Governance of the New Zealand health system

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The core argument (and question: do we have a health system?)

• Governance arrangements in the NZ health system are very complex
• There are multiple parallel and compartmentalised structures
• It requires substantial negotiation (to navigate; and in order to get things done)
• The reasons for the complexity are historical as well as organisational
Today’s menu

• Institutional foundations of the NZ health system
  – Why what we have today makes for complexity

• Present governance arrangements
  – DHBs, elected boards, etc

• Reasons for hope
  – Clinical governance
INSTITUTIONAL FOUNDATIONS OF NZ’S HEALTH SYSTEM: THE HISTORICAL DETERMINANTS OF COMPLEXITY
The Social Security Act (SSA) 1938: core principles for health care

• Health care should be a fundamental right; all should have equal rights to health care and to the same standard of treatment
• Services should be universally available
• There should be no access barriers
• The health system should have a preventive not curative focus
• Services should be integrated, not fragmented between primary and hospital-based care
The BMA (NZ) opposed the government’s funding model

- BMA (NZ) leaders argued that full government funding would undermine doctor-patient relationships
• Sir Henry Brackenbury (Vice President, BMA UK) argued that:
  – Charging patients a fee-for-service likened medical practice to the selling of goods over the counter
  – Doctors should be able to give full attention to patients without having to worry about presenting them with a bill
  – National health insurance is best funding method
To get the health care plan implemented, the bargain struck was:

• Doctors would maintain their independence and private business ownership model, and their ability to directly charge each patient for services provided. They would receive a subsidy per visit from the govt, meaning patients directly paid around a third of the cost.

• Doctors would be permitted to work in public hospitals for which they would be paid a salary, while maintaining their capacity to work in the private sector. Hospitals would not have patient charges.
The post-1938 bargain means that:

• Our health system is compartmentalised
  – Different health care providers work in quite separate systems:
    • Public employment
    • Private employment
    • Primary care
    • Hospital-based care
  – Different funding streams exacerbate the compartmentalisation
Debating these structures raises many intractable questions

- Attempts to reduce primary care fees have been troubled
- Business ownership and funding models
- Dual practice
- Private specialists and fee transparency
  - Private practice relies on public subsidies and backup
  - Many countries have a regulated fee schedule that is common to public and private service
- Incentives in the different parts of the health system
NZ health system scorecard

- Healthy lives = 75%
- Quality = 79%
- Access = 64% (C+)
- Efficiency = 81%
- Equity = 57% (C)
- Total = 71% (or B grade at Otago U)

Costs

Cost-Related Access Problems in the Past Year

Percent of sicker adults who because of cost:

Source: 2011 Commonwealth Fund International Health Policy Survey in Eleven Countries

Data collection: Harris Interactive, Inc.
Doctors’ Perception of Patient Access Barriers

Percent of primary care physicians reporting their patients OFTEN have:

- Australia: 60.0%
- New Zealand: 75.0%
- Sweden: 49.0%
- United Kingdom: 28.0%
- United States: 28.0%

Source: 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians
Data collection: Harris Interactive, Inc.
PREVENTIVE NOT CURATIVE FOCUS FOR THE HEALTH SYSTEM
INTEGRATION
Coordination Problems in the Past Two Years

Source: 2011 Commonwealth Fund International Health Policy Survey in Eleven Countries

Data collection: Harris Interactive, Inc.
NZ has integration ingredients

• Single-payer health system
• CEOs in each region: clear lines of authority, at least in the public sector
• Potential for single health system in each DHB region
• Potential for a single national health system
DISTRICT HEALTH BOARDS
Why have elected health boards predominated in NZ?

How well do elected health boards perform?
DHBs...

- Embed the historical regionalisation in the NZ health system
- Reform process failed to tackle compartmentalisation
- Governance model is unique to NZ
  - Elected members accountable to government before voters
  - Model does not fulfil expectations of ‘representative democracy’
- Limited evidence that DHB Boards have skills to drive high-performance of complex big-budget organisations
  - Not clear that elections produce well-equipped boards
- Not clear that public interested in elected model
- Most ‘governance’ happens beyond the DHB Boards
- ‘Governance’ has become increasingly complex
- Questions over how many elected members there should be
Key organizations in New Zealand’s health system (2012)

National level:

* Pre-existing:
  * Ministry of Health
  * Pharmac
  * National Health Committee

* New since 2008:
  * National Health Board (a business unit of the Ministry of Health)
  * IT Health Board
  * Health Workforce New Zealand
  * Quality and Safety Commission
  * Health Benefits Limited

Local level:

* 20 District Health Boards with associated public hospitals
* 36 Primary Health Organizations
* Other contracted health and disability support service providers

* New since 2008:
  * 9 pilot Integrated Family Health Centres
  * Considerable ‘regional’ activity (e.g. SI Alliance; HealthShare; CapCoast integration)
BUILDING HOPE THROUGH ‘CLINICAL GOVERNANCE’
What is ‘clinical governance’?

