



Better Sooner More Convenient

Health Discussion Paper by Hon Tony Ryall MP
NATIONAL PARTY HEALTH SPOKESMAN

National
www.national.org.nz





Over the coming decades, healthcare in New Zealand faces some big challenges.

Our population is ageing. More and more health professionals will be lured overseas to higher-paid jobs and better working environments. New technologies and services will change how care and treatment is provided.

To confront these challenges and provide the healthcare that New Zealanders deserve, our public health system needs to be adaptive, innovative, and forward-looking.

At the moment, it is in a completely different space. Our hospitals lurch from crisis to crisis. Our emergency departments are treating patients on trolleys in corridors. The entire system is characterised by growing bureaucracy and endless waiting.

Despite increasing the annual health budget by \$5 billion since coming to office, Labour has failed to deliver the extra operations, treatment, and care that patients rightly expect. Too much of your money is being wasted, and too few improvements are being made.

We can't afford to go on like this.

National wants our public health system to deliver better, sooner, more convenient care for all New Zealanders. We want reduced waiting times, better individual experiences for patients and their families, improved quality and performance, and a more trusted and motivated health workforce.

We want a health system that doesn't just react to the health problems of today, but adapts to meet the challenges of tomorrow.

That's why I have asked our Health Team to examine in some detail how we can improve healthcare in New Zealand.

This discussion paper is the result of that process. It's not an exhaustive study of every issue in the sector, but it looks at the key areas of poor performance. It offers proposals for discussion and seeks your feedback.

In early September, we released our Aged Care Discussion Paper. Over the next year, we'll present proposals in other areas of health such as preventive health, child health, maternity care, mental health, cancer services, and disabilities.

The end product will be a suite of policies designed to restore the public's confidence in our troubled health system and build a healthier future for all New Zealanders.

We look forward to your comments.

Yours sincerely

A handwritten signature in blue ink, appearing to be 'John Key'.

John Key
NATIONAL PARTY LEADER

Better Sooner More Convenient

CONTENTS

	Our Health Policy Principles	3
	Summary of Proposals	4
	New Zealand's Health Challenges by Hon Tony Ryall	6
1	Health Spending in New Zealand	8
	· How much do we spend?	8
	· How much should we spend?	9
2	Reducing Endless Waiting	13
	· Waiting for elective surgery	13
	· Waiting in emergency departments	19
	· Waiting for medicine	22
3	Towards Better, Sooner, More Convenient Primary Care	23
	· Primary care	23
	· Moving care closer to home	25
	· Focusing on prevention	28
	· Health and social care together	29
	· Connecting the different islands of healthcare	31
4	Improving Performance And Quality	33
	· The productivity problem	33
	· A new partnership with the health professions	36
	· DHBs working together more effectively	38
	· More information for patients	39
5	Strengthening The Health Workforce	41
	· Our health system's greatest resource	41
	· Planning for the future	43
	Have Your Say - Feedback form	

Published in 2007 by The Office of the Leader of the Opposition.
Written by Hon Tony Ryall and assisted by National's Health Team.

Cover photo: Friendly game of touch rugby on Waikuku Beach,
North Canterbury

All rights reserved. © Copyright 2007

Our Health Policy Principles

OUR GOALS

National wants a high-quality patient-centred health system that cares about the wellbeing of New Zealanders.

We want New Zealanders to enjoy long and healthy lives.

We want patients to have better, sooner, more convenient healthcare.

And we want a public health system that continually improves to meet the public's justified expectations.

To reach these goals, we are developing policies that are guided by the following principles:



OUR PRINCIPLES

Putting patients first

The patient should be at the centre of all health services. Patients should be in control of their own care and be able to make informed choices.

Care close to home

More healthcare services should take place as close to home as possible. Complex healthcare should be provided by the most skilled professionals with access to the best medical technology.

Integrated care

Care should be seamless. The health system needs to bring together the skills of practitioners and staff from different service areas in order to provide the best care for patients. Health providers need to work more in partnership with social and community organisations to promote well-being.

Trusting health professionals

Clinical professionalism underpins public trust in the health system. Doctors, nurses, and other health professionals are better motivated and provide better care and treatment when they are trusted, valued, and fully-engaged. This will also improve the quality and safety of care.

Working together for better care

The effective use of finite health resources requires everyone who provides, manages, and funds care to work together. Communities, management, and health professionals need to take responsibility for shared decisions, and innovation should be encouraged.

Healthier lifestyles

With increasing access to better health information, New Zealanders will be empowered to take more care of their health. Many ailments are preventable through healthier lifestyles. People with chronic illnesses can be better supported to manage their own health.

Summary of Proposals

This discussion paper includes numerous proposals for better, sooner, more convenient healthcare. The main proposals are summarised below.

REDUCING ENDLESS WAITING

Sooner, more convenient care in GP surgeries

GPs with special interests should be able to provide a wider range of minor surgery in their clinics. They should also be able to provide a level of specialist assessment currently provided in hospitals, including the ability to order immediate diagnostic tests.

Walk-in access at general practice should be more widely available to provide choice and faster care for patients.

Smarter use of the private sector

The judicious use of public-private partnerships can increase the availability of elective surgery and reduce waiting lists. National will focus on ensuring patients receive the care they need, sooner, rather than obsessing about who owns the facility they are treated in.

Innovative management

Separating acute and elective service provision can allow health professionals to concentrate on the efficient delivery of elective services without being disrupted by urgent cases. Similarly, improving discharge planning and staffing, as well as actively involving general practice, can reduce emergency department delays.

Rewarding surgical teams

The health system should reward innovation and productivity improvements at the hospital specialty level. Specialties should be able to share efficiency gains to provide additional services or clinical support for patients.

GPs in emergency departments

Hospital emergency department delays can be reduced by some co-location of GP services. This can result in patients being seen earlier. Improved telephone services after hours can help relieve pressure on the GP workforce.

Quality use of medicines

We can speed up our medicines approval process by

recognising international medicine approvals. Improved medicine management presents further opportunities to improve the effectiveness of public investment in medicines.

TOWARDS BETTER, SOONER, MORE CONVENIENT PRIMARY CARE

Moving more services closer to home

Some hospital services should be moved to Integrated Family Health Centres (co-located multi-disciplinary teams). These centres can provide a full range of services, including specialist assessments by GPs, minor surgery, walk-in access, chronic care, increased nursing, and allied health services, as well as selected social services.

Coordinating care

Primary care can provide a much wider range of care and support for patients. National will place greater responsibility on and provide stronger incentives for PHOs and general practice to coordinate the ongoing care of their patients.

Chronic care and social support

Specially trained nurses who are involved with chronic-care patients should be engaged to act as brokers, or case managers, for non-health agencies to support at-risk families.

Devolving more care to the primary sector

More treatment and diagnostic services should be devolved to primary care. DHBs should be held accountable for the devolution of services to general practice and Integrated Family Health Centres.

Primary-care funding

Universal subsidies for GP visits should be maintained.

IMPROVING PERFORMANCE AND QUALITY

New leadership

New political leadership is desperately needed to give clear direction on the shared mission for the public health system. The current failed mission of "political peace and quiet" should be replaced by a relentless drive towards healthcare which is "better, sooner, more convenient".

A new partnership with the health professions

Doctors, nurses, and other health professionals should be more involved in the planning and operation of the public health system. This includes greater involvement in District Health Board (DHB) decisions and throughout the wider health sector.

Clinical networks

Clinical networks should be established across regions to assist in planning, delivery, and evaluating services. These networks would involve clinicians, non-governmental organisations (NGOs), and patients.

More effective spending and planning

It is inefficient and inhibiting to have 21 DHBs that duplicate planning, monitoring, and funding functions. The funding arms of DHBs should cooperate as shared-service networks across their regions. This can improve performance, support clinical networks, and provide more strategic decision-making. It can also improve the administration of provider contracts.

Greater choice for patients

DHBs should have greater freedom to supplement public services by using private providers, such as private hospitals, GP clinics, and Maori and Pacific health providers. Labour's ideological aversion to private providers is unnecessarily limiting patient options and harming their health.

Long-term health service plan

A 20-year plan can identify the demographic, technology, quality, and safety changes that will affect health services. It can assist in ensuring capital and staff capability needs are well planned.

Public-Private Partnerships

The public and private sector should jointly plan for required capacity in both facilities and workforce. Some new hospital infrastructure and investment in new technologies, such as PET scanners, can be financed by public-private partnerships.

Better information for the public

The public should be provided with better information on hospital and PHO performance. The introduction of star ratings should be considered as one of a range of approaches to improve performance reporting in areas such as safety, staffing, productivity, and patient satisfaction.

STRENGTHENING THE HEALTH WORKFORCE

A new partnership with the health professions

Doctors, nurses, and other health professionals should be more fully engaged in the planning, operation, and evaluation of the health system. New Zealand can never compete solely on salaries, so we have to offer a stronger and more-engaged clinical environment.

Boosting health workforce numbers

Health workforce numbers can be boosted by:

- Medical training self-sufficiency, including training more students in rural and provincial areas.
- Investigating bonding and student loan debt write-offs for those health professionals working in hard-to-staff areas (geographic and speciality), and for those re-entering the workforce.
- Recognising enrolled nursing as a valuable part of the workforce.
- Reducing personal taxes to make it more attractive for health professionals to stay in New Zealand.

International recruitment

A one-stop shop approach should be developed for international recruitment into the health system. This single programme will attract candidates to New Zealand and then provide an opportunity for them to choose where they would like to live and work.

New Zealand's Health Challenges



As a nation, we can meet the health challenges we face through strong leadership, better collaboration, a focus on the needs of patients and their families, and a new partnership with the health professions.

New Zealand's health system, like so many other countries, faces the following pressures:

- An ageing and growing population.
- New technology and medicines.
- Sustainable funding.
- Falling hospital productivity.
- Shortages of doctors, nurses, midwives, and other health professionals.

New Zealand must address its evolving and increasing health needs in the context of a number of health challenges:

1. *Public concern that the health system is increasingly characterised by endless **waiting**.*

Despite an extra \$5 billion a year in health spending, New Zealanders have to be sicker to qualify for surgery. It's harder to see a hospital specialist. Emergency departments are gridlocked. Radiotherapy waiting times are frequently excessive. Increasingly, people have to wait longer to even see their local GP.

2. *Public desire for **more personalised** public services closer to home.*

Patients are rightly frustrated by delays, poor choice, and lack of convenience in the public health system. They need to be confident that vital services will be there

when they need them. Patients also want care closer to home.

3. *Questions about the long-term **sustainability** of a health system so dominated by **bureaucracy**.*

Productivity in the health sector is actually falling at a time it desperately needs to be increasing. Bureaucracy is out of control. Since 1999, more managers have been employed than doctors. The Government's priorities are wrong, and doctors and nurses are understandably disillusioned by a lack of trust and respect.

4. *Access to services is hampered by chronic health **workforce shortages**.*

There are serious staff shortages in almost all areas of the health system. Countless official reports and poor Ministerial leadership have achieved little. The situation is worsening every day. The average age of the health workforce is rising rapidly.

New Zealand's health service can be improved to meet these challenges without the distraction of massive restructuring. National is committed to making continuous real improvements in healthcare because the human and financial cost of the status quo is unacceptable.

The task facing a National Government will be to re-orient the health system in such a way that it fosters improved quality and productivity, and becomes more patient-centred and provider-friendly. Experience shows that the process of engaging all stakeholders in system improvement is critical to achieving better outcomes, yet sadly there is little evidence of this approach in the health system today.

National wants to improve the health status of all New Zealanders by working closely with Maori, Pacific, and other at-risk sections of our communities. This will require a collaborative effort between the government, provider groups, and organisations throughout the health system.

This discussion paper seeks your views on the most pressing issues facing patients and the health system today. It does not cover all the concerns in the sector. Other important issues, such as preventive health, child health, mental health, maternity, cancer services, and disabilities, will be detailed in future policy documents. An Aged Care Discussion Paper was released in early September and Rural Health was canvassed earlier in National's Rural Issues document. This discussion paper seeks your views on National's proposals to improve health services.

In preparing this discussion document, the National Health Team would like to acknowledge the advice and comments received from many people and organisations in our health system. Their contributions have been invaluable and are greatly appreciated.

As the National Party Health spokesman, I'd like to thank my hard-working associates: Dr Jackie Blue MP, Dr Jonathan Coleman MP, Jo Goodhew MP and Katrina Shanks MP.

We look forward to receiving your comments on this Health Discussion Paper.

Yours sincerely

A handwritten signature in black ink that reads "Tony Ryall". The signature is written in a cursive, flowing style. Below the signature is a short horizontal line.

Hon Tony Ryall MP

Health Spokesman

1. Health Spending in New Zealand

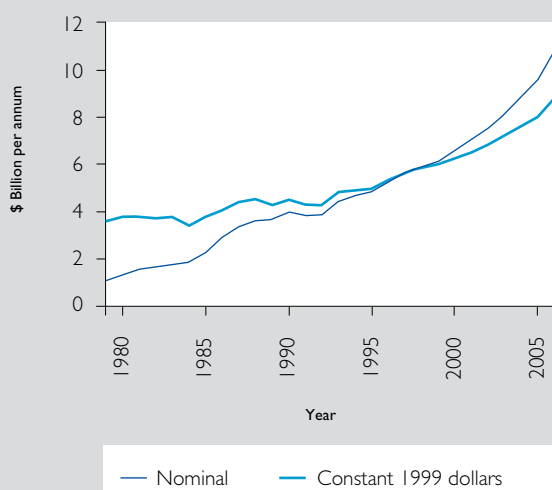
Public health spending will continue to grow as our population ages and as the range and cost of new services, technology, and medicines grows.

HOW MUCH DO WE SPEND?

Government health spending has grown in real terms at an average of 4% per annum over the past 50 years¹.

Health Spending

Vote Health Expenditure



Source: Ministry of Health

Since 2000, health expenditure has grown at around 9% per annum. The Budget for 2007/08 shows Vote Health is 14.6% higher than the year before²!

This rapid growth poses serious questions for many New Zealanders:

- Why is health spending growing so quickly?
- Is this spending growth sustainable?
- Is the tax-paying public getting value for money?
- Why do waiting times keep growing when so much more is being spent?

Looking forward

The Treasury's latest Long-Term Fiscal Model projects public spending on health doubling as a percentage of GDP to 12% by the year 2050³.

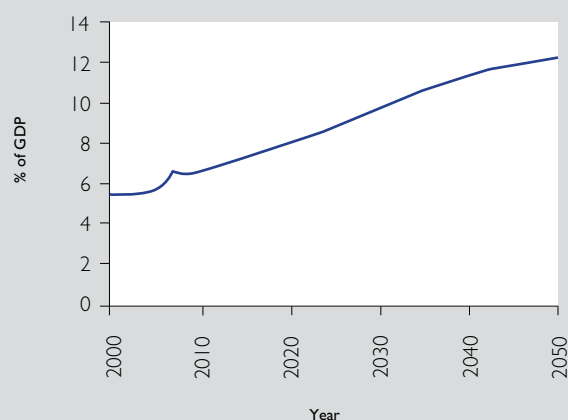
A mix of public and private spending funds New Zealand's health system⁴. Private contributions (including health insurance premiums) are a small but important part of overall health spending.

Growth in healthcare spending has three principal drivers:

1. Population size.
2. An ageing population and the consequent increases in health needs.
3. "Cover and cost" – the services provided by the public health system (including innovation and new technologies) and the cost of producing these services (including salaries).

Future Health Spending

Treasury modelling shows health spending will double as a percentage of GDP by 2050.



Source: The Treasury

¹ John Bryant et al., *Population Ageing and Government Health Expenditures in New Zealand, 1951-2051: New Zealand Treasury Working Paper 04/14* (The Treasury, 2004), 18.

² In nominal terms.

³ The Treasury, *New Zealand's Long-Term Fiscal Position* (The Treasury, 2006), 68.

⁴ In 2006/07 Health Funds Association of New Zealand estimates 71% of health care spending was publicly-funded, with 24% paid directly out of the pocket by individuals, and 5% paid through private health insurance.

HEALTH SPENDING OVERSEAS

A comparison of health spending per capita with GDP in OECD countries shows that richer countries spend more on health than poorer countries. New Zealand's level of health spending is about what is expected for our income level.

However, other countries we like to compare ourselves to, such as Australia, spend more on health, in part because they have higher incomes, even after adjusting for differences in purchasing power.

