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Tēnā koe Heather

The Royal New Zealand College of General Practitioners (the College) welcomes this review of the New Zealand health and disability system and this early opportunity to share our views on ways it can be improved.

Introduction

*Piki kau ake te whakāro pai, hauhake tōnu iho
When a good thought springs up, it is harvested.*

Our College's kaupapa is to set and maintain education and quality standards for general practice and support our members to provide competent, equitable care to their patients. We do this to improve health outcomes and reduce health inequities.

Improving health equity in New Zealand is one of the College's strategic priorities. We are committed to improving training and professional development programmes to ensure that general practitioners and rural hospital doctors have the capacity and capability to effectively meet Māori patients' health needs.

We are committed to addressing health inequities in all communities. And we have a role to play in ensuring all our rural members can deliver quality primary health care for rural communities.

In particular, the College is committed to lifting general practitioner performance to ensure all patients are provided with the same level of quality of care regardless of ethnicity or location.

The College's focus on health equity is not new; it has been our core message to the Ministry of Health and Parliament for several years. In our submission on the New Zealand health strategy (2015)¹ we commented on the need for an equity focus, we reiterated this need in our letter regarding the terms of reference of this review, and it is a focus of this submission.

For nearly two decades, the Ministry of Health has attempted to create a health and disability system that addresses inequities. Sadly, these inequities still persist, especially for Māori, Pasifika and those with high health needs.

The College agrees with the Ministry of Health's definition of equity, released in March 2019. It states, "*In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust.*"

¹ Royal New Zealand College of General Practitioners. Submission on the update on the New Zealand Health Strategy. https://issuu.com/rnzcgp/docs/2015.12.03_hmb329-15_ltr_to_nz_heal?e=31468747/63081713

*Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes”.*²

We submit that New Zealand needs a health and disability system predicated on delivering equitable health outcomes, rather than the current system that measures success according to performance against activity-based targets.

Our submission outlines what we believe are some of the key barriers to achieving health equity in New Zealand and what we believe is needed to change to overcome these barriers. You will see that we have included quotes from our members to illustrate the system inequities they would like to see minimised or eliminated.

We realise that health inequities are a ‘wicked’ problem, in that there is no one cause or solution.³ However, we firmly believe that having equity as the cornerstone of a health system, instead of at the perimeter, is the first step to achieving an effective health system.

As the largest medical college in New Zealand, we realise we also play an important part in contributing to an effective health and disability system and we view this submission as one of several contributions that ourselves and our members will be making to the panel.

Principles that underpin our submission

We have based our submission on these principles:

- effective primary care is necessary for a healthy population and cost-effective health system;
- health funding should be fair, transparent, and follow the patient;
- it is unacceptable for patient outcomes to be affected by ‘postcode equity’, that is, where patients live in New Zealand should not be a factor in their ability to access the health and disability services they require when they require them;
- the health and disability system need robust national infrastructure to enable it to perform well, particularly, sufficient numbers of vocationally trained medical practitioners and allied health professionals to service an increasing population that is getting older and sicker, as well as enablers such as electronic patient records; and
- New Zealand is a small country with a small population which is currently overburdened with too many administrative organisations within the health and disability system.

Barriers to accessing care in New Zealand

The first step in having a more equitable health and disability system is to make equity a national priority.

As Sheridan et al writes, such a change requires “a commitment to health equity and evidence informed action by people at all levels within the health system, including those responsible for policy, resource allocation, service provision and measurement”.⁴

² Ministry of Health. Achieving equity. <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2018/achieving-equity>

³ A wicked problem is a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize.

⁴ Sheridan NF, Kenealy TW, Connolly MJ, Mahony F, Barber PA, Boyd MA, Carswell P, Clinton J, Devlin G, Doughty R, Dyal L. Health equity in the New Zealand health care system: a national survey. *International Journal for Equity in Health*. 2011 Dec;10(1):45.

In order to achieve health equity, there is a need to develop health services that respond to patients' needs. These services will vary, as different people will need different services to achieve the same positive health outcome. Currently, our members are implementing a range of initiatives in their own practices to meet the needs of different patient groups.

Racism

Racism within the New Zealand health and disability system has been well documented.

