

A Prescription **FOR CHANGE**



GARETH MORGAN
& **GEOFF SIMMONS**

A follow up to

HEALTH⁺
CHEQUE



I don't stand for rationing care.
I stand for being rational in dealing
with scarce resources.

◇ Ralph Crawshaw MD (Oregon, USA)



Contact us through our website: www.healthcheque.co.nz

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◇ **Executive Summary**

The book *Health Cheque* was the result of nine months of independent study on the state of our health system. The results were illuminating – our local health system scrubbed up pretty well on global comparison, but it’s clear that there is a big mismatch between the public’s expectations and what the health system can actually deliver. Demand for healthcare keeps growing and there are not sufficient resources – workforce, beds, or money, to keep pace. Some hard calls need to be made in the future to keep the system afloat and make sure care goes to those with the greatest need and ability to benefit.

Health Cheque asked questions about the future of our health system but did not explore in detail the changes that need to be made. That task is left to documents such as this *Prescription for Change*, which sets out three areas for change.

Prescription One is Managing Demand – reducing the pressure for more treatment, particularly where that treatment yields little in the way of health benefits. This is one area where Government policy is currently not focused.

There is a need for a stronger focus on the prevention and management of chronic diseases to keep people out of hospital. Once in hospital, patients need better information on the downsides of medical treatment, particularly on the appropriate balance of treatment and care at the end of life. The use of user charges could also reduce the demand for treatment.

Prescription Two is Rational Prioritisation – where should we focus our limited healthcare workforce and budget? The Government is making some changes here by asking the National Health Committee (NHC) to advise on new technologies. This is a step in the right direction, but should go further.

In our view the NHC should be a substantial, independent body that oversees all changes to healthcare spending with input from health professionals and the public. Independence is crucial to avoid political meddling and improve outcomes for the public.

Prescription Three is Greater Efficiency of Service Delivery – we need new ways of delivering healthcare, particularly in provincial areas. Hospital treatment is becoming increasingly specialised and expensive, so our old model of a fragmented hospital sector has become an extremely expensive way to deliver services. As well there are now more ways to help keep people out of hospital. Health professionals should re-design delivery of common treatments in their region. They should develop consistent ways of treating common conditions, reducing waste, duplication and variation in care.

Staff time or resources freed up could be reinvested in that treatment area, allowing a focus on the truly complex cases. Facing up to the consequences of delivering healthcare services in some of the old ways – a hospital on every corner – is critical to capturing the benefits from technological and medical practice advances. Such change requires trust, and the agreement of staff and administrators to monitor outcomes, not inputs.

This document summarises the lessons from *Health Cheque* before looking at three areas for change, and finishes with what is unique about this Prescription.



◇ **Summary of Lessons from *Health Cheque***

Health Cheque set out some principles for what our health system should try to achieve, and some problems with the current way of doing things. These are summarised below to provide some background. For more details on the book see www.healthcheque.co.nz.

Principles

- i. There will never be enough staff or money to resource all healthcare demands, which are growing faster than our ability to meet them.
- ii. The purpose of our health system should be Longer, Healthier Lives For All.
- iii. Given a limited budget and workforce levels, spending should be focused on getting the greatest improvement in our collective healthy years of life.
- iv. Some form of prioritisation/rationing for health spending is unavoidable.
- v. Individuals are responsible for aspects of their own health that are within their control, and the health system needs to reinforce this responsibility.

Problems

- a. Healthcare costs are rising far faster than our national income, and the supply of staff is constrained.
- b. The additional benefits obtained from constantly rising spending appear to be small – because the supply of staff is constrained, additional funding simply lifts wages.

- c. At the margin there's a bias for the system to deliver expensive new treatments, without full evaluation of whether these are better bang for buck than investing in further improvement in the delivery of simple, tried and tested procedures.
- d. Current healthcare spending priorities are determined by politicians, the media, pressure from interest groups, and by doctors focused solely on the well-being of the patient in front of them. There's a distinct lack of evidence-based 'whole of nation' prioritisation.
- e. There is a tendency to focus on treating the urgent cases, rather than reinforcing the incentives for prevention and primary care. This leads to more money spent on the elderly than on the young, amongst other problems.
- f. Often we continue to treat the dying when perhaps we should do more caring instead.
- g. There are huge gaps between the health of Europeans on one hand and Maori and Pacific Islanders on the other. This highlights a failure of prevention and early intervention measures with these groups.
- h. We have an aversion to policies that might arrest the continual rise of chronic conditions because they impinge on commercial interests or are seen as creating a 'nanny state' (e.g. alcohol and poor quality food).
- i. There are barriers to innovation in work roles, which restrict productivity gains.
- j. The health system is better at treating one-off problems, rather than managing ongoing chronic diseases (which are on the rise).
- k. There are often poor relations between hospital administrators and staff.

