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Submission to the Pae Ora Legislation Select Committee

On the Pae Ora (Healthy Futures) Bill

Introduction:

I am a New Zealand born and trained Vocationally Registered (Consultant) General Practitioner who has worked as a rural GP in South Taranaki for 41 years (35 in solo practice).

[1] I support the **policy objectives** of the Pae Ora Bill, noting in particular the emphasis on "all New Zealanders" [-see Issue B (Equity)]. However, I am concerned that the concept of "reducing health disparities" is not used to deny health options to some, because others cannot access them. There should be a principle of lifting people up rather than dragging others down to achieve better outcomes.

As an example, the use of Coronary Artery CT Calcium scoring is relatively new but effective low intervention technique to better establish an individual's coronary risk, but is not publicly funded. Those who are motivated and financially able to have this investigation can improve their health outcome considerably but in doing so are increasing health disparity from those not motivated or financially able to have the screen. Denying the former group access would reduce disparity but also reduce overall health, so reducing disparity in this example depends on cost-benefit-priority decisions on public funding by politicians and/or managers who in my opinion have in recent times shown minimal understanding of where public health money is best spent [-see Issue A (Affordability)].

[2] **Health System Issues** identified by the Health and Disability System review include complexity, fragmentation, lack of leadership and accountability, inconsistent implementation and significant inequities. These issues have been present for some time but more so in the last two decades with the expansion of a corporate management ethos.

My observation has consistently been that the wrong people are making the wrong decisions and that the possession of an MBA has more influence than a clinical qualification. These managers employ more managers and consultants who are more likely to be accountants than clinicians.

My GP colleagues have been bitterly disappointed that Vocationally Registered GPs, the "Specialists" in overall health are consistently not only not included but are ignored by every recent health review and Pae Ora is an example where the importance of primary care is ignored.

[3] In principle I support the **Reforms**, in particular the removal of DHBs, which have in essence been self-congratulating Hospital Boards, as well as the PHOs which have failed to achieve equity for the over 300,000 non-enrolled New Zealanders [-see Issue B (Equity)].

The danger here is that Health New Zealand will take over the failed DHB management system and its non-clinical managers, so we end up with just a re-arrangement of the deck-chairs on the Titanic, rather than a new approach with evidence-based decisions and an understanding that the key to an affordable health system is a quality primary care system [-see Issue A (Affordability)].

I also accept that a Māori Health Authority is an opportunity to provide a Māori perspective and to some extent some tino rangatiratanga, so that failures in our current health system that could contribute to Māori health inequities can be addressed. However, there are concerns about correctly identifying and addressing the determinants of health (and poor health) when it comes to the "commissioning function" of the Authority, as well as dangers of stereotyping [-see Issue B (Equity)].

ISSUES

[A] Affordability

The big political issue in health has always been costs, how much the Government can afford, what the public should pay, affordability of expensive drugs etc. Pharmac has recently been criticised for not funding expensive medications for various cancers, auto-immune diseases, cystic fibrosis etc, while DHBs (and insurance companies including ACC) have limited GP access to modern investigations (CTs, MRIs) and Governments have tried to control patient fees charged in primary care.

Unfortunately, these methods produce adverse health outcomes for many patients, drive up expensive secondary and tertiary demand and have resulted in a health workforce overloaded with managers and very light on General Practitioners. Low or no fees actually reduce access as low GP numbers often cannot meet the higher demand and so more people attend EDs.

There is good evidence that improved primary care (prevention of poor health, early detection of disease and management of disease in the community) reduces the need for expensive secondary care. While the main determinants of health (maternal education, housing, employment, sanitation etc) are outside the scope of General Practice, there is also good epidemiological evidence that countries with low GP to Specialist* ratios have poorer health and higher health costs compared to countries with high GP to Specialist* ratios. [*not including GP specialists]

Unfortunately, there is nothing in these health reforms that addresses this issue of improving primary care (apart from removing the failed PHOs). **The most urgent problem for the New Zealand health system is to address the critical shortage of GPs**, traditionally managed by

exporting our best to Australia while importing doctors from South Africa. Even if we resume importing doctors, the situation will deteriorate with our aging population and as older GPs retire with few NZ graduates taking up General Practice. Luckily attraction, training and retention of culturally safe NZ GPs is not difficult, it is just not being addressed. The basic concepts are:

