National Council of
Women of New Zealand
Te Kaunihera
Wahine O Aotearoa

National Office
Level 4 Central House
26 Brandon Street
PO Box 25-498
Wellington 6146
(04) 473 7623
www.ncwnz.org.nz

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Submission to the Ministry of Health on the Future Shape of Primary Health Care

Introduction

Experience and qualifications

The National Council of Women of New Zealand (NCWNZ), an umbrella organisation first established in 1896, speaks on behalf of a wide cross-section of women in New Zealand. Currently, our membership represents women from some 150 societies affiliated through 36 branches spread throughout the country. Our organisation speaks for the consumer and as it is not involved in the provision of services, can maintain an independent apolitical perspective.

NCWNZ has always regarded healthcare as one of its priority areas and has considerable policy in the area. Comments for this submission were received from members of the Health Standing Committee and branch member groups.

Scope of Submission

This submission will follow the format of the discussion document's questionnaire on specific issues for which comments were sought.

Specific Comments

Question 1: Improved Health Status

In general, our members supported increased emphasis on improving the health status of New Zealanders through greater emphasis being placed on primary care services and their role in health education and preventative care. Some apprehension about population-based funding and loss of personal choice was expressed. If we are to avoid creating further barriers and reduce demand on secondary and tertiary health services, there will need to be certain flexibility in accessing primary care services.

Question 2: Affiliation

We offer the following comments:

2.1. Affiliation to one practice/one practitioner is seen favourably, however, procedures for changing affiliation to a practitioner must not be complicated or difficult.

2.2. Mobility of populations and distaste for registering may present problems. For example, some young mothers may have several changes of address during a pregnancy if they experience problems with family members.

2.3. Continuity of care is best achieved by use of agreed care planning with clearly defined responsibilities of both doctor and patient.

2.4. The advantages and disadvantages of a GP choosing to remain an independent practitioner will need to be made clear for the patient

2.5 As an incentive for primary health care organisations to encourage affiliation by patients, fee-for-service payments for casual consultations should be based on a certain percentage after taking cognisance of how seasonal trends (eg a summer/winter holiday resort) affect numbers of casual consultations.

2.6. The criteria for capping health care organisations in each region need to be determined.

2.7 It is not clear whether there is a requirement for primary health care practitioners to belong to a group or organisation in order to be funded?

Question 3: Representation from users, community & practitioners
This was an acceptable theory, however, to achieve inclusive representation, the public will need to see evidence that their views are being reflected in planning and future objectives. Comments made by NCWNZ members include:

a) The need for the aims and objectives of GP organisations to be determined.
b) The frequency and location of representational meetings need to be determined.
c) Facilitation of these meetings is important and it is important that Chairing of such meetings ensures a fair hearing for all.
d) The method of appointment for service user representations needs clarification (e.g. nomination, appointment or self-selection).

Question 4: Services that people need
NCWNZ have already uncovered some concern about the needs assessment of elderly, the criteria applied and the inconsistency of that assessment. The assessment process obviously flows on to the effective provision of services to the elderly.

Question 5: National consistency and affordability
Nationally consistent standards must address issues of rural and under-resourced urban areas. Access and care needs to be provided to the same extent as in more affluent areas.

Question 6: Funding per affiliated population characteristics
Allocation of funding and resources based on regional or district population needs is problematic since it does not recognise sub-regional needs. Analysis should incorporate sub-regional demographics so that specific needs of certain populations within District Health Boards areas are identified. For example, Health Waikato's catchment area has overall, a lower elderly population than other areas in New Zealand. Planning at regional level shows a lesser need for services for the elderly. However, sub-regionally there are districts with high ratios of people aged 65 and over whose needs are not being met. In particular the following comments were received:

6.1 Given the higher costs and time involvement for rural practitioners, additional funding and resource allocation for these practices need to be clearly addressed?

6.2 Whilst many primary care providers are now identifying populations they serve by registration, whanau/hapu affiliation or school-based clinic clientele, care needs to be taken in ensuring that socio-economic status, population age-structures and density of the provider's catchment area are also taken into account, eg. some districts have greater numbers of lower socio-economic status, a greater ratio of usually resident people 65 and over and lower population density.

6.3 Greater demand is placed on primary care services when waiting lists and delays in surgery/ secondary and tertiary health care occurs. For example, delays in hip-replacement surgery involve increased dependency levels, higher use of domicillary services, visits to GPs, increased pain treatments and poor quality of life for the person waiting for the surgery.

Question 7 Greater co-ordination of services between primary and secondary care and other non-health sectors

We support this proposal as an important role of primary health care and believe it highly desirable that not only should there be greater co-ordination of services but also that primary health care organisations should have input into District Health Board policies. In particular:

7.1 There is a need to co-ordinate people whose healthcare involves accessing many different services - perhaps through case management or individualised care plans.

7.2 The return of the Public Health Nurse's role in communities was advocated by many members. Aspects of their involvement were:

7.2.1 Since secondary and tertiary health services are the greatest users of health dollars, district and community nurses should have shared input to ensure continuity of services.

7.2.2 In defining primary health care responsibilities, provision should be made to allow for access to and time with GPs by District nurses to discuss mutual patients.

7.3 Current delays in obtaining referral appointments with specialist services must be overcome.

Question 8: Special relationship between Crown and Maori reflected in service agreements

We support present and developing arrangements between the partnership of Maori and the Crown under the Treaty of Waitangi and believe it best that Maori and their representatives have direct input to these policies.

Question 9: Other issues

Other issues highlighted by respondents included the following:

9.1.Disparities in health status

Comparison of the New Zealand population's life expectancy rates to Canada, Australia and the UK must also take account of the influence the different health status and demographic transition of our Maori and Pacific Island populations have on our life expectancy rates, ie. our Maori and Pacific Island populations are younger, have higher fertility levels and their health status and life expectancy levels are considerably lower than the rest of the population. These determinants skew our national data.