These are the issues that threaten the future viability of our health system.

Ongoing change is needed, and we are recommending three broad areas to begin this change: managing demand, rational prioritisation and improving service delivery.



◇ Prescription One: Managing Demand

Demand for healthcare has risen far faster than the resources in the health sector – be it staff, buildings or money – can match. There are a variety of reasons for the shortfall between supply of health services and demand for them. Patients are demanding (and doctors are supplying) more treatment for the same condition. The population is ageing and a large proportion of spending occurs in the last years of life. A major cost driver is expensive new treatments which tend to increase the demand for health services. Improved technology is also keeping people alive with conditions that need ongoing management. This growing demand needs to be managed alongside any attempts to improve the supply of health services, without an impact on the equity of health outcomes. In our view the Horn Report and current Government policy is not addressing all of these future challenges, particularly at the end of life.

Patients should be provided with better information on the downsides and risks of every medical treatment, particularly at the end of life.

Modern medicine cannot provide limitless cures for all. No treatment is guaranteed to improve a condition and may indeed make it worse. Providing more information on the effectiveness and downsides of treatment will allow people to make an informed choice about what treatment they want to receive. Potential downsides include limited effectiveness, side effects and even the potential for medical mistakes. Better monitoring of outcomes will assist in providing this information (see Prescription Three).

This is particularly important around end of life situations, where we often continue to pursue treatment (trying to cure the condition) when care (helping the patient deal with the condition comfortably) might be more appropriate. A public conversation is needed on this issue, as well as a shift in the culture of health professionals and patients' families. We must start to talk about what the patient values, for example whether it is worth attempting resuscitation if there is a high risk of disability. Switching investment to end of life care looks to be a more viable alternative over more treatment. Communication is the key to managing this and one point of contact for patients could help; perhaps patients nearing the end of life could be assigned nurse 'case managers' who can help them talk through the issues.



◇ *Example:*

Decision Aids in Canada and United States

This approach has been trialed in Canada and the United States using tools called decision aids. Decision aids increase patient knowledge, reduce uncertainty and make them more realistic about the treatment. On average the patients using decision aids opt for more conservative, less invasive procedures in around one quarter of cases, with no impact on satisfaction.

In other words, fully informed patients actually request less treatment than uninformed patients. This also applies to end of life situations, where enhanced communication has improved patient and family satisfaction, while reducing the demand for treatment.

Responsibilities for cost-effective prevention issues right across the public sector need to be clarified and resourced.

Currently the health system is focused on the treatment of disease. The scope for better returns from investing in the prevention of poor health is substantial.

For example;

- ◇ US evidence points to a 4:1 return (in terms of quality adjusted life years gained) from investment in prevention and primary healthcare, as compared to hospital treatment.
- ◇ The Wanless Report in the UK projected that fully engaging the public in their own health could reduce healthcare spending by 2% of GDP by 2022.
- ◇ NZ projections suggest that investing \$60m pa now on diabetes prevention could save \$370m pa by 2021. This is the other point about prevention – it is more expensive now, with a long pay back period (beyond the electoral cycle).

This is a glaring omission given the many societal factors that can have an impact on our health, such as housing, urban design, education and alcohol and food consumption. The need for a public voice to counterbalance the considerable corporate investment in advertising activities that have adverse health effects is overwhelming. There are two roles here: input into policy making and an independent public voice. These roles need not be provided by the same organisation.



◇ *Example:*

Public Health Commission

The 1990s National Government set up the Public Health Commission to lead a public conversation on health matters that were outside the 'health system' – such as diet, exercise, housing, smoking and alcohol. Sadly they were silenced by powerful corporate lobbies.

Smoking reduction has long been a success story in public health circles. The policy technique to address it was multi-faceted – excise duties, regulation, education and stigmatising the activity. Contrast that to our approach to booze – we've made it cheaper, lowered the drinking age, and celebrate the binge culture as an induction to adulthood. The health sector cost of that negligence is horrific. Adoption of the same approach as was taken to smoking for booze and bad food would lead to enormous health sector savings.

