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Des Gorman: [Greetings in Maori language] Just to introduce myself, I pay respect to the peoples of this land, the [Tanga ...], Maori would know them, to their ancestors and everyone else that's gone before us. That good-looking Queenslander there in the bow tie is me. Dad comes from North Queensland, Mum was a Maori lady, and so I was raised in very much a mixed race environment.

What I'd like to talk about today though, and I must say at the outset that I'm not a general practitioner; I'm a specialist physician. In that context I don't come with a secular interest, but I come with a deep abiding respect for our general practice colleagues. The sooner we stop referring to people like me as specialists and call me a partialist, and refer to our general practitioner colleagues as generalists we'll actually get the balance right. It's a very pejorative perspective we start with.

I'd like to talk about the rationale for a general practice and primary care led health system. I think there is an overwhelming argument in basis of this. I'll give you some background for New Zealand primary health care strategy and what led people to such a typical New Zealand over-response or over-reaction. I'll give you a quick progress report and I probably won't have time today to talk about the way ahead.

So the rationale to begin with, these are the sorts of data that are increasingly been confronting us. This is North American data. If you have a myocardial infarction what is your chance of success? In that community, for every extra GP per 10,000 your mortality falls by nine per cent. In that community per extra specialist per 10,000 your mortality goes up by two per cent. There is a very perverse relationship between specialisation of a medical workforce and wellness. It should worry all of us that the North Americans are heading down a super-specialist path as fast as their health disease industry partners will carry them.

[Unclear] words are denoted in square brackets and time stamps may be used to indicate their location within the audio.

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These are the sorts of data, the graph, as you look at the left hand corner, should worry you. That shows North American trends and specialist choices. You'll see there the one on the extreme left is general practice from 1998 to 2006, the number of North American graduates wanting to train as GPs has halved. Why does that worry us? Because they can steal our graduates who want to be GPs, the very people we want to keep.

Those two graphs on the other side are US Medicare data on the vertical axis are qualities of the health system measured by the frequency of best practice. On the horizontal axis are the numbers of GPs or the number of specialists. The top one there is the number of specialists, showing as the number of specialists goes up the quality goes down. The bottom one shows as the number of GPs goes up, the quality goes up. The reality of my specialist colleagues is we get involved in end of life, low utility, high technology care - that's the nature of specialists - at the expense of low technology, high utility, across life care.

Now this is the good thing, we specialists manage to achieve this at greater cost. What we have now is the number of specialists and GPs in the horizontal scale. The vertical scale is cost per Medicare beneficiary and you see there's a general trend as you increase the number of GPs not only drive to up quality but you drive down cost. Conversely, if you see there the number of specialists, you not only drive up costs but you drive down quality. There is no conflict between a quality agenda and a financial agenda. They are common agenda.

The background of the New Zealand primary healthcare strategy - by the way, it's a reasonable model for you to use - it's the same population essentially as the State of Victoria. New Zealand's got a perceptibly well-funded health system. It's about 80 per cent of the OECD average and that top graph shows you the solid lines are the OECD average spent on health. The dotted line just below it is Aotearoa and those graphs just below refer to survival rates up the year 2000 for European and Maori

males and females and basically the gap in life expectancy between my Maori family and Europeans in New Zealand is something around 10 to 15 years.

That's a bigger gap than the life expectancy between North American Indians and the colonisers of North America. New Zealand is only made to look good by one country; it's called Australia, in regards to indigenous health.

We have 70 per cent of the OECD average of number of doctors per capita. Australia, by the way, is only 80 per cent of the OECD average for doctors per capita. What makes it worse in both Australia and New Zealand is that the doctors are mal-distributed against need, both disciplinary, geographically and also culturally. For example, Maori comprise about 15 per cent of New Zealanders but only 2.7 per cent of the medical workforce.

We are the most reliant country in the OECD on overseas trained doctors. The top graph shows you the origins of nurses, other specialist people and doctors and without dragging you through that graph, what that shows is that 52 per cent of all doctors working in New Zealand today were born overseas. The Australian rate, by the way, is 43 per cent. Unlike us, who export furiously, you don't. You are the epitome of an irresponsible first-world country; you are raping from countries that have a greater need for health providers and you don't give them up. You contribute almost nothing to the global health workforce.

That bottom graph is the one that should give us no cause for comfort: the top line there are the number of training positions in general practice in North America, the bottom line is the number being filled by North Americans. The gap is coming out of our particular communities. We should be very worried about the North American disinclination to general practice.

We should also be very worried about health costs. Basically I've looked at some various costs there, and it's very clear that when Robert Fogel predicted that western health costs will be about 20 per cent of GDP by 2020, I think he's going to be going to be bang on the mark. We're already 4.3 million health workers short

globally. You imagine Australia with 20 per cent of GDP being spent on health and one Australian in five being employed in health, that's untenable, quite simply untenable. To quote Jean-Paul Sartre in this context, the status quo is not a way forward.

