

Witness Seminar

Health Policy-making in an Era of Reform: New Zealand's Health System in the 1980s



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First published by the London School of Hygiene & Tropical Medicine, 2018

Funded by the Wellcome Trust, Investigator Award number 106720/Z/15/Z

ISBN 978-0-9957874-3-8

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Health Policy Making in an Era of Reform: New Zealand's Health System in the 1980s

The transcript of a Witness Seminar held at the University of Auckland on 28 February 2018

Chair: Linda Bryder, University of Auckland
Organisers: Hayley Brown and Martin Gorsky,
Centre for History in Public Health,
LSHTM
Linda Bryder, University of Auckland

Photographs: Hayley Brown

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Instructions for Citation

Please cite the publication as a whole as: Hayley Brown, Linda Bryder and Martin Gorsky (eds), *Health Policy Making in an Era of Reform: New Zealand's Health System in the 1980s. Transcript of a Witness Seminar*. (London: London School of Hygiene & Tropical Medicine, 2018)

References to direct quotations from this witness seminar should follow the format below:

[Witness name], in *Health Policy Making in an Era of Reform: New Zealand's Health System in the 1980s. Transcript of a Witness Seminar*, held 28 February 2018, (London: London School of Hygiene & Tropical Medicine, 2018) <http://history.lshtm.ac.uk/witness-seminars.html>, [page number of reference].

Preface: Witness Seminar

The witness seminar is a form of group oral history that has been used especially productively in the area of medical history. Involving a structured interaction of key individuals who were involved in a set of events or developments, it enables participants to spark off each other, to debate, complicate and share memories from varying perspectives. In New Zealand Linda Bryder and Derek Dow were instrumental in organising a 2014 seminar on New Zealand doctors and overseas training in the 1950s and 1960s, and although this was not the only exercise of its kind to be organised by oral historians in this country, the seminar paid homage to a format originally developed by the Institute of Contemporary British History.

The transcript which follows of this 2018 seminar on 'the long 1980s' has similar transnational elements to the 2014 gathering, but is more purposely embedded in a wider project on international health systems. Auckland-based Professor Linda Bryder is once again a key coordinator, along with Professor Martin Gorsky and Dr Hayley Brown, both from the London School of Tropical Medicine and Hygiene. Productive comparisons with the British health system surface frequently in the transcript, which includes an introductory statement from Gorsky elaborating on the existing literature and historical context of reforms. Many of the participants in the seminar were well acquainted with overseas developments, even if they did not join those who travelled around the world to study them (in what one of the witnesses describes as 'junkets' to learn about developments elsewhere).

And yet, as well as the international context, the transcript also tellingly underlines what participant David Caygill refers to as the 'very intimate democracy' in which New Zealand's health reforms were enacted. There are stunning examples of the inefficiencies of the old hospital board system (empty hospital wards; disused, but expensive equipment; inequitable resourcing decisions made on the basis of pork barrel politics; the CEO-equivalent who sold insurance in the morning and ran the hospital in the afternoon!) But the health reforms of the 1980s and 1990s themselves depended upon the ability of certain ideological positions to become entrenched and enacted with a minimum of debate in this small democracy. Equally striking is the sense of 'how the bloody hell do you do this'; of a lack of capacity to implement ambitious reforms, and of some regret at a loss of control to those from industry who had little experience in the health sector.

Linda Bryder, the chair of the seminar, guides the fifteen participants - former politicians, public servants, researchers and medical personnel - through four stages of discussion. The first involves the health sector at the start of the 1980s; the second, the ideas in such 'big reports' as the 1986 Health Benefits Review and the 1988 Gibbs Report on 'Unshackling the Hospitals'; then discussants comment upon the formation of area health boards; and, finally, they give their perspectives on the accelerated changes of the early 1990s. The result is a fascinating insight into the interaction of policy and practice, leavened by very human stories, and some pertinent comments from a specially chosen audience. Debbie Hager asks about the perspective of those affected by the changes at a less rarefied level, including

personnel subject to constant restructurings and job losses (perhaps an issue for a different kind of exercise), while Derek Dow points out the loss of institutional memory when so many initiatives, New Zealand and elsewhere, involved starting from new, and the dislodging of those attached to the old order. One of the roles of this kind of witness seminar is to partially fill gaps left by the loss of institutional memory and to provide, from multiple perspectives, an understanding and assessment of this period of heroic change. The transcript invites careful reading and, for future policy makers, constant reference.

Margaret Tennant
Professor Emerita
Massey University
2 November 2018

Contributor and Audience Members

Chair

Prof Linda Bryder: Professor of History, University of Auckland

Convenors

Dr Hayley Brown: Research Fellow in History, London School of Hygiene and Tropical Medicine

Prof Linda Bryder: Professor of History, University of Auckland

Prof Martin Gorsky: Professor of History, London School of Hygiene and Tropical Medicine

Witnesses

Mr Tony Baird: ONZM, obstetrician and gynaecologist; Chairman of the NZMA (1987-1998); of ASH (1989-92); and of the Council of Medical Colleges (1995-1997); President of the RNZCOG (1994-1997) and the NZMA (2012-2013); Honorary Senior Lecturer, University of Auckland.

Hon. Dr Michael Bassett: CNZM, QSO, Member of Parliament for Waitemata (1972-75); Member of Parliament for Te Atatu (1978-90); Opposition Spokesperson for Health (1980-1984); Minister of Health (1984-1987).

Hon. David Caygill: CNZM, Member of Parliament for St Albans (1978-96); Minister of Health (1987-1988); Minister of Finance (1988-1990); Chairman of ACC (1998-2004).

Prof Garth Cooper: Professor of Biochemistry and Clinical Biochemistry at the University of Auckland (1995-); Professor of Discovery and Experimental Medicine and Director of the Centre for Advanced Discovery and Experimental Therapeutics at the University of Manchester (2011-); Member of the Maori Health Committee (1996-2001) and the Research Policy Advisory Committee (2000-2005) of the Health Research Council (HRC) of New Zealand.

Mr Geoff Fougere: Senior Research Fellow, Department of Public Health, Otago University (Wellington). A member of the Health Benefits Review, he has also served in a wide range of other advisory positions in the health sector including the National Health Committee (2002-8) and the National Ethics Advisory Committee (2008-11).

Dr Ian Hassall: Paediatrician; Deputy Medical Director of Royal New Zealand Plunket Society (1978-89); Children's Commissioner (1989-94).

Mr David King: District General Manager of the Exeter Health Authority (1974-1989); General Manager of the Auckland Area Health Board (1989-1992); Head of Mental Health Task Force UK (1992-1995).

Prof Colin Mantell: (Ngāi Tahu) Professor of Obstetrics and gynaecology (1978-1996); Professor and Head of Department of Maori and Pacific Health, University of Auckland (1996-2005).

Rt. Hon. Sir Donald McKinnon: ONZ, GCVO, Member of Parliament for Albany (1978-84; 1987-96); Member of Parliament for Rodney (1984-1987); List Member of Parliament (1996-2000); Opposition Spokesperson for Health (1987-90); Deputy Prime Minister (1990-96).

Mr David Moore: Founding general manager of Pharmac (1994-98); Health Funding Authority (1998-2000); Director of Pharmac Board (1998-2010); current chair of Patients First Board.

Dr Rod Perkins: Chief Executive of Dementia Auckland (2016-18); Senior Lecturer in the Business and Medical School, University of Auckland (1993-2009); Various management posts at Auckland AHB (1988-1993); CEO of Thames Hospital Board (1980-1985).

Prof Claudia Scott: ONZM, Professor of Public Policy at Victoria University of Wellington; Chairperson of Health Benefits Review (1986).

Dr Graham Scott: CB, Secretary to the Treasury (1986-93); Chairman of Health Funding Authority (1997-2000).

Dr Ian Scott: Specialist in palliative care, addiction medicine and public health (1969-2016). Elected Member of Auckland DHB (2001-2010); Chairman of the Auckland Primary Health Organisation (2010-2014); worked as a GP for 20 years.

Assoc Prof Tim Tenbenschel: Associate Professor in the School of Population Health at the University of Auckland, specialises in health policy and health systems.

Audience Members

Dr Bruce Arroll

Hannah Chisholm

Dr Bronwyn Croxson

Dr Derek Dow

Dr Debbie Hager

Dr Anna Howe

Andrew Lynch

Judy Murphy

Gillian Robb

Kieran Sinclair

Antonia Verstappen

Dr Laura Wilkinson-Meyers

Witness Seminar Transcript

Martin Gorsky: Well, ladies and gentlemen, a warm welcome to our witness seminar, and thank you very much for coming. My name is Martin Gorsky, from the Centre for History in Public Health, London School of Hygiene and Tropical Medicine. And on behalf of my colleagues, Linda Bryder, from the University of Auckland, and Hayley Brown, also from the Centre, welcome again. You might have been surprised in correspondence to be receiving letters from the University of London about all this, given that we'll be looking back over New Zealand's health policy history. So before we kick off, by way of brief introduction, I'm going to say a little bit about the project that was the spur to this meeting and about why we've invited you here.

The project which we're working on, 'Health Systems in History', is aiming to take a comparative and internationalist approach. By 'health systems', I mean a holistic conception of organised medicine, including its financing mechanisms, services, labour force, technologies, legal frameworks and outcomes. What we want to understand is the ideas and policies that inform their development. In the literature on health systems in the advanced industrial nations, there's a tendency to focus on what we might call the ideal types, like Germany, where social health insurance was pioneered, colloquially known as the 'Bismarck' system; then Britain, with its universalist, comprehensive National Health Service, the 'Beveridge' system; and the United States as a kind of outlier with its more pluralistic and privatised arrangements. The other strand in the literature looks at low and middle-income countries beyond the West. Here the story of health systems is entwined with the colonial relationship and the forced encounter with Western medicine, then subsequently, after imperialism, with efforts to build health services in post-colonial development settings.

When I was talking about this with Linda Bryder, at the planning stage of the project, one of the points she made was: where is New Zealand in this story? After all, ten years before Britain started its National Health Service, New Zealanders were there first with the Social Security Act of 1938, setting up a largely statist, universalist and comprehensive system. Shouldn't its founder, Gervan McMillan,¹ also be up there with Bismarck and Beveridge in the pantheon of people responsible for the different health system types? And subsequently, hasn't it been New Zealanders who have been pioneers at managing and administering what we might loosely call a NHS type health system? Also, New Zealand may speak to the non-Western experience too, in that its deeper history comes out of the imperial era, albeit as a white, Anglophone settler colony. So perhaps it can give us another take on the development of health systems internationally. For these reasons then, it seemed well worthwhile to consider New Zealand as a key case study.

¹ David Gervan McMillan (1904-51) MB ChB NZ 1929. MHR 1935-43 and Chairman of National Health Insurance Committee of House 1936; his pamphlet, D.G. McMillan. *A National Health Service: New Zealand of To-morrow*. (Wellington: New Zealand Labour Party, 1935) set out a vision for health system reform.

Next, I want to say something about the period that we've chosen to talk about today. I'll call it the 'long 1980s', because although we're going to be focusing on developments in the '80s, we'll be glancing back to the 1970s and certainly coming forward to the 1990s.

For health systems, this was very much a period of change, a pivotal period. First of all, the long post-war boom, the 30 'glorious years' of sustained growth for the western nations, had come to an end with the oil price crisis of the mid-70s. A bellwether of what this meant for social security and health systems was the issuing of reports by institutions like the OECD, asking for the first time how sustainable existing welfare systems were for the future. Wherever we look amongst the Western nations in the 1980s, we can begin to see a new policy direction, largely driven by health economists advising government about cost containment. In Germany, and in Japan, for example, there was a new focus on the costs of drugs and on holding down medical fees. Even in the US, the paragon of free-wheeling, privatised medicine, policy-makers turned to strategies like diagnostic related groups, to get a grip on prices within Medicare and in Health Maintenance Organisations. The 1980s also saw the arrival of patient consumers, making their voices heard, either through broader initiatives like the women's movement, or through more specific health activism. And beyond the West, the promotion of top-down, statist planning of health systems was also coming to an end. The debt crisis of countries in Africa and Latin America was leading to the structural adjustment philosophies, favoured by the International Monetary Fund and the World Bank, which in turn encouraged more pluralistic and diverse forms of health provision and financing.

So that is the broad backdrop to the period we're going to be talking about today. And finally, as a Britisher, I just want to reflect on what was going on in my country in this period, because Thatcherism, and Mrs Thatcher's approach to UK health policy, arguably has some interesting parallels with what was happening here in New Zealand. Government was bearing down on costs, and in some years actually shrinking the level of health expenditure as a proportion of GDP. It was starting to 'think the unthinkable' about whether a tax-based NHS system should continue, as well as introducing more privatisation, like tax breaks for private medical insurance or tendering for ancillary hospital services, and altering administrative structures to strike a different balance between central control and local democracy. It initiated the Griffiths Report on hospitals, when a leading industrialist was brought in to inject business acumen to the improvement of public sector hospitals.² Then at the end of the 1980s, came *Working for Patients*, the key discussion document leading shortly thereafter to the internal market in the NHS, with its purchaser/ provider split, drawing on the ideas of Alain Enthoven.³

² R. Griffiths. *NHS Management Inquiry Report*. (London: DHSS, 1983).

³ Department of Health. *Working for Patients*. (London: HMSO, 1989). The White Paper *Working for Patients* was the outcome of a review of the NHS initiated by Margaret Thatcher in January 1988. It included inter alia the principles of the internal market, with a purchaser/provider split, GP fund-holding and the creation of hospital trusts, and directly informed the legislation which introduced these reforms. Alain C Enthoven (1930-), American economist, who argued the case for integrated

And that brings me to New Zealand and today, and why we think this is such an interesting and important case to discuss. In New Zealand the end of the years of expansion came particularly hard, and had some distinctive features. The country's agricultural export trade started to suffer, particularly with Britain joining the European community, with all the implications that had for social security and the welfare state. Politically, 1984 was a rupture point with the arrival of Fourth Labour and the Lange government.⁴ Ministers now took a different approach to politics, not relying so much on the bureaucrats and the civil servants, but trying to open out to expert advisors and to business, with Treasury giving a lead to the political philosophy, which informed the leading policy-makers.

What then were the key issues, and what questions might we cover in the discussion? Taking first the major policy documents that shaped ideas in the period, we'd certainly like to learn more about the *Health Benefits Review* of 1986.⁵ This looked in quite a fundamental way at the different forms of financing which were available and at how New Zealand should best balance public/private funding and insurance in the mix. We'd like to understand better what informed that, and what its impact was. Next, in 1988, came *Unshackling the Hospitals*, the Gibbs Report,⁶ when another prominent industrialist was brought in to give his views on the running of the hospital system. Again, we'd like to learn more from you about how that came about, and what kind of effects that had in the short and longer term.

Second, this was also a period of thinking about how to improve the way the system functioned. One aspect of this was reforming the area health boards,⁷ and we'd also like to know what was going on there. How much of that was a continuation of earlier trends to rationalisation and integration, and how much reflected new challenges of democratic input? After all, this was a significant period of consumer activism, not least by Māori health care organisations, and we'd like to learn something about their impact. Indeed, throughout the later 1980s, Māori health seems to have been given a higher priority, and we'd like to know more about the roots of that and how it played out. There were also some fundamental structural reforms at the end of our period. Simon Upton's Green and White Paper⁸ heralded New Zealand's venture towards the internal market, with the introduction of user fees, and the idea of billable non-core services. Then there was the creation in 1993

delivery systems for healthcare, stating that this controlled costs while leading to improved medical care.

⁴ David Russell Lange (1942-2005). Auckland lawyer and son of a South Auckland GP and a former nurse. MP for Mangere 1977-96 and Prime Minister 1984-9.

⁵ *Choices for Health Care: Report of the Health Benefits Review*. (Wellington: Government Printer, 1986).

⁶ The Gibbs Report was named after its chair Alan Gibbs (1939-), businessman and entrepreneur, and supporter of the Fourth Labour Government's Finance Minister Roger Douglas. He was appointed chairman of Hospital and Related Services Taskforce in 1987, which led to *Unshackling the Hospitals: Report of the Hospital and Related Services Taskforce*. (Wellington: Government Printer, 1988), commonly known as the Gibbs Report.

⁷ The Area Health Boards Act 1983 was implemented in 1984. By 1989 only 7 of the 29 New Zealand hospital boards had adopted this model.

⁸ Simon David Upton (1958-), Member of Parliament for the National Party, 1981-2001, and Minister of Health 1990-1993. The Green and White Paper was titled, *Your Health & the Public Health. A Statement of Government Health Policy*. (Wellington: Minister of Health, 1991).

of Pharmac,⁹ to get a grip on the prices of drugs. We'd like to learn more about how those things came about.

Finally, given what I have been saying about the British NHS at the same time, there were clearly some interesting contrasts and similarities with what was going on in the Thatcher period. Why might that have been? Was it common structural problems affecting this type of health system? Or are we looking at the international diffusion of ideas?

So those are the some of the things that we're hoping to take away from our discussions today. Broadly, here's how we'd like to take the talk. In the first section, we'd like to look back to what the situation was at the start of the 1980s and gather people's impressions about that. Then in the second section, we'll focus on the ideas that were coming through in those big reports. And then after our tea break, a look at policy, a look at what was going on with the area health boards and other things people might want to talk about. Then we'll come up to that period in the early 90s, when the major reforms really started to be introduced.

Linda Bryder: It's my privilege to be chairing this session, so welcome everyone. And thank you, Martin, for the history lesson. And thanks Hayley. We're hoping that this will be relatively informal, as people get into it, and please feel free to interrupt people or speak whenever you feel like it. But I will try and control it, and we don't want a bun fight, but I'm sure we won't have a bun fight. I just want to stress the informality, and I also want to be inclusive of our audience, so called. Please feel free to catch my eye, and if you have a comment or a question for our witnesses, please feel free to participate.

And also, usually we try not to encourage people to talk for a very lengthy period of time in one go, so if you do keep your contributions relatively short that would be useful. Particularly when we have our opening, which I'm just going to introduce to you now.

I want you to cast your minds back to 1984. And you were all there, right, whatever your later roles were, and I'm assuming in New Zealand, but it doesn't really matter where you were. But just cast your minds back to 1984, and I'm going to invite you to speak for a few minutes about what your perception was of New Zealand's health service, or health system, taking on board the sort of things that Martin was talking about. At that particular point in time, and what your vision would be for change.

Now, this sounds like a lecture in itself, that's why I'm saying please keep your responses short, so that we can give everyone a chance to speak to this initial question. So it's your perception, but also really perhaps your perception of the group that you represent. Here, for example, Ian Hassall might want to look from the perception of the Plunket Society, and Colin and Garth, you know, you could look from the perspective of medical profession, but also from the perception of Māori concerns.