Reduce hospitalisation rates by better prevention and management of chronic diseases and the aged. Chronic diseases have no cure and so need ongoing management. Rates of chronic disease are on the rise. Considerable investment has gone into primary care in recent years with the aim of preventing and managing chronic disease. This has had an impact, but perhaps not as much as the investment would suggest. GP income still largely comes from fees for service, so there is little incentive for GPs to improve the health of their clients and keep them out of hospital. Future investment should move away from universal increases for primary sector health professionals and instead give greater responsibility and funding to those providers that can demonstrate they are delivering cost-effective improvements in the health of their population, and reducing the burden on the hospital system.

This changed funding approach should encourage new ways of delivery with a focus on prevention. Investment in research, evaluation and knowledge transfer will then be needed to identify and encourage further uptake of good practice. Training and capacity building, particularly amongst primary sector leaders, is probably also needed to hasten innovation and the uptake of new approaches. If certain areas have laggards or gaps in coverage, DHBs (District Health Boards) and PHOs (Primary Health Organisations) may need to seize the initiative and set up their own salaried clinics.

Over time, funding should increasingly focus on outcomes so that primary care providers are incentivised to find new ways to prevent and manage chronic disease among high risk patients. Greater use of nurse practitioners, community outreach nurses, dental hygienists, nurses as holistic case managers for chronic patients, peer mentors and even patient self-management are all possibilities. The Whanau Ora model may encourage such a shift in delivery.



◇ *Example:*

Hawkes Bay B4 School Checks

Children from poor families tend to do worse at school. Part of the explanation for this is the higher rates of health problems amongst these children. Many children start school hampered by hearing problems, behavioural issues, and respiratory diseases as a result of poor housing. This was the genesis of the B4 School programme – free check ups for four year olds.

As with most attempts at ‘universal’ healthcare, the key difficulty is in reaching the poorest families, who don’t understand their entitlements and may not trust public sector providers. Hawkes Bay DHB has tackled this problem with gusto, giving some indication to how the Whanau Ora model could work.

In addition to nurses working in general practices, they have independent outreach nurses working in the community. They build up relationships with families, and visit people’s homes to ensure that as many children as possible receive their check. Then they make sure these families follow through with any referrals for treatment or other services that are needed to make sure the child is ready for school when they turn five. This includes giving them a lift to see a specialist, if necessary.

So far this approach seems to be producing results. In an area where half of all babies are born into the poorest 20% of families in the country, they have managed to reach 84% of all four year olds. Half of these have been referred to further services, particularly to receive their dental entitlement. Sure, it takes more resources to reach out to the poorest parts of the community but this is surely cheaper than waiting for them to turn up in hospital.

The incentives to take up treatment need to be leveled by removing the free ‘back doors’ to treatment – ACC and A&E.

Removing free back doors would ensure that people’s behaviour is not altered by price differences, and that they enter the system through the most appropriate route. Any new user charges can be balanced by reducing barriers to care for those on low incomes. This is likely to take time to implement because to be cost effective it will need to be backed up by greater use of information technology in patient management systems.



◇ **Prescription Two: Rational Prioritisation**

Given the numbers of health return for dollar spent, prevention and early intervention is a more efficient way to spend our healthcare dollar – it will give us more healthy life years for every dollar invested. However prevention does not prevent us needing hospitals eventually; pretty much everyone ends up in hospital sometime. But reducing the number of visits we each have to make thanks to better measures to avoid chronic conditions, for example, would be a major saving.

As it stands, not everyone gets a fair go from our publicly funded healthcare system. Currently the squeaky wheels get oiled, rather than treating people in ways that give the biggest increase in our healthy lifespan. Priorities for spending are dominated by many questionable factors including media or lobby group pressure, fickle political and Ministry of Health requests and internal hospital politics. Treatment does not go to the patients with the greatest need and ability to benefit.

Establish an *independent* body to oversee new spending, operating in a similar way to Pharmac.

Where should new funding go within the health sector, and how do we know we are getting the best value from that spending? Our vision is that this decision is based on the best available evidence of where we can add the most extra healthy years of life for each dollar invested. The Horn report proposed that the National Health Committee (NHC) have responsibility for new treatments, but the implementation details are not yet clear. Our concern is that this focus is too narrow, and when

established the NHC will simply be an advisory panel reporting to the Minister. In our view the NHC should be a substantial body with considerable expertise at its disposal, with responsibility for overall changes to spending (not just new treatments), and with independence from political interference. This independence is a win/win – it takes pressure off the Minister of Health to get involved in how money is spent, and offers the public a clear, transparent public sector offer with the best possible health outcomes.

