Sent: Sunday, 8 November 2015 11:33 p.m.
To: 'nzhs_strategy@moh.govt.nz' <nzhs_strategy@moh.govt.nz>
Subject: Submission: Update of the New Zealand Health Strategy

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1. **Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?**

Yes, there seems to be a lack of understanding that:

(a) most health services in New Zealand are provided in General Practice
(b) there is a crisis in numbers (which will get worse as older GPs retire and Vocational Registration isn't recognised as a specialty)
(c) retention and recruitment of GPs has been largely ignored and
(d) there is a subsequent frustration and anger in General Practice that Government and the MoH listen to PHO managers who do NOT represent GPs
(e) There is a frustration by GPs that funding for low socio-economic groups continues to be via VLCA practices (which include many patients not needing extra funding but happy to receive it) and those low socio-economic patients attending non-VLCA practices are denied that support. This is an even greater inequality (really an inequity) for those attending non-PHO practices and Urgent Care Clinics.
(f) Not all General Practice in NZ is within the PHO system. The "Nz-health-strategy-consultation-draft-part-i-future-direction" paper does note that 95% of New Zealanders are enrolled in a PHO but the strategy then ignores that 5% outside the PHOs.

The questions that should be addressed include:

"How to make General Practice a desirable option for NZ graduates"

"How to support General Practice teams (the GP/Practice Nurse/Receptionist) to provide integrated care". General Practice has demonstrated its ability to successfully integrate with other health providers, pharmacy, laboratory, imaging and secondary services yet these documents seem to inflict more DHB control on services and promote "integration by fragmentation" of services by other groups independent of and/or separate from General Practice.

"How can funding for primary services be better targeted? Should funding be based on Community Service Card holding patients instead of the type of practice?"

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. **Does the statement capture what you want from New Zealand's health system? What would you change or suggest instead?**

There are some excellent aspects and some not so.

[1] "**all** New Zealanders" must mean ALL, not "those enrolled in a PHO" or "those attending a VLCA practice" or "those in a particular DHB, Territorial Authority or Area Code" or some other discrimination based on age, gender, race, access to computers. Currently non-PHO enrolled patients are discriminated against both financially and in access to services exclusively provided by PHO funding which comes from population based funding for ALL New Zealanders, not just those in PHOs. It is interesting to see that men (Maori and non-Maori) have a markedly lower life expectancy than women but are generally not seen as a high risk group!

[2] "people powered" is not the best way to run a health service. People do not always appreciate what the scientific evidence is telling us. Each DHB, PHO, etc re-inventing the wheel and pushing their idea of health promotion, disease prevention, running pilots etc is fraught with danger and inefficiency when a central health policy group of health experts (not managers) researching the evidence and promoting health messages nationally (eg on TV) would be more cost-effective.

[3] "closer to home" should mean empowering General Practice and supporting Community Hospitals not closing or downgrading them. It is not always the best option, for instance having one national Neurosurgical Unit instead of the current 3 or 4 units may not be "closer to home", but would be more efficient and allow experienced people to do the "hi tech" stuff. However the on-going physio, rehab etc should be decentralised to the Community hospitals.

Home support to enable people to remain independent in their own homes for as long as possible should not be limited to cities.

[4] "Value and high performance" might sound fine but more audits and DHB / PHO interference in General Practice will not achieve this. Recognition of the value of Fellowship of the Royal New Zealand College of General Practitioners should be the prime gold standard.

[5] "One Team" is what we had, it was called the General Practice Team and was the gatekeeper, referral centre and co-ordinator of primary and secondary services. The introduction of other "teams" bypassing General Practice has led to fragmentation of care and increasing costs without any demonstrated benefit. General Practice should be brought back as the "patient home" and other services involved with patient care should be linked to that home and involve the GP team more effectively.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

Some of it. It depends on the interpretation. We have addressed some of our concerns above.

The basic principle left out was how to fix the inequities and failures of the 2000 Strategy. The huge cost of the PHOs may have reduced cost access for some (but not necessarily those most in need) and people still report cost barriers to medications and access to the GP of their choice. There is no evidence that the PHOs have done anything positive and in the opinion of many GPs may well have reduced retention and recruitment of NZ trained GPs. Had I not stayed independent and not been bothered by a lower income, I probably would have left New Zealand General Practice a long time ago and I remain the only New Zealand trained GP in South Taranaki who didn't leave.

Allowing GPs to practice independently without their low socio-economic patients missing out on Government subsidies is a major correction needed.

There is little point in promoting policies that are not supported by small or solo practice and/or rural GPs.

4 Do these five themes provide the right focus for action?

Not entirely (see 2 & 3)

Roadmap of Actions

5 Are these the most important action areas to guide change in each strategic theme?

Not really. There are a number of half-baked and unproven themes here.

For instance Patient Portals are promoted without any consideration of cost, privacy, access to computers/internet, interpretation and prioritisation (for appropriate bookings). This should not be a cost to General Practice if the GP doesn't find it useful or efficient, or to the state or other patients not using the system. Most GPs are waiting for these issues to be settled and for some competition to bring down the cost.

Integration does not mean having all services under the same roof. How this would be anything other than a bunch of health professionals in a big clinic hardly aware of each other is not addressed. Modern electronic systems (starting with the phone) far outweigh co-location. I can discuss pharmacy issues with the non-co-located pharmacist or psychological issues with the non-co-located psychologist better than if they were in the same building. Specialists make appointments, they don't have patients wandering over from the GP to be seen. Integration is returning to having the GP home as the co-ordinator and gatekeeper to other services including imaging.

Pharmacy prescribing is fragmentation at its worst. Perhaps GPs should start dispensing.

The continuation of VLCA funding needs to end and have funding follow the individual need whichever practice the patient attends. This was one of the worst problems with the population based capitation funding model which this Health Strategy should have addressed.

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions?

Actions should be evidence based and we see very little of this.

There should be a move away from the failed population based model towards individual need models. At the very least there should be more General Practice options to stimulate enthusiasm for doctors to train for General practice and for patients to have better continuity of care with a trusted GP instead of the failed idea that people are happy with big clinics and no continuity of care.