ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Heather Simpson
Chair
Review of Health and Disability Sector
Ministry of Health

Dear Heather

Draft Terms of Reference for the Health and Disability Sector Review

Thank you for the opportunity to comment on the draft Terms of Reference (ToR) for the review of the health and disability sector. We agree that such a review is timely. Our comments are provided under each of the ToR's subheadings.

Key points

- We support the aim of addressing inequities and the emphasis on examining the impact of demographic and inflationary pressures and the resources required to deliver services.
- Include in the 'Purpose' a brief description of what New Zealanders 'expect and deserve'.
- Include in the 'Background':
    - Recognition of the district health board model as a strength of the system.
    - Recognition that years of real funding cuts have left the all parts of the system unable to adequately respond adequately to current health needs, and that all parts of the system need strengthening.
    - Recognition of the increasing costs of health and social care for older people specifically.
- The rationale for a greater focus towards primary and community-based care while 'maintaining' tertiary care services appears to be based on two fundamental assumptions which are not supported by the evidence.
- Despite the many challenges in introducing more preventive measures while attempting to attend to immediate needs, strengthening prevention is a no-brainer, as is adapting services better to manage increasing chronic illness. The evidence shows the best chance of succeeding is through comprehensive integration of hospital, primary care and other community-based services. A focus on the continuum of care between community and hospital, which will vary from DHB to DHB, rather than a focus on a part of the continuum. A better supported and enhanced 'Canterbury Initiative' is a model which, if adopted across the country, has great potential to positively transform our health system.

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- Include in the 'Current system' recognition of the long-term shortages of specialists.
- We do not believe there is a need to restructure the hospital system or the DHB system. We agree, however, that the small-business model in primary care has significant shortcomings that need addressing.
- We support most of the suggested broader topics for recommendations to the Government. However, we believe strongly that to be positively transformative the primary focus needs to be relational – at every level – rather than structural.
- Include in the 'Scope of the review' additional topics for recommendations to the Government on:
    - *Whether the health system is operating in the most effective and efficient way, with a particular focus on implementing evidence-based models of service delivery.*
    - *How to develop a genuine patient-centred care approach in all health and disability services, recognising the evidence showing that for patient-centred care to be realised, the needs and wellbeing of those providing the care must be addressed.*
    - *How health and disability workforce planning can be improved.*
- Rather than talk about giving primary care greater priority creating a "better balance towards primary prevention", the emphasis should be on developing a wholistic multifaceted approach to reducing demand for hospital care and improving and maintaining people's health.

Draft Terms of Reference: Comments

Purpose

We strongly support to aim of addressing health inequities. We presume the inequities referred to in the ToR are the serious inequities that exist in health status as well as inequities in access to services. Some clarity on this would be helpful.

We also believe it would be useful to spell out what New Zealanders may reasonably "expect and deserve" from our public health system. According to the World Health Organisation, the primary purpose of a public health system is to promote, restore and maintain health. We believe New Zealanders would expect these functions to be delivered through accessible services that respond to their health needs effectively, efficiently and equitably, and in a timely manner, recognising that good health is vital to wellbeing and contributes to economic growth.

We strongly support the emphasis on examining the impact of demographic and inflationary pressures and the resources required to deliver services into the future.

Background

We would include in the health systems strengths section the structurally integrated model of district health boards with responsibility for the full range of health care for the defined populations they serve. It is important to point out that, despite the strengths of the system, successive years of real funding cuts coinciding with increased health needs due to an aging population, and lack of action to

address significant determinants of ill health, has severely dented the capacity of the system to adequately respond.

The increasing costs of health and social care for older people specifically also need to be better recognised. Average life expectancy is still increasing, but as limits of longevity are approached the burden of frailty before death is also increasing, contrary to the reduction of dependency anticipated by the theory of 'compression of morbidity' and despite the long-established policy intent of healthy aging/health living.[1] [2] [3] [4] With the hoped-for decrease in dependency not being realised, older people's increasing (but not unpredictable) needs towards the end of a longer life will continue to overwhelm the system, and greater inequities are likely to occur, unless adequate resources are provided to match the need.[5] [6]

We strongly support the aims of addressing inequities. Further to our comments above, as well as inequities in access to health services, inequities in health status must also be addressed. In the latter case especially, while much can be done within the health system to improve health status, success is significantly dependent on addressing the well-known determinants of ill health

Clearly a review of the health and disability sector alone will not address the former, yet poor health status in some sections of society has a significant impact on the health system and the ability to "improve … health outcomes across the population". We recommend therefore that the review includes recommendations to the Government on illness and injury prevention and health promotion actions beyond the health system as well as within it. This could include acknowledgement of existing policies, and perhaps ways to enhance those policies, as well as new strategies and potential collaborations between the health and disability sector and other sectors, and possibly recommendations for further work in specific health promotion illness and injury prevention actions.

The paper suggests that in order to address increasing demand for health services a greater focus towards primary and community-based care is required, while 'maintaining' tertiary care services (we note with concern the omission of both secondary and quaternary care). This appears to be based on two fundamental assumptions which are not supported by the evidence.