⁹ The Pharmaceutical Management Agency (PHARMAC) was created in 1993 to actively manage government spending on medicines and to achieve better value and health outcomes. <https://www.pharmac.govt.nz/about/our-history/>, accessed 27 November 2018.

What I'm going to do, I've thought about this, and I thought, well, we should invite the politicians to start, because they like to talk.

(Laughter)

And they're used to this kind of public forum, when they have to express their views on things. We'll start with Michael, and then David, for your vision, what you thought of the health system in 1984, and your vision for its future, at that particular point in time.



David Caygill and Michael Bassett

Michael Bassett: A few observations about the scene, as I saw it, when I became the Minister of Health in 1984. The first is that it was an era of rapidly rising health expenditure. In 1969, we spent more on education than we spent on health, and those positions reversed during the 70s and the 80s. And today, of course, there's a very considerable gap between the two. The second thing was that there was an enormous amount of careless expenditure that struck me. I recall the years leading up to 1984 and going out and doing a bit of good old fashioned politicking, and there were political hospitals that had been built around the country that weren't being used. I can recall going into Horowhenua Hospital, and you could have fired a gun off and been in no danger of hitting anybody. It had been built because there was an election coming up in 1978, and it was a marginal seat.

I remember going to Tokoroa, same thing, all the furniture had been ordered, it was all stacked up around the walls. The doors had never opened. There was also a misallocation of health resources, which shocked me, in the 29 hospital boards around the country. In Auckland, there was a shortage of geriatric beds. In Ranfurly in the South Island, in the Maniototo, the hospital beds were mostly being used for old age, it was really a pensioner village. I mean that was stunning. The theatre had been built, nobody was using it, there was a great big dust cover over it the day I went in there. It had never been funded properly, they couldn't get the people to go and serve in it. So the misallocation of resources.¹⁰ And at the same time here in

¹⁰ Ranfurly Hospital opened in 1929. In 2017 plans were announced for a rebuild of the hospital.

Auckland, you know, they were pulling down Cornwall Hospital, which was a geriatric facility, and they still hadn't really gotten the one out in Manukau, and the one in my electorate, in Te Atatu, fully functional.¹¹

There were hospitals, maternity hospitals, in the country, at least half a dozen of them, where there were only 24 to 28 births a year. In other words, a staffed hospital, where there was one birth every two weeks. And the results of this sort of expenditure didn't actually show up in improved health care; in fact, for a time, between 1970 and 1980, there'd actually been a slight decline in life expectancy. Which is hard to believe in today's day and age, but I mean things were not actually improving. So the problem for me was very much one of how, given the fact that there was an economic crisis, and there was not going to be much more money, how on earth could one rein in expenditure and redirect it in some way to try to improve health outcomes.

And a series of things actually occurred, and I think we can leave it perhaps at that and go on to David.

Linda Bryder: Thank you for opening it, that's very useful. Would you like to follow on from that, David?

David Caygill: Well, the short answer to that question is no.

(Laughter)

I mean of course I will say something, but at the risk of startling everybody, I think it's important to understand how politics works, at least in this country. The truth of the matter is that in 1984 I hadn't given the health sector more than a passing thought and I didn't for another three years. I didn't expect to become Minister of Health, succeeding Michael as I did in 1987. Indeed, I had the temerity to tell the Prime Minister [David Lange] in 1987 that I thought appointing me was a silly thing to do, and he shouldn't do it. He said, well that's all very well, but I am, so that was the end of that. I'd come into politics at the age of 30, in 1978, with a background in local government, having trained as a lawyer (but with an undergraduate degree in economics and political science). So I was interested in education, and as a student I had begun to think about economic issues. But I never expected to be involved in the health sector, although I was happy to accept that responsibility and am happy now to try and to explain my way out of the things I did do.

But no, I'd rather give some more time to Michael, or the other people who were thinking about health in 1984, because the truth is that I wasn't.

Linda Bryder: Fair enough answer. Thank you. Who would like to go next? Ian, would you like to go next?

Ian Scott: Why are you picking on me? Well, I mean, it's nice to hear the politicians acknowledge their mistakes and their responsibility for creating an inefficient health service that didn't know how to spend the money effectively. Because that's really what you described. What you left out, Michael, was the White Paper on health

¹¹ The hospital in Te Atatu (Waitakere Hospital) was originally a maternity unit, converted to a general hospital in 1955.

services, which the Labour government put out.¹² And the interesting follow up to that was we lost the election, but Professor Kerr White came as WHO consultant¹³ to the New Zealand government in 1976. And I was at that time still at the medical school, and unfortunately, I think, for the Department of Health, they rang the dean of the Auckland medical school,¹⁴ and said can you look after this guy for four days in Auckland, when he first arrives.

So the dean rang me and said, could I organise a programme for Professor Kerr White? Which is what I did, and that gave me an opportunity to show him how our health services in New Zealand worked from the ground up. So we had morning tea with Pacific Island families in South Auckland, met with general practitioners and their staff and health inspectors. We also held a half-day seminar on the place of small maternity units in Auckland. This really upset one O & G specialist who was wanting to close them all down. And so we created quite a stir. But the fascinating thing was that Kerr White was saying, is that we had twice as many hospital beds in this country as we needed. Now, admittedly, and Michael Bassett has provided the political explanation for that, with the example of Horowhenua, which is where I live now. That hospital still is in existence, but now closed down, and they've managed to finally sell the site in the past few years. And I think it's going to be turned into housing.¹⁵



Ian Scott and Rod Perkins

Michael Bassett: It will be in pristine condition.

Ian Scott: Yes. But you're right. Rather than sitting in an inadequately staffed cottage hospital in Levin, they would have been better off in Palmerston North or Wellington Hospital. Professor Kerr White was also a strong advocate for primary health care and while in Auckland was asked to comment on the twin hospital proposal for South Auckland which involved building a hospital in the Manukau Town centre and one at Botany Road. Each was to cost \$30,000,000 to build. Kerr White suggested that the cost of maintaining each hospital would likely be

¹² *A Health Service for New Zealand*, White Paper prepared by the Department of Health, (Wellington, Government Printer, 1974).

¹³ Kerr Lachlan White (1917-2014) was appointed chair of the Department of Epidemiology at the University of Vermont in 1962 and moved to become Professor of Health Care Organisation at Johns Hopkins University in 1965. From 1978-84 he was Deputy Director in Health Sciences at the Rockefeller Foundation, New York. After he retired Kerr White was in demand as a consultant in Australia, New Zealand, China, Europe and the Americas. His reputation as an expert on the appropriate balance of primary and hospital care rested, *inter alia*, on his classic article K.L.White, T.F.Williams, B.G.Greenberg, 'The ecology of medical care', *New England Journal of Medicine*, 265, 1961, 885-92, commonly regarded as a founding text of health services research.

¹⁴ David Simpson Cole (1923-2008) was Dean of the Auckland Medical School 1974-89.

¹⁵ The former Horowhenua Hospital in Levin was sold in 2014. The hospital closed in 2007 when the Horowhenua Health Centre opened on land next door.

\$10,000,000 annually and so suggested we should start by putting that amount into community services and then in 3 years' time measure the impact those services had on need and how many hospital beds should then be built to service the community.

At that time they were also talking about building Starship,¹⁶ and it seemed to me that Starship was going to be the most expensive hospital ever built in New Zealand. And I couldn't work out why they were going to stick it on site there in the middle of Auckland, when in fact when you looked at the admission rates to Auckland Hospital, by people under the age of 16, the real need was in North Shore and in South Auckland. So that's where the hospital should have been built, if you needed a hospital to solve those problems.

But I did an analysis over a period of one year of children's admissions, and then took the data to Bob Elliot¹⁷, who was professor of paediatrics at the time. And I said, Bob, can you tell me how many of these admissions are preventable, and on the basis of his knowledge, he said 66% of all these hospital admissions could be prevented with the right services in the community. So I presented that data to the board of the health committee on child health services.

Linda Bryder: What year was that?

Ian Scott: I can't tell you exactly –

Michael Bassett: The debate was going on from about 1980 through really until I resolved it in 1985, by saying The Auckland Children's Hospital would go ahead on the central site.

Ian Scott: But, you know, I presented this to the board of health committee, child health services, and Bob Elliot leapt to his feet and said, that's not true. And I said, well, sorry Bob, but it's your data, you told me that 66% of these admissions could be prevented. And of course, what I was really arguing for was better primary health care, which is the perspective I've always had about what we should be doing about our health services. We should be providing services to people in the community, as close to where they live as possible. It's really supporting those services, and then you build hospitals to solve the problems that you can't solve in the community basically. So I'll leave it there.

Linda Bryder: That's really good, a good opening for the discussion, and the *Choices for Healthcare*. Who would like to follow on now from that? Ian has introduced the importance of primary health care, as opposed to hospital beds, and cost. You would, Colin?

¹⁶ Starship Children's Health, opened in 1991, was New Zealand's first hospital built exclusively for children, and the largest such facility in the country.

¹⁷ Robert Bartlett Elliott (1934-) was Professor of Paediatrics at the University of Auckland 1970-99.

Colin Mantell: I'm just picturing 1984, and the picture for Māori in 1984. It was early Treaty times,¹⁸ so there hadn't been any settlements. And the actual concept of any Māori-led initiatives would not have passed muster in any kind of political grouping. And what I see has happened in the time since is that there is an increasing credibility for things Māori. Mark Solomon, at Ngāi Tahu,¹⁹ has raised Māori business such that it is credible everywhere in the country and it has upset a lot of places as well. And I think that's the climate in which we started in 1980, 84. Just a little comment for Michael, some good things happened in Ranfurly. I was born there.



Colin Mantell

(Laughter)

Michael Bassett: Not in that surgery, that operating theatre.

(Laughter)

Linda Bryder: Thank you. Who else, so Tony Baird....



Tony Baird

Tony Baird: I just re-read *Nineteen Eighty-Four*, the George Orwell one, which of course since the election of a certain President in the USA is in the top 10 in USA's books. And the comparative, we're living in comparable times. I was involved in the Medical Association; I was chairman of the council from 1987 to 89.²⁰ In 1984, I was working for then National Women's,²¹ and it was a decade of enormous change. And I was able to meet two Ministers of Health and several others during that time.

The Medical Association was busy, Richard Prebble described it as the country's strongest union, trade union. The State Services Act²² dealt a deal to that, and we had to break up and do

¹⁸ The Treaty of Waitangi Act 1975 established the Waitangi Tribunal and gave the Treaty of Waitangi recognition in New Zealand law for the first time. In 1985 the Tribunal's jurisdiction was extended back to 1840.

¹⁹ Sir Mark Wiremu Solomon (1954-) has been a Māori tribal leader since the mid-1990s. He was knighted in 2013 for services to Maori and business.

²⁰ The New Zealand Medical Association was formed in 1886 and a decade later became a branch of the British Medical Association, retaining that status until 1967. That year it changed its name to the Medical Association of New Zealand, reverting to its original title in 1976.

²¹ National Women's Hospital was opened in Auckland in 1946 and moved to a purpose-built hospital in 1964, the largest women's hospital in Australasia.

²² The State Sector Act 1988 replaced the State Services Act 1962 and reshaped the management of the State services in New Zealand.

different bits. But we were concerned with discipline, research was getting organised with crossover trials and such like. Informed consent, we were talking about, it was a theme throughout the centenary of the Medical Association in 1987. There was the Gibbs Report, of course, which came out around that time, but we're dealing with that?

Linda Bryder: Yes, we are. We're coming to that.

Tony Baird: Neo-liberalism, where everything has a cost, which was a bit of a surprise. But what I remember mostly, before going on to chair ASH,²³ the Smoke-free Environments Act,²⁴ was the antagonism towards the medical profession. And I don't know where that, how that came about, but clearly it was a feature of the enquiry into National Women's.²⁵

Ian Scott: Do you mean politically, or –

Tony Baird: Yes, politically, not in terms of the patients, necessarily.

Linda Bryder: I'll hold that point; we can get back to that later. Yes, I was going to suggest Ian Hassall.



Geoff Fougere and Ian Hassall

Ian Hassall: We seem to have embarked on a paediatric theme – So I might continue on with that, being a paediatrician by trade. I was the clinician at the old children's hospital, Princess Mary, at the time all of the hooha about creating a centre of excellence, so called, for paediatrics in Auckland, and indeed, in the country, was going on. And I was part of it, a member of a committee, which, to our shame, in the

²³ ASH (Action on Smoking and Health) was established in Britain by the Royal College of Physicians in 1971 with the goal of eliminating the harm caused by tobacco. The New Zealand ASH was formed in 1983.

²⁴ Smoke-Free Environments Act 1990.

²⁵ *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters.* (Auckland: Government Printing Office, 1988).

first place recommended a 400 bed hospital on the site. That was pared down, quite correctly, to something about half that, less than half that.²⁶

Michael Bassett: 188.

Ian Hassall: That's right. And rightly so, but my excuse is, and our excuse is, was that that was the way things were at that time, a little bit along the lines of what you were saying, that beds were a prize, a high number of beds were a bigger prize than a small number of beds. So I was involved in that, I believed in the centre of excellence idea, notwithstanding where all the patients were coming from. But I think we did need somewhere where there could be an aggregation of specialists in care of children, which would have enabled us to attract research programmes, and treatments that were going to be the best that we could devise. But in 1981, I ended my period of clinical work. Before that in 1978 I joined the Plunket Society as one of their medical advisors.²⁷

And the reason that I did that, and was invited to do that, was I had increasingly become aware that a lot of the problems that arose in the hospitals, or at least turned up in the hospitals, had their origins elsewhere, which was no great revelation, but it was to me. And that there were many things going on there that needed to be dealt with, there and then. And it wasn't so much that the primary care set up that was run by general practices could deal with that at the time, and there had arisen around that time the notion of community paediatrics. The Butler and Bonham Study in the UK²⁸ had recommended that there be community paediatricians who were appointed specifically to look at conditions in the community and how they could be improved for the sake of children's health and wellbeing.²⁹

As part of that idea there were also WHO sponsored conferences in Alma Ata, which is now Almaty³⁰ and in Ottawa,³¹ that looked at the principles of primary care and preventive care of children. And they were very keen on the idea of participation by people who have illness, or have relatives who have illness, in the whole organisation of their care and caring for them where they were, rather than at some great distance. So it seemed to me that the Plunket Society was very much in that ballpark, that the Plunket Society was an organisation that had been set up in New Zealand by people who were concerned for the care of the mothers and babies. Their motto was to help the mothers and save the babies, and it was quite a

²⁶ The Princess Mary Children's Hospital, located in the grounds of the Auckland Hospital, opened in 1918. It was replaced in 1991 by the Starship Children's Hospital.

²⁷ The Royal New Zealand Plunket Society is a non-governmental organisation which provides healthcare and support for mothers and their infants.

²⁸ Neville R Butler and Dennis G Bonham. *Perinatal mortality: the first report of the 1958 British Perinatal Mortality Survey under the auspices of the National Birthday Trust Fund*, (Edinburgh: E & S Livingstone, 1963).

²⁹ Committee on Child Health Services (chairman Professor S.D.M. Court) *Fit for the Future: Volumes 1 and 2*. (London: HMSO, 1976).

³⁰ WHO. Declaration of Alma Ata: International conference on primary health care, Alma Ata, USSR, 6-12 September, 1978. www.who.int/publications/almaata_declaration_en.pdf

³¹ WHO. Ottawa Charter for Health Promotion: First international conference on health promotion, Ottawa, Canada, 17-21 November, 1986.

www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion-1986

powerful organisation in New Zealand. It had become a lobbyist over a long period of time, and Linda has written about all of this in her book.³²

And, so that seemed to conform to both my own view, because I'd become increasingly, as a clinician, interested in things that arose in the community. Like child abuse, cot deaths, accidents, all three of those which were considerable contributors to ill health and death of children. So it was, to my mind, part of an important part of the fabric of child healthcare and should be given a larger part in it.

Linda Bryder: Yes, and it shows that, you know, it's not all about even New Zealand's traditional welfare state, it's not all about government, it's voluntary community involvement as well. That was the really good exemplar, the Plunket Society. So who would like to go next?



David King and Tim Tenbense

David King: Having worked in both countries, I can offer some comparative comments from time to time. Just looking at funding, its inadequacy was a problem from the outset for the NHS. The Guillebaud Report 1956,³³ concluded the NHS was not wasteful and needed increased funding. Even so, in my experience the NHS was always threadbare. Invited here in 1984 to talk about deinstitutionalisation, I was taken to a meeting of the Auckland Hospital Board at the offices in Wellesley Street. And it was the first time I'd ever seen

bear-baiting with the members hounding the Chairman to fund pet schemes, for I discovered that the elected members of the board had no financial responsibility, and therefore they were demanding more, each for their own bailiwick, and always (according to Barry Curtis, the Mayor of Manukau City)³⁴ to the detriment of South Auckland: it seemed crazy. Afterwards, the Chairman, Sir Frank Rutter,³⁵ took me to lunch in the Northern Club, and following that we drove to the North Shore for my advice on what Sir Frank described as a white elephant called the North Shore Hospital that, at the time, had two wards occupied and the rest empty.³⁶

³² Linda Bryder. *A Voice for Mothers: The Plunket Society and Infant Welfare 1907-2000*. (Auckland: Auckland University Press, 2003).

³³ C.W. Guillebaud, (Chairman). *Report of the Committee of Enquiry into the Cost of the National Health Service*. (London, HMSO, 1956).

³⁴ Barry John Curtis (1939-), Mayor of Manukau City 1983-2007. Knighted in 1992.

³⁵ Frank William Eden Rutter (1918-2002) MRCS LRCP 1942. Chairman of Auckland Hospital Board 1974-88. Knighted in 1986 for services to hospital boards.

³⁶ North Shore Hospital, founded as a maternity hospital in 1958, expanded to become a tertiary hospital in 1984, serving a catchment comprising North Shore, Waitakere and Rodney districts.

(Laughter)

But you have to remember that having grown up in London after the war, I learned that New Zealand was the richest country in the world, but as I subsequently realised, that amounted to an Austin A40 motor car, and a Bakelite Radio: nevertheless, life here was better than in austerity Britain.

(Laughter)

Linda Bryder: It was true in 1951.

(Laughter)

Michael Bassett: Can you pause for a second? That idea of area health boards, re-named hospital boards as they were with additional functions, was something I think we've got to give credit to George Gair,³⁷ who was the Minister [of Health] 78-81, for devising.³⁸ He also came up with the idea of equitable funding for boards. But prior to that, what happened was that whoever squeaked loudest got the most money. And the two big victims of equitable funding initially were Wellington, because of course, that was where the politicians were.