A clear implication is that raising New Zealand's overall economic performance will enable us to lift healthcare spending. A National Government will provide the policies to help make New Zealand a richer country which, in turn, will mean we can afford more and better health services.

At the same time, New Zealand must strive to get better performance from existing spending by reducing waste and bureaucracy, and lifting productivity.

The type of services and technologies that are available in other countries condition our own expectations – even if those other nations are wealthier.

HOW MUCH SHOULD WE SPEND?

When considering how much New Zealand should spend on health, global evidence provides three observations:

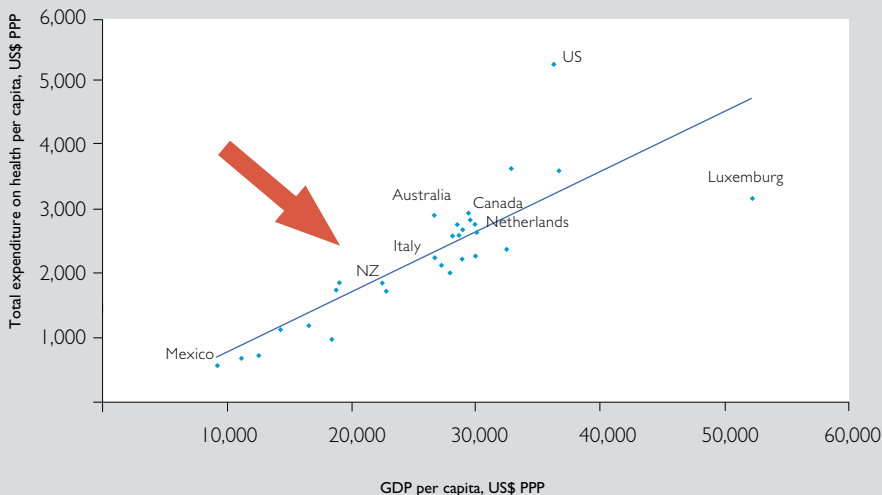
- All countries in the OECD are struggling with this question – regardless of the level of their spending.
- More spending does not necessarily improve individual or population health outcomes.
- Differences in spending levels and inputs may say more about preferences for treatment or delivery patterns than about the best level of resources. For example, New Zealand has a relatively high ranking in terms of the availability of mammograph machines per million, but a lower ranking for MRI scanners⁵.

At the core of New Zealand's public health system is the fundamental goal of bringing the greatest benefit to the largest number of people, at the least cost to the country as a whole.

⁵ Nadeem Esmail and Michael Walker, *How Good is Canadian Health Care? 2005 Report: An international comparison of health care systems* (The Fraser Institute, 2005), 42.

International Health Spending

Wealthier countries can afford to spend more on healthcare.



Source: OECD

For the most part, primary healthcare is heavily subsidised and public hospital care is free at the point of use. This ensures that every person can afford healthcare and disability support, regardless of their income, health status, or risk profile. It also encourages individuals to access sufficient healthcare to generate spill-over benefits for the country as a whole. For example, a vaccination lowers the risk to the population of communicable diseases.

International commentators agree that it is not possible to calculate an ideal health budget. Each country must decide for itself, based on what it can afford and the priority it gives to healthcare against competing demands such as education and security.

As New Zealand gets wealthier, we should expect to spend more of our national income on health. But ultimately, what is most important is not how much we spend, but what services we can most effectively provide, and what health outcomes we can most effectively bring about, with the resources we have.

National's policy and action in government will have a significant positive influence on increasing our country's wealth.

Influencing health sector productivity will come from fully-engaging health professionals, and continuous improvement in the way the sector delivers health services.

We need to improve the management of the spending pressures through a mix of evaluation and evidence-based practice. Influencing the behaviour of patients and health professionals also offers opportunities for improvements⁶.

Besides being the dominant funder of healthcare, the government is also the owner of substantial capital supporting the sector – most notably, the public hospital network. The substantial demands for capital investment for equipment and new facilities will be on-going.

6 John Appleby and Anthony Harrison, *Spending on Health Care: How much is enough?* (King's Fund, 2006).

Our ageing and growing population

Health expenditure per capita increases strongly with age. (See Health Spending by Age chart on the next page).

Additionally, the number of New Zealanders over 65 will increase dramatically in the future.

Eight-five percent of people over the age of 65 have a long-term illness or chronic condition⁷ such as diabetes, arthritis, stroke, or heart disease. Many have multiple conditions. Eighty percent of New Zealanders die of chronic illness⁸. It is this prevalence of chronic conditions that produces the increased demand for health services by older people⁹.

In 2005/06, the amount of public money spent on healthcare over the life span of a person – on average – was \$220,000¹⁰. About half of this amount is likely to be spent over the age of 75 and nearly half of that on support services such as home-based support or residential care.

As the demographic balance in New Zealand changes we will spend an increasing proportion of the health budget on older New Zealanders.

A lesser but still important demographic factor is the northward flow of population and the growth of Greater Auckland. This presents significant challenges for facilities, the workforce, and services. By 2026, the population of Greater Auckland is expected to grow by 46%, compared to a national population increase of just 22%¹¹.

The impact of our ageing population on our health system will depend very much on the quality of those extra years of life. Some of the variables include:

- Increasing longevity tends to delay rather than increase overall health spending because most healthcare costs are incurred in the last few years of life (the idea of 'distance to death').

7 Ministry of Health, *Older People's Health Chart Book 2006* (Ministry of Health, 2006), 30.

8 National Health Committee, *People with Chronic Conditions: A discussion paper* (National Health Committee, 2005), 7.

9 More people die of chronic conditions as fewer people die of acute conditions both at a younger and older age.

10 Parliamentary Library (2007).

11 Statistics New Zealand, *Subnational Population Projections 2001 (base) – 2026 Update* (Statistics New Zealand, 2005), 3.

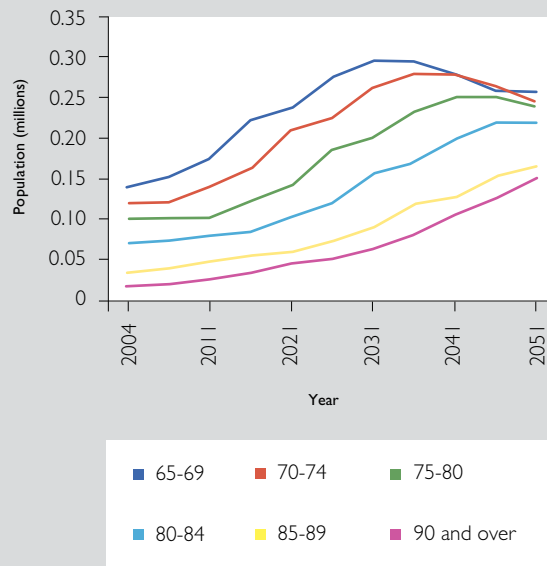
- A longer lifespan increases the number of years a person lives with a disability or chronic disease, and increases health spending over their lifetime (the idea of 'morbidity expansion').
- People who live longer tend to spend more of those years in good health (the idea of 'morbidity compression').

Experts have not reached a consensus on which of these variables will prevail in the future. Nevertheless, the ageing of our population – and the growing prevalence of obesity, diabetes, and other chronic conditions – will effect health spending. Better screening for cancers (breast, cervical, colorectal) will reduce treatment demand and deaths in the ageing population, but more people will have chronic conditions and orthopaedic demands.

This suggests that the greatest pressure on our public health system will come from the increasing prevalence of chronic conditions. We will need to put more resources into helping patients with chronic diseases who become increasingly vulnerable as they age. These people deserve respect, a good quality of life, and appropriate support.

An Ageing Population

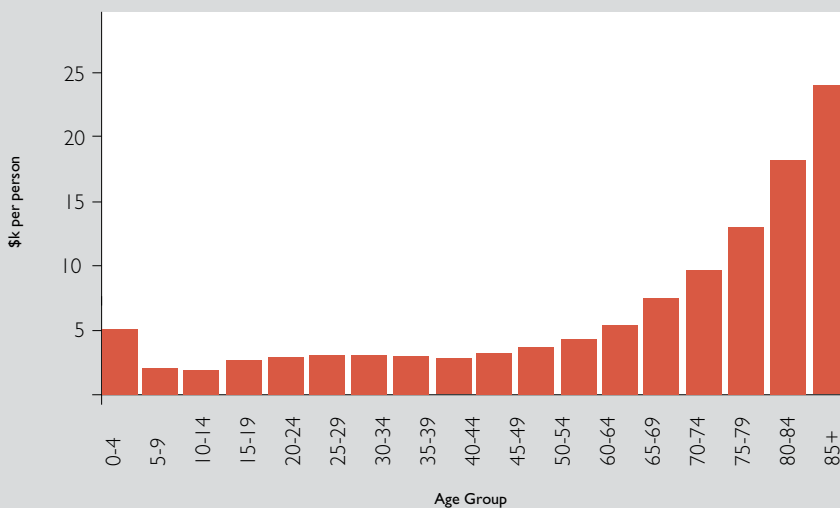
Projected New Zealand Population over 65 years of Age by Age Range from 30 June 2004 to 30 June 2051.



Source: Statistics NZ

Health Spending by Age

Public spending on healthcare is heavily weighted towards older people.



Source: The Treasury

Innovation in technology and medicines

To date, our ageing population has had only a modest impact on spending. And Treasury¹² says that; contrary to public expectations, a more important determinant of future health spending will be the range and cost of new services, technology, and medicines that become available. This is commonly referred to as “cover and cost”¹³.

“Cover and cost” has been the main cause of the growth in health spending over the past 50 years, and it accounts for 60% of annual expenditure growth (see table below).

There are two methods by which the public can gain increased health cover. Either when a particular service is expanded to more people, or when “brand new” services are introduced.

This is partly fuelled by rising expectations. As New Zealanders become wealthier we expect more from our health system. As we see better healthcare available overseas we expect more here.

New interventions – surgical and pharmaceutical – and improvements to ‘old’ interventions can be more effective or more palatable for a wider group of people. The benefits to people’s health are welcome.

Improving access to effective new technologies and drugs at a price New Zealanders can afford must be a priority for our public health service.

Factors Driving Spending

Average annualised growth rate for real government health spending, 1951-2002

Average growth rate p.a	1951-1961	1961-1971	1971-1981	1981-1991	1991-2002	1951-02
Population	2.20%	1.68%	1.03%	0.82%	1.34%	1.39%
Age and Health	-0.10%	-0.09%	0.35%	0.68%	0.45%	0.25%
Cover and Cost ¹	3.31%	3.45%	3.99%	-0.60%	1.85%	2.35%
Total	5.40%	5.04%	5.37%	0.90%	3.64%	3.99%

¹ “Cover and cost” encompasses in this case innovative new technologies, labour costs and changing service delivery. This includes expanding accessibility of existing services to a wider group, or making new services available.

¹² John Bryant et al., *Population Ageing and Government Health Expenditure: New Zealand Treasury Policy Perspectives Paper 05/01* (The Treasury, 2005), 6.

¹³ This will also mean fewer younger people to look after old people, and changes in spending patterns in health services.

2. Reducing Endless Waiting

A successful health system must meet the public's strong desire for less waiting and provide better, sooner, more convenient healthcare.

The waiting game

Most of us know someone who has waited months for surgery, a specialist appointment, or a special diagnostic test – and sometimes all three! We know people who can't get an after-hours doctor. We see people who have waited hours and hours in hospital emergency departments.

For too many people, waiting in our health system is like standing at a bus stop – when every passing bus is full.

Labour used to argue that the solution was to spend more money and employ more hospital doctors. After spending an extra \$5 billion a year since 1999 and actually getting fewer patients seen, it's clear that the solution is not this simple.

New Zealand's population is growing, but the level of service has not increased. Patients are forced to wait and wait at a number of steps on their diagnosis and treatment journey.



WAITING FOR ELECTIVE SURGERY

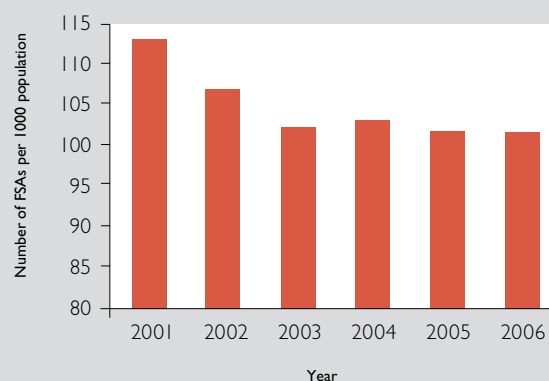
First Specialist Assessments

Patients have to wait for a First Specialist Assessment (FSA), where they are referred by their GP to a hospital specialist to enable a diagnosis to be made, or for the patient to be considered for surgery¹.

Although demand for FSAs has been growing, there has actually been a reduction since 2001 in the number of appointments made available by the health system². When population growth is considered, the situation is even worse.

Specialist Assessments Declining

First Specialist Assessments completed per 1,000 population are declining.



Source: Ministry of Health and Statistics NZ

Patients also have to wait and wait for follow-up specialist appointments. Those who are lucky enough to be seen by a specialist and accepted for surgery then face another waiting list – the waiting list for elective surgery.

Elective Surgery

The delays and difficulty in getting elective surgery is undermining confidence in the public health system.

Elective surgery is surgery that is necessary, but the timing of

¹ Interestingly, many people awaiting a FSA and an appointment with a specialist may only be seeking access to a diagnostic procedure, the results of which would help assist a GP determine whether a surgical response (and an appointment with a hospital specialist) is needed.

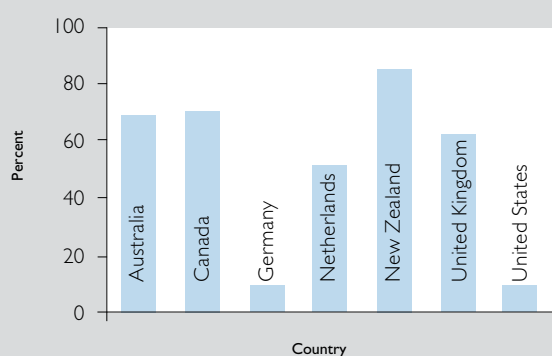
² Answer to Parliamentary Question for Written Answer 5358 (2007).

the procedure can be scheduled because it does not require immediate attention. Elective procedures include cataract surgery, hip replacement, knee replacement, coronary artery bypass surgery, angioplasty, hernia repair, hysterectomy, prostatectomy, and surgery for varicose veins.

A 2006 international survey found that 85% of New Zealand GPs reported that their patients often faced long delays for elective surgery³ or hospital care. This was the highest level of all the countries surveyed⁴.

Kiwis Waiting Longer

Percentage of GPs saying their patients have to wait a long time for elective surgery.

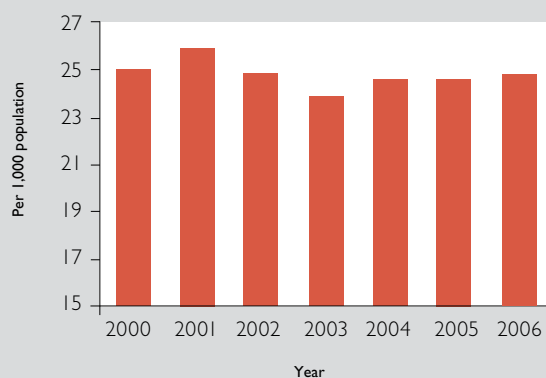


Source: The Commonwealth Fund

The number of people getting elective surgery has fallen⁵. Again, population growth compounds the problem.

No Increase in Elective Surgery

Elective surgery discharged per 1,000 population for all district health boards by calendar year.



Source: Ministry of Health and Statistics NZ

3 These people need surgery to improve their health or quality of life. While their condition may be painful or affect their lifestyle it is not considered an immediate threat to their life or health.

4 Cathy Schoen et al., "On the Front Lines of Care: primary care doctors' office systems, experiences, and views in seven countries", *Health Affairs* (W25:555-571, 2006), 564.

5 Answer to Parliamentary Question for Written Answer 3864 (2007).

SIDEBAR

THE 2006 WAITING LIST CULL

A Labour Government edict in 2006 saw an estimated 35,000 patients culled from waiting lists nationwide for no medical reason whatsoever. The patients had been waiting more than six months⁶ and had become a political embarrassment for Labour.

As part of a hospital monitoring system, the Government has a number of so-called Elective Service Performance Indicators. DHBs get a "green light" for meeting the Government's goal of offering appointments or surgery to only patients who can be seen or treated within six months.

