the Funding and Provision of Health Services to recommend changes which would 'make funders and providers more efficient and more responsive to consumer preferences' (Upton 1991, p137).

The recommendations of the committee were accepted as government policy and announced by the Minister of Health on budget night, July 1991 (Upton, 1991). It was proposed that four regional purchasers be established, public hospitals be restructured as for-profit businesses (called Crown health enterprises or CHEs), and that all public and private providers compete for contracts with these regional purchasers. Funding for public health services would be 'unbundled' from personal health services and a separate organisation, the Public Health Commission, would be established to purchase public health services.

After two years of intense activity, the new system was introduced on 1 July 1993. Over the next three years both purchasers and providers worked towards developing the mechanisms and collecting the information required to support a contracting regime. However there were numerous conflicts between what providers planned and what the purchasers were willing to fund. Contract negotiations were often prolonged and relationships tense. Workers reported a sense of alienation and many chief executives resigned (Cumming &

Salmond 1998; Ashton 1999). In 1995, the Public Health Commission was disbanded and its functions were incorporated into the Ministry of Health.

At the end of 1996, a National-led coalition government came into power. The junior partner in this government (New Zealand First) was philosophically opposed to the notions of competition between providers and of profit-oriented hospitals. There were also concerns about the transaction costs associated with four regional purchasers. The four purchasers were therefore merged into a single body (the Health Funding Authority) in July 1997, the CHEs were renamed Hospitals and Health Services, and there was a shift away from arms-length price and volume contracting towards longer-term relational contracting. These changes stimulated yet another round of restructuring along with the inevitable redundancies, new appointments, establishment of new systems, and development of new relationships.

By now, there was a widespread sense of change fatigue throughout the sector but in November 1999 another general election brought another change of government. The Labour Party, which led the incoming coalition government, had argued in its election manifesto that the National Party ‘...has allowed our public health system to be run down, privatised and commercialised in the name of the so-called “health reforms”’ (New Zealand Labour Party 1999, p4). The new government therefore placed high priority on the need to restore ‘...public faith in a quality and comprehensive public health system’.

Towards this end, the manifesto outlined a completely new structure for the public health system. The key elements are:

- the establishment of District Health Boards (DHBs) with majority elected representation. DHBs, which are to be established on existing Hospital and Health Service areas, will own public hospitals and be responsible for the planning, provision and evaluation of health services between the public, private and non-government sectors
- the Health Funding Authority to be disbanded and its functions to be shared between the Ministry of Health and the DHBs
- DHBs to be funded on a population-basis and to either provide services directly or enter into long-term funding arrangements with other non-government providers.

These arrangements bear some resemblance to the area health board structure that existed prior to 1993. However, this time around, the DHB budgets will include funding for primary services and disability support services as well as the funding for hospital and related services. The proposals will effectively put an end to the market-like arrangements that have been in place since 1993 and signal a return to a non-commercial public health system. They also signal a shift back towards decision-making at the local level.

The numerous changes in health policy in New Zealand over the past decade have stimulated a flurry of analysis and comment. Most of these commentators have discussed the content and implications of the various policies (for example, Scott, 1994; Cumming and Salmond, 1998; Ashton, 1999). However these experiences also provide some important lessons about the process of policy-making. The analogy of a journey down a rocky road is used to highlight the essential nature of the experiences of health reform in New Zealand.

Lesson No 1: First decide where you want to go. Then decide which road you should take to get there

In 1991 when the incoming National government set up its ministerial committee to review the funding and provision of health services, economic and social policy in New Zealand had for almost a decade been dominated by what became known as ‘Rogernomics’ (after Roger Douglas, Minister of Finance from 1984 to 1988). This was New Zealand’s version of free market economics: import tariffs and export subsidies were removed, many economic activities were deregulated, government assistance to industries was terminated, state-owned assets were sold off, and government departments were commercialised. These policies reflected a fundamental belief in the ability of free markets and competition to enhance economic performance.

This belief was also clearly reflected in the terms of reference provided to the ministerial committee on health services. Rather than setting some boundaries for the committee’s enquiries, the terms of reference signalled to the committee that the government’s preferred reform path was towards a more competitive system. They suggested, for example, that there was a need for ‘greater freedom for consumers to choose between alternative

fundors and providers of health services' and for 'competition between public and private sector fundors and providers of health services' (Upton, 1991, p.137). The assumption seemed to be that, because markets had been freed up in other sectors, it was desirable to move towards more competitive arrangements in the public health system.