And anybody around Wellington could go along and squeak the handle in front of the Minister and so they got more than their just deserts. And the other was where the medical school was, Otago. And so they ended up being the big victims of equitable funding, and it took a long time, really to nurse those people around. And I don't think it's completely solved even now. I mean, there is a constant dearth of money in the Auckland region, because that's where the population growth is at its greatest. And the Bay of Plenty is sort of tagging along in hot pursuit.

Linda Bryder: Graham, would you like to come into the 80s, from your perspective?

Graham Scott: My perspective is a bit like David's. My direct involvement in health was mopping up after the Upton reforms, where I was appointed to rescue a failing RHA, and then finally amalgamate the four RHAs into the national Health Funding Authority.³⁹ That's out of scope. But that's the basis of my intimate knowledge of the health system. Going back to 1984, I had been advising Sir Robert Muldoon from the Prime Minister's department during the years before that.⁴⁰ We became increasingly worried about the deterioration of economic conditions, and in fiscal policy particularly.

So by 1984, when that government collapsed, it left the incoming government, whose Ministers have already spoken, with a dilemma. They would either follow

³⁷ George Frederick Gair (1926-2015). Journalist then National Party MP 1966-90. Minister of Health 1978 - 81. High Commissioner of NZ to the UK 1991-4.

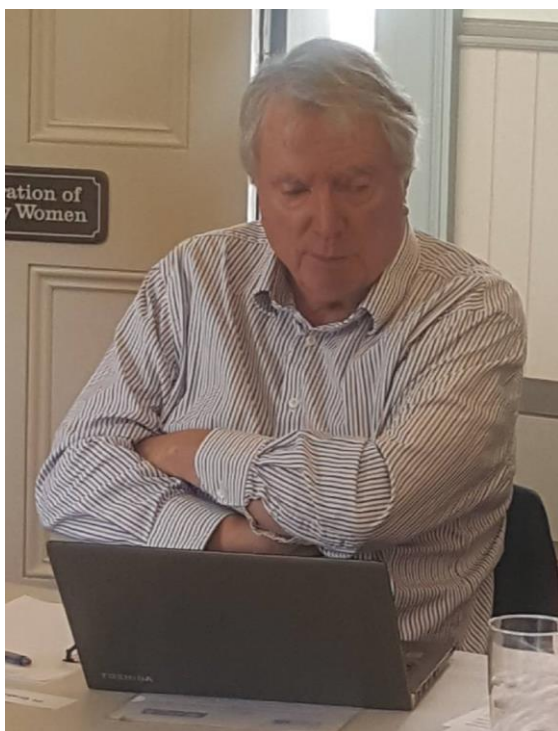
³⁸ The Area Health Boards Act 1983 was implemented in 1984. By 1989 only 7 of the 29 New Zealand hospital boards had adopted this model.

³⁹ The Health and Disability Services Act 1993 established four regional health authorities (RHAs) as part of the purchaser-provider split in health care. The Health Funding Authority (HFA) was up by the Government in 1997 to replace the four RHAs and given responsibility for funding public health care. The Fifth Labour Government dissolved the HFA by Act of Parliament in 2001 and allocated purchasing roles to the Ministry of Health and the District Health Boards.

⁴⁰ Sir Robert David Muldoon (1921-1992). Prime Minister of New Zealand and Minister of Finance 1975-84. MP for Tamaki 1960-1991. In 1984 he became only the second Prime Minister to be knighted while in office.

what the Australians had done, with a tripartite political agreement about how to reform the Australian economy. Or they would do essentially what they did. And unlike Australia, the head of the Federation of Labour in New Zealand firstly refused to do such a deal with the Muldoon administration. But surprisingly also refused to do it with Labour. And that set us on a path of structural adjustment, fiscal consolidation, and financial reform, which was the backdrop to all of this. And of course, the narrative from the left in New Zealand has always been that this was Thatcherism, Reaganism, and even Pinochet-ism.

(Laughter)



Graham Scott

But the reality of it was that that government inherited an economic and fiscal crisis, and in the background of it, this sort of story that Michael was telling earlier about waste in the health system was everywhere. And the Ministers in that government set up a group of Ministers that went through all the various parts of government expenditure and came out generally horrified with waste they found all over the place. The final contextualising point is that I was very involved in the creation of the State Owned Enterprises, which were a device which was intended to make running government business organisations more efficient.⁴¹ And it did, and it worked.

So there was an inevitable tendency to think, well, maybe that could work in some kind of way in the health system, where in fact, quite a lot of the preconditions that had led to the success of a lot of other State Owned Enterprises didn't really apply there. So it got very complicated. Instead of just thinking about a telephone system or a postal system, you're thinking about a complex adaptive system, which is what a health system is. And it doesn't yield to simple structural solutions to performance problems very easily. And that's the perspective that I have on it all. But this question of waste through the state was not just about the health sector, it was everywhere, and health just got swept up in that.

Linda Bryder: Thank you, there are some points there we will be able to follow up on for sure as we go through the afternoon. Rod, did you have anything from your perspective?

Rod Perkins: I'm Rod Perkins, and I was an administrator back in those days. And I may have become a manager since, I don't know. But it's been nice today to see two

⁴¹ New Zealand's State Owned Enterprises Act was passed in 1986.

of my Ministers, because I was the chief executive of the Thames Hospital Board when Michael was Minister of Health. I was a senior wallah in the Auckland Board when David was Minister of Health. Management was different then. I can't help but remind you that back in the 1980s in Ranfurly, the hospital board CEO sold life insurance in the morning and ran the hospital in the afternoon. And –

Michael Bassett In one of the hospital boards, he used to act as the dentist part-time as well, north of Gisborne.

Rod Perkins: Yes. And then the reference to one birth every two weeks, I recall vividly Aussie Malcolm,⁴² who was the Minister of Health, I think in 1983, and I were visiting Waihi, and I rang up to say he's insisting on visiting Waihi. Because the old Thames Hospital Board had hospitals in Thames, Paeroa, Waihi, Cape Reinga and Coromandel. And anyway, he wanted to visit Waihi⁴³, and there were no women and babies, but there was staffing.

(Laughter)

And I inquired as to whether there was anyone that had just been discharged who might like to come back for the afternoon. And there was, so we gave her a cup of tea and cakes, she came in with her baby, and Aussie didn't identify her as being slightly past just giving birth. But that was the context, wasn't it?

(Laughter)

Something since that's broader than just that 10 years. There was a real interest in separating planning and management, and that subsequently led to other changes, including the idea of service development groups. Planning and management being separate (with clinicians and community involved) from responsibility for management including living within budget. That was part of my memory of 1984. A lot of work had started in the 70s, but it had matured somewhat, and it was kind of cut, pretty well cut dead by the mid-1980s. And the only other thing I'd say at this point –

Linda Bryder: So it got cut dead, why?

Rod Perkins: Oh, because there were other things to concern ourselves with.

Linda Bryder: Oh, for money reasons?

Rod Perkins: Yes, and the things that have been covered. The other thing I'd just mention is Des Ryan⁴⁴, who I interviewed when I was doing a study, who was the deputy director general of health, and a very influential and important person in the 80s, told me about the trauma of having to go on to a marae.⁴⁵

(Laughter)

⁴² Anthony George (Aussie) Malcolm (1940 -), Member of Parliament for the National Party, 1975-1984, and Minister of Health, 1981-1984.

⁴³ Waihi is a small town at the foot of the Coromandel peninsula. Its hospital primarily caters to the elderly and also has a maternity annexe.

⁴⁴ Des Ryan, Deputy Director General of Health Administrative, 1976-1981.

⁴⁵ Marae are meeting grounds and the focal point of Māori communities.

The Ministry of Health, the senior people, had to go onto a marae at about 1984, and it was very, very –

Linda Bryder: Scary.

Rod Perkins: Yeah, and that was the beginning for a lot of the bureaucrats, 1984.

Linda Bryder: Garth, do you have anything to add, speaking of marae?



Garth Cooper and Colin Mantell

Garth Cooper: 1984, I was a fourth year registrar in Middlemore Hospital,⁴⁶ working with Dr David Scott⁴⁷, and Dr Bill Mercer⁴⁸, amongst others. And their concern, which they shared with me, was in particular the question of access to the hospital and medical care, with particular focus on Māori and Pasifika. This was a focus that was shared with David Lange, whose electorate was within the catchment district of Middlemore Hospital, with whom we had conversations about what we were trying to do. So with their backing and encouragement, we began a community based programme, working out of the, one of the Whaiora marae in Otara. The aim being to make the hospital and its services more accessible to Māori and Pasifika.

And we chose, with the support of the marae, to develop a model that was equitable between Māori and Pasifika, that wasn't necessarily approved of by all of the people in the community. But we developed a programme of lay community health workers, in Otara in particular, based out on the marae. Where the aim was basically to, at one level demystify the delivery of healthcare, but also to forge links between the community and the hospital services. Trying to start to move the hospital, some of the hospital services, out into the community, which was the aim. And working in particular areas such as, Bill Mercer's interests, for example, was teenage pregnancies, and trying to optimise the outcome, which I think that we were very

⁴⁶ Middlemore Hospital, located in South Auckland, opened in 1947. See D Scott (ed), *Middlemore Memories: the first 50 years of Middlemore Hospital...as recalled by the people who created it.* (Auckland: Middlemore Hospital, 1997).

⁴⁷ David John Scott (1940-2007) MB ChB NZ 1956 was an academic physician with a specialist interest in diabetes.

⁴⁸ Wilbur Harry Mercer MB ChB NZ 1951 MRCOG FRCOG.

successful in doing, with also the input of Heather Thomson,⁴⁹ if anybody knows Heather.

And then also in the sort of chronic disease, where David Scott was focused. So with the help of Barry Curtis, we developed a programme which I taught in to educate lay community health workers in South Auckland. And Manukau City actually developed a ... they actually got certificated by Mr Curtis, and I believe that that programme went on to actually develop the languages that we're looking to do. And I know that David went on after I left to start moving clinics into the, way outside the hospital, increasing amounts of hospital care was delivered into the systems that now exist for that. And I believe that, well, that I guess was driven by these forces that we're hearing about here, but that was my experience of 1984.

Ian Scott: Colin Dale⁵⁰ was a very significant player in Manukau City Council.

Garth Cooper: Yeah, yes, I would just be looking from my lowly rank as a senior registrar.



Tim Tenbense and David Moore

Linda Bryder: We have two younger witnesses over here, would either of you like to talk about 84?

David Moore: No. Not from a health perspective.

Tim Tenbense: Well, I'll just say something...

Ian Scott: Were you still at school then?

Tim Tenbense: No I was out of school.

(Laughter)

I was, but I wasn't in the country, so I don't qualify as a witness.

But I was working in the Australian Commonwealth Health Department

as a staff clerk. And my perception, interest in the health system was basically non-existent. So only maybe started in 1998 conversations with people like Rod, and most of what I learned about that time was from Rod, and Toni Ashton.⁵¹ So I'll leave it at that.

⁴⁹ Heather Thomson (Te Whānau-ā-Apanui), worked as a nurse at Middlemore Hospital where she ran a specialist service for pregnant teenagers. Held management positions in Auckland and then Bay of Plenty. Served on the Medical Council and the Pharmac Community Advisory Board.

⁵⁰ Colin Dale (c.1939-), district health inspector from 1964 then Chief Executive, Manukau City Council 1985-2006.

⁵¹ Toni Ashton, Professor of Health Economics, School of Population Health, University of Auckland since 2012.

Linda Bryder: Well, I saved you up until the last, because talking about 84 and 86 are pretty close. On our agenda we had that we're going to take a look at this wonderful publication, and I'd like you all to, I'll pass it around, so you can see the wonderful moustache!

(Laughter)

Geoff Fougere: David [Caygill], similarly at the time.

Linda Bryder: "Choices for Healthcare", obviously you must have seen that Martin chose to highlight this on the agenda. I think he already signified in his introductory talk that he'd like to know where this came from. And you two are very uniquely positioned to tell us, so I'll leave you to introduce that. One of you.



(L-R) Graham Scott, Linda Bryder, Claudia Scott, Geoff Fougere, Ian Hassall and Garth Cooper

Claudia Scott: Okay, well I'm looking in the direction of the Minister.

(Laughter)

Who approached me and said, would you be willing to do this report on health benefits. I said, yes, on two conditions: one, is that we're happy with the terms of reference and two, is that we'll report to you, and the report will be published. I felt that was really important, because as an academic I have seen too many cases where academics are hired to do things, and I didn't think the Minister would do that, but –

Michael Bassett: And the report disappeared without trace.

Claudia Scott: Yes, exactly. The Health Benefits Review was foreshadowing the Green and White Paper. I was asked to be on this as well. I said no because I could feel that the budget was going to come up, and those involved were running out of time, and it would all be very difficult. So I was very grateful, and I think that there was a little bit of the job that you have originally started, like let's look at health

benefits, but for me, I had a look at the health system. So I don't know whether you were surprised how broad our report we went to, but anyway, that's what we did. And I think it stood in good stead, and then you carried on with another report, and linked the brief for that to ours, and then Alan Gibbs thought one of our options was okay. I thought whoa, this is really pretty good (laughter). And so on.

Linda Bryder: So it was pretty good.

Claudia Scott: Well, you know, at least the group said so, but it was foreshadowed by the changes again, and the Ministers and so on. So it just creates a lot of confusion. So that's all I'd really like to say, I'd like to hear other people talk about it, and –

Linda Bryder: Just before you go, perhaps you should tell people what you were doing at the time, when you were asked –

Claudia Scott: When I was asked, I was actually at Harvard University on leave, and somebody came to visit me and said, would you do something in health? That's how it happened, but I was coming back to this. I was an academic, and I'd done a lot of work with the New Zealand Planning Council. I think I was regarded as somebody who might be able to cope with some of these issues from a fresh start, because I wasn't imbedded in the sector. And Geoff and John Marwick⁵² (who's not here today), made a great team. We had John who was a longstanding practitioner GP, and we had to really deal with that.

Geoff was certainly a tremendously experienced person, because he was teaching health and doing research on health policy. He also knew a lot about pharmaceuticals, and pharmaceuticals are really important, because when you looked at the health benefits, they were such a small proportion of money going to general practice and to what was then called the patient benefit. And that made it very different from what was going on in the UK - so that to me is a very important point of difference. A lot of general practitioners came to New Zealand to get away from contracting with the government, and I think that is a good comparison, and is important in terms of making those judgements.

Geoff, I want to just –

Geoff Fougere: Right, a couple of comments. I was at the time a young academic. My teaching and research interests were broadly in politics and public policy, and so health was one aspect of that. And to pick up on some of that, particularly Michael's comments, the other side, in a sense, of the excess in Ranfurly, as Michael noted, was paucity in Auckland. And the skewed politics of the sector. So there were key issues about waiting lists and key issues, particularly, about access to primary care. And I got into health because I had a generic interest in how states and markets intersect. But particularly because here was a health system in disarray. And yet, the political pressures such as they were that it generated, were exacerbating the disarray, rather than diminishing it.

And I had been particularly interested in how that fuelled the rise of private medical insurance in New Zealand. Peoples' response to long waiting lists, access to primary

⁵² John Charles Marwick MB ChB Edin 1971.

care problems and so on, was not to mount significant voice for a rethinking and a modernisation of the health system. It was to solve their own problem in a straightforward and simple way, which was to exit the public health system, and to take up health insurance to access the private sector. My research had been on how this combination of exit and voice in response to failings in the public health system had further exacerbated its problems and further undermined support for it.⁵³ So that was my connection into the health sector.



Claudia Scott, Geoff Fougere and Ian Hassall

I'd also been at Harvard for some time focusing on other topics, but coming back to New Zealand, I got drawn back into health. Partly because it just deeply interests me, it's a deeply interesting set of problems. Like Claudia, for me it was also really important Michael, that you agreed that we could publish the report, whatever. And the other thing that was really important for me from the beginning was that it was going to be an options report. Because I saw, and see, the world as a complex and uncertain one, and I was dismayed by a run of reports at the time, which ran along the lines the past was terrible, at least everything since 1935, but now there is a chance to recover a bright future and let us tell you the one and only way to realise that future. And there was not much acknowledgement of complexity or alternate possibilities in that approach.

So the options part was important, and when I reread it, one of the phrases I liked most was that the report was intended as a contribution to debate, rather than pre-empting debate. And for a while, it certainly operated as that, it helped generalise the discussion out into the community. People took up its terms, particularly the outline of alternative ways of organising the health system, they learned from the information it contained and it did significantly widen the debate in various ways. 1984 was for all of us, I'm sure in one way or another, a moment of fresh possibility after a pretty dismal period before. And one of the issues that was definitely on my

⁵³ See G.Fougere, 'Exit, Voice and the Decay of the Welfare Provision of Hospital Care', unpublished MA thesis, University of Canterbury, 1974.

mind was how could you modernise a health care sector, which aimed to provide access to people on the basis of need in a way that did actually deliver on that promise in the new context that the health system now operated in.

Constructing the Pharmaceuticals chapter was interesting; I'll just make one comment on that. Re-reading it, the pharmaceuticals chapter lays out an argument for a Pharmac-like organisation, and talks about how it could induce competition in an area in which that was not the case, in ways that would be of public benefit. I got into it partly because it was useful in thinking about some of the complexities of the state, and its relation to markets. And partly because it was so apparent that the bulk of the primary care budget was being used up in pharmaceuticals. And to tell my own Ranfurly story, I went and talked to the people in the then Department of Health who were responsible for this. And I said: 'How come these prices are being adjusted every month just as the pharmaceutical companies demand, under supposedly price control?'

And basically, the people who were doing it were good hearted, clerical people, who had no skills other, as far as I could tell, than simply ticking whatever box it was. So that was on one side here, and on the other side there was Australia, which had a bargaining regime and Canada which had a somewhat different kind of one. And the cost of pharmaceuticals in those two countries was running 30 and more percent under the OECD average, while they cost much more in New Zealand. That was where the impetus of that came from.

Ian Scott: Can I just, you mentioned the problem with funding primary health care, and the majority of the budget was on pharmaceuticals. And we also heard before that there was a problem with the politicians and doctors in general. One of the things that impacted on primary health care in New Zealand, about the 60s, 70s and so forth, was the number of people that fled from the health service in Britain and came out here. And a lot of them wound up being quite influential, in terms of the Medical Association. I won't name anybody from Auckland, but there is an obvious person one could mention in Auckland. And they brought with them a whole lot of views about state-funded healthcare, which I think did a great disservice to our services in New Zealand.