Amazingly, under this system a DHB can get "green lights" by treating no patients at all. Something that sounds like a script for Yes Minister is no way to run a patient-focused health system!

To conceal the burgeoning waiting lists of patients waiting for an appointment with a specialist and those promised surgery, the Government effectively advised DHBs to "shut the front door".

Thousands were returned to their GPs, including 24,000⁷ patients whose specialists had said surgery was the best option for them. These needy patients have simply been purged from the system. Labour has deliberately stopped counting people who need elective surgery in a cynical attempt at data cleansing. It is no surprise that Kiwis are losing faith in the health system.

A hospital's delivery of elective surgery is affected by the demands of acute – or emergency – surgery. Between 2000 and 2006, acute surgical discharges increased by 6% from 75,303 to 79,862⁸. The availability of medical staff, particularly nursing and anaesthetic staff, is also a major constraint.

Despite all Labour's promises about reducing waiting times, the average waiting time for elective surgery has steadily increased⁹. The chart below starkly shows the average time patients waited between being promised surgery and finally receiving it.

6 Martin Johnston, "Hospitals cull waiting lists by thousands", *New Zealand Herald*, 29 January 2007, 1.

7 Ibid.

8 Answer to Parliamentary Question for Written Answer 6175 (2007).

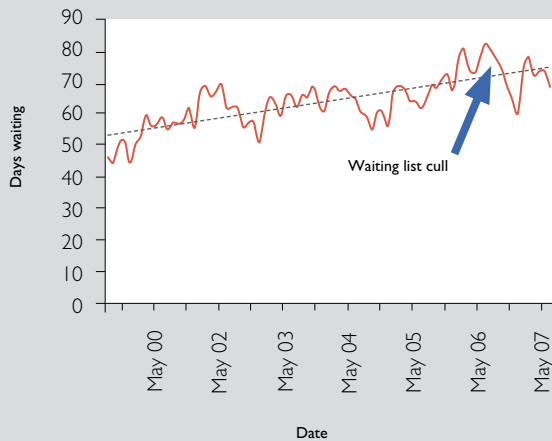
9 Answer to Parliamentary Question for Written Answer 5334 (2007).

In September 2002, when all DHBs began reporting waiting-list data, the average time people waited after being told they would definitely receive surgery was 56 days (8 weeks). In May 2006, as the waiting-list cull began, the average time had increased to 81 days, or almost 11.5 weeks.

Labour sees waiting lists and waiting times as fixed. They believe the only way to reduce waiting times is to provide more funding, more beds, more doctors, and more nurses, and then data-cleanse the waiting lists. This narrow approach is always going to fail, as demonstrated by the continued growth of waiting lists since 2001.

Increasing Waiting Time

The average wait for elective surgery has steadily increased despite the waiting list cull in 2006.



Source: Ministry of Health



WHAT WORKS OVERSEAS

Waiting times for elective surgery are a major health concern in around half of all OECD countries. Researchers Hurst and Siciliani¹⁰ found that waiting times can lead to deterioration in patient health, loss of productivity, extra costs and, at worst, death.

Their review of hospital waiting times across 12 countries¹¹ concluded that international comparisons of waiting times are difficult because so much hinges on how providers are paid, the existing level of excess demand, and initial waiting times. However, international experience on what works and what doesn't is instructive.

More money

The authors of the report noted that large increases in funding may lead to modest improvements in waiting times. However, it may also lead to cost inflation if capacity is fixed and already fully utilised.

It is clear that temporary policies have temporary effects. A number of countries have adopted such a "blitz" approach by introducing waiting times funds¹², which have reduced growth in waiting times temporarily. Critically, once the fund disappears, waiting times grow again if nothing is done to address the rate of surgery or demand.

A reliance on occasional cash injections to clear backlogs also sends the wrong signals to the hospitals. It rewards hospitals with growing waiting times. Such funds can actually be a perverse incentive to increase the number of people who are waiting for surgery.

Rewarding surgical teams

Activity-based payments are frequently used as a way of tackling waiting lists. Both England and the Netherlands remunerate their public hospitals on an activity-related basis. They believe this rewards productivity and value for money.

In a number of jurisdictions (Spain, England, and Ontario¹³), specialists receive bonuses tied to the elective surgery targets, and in England's National Health Service, executive directors

¹⁰ Jeremy Hurst and Luigi Siciliani, *Tackling Excessive Waiting Times for Elective Surgery: A comparison of policies in twelve OECD countries* (OECD, 2003), 4.

¹¹ *Ibid.*, 11

¹² Including England, Australia, Spain and the Netherlands. *Ibid.*, 24-27.

¹³ Ontario Ministry of Health and Long Term Care, interview with author, Toronto (2006).

at health authorities can be sacked for not reaching waiting times or other targets¹⁴.

PROPOSAL

Our health system should reward innovation and productivity improvements at the hospital specialty level. Specialties should be able to share efficiency gains to provide additional services or clinical support for patients.

Public-Private Partnerships

Making greater use of the private sector is an approach that has been used with some success in Spain, Ontario, and England. The private sector is able to quickly complement public sector capacity when needed. It also puts competitive pressure on public hospitals to lift their performance.

Given that New Zealand has a limited health professional workforce (including theatre nurses and anaesthetic technicians), there is some risk that this approach would displace, rather than increase, activity here¹⁵.

Concerns are often raised that specialists working in both the public and private sector have an incentive to under-perform in the public hospitals in order to increase more lucrative private work. There is always potential for such conflicts of interest, but the actual evidence is mixed.

British research¹⁶ shows that English specialists working in both sectors tended to be more productive in the public hospital compared to their counterparts who were public hospital full-timers. This can be partly explained by the performance-related pay offered to productive teams.

14 A recent Ministry of Health working group "Address Disincentives Working Party" highlighted that there are virtually no incentives for specialists here to seek improvements, because they do not share any of the gains to the DHB from any innovation that reduces costs of current services, or from substituting other (cheaper or more effective) services for current services. In fact they may be penalized if it is seen to be underdelivering. Ministry of Health, *Addressing Disincentives Working Party Report* (Ministry of Health, 2006), 10-11.

15 The Health Funds Association of New Zealand reported in 2006 that both volumes and average costs of common elective procedures were similar in public hospitals and the independent sector. Roger Styles, *The Important Role of the New Zealand Private Health Insurance Sector: Major Elective Surgical Procedures* (Health Funds Association of New Zealand, 2006), 2-3.

16 Karen Bloor, Alan Maynard and Nick Fremantle, "Variation in activity rates for consultant surgeons and the influence of reward structures in the NHS", *Journal of Health Research and Policy* (Vol 9:2, 2004), 82.

Innovative management approaches

An alternative approach is to tighten up on operational systems, including:

- Scheduling operating rooms to reduce same-day cancellations.
- Optimising patient health status prior to surgery.
- Improving patient education.
- Using electronic patient records.

An Australian evaluation shows that such an approach yielded a 5% improvement in operating room utilisation, a 59% decrease in same-day cancellations, and a 26% fall in unbooked re-admissions¹⁷.

According to the Health Roundtable¹⁸, a trans-Tasman benchmarking organisation, the Alfred Hospital in Melbourne is one of Australasia's best performing hospitals from an efficiency perspective. The Alfred has just opened an elective surgery centre on campus to separate elective surgery from emergency surgery. This separation is expected to increase the number of elective surgeries performed because it removes the pressure to divert staff to acute, or emergency, situations¹⁹.

PROPOSAL

Separating acute and elective service provision can allow health professionals to concentrate on the efficient delivery of elective services without being interrupted by urgent cases. Similarly, improving discharge planning and staffing, as well as actively involving general practice, can reduce emergency department delays.

Improved link with community services

In some instances, the ability to cope with acute and non-acute patients after discharge is a greater impediment than a shortage of resources for elective surgery. In Scotland, a lack of community support services kept older patients in hospitals longer. This tied-up beds that could have been allocated to elective surgery patients.

17 National Demonstration Hospitals Program, *Performance Evaluation* (Commonwealth Department of Health and Family Services, 1997); quoted in Jeremy Hurst and Luigi Siciliani, *Tackling Excessive Waiting Times for Elective Surgery: A comparison of policies in twelve OECD countries* (OECD, 2003), 29.

18 Health Roundtable meeting with author (2007).

19 Alfred Hospital, interview with author, Melbourne (2007). Such an approach is also taken by Counties Manukau DHB.

PRIVATE HEALTH INSURANCE

Almost 1.4 million New Zealanders, or 1-in-3, have private health insurance (PHI). This compares to 1-in-2 in the mid-1980s. The type of PHI purchased has changed. Rather than comprehensive coverage, most of those insured are now limited to a range of surgical and medical procedures similar to the elective surgeries offered in the public health system. In the year ending June 2007, around \$590 million in claims were paid out – the vast majority being for medical and surgical procedures²⁰.

Many countries subsidise PHI to encourage people to substitute private surgery for public surgery. This reduces waiting times and waiting lists for the non-insured.

In Australia, the proportion of Australians covered by PHI fell from 50% in 1984 to just 30.5% in 1998. Since then, Australia has been the most active OECD country in promoting voluntary PHI coverage²¹. Various tax incentives were brought in during the late 1990s. However, despite public opinion polls predicting there would be a much greater uptake of PHI, the number of insured people has remained static²². Tax breaks did not increase PHI uptake.

20 Health Funds Association of New Zealand, *Health Insurance Statistics June 2007* (Health Funds Association of New Zealand, 2007), 3.

21 Francesca Colombo and Nicole Tapay, *Private Health Insurance in Australia: OECD working paper No. 8* (OECD, 2003).

22 An explanation for this may be that the tax rebate was insufficient to make private health insurance affordable. Private Health Insurance Administration Council, interview with author, Canberra (2007).

However, the introduction of 'lifetime health cover' in 2000 resulted in the percentage of population covered by private health insurance increasing sharply to 44.1% in 2002. It is currently 43%. 'Lifetime health cover' offered 'community rating' of insurance premiums for all people who joined a PHI scheme before a certain date. Community rating means a standard premium regardless of age or risk.

This contrasts with the situation in New Zealand where PHI is age-banded. Young people with insurance pay much lower premiums than older people.

Australia's private health sector provides 56% of all surgery. Australian private providers can also provide acute care and medical training. As an example, the Australian private sector performs 45% of the nation's cardiac surgery²³.

The lesson from the Australian experience is that tax rebates do not increase uptake of PHI but do make it cheaper for those who already have it. It appears unlikely that PHI tax rebates by themselves would shift significant demand from the public to the private health sector.

A tax rebate for PHI in New Zealand could cost an estimated \$200m - \$250m²⁴. The Australian experience suggests that such a rebate would not result in more elective surgery overall.

23 Australian Private Hospitals Association, interview with author, Canberra (2007).

24 A Treasury report from 2002 concluded the full cost of a 30 percent rebate would be \$202 million less \$94 million in savings to the health system. This estimate was based on significant update of private insurance that the Australian experience would indicate is unlikely. Estimate based on PHI premium of \$0.7 billion. The Treasury, *Costs of Subsidising Private Health Insurance: T2002/I225* (The Treasury, 2002), 3-4.

What can be done here

To reduce elective surgery waiting times we need:

- Better use of clinical services.
- Smarter use of the private sector.
- Smarter use of primary care.
- Better information management.

Better use of clinical services

Waiting times for elective surgery will be reduced only by engaging the people who can make a difference – doctors, nurses, and other health professionals – more completely in planning and decision-making. In Chapter 4, we investigate in more detail how the Australian approach of setting up "clinical networks" can encourage this process.

Smarter use of the private sector

New Zealanders should have timely, high-quality, cost-effective access to elective surgery when they need it. This cannot be achieved without using the resources and capacity across the public and private components of New Zealand's health system.

Labour has indicated to DHBs that its strong preference is for publicly funded procedures to be performed in publicly owned hospitals. DHBs have been advised to use the private sector only as a last resort, after all public capacity has been expended²⁵. Labour believes that use of the private sector should be "an interim measure to reduce backlogs of patients"²⁶.

25 Ministry of Health, *Reduced Waiting Times for Public Hospital Elective Services: Government Strategy* (Ministry of Health, 2000), 15.

26 Annette King, *District Health Boards and the Non-Government Health Sector* (Cabinet paper, 2000).

This ideology encourages expensive, last-minute, spot-purchasing activity by DHBs near the end of their financial years as they seek private-sector assistance to meet their annual targets²⁷. This last-resort approach inflates the cost of elective surgery and absorbs unnecessary resources. It has done little to reduce waiting times or improve patient access to care when they need it.

The cost of DHB-funded procedures delivered in the private sector would be less if they were planned further in advance. If the private sector had longer-term contracts it could respond with more efficient pricing. This would encourage a planned, rather than ad hoc, approach.

DHBs should make sure patients get treated at the right time. Whether they are treated in a public or private hospital should be a secondary issue.

PROPOSAL

The judicious use of public-private partnerships can increase the availability of elective surgery and reduce waiting lists. National will focus on ensuring patients receive the care they need sooner, rather than obsessing about who owns the facility they are treated in.

Smarter use of primary care

Under Labour's present policy settings, the critical issue of insufficient specialist appointments and elective operations is never going to be resolved.

To achieve sooner, more convenient healthcare, the primary-care sector (such as PHOs, general practice teams and Maori and Pacific health providers) should play a greater role in providing specialist-type assessment, minor surgery, and more post-operative care. Such roles are already performed in isolated pockets around the country, but this approach is not widespread.

Some DHBs operate special funds that allow general practice teams to access investigations, care, or treatment in order to help their patients remain out of hospital and manage their care safely in the community. These funds typically provide a small budget of \$200 to \$350 for a GP to manage the patient without a hospital admission.

²⁷ Author's interview with various participants in the health sector (2006).

For example, the funds pay for urgent blood tests, x-rays, home nursing, transport, or physiotherapy. They are often used for investigating possible deep vein thrombosis, pneumonia or intravenous treatment for cellulitis (skin infection). A range of community diagnostic, therapeutic, and logistic services are provided at no cost to the patient²⁸ (apart from the initial GP consultation).

See the case studies on the opposite page for examples of how some GPs are providing smarter primary care.

Post-surgical follow-ups could also be done in general practice, providing sooner, more convenient service, and releasing hospital specialist time. This kind of innovative primary-care treatment should be encouraged across the country.

PROPOSAL

GPs with special interests should be able to provide a wider range of minor surgery in their clinics. They should also be able to provide a level of specialist assessment currently provided in hospitals, including the ability to order immediate diagnostic tests.

Better information management

Changing patient admission and discharge practices, and keeping better track of patients and the beds they are occupying can free up a surprising level of bed capacity. Improving information management requires a combination of incentives, management skills, and buy-in by the health workforce²⁹.

Electronic patient records can improve the patient's journey along the "continuum of care" by providing accurate information to and from providers. This improves service quality by helping to prevent errors. Many specialists are keen to take greater responsibility for managing their patient flows³⁰.

²⁸ East Health Primary Health Organisation, Pakuranga, www.easthealth.co.nz. Also available in some other areas.

²⁹ Stephen Black, "Personal Views: More and better management is the key to fixing the NHS", *British Medical Journal* (333:358, 2006).

³⁰ New Zealand surgeons, interviews with author (2007). Expanded further in productivity section.

CASE STUDIES

SMARTER PRIMARY CARE

Innovative GP treatment

A 76-year-old living in a rest-home with a history of strokes had a feeding naso-gastric tube removed two weeks previously. However, as a result of weight loss from an acute illness, the tube required reinsertion. After discussions with a hospital specialist, the GP reinserted the patient's tube in the rest-home and a portable x-ray was ordered to confirm tube position. The PHO used its DHB-sourced fund to pay for this procedure and this prevented an unnecessary admission to hospital³¹.

Specialist assessments

ACC has commissioned a number of GPs with a special interest (GPSI) in orthopaedics to provide assessments in Dunedin and Hawke's Bay. Though the wait for a hospital specialist is usually two to three months, a patient can see a GPSI within a week. These specially trained GPs have the right to refer patients for immediate diagnostic tests.

Only 1-in-10 patients with back problems, and only half of patients with hip and knee problems, are referred to the hospital specialist after the GPSI assessment³². Patients can get their scans, care (such as physiotherapy), and/or surgery much sooner. ACC describes this as a win-win for patients and the funder³³. It seems likely the scheme could be expanded so more patients can benefit.