The Minister of Health would give the NHC criteria to make their decision and a dedicated budget. Pharmac and the former Health Funding Authority have already done a great deal of work on criteria which can be built upon. Each year, the NHC would put forward proposals for ways to spend additional healthcare funding, as well as some areas where spending could be trimmed. New funding proposals would include some guidelines to limit the types of patients that are eligible for the treatment, as well as how the service should be delivered to ensure cost effectiveness (e.g. through nurse led clinics). Similar to Pharmac, these proposals would come from health professionals, be informed by the evidence on cost and effectiveness (particularly estimates of Quality Adjusted Life Years – QALYs – gained per dollar spent), with input from well informed public focus groups. All NHC proposals would have to meet the budget and be transparently justified based on the criteria set out by the Minister.¹ Ideally there should be no room for the Minister of Health or others to influence or change the decisions of the NHC. If political approval is needed they should only be able to accept or reject funding proposals in their entirety (see Prescription Three). If the Minister wished to fund additional activity then separate funding would need to be allocated. More information on this process is available in the annex, pages 25-26.



¹ It seems it is difficult to codify all the criteria that humans use to make a ‘fair’ decision and to give them appropriate weighting. In our view, the system should be as transparent as possible but with the ability to alter decisions based on judgement by the NHC.

This approach aims to spend new money in the most effective way across the health sector. This could include agreeing limits to treatments for certain patients, particularly where it is an expensive treatment with very little improvement in length of quality life. This would be achieved by incremental improvements over time – introducing or expanding effective services and trimming ineffective ones.

At the risk of preempting the sort of changes that might take place, here are some possibilities:

- ◇ lower spending on ‘novel’ treatments with an unproven track record;
- ◇ switch of investment toward primary care to help in the prevention and management of key chronic diseases, especially for early childhood, young people and Maori and Pacific Islanders; and
- ◇ boosting some effective, tried and tested procedures.



Prioritisation has been tried before in New Zealand, so we have examples of how it might work. A similar approach was trialled by the Regional Health Authorities in two regions of New Zealand in 1997 for respiratory services. The result was an agreement to invest in smoking cessation, community based clinics and sleep apnoea services. Savings were also identified by improving the quality of prescribing. In general this outcome was positive – new spending was largely directed towards expanding existing successful interventions, largely in prevention and primary care where the greatest health returns tend to be. A new service for sleep apnoea – people who can't breathe while sleeping – also demonstrated value and received funding. This rational approach was turned upside down by the return to the DHB structure; sleep apnoea services are still patchy nationwide despite being clearly cost-effective.

The weakness of attempts at prioritisation is often that people are loath to disinvest in treatments, even when they are shown to be ineffective. One example is treatment after a heart attack. There are two major ways to treat a patient – with drugs to thin the blood or by putting a stent in the artery to prop it open. Invasive procedures such as stents are helpful during the heart attack, but evidence suggests that once the heart attack is over and the patient is stable, these two methods both provide the same amount of QALYs – in other words they are equally effective in keeping the patient alive. Implanting stents is a more expensive procedure, so this means that generally drug based treatment is more cost effective and should be used more. The only problem is that cardiac surgeons have an incentive to use stents, because they are trained (and employed) to undertake the procedure. Such a make-work scheme is very expensive.

Will health professionals act voluntarily to cull this waste? Cardiac surgeons will no doubt argue that their judgement is necessary to tell when a stent is appropriate, and they might well be right. Nevertheless, through the NHC health professionals could agree at the national level the circumstances and patients for which stents are justified. With transparent information on surgeon performance this issue could be monitored for improvements.

◇ Prescription Three: Service Delivery

Rapid changes are occurring in how healthcare can be delivered. There are now many innovative ways to help keep people out of hospital. Meanwhile, hospitals, medical treatments and healthcare professionals are becoming increasingly technical and specialised. This makes the system more expensive to run, and ultimately it makes sense to have fewer, larger hospitals.

However, public expectations are tied to old ways of doing things – a hospital on every street corner. These small hospitals are expensive, they struggle to find staff and when they do they often don't have enough work to keep their staff occupied. Finally, these hospitals cannot offer the full range of services, so often need to pass serious patients on to larger hospitals. This undermines the rationale for local care in the first place. For the services they can offer, they tend to oversupply the local market in order to keep their staff busy. As a result many provincial areas get greater funding for healthcare but provide fewer useful services.