As far as the objectives of reform were concerned, the usual references were made to the need to improve access, efficiency and consumer choice. However, all of these are measures of process rather than of outcome. No indication was given as to how these measures might be expected to impact upon the health status of New Zealanders. Thus in effect, the 1993 reforms were driven by the selection of the competitive path and of the processes associated with that path rather than by any broad vision about where that path should lead.

In contrast, a key part of the proposal for reform in 2000 has been the development of the New Zealand National Health Strategy which sets out the government's aims in respect of improving the health status of New Zealanders and reducing inequalities in health (King 2000a). The strategy suggests some fundamental principles which should be reflected across the sector, proposes a set of goals and objectives, and identifies those service areas which need to be given priority if the goals and objectives are to be met.

Lesson No 2: Don't get diverted off the main track

If it is not clear what your final destination is intended to be, it is easy to get diverted off the main track. In the early years of reform in New Zealand, there was a tendency to be diverted down the path that signalled 'Improved Financial Performance' and in so doing, to lose sight of the main road towards improving quality of care and patient outcomes.

The roles and responsibilities of the public providers (i.e. the CHEs which provided hospital and related services) were set out in the Health and Disability Services Act 1993. In their role as a provider of services, each of the 23 CHEs was required 'to exhibit a sense of social responsibility by having regard to the interests of the community in which it operates' and 'to be as successful and efficient as comparable businesses that are not owned by the Crown' (Health and Disability Services Act 1993 S11). While both of these are admirable objectives, in a cash-strapped publicly funded health system the two objectives were potentially in conflict.

Each CHE was required to submit a set of performance indicators to a government monitoring agency on a regular basis. These indicators were wide-ranging and included measures such as consumer satisfaction and level of service outputs as well as a range of financial indicators. However much pressure was put on the CHEs to stay within their budgets and those having difficulties were required to produce business plans that would reduce operating costs to an acceptable level. Some managers expressed concern that, sooner or later, the quality of patient care would be undermined by this focus on financial performance.

In 1997, the Auditor General (David McDonald), who was responsible for auditing the financial statements of public organisations, was critical of the emphasis that was being placed on the financial performance of public hospitals. 'Undue preoccupation with financial measures of "success" is a distraction from pursuing better performance measured in non-financial terms' (Laxon 1997).

In one hospital, a series of patient deaths and complaints between 1993 and 1996 led to an investigation being undertaken by the Health and Disability Commissioner. The findings were complex but included the fact that, under pressure from the governing board, the chief executive had prepared a business plan to which he was fundamentally opposed (Health and Disability Commissioner 1998, p11). This in turn led to a change in management style, a breakdown in communications, poor staff morale, and a disruption of services. All of these were found to be factors contributing to the poor quality of patient care and to adverse health outcomes.

Lesson No 3: Consult with the family at an early stage

The ministerial report which announced the proposed changes to the health system in 1991 was officially entitled *Your Health and the Public Health* (Upton, 1991). However it became known as 'The Green and White Paper'. This was because the report was intended to be partly a discussion document and partly a policy document. Its cover was therefore coloured green and white, following the British tradition in which discussion documents of the government are known as 'green papers' while policy documents are known as 'white papers'.

While the colour of the report's cover was more green than white, it very soon became apparent that the intention of the document was more white than green. Although two specific issues were open for public discussion (i.e. financing arrangements and the identification of a list of core services), the proposed structure of the health system was not open for debate. According to Atkinson (1994, p195) '... the main elements of the reform plans had been devised in secret with little or no consultation with relevant health practitioners or the public'. Blank (2001, p149) goes even further and suggests that the reform process '... consciously attempted to neutralise the medical profession and exclude the public'. Whether the lack of consultation was deliberate or not, the proposed new structure was certainly presented as a *fait accompli*.

Between 1991 and 1993 a series of stakeholder seminars was conducted around the country. However, rather than consulting with and seeking the opinions of the health care community, the main purpose of these seminars was to explain the proposed changes and the rationale behind them. The seminars were conducted by public servants who were ill-equipped to answer many of the more technical questions that were of interest to health professionals (Atkinson, 1994). Blank (2001, p152) suggests that 'the health care community saw the seminars as demeaning and further evidence of their marginalisation in the new health care system'.

Another strategy that backfired was the government's attempts to sell the reforms to the public through a series of public relations programmes and advertising campaigns. The wisdom of spending millions of dollars of taxpayers' money on such campaigns was criticised in the media, and the public debate stimulated by this criticism undermined the message that the campaigns were intended to convey (Atkinson 1994). Many regarded the campaigns as propaganda rather than as legitimate means for educating and informing the public of the forthcoming changes.

