PHO Alliance

He huinga ratonga hauora

A time to act:

7 actions which will help sustain the New Zealand health service for future generations

17 February 2015

Introduction

The renewed mandate for the Government following the 2014 Election and the appointment of a new Health Minister come at a pivotal time for the New Zealand health sector.

An ageing population living with more long-term conditions, increasing incidence of obesity, the global financial crisis, technological advancement and rising public expectations are all combining to place unsustainable pressures on hospitals, general practices and aged care providers.

An emphasised focus on health promotion, prevention and health literacy is critical to address the wider determinants of population health and a fundamental shift is urgently needed in the way we deliver health and care to ensure we provide the right care at the right time in the right place. If we get the care right, it will be right for the patient as well as the system, then sustainability will follow.

We acknowledge there is no single panacea, but over the following pages we shine a spotlight on 7 key actions members of the PHO Alliance believe will, when combined, help deliver a sustainable, effective and patient centred health and care system for the future.

Some of the proposed actions will require bravery to implement given that they confront an established way of thinking and established practice. However, improved patient outcomes must stand above existing arrangements and organisational barriers.

We hope our proposals provide a valuable contribution to the sustainability debate.

John Ayling
Chair, PHO Alliance

Our actions to optimise the health sector

Reprioritise funding and services

1. Prioritise more services and funding to those most in need
2. Abandon health targets that do not have an evidenced link to patient outcomes
3. Support IT systems which directly underpin patient centred integrated care

Remove the barriers to access and eliminate perverse incentives

4. Make all primary care consultations affordable
5. Give patients the choice about who they would like to address their health concerns
6. Remove the barriers to diagnostic services
7. Divorce the conflicted relationships which DHBs have as controller of local health service funds and managers of secondary care hospitals

Reprioritise funding and services

The health sector is facing possibly its biggest ever challenge. The New Zealand population is getting older and is living with more long-term conditions.

Not everyone is affected equally however. There remains an unacceptable gap for both health outcomes and life expectancy between Maori and non-Maori.

That we live with such inequality and inequity in the 21st Century in a developed society needs to be the prime focus of health care improvements. If we can reduce health care disparities then all New Zealanders are going to benefit from the changes we make.

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1. Prioritise more services and funding to those most in need

There is no debate that the health status of Maori, Pacific Islanders and those New Zealanders living in the most deprived communities is unacceptably worse than the rest of the population.

We say the only fair way to address such inequalities is to seek the same outcomes for all, and to achieve that will require more targeting and resources for those most at need.

We also say that the biggest health gains for New Zealand will be made by focussing on those most at need.

The current system of universal capitation funding is failing those who need it most and the formula for allocating health dollars across both primary and secondary care services needs an overhaul to be targeted for best effect.

The big advances in reducing inequalities come when bold decisions are made about funding priorities.

As well as the core funding formulae, the myriad funding silos which span Ministry of Health Programmes and each DHB need considering as a whole and targeted more appropriately. The emerging Integrated Performance and Incentive Framework must make a significant impact upon inequalities locally, or it will fail an otherwise great opportunity.

2. Abandon health targets that do not have an evidenced link to patient outcomes

We say more about perverse incentives and unintended consequences later, but nowhere is this more evident than the misalignment between health policies based not on the needs of our communities but on easily measured "widgets" which make good media releases.

Setting a maximum six hour waiting time for ED does not ensure that we have a high performing health system. It fails to ensure a better alternative is put in place before admitting patients to costly hospital wards causing further anxiety to them or their loved ones.

And a six hour waiting time for ED certainly doesn't ensure that optimal multi-disciplinary care and support is provided to those who are most vulnerable to enable them to live independently and happily with their families and Whanau.

Setting DHBs targets for the numbers of patients receiving elective procedures while clearly of individual benefit reinforces a disease focused approach and does nothing to incentivise providers to prevent the onset of illnesses or find alternatives for referrals to secondary care.

We believe there would be benefit in greater use of patient reported outcome measures (PROMs) rather than singular activity based measures. PROMs are a means of collecting information on the effectiveness of care delivered to patients as perceived by the patients themselves. Such measures are becoming more established overseas and include the Aberdeen Varicose Vein Questionnaire and the Oxford Hip Score.

The PHO Alliance recognises that improvement projects such as multidisciplinary pathway development have made a useful contribution of encouraging and supporting primary care practitioners to assume greater clinical responsibility for patients, with a consequent reduction

in unnecessary referrals into secondary services and more localised care for patients. This is as it should be. However the reluctance to recognise the financial implications of changing patient flows so that patients can remain within the primary care domain risks compromising these gains.