So the background of the New Zealand primary health care strategy comes from the middle there, the red bit: reduced recruitment and there was a 25 per cent loss of the primary care health force per annum. Not surprisingly, in hospital based teaching and medical students we had falling income. We had quite significant generational factors and a low level of interest in small business partnership. All of which lead to an ongoing collapse of the primary care sector.

This shows the background in a schematic form; if you look at the top right, what was driving the government at the time was the ideology of an increased community involvement and reduced doctor control, which in fact is the same driver as the clinical governance models coming out the UK. It's interesting that after 10 years there at best you'd give it a mixed report card. Ten years of clinical governance in the UK has not produced the gains that were expected, nor for that matter has this.

So the primary health care strategy resulted in population-based capitation, and the formation of things called primary health organisations. There's 82 of them, they are not for profit, they have community partnership, they have a funding role and they are responsible for quality in education.

It wasn't entirely an unforeseen or unplanned process. There was a trial of capitation in the Waikato region in the 1990s, but what is the overall net result? The net result is an increase in the income for most general practitioners, a significant reduction in their workload, and there is still some general medical schedule benefit persisting but there's not much of it. Most of the general practice workforce is now capitated.

However the primary health organisations formed independent practices associations that either stay as they were, they could stay as independent practice associations or they could adopt a

community governance model and become a PHO, which most of them elected to do. The funding chain is from the Ministry of Health through the absolute nonsense of 21 DHBs. This is a regionalism, this is a triumph of regionalism over intelligence: 21 DHBs through PHOs who then fund either the independent practitioners or the Independent practice associations.

Let's give it a quick progress report. The graph on the right interests me. These are Australian data from Ian McRae. He gave these to just last week at Australian National University and looks at the relationship between GP numbers on the left-hand axis and the Australian fee for service activity on the right. You basically see there is a reasonable argument in Australia that the more doctors you train, the more you put in the marketplace, the more health they'll practice and the more interventions you'll see. That's not necessarily a bad thing, but there is a very clear linkage here between the number of doctors and the services in Australia.

What's happened since capitation in New Zealand, there's been increased income and reduced workload. There's about \$200,000 for urban and \$300,000 a year for rural GPs. In fact where I live on the north shore of Auckland the average general practitioner income is \$340,000 a year. By the way the italicised bits are those that should cause us concern and the non-italicised are positive outcomes. I've written there, no quantitative data in respect to loss of capacity, that's not entirely true I found out last night. The medical council data showed that since capitation the average fulltime GP has gone from 48 hours a week to 42 hours a week. That's six hours per week less, that's 12.5 per cent. That's essentially 250 GPs retired as a result of that capitation.

Now the expectation was that that would be met by nurse practitioners and be met by increased recruitment. There are 50 extra general practitioner registrars in training, so they are certainly not going to make up for the 250 GP loss. One of the great failures of the primary health care strategy has been the

inability to replace the doctors with nurse-led clinics. There are a number of reasons for that. Our encounter groups with the nurses over the last few months are showing the following. First of all the nurses believe they're not appropriately trained or remunerated to leave chronic care clinics.

The second thing is that there is a strong disinterest in actually breaking up what is a very attractive employment model where they are home in the morning when the kids go to school and they home in the afternoon when the kids return from school. So there are lots of nurses who are not especially interested in taking on what are more punitive work hours.

The final thing is an indefinable reluctance to lead clinics. The bottom line though is that while there has been some uptake, the chronic care initiatives, the nursing initiatives, has nowhere near replaced the loss of medical capacity. So what the capitation has done, without question, is taken capacity out of the system.

The system has the benefit of being simple and a predictable budget but there are problems in enrolling new people. If you want to establish a novel practice you have to work for three or four months without any income at all until such time as people become registered at your practice and their capitation flows through to you. There are profound population-based anomalies because the rate of capitation depends on your social class and race.

If you happen to be then a rich white person living in a predominately poor brown area, you will do extremely well. On the other hand if you are a relatively poor white person living in a relatively rich white area, you will do extremely badly. So there are significant anomalies because the capitation is on a population basis, not on an individual basis.

The major problem here is that we can see no real incentives for service quality and I won't discuss it today. I'll just put up here the UK quality outcomes framework as one of the many models that may need to be reinserted into the system to drive some incentives around quality.

One of the things quoted by the advocates of the system is there's changing attitudes to business ownership and increased attraction to careers in general medical practice. There's conflicting evidence of that as far as we can see. At the medical school I can tell you the dean of medicine, only one in 10 of my graduates want to do general practice and the reason for that is the role models they see do not turn them on. It has nothing to do with the nature of the practice or the type of patients. They are not attracted to the role models they see and this is the hidden curriculum of professionalism and career choice at play.

There is a shortage of GPs and nurses, and perversely that actually maintains the capitation and the income. There is actually a disincentive to get the numbers up because that would drive the capitations down, so there are perverse factors at play here.