And they still do, they still have some impact there. But that might be part of the reason why politicians do like what the doctor said, but as doctors, I was talking to somebody the other week, and I was saying that I couldn't believe that on the issues of child poverty, for instance, the doctors in this country hadn't stood up and said we're not going to put up with this, can't go on like this. But we haven't. The only issue in New Zealand the doctors have fought as a social issue was nuclear war. We formed the NZ chapter of IPPNW.⁵⁴ And there we were very successful. But I've never seen the doctors in New Zealand stand up and say to a government, this is our view about this issue, and we can't abide it happening. The only issue that I've seen doctors combined on was the issue of how much money they want to be paid for whatever. And I've always found that somewhat disappointing.

⁵⁴ International Physicians for the Prevention of Nuclear War (IPPNW) was founded in 1980 by physicians from the USA and the former Soviet Union. IPPNW(NZ) was established in 1982.

And I think back to Maurice Matich,⁵⁵ who was chair of the Medical Association. When I worked for him for a year in Dargaville, he told me that when he was chairperson of the Medical Association they decided they should go to the government and ask for the GMS⁵⁶ to be increased. But they thought they ought to be better prepared than they were for it. And so they did a survey of general practitioners to find out what the GPs were actually earning. And he said the embarrassing thing was they were earning so much more than they expected, and that there was no case to go to the government. Which takes you rather back to the National Health Service, when –

Michael Bassett: And none of the affordability for the patient.

Ian Scott: When the NHS was formed the Minister of Health decided he was going to buy the doctors by paying them more than they earned. Unfortunately, this was determined on the income tax they paid, and so Bevan wound up paying them £200, less than they were in fact making. So the Labour Government lost a lot of credibility.

Michael Bassett: Madam Chair, before you go off the Health Benefits Review, I don't think you'll want to come back to it, I commissioned it, and I thought I should just say a word or two about it.

Linda Bryder: Sure.

Michael Bassett: I've been burdened all my life by being interested in history, and I approach any issue by always asking, whatever the problem is, why, where did it come from, what caused this? Because I always think that you might find at least part of the answer through that. And the thing that struck me about the benefits when I looked at them after 1984, was that they each operated according to a different set of rules.

In effect, they'd come in, they'd grown like Topsy, and whatever benefit it was that you got, it was the best that the government could negotiate with provider groups at that particular time. And so, the maternity benefit, for instance, was a fully funded benefit, comes 1939, has its own particular method of solving remuneration for the doctor. When you got to the question of the general medical services benefit, the war is on, and the government, which is very keen to try to see if they can get a whole fund arrangement with the medicos, they couldn't. And it was no time to be fighting a fight.⁵⁷

And so the part charge comes in, and take that on 30 years, you know, and we're looking awfully sick. The fee for service constitutes most of the doctor's payment. And then you got a whole lot of the other benefits, and they all have their different sets of rules. And so what I was thinking of when I empanelled the thing was that the

⁵⁵ Maurice Dominic Matich (c.1922-2015) MB ChB NZ 1947. Matich was a member of the New Zealand Royal Commission on Contraception, Sterilisation and Abortion which sat from June 1975 until March 1977.

⁵⁶ 'GMS' stands for General Medical Service benefits.

⁵⁷ The dispute between the Labour Government and the medical profession regarding medical benefits was finally resolved in 1949 with the Social Security Amendment Act introducing a GMS benefit to be paid by the Government as a fee-for-service, but allowing doctors to charge a 'token' amount to patients over and above the benefit.

group would get to what really should underpin benefits and the relationship of the state to the consumer. And Claudia and her group did that, and more, a lot more. She said she got right in, stuck into the health system as a whole. That just by way of a background.

Claudia Scott: Can I make a quick comment on that? Because what interested me is coming fresh to the sector, asking why are we funding dental care for kids in their teens, and we're not giving children free care? These things just hit me, this is just bizarre, it is all very ad hoc. And then from there, you went, and raised the GMS, and then GPs raised their fees, and then the matter ended up in court.

Michael Bassett: An awful lot of this has not yet been solved.

Claudia Scott: No, it's not solved.

Tim Tenbenschel: I just have a question, and that is, okay, from what people can recall, what was a typical charge for a visit to a GP, and I guess what, how did that compare to what the GMS was?

Michael Bassett: GMS was pretty pathetic in 1984. The GMS payment for an adult consultation was, if memory serves me right, \$1.25, and the rest was the direct fee for service –

Ian Scott: That's right.

Michael Bassett: For, and the total amount of the service would have been something in the order of about \$15, I think, \$12 to \$15. And so the patient was paying the difference between the \$1.25 and that total sum. Whereas right at the beginning, in 1941, when the benefit had first come in, seven and sixpence, or 75 cents was paid by the state, two and sixpence, 25 cents was what was paid by the patient. And that seemed reasonable and able to be lived with in 1941. It was looking awfully sick by 1984.

(Laughter)

Tony Baird: No, I was just going to say altruism of the medical profession, and we also negotiated a stocking allowance for the nurses.

(Laughter)

Claudia Scott: Made the point, thank you.

(Laughter)

Rod Perkins: Something Tony may be able to reflect on. I remember, I was involved in the mid-70s in the Department of Health, when the White Paper came out. The White Paper was drafted by people in the Ministry of Health, with David Morris from the UK.⁵⁸ And received a huge backlash from the Medical Association, I remember it vividly, it was seeking to fundamentally change the whole organisation of healthcare

⁵⁸ David Morris MB ChB Edin 1961 began work as assistant director in the Hospitals Division of the Department of Health on 26 April 1973, nine days after he arrived from the UK. On 23 May 1975 Health Minister Tom McGuigan told Parliament that, 'Were it not for the overriding personal considerations which determine his return to Britain, Dr Morris would have welcomed the opportunity to work in the reorganised New Zealand health service.'

in New Zealand. But Tony, my memory of the Health Benefits Review was that Medical Association didn't have anything like that same opposition. Is that right?

Tony Baird: That'd be correct, yes.

Linda Bryder: The reception was quite different.

Ian Scott: Well, in Auckland, in Auckland with the White Paper, of course the big argument was that it should have been a Green Paper, not a White Paper anyway. But in Auckland, they tried to impose a levy on all the doctors in Auckland, the Medical Association. And I said, I wasn't going to pay the levy and then so they said that they were going to expunge me, you know, delete me from the organisation.

Linda Bryder: Is that the 74, 75?

Ian Scott: Mm. And I got really quite incensed about this, and then I found that they also had another levy, which was for building their own rooms in Auckland. And they'd never got that approved, that levy had never been approved by the national organisation. So I said, well if you continue to threaten me, legally and so forth, then I'm going to take you to court and have that levy disallowed. And you're going to have to pay back the building levy people have been paying for 25 years. And so they shut up and went away and agreed that I didn't have to pay a levy to oppose something that I actually supported. And the thrust of their opposition was that they said you're going to put all the GPs on salary, that was what they managed to boil it all down to.

We have a question from the floor.

Derek Dow:⁵⁹ I came out here from Britain in 89, 90, and ended up writing a history of the Health Department, so very much an outsider's view. But you've been talking about the White Paper, and John Hiddlestone,⁶⁰ who was Director-General of Health, his memoirs recounted a discussion he had with Bob Tizard,⁶¹ who's the Minister at the time the White Paper was put together, shortly after. And Tizard said, "if there's any credit in health it goes to the politicians, and if any shit hits the fan, it's your responsibility." Hiddlestone's comment in the autobiography was the White Paper hit Bob Tizard, not me.

(Laughter)

This raises the question of what the relationship is between the politicians and the officials, in terms of responsibility and control of what happens. Seems to me it's often been quite unclear as to who should get the credit and who should get the blame.

(Laughter)

⁵⁹ Dr Derek Dow has been a freelance historian in New Zealand since 1990. His publications include *Safeguarding the Public Health: A History of the New Zealand Department of Health*. (Wellington: Victoria University Press, 1995), and *Maori Health and Government Policy 1840-1940*, (Wellington: Victoria University Press, 1999).

⁶⁰ Herbert John Hall Hiddlestone (1925–2008). MB ChB NZ 1949, Director, Division of Hospitals 1970–3 & Director–General of Health 1973–83.

⁶¹ Robert James (Bob) Tizard (1924–2016). MP 1957–60 and 1993–1990. Minister of Health 1972–4 and Deputy Prime Minister 1974–75. In 2007 at the age of 83 Tizard was elected to the Auckland District Health Board.

Linda Bryder: Any comments on that, Rod?

Michael Bassett: Well, I suppose the principle is always meant to be that the Minister takes the responsibility, I mean that's the British tradition. But I think about the only Minister that ever really did stand up and take the blame was Āpirana Ngata,⁶² and he resigned. But that's not been something that has happened here, to any great extent.

Rod Perkins: I guess, I do vividly remember when David Caygill was the Minister of Health, and there were difficulties with the Auckland Area Health Board, and the Auckland Area Health Board was subsequently replaced by Harold Titter as a commissioner.⁶³ And there's no question in my mind that those decisions were taken by the government at the time, that was very definitely –

Michael Bassett: That was Helen Clark⁶⁴ –

(Laughter)

David Caygill: Indeed. At the risk of being unfair to somebody I have an enormous regard for, it's always occurred to me that when Helen took over as Minister of Health in December 88⁶⁵ and decided to intervene and sack the Auckland board, it's always struck me that I would almost certainly not have done that. And I don't mean that to criticise her or undermine her. Just that it was absolutely a personal decision, she probably understood what was going on in Auckland much better than I ever would have.

But I say that simply as a way of trying to illustrate something that I think is quite important, at least in our political system. I suspect it's also true of Britain. And that is the way that some decisions are in the end quite personal. I enjoyed a good relationship with Frank Rutter, the chair of the Auckland Board. For example, there was a curious moment in my office when he was talking with, and I've forgotten the fellow's name, the person in charge of the mental health services in the Department and he made the idle comment that the two of them should be able to sort this out, because they were both Welshmen.⁶⁶ And I quietly said, well, actually, that's three of us. Because I'm quarter Welsh, but anyway.

We'll come back to perhaps a better illustration of the personal nature of political leadership when we talk about what happened in the wake of the Gibbs Report. In the end, you make decisions of that kind as much on the basis of temperament I think, as well as your best judgement about what needs to happen. I don't believe I would have sacked the Auckland health board, and I'm not saying that Helen was wrong to do it, but just that there's a contrast that ultimately rests with the personality of the Minister.

⁶² Sir Āpirana Turupa Ngata (1874-1950). Ngāti Porou leader and MP 1905-43, was Minister of Native Affairs 1928-34.

⁶³ Harold Titter, a chartered accountant and managing director of carpet manufacturer Feltex NZ Ltd, was appointed Commissioner of the Auckland Area Health Board in 1989 and was later Pro Vice Chancellor, University of Auckland.

⁶⁴ Helen Elizabeth Clark (1950-) was Minister of Health 1989-90 and Prime Minister of New Zealand 1999-2008. From 2009-17 Clark was Administrator of the United Nations Development Programme.

⁶⁵ Helen Clark officially took over the role of Minister of Health on 30 January 1989.

⁶⁶ Basil James (c.1930-2017) MB BChir Wales 1954. Director of Mental Health for New Zealand 1980-9.

Linda Bryder: Yes, thank you, that is –

Rod Perkins: Well, I was quite pleased that did happen, because I was responsible for mental health and had Titewhai Harawira –

(Laughter)

As a direct report.

Ian Scott: She was beating up all her patients.⁶⁷

(Laughter)

David King: She did. A footnote, after my appointment in Auckland, Helen Clark (then, Minister of Health) and her chief assistant, Heather Simpson,⁶⁸ came to Exeter to examine what I had done there. The attention was as thorough as that.

Bruce Arroll:⁶⁹ I was a GP in Canada in 1984, a New Zealand graduate, and now GP in Auckland. I just thought I'd comment, just to echo what you said, Ian. I've grown up with British doctors, and they all hated the NHS system. I thought it was a lousy system, and then when I was a medical, well when you taught me actually, British patients rather liked the NHS. It was a complete revelation to me, that that was the case. But my question was why did the Health Benefits Review get a better a reception than the White Paper? What had happened in the intervening period?

Michael Bassett: Yes, yes, I mean, David Caygill, bless him, has the White Paper here. And in case people have either been a little confused from earlier comments, it's 1974, not 1984. And the White Paper got plenty of comment at the time, as Don McKinnon in the early stages of his political career will remember. But there was a fair hooaha about the White Paper and this belief that it was going to make us all join a British-style system. In the end, it sank, I think, without trace, whereas the Health Benefits Review committee goes on to become important, it's a much more significant document, I think.

David Caygill: My view is that the White Paper was fundamentally focusing on structure.

Michael Bassett: Yes.

David Caygill: I think it was the precursor to the Area Health Boards, although they began under a National Government, and then got rolled out under Labour. Choices for Health Care was much more about services and finance and equity. It had some implications for structure, but was not fundamentally focused on structure.

⁶⁷ In 1988 Harawira, her daughter Hiniwhare, son Arthur and two others were found guilty of beating a Carrington Hospital patient. At the time Harawira was head of the Whare Paia Maori health unit. The jury also found Harawira guilty of a charge of threatening to kill. She was jailed for nine months, https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10864470, accessed 2 August 2018.

⁶⁸ Heather Simpson, a former economics lecturer, was policy adviser then chief of staff during Helen Clark's time as Prime Minister and later a special adviser to Clark in the UN. She was often referred to as 'H2', with Clark known as 'H1'. In 2018 she was appointed to lead a review of New Zealand's health and disability services. The final report of this review is due to be delivered by March 2020.

⁶⁹ Bruce Arroll MB ChB Auckland 1979 became a senior lecturer in the Department of General Practice and Primary Health, University of Auckland, in 1991, was awarded a personal chair in 2005, and became the Elaine Gurr Professor of General Practice in 2008. He was head of department 2005-11.

Linda Bryder: So a late arrival has been sitting there quietly, the opposition spokesperson for health in the late 80s. I opened the discussion by asking people to give a general view of what they thought of the health system actually 84, before. I'm sure you have views on that, so we'll just let you reflect on it as a politician at the time.

Don McKinnon: Well, thank you, and my apologies for –

Linda Bryder: That's okay, we knew you were coming late.

Don McKinnon: Traffic and everything else. But in coming into a seminar like this halfway through, it's like joining a party when everyone's had a couple of drinks.

(Laughter)

You haven't quite caught up all the jokes and things like that. It was a taxing exercise for me when asked to be involved in this, because, one, I never became the Minister for Health, though I did have aspirations to be after spending three years as opposition spokesman. That wasn't to be. And it was at a time where things were moving pretty fast, but not having been a Minister, I didn't need to take any responsibility for anything either. But it was almost a luxury to be in opposition, because the then government under David, Michael and Helen, you know, wheeled up these great reports, which gave us a tremendous amount of scope to talk about. Now my party just loved the Gibbs Report, you know, this was a three-course meal.

(Laughter)



Linda Bryder and Don McKinnon

And I, you know, I can see sitting opposite David in the House, and I was, you know, you've got the Gibbs Report, when are you going to implement it. And David, he can spin around on this one, answering questions for a very long time, but it was ideal for my party, because it so placated the right. And the right wanted to see, you know, market forces, blah, blah, blah, sort of thing, which was not unusual. Personally, I believe it wasn't actually implementable in its form, because it was such a massive change to everything that was going on. But I was quite happy to proselytise in certain parts of the country,

which I knew would lap it up. In fact, I thought if I was pushed to

really go down that track, I'd be trying to convince the party, well, let's just try it in Otago/Southland –

(Laughter)

Take a nice conservative region and see what they do with it.

David Caygill: Why didn't I think of that?

(Laughter)

Don McKinnon: That gets it out the way for a little while. But it was, it was really not difficult, and I look back to some of the stuff that we were talking about at the time, and delightful to have Graham Scott beside me here, because after, we talked about the need for, you know, bringing about more targeted assistance. Recognising that hospitals could be funded by block rounds and combination of services provided, there had to be great equality, etc., etc. And I ran into one of the, one of Graham's Treasury officials, I can't remember his name, but he said, have you guys sorted out your health manifesto for the election? I said, well, pretty well. He said, I suppose it includes greater reliance on the person, more market-orientated, greater concerns for the under-fives and over 75s, and better targeting.

I said, well, yeah, that's about right. He said, well we expected that from you. I said, what do you expect from the other side? Oh, they'll just say more general universal benefits, greater entitlements, recognise that people should not be left behind, and targeting things that work. So it really didn't matter what political parties were saying, the bureaucracy had really decided in advance that one was going to move slightly this way, one would move back this way, and really, we probably agreed on about 80% of the middle. But I think the bigger challenge for us in the political class was we had no training at all in the field of medicine. I was an agriculture student, so you can see what kind of medicine we talked about.

And everyone spoke a different language. It was the language of the medical professionals. There was the language of the medical administrators, there was the language of the senior bureaucrats. There was the language of the people who got elected to health boards, health bodies. They never really met very much or coincided on the arguments. Each worked in their own zone, proselytised their own issues, and nothing much came together. And no matter, you go racing around the world, what does Canada do, what does the United States do, what does he do, what does that do.

So you could sort of pluck out things that might work, but like anything else, you can never actually transplant an idea from one country and put it into another country. It just doesn't take root, it becomes a whole cultural thing. And I think, from what I see in watching health very much from a distance, until I get to be in the over 85s, you just know that this debate will kind of be always pretty messy. Because there are so many quite strong, influential groups, which are never really going to agree, apart from agreeing to keep on fighting for their particular corner. Thank you.

Linda Bryder: Thank you, and you've moved the conversation on to the Gibbs Report, which is on our agenda, before afternoon tea. Do we have any other comments people would like to make on moving on from the "Choices for Healthcare" to "Gibbs"? Who would like to?

David King: Just one, that I agree entirely with what Don has said, but in fact, I think for the 70s, certainly in the UK and subsequently in what we did here, the changes were structural, reorganising services based on populations of a magnitude to justify comprehensive secondary care provision, a district general hospital with supporting units. In the UK, it meant trying to rationalise cottage hospitals, and here it was to reorganise services in Auckland to three, ideally four, but as it turned out three, stand-alone districts: population based funding and decentralisation of services to the districts. And that was not easy, getting orthopaedics to the North Shore was quite a journey.

Don McKinnon: I'd make one more –

Linda Bryder: Yeah, sure.

Don McKinnon: Having thought suddenly before about what I was expected to do here today, I picked up in the comment in the *Economist* only a week ago, from the wonderful centre of capitalism run by Warren Buffett in Omaha, Nebraska. He said a hungry tape worm is devouring the whole economy through our health costs. And I thought, well –

Linda Bryder: Wow.