3. Put integrated IT platforms in place

We agree with the vision of the National Health IT board and believe we need to do more to make it a reality.

To achieve high quality health care and improve patient safety, New Zealanders need a core set of personal health information available electronically to them and their treatment providers regardless of the setting as they access health services.

We need to find information solutions which allow patient centred integrated care. These systems need to be interoperable, share data and be accessible to not only health providers but patients. For this to occur there has to be strong national and regional leadership to make unified decisions about how to progress towards the NHITB vision statement. This should be driven by the needs of patients and clinicians not by IT vendors.

Remove the barriers to access and eliminate perverse incentives

We constantly give advice to patients and colleagues about making the right decisions to get the best outcomes and to most successfully navigate around the myriad components of our health system.

It would therefore be reasonable to expect that our health system and those organisations within it, are configured in a way which supports those same patients and health professionals to make the right choices, first time and every time.

Yet ask any health professional and most patients about their experiences and many are likely to reflect on absurd barriers in the system which has prevented them from doing the right thing.

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4. Make all primary care consultations affordable

If we are serious about encouraging patients to visit their GP rather than ED, and if we are serious about ensuring all women receive cervical screening when appropriate, then we should make all such appointments and associated consultations affordable.

To allow patients to attend ED with its immediate access to diagnostics and its high-tech facilities with no co-payment, yet have financial barriers to see their GP is perverse.

It is also a significant barrier to access for those very same vulnerable high needs patients for whom we want to encourage greater health engagement to reduce the unacceptable health inequalities we face in New Zealand.

There is a bundle of international evidence about the whole system benefits of a strong primary care sector. We believe removing the barriers to accessing ours will improve outcomes but also save money as we reduce demand upon high cost secondary care services and ED.

The current Very Low Cost Access (VLCA) capitation funding formula is failing. There are 590,000 non-high needs patients receiving the benefit of VLCA funding. We need to have a funding formula that is targeted to the need of the individual patient.

5. Give patients the choice about who they would like to address their health concerns

We believe, that for many reasons, a GP may not always be the best health professional for patients to see when they turn to the health system for support or assistance. If we moved towards an integrated, multidisciplinary team approach in primary care, we consider that patients would be able to make their own decision about when to see the dietitian, the podiatrist, the physiotherapist, the nurse, or the counsellor for instance.

Such direct access would make better use of all our health professionals' skills and significantly free up GP time for those patients who really need them or for when the patients needs are just too complex for them to make their own decisions.

Once again, we believe removing the funding barriers and better co-ordinating access to all our primary care health professionals will not only improve outcomes but also save money as we optimise the skill mix for the primary care workload and reduce demand upon high cost secondary care services and ED.

6. Remove the barriers to diagnostic services

We recruit and fund a highly qualified, highly experienced and highly capable multi-disciplinary team based in primary care and aligned to the medical home which is general practice. We expect them to manage risk on a daily and patient-by-patient basis. We look to them to manage demand for secondary and specialist care so as to ensure high cost acute services are utilised appropriately.

Why then do we prevent those same practitioners and professionals from accessing probably the most important decision tool available to them?

Failure to provide access to the full suite of diagnostic services to our vital primary care workforce results in delays to diagnosis, anxiety for patients, duplication of costs through outpatient appointments and an overwhelming failure to provide the right care at the right time in the right place.

Empowering and mandating the primary care teams to utilise the traditional secondary care domain of diagnostics and we believe referrals will reduce, duplication of costs will reduce, and, most importantly, more patients will receive earlier interventions and support to live independently in the community without the need for avoidable hospitalisations.

7. Divorce the conflicted relationships which DHBs have as controller of local health service funds and managers of secondary care hospitals

We already know a strong high quality primary care sector is vital to a strong high quality wider health sector which is financially sustainable and which delivers better outcomes for patients.

Such a vision requires investment in primary care capability, capacity and infrastructure. In New Zealand, we feel investment in primary care has continually been eroded over recent years rather than increased.

We believe this will not change whilst we have financial pressures at the same time that DHBs have the unenviable task of controlling those investment decisions locally and simultaneously being held robustly and publicly to account for the performance of secondary care acute hospitals. Very few Directors or Executives the world over could rationally increase the risk to their own bottom line by investing in another sectors growth and capacity.

We need to look again at the purchaser/provider split without creating an industry of accountants and contract managers unwittingly diverting health funds away from real patient care.

About the PHO Alliance

The PHO Alliance is a consortia of member PHOs working together to share learning, share best practice and support better outcomes for patients.

Our member PHOs encompass some 1.2 million New Zealanders living in some of the most deprived communities from Cape Reinga to Bluff. Our reason for being is to improve community health and the enrolled populations of our members.

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