There is no doubt that primary care services need to be substantially better resourced to improve access to those services, but the evidence from here and overseas shows improved access and greater use of primary care does not usually lead to reduced demand for hospital services. Secondly, there is an apparent assumption that the current level of tertiary (and secondary?) services is adequate to respond to current demand, which is demonstrably not the case. Given these issues are central to the overall approach taken by the draft ToR, they are worth some elaboration (we will be producing a more in-depth paper examining the evidence on attempts to reduce hospital admissions through illness prevention late this month).

First, Ministry of Health data show acute hospital admissions have dramatically increased over the last seven years despite increased access and use of primary care services. Similar trends have been reported overseas, including in Britain's National Health Service (NHS).[7] [8] [9]

A literature review examining the features of primary care that may affect unscheduled secondary care use concludes: *It is clear that the decision to attend unscheduled care and the need to be admitted to hospital as an emergency are both the product of a complex interaction between individuals, their*

context, the organisation of healthcare, the behaviours of healthcare practitioners and the wider context of society. Further research needs to try to unpack in more nuanced detail the operation of these factors and the complex interactions between them. [10]

Further, international studies indicate wide variation in GP hospital referral rates, with many referrals being deemed unnecessary. Studies relating to referrals from aged care facilities show similar trends. (Building strong integration between hospital specialist services and community-based services is an important way to address this, as discussed further below.)

While greater use of primary health care services should provide more opportunities for illness prevention measures, the evidence from New Zealand and overseas shows many shortcomings in practice. A report from the Grattan Institute in Australia, for example, noted in 2016 that only 30% of patients attending GPs have their cholesterol adequately managed; less than 20% of people with high cholesterol who see a GP reach recommended cholesterol levels; less than 30% with high blood pressure who saw a GP had it adequately controlled.[11] [12]

The evidence shows significant changes in policies and improvements in practice are needed to overcome the barriers to implementing effective prevention measures in primary care. A Dutch study identified 41 such barriers, many of which are cited in other studies, including lack of resources, heavy workloads, attitudes of patients, attitudes of practitioners, lack of evidence for the long-term-effectiveness of some prevention programmes, lack of skills, and disincentives in funding and payment arrangements, among others.[13]

Failure to recognise and attempt to address these barriers in primary care prevention policies is behind many of the shortcomings identified in those policies. One recent English scoping study on health promotion and disease prevention in primary health care wrapped up saying: "Based on our analysis we conclude that there is insufficient good evidence to support many of the health improvement interventions undertaken in general practice and primary care." 'Health Check', the National Health Service flagship for illness prevention in primary care in England, has been found wanting in studies published in the *British Journal of General Practice*. Subsequently one commentator has considered the scheme 'unfit for purpose' as it is inefficient at case finding and lacks an adequate quality-assurance mechanism to ensure subsequent treatment is effective.[14] [15] [16] [17]

With regard to the second point concerning the adequacy of hospital services to respond to current demand, the evidence shows hospital services are have been under sustained and increasing stress and are not meeting many people's needs. This includes:

- A survey of nearly 1500 public hospital specialists in which 50% reported symptoms of burnout.[18]
- Surveys of DHB clinical head of departments indicating significant specialist shortages across most specialties.[19]
- A public survey in which 9% of respondents reported an unmet need for hospital care.[20]
- A study showing New Zealand's cancer survival rates have fallen well behind Australia's.[21]
- Commonwealth Fund reports showing New Zealand ranks poorly against other comparable countries on access measures such waiting times for elective surgery, for first specialist appointments, and for treatment after diagnosis.[22]
- DHB data showing long delays for people to obtain a first specialist appointment.[23]

- Ministry of Health data showing many people needing hospital treatment fall below District Health Board treatment thresholds.[24]
- New Zealand and Australian data showing the number of surgical procedures performed in New Zealand per head of population is well below that of Australia.[25]

Unless these pressures and shortcomings are addressed, we do not believe the review will achieve its goals of improving the performance of the system. The current bottlenecks to accessing hospital care would continue and most probably become worse, which would in turn increase pressure on primary care services.

Just as there are multiple factors associated with implementing effective prevention measures, the health literature shows the same applies regarding increased acute hospital admissions, which requires multifactorial responses. In general, the evidence points to a 'systems approach' being required to reduce pressures on hospitals. This recognises the complex adaptive nature of the health system and the need to view it as a complex whole of inter-related and inter-dependent parts rather than as a group of separate entities. The quality of the interaction between these parts is a critical factor.[26] [27] [28]

Common themes identified as helping to contain increases in hospital admissions include better integration between primary care and social services and between primary and hospital care; continuity of care; and more effective hospital discharge programmes. Context is also important: interventions for certain groups of patients may not necessarily work for others and a collaborative, multidisciplinary approach across clinical settings is needed to devise the appropriate responses. This is especially so for the growing number of dependent older people with multi-morbidity either being cared for at home or in aged care facilities.[29] [30]

As mentioned above, strong integration across secondary and community-based care is important in reducing increasingly unnecessary hospital referrals due to a range of factors including higher patient expectations and pressures and GPs' perceived deficiencies in medical knowledge. Greater collaboration between specialists and GPs is also becoming increasingly critical for ensuring diagnoses are not delayed, especially recognising the increasing prevalence of complex, interacting multiple co-morbidities and undifferentiated symptoms in patients presenting in general practice.