Minor surgery

The award-winning Waitemata Health Skin Lesion Service used specially trained GPs to treat potentially life-threatening skin cancers. This dramatically reduced waiting times. Patients were treated faster in a more convenient setting away from the hospital³⁴. This freed up senior surgeons to concentrate on more complex cases.

31 East Health Primary Health Organisation case study.

32 Dunedin GP, interview with author, Dunedin (2007).

33 ACC Senior Management, interview with author, Wellington (2007).

34 Sharad Paul, *New system speeds up care for people with life-threatening skin lesions* (New Zealand Health Innovations Awards, 2003), available from <http://www.healthinnovationawards.co.nz/03profilecommend3.html>.

WAITING IN EMERGENCY DEPARTMENTS

Emergency departments are the main point of entry to the secondary health system for seriously ill patients, and are accurately described as the "barometer" of how well a whole hospital is doing³⁵.

Triage times

Waiting times at emergency departments have a direct bearing on health outcomes³⁶. The Ministry of Health has established "triage times", by which patients in various urgency categories should be seen³⁷. Triage 1 is the most urgent category with a benchmark of 100% of patients being seen immediately. Triage 2 has a benchmark of 80% seen in 10 minutes while triage 3 has a benchmark of 75% seen within 30 minutes³⁸.

The chart overleaf clearly shows hospitals are failing to meet the triage times for all but life-threatening conditions³⁹. The Ministry of Health understates this problem when it admits "there is some room for improvement"⁴⁰. This information does not show how long many patients actually waited in excess of the Ministry's own benchmarks, nor does it indicate the seriousness of their conditions.

35 Emergency department specialists, interview with author, New Zealand (2007).

36 Ministry of Health, *The Annual Report 2005/06 including The Health and Independence Report: Annual Report for the year ended 30 June 2006: Director-General of Health's Annual Report on the State of Public Health 2006* (Ministry of Health, 2006), 70.

37 As recommended by the Australasian College of Emergency Medicine. Australasian College for Emergency Medicine, *Guidelines on the Implementation of the Australian Triage Scale in Emergency Departments* (Australasian College for Emergency Medicine, 2005), 5-6.

38 Time recorded is the time elapsed between arriving and commencement of treatment by a doctor; the Government has changed the latter factor to treatment by a nurse. Ministry of Health, *The Annual Report 2005/06 including The Health and Independence Report: Annual Report for the year ended 30 June 2006: Director-General of Health's Annual Report on the State of Public Health 2006* (Ministry of Health, 2006), 168-169. New Zealand Parliamentary Debates (Vol 629, 2006), 1663.

39 Answer to Parliamentary Question for Written Answer I6063 (2007).

40 Ministry of Health, *The Annual Report 2005/06 including The Health and Independence Report: Annual Report for the year ended 30 June 2006: Director-General of Health's Annual Report on the State of Public Health 2006* (Ministry of Health, 2006), 168.

Increasing Waiting Times

Triage times in emergency departments

	Triage 1	Triage 2	Triage 3
DHB	% Seen	% Seen	% Seen
Auckland	100	57	39
Bay of Plenty	100	71	55
Canterbury	100	48	45
Capital & Coast	85	80	63
Counties Manukau	100	67	30
Hawkes Bay	100	79	58
Hutt Valley	100	66	40
Lakes	100	76	77
MidCentral	100	83	68
Nelson Marlborough	100	86	79
Northland	100	74	66
Otago	100	83	58
South Canterbury	100	81	80
Southland	100	51	56
Tairāwhiti	100	100	100
Taranaki	100	76	64
Waikato	96	48	35
Wairarapa	100	100	100
Waitemata	63	48	40
West Coast*	-	98	74
Whanganui	86	68	66
Total	96	65	52

West Coast had nil triage 1 patients for quarter ending 30 June 2007

Source: Ministry of Health

Why are we waiting?

Emergency departments are clogged for two principal reasons. The first is “bed blocking”, where people are stuck in the emergency department because hospital wards are unwilling or unable to accept them. The second is the number of emergency patients who could be more appropriately seen in a GP clinic.

More and more patients face long waits because of bed blocking. Experience indicates that this is a function of slow discharge from the wards.⁴¹ At a higher level, an insufficient number of available public hospital beds in some areas is a problem⁴². Nursing and theatre staff shortages also contribute to delays.

41 Emergency department specialists, interview with author, New Zealand (2007).

42 Errol Kiong, “More beds on way to help ease hospital’s gridlock”, *New Zealand Herald*, 19 July 2007, 1.

Emergency department demand is very sensitive to alternative provision of after-hours services by GPs and independent Accident and Medicals (A&M). In many parts of the country, after-hours services are under pressure. Demand is also sensitive to the cost of a visit to the GP, even with the considerable reduction in GP fees.

GPs are in short supply and this is particularly so in rural areas. Research by the Rural GP Network suggests that in rural areas, after-hours on-call is a significant barrier to the recruitment and retention of doctors and nurses⁴³.

Patient flow and teamwork

Improving the management of the flow of patients in and out of wards on a timely basis can have a significant impact. National will trust and value health professionals, and this will help improve the stability of staff numbers.

More experienced doctors could be brought to the front of the hospital in emergency departments. Though this would initially cost more in salaries than employing junior doctors, it would more than pay for itself in faster turnaround and fewer people being admitted to hospital beds.

CASE STUDY

TEAMWORK AT FLINDERS MEDICAL CENTRE

Flinders Medical Centre, a medium-sized public sector teaching hospital in Adelaide, South Australia, has been implementing “Lean Thinking” – a highly evolved method of managing an organisation to improve the productivity, efficiency, and quality of its products or services – to improve emergency department and wider hospital performance.

Professor David Ben-Tovim, the director of the team that redesigned care at the hospital, said: “We can do 15-20% more work, offer a safer service, on the same budget, using the same infrastructure, staff and technology. Everything has improved: cost, quality, delivery, service, and staff morale”⁴⁴.

43 Dr Ron James, *New Zealand Rural After-Hours Primary Care Provider Survey: The impact of on-call on providers and their families* (The New Zealand Rural General Practice Network, 2006), 23.

44 Dan Jones and Alan Mitchell, *Lean Thinking for the NHS* (NHS Confederation, 2006).

Co-location of GPs in emergency departments

In some provincial areas, GPs and hospitals may be able to work together like they already do at Blenheim's Wairau Hospital. There, a DHB nurse triages after-hours attendances and directs patients to either an on-site GP clinic or the hospital's emergency department.

PROPOSAL

Hospital emergency department delays can be reduced by some co-location of GP services. This can result in patients being seen earlier. Improved telephone services after hours can assist patients to get advice, and help relieve pressure on the GP workforce.

Walk-in access at General Practice

Consolidated GP clinics are providing walk-in clinics where their patients can receive prompt care without appointments. These are often co-located with diagnostic services. Walk-in clinics should be more widely available to provide more choice and faster care for patients.

PROPOSAL

Walk-in access at general practice should be more widely available to provide choice and faster care for patients.

Local solutions to after-hours care

Patients seeking care or advice after hours should get a safe and high-quality service. Doctors and nurses in both general practice and emergency departments should work together as best suits local circumstance.

Recognising the pressure after-hours rosters put on general practice teams, more practices are using telephone-based triage services. In rural areas, the use of "telephone triage" could be extended to relieve much of the pressure being faced by GPs on after-hours rosters.

CASE STUDIES

TELEPHONE TRIAGE

HML, a subsidiary of Auckland GP organisation ProCare, runs a growing after-hours nurse-led triage service handling a half a million calls a year on behalf of GPs around the country. It is remarkably inexpensive and is integrated with general practice so the practice gets a record of the call⁴⁵.

In Tasmania, GP Assist offers nurse triage, with referral to an on-duty GP who then assesses the case and decides what should be passed over to the patient's own GP. Only 7% of all calls are referred to the caller's actual GP or local GP roster⁴⁶.

The Government funds a 24-hour help line service called Healthline. It provides some after-hours assistance for general practice patients.



⁴⁵ ProCare Auckland, interview with author, Auckland (2007).

⁴⁶ Tasmanian health professionals, interview with author, Hobart (2007). See also www.gpat.com.au.

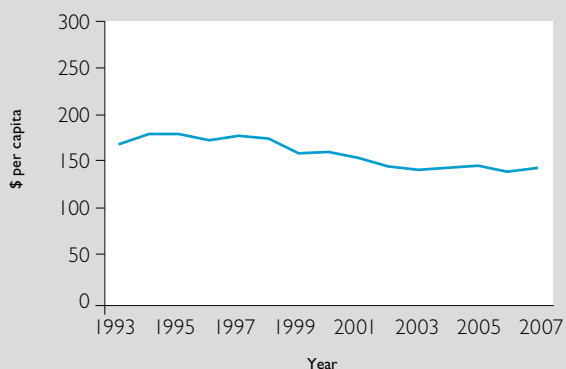
WAITING FOR MEDICINE

The New Zealand public health system lags behind many countries in the provision of medicines. For example, access to funded, innovative new medicines in New Zealand is only a quarter of that in Australia⁴⁷.

Per head spending on pharmaceuticals in New Zealand has fallen.

Declining Pharmac Spending

Real Public Expenditure on Pharmaceuticals per capita



Source: Pharmac

The registration of a new medicine takes at least two years in New Zealand⁴⁸. This is far higher than the 11-12 months in Australia, 15 months in the United States and 9-10 months in Britain⁴⁹.

Public and clinical confidence in the Government's medicines policy is at an all-time low.

What can be done

Rather than conducting its own in-depth analysis of new medicines, New Zealand could unilaterally recognise prior registration and approval in Australia, the United States, or Europe. While the final registration decision would remain here, considerable weight would be given to recognition

47 In the six years to mid-2006, 78 new innovative medicines were subsidised in Australia, of which only 20 were subsidised by New Zealand authorities. Michael Wonder, *Access by patients in NZ to innovative new prescription-only medicines: How have they been faring in recent times in relation to their trans-Tasman counterparts* (Novartis Pharmaceuticals Australia, 2006).

48 Liane Topham-Kindley, "Vacuum in wake of bill's shelving", *NZ Doctor*, 1 August 2007.

49 Parliamentary Library (2007).

in any or all of those three markets. This would bring more medicines to market in New Zealand much sooner. Singapore already operates such a system.

Though Pharmac has done considerable work on the supply side of medicines, much more could be done on the demand side of the equation.

A World Health Organisation study⁵⁰ shows that 50% of patients who suffer chronic conditions fail to use their medicines properly. If patients can be helped to correctly manage their medications, they will better manage their conditions and improve their health. Taxpayers will save money.

The management of patient medications in both community and hospital settings provides the opportunity for pharmacists to provide improved services and for patients to receive better care. Pharmacy lies at the interface between the health system and self-care⁵¹. Pharmacists can do more to help those with chronic conditions, and review patient medicines as part of the primary care team approach.

Improved information-sharing between medicine providers can help educate patients on the use of their medications.

Wealthier countries can afford to spend more on medicines. In New Zealand, there may be opportunities to leverage the value of spending on medicines through GP-prescribing initiatives between DHBs and primary care.

PROPOSAL

We should speed up our medicines approval process by recognising international medicine approvals. Better medicine management presents further opportunities to improve the effectiveness of public investment in medicines.

50 World Health Organisation, *Adherence to Long-term Therapies: Evidence for action* (World Health Organisation, 2003), xiii.

51 Royal Pharmaceutical Society, "The self-care challenge", *Chemist & Druggist* (11 March 2006).

3. Towards Better, Sooner, More Convenient Primary Care

More personalised primary care, closer to home, can make Kiwis healthier and reduce pressure on our hospitals.

PRIMARY CARE

More personalised care

New Zealanders find the health system confusing because patients often have to navigate their way between remote islands of healthcare.

National wants more personalised healthcare. This requires a patient-centred health system where individuals are active partners with health professionals in the management of their own treatment and care.

Patients want greater choice. This includes more convenient opening hours and locations, and more ways to get medical advice and support. Patients also want a wider range of services closer to home and with much less waiting.

For most people, the GP clinic is their regular and most important connection with the health system. It is the first point of contact and a gateway to other healthcare.

Primary-care offers the best way to deliver timely healthcare closer to home for New Zealanders. International research demonstrates that those health systems with strong and vibrant primary-care services have much better health outcomes for a lower cost than those that focus on specialist or tertiary care^{1, 2}.

Other studies conclude that countries with more primary-care doctors per head of population achieve lower rates of death from heart disease, cancer, and stroke, irrespective of socio-demographic factors³.

A strong primary-care system should contribute to better management of chronic disease, more continuity of care, greater accessibility, and earlier intervention⁴.

Primary Health Care Strategy not working

Even though the stated goal of the Labour Government's "Primary Health Care Strategy" (PHCS) is to revolutionise primary care services, much remains to be done.

Apart from lower fees and the formation of 82 Primary Health Organisations (PHOs), there has been remarkably little progress in achieving the other, more quality-focused goals. Too much of the Government's effort has gone into trying to control general practice and their fees, and this has significantly distracted the system from focusing on the clinical care of patients.

The Health Minister told the Cabinet last year that the Primary Health Care Strategy (PHCS) is failing to deliver:

- The "quality improvements" offered by multi-disciplinary teams.
- A wider range of services provided in a primary setting^{5, 6}.
- A strong and expanded involvement of nurses.

The PHCS also envisaged a wider range of services provided in a primary-care setting, such as pharmacy, oral health, community nursing, midwifery, hospital follow-ups, and Wellchild services. However, the Minister admitted to the Cabinet that progress here was also weak.

Similarly, he was forced to acknowledge slow progress in getting primary and secondary services working together, and said that, in general, performance "lags behind the policy direction"⁷.

1 Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health", *The Milbank Quarterly* (Vol 83:3, 457-502, 2005).

2 Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care", *Health Affairs* (W4:184-197, 2004), 193.

3 Barbara Starfield and Leiyu Shi, "Policy relevant determinants of health: an international perspective", *Health Policy*, (Vol 60:3, 201-218, 2002).

4 Ibid.

5 Hon Pete Hodgson, *Primary Health Care Strategy: Monitoring its Achievement 2005* (Office of the Minister of Health, 2006), 8-9.

6 The latest Commonwealth Fund survey of primary care physicians across 7 countries found NZ general practice second to bottom for using multi-disciplinary teams. Karen Davis et al., *Mirror, Mirror on the Wall: an international update on the comparative performance of American health care* (The Commonwealth Fund, 2007), 17.

7 Hon Pete Hodgson, *Primary Health Care Strategy: Monitoring its Achievement 2005* (Office of the Minister of Health, 2006).

National will work with the health professions to focus the PHCS on improving the quality and performance of the service as a whole, rather than focusing solely on the cost of a GP visit. This focus will provide better health outcomes for patients.

Pressures on primary care

Report after report notes disillusionment within primary care. Here are some excerpts:

“Primary healthcare is a critical area for medical workforce development and it has seen substantial change over the past 10 years. For most GPs these changes have come on top of a decade of change that has included the formation of independent practitioner associations, computerisation, increased bureaucratic requirements for funding, quality assurance and re-accreditation. This has been stressful for many GPs.”⁸

“After-hours on-call was a major barrier to recruiting both permanent staff and locums, and the main reason they were contemplating leaving rural practice.”⁹

“What came through most strongly were concerns among GPs and practice nurses about coercive behaviour by government agencies, an atmosphere of mistrust, bureaucracy, and the lack of respect that they say characterises the behaviour towards them and towards primary care.”¹⁰

These comments show general practice is facing several pressures¹¹, including international demand for NZ-trained health professionals, GP shortages (especially in rural areas), primary-care nursing shortages, ageing healthcare workers, changing work patterns, & withdrawal from after-hours care.

Is new funding for primary care missing the target?

The National Health Committee suggests that financial

barriers to access, a lack of focus on health promotion, and health services working in isolation are preventing the reduction of avoidable hospitalisations and premature deaths.

The Primary Health Care Strategy promised greater emphasis on primary care and prevention, more health promotion, and health services working together better:

More money has been poured into primary care in recent years but much of it has been aimed at reducing patient fees. Critics have argued that the extra money was not well targeted because it did not help those people who do not use primary care but who ‘should’.

Because these subsidies go mainly to people who would have gone to the doctor anyway, some argue that the extra spending can do little to raise health outcomes. In other words, they argue this approach might do some good but it is not the most productive use of health funding.

The current Government’s policy has several subsidy levels for patients, depending on the nature of the patient’s general practice. These include:

- Low-cost access.
- Very low-cost access.
- Non-PHO.