Michael Bassett: I think if we had Roger Douglas, he would say just that.⁷⁰

Don McKinnon: Welcome to the real world. Advancing health costs are there all the time.

Michael Bassett: But that's not new; I remember sharing a platform with George Gair in 1981, and George saying that at the rate of increase in the health vote at that time, by 2030 New Zealand would be devoting its entire government budget to health. And so really, if you think about that, what happens in the early 80s is that a whole series of things start to try to bring the health budget under some kind of control. And –

Graham Scott: And it worked, if you look at the difference from when you had hospital boards, the area health boards dropped the rate of growth of expenditure.

Michael Bassett: Yes.

Graham Scott: And then the reforms under National dropped it again –

Michael Bassett: Indeed.

Graham Scott: And so you previously had rates of increase of cost between four to five percent, and they dropped to around two and half, three and a half.

Michael Bassett: We haven't talked about the area health board thing, but you're about to –

Linda Bryder: Yes, that's after our first –

Michael Bassett: Comes later on?

⁷⁰ Roger Owen Douglas (1937-). Minister of Finance in the Fourth Labour Government 1984-8. Co-founder in 1993 of the Association of Consumers and Taxpayers, which was the nucleus of the ACT New Zealand Party, and represented ACT in Parliament 2008-11.

Linda Bryder: We'll come back to it.

Michael Bassett: Okay.

Ian Scott: What I've always wondered is why we've never had a national planning structure, that says for a population of four and a half million what we need, and where should it be? Because we've never had that, and it seems such a ludicrous notion that a population the size of Sydney, or slightly less than the size of Sydney, has so many bits that are self-governing. And no opportunity, you know, I mean if you look at oncology –

Linda Bryder: Yeah, so that comes into, very much comes into the health boards, you attempt to rationalise the country's –

David Caygill: Well, look, I'm happy to speak to how I felt when the Gibbs Report landed on my desk, and how I responded to it.

(Laughter)

I mean, I've got some ideas, and would be happy to share them, it's nice to have a chance. I wonder whether, and I don't want to drop him in it, but before we proceed to how it was treated when it arrived. Michael, do you want to say anything about what you were looking for in commissioning the report? Because it was Michael and Roger Douglas, who appointed Alan Gibbs, John Scott⁷¹ and Dorothy Fraser,⁷² and by the time the report was done ...

Michael Bassett: It's presented to you, I'd gone.

David Caygill: Exactly.

Michael Bassett: And this baby was delivered to you, yeah.

Well, it was an interesting thing. My problem was that 75, 74 point something or other percent of the entire health budget went to the hospitals in 1984. Well, I mean there was a hell of a lot more that needed doing beyond the hospitals. And I worried away at this all the time, and I kept thinking, how on earth can we reform the hospitals? Well, the area health board idea had been floated, and it's floated in the early 80s, and really there was a guru up in Whangarei, who was the intellectual grunt. I've forgotten his name, but he was a friend of Aussie Malcolm's.

And three hospital boards were singled out and volunteered to become area health boards in 1984. But none of them had actually moved and I found them singularly hard to move. And I remember one quite difficult conversation with the chairman of the Nelson Hospital Board, because they had signalled that they wanted to become an area health board. But they reminded me of Teddy Roosevelt's famous comment about how on the one hand he wanted to bust the trusts, on the other hand, not so fast. And that was basically the line that these guys were following. Wanganui was another, and –

⁷¹ Sir (Philip) John Scott (1931- 2015) MB ChB NZ 1955 MRCP Lond 1960 FRCP Lond 1975 MRACP 1959 FRACP 1966. Professor of Medicine, University of Auckland 1975-96. President, Royal Society of New Zealand 1997-2000.

⁷² Dorothy Rita Fraser (1926-2015) DBE, LL.D (Hons), QSO, JP (Dame Dorothy), Member of the Labour Party, spent 29 years on the Otago Hospital Board, was a Dunedin City Councillor, married to former Labour Cabinet Minister Bill Fraser.

What was the third?

Rod Perkins: Wellington?

Michael Bassett: Oh, Wellington, was it right in the van at the beginning? No, on reflection, it was Whangarei. Okay. Well, things were not moving. So the question really that was festering in my mind was how you got a better bang for the health buck. And something had to be done about the hospitals; every time I kept being reminded in Cabinet by Roger Douglas, that the health vote seemed to be expanding at a more rapid rate than everything else. I became more irritated, and I recall walking around the block, as I often did after lunch, a Cabinet meeting, Monday, and with Roger. And I said, you've been thinking about a health, a hospital review, haven't you? Oh yes, he had, he'd been talking to Gibbs over the summertime. And I said, I thought it might be Gibbs, because I'd heard Gibbs saying that if only the hospital vote could be given to him, he could pare it down.

And I said, well, he's certainly somebody who's tough, and somebody who understands the business world, and markets and so on. So Roger said to me, well, can we get this past the Prime Minister? And I said, well, there's only one way to find out, and he'll be up in his office right now, perhaps we should go up and see him. So we did and told him what we were thinking about. And I thereby signed my death warrant as Minister of Health, because Lange never trusted me in the health area again. And that's why he was determined to have any A.B.B. Anybody But Bassett, and went for a C –

(Laughter)

And anyway, then it became a question of who balanced the thing out. And Dorothy Fraser, of course, who was a very conservative, well, she was Labour in her background, but, well fundamentally a conservative person from Dunedin, the chair of the Otago Hospital Board. And John Scott, who was, in those days, recognised, I think, as the foremost physician in the country. And, so I thought I had quite a good balance, and I set them going. And slowly, but surely, the various people in the department got into the swing of this, and there were, in particular, two or three in the department who gave the study some muscle. And in the end, I ceased to be the Minister of Health after 37 months in the job, David takes over, and this slightly ungainly baby was delivered into his hands, about April, March, April of 1988.

David Caygill: And I wondered what the hell I'd inherited.

(Laughter)

I mean, as I said before, I hadn't been thinking particularly about health policy before 1987, and suddenly I found myself Health Minister on the re-election of the government in August 87. The Alan Gibbs exercise was well underway by then. I attended a couple of its meetings and it is hard to describe the atmosphere. I was a bit bemused by it all. I might not expand on that thought at this moment. I mean, I'm assuming people are familiar with what was in the report when it arrived. I think it's capable of being characterised in a number of ways. There's a lot in it for a relatively small report; it was very well written as a document, it's very accessible, very readable. But it repays thought, in my view, and the immediate reaction that it got, once it was out, wasn't, as I saw it, very thoughtful at all.

For example, the first thing I found myself having to contend with was that the Director-General of Health indicated that if we intended to proceed with the report, he would resign as director-general. I wasn't terribly pleased by that; I thought it rather illustrated a lack of confidence in me, and I found it hard not to reciprocate. So we'll just park that.

What was more important really, I think, was that I was –

Rod Perkins: George Salmond.⁷³

David Caygill: George Salmond, yes.

I mean, I liked George, and I thought we had a good relationship. But that particular incident didn't form a strong bond between us. I mean, I think George fully expected that I would just charge ahead and implement the report, whereas I wasn't at all sure that that was the right thing to do.

Rod Perkins: What did you just say then? You thought George what?

David Caygill: I thought George Salmond, the Director-General, had assumed that the government would simply implement the report. And I wasn't sure that that was the right thing to do. In particular, I was troubled by the way Alan Gibbs was describing the report. More than troubled, I was cross with him. One of the key aspects of the report, in my view, was the supporting work done by Arthur Andersen,⁷⁴ whose consulting report was available separately but fed into the Gibbs report. Arthur Andersen sought to establish the dimension of efficiency gains that might be achieved in the hospital service, and the final report itself drew a comparison between the total size of efficiency gains that Arthur Andersen had identified and the cost of dealing with everybody who at that time was on the waiting list.

And they were broadly of a similar magnitude, which is an interesting and relevant comparison in one sense. But what Alan did with that, and he did it more than once, was to imply that if you implemented his report you could eliminate waiting lists. And that's not the same thing at all, and the report said as much, that in a public health system waiting lists, or rationing of some kind, is inevitable. People are either making decisions for themselves, based on the prices that they face. Or they're not, in which case the system allocates services in some administrative way. And my view simply was that Alan had been long enough focusing on this issue now, that he ought to understand very well what his proposals could and couldn't achieve. I thought that from the very outset his reforms were being oversold, and to go down the route of a very significant structural change, an upheaval, with all the political investment that would take, only to end up, at some point in the future, still facing waiting lists, having been told that this change would eliminate them, I thought that that was a recipe for failure in a number of dimensions.

⁷³ George Cockburn Salmond (1937-) MB ChB NZ 1961 DPH 1966 PhD 1971. CNZM 2017. Director of Management Services and Research Unit, NZ Department of Health 1973-83, then Director-General of Health 1986-1991. Founding secretary and later president of what was to become the New Zealand College of Public Health Medicine.

⁷⁴ Arthur Andersen & Co, *New Zealand Department of Health, Public Hospital Performance Assessment*, September 1987; Arthur Andersen Ltd was registered on 7 March 1988 to provide auditing, tax and consulting services. It later merged with Ernst & Young in NZ.

Ian Scott: It was naïve, wasn't it?

David Caygill: Well naïve is not how I would describe Alan.

(Laughter)

Ian Scott: I don't know.

David Caygill: I think he got carried away. I mean, I don't mean to, I don't mean to offend –

Ian Scott: But I mean I understand from John Scott, that initially the implication, the suggestion was it was going to be 600 million dollars saved from the health services.

David Caygill: Well I get wary of figures like that. Because you might ultimately see them, but you won't see them in one go, you won't see them quickly, and by the time you start to see them other things will have happened, so you'll never be quite sure what it is you're seeing –

(Laughter)

And so on, and so on. Look, to cut to the chase if I can, two or three more points very quickly. The report was overwhelmingly opposed by health groups, and fundamentally I made the political decision that it was easier to implement the things in the report that I think did make sense, notably getting rid of tripartite management in the hospital system, which was on its way out anyway, because it was disappearing in England, but I thought the report made a solid case for moving on beyond that. And the other thing that I thought was valuable was, it stood out less in the report, but we ultimately used that report to get rid of the separate system of funding for capital expenditure. One of the reasons hospitals were being overbuilt in New Zealand was that they were funded separately, but by the centre, and it took so long to get capital expenditure approved, there was a separate queue for your capital, so you always bid for twice what you needed. Because by the time you got it, you might well need that, who knows.

Well by taking the population-based system that, as Michael said, we had by then in relation to current expenditure, and folding your capital component into that, that imposed a discipline that I think was useful and sensible. And I don't think that was a small reform, although it didn't capture much attention. But to me it was easier to do things like that, having rejected the report, than to turn it around the other way, accept the report, and then try and modify it at the same time as you were defending it, as I would have needed to do, had I said I was going to be implementing the report.

So that was my way of responding to it. I thought the report, fundamentally, the more time went by, and the more I had the opportunity to think the thing through, I thought the report had two fundamental flaws, or there were two fundamental subtexts that it didn't come adequately to grips with. One was what I might call the place of democratic governance in a public system. Alan himself said, "I don't understand area health boards. You tell me you want them, but I don't know how to make them fit." Instead he was designing a commercial system, he was focusing on the way you could get efficiencies out of the hospital system, and he came up with a corporate solution for hospitals. And he knew well that my response was going to be

okay, but where's the governance, how does that fit in? And he was awkward about that, and I thought the report ended up being awkward about that: about the role of public governance in an ultimately public health system.

And the second flaw or failure in the report, it seemed to me, was maybe more fundamental still. In the end I think that that report, although it put its finger on some serious problems, and although it identified some ways in which we might ultimately have got some efficiencies, it was essentially focusing on what I think of as the supply side of the system, the delivery end. It had very little to say about the purchasing end, the consumers. For example, it said almost nothing at all about the role of primary care, except that this was important for somebody to think about it, but it didn't. If you think about where Britain, and to some extent even New Zealand subsequently went with PHOs and IPAs,⁷⁵ you can see what I'm talking about. The notion that you needed some countervailing heft on the purchasing end isn't there in that report, and if you're trying to drive efficiencies, pricing will get you some distance, I agree that it might help. Gibbs was right in saying there's no pricing in the hospital system, that people have no idea what their costs are. But to imagine that you could get significant efficiencies simply by moving to a DRG⁷⁶ system, if all the purchasing was still being done at the centre, I think is flawed. I thought it was problematic, and that seemed to me to be in the end, really the most significant problem with the report. Although it would be fair to say that by the time I'd worked my way through all of that, I'd long since tried to create some political space by rejecting the report altogether.

(Laughter)

Linda Bryder: Thank you for that, because actually that set out the report pretty well, hasn't it? And there's lots that will come out of that about the importance of primary care and preventive medicine. And we want to maybe talk a little bit more about any international influences as well over this period, and into the 90s, long term effects, Pharmac, and - We've got lots still to talk about, but we are going to offer you a cup of tea now. Because it's just gone over time for the first half of this. Thank you everyone, it's been a wonderful start to this discussion.

(Break)

Linda Bryder: We've got lots to talk about, and we'll continue our conversation. I think we were meant to have finished with "Unshackling the Hospitals" in the first half. However, we haven't, so we'll just stick with that for a little while, and then move into international comparisons or influences, and moving into the 90s. Well, I think we need more focus on looking at primary health care and preventive medicine as well, Māori health in particular, we would like to explore, and Pharmac we'll come to.

⁷⁵ PHO is the acronym for primary health organisation and IPA is the acronym for Independent Practice Association. See NZ Ministry of Health, *A Guide for Establishing Primary Health Organisations*. (Wellington, 2002).

⁷⁶ A DRG, or diagnosis-related group, is a system developed by the Yale School of Management and the Yale School of Public Health to classify hospital cases. It was first introduced in the USA in 1982 to determine Medicare payments for hospital 'products'.

But that's not to pre-empt where we go, but I don't think we've quite finished with the "Unshackling the Hospitals". I say that because I heard some very interesting things downstairs, didn't I? We'll just spend a few more minutes and get on record a few more comments on this influential report, which it clearly was. And you can start, David.

David Caygill: If I might, there was one point only that I omitted to add to what I said earlier. It relates to the views of the other two panellists, because although we refer to it as the Gibbs Report, and Alan clearly had a major hand in it, and it's not unreasonable that it's known by his name, given that he chaired the group, but he wasn't the sole author. For quite a while I wondered whether Alan might be in the minority, and whether John Scott and Dorothy Fraser, who Michael introduced, would go along with what Alan was recommending. Well Alan was clever, and in the end, they did. But I think it's important to observe that Alan wasn't the sole author and to give credit and responsibility to the others as well. John, as I understood it, talking with him after the report was public, believed that there were considerable efficiencies and improvements to be gained in the health system.

And whereas Alan was focused on the advantage of a more corporate model, and John was focused on the gains that might be available within the system, Dorothy came to the same broad conclusions, but via a third route again. Dorothy, in particular, saw the hospital boards as being in a position of conflict. They were simply, in her view, exercising too many roles. They were governors, yes, but also they were owners of capital facilities, and they were employers. There were significant human relations issues involved in running those big organisations. And they were also delivering, they were providers, to use the terminology of the time, of very significant services. So she saw those roles as creating very considerable issues of conflict, which to my mind is yet another slightly different perspective on the same set of issues.

Linda Bryder: Thank you for that. We will talk about the health boards in a minute. Garth also had a comment on –

Garth Cooper: Oh well, it's just I worked close, very closely actually, with Sir John Scott for many years. And he used to talk to me sometimes about his time doing that, and I just have a couple of comments to make. One of them was that he thought that Alan Gibbs as his basic model used that for a large supermarket.

(Laughter)

And the second comment John made was that he thought it was, I mean, he's not here to say these things anymore, because he's sadly not with us anymore. But the second thing that he used to say to me was that he saw his role throughout as being one of prolonged damage limitation. He said that to me directly on numerous occasions. Yeah, and he felt that if he didn't do that, then, you know, there would have been a pretty bad outcome. And I guess that's what you were saying before, was it, in relation to your position, the way that you used it, or didn't use the report?

David Caygill: For me there was a fundamental question. Others can speak to this, but this was a time when lots of things were going on. We were doing lots of things. This was another big thing we could have done. Leave aside the question was it right

or wrong, that's fundamental, we start there of course. But just focus on the fact that this was not a small thing, this was a big thing. Well, we either did it and did very little else in the health portfolio for the next two years, probably longer. Or we did the bits of it that made most sense. We addressed the tripartite management system, for example. I think it had outlived its usefulness. And we addressed the funding model. But, yes, I made the judgement that the report as a whole was too large in its implications to proceed with.

Linda Bryder: Graham, you had something to add?

Graham Scott: Well, it's kind of interesting about personalities and anybody who knows Alan, knows he's an avant garde personality.

(Laughter)

But, you know, what's important is what's actually in the report. And two things about that. One of them is that Alan has said to me, and I'm sure to many others, that he would have preferred privatisation, but he thought this might work. In other words, he feels he compromised in his report. But more importantly than that, the comment was made earlier about it being a supply side reform, and picking up on the comments like a supermarket, well the thing about a supermarket is that people buy stuff from it at the price that it's on the shelves, and they don't need a lot of help. Whereas for the reasons that David mentioned earlier, people are paying nothing, or something far short of the cost of this, so inevitably there is an agent who does the buying on their behalf.

And in that sense, what's in the report on the regional authorities is actually what the next government did, in many respects. And I hadn't noticed before that it recommended that they would be elected bodies, and of course the final criticism that the next Labour government⁷⁷ made about the funder provider split was the lack of elected people on it. So there's more nuance and subtlety to this, but the essential thing, as I see it, that we've struggled with is this question of who buys, and what power do they have. And this report takes a very optimistic view of what the regional health authorities do. It assumes they had a degree of power that could override the politics of the hospital, could shift money out of secondary care and into primary care and all of that.

Well, the experience on the ground over the next 10 years was that those purchasing agencies struggled to overcome the inherent politics in the supply side of the hospital. And I think we're still living with that problem today. These supply side pressure groups and organisations are very, very powerful, and politicians are very reluctant to face down doctors who are waving shrouds around in their surgeries. And we've ended up still with a split between primary and secondary care, because the last Labour Government wasn't able to bring in the primary care budget into a single purchasing budget. That is business that still remains to be done.

So looking back on it, it's kind of easy to chuck off at the report a bit, but I actually think there is, in terms of the intellectual and policy development of trying to get a better New Zealand health system, you know, it's an artefact. And it's got some

⁷⁷ The Fifth Labour Government held office 1999-2008.

things in it, which actually did cast quite a long shadow in the next government's reform programme, but Don may want to contest that.