9.2 Demographic & Social factors/Epidemiological factors

Whilst Maori and Pacific Island populations are younger they also have greater prevalence of certain health conditions and have lower life expectancies. Earlier onset of disability/frailty in these subgroups must be recognised and be included in planning future community support and care.

9.3 Barriers in accessing Primary Health Care Services

Whilst it is recognised that Primary health care services are the predominant gateway to our health system, there is a need to address hidden costs that are also barriers to visiting GPs.

These include:

a) insufficient income to cover rent, power/heating and food
b) limited or no public transport services
c) reliance on others for transport
d) cost of maintaining a car
e) cost of child care /sitters for children/other siblings/other and elderly dependants
f) cost of time off work
g) times of day available for appointments
h) proximity of pharmacies/diagnostic laboratories to GPs premises

9.4 Early discharge from hospitals into the community
This often occurs without appropriate education/support/consideration of carer needs and their ability to cope. Negligible 'home care support services' are available if one lives 2-3 hours drive from a town centre.

9.5 Patient education
We applaud the emphasis being placed on health promotion and disease prevention. However, sectors of the population do not have access to computers and the Internet, cannot afford a telephone, do not understand the language of medical care, may be illiterate or not have English as their first language - all barriers that must be overcome.

9.6 Dental Care/Sight and hearing
The impact of dental health and hygiene, impaired sight and hearing on a person's health should not be overlooked

9.7 Disability support
Concern was expressed that budget levels and delivery of care for older people, high health care users and the disabled may restrict their care needs being met or registering with a preferred provider.

9.8 Role of Health Boards
Many of our respondents had concerns about the devolution of service planning to 22 different health boards. How will timely collection and monitoring of national health statistics be addressed to establish health status, health gain, the allocation of resources and planning for future health care needs and services?

9.9 Inclusion and funding for Not-for-profit support groups
Contributions to health care by some community organisations are currently not 'eligible' for funding yet their services reduce demand on funded primary care service. Many informal carers supported by these organisations have greater health risk because of their carer roles. Serious consideration should be given to recognise and fund paid personnel of support organisations providing care, advocacy, support & education to these carers and families, eg Alzheimer's Society, Multiple Sclerosis Society, Parkinson's, etc

9.10 Quality services / Best Practice standards
Clearly defined criteria for quality/best practice standards will need to be established. These should also include:

9.10.1 Staffing levels - Provision for sufficient numbers of nursing staff, cleaning staff etc to be included as a standard.

9.10.2. Monitoring - The need for monitoring standards is paramount. Provision must be made for professional provider practices to be reviewed every 1-2 years to ensure they continue to meet quality/best practice standards.

9.11 Workforce & training
Population based funding of primary health care services needs to include a component to cover and encourage appropriate training and education of their personnel. In addition, national strategies must place greater importance on the appropriate training of adequate workforce numbers to ensure that future demand for certain services are met, eg training to identify and prevent/treat early symptoms of chronic and age-related conditions.

9.12 Maori, Pacific Islanders, immigrants/refugees
9.12.1. Suitably trained care providers - Our members believe that care providers to all ethnic groups must be suitably trained in the care they provide.

9.12.2. Holistic care - The holistic care factors identified as having special relevance to Maori, are applicable to all populations.
9.12.3. Literacy and language barriers
Not everyone is literate. Oral/Aural communication and teaching is essential for these people.
9.12.4. Input from Asian/multi ethnic groups
Asian and other multi-ethnic groups must be included in planning and achieving the desired outcomes for their populations.

9.13 Consultation and surveys
Communities have become cynical about these and need to see evidence that consultation will lead to a negotiated strategic plan and development of appropriate solutions rather than plans that are contrary to their input being imposed on communities.

9.14 Self-help information
9.14.1. All such information must be easily accessible.
9.14.2. Diagnoses, anatomy, physiology, drugs and side effects should be explained in lay terms as much as possible to afford better comprehension.
9.14.3. A range of teaching resources and personnel could be made available to practitioners, eg health care/public health videos and access within the practice to view them, staff available to discuss and establish individual care plans.

9.15 Information systems
Data output from information systems are only as good as the quality of data input. Evidence already exists of data omitted from discharge forms - such omissions compromising future care.

9.16 Addressing health needs of defined groups.
9.16.1 Criteria used in defining groups. It is not clear what criteria will be used to define target groups. If age will be the criteria, considerable duplication of services may occur.
9.16.2 Privacy and personal choice - Members felt that targeting individuals with certain high risk factors may be construed as erosions of privacy and personal decision making.
9.16.3 Setting of targets such as immunisation. - Whilst every encouragement should be given to improving national immunisation rates across all ethnic groups, practitioners should not be penalised for not meeting targets? Despite efforts made, the high mobility of patients in some areas results in practices not being able to achieve targets set.

9.17 Need for stability within health sector
Our membership has expressed concern about the constant restructuring that has occurred in the health sector in recent years. Not only does this affect the general public and raise their anxiety about availability and accessibility of services in their times of need, but it is also very unsettling for the health sector workforce. Each change in management structure appears to waste scarce financial resources, with little demonstrable improvement in the general health of the population compared to other OECD countries. Re-assuring the general public may require well publicised evidence that your planned restructuring will deliver better healthcare for New Zealanders.

In closing, we would like to acknowledge the opportunity to comment on these proposals and look forward to seeing our comments incorporated into the New Zealand Health Strategy.

Barbara Glenie
National President

Elizabeth Bang
Convener, Health Standing Committee