This system leads to patients being subsidised differently even though they may have similar circumstances.

However, certainty of funding for patients will remain a priority for a National Government, and removal of universal subsidies will be fraught with difficulty since they are now well entrenched. But it should be noted that up to a third of low-income people did not apply for community services cards despite the obvious benefits¹². Re-introducing a means-tested regime could prove cumbersome and distracting.

8 Medical Reference Group – Health Workforce Advisory Committee, *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning the medical workforce in New Zealand* (Health Workforce Advisory Committee, 2006), 36-37.

9 Dr Ron James, *New Zealand Rural After-Hours Primary Care Provider Survey: the impact of oncall on providers and their families* (New Zealand Rural Government Practice Network, 2006), 4.

10 IPAC Sustainability of General Practice Survey, 2006.

11 MidCentral Health, *From Corner Dairy to Sustainable General Practice* (MidCentral Health, 2007), 16-17.

PROPOSAL

Universal subsidies for GP visits should be maintained.

12 Barry Gribben and Felicity Goodyear-Smith, “Can community service card possession be used to measure need?”, *New Zealand Family Physician* (Vol 29:1, 24-29, 2002), 24.

ADDENDUM

Doctors' Fees

Labour has made the health system increasingly bureaucratic and New Zealanders are becoming more concerned.

One example is the fees review process, which Labour falsely claims caps GP's fees.

National is committed to maintaining affordability in GPs' fees and we seek your input on this matter.

Over a million mainly low income New Zealanders are enrolled in general practices that have contracted to offer a very low fixed patient fee (free for under-6s, up to \$15.50 for adults) in return for an increased government subsidy. National does not propose to change this.

MOVING CARE CLOSER TO HOME

Internationally, health services are shifting from hospitals to primary care¹³. This shift demands a level of investment in facilities and personnel beyond that possible in smaller practices. Similarly, in New Zealand the PHCS envisaged more mental health, public health, and disability support in primary care.

There is, simultaneously, a growing public demand for faster service, closer to home. The public are frustrated by delays in accessing diagnostic tests, specialist assessments, mental health services and, in some parts of the country, even seeing a GP. To respond to this desire and the pressures associated with it, general practice – as the driver of improved primary care – needs to develop new organisational approaches.

Building on the strengths of general practice

The failure to move healthcare from secondary (hospital and specialist focused) to primary care in any significant way, despite its constant restatement as a policy objective, is one of the greatest puzzles of health policy over the past few decades, according to British Professor Paul Corrigan¹⁴.

Prof Corrigan¹⁵ suggests that the lack of critical mass in a general practice – small scale – has been the main barrier¹⁶. Issues like capital, operating costs, and personnel prove daunting for any small business looking to change its configuration.

Unlike Britain, general practice in New Zealand has evolved over the past 15 years to be strongly networked, with high levels of clinical competence and a wide range of innovative services.

There is an opportunity to build on these advances. We should actively encourage further hospital-based services to be moved into primary care. This will include increased collaboration with nursing and allied health professionals, as well as specialist consultations in a primary setting. These changes will provide patients with faster services, delivered by teams of health professionals, at more convenient locations.

¹³ Particularly England with the devolution of funding to Primary Care Trusts.

¹⁴ Prof. Paul Corrigan, *Size Matters: making GP services fit for purpose* (The New Health Network, 2005), 10.

¹⁵ Prof. Corrigan was special advisor to the British Secretary of Health 2001-2005.

¹⁶ Prof. Paul Corrigan, *Size Matters: making GP services fit for purpose* (The New Health Network, 2005), 10-11.

We want to promote this development on a basis of trust and respect for general practice, and we are committed to working with primary-care teams to achieve this outcome.

The key tasks expected of primary-care over the next five years are at the very least¹⁷:

- Delivering real health improvement for individuals and communities.
- Creating clear frameworks for the management of chronic conditions.
- Delivering primary care in a closer relationship with social care.
- Providing more of the diagnostic and outpatient services currently carried out in hospitals.
- Providing more minor surgery.

To meet these challenges, some new facilities will be required that allow co-location of multi-disciplinary team practices. These will require capital investment and sound management.

Integrated Family Health Centres

The hallmarks of existing general practice are:

- Continuity of care.
- High-quality and strong clinical leadership.
- Personal service.

These values will be maintained in larger primary healthcare facilities. Our “working title” for this new type of facility is Integrated Family Health Centres. Suggestions are welcomed.

Not every general practice will want to become part of a larger multi-practitioner health centre and nor will they have to. Smaller practices provide quality care and may choose to continue to operate as they see fit. However, in order to deliver a wider range of hospital level services in the community, scale will be needed.

The professionals working in Integrated Family Health Centres could include:

- General Practitioners.
- General Practitioners with Special Interests (for example, skin surgery, mental health).
- Pharmacists.
- Midwives.
- Oral health professionals.
- Physiotherapists.
- Podiatrists.
- Primary care nurses (including practice and district nurses).
- Visiting nursing and medical specialists.

The increased scale of the centres would allow the provision of additional services including:

- Extended hours walk-in access.
- Radiology.
- Laboratory specimen collection and some on-site processing.
- Day-stay surgical procedures.
- Observation beds.

The scale would also allow for more professional training to take place within Integrated Family Care Centres.

Co-location can also reduce the number of episodes of care that a patient experiences. For example, rather than a person with diabetes making separate visits to their podiatrist, dietician, GP, smoking cessation nurse, and diabetes nurses, their care may be coordinated at one location, reducing the number of visits required.

A range of social care could also be based in the Integrated Family Health Centres according to the priorities of local communities. The services could include:

- Counselling
- Needs assessment service coordination (NASC)
- Social and family support

¹⁷ As per Corrigan's approach.

Funding

PHOs would receive delegated funding from DHBs to enable their member centres/practices to undertake a broader range of responsibilities (such as more assessments and minor surgery, diagnostic testing and other services). Only those PHOs with the appropriate skills and capacity will be able to accept these additional responsibilities.

While the ownership structures of Integrated Family Health Centres will vary, a critical success factor in the development of general practice has been the ownership role of GPs. Innovation and quality are properly incentivised by this personal investment.

Attracting capital investment into such developments depends on their commercial returns. There are various options for how DHBs could encourage general practice in the development of Integrated Family Health Centres¹⁸. From experience elsewhere in New Zealand it is clear that facilities development can be the catalyst for consolidation¹⁹.

Advantages

Patients will benefit from this new approach by²⁰:

- Receiving a much wider range of healthcare in a more convenient location, closer to home or work.
- A seamless approach to the delivery of care at one location.
- Enhanced recruitment and retention of GPs and practice nurses.
- Better coordination and less duplication of information provision and tests
- More convenient hours.
- A greater focus on prevention with associated health professionals at hand.

18 These could include various risk sharing arrangements, contracting of services, or funding rental gaps. In Britain, Local Improvement Finance Trusts (LIFTs) were established to assist in delivering improved community health care facilities. In the 1990s the Community Transition Assistance Scheme (CTAS) assisted various NGOs to develop their infrastructure here in New Zealand.

19 Various General Practitioners, interviews with author, New Zealand (2007).

20 Jennifer Doggett, *A New Approach to Primary Care for Australia* (Centre for Policy Development, 2007), 20.

Health professionals will benefit by²¹:

- Improved collaborative working arrangements (including after-hours).
- Allowing focus on areas of special interest.
- Greater job satisfaction and flexibility.
- Shared administrative function.

Significant savings would accrue to the public health system and patients by relieving pressure on public hospitals, reduced travelling time, less duplication of services, and more appropriate services being provided locally.

PROPOSAL

Some hospital services should be moved to Integrated Family Health Centres (co-located multi-disciplinary teams). These will provide a full range of services, including specialist assessments by GPs with special interests, minor surgery, walk-in access, chronic care, increased nursing and allied health services, as well as selected social services.

SIDEBAR

NURSE-LED WALK-IN CENTRES

Walk-in clinics led by senior nurses are an increasingly common feature in both the British and American health systems. America's second biggest pharmacy chain has bought the "Minute Clinic" chain and plans to double the number of in-store clinics to 300. Their slogan: "You're sick. We're quick".

Patients arriving at another nurse-led chain – RediClinic – are given a pager so they can shop in the mall until the clinic can see them²².

21 Ibid.

22 The Economist, "McClinics: 'convenient care' clinics are taking off", *The Economist*, (12 April 2007).

SIDEBAR

QUALITY PRIMARY CARE KEEPS PEOPLE HEALTHY AND OUT OF EXPENSIVE HOSPITALS

The National Health Committee found that well over half of premature deaths could be prevented through quality primary care²³.

Effective primary care can help patients stay healthy and avoid ending up in hospital. Research²⁴ found that 10% of hospitalisations in 1997 would have been avoided if there had been appropriate primary care. Avoidable hospitalisations had increased 32% over the period 1980-1997.

Avoidable hospitalisations are highest among the poor, children under 5, and people aged over 75. The key conditions are asthma, pneumonia, congestive heart failure, and cellulitis.

A study of hospitalisations in Canterbury found that more than 30% of all admissions were considered avoidable^{25 26}. Those avoidable admissions accounted for 94,500 bed days in 2003 at a cost of \$97 million. The Canterbury DHB covers over 11% of the New Zealand population. This cost estimate does not include the cost of sickness and disability benefits, lost production, or the intangible costs of the pain and suffering which could have been avoided.

The leading causes of avoidable hospitalisations in Canterbury were cardiovascular disease, stroke, and respiratory illness. If avoidable hospital costs in Canterbury are representative of the rest of New Zealand, then the implications are striking.

Providing high-quality primary care can dramatically reduce avoidable hospitalisations, keep people in better health, reduce waiting lists, and free up resources to treat other patients.

23 National Health Committee, *Improving Health for New Zealanders by Investing in Primary Health Care* (National Health Committee, 2000), 11.

24 Arunachalam Dharmalingam et al., "Trends and patterns of avoidable hospitalisations in New Zealand: 1980-1997", *The New Zealand Medical Journal* (Vol 117:1198, 2004).

25 Ian Sheerin et al., "Avoidable hospitalisations: potential for primary and public health initiatives in Canterbury, New Zealand", *The New Zealand Medical Journal* (Vol 119:1236, 2006).

26 The Ministry of Health found that in 1997-98, 30 percent of hospitalisations were theoretically avoidable; two-thirds of these could be avoided if earlier care had been given. Ministry of Health, *Our Health, Our Future, Hauora Pakari, Koiora Roa: The Health of New Zealanders 1999* (Ministry of Health, 2000), 380.

FOCUSING ON PREVENTION

Successfully tackling the challenges facing the New Zealand health system requires a commitment to preventing ill health and a focus on maintaining well-being.

People make personal decisions that affect their health and well-being – eating, drinking, smoking, or exercising. Although these choices may be shaped by public health messages or cultural experiences, they are still choices that individuals are responsible for. The Government should be providing the information and support that people need to make healthy choices, instead of making those choices for them.

Prevention can be seen as a three-pronged approach based on health promotion, supported self-care, and early detection of disease²⁷.

Health promotion

Encouraging individuals and members of at-risk communities to adopt healthier lifestyles can make a big difference. Besides increasing awareness about health issues, promotion should identify and target the socio-cultural aspects of human behaviour.

Our "cultural hard drive" has to alter so that healthy choices are preferred. A successful long-term approach will provide people with the education, skills and desire to make healthy dietary and lifestyle choices and stick to them.

Self-care

As technology advances there will be more opportunities to help individuals take greater responsibility for managing their own health, particularly those with chronic conditions.

Self-care can involve training and education, and the use of special equipment and support networks²⁸. With the significant workforce problems in the health sector, and the increasing prevalence of chronic conditions, patients will need to play a greater role in the management of their own conditions.

27 At a stage where appropriate intervention may reverse the process or at least delay progression.

28 Ayesha Dost, *Self Care Support: the evidence pack, summary of work in progress 2005-07* (Department of Health, 2007).

HEALTH AND SOCIAL CARE TOGETHER

For example, people with diabetes can optimise self-management of their condition through appropriate disease-specific education, home monitoring of blood sugar levels, and consultation with local diabetes societies. Disease-specific support groups can also play an important part in self-care.

There is increasing evidence that supporting self-care reduces GP consultations, emergency department visits, and demands on hospitals. Even small improvements in self-care of chronic conditions can have a large impact on demand for healthcare²⁹.

Early detection and screening

Early detection and screening saves lives.

Incentives are needed to encourage the screening of high-risk patients at a primary-care level. Consideration is being given to setting up a colorectal cancer screening programme. This will generate substantial demand for operators of colonoscopy equipment and create discussion about how such a service could be better based in primary care.

The growing prevalence of obesity and type 2 diabetes – sometimes called “diabesity” – will be a key challenge in prevention and promotion. Screening is important. The latest available data suggests that one in five New Zealand adults is obese and one in three adults is overweight. The World Health Organisation estimates that obesity costs New Zealand \$300 million a year. Obesity is a risk factor for many chronic diseases, including type 2 diabetes, heart disease, hypertension, stroke, gallstones, and some cancers³⁰.

In New Zealand, about 142,000 people have type 2 diabetes. Many are undiagnosed. In some groups of people – particularly Maori and Pacific peoples – up to 12% aged over 40 will have type 2 diabetes³¹.

National recognises the importance of health promotion and preventative health, tailored to at-risk groups. We also believe there are opportunities to expand self-care.

Chronic care

Chronic diseases account for more than 80% of all deaths in New Zealand, and, according to the National Health Committee, 70% of public sector health funds are spent on chronic disease. Chronic diseases include:

- Asthma.
- Arthritis.
- Diabetes.
- Chronic neck or back problems.
- Depression.
- Cardiovascular disease³².

It is common for people to have more than one chronic condition and for others to live with multiple conditions.

The key elements of better support for people with chronic illness are to ensure early identification of chronic illness, prevent complications where possible, slow the progression of disease, and prevent other conditions from developing.

Chronic conditions are largely preventable and share a range of common risk factors, such as inactivity, unhealthy diets, obesity, depression, stress, smoking and alcohol misuse.

In Britain, research by Edwards³³ estimates that people with chronic disease are 80% of the workload of general practice and 60% of hospital workload. Those figures are likely to be similar here. Edwards also states that chronic-care services are best delivered across a larger number of patients than in a single practice.

The Government's “Care Plus” programme was designed to provide additional support to general practice to focus on patients with multiple chronic conditions. A recent analysis raised questions about the efficacy of this programme and noted that though it was a goal to keep patients out of hospital, Care Plus patients ended up being hospitalised 40% more than non-Care Plus patients³⁴.

²⁹ Ibid.

³⁰ Ministry of Health at www.moh.govt.nz/obesity.

³¹ Diabetes New Zealand, *About Type 2 Diabetes*, available from <http://www.diabetes.org.nz/about/type2.html>.

³² National Health Committee, *People with Chronic Conditions: a discussion paper* (National Health Committee, 2005), 7.

³³ Nigel Edwards – Policy Director at NHS Confederation, interview with author, London (2006).

³⁴ This may also reflect Care Plus patients getting appropriate hospitalisation while others are not.

Similarly, the Auditor-General's recent review of the "Diabetes Get Checked" programme led him to conclude he simply could not say whether the scheme was working or not³⁵.

How Integrated Family Health Centres can help

Evidence shows a multi-disciplinary approach to supporting chronic-care patients helps improve outcomes, particularly approaches that focus on helping patients self-manage their conditions. This is, of course, consistent with view that we are all responsible for our own health and should act in ways to enhance it.

Focusing on those with multiple chronic conditions is very effective but requires more infrastructure at the primary-care level. This sort of approach needs sufficient spaces for nurses and allied services to treat people and operate their own clinics. This would be supported through the new Integrated Family Health Centres.



Chronic care and social support

Some people with chronic conditions face considerable social issues such as welfare dependence and poor housing. These social conditions may cause or worsen their chronic conditions. Sufferers share their homes with others who may also be at risk of developing chronic health conditions. It therefore makes sense to deal with health and social problems simultaneously.

The Ministry of Social Development has some programmes, like Family Start, that aim to assist many families with sufferers of chronic conditions. For example, some DHBs insulate homes to prevent or control respiratory disease.

Nurses are held in much higher esteem than many other agencies that might seek to intervene in a family's situation. This means PHOs could take a greater role in managing social needs funded from Vote Social Development³⁶.

Under this proposal, specially trained nurses would work more directly with government agencies, such as Work and Income and CYF, to provide cross-sector support to people at risk.