Meanwhile health professionals are often disempowered. They face few incentives to improve ways of working and because so much money is soaked up keeping the hospital network of fragmented, undersized specialist units afloat they can't invest in innovative new ways of helping people to stay healthy. There is little incentive to provide cost-effective treatment, and instead front line clinicians are most concerned to preserve their culture of hypersensitivity to risk resulting in minimal delegation of duties. Finally there are barriers to health professionals

working together across the whole health system. As a result of all this health professionals report considerable wastage, duplication and variation in the current health system. It doesn't have to be this way. Health professionals are highly trained and generally motivated to do the best for their patients. They also make the decisions that have the biggest impact on the cost and effectiveness of medical treatment. They then have the expert knowledge. It's a question of organisational structure – ensuring that as a group they have shown they work out how to deliver health care so that it helps the most people possible. This is true clinical leadership.

Empower health professionals to review the delivery of common treatments.

Why not empower health professionals to design the best way of treating patients within a given budget? This already happens in some areas.

Healthcare professionals could be offered the opportunity to band together in each region to focus on the problems they identify. To ensure buy-in, there would be no reductions in staff or funding within the area – any savings would be reinvested. Each process would receive input from the latest evidence and would be facilitated by the NHC and local DHBs, who would need to set the context and vision for the process. Participants would need some training to ensure all understood the need for the exercise. A cross section of the workforce should be involved for example GPs, physios and nurses. This is important to include a variety of views and ensure the solutions provide value for the whole health system.

This pathway or roadmap would set out how the treatment would generally be delivered, to which patients, to what quality standard, and by when. Once the group has identified the issues, they would be free to implement solutions *within the existing budget*. This process would over time standardise and streamline most treatments, freeing up clinicians to focus on the difficult, complex cases. The clinical pathways could also be built into IT systems as they have been in many successful pilots.

The real challenge in making true clinical leadership work is changing the relationships between health professionals and administrators, moving to an environment based on trust, teamwork and responsibility. The creation of this trust is the much needed cultural change that is often discussed in the sector. On one hand, leaders in the health sector, particularly in the Ministry, have to give up control and move away from input based monitoring. On the other, greater clinical autonomy has to come in exchange for an acceptance of increased monitoring and transparent reporting of treatment outcomes (including patient reported outcomes). There would need to be some light touch, nationally consistent reporting including patient reported outcomes. This information would then feed into the NHC prioritisation process. Health professionals would also need to establish measures which are relevant to their treatment area, and use these to monitor continuous improvement in the quality of treatment.

These sorts of changes are already happening in some DHBs. Health professionals are realising that they need to work together to get the best outcome for the patient with the available resources. The only question is why it isn't happening everywhere in the country.



The Canterbury Initiative encourages health professionals to understand that they function as one health system, have limited resources to deliver the best possible care, and can work together to make things better. Health professionals from across the spectrum of primary and hospital care are invited to work together to identify and improve certain treatment areas. The process aims to agree on consistent, evidence based ways of treating the majority of patients. This reduces waste and duplication and frees up resources to focus on the difficult cases. The health professionals are then encouraged to suggest ways of improving the way patients get treated, which are generally implemented within the existing budget. These pathways are then embedded in IT systems available across the health system so that everyone understands the correct procedures.

Urology was one of the first pilots of this new approach and has earned the trust of administrators to become an autonomous clinical unit. They have a governance committee to oversee their devolved budget, and they have the right to reinvest half of any savings they can generate in their own unit (they also lose half their losses). Now they have hired a specialist manager to oversee opportunities for continuous improvement. Doctors agreeing to hire administrators? Incredible.

This budget approach motivates staff to look for ways to improve delivery. Urology was one of the first areas to train a specialist nurse to lead the pre-admission process, which checks if patients are fit and ready for the operation two weeks prior to surgery. This check also reduces the rate of surgical no-shows and reduces patient expectations of length of stay. This nurse position saved 15 hours per week of doctor time resulting in a cost saving, and also improved the quality and consistency of pre-admission checks due to the specialist nurse role.

Having money to reinvest allows Urology to take up new technology relatively quickly. Digital dictation is a recent example of this, as it improves the quality of typing and reduces times spent on typing tasks. Urology was the first department in the DHB to use this new technology, which will probably now be implemented elsewhere.

Review the best way to provide services in the future.