The small business model persists; the fee for service mentality persists. It is still hankered after and there is a very slow and limited evolution of the team concept. We overestimated, or the planners did, bearing in mind that most of this was planned by people who wouldn't know what a patient was it walked up and bit them on the arse. The expectation of teamwork evolution was profoundly overestimated. Not the utility of it, the rate at which it would occur.

There's an argument there is increased patient access secondary to reduced cost. The data I have looked to see that is questionable. One of the things that's very clear is that the doctors have decided that capitation is inadequate for after hours services and the after hours services run by GPs have essentially gone away. There is confusion regarding the priorities, but what do you expect when you have 21 DHBs? The chronic care and educational initiatives really only require an economy of scale, which requires large PHOs to deliver them.

There is a claim that there's been implementation of successful chronic care initiatives for diabetes, depression, congestive heart failure and chronic obstructive pulmonary disease in nurse-led

chronic care clinics. I have gone and dragged the data out; the only convincing data I can find anywhere for anything is reduced HBA1C levels in lipids, so there may well be some increased wellness around the management of diabetes. I can find no evidence to support any improvement in anything else.

As I mentioned before there was this difficult to articulate reluctance for the nurses whom are long term in general practice to take on the leadership roles around chronic care initiatives. I understand the argument they are not adequately trained or remunerated. I understand the argument that it interferes with what is a very attractive employment model, but there's something else as well.

There's persistence of emergent role confusion and in that regard we are getting bizarre situations such as nurses differentiating patients for doctors. If there's a more ridiculous thing than that I've never heard of it. The only justification in my opinion for taking 15 years and \$3 million to train a health provider is differentiation, patient diagnosis and care planning. That you'd train a doctor to do that then get a nurse to do and then have the doctor running a clinic makes no sense to me. That is literally back to front.

This is the sorts of model that some of the PHOs are trying to put in place and I think and regard this as an innovative model, yet of course it's just absolute common sense. You may have a triage nurse at the front door, which may direct some people to a nurse-led chronic care clinic. In the context of an undifferentiated problem, that's the role of a GP: the differentiation. That's why they take so long to train. That differentiation may result in just reassurance, treatment or referral; or it may require referral to a nurse-led chronic care clinic such as a diabetes clinic.

So what score would we give the New Zealand primary health care strategy? I think you'd give it a begrudging B minus. The capitation has resulted in a loss of incentivisation around quality of care, and around practice of care. It's resulted in loss of

capacity. The anticipated replacements of that capacity were over-forecast.

So what is the way ahead? This may seem remarkably medically chauvinist - but of course when you see me you see a medical chauvinist by definition, a doctor-first health planning process - it beggars belief that people are still modelling for future health services without deciding what doctors will do in 2025 or 2030. I just picked up the Medical Training Board report from New Zealand. It is a useless document because it has no vision in it. It's got magnificent modelling, but no vision. If doctors in 2025 or 2030 are sclerosing varicose veins, doing cataract operations, botox injections and so on; you are going to need a hell of a lot more than 3,500 graduates a year.

If on the other hand if doctors in 2025 or 2030 are going to be constrained to a largely cognitive, problem solving domain then you will not need many; but you'll need a large number of other protean, trained-for-purpose health providers of different sorts. So the doctor-first health planning process, unless we decide the role of this expensive, slow to train element of a health provider network, with all due respect, the rest of the plan becomes somewhat guesswork.

There needs to be an affirmation of generalism and this is urgently needed. This is the hidden curriculum in medical education, in other words this is the apprenticeship model that our industrialisation of the health work force has largely destroyed. We need to reconstitute apprenticeship and apprenticeship where there are attractive role models, which will attract people in those areas of high utility.

It goes without saying that sooner or later Australia and New Zealand are going to have to be brave enough to remunerate against need and to deal with the privileged parts of my profession who make a lot of money belting bones with a chisel.

Finally, there needs to be field trials of innovative health provider training. We have been talking about innovations in health provider training for 20 years and it's still talk. The Maori word for

meeting is Hui, and my expression here is there has been a surplus of Hui and not much do-ey. We have to stop taking about innovative health providers and trial them.

Fred Hollows was a Marxist Leninist from the University of Otago, the Australians remember well for his cataract technicians, showed in a limited sense that you could train someone to do a cataract operation. What he didn't do was collect the evidence base you needed to prove to a sceptical ophthalmological community that that's a proper thing to do. So when it was suggested in New Zealand that we train technicians to do cataracts, the surgical response was dramatic and exaggerated because the evidence base was not there to refute that response. We need innovative trials of health provider training and deployment which produce the evidence base to enable a diversification of the health workforce.

So [Maori], I challenge in the name of Jean-Paul Sartre to give up the status quo. [Maori], that means thank you very much.

END OF TRANSCRIPT