• The idea that:
  – ‘everyone in this health organisation has two jobs: improving the system of care as well as providing care’

• Clinical governance is the organisational fuel for health care quality and health system improvement

• Aims include partnership with management, building trust across the organisation, reducing clinical variation, standardising processes where possible, placing patients at centre of service design etc

• Expect to see:
  – Involvement of health professionals (clinicians) in leading and improving the system for organising and delivering care;
  – Leadership by clinicians, including clinicians stepping into leadership positions as well as leading by example and leading change;
  – A clinical workforce who are engaged and committed to service improvement in their organisation and to better patient care;
  – Clinical oversight of the organisation
Clinical governance evidence-base

- 2010 McKinsey/LSE research shows hospitals with clinically-trained leadership are more likely to have standardised processes in place, and better patient outcomes
- 2011 study of US hospitals backs this up

Improve quality while you reduce costs.

With ProvenCare®, we’ve proven it. It is possible to simultaneously raise quality and lower the cost of healthcare. We took care of the learning curve. In our pilot program for CABG procedures, we defined 40 critical steps to improve outcomes that produced these results:

**IMPROVED CLINICAL CARE**
- 21% reduction in complications
- 17% reduction in postoperative atrial fibrillation
- 60% reduction in neurologic complications
- 43% reduction in pulmonary complications
- 22% reduction in blood products used
- 55% reduction in reoperation for bleeding
- 25% reduction in deep sternal wound infections
- 44% reduction in readmissions within 30 days

**REDUCED COST**
- 5-day reduction in length of stay
- 7.8% revenue growth
- 16.9% growth in contribution margin of index hospitalization
- 44% reduction in readmission rate

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Clinical Governance Assessment Project (CGAP) background

• 2009 ‘In Good Hands’ report makes several recommendations for DHBs
• Minister of Health endorses and instructs DHBs to implement these:
  – “This is not about massive structural upheaval, it is about operating differently to develop and support strong clinical leadership and governance throughout the health system”
• We surveyed 3400 ASMS members in mid-2010 to gauge perceptions of implementation of key recommendations from In Good Hands
  – “To what extent are DHBs implementing In Good Hands?”
• Developed the Clinical Governance Development Index
  – DHB average score of 46%
• Findings published in *BMJ Quality and Safety*
• Method now being replicated by Irish Health Service Executive
CGAP background (2)

• NHB, HQSC and the DHBs partnered with Centre for Health Systems on follow-up study
• Broader scope with mixed method design:
  – Survey of all registered health professionals in DHBs: largest-ever in NZ; 41030 invited to participate (May-Jun 2012)
  – DHB case studies: self-review; 165 interviewees in 19 DHBs (Jul-Nov 2012)
  – Final meeting in Wellington to discuss findings (Dec 2012)
Findings

• 25% survey response; 10303 completed surveys
• Respondent characteristics close to those of broader health professional workforce
• 3500 written comments on surveys
• 19 days of interview data
Clinical governance is progressing well

- The journey has only recently commenced
- CG development is complex and takes time
- The DHBs are, without exception, committed to CG development
- Many DHBs have made bold steps in terms of implementing often highly innovative structures to facilitate and advance clinical governance and leadership
- There are variations in how DHBs have approached CG and in its development (20 different approaches!)
- Considerable opportunities to learn from one another
- Some questions about DHB Board comprehension of and support for CG
- Good progress since 2010 ASMS member survey
Comparison between ASMS survey and CGAP survey: Senior Medical Officers only