- Value GPs. This means better remuneration and better access to appropriate investigations and management (based on clinical criteria not type of practice or employer).
- Have a recognised career pathway. This means proper specialist recognition of the 11 year training pathway it takes to become a vocationally registered (Consultant) General Practitioner with higher remuneration (including ACC and any other public subsidy), unrestricted appropriate prescribing and test ordering etc. At present a Specialist GP has very little advantage over a newly qualified (untrained) doctor or one trained in a different scope (like a rural hospital specialist), or even a Nurse Practitioner or other generic "Health Professional", unlike other countries where GPs are respected.
- Remove bureaucracy. GPs are responsible to their patients and clinical standards are the role of the Medical Council and the RNZCGP, not DHBs, PHOs and soon the to be Health New Zealand. Just look at the multiple hoops General Practice had to jump through in order to provide COVID vaccinations when it could have been easily rolled out like all other vaccines along with a simple IMAC update course.
- Sort out GP remuneration / subsidies. Currently capitation has fallen well behind inflation and for non-capitated (non-PHO) services, GMS and Practice Nurse Subsidies are 30 years out of date. GPs are currently calling for a "General Practice Summit" with the Minister of Health to stop the sector collapsing and to get clarity for the future. Pay equity for Practice Nurses urgently needs recognition (in their capitation or Practice Nurse subsidies). Unfortunately, all that is happening are some DHBs setting up their own expensive low fee General Practices using money denied existing efficient General Practices making General practice even less attractive.
- Avoid a "one size fits all" approach. Some GPs want to be employed, others self-employed, some prefer solo, some group practice. Forcing independent GPs to fit a mould risks losing even more GPs.
- A third Medical School aimed at producing rural GPs must not be seen as producing "barefoot doctors". A science based graduate entry should be required to be able to shorten the course and the registerable degree must be equal to an MBChB. Graduates should not be called GPs until they achieve their Fellowship of the RNZCGP.
- Ensure General Practice advice into health policies. In my opinion, every health review and every health commission / authority should be required to have two vocationally registered GPs (NOT PHO managers), one nominated by the RNZCGP and one from the GP Council of the NZMA to give a balanced clinical and primary care focus to health policy. I am sure that there will be plenty of retiring GPs happy to have zoom meetings as they reduce their clinical work load without having to deplete the GP workforce further.

[B] Equity

Apart from Māori health outcome inequities, the most obvious system inequity has been the post-code lottery between practice types in General Practice creating **three classes of New Zealanders**, namely: (1) those in a Very Low Cost Access (VLCA) clinic only paying a token fee (even if they are wealthy); (2) those attending Access practices paying considerably more; and (3) those attending non-PHO practices and Accident & Medical (A&M) clinics, often paying the full fee (less ACC and very low General Medical Services (GMS) subsidies. This practice differentiation is NOT

needs or ability to pay based and it disadvantages the 300,000 plus New Zealanders who are not enrolled in a PHO, often the itinerant, homeless, “off the grid”, high risk people who then use EDs instead of an A&M clinic or attending a GP as a casual patient.

This reform is to ensure healthcare becomes equitable for ALL New Zealanders, yet if after 20 years there are still 300,000 people not enrolled, there has to be at least an alternative to capitation. The simplest way to ensure access for the unenrolled is to significantly increase the GMS payment a GP or A&M clinic can claim (along with a significant Practice Nurse Subsidy) to reduce the pressure on EDs (and the 6 hour wait). **This can happen immediately** by just making the payment more closely reflect the cost of the service as both GMS and PNS remain in place under the Section 88 of the New Zealand Public Health and Disability Act (2000) legislation. The income threshold for qualifying for a Community Services Card (CSC) needs to be raised significantly.

The difference between VLCA and Access practices needs broader consideration and the suggested General Practice Summit should be planned ASAP, not put off for two more years.

Finally, I come to the controversial **Māori Health Authority** issue. This has the potential to create more division rather than improve racial harmony and inclusion in New Zealand as many see it as a form of separatism and racial discrimination. I believe there are three principles that can avoid that divide, while still addressing the health disparity and give Māori a greater influence over their health.

[1] It will be important not to stereotype Māori. Labour MP Willie Jackson was quoted on TV3’s *The Hui* (Newshub 23/11/21) objecting to Māori being treated “like we’re all one homogenous group … We’re not. You know, 60-70 percent of our people don’t want to know about the marae, they don’t want to know about the Māori party, heck, they don’t even want to know about Māori in Labour, right?”

My Māori patients are also very different, some learning or knowing te reo Māori and tikanga Māori, others speak “Maori English” (now recognised as a distinct dialect of NZ English) with little te reo Māori, others are culturally and linguistically identical to non-Māori Kiwis (sometimes labelled “brown pakeha”). Some are well off and insured, others are on benefits but not being in a PHO means the only difference in fee support is the small GMS subsidy the less well-off are entitled to, determined by having a Community Services Card.

A Māori Authority should be careful to ensure any publicly funded / commissioned services are not exclusive to the colour of one’s skin (or to those who can recite their whakapapa), but available for anyone comfortable with tikanga Māori. It should also ensure programs targeting Māori are not marae exclusive otherwise many Māori miss out. Services should also not exclude Māori not enrolled with a Māori provider.

[2] The Māori Heath Authority should identify and then address health issues that disproportionately affect Māori (eg diabetes or smoking) but not discriminate on race in that management. That way more Māori are benefited because of that higher prevalence but affected non-Māori are also helped.

[3] Finally, I believe the Māori Heath Authority should commission more research on establishing the modifiable determinants of poor health affecting Māori as there exists more than sufficient research to show that a health inequity exists. We need to understand what can be done to improve health outcomes. Commissioning programs to address those determinants in a way relevant to those involved or affected is not discrimination whereas funding general services based on race independent of need is.

Overall primary health care funding should follow the need and ability to pay (based on an income threshold updated CSC).

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