At a system level, Came et al's study of New Zealand health contracts found statistically significant variation in the length of contracts, intensity of monitoring, compliance costs and frequency of auditing between contracts awarded to Māori public health providers and Western providers.⁵

One of our members described the impact scarce resources has on the patients and practitioners at their Māori health organisation:

"As part of a small, Māori health clinic which is part of a wider Māori health organisation, our clinic liaises closely with its own pool of community and social services. Many of these are free for patients, which improves access. The clinic and doctors prioritise patient care above many of the fiscal constraints we work within, meaning we often run our consultations overtime, often offer free appointments (especially follow ups), often stay late, and the clinic struggles to make ends meet. The benefits for patients (who as a group are reluctant engagers with the medical system) are obvious, however I am not sure how sustainable our clinic is in the long term".

These findings reflect Sheridan et al. conclusion that work to address equity exists not because of the system, but because of Māori providers and certain individuals within Western practices actively working to address inequities. For any of these initiatives to be sustainable they need to be adequately supported.⁶

"Working with Maori providers in your community helps but working in a different way is not funded. Recently we completed a smear evening with our Maori provider in their rooms [for] about 20-30 women in one night. We ended up working for free as there was no funding for us for this - the facilities were less than ideal as there contracts do not pay enough, a lot of time organising this is also not paid for so what happens usually, nothing and that is why we have inequity... There is no meaningful funding for innovation in general practice."

Under-resourcing and over-monitoring are not unique examples of racism in the New Zealand health and disability system. Jansen et al's study on how Māori experience the health system demonstrates vast differences between Māori and their European counterparts. Jansen writes "despite years of political mandated to improve or eradicate health disparities, Māori still report being less likely to be offered choices at their general practice, to be seen on time, and to be seen within their preferred timeframe".⁷

More recently, the He Ara Oranga: report in the Government Inquiry into Mental Health and Addiction also commented on how the health system fails to serve Māori. "Western model of mental health, enshrined in the health system and legislation, is based on beliefs that are not shared by all Māori and are not always

⁵ Came H, Doole C, McKenna B, McCreanor T. Institutional racism in public health contracting: findings of a nationwide survey from New Zealand. Soc Sci Med. 2018 Feb; 199 :132-139
<https://doi.org/10.1016/j.socscimed.2017.06.002>

⁶ Ibid.

⁷ Jansen P, Bacal K, Buetow S. A comparison of Māori and non-Māori experiences of general practice. NZ Med J. 2011 Mar 3;124(1330):24-30.

helpful...Many Māori pointed out that current mental health services, strategies and policies do not reflect a genuine partnership between the Crown and Maori.”⁸

Pacific voices of the inquiry echoed that of Māori: “Pacific peoples spoke of a lack of quality and described services they found hostile, coercive, culturally incompetent, individualistic, cold and clinical”.⁹ A recent study of morbidity showed that over half of Māori and Pacific peoples’ deaths were deemed avoidable.¹⁰

And for individual patients, Anderson et al’s studies on rheumatic fever also noted that racism and a lack of cultural competency has been a barrier for patients receiving treatment for Māori and Pacific people. “Examples included nurses touching the heads of Māori patients without their permission...and male doctors asking young Pacific girls to expose their chests for medical examinations without family present. Patients explained how such experiences left them feeling scared, vulnerable and disrespected”.¹¹

Recommendations for change

1. Ministry of Health to ensure that the ethnicity of the providers or patients is not a detrimental factor for funding or monitoring any health and disability contracts for service.
2. Cultural competence and cultural safety training are core requirements for all health and disability workers.

Service provision based on geography

The devolved nature of service provision in New Zealand has also led to inequity.

The current system of district health boards (DHBs) and primary health organisations (PHOs) is meant to provide health care relevant to regional population needs. While excellent in theory, the short-term nature of their funding and electoral cycles has combined to create a system focused on short-term successes and activity-based measures, in preference to evidence-based initiatives that build healthy populations, and system and workforce resilience.

In addition, a health and disability system devolved to regions relies on New Zealand having an immobile population. In fact, *Growing Up in New Zealand* reported that between birth and two years of age, 45.3 percent of children had moved at least once, and 38 percent had moved twice or more.¹²

The lack of integration between health bodies means it is difficult for patients to access services across different regions. In addition, different DHBs and PHOs prioritise different services and this can lead to inequitable outcomes for patients suffering from the same disease or disability. We call this ‘postcode equity’; a system that relies on the patient residing in the ‘right’ region (one that has prioritised their disease or disability) to receive the care they need, when they need it.