As the process above unfolds, the most cost-effective way to deliver healthcare will become clearer. Administration and capital spending could then be reorganised around new ways of delivery. To use the famous cliché, *form follows function*. For example once this process is completed it is likely that the number of DHBs could be reduced to four or five from the current 20.

As health professionals review the public offer in different regions, this will bring together an understanding of how services can be delivered in the future. The public no doubt will be resistant to change because they fixate upon the simple stuff – buildings and institutions rather than services and it is likely that some people will react to changes in their local facilities and think they are ‘losing’ local services. This conversation needs to be carefully managed. If health professionals are involved and can assure the public they will get better care for the given budget then such resistance should be lowered. Education of the public – something best facilitated by transparency – is critical for this transition.

The crucial element will be when health professionals review the delivery of Emergency Department services. This is the heart of the hospital – quick access to emergency treatment. It is a large capital investment around which the rest of the hospital is often based, and it is also the major reason people want a hospital close by. Maternity care is also likely to be crucial. People like to have these services close by for obvious reasons, but with effective outreach and good transport, fewer, larger hospitals should be able to provide more effective care.

The savings from reducing the number of hospitals could be invested in many innovative ways. Greater investment in Information Technology is overdue: individual patient records will help reduce mistakes and duplication in treatment. Investments could also be made in clinical networks and telemedicine to give local GPs specialist skills and access to external expertise.

Technology could be deployed to monitor conditions in the home, supported by an outreach nursing service. Existing hospital facilities in the provinces could even be used in new ways – for example the hospital could become a primary care super-centre, with GPs managing an

emergency triage. There could be some beds provided to allow patient recuperation closer to home.

Getting such a change through the political process would be challenging. This is where we could learn from the United States approach to closing military bases. What they did was to develop a plan for military base closures, which highlighted reinvestment elsewhere, then politicians were offered the option of accepting or rejecting the package as a whole – without room for debating modifications. This moved politicians away from parochial interests and horse trading to view the proposal from the common good. The same could be done here with a plan for hospital closures and reinvestment of the savings elsewhere in the health system.

◇ *Example:*

Kaiser Permanente/ Geisinger

These two American insurance companies give us some idea of what is possible when running a health system. Rather than investing in hospitals, both have invested in keeping people out of hospital.

Kaiser Permanente have a comprehensive patient record which covers primary and secondary care. This IT system automatically flags when patients are at high risk of becoming ill, and assigns them a higher level of care (such as assigning a nurse to regularly visit the patient) to prevent that happening. Hospitalisation rates are one third that of international benchmarks and waiting times are lower, at no additional cost. Kaiser actually has evidence of keeping hospital bills down after investing in prevention. Interestingly their system is completely salaried and doctors can't work outside so there is no incentive for them to overtreat. Kaiser also works hard to educate their patients on the benefits of prevention.

Geisinger services a rural community, similar to much of New Zealand. It does this with relatively few hospitals, by investing in new technology to manage patient health remotely. Outreach nurses are deployed to visit the patient if the monitoring information indicates any risk.

◇ **What is Different This Time?**

Some of the ideas, particularly those raised under Prescription Two, have been tried before. What is different about these proposals that might actually have them work this time? There are two essential differences between these proposals and the changes attempted in the 1990s.

Firstly the reforms of the 1990s tried to introduce competition and prioritisation simultaneously. Getting hospitals to compete proved to be a bridge too far in the health system. Among other things it prevented the health system from working as a whole and in this sector economies of scale really matter, the fixed costs being so high. On the other hand the concept of prioritisation was sound, but has frequently been written off because it was part of the same reform package.

Secondly the attempts at prioritisation during the 1990s tried a mixture of completely bottom up processes involving the general public, and top down autocratic processes based on evidence. While both are important, neither of these approaches is complete on its own. Both are needed, along with a crucial third element. Clinicians are the key drivers of cost in the health system, and yet they were not sufficiently brought into the 1990s processes. Their buy-in and leadership is crucial to make change work as clinicians are the key decision makers on the ground. All that is needed is for their decisions to be at the national level, not just at individual patient level.

◇ **Comparison with Ministerial Review Group (Horn) Report**

Some progress has been made on many of the points raised in this document following the publishing of the Ministerial Review Group's (MRG) report. However the MRG proposals are being watered down as they are implemented. The following table compares the situation pre-MRG, how it appears that the MRG proposals are being implemented, and the Policy Prescriptions recommended in this document.