The reform proposals for 2000 were again presented to the public and the health care community as a *fait accompli* with little or no consultation at the agenda-setting stage of the policy cycle. However, while the family was not consulted about the selection of the road for this latest journey, the process of developing and implementing the reforms has been open for suggestions this time around. A steady stream of discussion documents and newsletters - including a discussion document about the New Zealand Health Strategy (King 2000b) - have been distributed and the public and key stakeholders have been invited to express their opinions and views via submissions, letters or by email messages to the minister. Hopefully the government will not only consider these submissions but, where appropriate, will also be willing to accept and act upon some of the suggestions that are put forward during the consultation process.

Lesson No 4: Be a considerate driver

If changes to the health sector are to be implemented successfully, consideration needs to be given to the views and potential experiences of those most affected by the changes. Widespread and meaningful consultation is an essential part of this process. However, consultation alone is unlikely to be sufficient to secure the support of key stakeholders.

In New Zealand, the implementation process in the early 1990s included a number of strategies that undermined the trust and support of those working within the system as well as of many members of the public who were using it.

Firstly, a wave of new chief executives and senior managers who had no prior experience in the health sector were appointed to key positions. While much money was spent on redundancies, very little was spent on familiarisation and training for these new managers. Their practices and attitudes therefore sometimes appeared quite alien to health professionals. Many of the managers struggled with the issues associated with working in a sector where somebody else - i.e. the clinician - makes resource decisions and where information about activity levels, costs and outputs is often inadequate.

Secondly, the reforms were accompanied by a language that was foreign to health sector personnel. The whole notion of a market place was reflected in terms such as purchaser, provider, risk management and contracts. Hospitals became enterprises, wards became cost centres, doctors and nurses became human resources and patients became clients. The use of such language was another factor that contributed to a sense of alienation amongst the workforce.

The competitive environment that prevailed in the early years of health reform also undermined many traditional norms and values. The threat of loss of contract discouraged the sharing of ideas and innovations, and information was often withheld on the grounds of commercial sensitivity. Collaboration between health professionals was thus undermined and the concept of a cohesive health care community was in danger of breaking down into institutional groupings, each with its own specific objectives and agendas. All of this was quite contrary to the traditional value systems of health professionals. Some of these problems were alleviated following the change of government in 1996 and the shift away from competitive contracting back towards a more collaborative regime. But the damage was done and many health professionals felt bruised by the experience.

Lesson No 5: Stick to the speed limit

A final lesson from the New Zealand experience concerns the speed of change. A major criticism of the 1993 reforms was the tight timeline that was imposed for implementing the changes. Following the announcement of the proposals in 1991 a period of exactly two years elapsed before the new organisations started business. The restructuring required the valuation of public assets, the complete reconfiguration of publicly provided services, and the establishment of about 30 new organisations.

There were numerous redundancies and reappointments, long-standing relationships were torn apart and traditional processes were replaced by completely new systems. Some commentators used metaphors such as 'blitzkrieg', 'lightening strike' (Easton 1994) and 'revolution' (Ashton 1992) to describe the process.

For front line staff, such rapid upheaval must have caused considerable stress, especially in those organisations where patient safety is dependent upon the maintenance of consistent processes and close staff relationships. The rapidity of change also undermined the ability of interest groups to have any meaningful input into the process. This in turn contributed to the alienation of many of those involved.

In the ongoing restructuring that occurred between 1993 and 2000, several organisations were replaced before they had time to mature. The Public Health Commission was abolished after only 2 years in existence and the RHAs were only three years old when it was announced that their activities were to be merged into a single organisation. The Health Funding Authority itself now has abolished after only 2 years in existence. To be continued the analogy of the rocky road, such rapid change is akin to trading a new car in for yet another new model before the running-in period has been completed. Organisations take time to mature, to learn what works and what does not work, to evaluate new systems and to make adaptations where necessary. Structural change is inevitably a costly process. Change can also sometimes bring new unanticipated problems. It seems wise to evaluate a system and to identify precisely which aspects require improvement before any new arrangements are introduced.

Conclusion

Although structural reform was a feature of many health systems during the 1990s, New Zealand was notable for the depth, speed and continuity of change. As we enter yet another round of health reform at the start of the new millennium it is important to review the experiences of the 1990s and to consider how the process of policy-making might be improved in the future.

This paper has highlighted just a few of the many lessons that might be learned. It suggests that, if new policies are to be implemented smoothly: the vision, goals and objectives need to be clearly stated; the need to achieve particular performance targets should not take priority over the broader objective of improving health status; public consultation should commence before the agenda is set and ongoing dialogue should be maintained throughout the policy-making cycle; the change process should not undermine the traditional norms and values of those working within the system; and changes should be introduced without undue haste with new structures and systems being evaluated before they are replaced.

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