⁸ He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction.
<https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf>

⁹ Ibid.

¹⁰ Walsh M, Grey C. The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand—a decomposition analysis. *The New Zealand Medical Journal*. 2019 Mar 29;132(1492):46-60.

¹¹ Anderson A, Peat B, Ryland J, Ofanoa M, Burgess H, Malungahu G, Wade J, Spray J, Leversha A. Mismatches between health service delivery and community expectations in the provision of secondary prophylaxis for rheumatic fever in New Zealand. *Australian and New Zealand journal of public health*. 2019 Mar 25.

¹² Morton et al. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Residential Mobility Report 1: Moving house in the first 1000 days.*
<https://cdn.auckland.ac.nz/assets/growingup/research-findings-impact/report05.pdf>

“We have asked the DHB for 4 years to fund long-term contraception services for young women under the age of 25yrs in our area, and despite promises have received no funding or contract. This is a disgrace! In contrast our adjoining DHB is able to offer this to those of our young women that live in their domicile. We have had no sexual health nurse visit this area or our schools for 10 years.”

Anderson et al’s study on rheumatic fever noted the siloed nature of the DHB was one of the barriers to accessing prophylaxis for rheumatic fever, which in turn, assumed static residency of patients. However, many of the families in the study had high levels of mobility, and their mobility coupled with non-integrated systems, was one of the factors that contributed to patients not getting the treatment they needed.¹³

Rural communities also suffer as a result of the siloed DHB system. In He Ara Oranga, rural service users commented that although they understood it may not be possible to have hospital-based specialist services close to home, they felt that DHBs ‘did not appear to collaborate well on a regional or national basis to provide consistent coverage’.¹⁴

An equitable system needs to be an integrated system. Patients need to be able to move seamlessly through DHBs and PHOs, and between community, primary and secondary care. As such, the College advocates for effective integration between service providers and administrative bodies. These providers and bodies also need to be able to share patient information; an electronic health record must be a priority recommendation from this review.

“I would like to see a universal integrated healthcare software system used by all healthcare professionals. It is ridiculous that health data isn’t collated in some way and makes true coordination of services impossible. Such a system would also bridge the gap between primary and secondary services – imagine an in-built messaging system so doctors can easily contact specialists, pharmacists, physiotherapists etc who are involved in a patient’s care”.

Recommendations for change

3. Implement a national system designed to deliver equitable outcomes, supported by cross-party political agreement for the direction of New Zealand’s health and disability system.
4. Implement infrastructure that enables providers at different levels to be able to talk to each other, eg: a single national, electronic health record
5. Review district health board boundaries according to current population health needs and population mobility information.

Cost

Cost is one of the most significant and tangible patient barriers preventing access to health care.

Recent initiatives by past and current governments have improved patients’ access to primary care. With the introduction of the free GP consultations for under-6s, extended to under-13s and then to under-14s, more children visited a GP in 2017-18 than in 2011-12, and the number of children who did not have a prescription collected due to cost has nearly halved.¹⁵

¹³ Anderson et al.

¹⁴ He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction <https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf>

¹⁵ Ministry of Health. Annual Update of Key Results 2017/18. <https://www.health.govt.nz/publication/annual-update-key-results-2017-18-new-zealand-health-survey>.

In addition, the extended access to low-cost general practice visits to Community Services Card (CSC) holders introduced on 1 December 2018 and related initiatives will also most likely mean that more New Zealanders will be able to overcome the cost barrier to access their GP. However as not all general practices are participating in the free or reduced-fee schemes, it should not be assumed that these targeted patients no longer encounter barriers caused by cost.

Despite these gains, high inequities still persist within the system. For example:

- Māori adults and children were more than twice as likely not have collected a prescription due to cost as non-Pacific and non-Māori adults and children respectively.¹⁶
- Māori adults were 1.5 times as likely as non-Māori adults to have experienced unmet need due to cost, and
- cost was almost twice a barrier to accessing after-hours services than non-Māori.¹⁷

While the free under-14s and CSC changes have clearly been beneficial for many patients, our members are reporting a corresponding demand for appointments. The increased utilisation, coupled with too few vocationally registered GPs, nurses, nurse practitioners, kaiāwhina, counsellors and community pharmacists, is resulting in patients having to wait several weeks to see their GP and too few community services available to patients for onward referral.