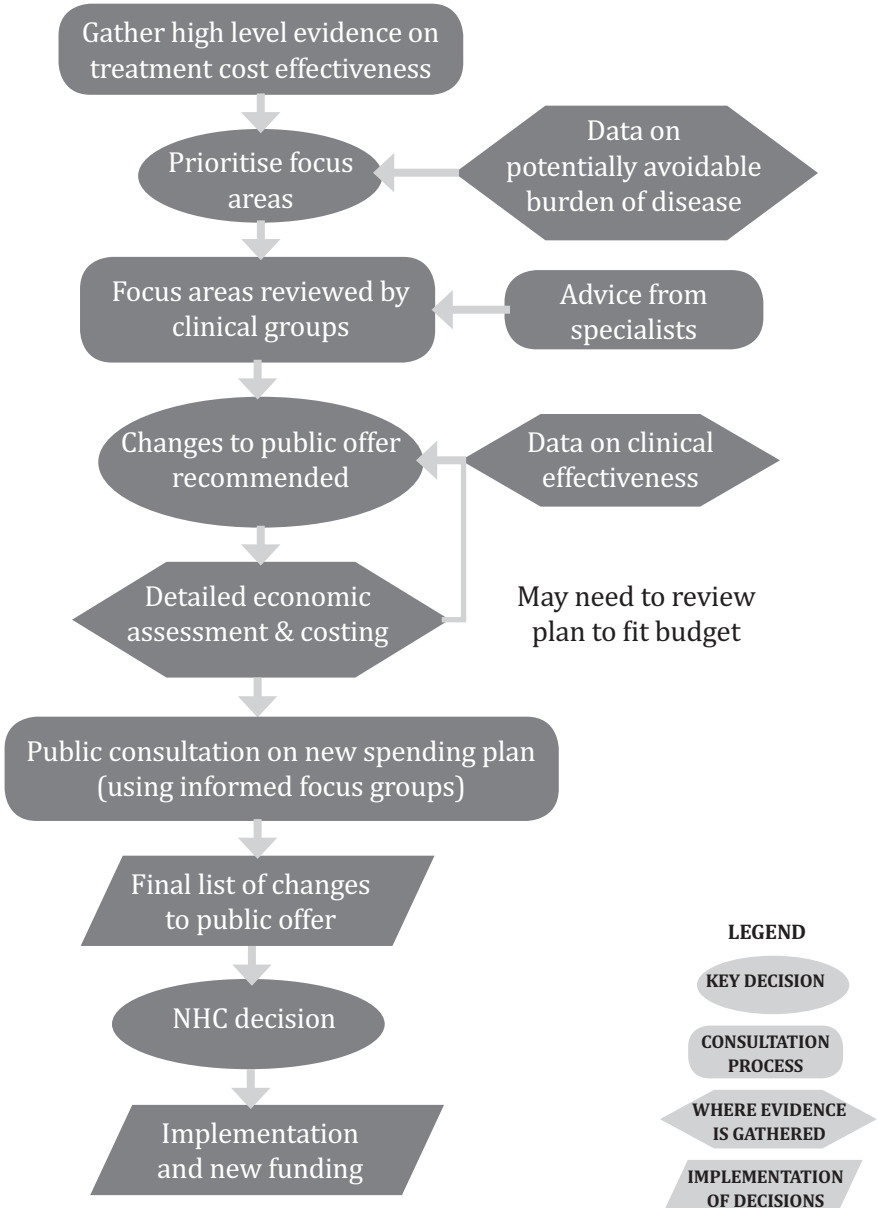
Managing demand is the only Prescription of substantial difference with the MRG proposals. This is due to the MRG's brief to focus on fiscal savings, whereas *Health Cheque* undertook a broader economic view of investing in future returns. Prevention is the most effective way to spend money but it doesn't necessarily save money because people still end up

in hospital eventually. This is why any increased focus on prevention also has to consider restricting certain treatments. The other Prescriptions are slightly bolder than the MRG proposals, and aim to hasten change, include clinicians and clarify Government decisions on key points.