PROPOSAL

Specially trained nurses who are involved with chronic care patients should be engaged to act as brokers, or case managers, for non-health agencies to support at-risk families.

³⁵ Kevin Brady, *Ministry of Health and district health boards: effectiveness of the "Get Checked" diabetes programme* (Controller and Auditor General, 2007), 67.

³⁶ As advocated by author and Social Development spokesperson Judith Collins.

CONNECTING THE DIFFERENT ISLANDS OF HEALTHCARE

The future of PHOs

There is an ongoing role for PHOs in the health service of the future. We will look to PHOs to work with general practice to develop capacity for providing more surgical assessments and minor surgery at primary-care level. We will also look to PHOs to focus on cross-practice provision of chronic care capacity.

There are 82 PHOs in New Zealand. These vary in enrolled population size from 3,000 to 350,000. Management fees paid to PHOs (their main source of administrative funding) are approximately \$30 million³⁷.

The capacity and activity of individual PHOs is extremely variable. PHOs have had an uncertain and largely unmeasured impact on clinical practice.

As primary healthcare develops in line with our proposals, we would expect PHOs and their associated providers to respond and organise themselves to best offer improved care and services to their enrolled populations. For example, a PHO would need to demonstrate a high level of capacity and expertise to receive delegated funding for some of the services delivered by Integrated Family Health Centres.

PHOs should be a partnership between community and clinicians. Strong clinician engagement is fundamental to achieving quality service. Clinicians should be free to choose their PHO.

PROPOSAL

Primary care can provide a much wider range of care and support for patients. National will place greater responsibility and provide stronger incentives for PHOs and general practice to coordinate the ongoing care of their patients.

37 Answer to Parliamentary Question for Written Answer 14116 (2007).

Few incentives for working together

Labour has paid little attention to how primary, secondary, and health promotion services should work together more effectively. The National Health Committee could only suggest that team approaches should be fostered through 'greater sharing of power and resources'³⁸.

The Primary Health Care Strategy is similarly vague about how coordination should occur and who should be responsible for what. For example, it requires both PHOs and DHBs to take responsibility for the coordination of care and management of resources.

If the responsibilities are unclear, it is critical that professional and financial incentives encourage the PHOs and DHBs to work together to reduce avoidable hospitalisations, expand the availability of specialist care, improve coordination, and lift the overall standard of care.

The Government has two main policy levers here: financial incentives, and central monitoring and encouragement. Currently, goodwill and great ideas are not supported by either financial incentives or clear policy directions.

PHOs' capitation funding (payment per capita of registered patients) was calculated by-and-large for general practice visits already happening. Because practices can keep any surpluses for their own programmes and facilities, they have incentives to keep patient visits down and select the most cost-effective treatments³⁹.

DHBs have every financial incentive to invest in primary care to avoid hospitalisation, but little devolution to primary care has occurred. This is mostly because the funders are dominated by their hospital arms.

38 National Health Committee, *Improving Health for New Zealanders by Investing in Primary Health Care* (National Health Committee, 2000), 22.

39 Howell (2006) argues that the mix of capitated subsidies and fee-for-service user charges undermines the financial risk-management incentives of capitation. PHOs can manage their financial risks by charging patients. And because patients are likely to be disproportionately those with higher health risks, user charges will go up. As a result it may be 'not so puzzling' that average user charges for lower subsidized PHOs were lower than higher subsidized PHOs. By contrast, Robinson (2001) suggests that a mix of capitation and fee-for-service is an optimal reimbursement design strategy, precisely because it counters the under-servicing and cream-skimming risks of a pure capitation regime. However, it would seem that the current combination is a coincidence, not a design feature. Bronwyn Howell, *A Risky Business: moving New Zealand towards a managed-care health system* (New Zealand Institute for the Study of Competition and Regulation Inc, 2006), 15-17. James Robinson, "Theory and practice in the design of physician payment incentives", *The Milbank Quarterly* (Vol 79:2, 2001).

Devolving services to primary care

Consequently, the pressure to deliver on organisational service and financial targets crowds out any appetite to do more work with primary care, particularly if that involves a significant shift of resources. This is particularly true where new primary-care initiatives have only longer-term pay-offs.

Central guidance and monitoring seems disorganised. There are too many so-called strategies, objectives, priorities, and action plans. It is a bureaucratic jungle. The policy is unclear and lacks an implementation focus. In the health sector, vague responsibilities and a lack of financial incentives are a sure recipe for inaction⁴⁰.

There is little or no incentive to take a strategic view to invest now in order to reduce hospitalisations and hospital costs in the future. Without these vehicles for collaboration, the likelihood of improved service continuity and standards is also bleak.

In light of this lack of progress, National will use central policy direction to ensure more diagnostic and outpatients services, and more minor surgery are devolved into primary care. Delegated funding arrangements from DHBs to PHOs and other providers will be used to support this policy.

PROPOSAL

More treatment and diagnostic services should be devolved to primary care. DHBs should be held accountable for the devolution of services to general practice and Integrated Family Health Centres.

⁴⁰ In March 2006 a working group jointly sponsored by the Ministry of Health and DHBs suggest it is now time to concentrate more on achieving the aims of the strategy. The document confirms that in 2005 there is still minimal coordination of health promotion activities, delivery is reactive, and coordination with secondary care is patchy and weak, as are linkages with other primary care services (such as pharmacy). Primary Health Care Strategy Implementation Project, *Primary Health Care Strategy - Implementation Work Programme - Working Document for Sector Engagement* (Ministry of Health, 2006), 1 & 14-19.

4. Improving Performance and Quality

We need to dramatically improve the performance of our health system. We can do this by focusing on patient needs, building a new partnership with our health professionals, involving the private sector more, and improving cooperation between DHBs.

THE PRODUCTIVITY PROBLEM

Getting less for more

New Zealand is spending more on health but getting less for it. In recent years, our public health system has seen a sustained period of funding growth. By 2007/8, taxpayer spending on health will be over \$5 billion per year more than it was when the Labour came to power. This means it will have doubled in eight years.

But, despite this funding increase, fewer people are getting the care they need. Fewer patients are receiving elective surgery or specialist appointments¹.

Our health system is not delivering the gains that New Zealanders have a right to expect, given the massive amount of extra funding poured into the health budget. Quite clearly, a lot of money is being wasted.

Even the current Finance Minister agrees, saying "we cannot currently be confident that the substantial additional resources which have gone into the health system have produced the best results for citizens"².

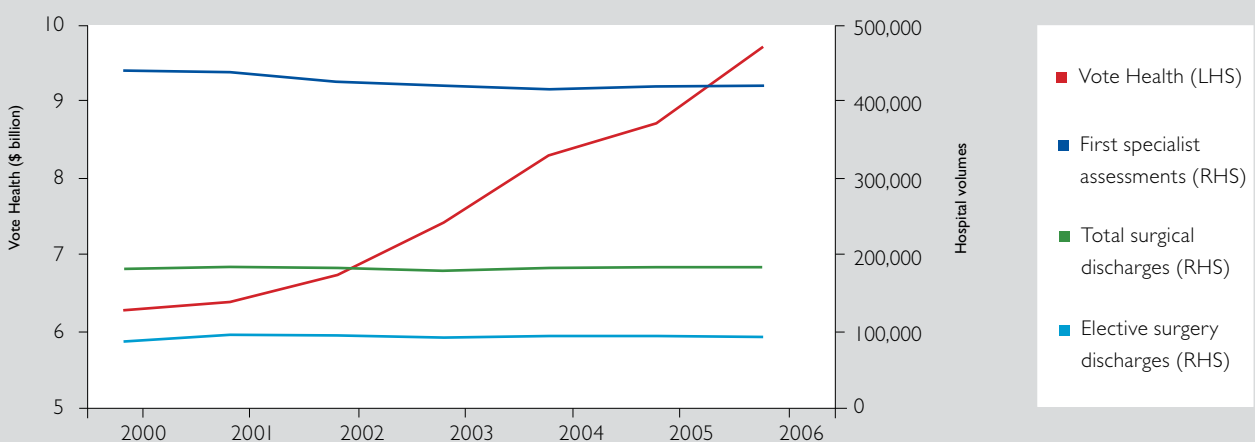
Falling productivity

A 2005 Treasury report concluded that hospital productivity has dipped despite massive funding boosts from the Government. The report, looking at a three-year period from July 2001 to July 2004, found that hospital spending had jumped 13.4% but measurable hospital outputs rose only 4.7%³. Treasury said that this equated to a 7.7% drop in productivity.

An analysis of productivity at the three Auckland DHBs⁴ concluded that it is taking almost \$3 of extra spending to get \$1 worth of extra benefit at the region's hospitals. The report found that a 13% rise in spending on medical and

Falling Productivity

First Specialist Assessments and surgical discharges have not increased despite massive spending increases.



² Hon Michael Cullen, *Value for Money in Health – the DHB sector*, Letter to Hon Annette King - Minister of Health (2005), available from <http://www.treasury.govt.nz/release/healthsector/pdfs/tr05-344.pdf>.

³ On a cost-weighted basis.

⁴ Andrew Gaudin, *Comparative Productivity Analysis Report: An updated report with 2005/06 data* (Andrew Gaudin, 2006), 4.

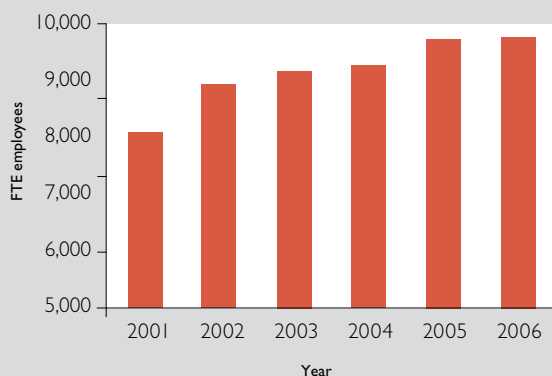
¹ Answer to Parliamentary Questions for Written Answer 831 (2007), 3176 (2007), 3864 (2007), 5354 (2007), and 6125 (2007).

nursing personnel between 2003/04 and 2005/06 had lifted hospital output by only 3.9%⁵.

Both reports conclude that most of the increased spending in the past eight years has gone into personnel, and most of this spending has gone into higher costs per staff member⁶ (e.g. salaries), rather than on additional staff numbers. In both reports, the actual output from each medical staff member reduced and there were large variations in output from specialties at different hospitals.

DHB Admin Staff

The number of management and administration staff employed by DHBs has grown



Source: Ministry of Health

People working in the health system know they could do so much more to ensure New Zealanders get better value for money, but they are frustrated by the current Government's policy.

PROPOSAL

New political leadership is desperately needed to give clear direction on the shared mission for the public health system. The current failed mission of "political peace and quiet" should be replaced by a relentless drive towards healthcare which is "better, sooner, more convenient".

5 Gaudin said different levels of performance between the three Auckland DHBs is costing more than \$35 million a year: "This potential increases significantly with maximum "best of best" productivity... it provides a compelling case for further action". Andrew Gaudin, *Comparative Productivity Analysis Report: An updated report with 2005/06 data* (Andrew Gaudin, 2006), 2.

6 Full-time equivalent.

Why are productivity gains so hard to get?

The information available paints a worrying picture of productivity loss in the health sector⁷. Possible explanations include:

- The growth of "managerialism"⁸ and burgeoning bureaucracy⁹ in the health sector. Many of the country's best health managers share this concern.
- Doctors and nurses are increasingly disengaged from the health system because they do not feel valued or listened to.
- Management and clinical focus is distracted by Labour's health reforms which began in 2000.
- Labour costs have grown faster than productivity improvements. Staff numbers, and wage and salary costs have risen, but activity levels have not grown at the same speed.
- There is a lack of discipline in ensuring the value for money of new policies and service extensions.

All these factors may well have contributed to the measured decline. However, there are three more issues to consider:

- DHBs have poor incentives and limited flexibility to seek productivity gains.
- Health interventions might be subject to diminishing returns¹⁰.
- The pay of staff is not linked to overall productivity.

None of these issues are easily fixed, but the current policy environment conspires against, rather than encourages, productivity.

7 See earlier section in this paper on productivity challenge.

8 Association of Salaried Medical Specialists, "Senior doctors to be more forthright on health system concerns" (Association of Salaried Medical Specialists, 2006).

9 Answer to Parliamentary Questions for Written Answer 4585 (2006), 8845 (2006), 10968 (2006), 10969 (2006), 13028 (2006), and 13030 (2006). These answers show an average increase in management/administration staff of 19.5 percent from 2000 to 2006, including a 47 percent increase at the Bay of Plenty District Health Board.

10 Appleby & Harrison (2006) in the UK suggest that there is some evidence that the health system has reached the point of diminishing returns. Extra spending seems to do little to change the long run trend of a number of indicators, such as life expectancy, or average length of stay. However, a hip replacement for example, can increase the ALOS in hospital, may not increase life expectancy, but certainly improves quality of life. John Appleby and Anthony Harrison, *Spending on Health Care: How much is enough?* (King's Fund, 2006).

Improving value for money

In reality, there is little pressure on public hospitals to focus on value for money. The funder arms of DHBs consider their hospital providers as monopolies and make few demands for improved performance. Government ideology largely marginalises the private sector as an alternative source of treatment even where it is cheaper.

Private providers can offer greater convenience to patients through choices about location, time and service levels. Crucially, they can also give DHBs the opportunity to look for savings in waiting times (through raising available capacity or better management of beds and workloads) and treatment costs.

The Ministry of Health, which monitors the sector, does not have many credible rewards or sanctions to encourage financial discipline. Under current Ministry policy once the break-even point has been missed by the DHB and the early payment benefits are lost, it makes little real difference how large the final deficit is.

It is easier for DHBs to fight the monitoring agency than to alter models of care or change service access.

PROPOSAL

DHBs should have greater freedom to supplement public services by using private providers, such as private hospitals, GP clinics, and Maori and Pacific health providers. Labour's ideological aversion to private providers is unnecessarily limiting patient options and harming their health.

Rising pay and falling productivity

To recruit and retain staff in the health sector, pay of professional health staff has to move with pay in the rest of the economy and, indeed, the wider global economy. This can lead to a situation where the pay of health professionals increases despite falling productivity. This situation can persist as long as there is limited flexibility to innovate with capital, technology, performance pay, and other models of care.

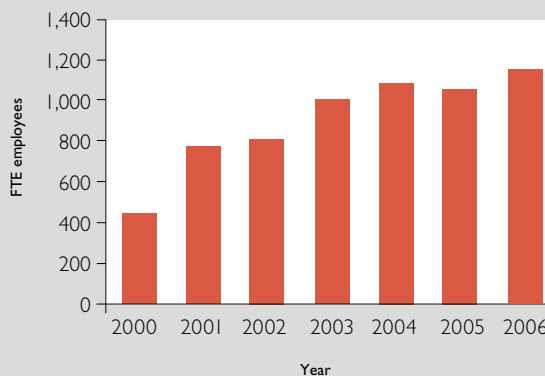
We simply cannot afford to pay our health professionals at the levels of some wealthier economies. We can, however, offer improved job satisfaction along with the unique and special benefits of living in New Zealand. A significant part of improving job satisfaction is offering trust, empowerment, and professional development.

Lack of clinical leadership

The public health system is today characterised by growing bureaucracy and "managerialism". Despite Labour's promise to cut a massive swathe out of the health bureaucracy¹¹, the reverse has actually occurred. DHB managers and administrators have increased by more than 1,800 since 2001. This has been accompanied by big increases in staff at the Ministry of Health.

Ministry of Health Staff

The number of bureaucrats in the Ministry of Health has more than doubled since Labour came to power.



Source: Ministry of Health

There is growing international recognition that patient-centred care depends on an infrastructure that supports clinical practice and fosters a culture of learning and teaching. New Zealand could learn from Australia and England where emerging frameworks are recognising the pivotal role of formal coordinated-care networks that are clinician-led and patient-centred.

¹¹ Rt Hon Helen Clark, "Speech to Auckland Regional Chamber of Commerce and Industry" (New Zealand Labour Party, 1996).

A NEW PARTNERSHIP WITH THE HEALTH PROFESSIONS

In Australia, promising improvements have been achieved by increasing the involvement of clinicians in the planning, management, and operation of the health service.

WHAT IS HAPPENING OVERSEAS

Clinical networks in Australia

In Australia, a growing number of formal coordinated-care networks¹² provide advice and direction on where and how health services should be delivered. These networks are focused on clinical practice rather than institutions.