Linda Bryder: Tim I think wanted to say something?

Tim Tenbenschel: Yes, just want to pick up on your point, Graham, about the optimism of this, the view about the strength of the purchaser, and you know, that seemed optimistic in the light of 10 years' experience afterwards. But I'm just wondering, the contrast between the two reports seemed to be that you had, on the first one the Health Benefits Review, I guess a source of expertise to say why that actually might be an over-optimistic view. There's plenty of experience internationally which suggests that those proposals would be over-optimistic. It wasn't just, we weren't operating in a vacuum, there was plenty of literature around at the time, and Geoff, I'm sure you would have, and Claudia probably would have had, you know, some exposure to that.

So I would just like to ask something that's a puzzle for me, looking in from the outside – why did there not seem to be any understanding of the sorts of things that were happening in other health systems?

Linda Bryder: Well, that's a good point, because I think one of the things Martin, for his comparative project, is wanting to look at is: were there any overseas influences, and particularly were there any British influences? Did people consult, look at other systems?

Martin Gorsky: When I read the Gibbs Report, there's quite a large chunk actually quoted from Griffiths,⁷⁸ the rather famous bit, where they go into a hospital and they're wondering where, no, hang on, let me try and remember the quote. It's Florence Nightingale with the lamp. So he clearly picked up on that, but actually looking at the influences, it seems to be much more America where he was looking; the DRGs, the use of Arthur Andersen, that what was going floating around.

So you know, I was just wondering if anyone could comment a bit more of where New Zealand was looking –

Claudia Scott: I want to comment on that. I hear that, and in a lot of articles that I see written on the New Zealand health system, you know, there's words like radical reform, and you know, Americanisation and market versus state, and you know, that's the way that conversation goes. But, say take DRGs, DRGs have always been a very prominent thing in Australia, so I think that if there's been an interest in DRG, it wouldn't come from America necessarily. And as you said earlier, Michael, the capitation form suits governments, doesn't it, because it decides well I'm going to spend this much on it. And so, yes, high growth areas get a bit more, but they can control it. And so the trouble with the DRGs, you're compensating at the right price, and I think that would scare some Ministers and governments for that reason.

So I felt, certainly moving onto this, the real influences there to me were the UK, but also the Netherlands, because they were dealing with the competing healthcare

⁷⁸ Sir Ernest Roy Griffiths (1926-94) was deputy chairman of supermarket chain J Sainsbury plc (1968-91). Griffiths was commissioned in 1983 to report on the management of the NHS and served as government adviser on the NHS 1986-94.

plans and core services, and that was coming out of those countries. But New Zealand had no health insurance data, we only collect taxes and spend it, and that's it. So we really weren't able to estimate the cost of health care for a particular individual or family unit. I wondered how it was possible to consider these reforms when there was not sufficient information to allow individuals to be subsidised for core services so they could opt out and select another health purchaser. We don't know how to income test it, it was too difficult to create with limited information and competing insurers who would fund services. And at the end of the day, the UK didn't introduce competing insurers that way, the Netherlands didn't go that way, and New Zealand did not adopt competing healthcare plans. I don't buy that idea of American influence at all; - I think it's the ogre out there because the US has many competing markets for funding, purchasing and providing health care. I don't really think that the US was a huge influence.

Martin Gorsky: By the way, sorry, I've just remembered the quote, '... if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge'. It was about management, and the lack of responsibility.

Linda Bryder: She would too.

Geoff Fougere: Can I just comment? The 'Americanisation/ America as origin of all kinds of policy proposals' came out of the oppositional framing of the debate over Green and White Paper in the 90s and reflects that. So it's anachronistic to read it back. The other thing, to go back to your framing at the beginning Martin, I mean, here was this long period of expansion of economies and health systems, and then there was the 70s period, and that slowed down economies, and then fiscal difficulties everywhere. And ironically in health, it always seemed to me it was the very success of cost containment, that actually led to the changes afterwards, because politicians, at least if there was a degree of central control, could get control over overall costs. (The US was the complete outlier of that). But what the politicians couldn't do, and which in turn generated uproar and controversy, was to then answer the question of how people were going to get access to the services that they needed?

And that in turn created the generation of ideas across a whole number of countries. But particularly it generated an openness to ideas, from wherever they came from. And people then marshalled around their favourite solutions, and suddenly the US was part of the conversation, ironically given the particularly marked problems of its own health system. But so, as Claudia says, the issues were being dealt with in the Netherlands, on the basis of their health system, and that was generating ideas. And similarly in the UK obviously, which is where you're interested in. And elsewhere.

Martin Gorsky: We recently ran a rather similar session to this in the UK, where we heard that various UK health economists from the University of York had come over to New Zealand and essentially got health economics going at the University of Otago in the 1970s.

So this kind of transnational thinking about health economics seems to be –

Claudia Scott: I'm going to make just a comment on what you have said. I wrote a book after the review, which looks at different health service systems. And so I visited the UK and I looked at the UK system, and was particularly interested in the GP fund-holding arrangements. When the governments said we want waiting lists to go down, in Britain they went down with no extra money. I think that's reflecting the nature of the contracting, and the more cooperative relationship between the government and the providers in the UK.

That would not happen in New Zealand. So, as was said earlier today, we like a capitation based formula, because the government can decide how much it's going to spend, but it's not compensating for population growth as it should be. That is how I see it. If the government has more contractual power, then the profession is going to play ball – which is more than has happened in New Zealand for a very long time. That's what I'd say.

If you look at midwifery, which in a sense displaced GPs who were doing maternity work, we had problems with two benefits being paid. So it's all very ad hoc here, there is a difference, and it's got to do with, as some people said here, our traditions are different. If there's a closer relationship between the government and the medical profession, they can work together to make some things happen without increasing funding. This is not true in New Zealand, where it is much more about the resources.

Linda Bryder: Well one way, of course, that it was different was in Māori health, would you say Colin, they didn't look overseas for models there?

Colin Mantell: No, well, no, I just touched on before about the similarity with business, how Māori have developed credibility in business sense. And I think that over the years that's involved health as well. But it's mostly to do with not so much health boards and health areas, but those peripheral things related to health, like the HRC,⁷⁹ has developed Māori programmes and Māori grants. The University itself has done so, the huge expansion in Māori graduates would, was a sort of indicator of acceptance of affirmative action policies over all. And now we're at the stage where not just in affirmative action, I'd like to record that in 2016 there were 100 Māori graduates in medicine between Otago and Auckland.

Lots of committees, like ACC,⁸⁰ like ERMA⁸¹ when it was existing, couldn't move without a significant Māori opinion. Now I have to regretfully tell you that I think we've come to the end of that time, and in the last two years, or two or three years, there's been a loss of Māori managers in DHBs. There's been pull back funding,

⁷⁹ The Health Research Council (HRC) of New Zealand is a Crown agency, established under the Health Research Council Act 1990. It replaced the Medical Research Council of New Zealand, a committee of the Health Department which first met in 1937. See Derek Dow, 'Medical research', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/medical-research>, accessed 27 August 2018.

⁸⁰ The Accident Compensation Corporation (ACC) from 1973 provided compensation (including treatment) for all accidents wherever incurred.

⁸¹ The Environmental Risk Management Authority (ERMA) was established to implement the Hazardous Substances and New Organisms Act 1996. From 2011 its functions were taken over by the Environmental Protection Agency.

there's been separation of funding. So while I'm very excited about what happened in the early 90s, I am a little sad about where we are moving on to 2016, 2018.

Ian Hassall: Colin, you didn't mention iwi providers. There seems to be me to have been a growth of iwi providers around the country. Is that correct impression?

Colin Mantell: Yeah, I think that's fair to say, but there are iwi providers, and Māori providers, up and down the country. They mostly have difficulty if they're, in the funding arrangements, if it is just a general practice type thing. And the ones that are successful have been pulling in contracts for rheumatic fever, for child health, this and that. And they have done well over a big area. I suppose the thing that I forgot to say mostly about what the nurses did. Don't forget the University established a new Chair in Māori Health⁸².....The first Chair of Indigenous Health anywhere in the world.

(Laughter)

Linda Bryder: Absolutely.

Colin Mantell: In fact.

Ian Scott: But I mean, Ngāti Hine up north have got very flourishing health services now, and it depends on, it depends for its ability to do what it's doing on their culture and their cultural norms, rather than ours. And I think that's why they're so successful now, because they haven't tried to emulate what some Pākehā has told them health service should be about.

Colin Mantell: Well, there are some health services, Māori health services, up and down the country that are the opposite, and they're all struggling.

Linda Bryder: Did you want to add anything, Garth?

Garth Cooper: Only that I think that from what people in that area told me, that the model is one that should be focused more, is more efficiently focused on Māori health as part of what health is. And that that really is the case. It certainly was the case in South Auckland, when we were working there.

Ian Scott: Well, that was certainly why Ngāti Hine is currently flourishing.

Derek Dow: Colin, some years ago, I worked on a history of Māori health from 1940 to 2000 which for political reasons connected with the Crown Forestry Rental Trust, never saw the light of day. One of the things that intrigued me, in the 1980s there was an attempt somewhere around Gisborne to introduce a multicultural health system, and local Māori health workers said no, this is a bicultural system, we're not going to have multicultural health. Now with the rising number of other ethnicities now in New Zealand, they see a continuing tension if they try to maintain Māori as a specific group within the health system.

Colin Mantell: I do see a conflict, and it's not surprising. And I think eventually both of these systems, both the multicultural and the separate Māori organisations, will thrive along side of each other. They do in Māngere now.

⁸² The University of Auckland established a Chair in Māori health in 1996.

Linda Bryder: Anyone else from the audience who didn't get a chance to speak in the whole hour and a half of the first half would like to say something, or ask a question?

Debbie Hager:⁸³ My name's Debbie Hager. I've got a very layperson's question about the Gibbs Report. My understanding is in the 90s that it was implemented in a way where people paid a cost for every health service they went to, including the A&E, which is where we got the rise of private A&Es, and for hospital services. And that continues for a while, and then those charges for tertiary services were withdrawn. And I've never understood that process, why it was put in place, and then why those charges were then withdrawn. So it is a layperson's question.

Linda Bryder: Rod?

Rod Perkins: Well my understanding was that by charging for outpatients at public hospitals, in the same way as people get charged to go to specialists and private or GP, it was going to reduce workload on the public hospital system. I vividly remember the afternoon that we were told we had to start charging for the STD clinic at Auckland Hospital. And I really worked hard with the Ministry that day to say, look, we can't do this, this is crazy, etc., etc., etc. But didn't get away with it, so just broke the law. And there was that, it was so, it was just driven by a crazy ideology really, and I wouldn't say that this was politically driven, it was more in the way people were handling, there was so much to handle. But that didn't last, charging people for outpatient appointments in the public hospitals, didn't last very long at all. But it required a huge amount of work to tidy up, to do it, in terms of systems and so on.

Graham Scott: Well, it was targeted, there was a community services card as well.⁸⁴

Rod Perkins: Yes.

David Caygill: I think it's also important that, I mean this is after my period, but we're talking about outpatients. There weren't charges for inpatient services.

Linda Bryder: Only briefly.

David Caygill: People talked about it –

Linda Bryder: Fifty dollars a night in the public hospital.

Michael Bassett: Yes.

Linda Bryder: For a while. Withdrawn quickly.

Rod Perkins: Why did it stop?

Michael Bassett: Oh, because it was election year, wasn't it?

Graham Scott: Probably.

(Laughter)

Michael Bassett: I'm sure it was 1993.

⁸³ Dr Debbie Hager has taught health promotion in the School of Population Health, University of Auckland, since 2005.

⁸⁴ The Community Services Card was introduced in 1991 to provide subsidies on healthcare costs for New Zealand citizens and permanent residents aged 16 or over who are on a low income.

Don McKinnon: I think actually the administrative cost of it actually was pretty high.

Rod Perkins: Of course.

Don McKinnon: And people go to A&E because, A, they've got a problem, not because they've got anything in their wallet, and then they're stuck with this fee.

Graham Scott: Hospitals started putting primary care facilities in the hospitals.

Linda Bryder: Did you have a comment Tony?

Tony Baird: I'm not sure it's relevant, but I got summonsed when I was chairing the Medical Council by Ngāti Porou, and at that time rheumatic fever was rife, but there was very committed group of aunties mainly who were doing their very best. And I think they almost wiped it out, but now it's back again as a problem, amongst Ngāti Porou. They struggled to have GPs, they had some services if you could get to the phone box if you had petrol in your car and four wheels. And then get to the phone box and find it broken.

The disparity between those regional services and where I work, you know, is so wide, I think. So I'm not quite sure how I got onto that, but did you mention forests down there? The forests have gone, you know, the forests are not doing well in Gisborne, Gisborne town itself lost its Wattie's⁸⁵ and that sort of thing. Yeah, sorry, the thing is, we've got to look, New Zealand is not homogenous, is it, there's this great gap, and Māori at the bottom of it in some places.

Don McKinnon: Well, the leading kaumātua in Ngāti Porou was Api Mahuika⁸⁶ at the time. He was sending all of his bright kids to Wellington to do law degrees. Bell Gully⁸⁷ in Wellington is half full of Ngāti Porou now. He probably should have sent some to do medicine.

(Laughter)

Tony Baird: Would they have gone back?

Don McKinnon: Probably. They are one of the most loyal iwi in New Zealand amongst themselves. Well, they see themselves as aristocracy.

Linda Bryder: Since our focus was on reports, we've also got this one. Unfortunately Simon Upton couldn't come, otherwise he would have been able to speak to it. Does anyone want to speak to it, any comments on the Green and White Paper, "Your Health and the Public Health 1991"? Any views on that, or are you familiar with it?

Tony Baird: He bounced down the steps of the Robb Lecture Theatre in University of Auckland Medical School, arrived late. He'd been to England and looked around, came back full of enthusiasm, and he did make a lot of sense actually about the, what he was thinking of. What was he thinking of?

Ian Scott: The provider funder split.

⁸⁵ J Wattie Canneries Ltd, founded in 1934, produced frozen and packaged fruit and vegetables. It underwent a merger to become Goodman Fielder Wattie in 1987 and was bought by the HJ Heinz Company in 1992.

⁸⁶ Apirana Tuahae Kaukapakapa Mahuika (1934-2015) was an Anglican minister and inaugural chair of the Ngāti Porou iwi authority 1987-2015.

⁸⁷ Bell Gully is a prominent and longstanding law firm in Wellington.

Linda Bryder: He claimed that the recommendations of the last two reports had been ignored, those ones we've been talking about, in this report. And that the present system was unsustainable. Structurally flawed, and also, he was advising government on how to achieve "New Zealand solutions", one which was appropriate to our unique history and social fabric. So not overseas influences.

Rod Perkins: Linda, pretty central to this was the idea that it would be possible with the best brains in the community to come up with a schedule of things that could be funded by the public. That was pretty central to the thinking. And I remember at that time, before the process got underway there were people that were curious about how this might happen. But there wasn't the scepticism that developed after the process got underway. And once we got underway, then people said, crumbs, this is very difficult actually.

Linda Bryder: Yes. David?

David Caygill: I just want to offer perspective from somebody who was by then still thinking about health policy but back in opposition, watching successive Ministers grappling with some pretty ambitious reforms. So a couple of thoughts. One, it seemed pretty obvious to me that the proposal to set up Crown Health Enterprises had begun with the Gibbs Report, and now, after a period of hiatus, had emerged in a slightly different context.

But fundamentally that's where that idea had come from. It also struck me that Simon and his colleagues weren't just trying to implement Crown Health Enterprises.⁸⁸ They were also looking to introduce health records on a personalised card, with all the technological and privacy and legal issues that needed to be resolved in relation to that proposal. And then there was this national health exercise, not unlike that in Oregon, attempting to define the boundaries of the procedures and services that the public health system would provide.

To me, those were three ambitious, understandable, reforms individually. But to do them all at once was a big ask. So in some ways, my view is, that if you're looking for why ultimately none of them lasted, then look at the way in which they were introduced at least. I would emphasise that fact that the government was trying to do all of them at once. And being part of a government that did lots of things at once, I can tell you that it's hard work, and in particular, it strains public support. In the end, we can go on arguing, and we probably should go on debating, whether elected government has a proper role in a public health system, in which case, what is that role, and where is it best located.

But that debate just never got resolved. It was easy, as Don said, for an opposition to say, well Crown Health Enterprises are no good, because they're not accountable to the public. The question, should they be, and if so for what, and what are the implications of that form of governance, just got glossed over, partly because I'm not sure we knew the answers.

⁸⁸ In 1993 the NZ health system was restructured under the Health and Disability Services Act to create a split between the purchase and provision of health services. Four Regional Health Authorities (RHAs) came into existence and the 14 existing Area Health Boards were replaced by 23 Crown Health Enterprises (CHEs).

I could draw an analogy, without trying to draw the debate away from this issue of governance. I later on got involved in a period of change to the ACC system, where competition was introduced, and then a change of government occurred, and the ACC system was put together again as a single monopoly. Why did that happen? Fundamentally I would say because the general public, as distinct from the political parties engaged in the debate, the general public was never convinced that that change was appropriate, was necessary or justified. And I would say the same here. Crown Health Enterprises didn't survive, because the public at no stage became convinced that they were the right answer to whatever the problems were that we were trying to address.

Ian Hassall: This might sound a bit like a hobby horse, and in a way, it is, but some of the discussion has talked about whether things were a success or not. In New Zealand, we have a tradition of making and unmaking policy in the absence of adequate information. Now I know there is always, information is always inadequate, but in other places, of course one of the models is Australia, they have set up processes to ensure that there is at least an attempt to gauge the value, impact effect of policy. I'm talking about the Australian Institute of Family Studies in Melbourne that was set up specifically for that purpose as I understand it.⁸⁹ We don't seem to do that in New Zealand, and I'm not talking about the financial effects or the wider effects of that kind, but really as a specific health effect.

And I know that, you know, that's impossible to gauge cause and effect in a very broad thing such as public policy. But we could at least make the attempt, and we could at least, you know it answers that question about the public wanting this or wanting that. I know that it's not easy to translate information into the form that the public will understand and accept of this kind. But again, it seems the attempt should be made. A lot of the stuff, and particularly in child health, has not been examined, the things that have been done.⁹⁰ So we have had, we have fallen behind in things, measures like child mortality, infant mortality. It hasn't gone down, gone up rather, but it has failed to keep pace with other countries' improvements in mortality.