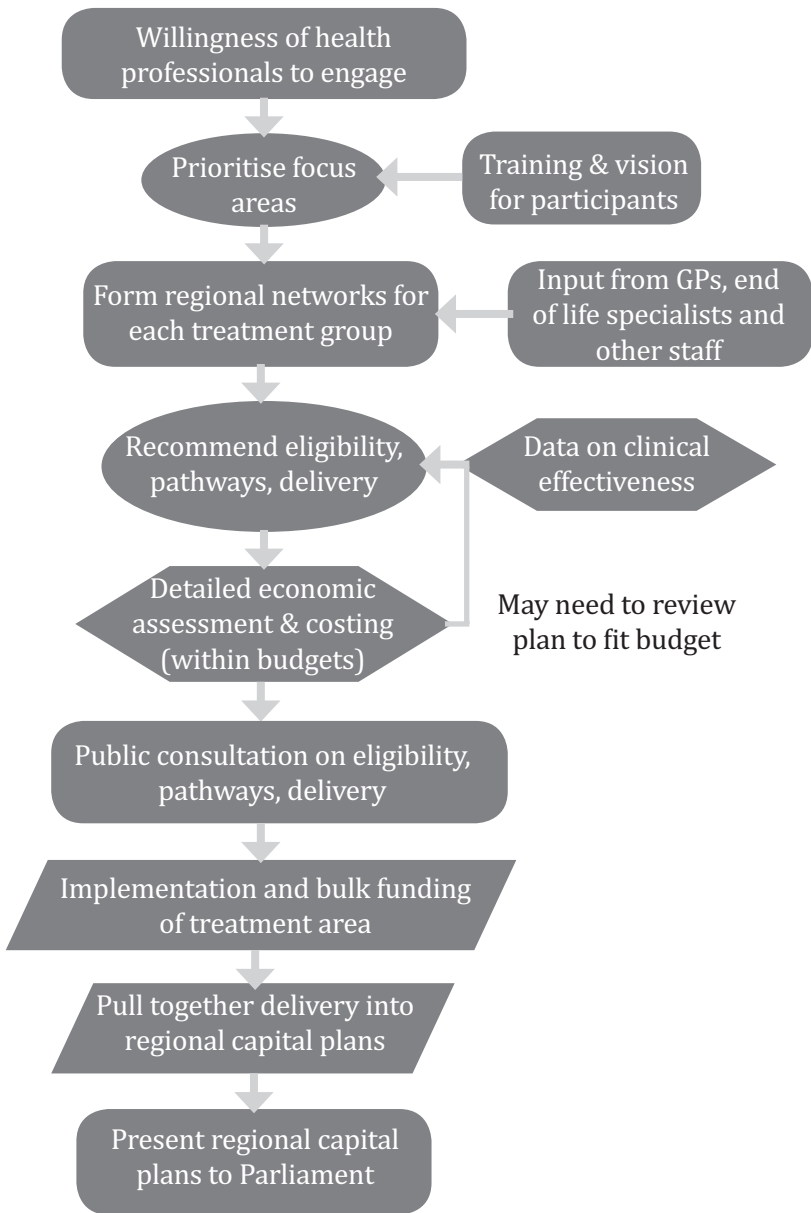
<i>HEALTH CHEQUE PROPOSALS</i>	<i>PRE MRG</i>	<i>POST MRG CHANGES</i>	<i>POLICY PRESCRIPTION</i>
Managing Demand	<i>Various DHB pilots of patient self-management, peer mentoring, telemedicine.</i>	<i>Clarify the role of PHOs. NHB is starting to look at patient self-management.</i>	<i>Information on treatment downsides, especially end of life. Invest in primary care to prevent and manage chronic diseases. Clear responsibility for public health. Review user charges.</i>
Prioritisation	<i>DHB led, with various political, media and lobby group inputs.</i>	<i>NHC prioritises new technology as part of budget process. Not fully independent from Ministry.</i>	<i>NHC is independent from Ministry, heavily involves health professionals and oversees all new health spending.</i>
Service Delivery	<i>Voluntary cooperation between DHBs.</i>	<i>NHB overseeing 'national' services. Require regional plans and structures made up of DHBs. Government can undertake binding arbitration when DHBs don't agree. Supportive of clinical networks. National Quality Improvement Unit (being set up).</i>	<i>Health professionals lead reorganisation of treatments for common conditions. This leads to review of capital requirements. Develop capital plan on that basis.</i>

◇ **Annex – Processes for Prescription Two and Three**

Prescription Two



Prescription Three



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This document brings together the feedback we had on *Health Cheque* from people working within the health sector. It sets out three Policy Prescriptions – three ideas we think can make our health system better.

If you want to keep a first world public health system without taxes going through the roof, then you need to get behind these ideas. It won't be easy, but together these Prescriptions could have a profound effect on the health of our country.