Clinical networks bring together doctors, nurses, other health professionals, and patients across geographic, provider, and specialty boundaries. Importantly, general practice is also involved. The networks provide advice and direction on how best services can be delivered for patients.

Development

Clinical networks have been created because of:

- Patient expectations of continuity of care, particularly when it involves different providers in a range of settings.
- The need to use resources efficiently, reduce duplication, and manage growing demand.
- Difficulty recruiting and retaining highly skilled staff and the need to promote flexible use of their skills.
- The need to improve service access for patients and, in particular, to sustain access in provincial and rural communities.
- Difficulties reconciling clinical skills, viable caseloads needed to maintain skills, and public expectations about the accessibility of services.
- The need to encourage best practice and improve access to teaching and research¹³.

Clinical networks have also developed in response to discontent from health professionals concerned about the increasing marginalisation of clinical input by some health managers and policy-makers. The parallels with the New Zealand situation are unmistakable.

¹² Greater Metropolitan Transition Taskforce, *Embracing Change: Report of the Greater Metropolitan Transition Taskforce* (Greater Metropolitan Transition Taskforce, 2004), 3-5.

¹³ Government of South Australia Department of Health, *Statewide Clinical Networks*, (Government of South Australia Department of Health, 2007), 5.

Working smarter

The New South Wales Greater Metropolitan Clinical Taskforce (GMCT) was established in 2001 to provide a structure for independent clinical advice. It is composed of Speciality Service Networks and acts as a Health Priority Taskforce and Advisor to the NSW Department of Health, Director-General and Minister of Health.

The NSW Government recognised the strong advantages in having formal mechanisms to receive advice from clinicians across the state. Consequently, the GMCT has developed patient-care solutions, helped address workforce shortage in an innovative way, and fostered collaboration across primary, secondary, and tertiary care. This has had a positive impact on the management of resources and health outcomes.

There are 20 specialty based clinical networks chaired by clinicians. Each clinical network brings together providers from across hospital and community settings. This creates a platform for doctors, nurses, NGOs, and administrators to come together to plan how their specialty can best meet patient needs. They develop best-practice care pathways for patients, using common evidence-based clinical standards. They also provide advice on how services might best be arranged to improve quality and patient care.

Clinical networks focus on the health needs of patients rather than geographical health service boundaries.

Rural networks

Rural and non-metropolitan communities have benefited significantly from clinical networks¹⁴. These communities, and in particular their hospitals, have benefited from being part of clinical networks that share services across boundaries and improve access for patients. Similar initiatives are now emerging in South Australia and Queensland.

The GMCT identified three principles related to improving the quality and safety of patient care – clinical leadership, networking of services, and clinical information for informed decision-making.

¹⁴ Greater Metropolitan Clinical Taskforce, interview with author, Sydney (2007).

CASE STUDY

THE NSW STROKE SERVICES NETWORK

The NSW Stroke Services Network was established in 2002 to provide a coordinated approach to care across the state by sharing available resources and promoting expertise.

The network involves more than 300 health clinicians, consumers and carers who work closely with allied agencies to improve stroke care. Significantly, there are now 23 Acute Stroke Units in state public hospitals, providing a uniform level of stroke care. These new care pathways and programmes have doubled the recovery rate and proven real value for money.

Promoting clinical leadership in New Zealand

The success of the New South Wales GMCT demonstrates the clear links between clinical leadership, morale, and efficiency.

Globally, clinical leadership is recognised as a fundamental driver for improved professional practice. But in New Zealand, clinicians' influence on patient outcomes is becoming increasingly limited. This failure to engage the people who have the expertise – the doctors and nurses who keep the health system going – is seriously eroding their ability to provide patients with the care they need.

The input and leadership of our clinicians can be maximised by:

- Investing in the development and operation of clinical networks that deliver on improvements at service planning, operational, and advisory levels.
- Fostering the development of smarter, pragmatic, innovative workforce solutions.
- Implementing funding arrangements that foster quality and innovation.

- Investing and committing to quality information systems, research, and ongoing evaluation of initiatives.
- Aligning informed policy, clinician leadership, contracting, and funding systems¹⁵.

Clinical networks should be established across regions to assist in the planning, delivery, and evaluation of services. These networks would involve clinicians, non-governmental organisations (NGOs), and patients.

PROPOSAL

As a priority, clinicians should be more involved in planning and operating the public health system. This includes greater involvement in DHB decisions and throughout the wider health sector.



¹⁵ Clinical networks could also be a key aspect of development and implementation of the long-term hospital plan discussed earlier.

DHBs WORKING TOGETHER MORE EFFECTIVELY

In order to provide better, sooner, more convenient healthcare, DHBs should use their funding more effectively to increase patient care in primary and community settings. They should also align their funding with the various quality-care pathways designed by the proposed clinical networks.

DHB funders have poor incentives to seek value for money by obtaining services from other providers such as private hospitals and groups of GPs. In part, this is because the close proximity of DHB funders and providers produces conflicting objectives. With 21 DHBs there is also inefficient duplication of planning, monitoring, and funding functions.

This fragmentation means a patient's ability to get surgery varies depending on which part of the country they live in. This is "healthcare by postcode", and patients deserve much better.

Recent Ministry of Health reports comparing 13 areas of elective surgical speciality at all 21 DHBs found huge discrepancies in surgery rates¹⁶. Auckland and Waitemata DHB residents, for example, are less likely to receive elective surgery through the public system than most other New Zealanders. Such inequalities also exist between ethnic and socio-economic groups.

Inconsistent service levels are a feature of current arrangements, with people in one part of the country receiving quite different services than others elsewhere. For example, in some areas, patients pay for private specialist referred lab tests while in other areas they do not. Providers find these inconsistencies frustrating.

Improving fairness and consistency of care

New Zealanders expect their health system to be fundamentally fair and consistent. In a country of 4 million people, consistent access to health services should be possible.

To achieve this, the health system needs greater cooperation between DHBs across the regions. Crucially, the funding and planning arms of DHBs should work together more as a "shared services network". This would:

- Support regional clinical networks.
- Concentrate and improve management staff capacity.
- Reduce duplication and waste.
- Ensure more consistent access to services.
- Foster regional workforce approaches.
- Ensure strategic decision-making on investment.
- Share best-practice between DHBs.
- Allow more impartiality in selecting alternative providers.

Working with clinical networks, the funding and planning networks can support DHB collaboration across the region for maximum patient and taxpayer benefit.

Better networking and cross-boundary DHB cooperation can concentrate expertise and improve efficiency and quality. This should apply to services as well as surgery. For example, aligned staffing and policies could be developed for primary care, child health, aged care, and pharmacy.

This approach does not mean DHB mergers or stand-alone regional funders. Rather, regional shared-services funding and planning networks can support their collective DHBs and maintain a strong connection with local communities.

Already the Otago and Southland DHBs are moving toward this "shared-funder" approach. In the northern region, DHBs are reportedly increasing their regional collaboration. National will acknowledge the strength of this trend and look to extend it to all regions.

PROPOSAL

It is inefficient and inhibiting to have 21 DHBs that duplicate planning, monitoring, and funding functions. The funding arms of DHBs should cooperate as shared-service networks across their regions. This can improve performance, support clinical networks, and provide more strategic decision-making. It can also improve the administration of provider contracts.

¹⁶ Ministry of Health, *Elective Services: Comparative Analysis of DHB Intervention Rates for selected Elective Services* (Ministry of Health, 2007), available from <http://www.moh.govt.nz/moh.nsf/indexmh/electiveservices-interventionrates>.

SIDEBAR

INFORMATION TECHNOLOGY

Smart investment in information technology can lead to substantial gains in quality, service, and productivity. The health system is currently lagging behind other sectors in effective use of information technology.

For example, if you have a plumbing problem, it's possible to ring a call centre for a plumber and describe the problem. The address and contact details are sent through on their mobile phone/PDA as well as a preliminary diagnosis.

From the same mobile device, the plumber can access their inventory, their pricing schedule, and any regulatory compliance documents from their local authority. When the job is finished, the plumber can print out an invoice for labour, parts, and travel before leaving the job.

In stark contrast, hospital doctors in many parts of New Zealand are working from paper-based records and files, verbal transfers of information, incomplete sets of documents in different places, and little, if any, understanding of a patient's general practice record.

This is not efficient and is sometimes dangerous. It is impossible to justify in the 21st century. There needs to be much more progress in developing clinical support software in hospitals, improving electronic health records, and using patient management systems in hospitals.

MORE INFORMATION FOR PATIENTS

Long-term health services plan

Hospital planning appears to be based on an assumption that changes in technology and practice will automatically reduce the Average Length of Stay (ALOS) in hospital beds resulting in a faster turnaround of patients. For example, the new Wellington Regional Hospital in Newtown has the same number of beds as the old hospital despite the city's growing population¹⁷.

However, the ALOS has been static for several years¹⁸. Though many hospitals still have some way to go to achieve best practice ALOS, increasing day surgery and improved primary care will mean that, in the future, patients admitted to hospital will be sicker and require more care.

This means that lengths of stay may not reduce further, and capacity problems may increase. Current hospital planning does not reflect this threat.

The public and private sector should jointly plan for required capacity in facilities and workforce. Some new hospital infrastructure could be financed by public-private partnerships. Similarly, investment in new technologies – such as PET scanners – could be shared between the public and private sectors.

Building more hospital theatres and beds may not be sensible if DHBs are not confident they can recruit and retain the skilled workforce required. Smaller hospitals are expected to experience increasing staffing shortages in the future, reinforcing the need for action on health workforce shortages.

We need a long-term health services plan that considers 20-year demographic, technology, and quality changes that will drive future requirements. This will assist in planning to meet patient demand in the future in a more coordinated way.

Health professionals must be actively involved in the development of this plan. The input of the proposed regional clinical networks will help ensure high quality services continue to be available in smaller centres.

¹⁷ Capital & Coast District Health Board, interview with author, Wellington (2007).

¹⁸ Answer to Parliamentary Question for Written Answer 5637 (2007).

PROPOSAL

A long-term health services plan can identify the demographic, technology, quality, and safety changes that will affect health services. It can assist in ensuring that capital and staff capability needs are well planned across the public and private health sectors. Some new infrastructure can be financed by public-private partnerships.

Public information on continuous improvement

There is a strong public desire for accountability from DHB managers and health staff. People are entitled to have access to useful information about their health services.

An important feature of improved performance and accountability is public scrutiny of DHB (and PHO) performance. The use of readily accessible performance measures would assist in a number of ways, including:

- A democratic value in enhancing patient (and voter) understanding of the performance of their DHBs and PHOs.
- Providing measures for focusing governance, managerial, and clinical attention on performance and linking incentives to these measures.

The use of star-rating in the English NHS has improved reported performance on the key targets¹⁹. The results have been confirmed by the New Zealand Treasury²⁰. Lessons from the British experience suggest that star-rating targets should²¹:

- Be seen as one of a range of approaches to achieving specific performance outcomes.
- Focus on improvements in performance to avoid mixed signals to various performers who are above the target.

19 Gwyn Bevan and Christopher Hood, "Have targets improved performance in the English NHS?", *British Medical Journal* (332, 2006), 419-422. Other conclusions were that the effect on services excluded from the star ratings is unclear, and that systems to minimise game playing and unintended consequences were needed.

20 Nicholas Mays, *Use of Targets to Improve Health System Performance: English NHS Experience and Implications for New Zealand: New Zealand Treasury working paper 06/06* (The Treasury, 2006), 6.

21 Ibid.

- Reflect outcomes that the organisation can actually influence.
- Report against various performance and quality targets, based on measurable outcomes and patient views.
- Be subject to external assessment.

Treasury concludes that a small number of targets focused on improving outcomes can improve our health system²². Clearly, establishing such a scorecard must involve close collaboration with health professionals to avoid inappropriate comparisons or measures.

Key indicators could include elective surgery waiting times, average lengths of stay, infection control, unplanned readmission rates, and cancelled operations. Information should be easily understood by patients and residents.

Enforcing professional quality and standards should remain the role of the various colleges and health professional organisations.

PROPOSAL

The public should be provided with better information on hospital and PHO performance. The introduction of star ratings should be considered as one of a range of approaches to improve performance reporting in areas such as safety, staffing, productivity, and patient satisfaction.

22 Ibid, 25-27.

5. Strengthening Our Health Workforce

A strong health workforce is our public health system's greatest resource. Trusting, valuing, and fully engaging our health professionals will improve patient care and job satisfaction, and help recruitment and retention.

OUR HEALTH SYSTEM'S GREATEST RESOURCE

The previous chapters have considered how New Zealanders can receive much improved service from their massive investment in the health sector. However, all these proposals will make slow progress unless we address the fundamental challenges facing the health workforce.

A strong, valued, and trusted health workforce is an essential requirement for an effective and sustainable health service.

Shortages in the health workforce

The health and disability workforce is central to the successful delivery of cost-effective, quality health services. To state the obvious, it is critical that we have a workforce with the right numbers and the right skills.

Today, the health workforce is in crisis¹. Workforce shortages are affecting:

- Doctors
- Nurses
- Midwives
- Medical radiation technologists
- Laboratory technicians
- Dental therapists
- Pharmacists

The New Zealand Nurses Organisation believes that there is currently a shortage of 2,000 nurses. The Association of Salaried Medical Specialists (the hospital doctors union), says 254 specialist jobs lay vacant at the end of last year, nearly 8% of the total².

In many communities, patients are unable to register with a general practice. This situation is expected to worsen.

1 "The available evidence clearly shows that New Zealand faces critical issues with the current capacity and ongoing development of its medical workforce. There is an overall shortage of medical practitioners, which is particularly noticeable in vocations such as general practice, pathology, and psychiatry. These shortages are evidenced by the current use of locums and temporary appointments to fill positions within New Zealand". Medical Reference Group – Health Workforce Advisory Committee, *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning the medical workforce in New Zealand* (Health Workforce Advisory Committee, 2006), v.

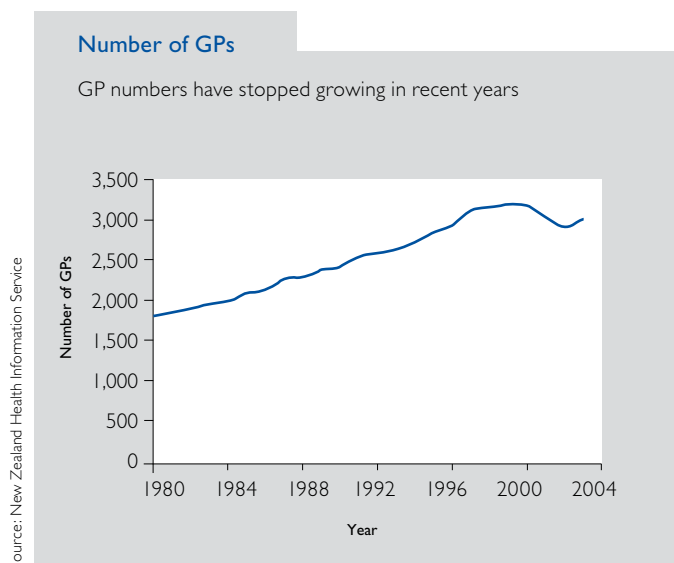
2 "National strike threat by senior doctors", *The Press*, 27 April 2007, 3.

Shortages in the health workforce are predicted to grow. Increasing demand for services is being driven by an ageing population, the growing incidence of chronic diseases, and increased patient expectations.

This gloomy picture is compounded by limited training places, the increased rate of retirements as the workforce ages, increased part-time participation, and lifestyle choices.

GP numbers in crisis

Most categories of medical staff increased in absolute numbers from 1980 through to the end of available statistics (2003). However, in recent years, growth has stagnated and even declined. This is due to by the downward trend in GP numbers as indicated in the graph below.



There are now fewer GPs in New Zealand than in 1999. The above chart is based on a straight headcount of GPs and not full-time equivalents. According to the Royal New Zealand College of General Practitioners, only 46% of GPs are full-time, 25% are part-time, and the remainder are locums or in other work³. The trend to part-time work is strong and continuing.

3 Judith Fretter and Madhukar Pande, *Forecasting GP Workforce Capacity: towards an understanding of GP workforce capacity, long-term forecasting and benchmarking tools* (The Royal New Zealand College of General Practitioners, 2006), 18.

Changing demographics will increase demand for GP consultations. For example, within the Midland region of the North Island, it has been projected that over the next 10 years, demand for GP consults will increase by 16% for Maori and Pacific, and 7% for general patients⁴.