And the one that really stands out is youth suicide, which really leapt up during our years of reform⁹¹, and has remained at a high level, compared with other countries, in New Zealand. And yet for a long time, nobody examined, or tried to examine, what that might mean in health terms. So you know, when we're making reports, when we're discussing this, we really need to be looking at what kind of information we have. And if we don't have it, how we can obtain it.

⁸⁹ The Australian Institute of Family Studies was established in Melbourne in 1980 to conduct research into family wellbeing and communicate this to policy makers, service providers and others.

⁹⁰ Committee on the Rights of the Child, Concluding observations, para 13. (Minnesota: University of Minnesota Human Rights Library, 1997).

www.hrlibrary.umn.edu/crc/newzealand1997.html

⁹¹ See for instance A. Blaiklock, C. Kiro, M. Belgrave, W. Low, E. Davenport, I. Hassall. "When the invisible hand rocks the cradle: New Zealand children in a time of change". Innocenti Working Paper No. 93, p36. (Florence: UNICEF Innocenti Research Centre, 2002). By 2017 New Zealand had the highest rate of youth suicide in the developed world, according to a UNICEF report.

Rod Perkins: I was just going to say that we haven't talked about technology yet, but operating on the ground at this time, I remember that we were trying to teach dieticians and nurses about Excel. God, they didn't know what that was, I didn't actually know very much, I was only a step ahead. And there was a huge, almost revolution, in hospital and health management, moving away from paper based systems to new systems. And it was very challenging. And the Green and White Paper talked about healthcare plans, and I remember Simon Upton at a lecture I was at once saying, with his hands kind of nervously at his side, that he didn't think that we should be so arrogant as to prevent people from the sort of choices that were potentially available to them. And my thought when I went back to the office was, crumbs, this is ambitious, this is very, very ambitious.

Because there was, there was so much work to bring the staff up to speed, to participate in setting budgets and taking responsibility for their services and so on and so forth.

Ian Scott: I mean, Simon, it's a pity he's not here, because when his report came out, on Waiheke, we looked at that, and I was one of five GPs then on the island. And I looked at it, and I thought, they're going to try and remove government from the decision-making about how health services should be for communities. Then why doesn't Waiheke turn around and say, we'll run our own health services. And so we set up the Waiheke Health Trust, as a result of that.⁹² And one of the basis on which I think the trust should operate is that none of the health professionals ought to be on the trust, the trust should be the community and the health professionals would be consultants to the trust. But I failed right at the first hurdle on that one, because the public decided that because I had the idea of setting it up that I should be the first chair.

And they just overruled me totally, and so I became the chair of the Waiheke Health Trust. It's still in existence, and I came over and spoke at a meeting that was being run in Auckland, and Simon was there. And I talked about what we were going to do, and how with the amount of money that's currently being paid out on Waiheke to the people that worked in health, we could run a very efficient health service.

I came and spoke to Rod, because he was at Auckland at the time, and I asked him about how we might purchase secondary care from him, and he told me to go get jumped on, basically, that it wasn't on. He talked about the cost of the bed that we didn't use, if we didn't send people in, and the cost of that bed would go on, a whole lot of economic stuff that left me completely puzzled. It obviously wasn't going to happen, but we still thought we could run the primary health care for Waiheke and do so very efficiently. But I was let down by some of my medical colleagues on the island, who said they didn't want to have anything to do with this, because it meant we would have to know what they were doing. And they weren't going to share in that.

But the upshot of that meeting was that Simon then got in touch with me and said, we're having these meetings all around the country, and I'd like you to come to

⁹² Waiheke Island is located in the Hauraki Gulf, about 35 minutes from central Auckland by ferry. The Waiheke Health Trust was set up in 1991 to provide community healthcare for everyone living on, or visiting, the Island.

them. And I said, well I can't do that, because I'm running a practice, well, we'll compensate you for that. And I said, okay, turned out what they were going to do was pay me \$900 a day for flying around the country. And so I did about 12 meetings around the place, and the most interesting one was in Greymouth.

And the weather closed in, and we were supposed to fly back to Wellington that evening, and they finally had to charter a plane to fly him and myself back, because we had a meeting with Mr Bolger⁹³ in his office that night. And the real issue for Mr Bolger, and I thought this was really, really quite strange, given the context of what the Green and White Report was, was Mr Bolger wanted, he had three GPs there. And we sat there, this enclave in the middle of his office on the ninth floor of the Beehive.⁹⁴ And then every other Minister that was involved with, you know, the health of the community, they sat there all around us with their advisors and so forth.

So there was about 20 people in the room. And Bolger's question was, do you think we should pay, put GPs on salaries, which I thought was an amazingly left-wing sort of question. And we all said, yes, but they didn't, so.

(Laughter)

Yes. But that was my interaction with Simon. It would have been interesting to have him here. At one level, I was impressed by some of his thinking, but I'd also like to have challenged him on –

Graham Scott: One of the things David didn't mention in his list of things that was attempted here is the alternative healthcare plans, and it is absolutely crucial. Because the whole design, in my view, depended on people being able to opt out of the system if they wanted to. And that seems to have been based on a view that something like that happened in the Netherlands. But, I need to put a footnote in here. Simon was determined that the Treasury wasn't going to be involved in much of this, and so I was, like, running alongside on the platform shouting through the window of the train carriages. One of the points that was concerning was whether this could actually be made to work.

Because essentially somebody was being given a voucher; they could say I want to opt out of the regional health authority and take my money and go to a health insurance company, or somewhere else. And I could never figure out what you would write on the voucher, or what would happen if the voucher had been all spent, and the person said, look actually, I'd like to come back to the regional health authority.

It struck me as a fundamental question about the design. Now, it was absolutely crucial, because it was taken out, and I remember a meeting with the Prime Minister where it happened. What it meant was you had the whole design that you can see in the organisation chart, the organogram, but the organogram never captured the horizontal pressure that these opt outs were supposed to be creating.

⁹³ James (Jim) Brendan Bolger (1935-). Waikato farmer, National Party MP 1972-98 and Prime Minister of New Zealand 1990-7.

⁹⁴ The Beehive is the common name for the executive wing of the New Zealand Parliament Buildings. The Prime Minister's office is located on the 9th floor.

So it looked like nothing had changed; in reality, a fundamental force had been taken out of it, and so you ended up with a multilayered pancake system of control, of vertical control. And the horizontal opt outs had been removed. And I think that point gets insufficient attention, because there were certainly some iwi that wanted to opt out. Tainui⁹⁵ particularly came to the Health Funding Authority, and said we don't want a contract with you anymore, can we have our money, we'll set up another one of these things. Nobody knew how to do it.

Tim Tenbense: That's an interesting point, I think, because in effect one could say what happened in Whānau Ora⁹⁶ between about 2010 and 2013 kind of had a go at doing that. But I guess what intrigues me about that whole period, because I came to New Zealand in 1997, so everything was exotic in terms of policy. Because in many ways things were done in a completely different way here to the way that they were done in Australia. And the question that has always sort of occupied my mind, and I can't quite get an answer to, or haven't really got a satisfactory answer to, is the question of implementation, thinking ahead about implementation. And I mean, one thought I've had is that, oh well, a consequence for the State Services Act would be, you know, in changing the State Sector Act, in terms of changing the roles of departments to ministries is that it's not their business to think about implementation. Because they don't get involved in operational stuff anymore.

And I don't know whether I'm right about that, but the common denominator about a lot of these stories from that time, not only in health but elsewhere, is well who was, if anyone, thinking about how the bloody hell you do do this. And where was that capacity in the system, was it in Ministries, was it anywhere?

Graham Scott: It was in the Prime Minister's department, with the HRD,⁹⁷ I think it was called. And there was the National Interim Provider Board that was headed by Ron Trotter.⁹⁸ The Ministry of Health was told to just get on and run the existing system and don't get involved in the reform. I mean, it was an incredibly complicated and fraught system of administration, but there were centres of control in it.

David King: I was just thinking, something not so far mentioned that happened at the time, is the closure of the mental hospitals. And that, let me assure you, was an absolute skin game, for the implementation is tough. Strange that it is often characterised as a crude cost cutting programme, where in fact, de-institutionalism added significantly to government spending. Not least, and it's only just recently occurred to me, that the hospital long-stay patients discharged to the community became eligible for sickness benefit that was denied them in hospital. Mental health

⁹⁵ Tainui is a confederation of four central North Island iwi and other related iwi.

⁹⁶ Whānau Ora is an indigenous health initiative which aims to increase the wellbeing of individuals through a whanau approach, centred on a Maori and tribal world view.

⁹⁷ Human Resource Development (HRD) is the framework for helping employees develop their personal and organizational skills, knowledge, and abilities.

⁹⁸ The National Interim Provider Board was set up in July 1991; see National Interim Provider Board, *Providing Better Health Care for New Zealanders: Report to the Government and the New Zealand Public*, (Wellington, May 1992). It was chaired by Sir Ronald Trotter: Ronald Ramsay Trotter (1927-2010), trustee and chairman of New Zealand Institute of Economic Research 1973-86 and chief executive and chairman of Fletcher Challenge Corporation 1981-7. Knighted for services to business in 1985.

budgets were ring-fenced and increased, there was major capital expenditure in new psychiatric acute and secure units, and houses for people with an intellectual disability. Strange, especially among academics, how the myth of major financial reduction resulting in loss of service lingers to this day.

Two other things to mention. I recall encountering one of our psychiatrists boarding a plane to London. He told me he was bound for a special meeting in a castle in Denmark to learn about a new wonder drug. I couldn't help thinking that there were, simultaneously, some Danish psychiatrists boarding a plane there, bound for New Zealand to learn about the same drug. Happily, Pharmac was invented a year or two later to put a stop to such junkets.

The other is that on return visits to England, people would ask me about an article they'd read concerning wonderful things now taking place in the NZ health sector: and on return to Auckland, vice versa and all bunkum. (laughter) Stories about the wonderful things now being done in other countries need to be treated with caution for they seldom stack up.

(Laughter)

But I also just have to say there was, in the 90s, a big political movement to privatise state-run health services, wasn't there, and all based on a book 'Privatization', by a man called Savas.⁹⁹ Changes that would garner 30% savings. I just looked at the Gibbs Report, and some of the numbers are so thirteenth chime - you know, fantasy - that you just have to wonder. There isn't a perfect health service solution, it's always tough and you have to struggle with what you've got and don't kid yourself there's a magic solution.

Linda Bryder: But I mean, would you agree then that the history of the hospital board system, you know, back from 1885 when it was first set up, and completely not related to the size of population around the country. That's been a long journey of reform and change and, does anybody want to comment on that? I mean, moving from hospital boards to health boards to regional...

Rod Perkins: Yeah, I've just made a study of that, and you can't have discussion about that without taking into account the state of New Zealand's roads.

Linda Bryder: Good point. So even if it's a little population, it still needs its hospital?

Rod Perkins: Well, and they had them too. And there was just, over time, an amalgamation, a coming together, and it hasn't finished. There used to be 70 or 80 different, Stratford Hospital Board, Hawera Hospital Board, and so on. I remember in the early 70s when all of those five hospital boards in Northland became the Northland Hospital Board, it was as though the world was coming to an end.¹⁰⁰

Graham Scott: Well they were pretty simple hospitals, they had general surgeons who eventually were thought to be too dangerous to be allowed to operate.

⁹⁹ See E.S. Savas (Department of Management, Baruch College/CUNY School of Business and Public Administration), 'It's Time To Privatize', *Fordham Urban Law Journal* 19, no. 3, (1992), 781-94.

¹⁰⁰ For the history of the Northland hospital boards see A.G. Wilson. 'Amalgamation - The Northland Experiment', *New Zealand Hospital* 22, no. 7, (1970), 21-4; M. Morrison, *Northland Hospital Board - then and now. Thoughts on thirty years of hospital board work*, (Whangarei: 1981); Anon, 'Northland Hospital Board - 34 years after amalgamation', *New Zealand Hospital* 36, no. 1, (1984), 12-4.

Rod Perkins: One of the problems up north was that one of the hospital boards had an anaesthetist and another one had a surgeon.

(Laughter)

I'm serious.

(Laughter)

Michael Bassett: My last act as Minister of Health was to close the Wairoa Hospital,¹⁰¹ because there was one surgeon, and they couldn't get rid of him. And he had a drink problem. A real danger that we'd lose more than were saved.

David Caygill: So I got rid of the committee whose approval was required before you could close a hospital. Mainly because I thought it was crazy, and unnecessary.

But in part, because what I discovered that, in at least one instance, where a board had failed to receive permission to close a hospital, they simply kept the hospital, and just didn't have anybody in it.

Rod Perkins: The Hospitals Advisory Committee, I remember it well.¹⁰²

Michael Bassett: It was worse than that, because one or two hospitals around the country actually had their own Acts. And one of the first things that happened when Picton decided it was going to close its little hospital, it suddenly became apparent that the Marlborough Hospital Board didn't actually have power to do this, that it had its own entitlement to stay open. I mean, talk about the mess that we'd blown up, I mean ad hoc(ery) knows nothing better than the New Zealand health system, the way it's grown over the years.

Derek Dow: This also raises something I first came across in Britain in the 1980s, when I was the hospital board archivist when they started restructuring the health system there. What they did was they went off to places like the Greater London Council, got the chief executive to come up and take charge of Glasgow. They got supermarket managers. And almost invariably, the first thing they would do is shuffle all their senior staff around, so they could get rid of the institutional memory. Once you got rid of that, start with a clean sheet of paper and we'll design something new. But of course, they almost inevitably made the same mistakes that their predecessors had made, 20 or 30 years earlier. I wonder if anything of the same kind of thing happened with the reforms in New Zealand, whether you threw out the baby with the bath water, to some extent.

David Caygill: Look, almost certainly, but the problem I've got with the suggestion, forgive me, because it's a reasonable question or a reasonable statement, but to me it kind of misses the point that these things aren't happening because people are trying to have fun with somebody else's system. Or they're bringing extraneous knowledge from outside when they ought to know better than that. What we're doing is responding to public pressures, especially given the public health nature of

¹⁰¹ Wairoa Hospital, located about 130 kms north-east of Napier, opened in the late 1890s. The Wairoa Hospital Board was amalgamated with Hawke's Bay in 1971. See G.A. Conly, *A Case History. The Hawke's Bay Hospital Board 1876-1989*. (Napier: 1992).

¹⁰² The Hospitals Advisory Committee, with equal representation from the Department of Health and hospitals boards, was set up under the Hospitals Act 1957.

this system. It's owned by and operated on behalf of the taxpayer. Added to which you've got enormous economic pressures going on. This is a country that might have had the second highest standard of living in the 1950s, but by the 1970s it sure doesn't, and by the 1990s it's got even less. Every time we look at Australia, we look at their system, but we haven't got the money that they have to do the things they are doing.

So the reason you're doing all of this – making all these changes - is to try to do more, with what feels like less, in a system where there is no limit to what can be demanded. People are not doing their own rationing, because they're not making private decisions, although there's some exceptions to that, particularly in the primary sector. For the most part people are happy to decide the size of house they can afford, or the wardrobe they can afford. But if somebody's told them they've got a health problem, and they've identified that symptomatically. They have no idea what is a reasonable amount to pay, and they won't be paying. So someone else will have to do the rationing: someone else will need to work out what health services are to be provided.

So you're operating in an environment of very significant and inexorable pressure, and then I think, responding to something, Ian, you said, to me, there's two other things that are worth remembering about New Zealand. One is that this is a very intimate democracy. It's very easy to get hold of a Minister, officials and MPs. So it's a very centralised system, even though we enjoy remarkable access to its decisionmakers.

There's a book called "The Fifth Schedule" (by Bernice Shackleton, a former Press Gallery journalist),¹⁰³ that was written about Waimate Hospital and how they got themselves into a schedule of the Hospitals Act that meant you couldn't close their hospital. There's lots of historical stories like that. On the one hand, it's very easy to appeal to the centre in this country, and one reason why do we not do the research that rationality suggests we ought to do before we make these changes is because politics is demanding a response much more quickly than that would allow.

And then the last point I'll make is that at least in the middle 90s, from the mid-80s to the mid-90s, we'd gone through a period of enormous change, I would still assert, responding to extraordinary economic pressures that have built up before then. But never mind, we dealt with it. And so by the time we were beginning to come out of that period, we were still undertaking extraordinarily ambitious reforms, because that's what the government had been doing for the last decade. So things that you, in another system, wouldn't dream of doing, without a lot more research and over a longer period of time, no, we were confident that we could undertake big changes.

Tony Baird: Yeah, talking about pressures, what we've got now is an increasing number of people whose health is really poor, and that's because of their lifestyles. The women booked for births at [National] Women's, a third of them are diabetic. The best treatment for diabetes is some sort of stomach stapling, the costs for that

¹⁰³ Bernice E. Shackleton, *The Fifth Schedule 1874 - 1975 : The Story of Waimate's Open Community Hospital*, (Waimate: Waimate Museum, 1984). Bernice Elizabeth Shackleton (1901-98) wrote the centennial history of Waimate Hospital at the age of 83. Her brother, Ronald George Shackleton (1899-2000), had been medical superintendent of the hospital 1957-64.

go up and up and up. And then we've got all the amazing things, like robots and ability to get your clot from the middle cerebral artery, when you're somewhere in the middle of Puketapu¹⁰⁴ and you get flown up here. How anyone can possibly devise a system that will meet the current needs, I can't think. We're talking about systems and structures and things, but the reality is that, you know, it's hugely complicated.

Linda Bryder: That might be a conclusion from the day, "It's so complicated, let's go home." No, I'm joking. Yes, Rod?

Rod Perkins: One of the characteristics of this particular time was that - and Claudia is an economist - that Claudia was followed by business people, and I remember well Peter Troughton,¹⁰⁵ who was in the department of Prime Minister and Cabinet, I think that's right? Yes. And he said, look, if we want any change here, we've got to get rid of all the number ones, half the number twos, and a third of the number threes. So I would have been gone, I went to university. But then there was also a belief that things, because business practice in Australia is similar to New Zealand, there was a belief that what was done over there, that worked, could be brought over here. And Peter Troughton got into all sorts of trouble when he tried to implement the New South Wales health model, that had certain populations need this hospital there, and this one here, and don't need that one. And you know, you need to have surgery here, don't need gynaecology here. And he got crucified.

But I often thought, crumbs, surely, we've got some people in health that could exercise the wisdom that the system needs. We became very dependent on people with strengths in business, we did, and they tripped up. And I felt that, like Lester Levy¹⁰⁶ today, in my opinion, is doing a very good job. He knows business and health. He's stopped being involved up here, but he knows about business, but he knows about health. We didn't have that in the early 90s. We didn't have people like that.

Don McKinnon: But there was no, it wouldn't have been any trust within the broad medical family of anyone outside that family to have a role of responsibility on finance, or anything. It was a huge barrier really.