As New Zealand is facing a shortage of GPs, there is a need for the government to invest in long term workforce planning and training. The government should also focus on encouraging GPs, rural hospital doctors and other medical practitioners to work in rural and underserved communities. From an equity perspective the government also needs to continue working towards a more diverse workforce that reflects the population it serves.

“We need more GPs and urgently! ... We need to remember that every dollar spent in general practice translates to \$6 saved at secondary level.”

“Increase number of trained GPs and nurses. Also, counsellors and psychologists (free or low-cost service) and should be easily accessible when need.”

“Patient population is rising. GP shortage will be an issue in future as many will be close to retirement age. So, training and making the GP work attractive is the key issue.”

Any changes to the health and disability sector cannot be achieved without the introduction of appropriate investment mechanisms – mechanisms that are capable of shifting funding towards models of care which ensures care is delivered equitably.¹⁸ The model needs to ensure that investment follows the patient, rather than the health service or health practitioner. Critical to this new investment approach will be flexibility to enable innovation to ensure models of care are the best fit for the patients they serve.

“15 minutes too little time to develop relationship, trust and really help patients. 15 minutes is a disservice. 15 minutes only allows for one issue – a lot of patients need more than this. The current system only works for a part of the population – the educated, generally healthy, financially stable person. 15 minutes means that GPs are trained to get the patients back for each issue (one issue per consult), this means only the health literate patients who can afford to come back, do.”

¹⁶ [ibid.](#)

¹⁷ Ministry of Health. Primary Health Care. <https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-ratonga-hauora-kua-mahia-health-service-use/primary-health-care>.

¹⁸ Royal New Zealand College of General Practitioners submission on New Zealand Health Strategy 2015. Accessible from https://issuu.com/rnzcgp/docs/2015.12.03_hmb329-15_ltr_to_nz_heal?e=31468747/63081713.

“Cost is a big issue for our patients. 15-minute appointments are too short for high needs patients that rarely interact with health system as it is. It means they have to make frequent visits to the Practice to manage their (usually chronic) illnesses and distance can be a barrier from their home and our Practice.”

“Better targeted funding attached to the patient, not the practice, so that when patients go to different places there is no 'loss' to the practice where they are enrolled.”

In relation to the last point, we note that current funding models in primary care are generally at a practice level rather than at a patient level.

For a practice with a very low-cost access (VLCA) contract, care to all patients enrolled with the practice is subsidised regardless of individual patient need. Similarly, for a practice that does not work under a VLCA contract there is no mechanism available to subsidise services to patients in need of care that they are unable to afford.

“Look at funding models that suit the needs of whānau or cultures that value collectivism, acknowledging this will take longer than 15 minutes. I think this may be achieved by expanding the whānau ora program and funding kaiāwhina/social workers to help patients navigate the health, social, housing systems.”

Recommendation for change

6. Appropriately fund different approaches and resources to achieve equitable health outcomes.
7. Investigate and remedy the current shortfall of vocationally registered general practitioners, rural hospital doctors and other health professionals in order to meet current demand for services, and also to make recommendations to future-proof New Zealand's medical workforce in light of the high numbers that will retire in the next 10 years.¹⁹

Rural inequity

In rural areas, our members also noted that a lack of local health services, not having convenient transport options, and the cost of travelling to access secondary services, were all barriers to equitable care. Fearnley et al. analysed the cost (time and financial) of patients attending rural hospital outpatient clinics and estimated this to be NZ\$182 per visit. Sixty-one percent of survey respondents reported that this cost had a significant effect on their weekly budget.²⁰

“A lot of my patients live in rural areas, and transport issues are a constant barrier. Many patients either do not have the capacity to drive or the resources, and they often miss appointments as a consequence.”

“The most relevant issue that we encounter as a rural practice is the ability for the workers to get time off to come to the practice. Offering out of hour clinics is not clinically nor financially sustainable for small rural practices either, no access to labs, radiology nor after hours pharmacy.”