<table>
<thead>
<tr>
<th>DHB</th>
<th>CGAP</th>
<th>ASMS Survey</th>
<th>Difference</th>
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<tbody>
<tr>
<td>West Coast</td>
<td>36%</td>
<td>41%</td>
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<tr>
<td>Bay of Plenty</td>
<td>41%</td>
<td>38%</td>
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<tr>
<td>Southern</td>
<td>42%</td>
<td>42%</td>
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<tr>
<td>MidCentral</td>
<td>47%</td>
<td>43%</td>
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<tr>
<td>Wairarapa</td>
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<td>39%</td>
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<tr>
<td>Waikato</td>
<td>52%</td>
<td>46%</td>
<td>5</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>52%</td>
<td>49%</td>
<td>3</td>
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<tr>
<td>Nelson Marlborough</td>
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<td>41%</td>
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<td>Auckland</td>
<td>53%</td>
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<tr>
<td>Northland</td>
<td>55%</td>
<td>46%</td>
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<tr>
<td>Tairawhiti</td>
<td>56%</td>
<td>55%</td>
<td>1</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>57%</td>
<td>54%</td>
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<tr>
<td>Lakes</td>
<td>58%</td>
<td>49%</td>
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<td>Whanganui</td>
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<td>Taranaki</td>
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<tr>
<td>South Canterbury</td>
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<tr>
<td><strong>Mean</strong></td>
<td>54%</td>
<td>46%</td>
<td><strong>8</strong></td>
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Examples of initiatives to build CG

- 24-member Executive Leadership Team, includes clinical directorate leaders, GPs, and PHOs
- Clinical Council with DHB ‘clinical oversight’
- Clinical Leadership Council pan-DHB region including NGOs
- Clinically-dominated ELT (one DHB requires members are clinically active)

- Staff material that spells out rationale for CG; shows why certain structures in place, what staff should expect and is expected of them
- Building partnership models of leadership
- Initiatives that demand clinical membership, such as ‘Clinical Practice Committee’ (reviews technologies and clinical innovations)
- Elected front-line reps on clinical board
Concluding thoughts

• We have a complex set of governance and service delivery arrangements
• It does not need to be this way
• Historical path dependency suggests altering the underlying structures set down after 1938 would be challenging; similarly challenging would be altering the balance of DHB Board membership
• A new compromise is required
Which principles for our health system today?

Social Security Act 1938
• Universality; no barriers
• Focus on preventive care
• Integration
• Equity

Or...
• Expect to pay
• Hospital focused, but trying
• Compartmentalisation
• Those who pay get timely and guaranteed access
Results of the proportional odds mixed model for relationship between gender, age and years of experience and familiarity with the concept of clinical leadership

<table>
<thead>
<tr>
<th>Gender</th>
<th>Odds ratio</th>
<th>95% CI</th>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
<td>0.86</td>
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<tr>
<td>30–39</td>
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<td>1.06–1.44</td>
<td>0.0061</td>
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<td>40–49</td>
<td>1.40</td>
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<td>50–59</td>
<td>1.57</td>
<td>1.34–1.84</td>
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<td>60 and over</td>
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<td>1.17–1.71</td>
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<td>5–15 years</td>
<td>1.10</td>
<td>0.99–1.23</td>
<td>0.0856</td>
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<tr>
<td>More than 15 years</td>
<td>1.25</td>
<td>1.11–1.42</td>
<td>0.0003</td>
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<table>
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<th>Odds ratio</th>
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<tr>
<td>Doctor</td>
<td>reference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>0.60</td>
<td>0.54–0.67</td>
<td>0.0000</td>
</tr>
<tr>
<td>Midwife</td>
<td>0.54</td>
<td>0.43–0.69</td>
<td>0.0000</td>
</tr>
<tr>
<td>Allied/Other</td>
<td>0.58</td>
<td>0.52–0.65</td>
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“In this clinical area, it is easy to speak up if I perceive a problem with patient care”

69% agree
CG survey questions

• The survey data portray positive development around several issues

• A healthy proportion of respondents see:
  – Themselves as ‘involved in a partnership with management, with shared decision making, responsibility and accountability’ (71%);
  – That their DHB has worked to ‘enable strong clinical leadership’ (78%); and to ‘foster and support development of clinical leadership’ (63%);
  – That quality and safety are goals of both clinical service (90%) and clinical resourcing and support (managerial/financial) initiatives (83%) in their DHB;
  – That their DHB had ‘sought to give responsibility’ to their team for ‘clinical service decisions in their service area’ (69%)