Rod Perkins: Well, we didn't have people educated in different disciplines, did we?

Graham Scott: I think it's true, your point that there wasn't a cadre of people that had skills in managing health service delivery systems that were getting much more

¹⁰⁴ Puketapu is a small rural community near Napier, in Hawke's Bay.

¹⁰⁵ Englishman Peter Troughton was chief executive of Telecom (1988-92) when the company was privatised in 1990. Between 1988 and 1990 he had cut staff numbers from 23,000 to 12,500; previously he had culled the Forestry Commission staff in 1986 from over 7,000 to under 3,000. He was also director of the Crown Health Enterprise Establishment Unit in the early 1990s.

¹⁰⁶ Lester Levy (1954-) MB BCh Witwatersrand, moved from his native South Africa to New Zealand in 1978. He has chaired numerous health bodies, including the Mercy Ascot Hospital Group, the New Zealand Blood Service, the Health Research Council of New Zealand, and, simultaneously, the Waitematā, Counties Manukau and Auckland District Health Boards. He was made CNZM in 2013 for services to health and education.

complicated than they had been. Capital Coast,¹⁰⁷ had a chief executive there who'd come out of industry and his nickname was Chainsaw Harrison.

(Laughter)

And a lot of, I mean, you might remember, Don, in the course of that early wave of reforms, a huge number of the chairs were fired, and a huge number of the chief executives were. Because you were going through a process of winnowing people out who could actually do what was a more complex job, in a more constrained environment, a lot of politics around it and so on. And doesn't apply in private industry, and frankly, didn't apply in some of the SOEs that were privatised. They went relatively smoothly from government ownership to private ownership, with no particular problem. Not all of them, but it was a very different kettle of fish in the health sector, for reasons of the complexity of people we've talked about.

Linda Bryder: Can we move the conversation to an important area of cost containment, which really started to bite, you know, back in the 70s maybe, and that's pharmaceuticals, and the concern about the rising costs? Since it was introduced in the 30s and 40s, free prescription charges –

Michael Bassett: 1941.

Linda Bryder: Forty-one was when they finally sorted it out, yes. And they didn't realise that we were about to enter a drug era, you know, pharmaceuticals were going to be extremely expensive, and just expand exponentially. And would anyone like to talk about that? And eventually Pharmac, you know, Pharmac seemed to be very important organisationally. Would anyone like to talk about the background to that?

David Moore: Probably inappropriate for me to talk about the 80s, at which time I was just leaving this university. But, after a stint at the, well two stints at the Treasury, and a bit of merchant banking, and a bit of consulting, came time to look for another three-year job. And at that time, the health reforms still looked to be the most complicated. It did also seem to me that at the time the health reforms directorate¹⁰⁸ had an enormous number of intelligent people, who were flailing, trying to get health care plans working. But without, you know, kind of fully understanding kind of what that meant in insurance terms.

So I took a job in May 1992, as an economist, and I think I was probably the only economist in what was the then Health Department. And then quickly spotted, because my background is in accounting as well as economics, that nobody was monitoring the books, and that certainly pharmaceuticals needed to be attended to.

So November 1992, I took over what was then called the drug tariff section. In those days, pharmaceuticals used to be organised alphabetically, you went from the A to Z of the drug. There were three people running the process; one was the negotiator; the second person was the secretary to a medical committee that took every important decision. And the third person was the person who promulgated the

¹⁰⁷ The Capital & Coast District Health Board is now (2018) the sixth largest in New Zealand, with a catchment of around 300,000 people.

¹⁰⁸ The Health Reform Directorate was responsible for implementing the new health infrastructure which followed the transition from the Department of Health to the Ministry of Health in 1993.

regulations. It was very reminiscent of the debt management office, when we renovated that, you know, you walked in and there was a spiral bound ledger holding 60 billion debt. And as another loan was taken out, you'd undo the ledger and stick in a piece of paper. Within, you know, a year and a half, we had modern, you know, kind of portfolio management technology sitting there.

It was very much, it seemed to me to be a golden opportunity, and one which would not be lost, if the health reforms didn't succeed. And also, attend to a topic which seemed to me to be far more important, which was the job of trying to make explicit the core services in pharmaceuticals essentially defined by the pharmaceutical schedule. It also was a community pharmaceutical schedule so it supported general practice. And in those days, it was pretty clear, even then in health policy terms, that general practice would answer all the, it continued the tension in hospitals. So the process was remarkably quiet and straightforward. We reached an agreement with Maurice Williamson¹⁰⁹ to keep it out of the courts and out of attention for a period of time.

We documented the current system, and sent it out to the pharmaceutical companies, who immediately threatened litigation. Which told you a lot of things about what the institutional arrangements had to be. And we went through a process of documenting everything in a book called the Purple Elephant¹¹⁰, about 150 pages of documentation of the current system. And then ran a process, which was really built up of relationships. We had, you know, kind of a contact within the health reform directorate, who was in fact John Wallace.¹¹¹ And we nurtured that with a Swiss-German economist, who'd come from the Treasury. And we built a relationship with what was to be the regional health authorities, and chaired the process with Graeme Edmond,¹¹² who had been a country drug representative, and took them through a process. Which ended up with Pharmac being established as a joint venture company owned by four regional health authorities.

Within that, I mean, so the process was, I think, very quiet, to the point that Pharmac was actually left off the Official Information Act list for a year before anyone noticed.

Linda Bryder: Thank you, that's very interesting, to get that insight –

Tony Baird: Pharmac, people I talked to in medicine support it, and I think the comments around the TPPA¹¹³ that a lot of the public support it as well. It's a process that works really well.

David Moore: Well they didn't support it at the time. There was –

Tony Baird: The medical profession? Oh, we're always negative at the beginning.

(Laughter)

¹⁰⁹ Maurice Donald Williamson (1951-), National Party MP for Pakuranga 1987-2017 and Associate Minister of Health 1990-6.

¹¹⁰ The Purple Elephant was the blueprint for PHARMAC that was developed by David Moore while he was at the Department of Health.

¹¹¹ John Wallace, Policy Lead at the Health Reforms Directorate.

¹¹² Graeme Edmond, Chief Executive of Midland Regional Health Authority 1992-1996; Chief Executive of Auckland District Health Board 1996-2003.

¹¹³ TPPA: Trans Pacific Partnership Agreement.

David Moore: At the time, yeah.

Michael Bassett: That's actually a very good point. The Minister of Health has reporting to him or her 101 or 102 different organisations. And in the end, negotiating with, they're all vested interests of varying kinds. And change is something that absolutely terrifies them: "always keep a hold of nurse for fear of finding something worse," is the spirit that sort of runs through the whole of these people. And your –

(Laughter)

I can't claim that as original, it was Hillaire Belloc's "Cautionary Tales" –

But the problem that you have is that if you're trying to advance anything, getting more than one or two, and usually in the health sector it could be half a dozen to 10 of those groups that you're going to need onside, is an extremely difficult thing. And coming back to the pharmaceutical thing, free pharmaceuticals introduced 1941, but in those days, there were almost no pharmaceuticals.

Linda Bryder: That's what I mean.

Michael Bassett: You've got to remember that even antibiotics aren't around until the late 40s, and poor old Peter Fraser, the Prime Minister,¹¹⁴ nearly died at the end of 1943, because of a septic problem he had. And there was nothing to treat it with, extraordinary business. But the exponential growth of the array of medicines available, coupled with the small economy, which is really starting to trend downwards, made it very, very difficult to fund pharmaceuticals. Nordmeyer,¹¹⁵ when he was Minister of Finance 57-60, (he'd previously been Minister of Health) played with the idea of charging a flat fee for pharmaceuticals. In the end, what happened in the 70s was that something a bit akin to an early version of Pharmac appeared; the department says, look, the drug in this particular field that we can afford is X, and that will be the freebie. But if your doctor insists that you have something else, you'll have to pay towards it.

So, some kinds of part charges had accumulated quite considerably before 1984. And then of course I did a "terrible and most wicked thing". In 1985 in order to get the money to make it possible to take children to a doctor for a relatively cheap fee, I put a one dollar flat fee on pharmaceuticals for people in the age range of 16 to 60, from the first of February 1985. Well, all hell broke loose, of course. And it wasn't very much longer, I don't think you did it, but I think Helen [Clark] did, bumped it up to about five bucks, didn't she? And certainly, the charge grew.

David Caygill: No, I think I did.

Michael Bassett: Did you do it?

(Laughter)

Linda Bryder: Yes?

¹¹⁴ Peter Fraser (1884-1950), former stevedore and Labour MP for Wellington Central / Brooklyn 1918-50; Minister of Health 1935-49 and Prime Minister 1940-9.

¹¹⁵ Arnold Henry Nordmeyer (1901-89), Presbyterian minister and Labour MP 1935-69. Minister of Health 1941-7 in First Labour Government then Minister of Finance 1957-60 in Second Labour Government, when he introduced the infamous 1958 'Black Budget'.

Ian Scott: I think Pharmac represents a major challenge to big pharma, from a very small country, we've been extremely successful. But why are we, and America, the only countries that allowed the pharmaceutical industry to advertise to our clients, our patients? Why are we the only two countries in the world that allow advertising by pharma, by big pharma?

Claudia Scott: Australia can.

Ian Scott: Do they?

Bruce Arroll: It's even worse, because the government actually pay for the drugs –

Claudia Scott: That's right - the drug companies are advertising.

Bruce Arroll: It's bizarre, you know, so it doesn't help. I was just going to say a word about Pharmac, I mean, it's sort of interesting, it's had its ups and downs. But it's just interesting though for the TPP thing how Pharmac was still the national treasure, nobody wanted to lose it. As a GP, I was just telling the general public that, so when I prescribe a medication now, I don't have to worry about what the costs are going to be, if I write a generic I know it's going to be funded. And I know Pharmac have sorted it out, so I don't have to do the rationing. It's actually a pretty good system as a GP, I don't have to worry about the ration, thinking oh, this is going to cost this, I don't have to do that. So I think there's been a pretty good –

David Moore: And the co-payments for pharmaceuticals have come down, whereas in Australia they've gone up a great deal. I'll just say that there was a comprehensive effort to work through the decision criteria that sat behind Pharmac's decisions. And they're not, there's a competition between them around therapeutic benefit. And each of those tests required development of, you know, some system, so there was a bioethical core debate that was run for some years.

Tony Ryall¹¹⁶ finally made us stop putting cartoons into the annual reviews, which kind of, you know, exemplified these debates. We made sure they got picked up in the papers over Christmas. And we had a strong relationship with the gentleman from Imperial College who came across. The same time as Bruce Arroll was busy teaching the doctors, you know, major strategic asset in Pharmac, which is always kept quiet. Which is a pharmacology and therapeutic advisory committee. There's about 60 or 70 doctors working through, and we're talking over. It's full of conflicts of interest, and questionable about whether it was fit for purpose.

But over time, and with Bruce's training in evidence based medicine, which was another theme of the times, we probably ended up with probably, I think, 200, 300 doctors trained in evidence based medicine. And also used to looking at choices within health budgets. And of course you know, Māori health and Pacific Island health was another one of the challenges in the decision criteria, and much focused on by the Māori members of the Pharmac board.

So all in all, you know, there's kind of half a dozen things there, which were more about management than about politics. But of course, the combination of deal making with a kind of organisation of the managers around therapeutic groups. So

¹¹⁶ Anthony Boyd Williams (Tony) Ryall (1964-), National Party MP 1990-2014. Minister of Health 2008-14 then became head of public policy practice for law firm Simpson Grierson.

they knew what their budget was, they knew what their innovations were, but they were going to have to pay for, but they also knew the pipeline that they could trade off as generics became available.

Linda Bryder: Is there anyone else who feels that they would like to say something, either on pharmaceuticals, or on inequalities, or area health boards?

Debbie Hager: I just wanted to say I thought, this has been very interesting, but I think it would be interesting to also hear the perspectives of the trade unions and some of the staff in the hospitals and other health services who were impacted by these changes, who lost their jobs. Who were restructured over and over and over again, and then the stress that was caused by that. I also would have been interested to hear from people, especially poor people, those who couldn't afford health insurance, because, as we know, there's a huge rise in health insurance during this period. And a huge increase in the number of private health services, so that those who were wealthy had good health, and those who were poor lost a lot of services as services became disestablished. So I think that we haven't heard that point.

And I'm also interested that all of this has been spoken about as if it was economic necessity, and I think the fact that this is hugely ideologically driven from Treasury, and from other places, has been somewhat, oh, not mentioned, or kind of sidelined in this discussion. Because this is not about, just about changes to a health service, it's about ideologically driven changes to a health service. And as we had ideological changes and everything else from 1984 through the 1990s. I just felt it's really important to really clearly put that on the record.

Ian Scott: I just can't help but reflect on the fact that sitting at this table, there are only two, three women.

Linda Bryder: I know, we tried –

Ian Scott: And –

Linda Bryder: That was just unlucky.

Ian Scott: I don't think it's unlucky, I think it's actually part of what our health services are like –

Linda Bryder: Were –

Ian Scott: Well still are today. You go to DHB meetings there's the same imbalance often, not in the hospital, we've got layers of management in the hospitals.¹¹⁷

But I would say we haven't got the structure right. We have been far too based on big hospitals, but we need preventive care, we need community care –

Linda Bryder: If I could just speak to the historical aspect of that, when we looked at possible participants, and most of the women who we thought of were not really involved until much later. So I suppose it is a reflection actually of New Zealand society in the 1980s.

¹¹⁷ As of 2017, across the 19 District Health Boards with boards (Southern DHB is currently run by a commissioner and two deputy commissioners) there are 206 board positions, both elected and appointed, and exactly half are held by men and half by women. However, men chair 12 of the boards and women chair 7.

Michael Bassett: Apologies for my wife, who would have come –

Linda Bryder: I know –

Michael Bassett: But she's at a District Health Board meeting all day.

(Laughter)

David Caygill: One of them became the Prime Minister [Helen Clark], so not too bad.

Michael Bassett: One question you haven't discussed at all has been the Cartwright Report. And the things that came out of that had a profound influence on the health sector, at all levels I think. The notion of informed consent, and so on, all that emerged out of that.

Linda Bryder: Yes, they were happening overseas as well –

Michael Bassett: And here yes.

Linda Bryder: And had also been discussed. So it's part of the process as well.

Michael Bassett: So it's how New Zealand actually catches up. It's been written about to a considerable extent and there's no point in mentioning how it came about. But David received the report, in early 1988 I think.

David Caygill: Yes.

Michael Bassett: And that was only the beginning of it.

Linda Bryder: So we've got two minutes, and I actually thought we'd let Martin have the last word on just, you know, for a couple of minutes. Sorry, I've put you on the spot, we didn't plan this, if you want to stand up, just make a few comments about what you think, what you've taken out of this afternoon as we draw to a close.

Martin Gorsky: This has been incredibly interesting to me. One thing that struck me actually in the first part, which I hadn't anticipated, was the discussion of the inequities, the inefficiencies of the hospitals, and their underuse, as well as the political explanation for that in terms of, if you like, partisan rewards for supporters. And what that's got me wondering about is the nature of the New Zealand state. Thinking particularly of the contrast with Britain, why did Treasury let that happen? Why did it go on so long, and why was it only in the 1980s that they tried to get on top of that? So that's something I wonder about.

Another thing that's been rather absent through the discussion, but has percolated into it in different ways, is public opinion and political culture. And that's something I'd really like to know more about. What were the terms of the possible in all this? Because it seems that part of the story of the ideas coming in, and the move towards the *Green and White Paper* has been one of people increasingly pressing the bounds of the possible, and perhaps reaching the point where they couldn't push anymore. So I was struck particularly by David Caygill's comment about half an hour ago, about the political culture of the time, and the shared sense that big, dynamic reforms were possible, and needed. And that this swept people along until the point was reached where it no longer was possible. That's been really helpful for me, and something that I hadn't anticipated.

A final thing I'm wondering about is whether we can see this era, the long 1980s, as a piece, or whether the impact of the individual as 'agent of change' - these big individuals we've talked about, like Alan Gibbs and Simon Upton - make it difficult to see clear lines of continuity running through. Or was there a greater degree of continuity, perhaps expressed by the civil servants, the people behind the scenes, which we haven't brought out in the discussion?

So those are some random reflections, from being put on the spot, but those are the kind of things that have been bubbling away in my mind as you spoke. Thank you very much.

Linda Bryder: It remains for me to thank you all, including the audience, for a wonderful afternoon, for participating in this, bringing your experiences here on this project. The process is that it will be transcribed, and you will receive it, and you can make notes on anything, if you want to expand on anything. Give more references, say anything at all. If there's something that you're not happy about, we can delete it.

Martin Gorsky: Yes, if when you see the flow of your words on the page, you're unhappy with that, and want to tweak the grammar or anything like that, you're perfectly entitled to do that as well. Just don't change the meaning. And of course, anything you don't want to go on the record, again, we can redact that.

Linda Bryder: You'll be consulted. And it'll be an opportunity for you to also give us more feedback, more information, which can always go in footnotes, or appendices. Not in the main text, of course, because that's a record of today, but it will be annotated. And so it's a wonderful process and thank you so much for participating and helping us with this project, which I'm sure will get an excellent result. So downstairs, in the same room, we're now offering you a lovely glass or two of the university wine, from Waiheke Island, and some nibbles to go with it. Please do join us and carry on the conversations. Thank you very much.

Timeline

While the seminar focuses on the 1980s and early 1990s, the timeline has been provided to give a wider context.

1969	Department of Health Review
1972	The Royal Commission on Social Security
1974	White paper, <i>A Health Service for New Zealanders</i> (the McGuigan Report)
1982	<i>Health Services Reorganisation: a Discussion Document</i>
1983	Area Health Boards Act: allows for Hospital Boards to become AHBs, but the change was not compulsory. Introduction of population based funding (PBF) formula.
1986	<i>Choices for Health Care: Report of the Health Benefits Review</i>
1988	<i>Unshackling the Hospitals</i> (the Gibbs Report) <i>Health: A Prescription for Change</i>
1989	The New Zealand Health Charter
1991	<i>Your Health and the Public Health</i>
1992	Introduction of user charges for services provided by public hospitals
1993	Health and Disability Services Act: four Regional Health Authorities (RHAs) were established. Purchasing and provision of health services were separated. The 14 Area Health Boards were reconfigured into 23 Crown Health Enterprises (CHEs) structured as for-profit organisations and subject to ordinary company law. Public health services were unbundled and a separate public health purchasing agency, the Public Health Commission, was established. The Ministry of Health replaced the Department of Health.
1993	Founding of PHARMAC