Nurses under pressure

Nurse numbers have increased and they remain stable in proportion to the population. However, with nursing playing an ever-greater role in providing better patient-centred care, the current growth may not be sufficient to meet demand.

A recent study by Auckland University found that 40% of staff nurses in New Zealand hospital general wards leave their jobs each year, costing hospitals an average of nearly \$25,000 to replace each one⁵. A survey of Directors of Nursing of DHBs suggested that 30-40% of nurses consistently intend to leave their jobs within 12 months⁶. This poor retention has a direct and detrimental impact on the quality of patient care.

According to the OECD⁷, 24% of New Zealand's nursing workforce in 2005 was overseas-trained (compared to 19% in 2000). New Zealand's doctor workforce was 36% overseas-trained in 2005, roughly the same as 2000.

Hospital locum blowout

The cost of medical locums has almost doubled in the past six years to \$90 million a year⁸. This increasing reliance on casual locums is affecting the quality of care for patients. Similar pressures are being felt in Australia⁹.

Senior doctors are expressing concern about the quality of a health system so dependent on temporary staffing. The skills and experience of locums can be variable and their working hours are not monitored. There is no training or performance review system for locums. The medico-legal liability of DHBs, locum agencies, and locum doctors is unclear.

As locum work becomes even more attractive, the number of doctors seeking to train as specialists may decline. Fewer specialists will make it harder for patients to be treated.



4 Pinnacle Group, *The General Practice Workforce: Impact of projected Population Changes on Workload and Workforce* (Pinnacle Group Ltd, 2007).

5 Errol Kiong, "40pc of general ward nurses quit each year", *New Zealand Herald*, 25 June 2007, 3.

6 Dr Nicola North et al, "The Cost of Nursing Turnover and Its Impact on Nurse and Patient Outcomes: a Longitudinal New Zealand Study", *Te Puawai* (April:25-30, 2005).

7 Dumont and Zurn, *Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration* (OECD, 2007), 169.

8 Answer to Parliamentary Questions for Written Answer 4507 (2006) and 13043 (2007).

9 Claire Skinner et al., *Medical Locum Challenge: Understanding the Impact of Locum Working Arrangements on the NSW Public Hospital System* (GMCT Metropolitan Hospitals Locum Issues Group, 2005).

PLANNING FOR THE FUTURE

National will use a mix of planning and incentives to improve healthcare for patients. This will be based on a new partnership with the health professions.

Trusting, valuing, and fully engaging health professionals will improve patient care and job satisfaction, and assist recruitment and retention. People who work in our health system are in it because of their commitment to caring. Money talks, but it is not the only, or even the prime, motivator. If we can make working in our health system a more rewarding career for our health professionals, we will be able to build a stronger workforce.

PROPOSAL

As proposed earlier, doctors, nurses, and other health professionals should be more fully engaged in the planning, operation, and evaluation of the health system. New Zealand can never compete solely on salaries, so we have to offer a stronger and more engaged clinical environment.

WHAT IS HAPPENING OVERSEAS

The OECD^{10,11} suggests that countries employ a mix of policies to try to influence the supply and distribution of doctors, nurses, and other professionals. These include education and training policies, migration policies, and policies affecting retention and retirement.

International literature supports workforce planning for the entire health service (sometimes called 'integrated workforce planning') rather than conducting separate planning exercises for individual professions¹².

Bonding

A number of countries offer scholarships and loans to students in return for a bonded commitment to practise in rural and deprived urban areas for a number of years. For instance, student-loan write-offs are used in Norway, Japan and the United States.

However, bonding schemes have been less successful in Canada and Mexico where a substantial number of students have been able to buy their way out of their service commitment. Few of these students opt to remain in rural and deprived urban areas after their required period of

service has expired¹³.

Training and career advancement

Britain, Canada, and Ireland have increased the number of places in nursing training. Others, such as Belgium, are promoting medicine and nursing to potential graduates.

Several countries have reported some success in stimulating the re-entry of nurses into the workforce by offering training courses and making a financial contribution to tuition fees and/or salary, in return for a commitment to remain bonded in the workforce for a minimum period of time.

Nurses are also attracted to and retained at workplaces where opportunities exist for them to advance professionally. The attraction is to gain autonomy and participate in decision-making while being fairly compensated¹⁴. This approach is likely to appeal to all health professionals.

Researchers Maynard¹⁵ and Duckett¹⁶ argue that policy-makers should consider the scope for role substitution and productivity improvements as part of the arsenal of weapons dealing with workforce shortages.

10 Steven Simoens and Jeremy Hurst, *The Supply of Physician Services in OECD Countries* (OECD, 2006), 9.

11 Steven Simoens, Mike Villeneuve and Jeremy Hurst, *Tackling Nurse Shortages in OECD Countries* (OECD, 2005).

12 Department of Health and Children, *Towards Workforce Planning: The Nursing and Midwifery Resource* (Department of Health and Children, 2002); quoted in Steven Simoens, Mike Villeneuve and Jeremy Hurst, *Tackling Nurse Shortages in OECD Countries* (OECD, 2005), 31.

13 Steven Simoens and Jeremy Hurst, *The Supply of Physician Services in OECD Countries* (OECD, 2006), 40.

14 International Council of Nurses, *The Global Nursing Shortage: Priority areas for intervention* (International Council of Nurses, 2006), 17.

15 Alan Maynard, "Medical Workforce Planning: some forecasting challenges", *The Australian Economic Review* (Vol 39:3, 323-329/2006), 325-327.

16 Stephen Duckett, "Next Steps in Health Workforce Reform", *The Australian Economic Review* (Vol 39:3, 318-322, 2006), 321.

WHAT IS HAPPENING OVERSEAS (Continued)

Wider scopes of practice

Internationally, more attention is being paid to new scopes of practice as a possibility. While quality and patient satisfaction is high, there is virtually no evidence of the cost effectiveness of role substitution¹⁷.

Scottish researchers Buchan and Calman reported that studies suggested nurses can provide some aspects of care which are equivalent to those provided by doctors in primary-care settings. Nurses ordered more tests than doctors and had longer consultations with patients. However, the researchers noted that many of the studies related to substitution of nurses for doctors when the diagnosis of the patient had already been established. They noted that a number of questions remained as to how proficient such nurses were in identifying rare illnesses and the side effects of treatments¹⁸.

Such reservations should not stop profession-led advances in this area. Any progress in this changing of scopes of practice would need to be established through well-designed trials and in consultation with the health professions and academics.

Opportunities abound for health professionals to work together in a more integrated way. For example, pharmacists could play a greater role supporting doctors and nurses in delivering services under specific-care plans for targeted patients, such as those with chronic conditions.

What can be done here

Improving job satisfaction for health professionals will have a significant impact on New Zealand's ability to retain and recruit health professionals.

Fully engaging health professionals in the health system will recognise and utilise the expertise and professionalism currently being lost. Health professionals should be allowed to focus on care and treatment through less paperwork and improved hospital systems. A patient focus should also help retention.

17 Alan Maynard, "Medical Workforce Planning: some forecasting challenges", *Australian Economic Review* (Vol 39:3, 323-329, 2006), 326.

18 James Buchan and Lynn Calman, *Skill-Mix and Policy Change in the Health Workforce: Nurses in advanced roles* (OECD, 2005), 5.

Professional development is important to job satisfaction. Improving access to new medicines and modern equipment should assist in retaining and recruiting hospital specialists.

National will work with DHBs to offer student-loan write-offs for health professionals working in hard to staff areas (geographic and speciality).

At a macro-economic level, lower personal taxes will make working in New Zealand more attractive to all health professionals.

POLICY

National will put in place an ongoing programme of personal tax cuts that will make it more attractive for health professionals to stay in New Zealand.

Medical training – a top priority

Recruiting, training, and retaining general practitioners is a top priority for National. Strengthening the general practice workforce will improve New Zealanders' health¹⁹.

New Zealand should be self-sufficient in medical training. This means increasing the number of funded medical student places²⁰.

More of that training should be done in rural and provincial communities. Both the Canadian and Australian experience indicates that medical trainees with substantial training in rural and provincial communities are more likely to work in those areas²¹.

Experience over the past 20 years alone indicates New Zealand should assume that re-training and re-deployment will have to be an essential element of the health workforce to address unpredictable changes in need and available technology.

19 Researchers Baicker and Chandra showed that health care quality and outcomes are positively correlated with the number of GPs, negatively correlated with the numbers of specialists, and somewhat independent of the number of nurses. Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care", *Health Affairs* (W4:184-197, 2004), 192.

20 Workforce Taskforce, *Reshaping Medical Education and Training to Meet the Challenges of the 21st Century: A Report to the Ministers of Health and for Tertiary Education from the Workforce Taskforce* (Ministry of Health, 2007), 14.

21 Ontario Ministry of Health, interview with author, Toronto (2006).

Professional colleges will need to consider the value of moving to a common modular education in the post-graduate environment. This would allow trainees increased flexibility to achieve their desired education and give them more mobility between different areas of specialty training.

National supports the Health Workforce Taskforce recommendation for a Medical Training Board to oversee improved medical education.

Nursing – vital to the future

A faster and more convenient health system would see more work done in community settings such as Integrated Family Health Centres.

As GPs involve themselves in this wider range of activity there will be more opportunities for others – such as nurses and pharmacists – to expand their roles and work alongside medical colleagues as part of a multi-disciplinary team.

In the future, health services will be delivered more in primary and community settings. Only 16.7% of New Zealand's nurses work in a primary health role now²². Positive clinical exposure to primary-care experience throughout the nursing curriculum, including elective placements, is critical. Integrated Family Health Centres will have a training function that will contribute to this.

There should be more support for new graduates moving into primary-care settings including, the development of skilled, experienced, knowledgeable nurses with high levels of clinical competence. Such nurses will make a valuable contribution to clinical networks.

Nurses play a pivotal role in the health sector, and their increasing focus as key providers of chronic-care support cannot be overstated. Nurses will play more of a frontline role in health. In the future, these highly trained health professionals will become brokers for other services for their patients, such as social care. Nurses will help people assume greater responsibility for their own health and well-being, building on a nursing focus on health promotion and illness prevention.

²² District Health Boards New Zealand, *Future Workforce: Nursing workforce strategy* (District Health Boards New Zealand, 2006), 19.

Many nurses are keen to re-enter the workforce, but struggle to pay for the return-to-nursing training and with the ongoing need to maintain competencies. DHBs could play a role here by supporting such training and bonding the nurses in return.

Moving beyond the narrow attention of previous years on filling vacancies with an “at the last moment” approach, the focus should be on retention of nursing expertise. Nurses should receive recruitment and retention incentives – like bonding – to work in priority areas to assist service coverage and bring care close to home.

CASE STUDY

SCOTLAND'S APPROACH TO NURSING TRAINING

In Scotland, nurses are guaranteed a year's employment once they leave their educational institute. This internship allows nurses to consolidate their training and gain practice experience. If they are unable to secure a job after that year, the training means they are well placed to work in another location in the health sector. This approach is worth considering here.

For more than 30 years, enrolled nurses have played an invaluable role supporting our public health system. Despite a mounting crisis in the health workforce, the number of enrolled nurse trainees has dwindled, their name has been changed to 'nurse assistant' and the profession has been increasingly marginalised as they have been pushed out of public hospitals.

Not surprisingly, the dedicated people in this profession have become demoralised and disenchanted by their appalling treatment. The proud place of enrolled nurses in our public hospitals should be restored.

PROPOSAL

Health workforce numbers can be boosted by:

- Medical training self-sufficiency, including training more students in rural and provincial areas.
- Investigating bonding and student-loan debt write-offs for those health professionals working in hard-to-staff areas (geographic and speciality), and for those re-entering the workforce.
- Recognising the important contribution of enrolled nurses.

Supporting locums

There are several approaches to managing the growing issue of casual locums. Doctors will be less likely to opt out of formal training experiences if that training maximises involvement in actual clinical work and enhances relationships with senior doctors and patients.

Locum doctors need to have greater professional and educational support from hospitals. This should include forms of accreditation, supervision, and performance review. There should also be less isolation.

Additionally, hospitals should work much more effectively together – across regions – to manage the demand and recruitment of locums. Finally, clinical leadership should be encouraged by empowering doctors to play a greater role in running the public health system.

International recruitment

As a country with a bright future, New Zealand should be an attractive destination for overseas-trained health professionals seeking a better life for themselves and their families.

WHAT IS HAPPENING OVERSEAS

UK experience

Under a British NHS policy of “Modernising Medical Careers”, 8,000 junior doctors completing their initial training will not be offered positions within that health system²³. It is expected many will seek work outside Europe, mainly in the United States, Australia, and New Zealand.

Current overseas recruitment programmes run by DHBs are spasmodic and uncoordinated. Last year, 10 DHBs sent up to five staff each to various employment expos in Britain²⁴. Multiple brands, websites, and competing interests undermine an opportunity to promote an efficient and unified “NZ Inc” approach.

PROPOSAL

A one-stop-shop approach should be developed for international recruitment into the health system. This single programme will attract candidates to the country and then give them the chance to choose where they would like to live and work.

23 Celia Hall, “Doctors’ training system ‘a shambles’”, *The Telegraph*, 3 March 2007, available from

<http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/03/02/nhs02.xml>.

24 Colin Espiner, “DHB hiring rivalry slated”, *The Press*, 17 March 2006, 5.

FEEDBACK. Health Discussion Paper

We welcome your feedback on the proposals outlined in this paper. Please detach this form, fill it out, and mail it freepost to Hon Tony Ryall MP, Parliament Buildings, Wellington. Alternatively, email your comments to tony.ryall@national.org.nz.

To assist your submission you may respond on this form, but please feel free to comment more broadly if you wish.

Agree

Disagree

Reducing endless waiting

- | | | |
|--|--------------------------|--------------------------|
| 1. GPs with specialist interests should be able to provide more minor surgery in their clinics. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Public-private partnerships should be used to help reduce elective surgery waiting lists. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Where possible, elective and acute (emergency) service provision should be separated to improve elective surgery volumes. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. More GPs should be co-located in emergency departments to reduce delays | <input type="checkbox"/> | <input type="checkbox"/> |

Towards better, sooner, more convenient primary care

- | | | |
|--|--------------------------|--------------------------|
| 5. Some hospital services should be moved to Integrated Family Health Services that can provide more care closer to home, such as specialist assessments by GPs, minor surgery, walk-in access, chronic care, increased nursing and allied health services, as well as selected social services. | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

Improving performance and quality

- | | | |
|---|--------------------------|--------------------------|
| 6. Clinicians – doctors, nurses and other health professionals – should be more involved in the planning and operation of our public health system. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Clinical networks should be established across regions to improve the delivery of treatment and care. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The funding arms of DHBs should co-operate as shared-service networks across their regions to improve efficiency and performance, and support clinical networks. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. DHBs should have greater freedom to supplement public services by using private providers. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. A long term health service plan should identify demographic, technology, quality and safety issues and help our health system adapt to them. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. The public should be provided with better information on hospital and PHO performance. | <input type="checkbox"/> | <input type="checkbox"/> |
-

FEEDBACK. Health Discussion Paper

	Agree	Disagree
Strengthening the health workforce		
12. Medical training self-sufficiency should be encouraged, including training more students in provincial areas.	<input type="checkbox"/>	<input type="checkbox"/>
13. Bonding and student loan write-offs should be investigated for health professionals working in hard-to-staff areas.	<input type="checkbox"/>	<input type="checkbox"/>
14. Enrolled nursing should be recognised as a valuable part of the health workforce.	<input type="checkbox"/>	<input type="checkbox"/>

Other Comments (including GP fee affordability)

Please feel free to send in a longer submission on a separate piece of paper.

Thank you for taking the time to give us your feedback.

If you would like to be kept informed of developments in National's healthcare policies, please take the time to complete your details below.

Your Details

Name: _____

Address: _____

Email: _____

National's Health Team

Hon Tony Ryall

MP FOR BAY OF PLENTY

Health Spokesman

Dr Jonathan Coleman

MP FOR NORTHCOTE

Associate Health Spokesman

Dr Jackie Blue

LIST MP

Associate Health Spokeswoman

Jo Goodhew

MP FOR AORAKI

Associate Health Spokeswoman

Katrina Shanks

LIST MP



National's Health Team, from left: Katrina Shanks, Dr Jonathan Coleman, Hon Tony Ryall, Jo Goodhew, Dr Jackie Blue.