¹⁹ Royal New Zealand College of General Practitioners. 2018 general practitioners' workforce survey 2018. https://www.rnzcgp.org.nz/RNZCGP/Publications/The_GP_workforce/RNZCGP/Publications/GP_workforce.aspx

²⁰ Fearnley D, Kerse N, Nixon G. The price of 'free'. Quantifying the costs incurred by rural residents attending publicly funded outpatient clinics in rural and base hospitals. *Journal of Primary Health Care*. 2016 Sep 1;8(3):204-9.

“Lack of public transport – even when an NGO in the neighbouring town will see them the patient can't get there – rural public transport or lack thereof is a major issue for health inequality for the poor and/ or elderly.”

Inequities in rural area are further compounded by the lack of clear agreement on the definition of ‘rural.’ Nixon et al. note there have been more than 16 different rural-urban classifications for the health sector.²¹ The most commonly used definitions classify small rural towns as urban, which has meant that people who fall within these small towns are not adequately funded for health care.

The ambiguity surrounding rural-urban classification has ongoing, serious implications for rural patients, particularly those of lower socio-economic groups and Māori. Nixon argues that for Māori these negative impacts are ‘likely to be more than additive.’²²

“I object to the definition of “rural” – I work on the edge of a small city but have patients who live up to 1.5 hour’s drive away. I make myself accessible via the portal and phone triage but want to be supported to do video consultations.”

“Rural GPs not acknowledged as Rural... I am a GP working in a small town and my practice is not considered rural by the DHB and I do not receive any rural sustainability funding.”

Recommendation for change

8. Create and implement a single definition of urban and rural for universal use within New Zealand’s health and disability system.
9. Investigate the mobile, technology-based and outreach services provided to rural populations to gauge their effectiveness in reducing health inequities in those communities.
10. Implement the proposed National Interprofessional School of Rural Health.

Recommendations

The problem of persistent inequities in the health and disability system seems overwhelming. However, we believe a shift in focus to deliberately, systematically creating an equitable system, a system which is focused on and responds to needs of patients, will result in better outcomes for all New Zealanders. The College’s recommendations for a system focused on equity are outlined below.

1. Ministry of Health to ensure that the ethnicity of the providers or patients is not a detrimental factor for funding or monitoring any health and disability contracts for service.
2. Cultural competence and cultural safety training are core requirements for all health and disability workers.
3. Implement a national system designed to deliver equitable outcomes, supported by cross-party political agreement for the direction of New Zealand’s health and disability system.
4. Implement infrastructure that enables providers at different levels to be able to talk to each other, eg: a single national, electronic health record
5. Review district health board boundaries according to current population health needs and population mobility information.

²¹ Nixon G. *Urban vs rural health disparities in NZ. Can we conclude anything from the data?* Presented at National Rural Health Conference 2019, 6 April 2019. Blenheim, New Zealand.

²² Ibid.

6. Appropriately fund different approaches and resources to achieve equitable health outcomes.
7. Investigate and remedy the current shortfall of vocationally registered general practitioners, rural hospital doctors and other health professionals in order to meet current demand for services, and also to make recommendations to future-proof New Zealand's medical workforce in light of the high numbers that will retire in the next 10 years.²³
8. Create and implement a single definition of urban and rural for universal use within New Zealand's health and disability system.
9. Investigate the mobile, technology-based and outreach services provided to rural populations to gauge their effectiveness in reducing health inequities in those communities.
10. Implement the proposed National Interprofessional School of Rural Health.

Conclusion

New Zealand needs a health and disability system predicated on delivering equitable health outcomes, rather than the current system that measures success according to performance against activity-based targets.

As stated at the beginning of this submission, equity cannot be an add on to the health and disability system, it needs to be at the centre of it. A system based on equity will enable decision makers, governance bodies and health professionals to work together to achieve a flexible, innovative, national health and disability system where different people with different levels of advantage can access different approaches and resources to get equitable health outcomes.

We realise that such a system shift will be difficult to achieve, however, we firmly believe that this shift is necessary to improve the poor health outcomes for so many New Zealanders, and we look forward to working with you to achieve this goal.

Nāku noa, nā



Dr Samantha Murton
President

²³ Royal New Zealand College of General Practitioners. 2018 general practitioners' workforce survey 2018.
https://www.rnzcgp.org.nz/RNZCGP/Publications/The_GP_workforce/RNZCGP/Publications/GP_workforce.aspx

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