Notwithstanding the challenges in introducing more preventive measures while attempting to keep up with immediate needs, strengthening prevention is a no-brainer, as is adapting services better to manage increasing chronic illness. The 'Canterbury Initiative' focuses on the continuum of care between community and hospital. It is recognised internationally as a stand-out model in this respect. As the King's Fund has reported, incremental moves to better integrate hospital and community services over the past decade have led to more services being provided in the community, and reductions in acute admission rates, average length of stay in hospital and readmission rates for both elective and acute surgery.[31] [32]

The changes in Canterbury DHB have been the result of collaborative working, relying on system leadership, and strong relationships and staff engagement across the health and care system. The changes required significant investment in staff training and development, investment in new technologies to support them to innovate, and giving them permission to do so.

Notably, the process involved many different initiatives developed and implemented over a number of years 'from within, by empowering clinicians and others who are prepared to take responsibility for changing the way things work, instead of seeking to drive change through external stimuli…' Clinical leadership was 'not focused on just a few heroic individuals in formal leadership roles,' but was shared and distributed as a collective responsibility.

The operating environment at the Canterbury DHB has been far from perfect, due in large part to the pressure brought about by years of under-resourcing, but its successes reinforce the whole-of-system approach centred around the needs of patients, rather than viewing 'primary' and 'secondary' care as separate entities.

The current system

Further to the above, the whole system needs strengthening, not just primary and community-based care.

There is no recognition of the long-term shortages of specialists acknowledged by Health Workforce New Zealand (HWNZ) as impacting on the "workloads, wellbeing and productivity of DHB-employed senior doctors".[33]

We do not believe there is a need to restructure the hospital system or the DHB system. The size of DHBs is appropriate for their objectives stipulated under the New Zealand Public Health and Disability Act 2000. Any attempt to decrease the number of DHBs, as has been suggested by various commentators over some years, including the Minister of Health, would in our view have the effect of distancing the organisations from the communities they serve and would create a highly time-consumer and politically fraught distraction when there are far more pressing issues to address. Flaws in the population-based funding formula are the main weakness in the DHB model but this requires only a fine-tuning of the formula, consideration of replacing the five yearly census data with PHO enrolment data, and measures to make the formula process more transparent, which could be addressed immediately rather than waiting until the review is completed.

We agree, however, that the small business model in primary care has significant shortcomings that need addressing in order to meet the expectations of an accessible universal health system, including 'after-hours' access. Alternative arrangements should be considered, such as encouraging as an option DHBs to directly employ salaried GPs, as is currently the case in some 'hard to staff' parts of the country.

Scope of review

On the whole we support most of the suggested broader topics for recommendations to the Government.

However, we believe strongly that to be positively transformative the primary focus needs to be relational – at every level – rather than structural. There is much potential for improving the efficiency and effectiveness of health services through a relational lens. Accordingly, in addition to the topic on health status equity discussed above, we submit the topic:

Whether the health system is operating in the most effective and efficient way, with a particular focus on implementing evidence-based models of service delivery, including distributed clinical leadership, integrated care between secondary and primary services and other community-based services, and networking between DHBs, sub-regionally, regionally and nationally.

Further, recognising the mounting international evidence that genuine patient-centred care can address many of the challenges policymakers around the work are grappling with, aside from being a laudable objective in itself, we submit the topic:[34]

How to develop a genuine patient-centred care approach in all health and disability services, recognising the evidence supporting strong collaborative relationships between patients and the health professionals caring for them, and the evidence showing that for patient-centred care to be realised, the needs and wellbeing of those providing the care must be addressed.

Finally, given the health and disability workforce is the sector's most important asset and accounts for a large slice of operation expenditure, we see effective workforce planning as a critical issue. HWNZ has been a huge disappointment. We therefore propose a further topic:

How health and disability workforce planning can be improved.

Most of the points that the review would consider in relation to the listed topics seem reasonable and sensible, but we have several comments:

International references should include organisations such as the European Observatory on Health Systems and Policies with its strong connections with the World Health Organization.

If the point about funding relates to some form of pay for performance or contestable funding we would advise a large dose of caution. Our examination of these matters has shown they have little or no merit in the New Zealand context and high risk of unintended consequences.

With regard to investment practices, the Auditor-General has raised question about the quality of investment management and the availability of skills in New Zealand in this respect. This may be useful to consider.[35] [36]

As discussed above, rather than talk about giving primary care greater priority creating a "better balance towards primary prevention", the emphasis should be on developing a wholistic multifaceted approach to reducing demand for hospital care and improving and maintaining people's health. It would involve improving the capacity and access to both primary care and secondary care and implementing policies for real integration and patient-centred care.

We look forward to seeing the final Terms of Reference and plan to make a comprehensive submission to the Review Panel.

Yours sincerely

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EXECUTIVE DIRECTOR

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