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Let's put patients before the deck chairs..

There's a lot of talk about the proposed establishment of "Localities" as part of the Government's health reforms. That's probably not a surprise given that the proposal sits alongside a separate proposal to remove the requirement for PHOs. What maybe *is* a surprise, is the fact that there are very few answers to questions such as what Localities will look like, how will they work and, how will they relate to established contracted providers?

I, like many, have been giving this a lot of thought. I've been reflecting on what the problem is that we are trying to solve. The ultimate aim should be, and must be, better health outcomes for New Zealanders. I believe therefore that this is a great opportunity to adopt a real focus on the *needs* of patients rather than perhaps the personal *wants* of some of the sectors organisational leaders.

Let's consider where we can make most difference. The inverse care law [Julian Tudor Hart 1971] is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served. Imagine a pyramid where the bottom of the pyramid represents the bulk of the population (let's say 80%) for whom good health and good access to services is predominantly the norm. Now at the narrow top of the pyramid we see a representation of the 20% of the population whose needs are higher and yet for whom access to the system or the right services is lacking. These theories around health needs assessment are everyday fodder to any health economist, public health specialist and many of the rest of us seeking to serve our communities and who are well accustomed to population health approaches.

Instead of establishing and resourcing Localities to serve the whole pyramid, perhaps we should adopt the well evidenced methodology of stratification of the population to enable a more-bang-for-the-buck approach which focuses on the 20% with greatest need at the top of the pyramid.

How would we do this? Fortunately, New Zealand has a primary care system built upon list-based general practice. We know that where such a system exists around the world it predominantly supports better access to healthcare, better population health, and better whole-of-health-system efficiency. We must not only be careful to protect that bedrock of one of the worlds best health systems, but also further use the significant value of the relationship it creates between patients and their general practice (which should not be confused with their individual General Practitioner).

That relationship of mutual trust and respect would enable each and every general practice to identify those patients at the top of the pyramid (which for some will be much higher than 20% and for some it will be lower) as well as agreeing with each patient what the gaps are within their own personal health needs assessment.

Through our new Localities, we then need to give those patients and their general practice access to the services and support that are currently unavailable or unaffordable to meet those gaps. That might be

extended appointments, a specialist mental health nurse, polypharmacy management, a physiotherapist, culturally sensitive midwifery support, a housing advice worker, or even extra food and heating support. The list is quite probably endless. But it is quite probably very affordable with the sums of money which the Government appear to be setting aside for the reform programme.

This approach would also rightly prioritise high-need Māori patients and their whānau who are, and may well have proactively chosen to be, enrolled with mainstream general practice providers who may not be formally recognised as kaupapa Māori. In many communities across New Zealand, such providers have by far the greatest absolute number of Māori patients enrolled with them. It does not mean their needs are any less and they offer a captive market around which the new Māori Health Authority could work with Health NZ and those general practices to structure the right Locality services and support for.

If we put function before form and focus on the patient, we can achieve great outcomes. We must protect the significant patient and system benefit which is provided by list-based and relationship-based general practice. We must ensure more funding gets direct to front-line services and is not diverted by investment in restructuring intermediate infrastructure that is not directly underpinned by a patient focused approach. Maybe the term Localities is misleading; localities are about places, *communities* are about people.

We only need take a quick sideways glance towards traditional secondary care settings to see the potential impact of a system which does not support or resource its valuable health workforce to provide for the real needs of the 20% of the population that may need them. For example, if we were to see a similar exodus of primary care practitioners into a private market for general practice, the impact upon New Zealand's vulnerable communities and the sustainability of the health system as a whole could be potentially catastrophic. Some general practice business owners and some general practitioners believe we are almost at that point – I hope the reforms are an opportunity to ensure that common sense prevails and our most vulnerable patients can ultimately benefit from the direct support they need.

As ever, GenPro is keen to support our sector colleagues to ensure optimum outcomes are secured from these very high-cost health reforms. We can collectively do that by supporting a patient focus and accepting that many of the deck chairs may have had their day.

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