Hon Pete Hodgson
Minister of Health

Speech

1 May 2006
EMBARGOED UNTIL 1:00 PM

The Crisis Syndrome: New Zealand's health debate

Address to the Institute of Policy Studies, School of Government, Victoria University of Wellington

Good afternoon and thank you for coming. Thank you as well to Jonathan Boston and the School of Government for hosting this speech. I want to acknowledge the presence of my parliamentary colleagues, Sue Kedgley, Barbara Stewart and Judy Turner. These are three people who are committed to improving the health of New Zealanders and who are committed to a constructive debate on the future of health in New Zealand.

Like a number of health ministers before me I have deliberately waited six months before giving a speech like this. The reason is that a period of osmosis is needed, and reading, listening and travelling.

I know we don't have anywhere enough time today to cover all the issues that are in front of the health sector. So I must, as they say, prioritise.

I'll begin by restating the underlying values that drive the health system under a Labour-led government.

Then I shall tackle myth number one, that the substantial increase in health expenditure over the past six years is somehow a waste.

That will allow me to take a brief look at the antics of my political opponents and the too-often uncritical reflection in the media. This will explore why and how so-called 'crises' are created – the crisis syndrome.

Then I will return to expenditure, but this time look at cost-effectiveness. Not how much we spend, but how well we spend it.

Electives have been in the news, partly courtesy of the crisis syndrome, and partly because we haven't got it right yet. I shall explore both, including the ethics of prioritisation.

I shall conclude by reminding us of the issues we need to be talking about more and I'll announce my six priorities for the coming financial year.

Today's speech

- Labour-led values are inclusive of all New Zealanders
- Myth busting
- Creating the 'Crisis' myth
- Pride in our cost effectiveness
- Electives crisis meets facts
- Priorities

Values

We are a Labour-led government. Following three elections, Labour has formed governing relationships with the New Zealand political parties that choose to put commonsense ahead of ideology and that are serious about improving the health of New Zealanders.

For our part, Labour believes in a health system that delivers equally for all New Zealanders. We believe that no New Zealand family should ever have to choose between putting food on their table and paying for a doctor's visit for their children.

We believe in the pursuit of efficiency, productivity and innovation so we can deliver more and better health services.

We refuse to separate health from the wider social and economic forces in our country. We focus on the determinants of health – poverty, housing, education, employment, the environment – because we know what drives inequality in outcomes.

We believe a country that is serious about further improving people's health is a country that better get serious about prevention and primary health. And a country that wants to achieve real results in preventative health better have direct community involvement in how health dollars are spent so a genuine population health approach can emerge.

We believe in a health system that is predominantly publicly funded, with a strong core of secondary and tertiary services being publicly provided as well. Around that core of public provision sits private and not-for-profit provision, freely interacting with and needing each other.

We believe in a workforce that is well trained, well motivated, well rewarded and well respected.

We believe in local democracy within the health system.

Most importantly, we pursue improvements in the health of our families because we know that healthy lives are central to the creation of opportunity for all New Zealanders.

These values have been put into action and have delivered not only a significant increase in health spending, but real, tangible improvements in health services.

Myth-busting

That significant increase has led to the development of myth number one. Most of you will have heard it – 'Despite spending billions on health, Labour has failed to achieve any real improvements in the health system.' It is just a myth.

We have undertaken the single largest hospital building programme in living memory with new public hospitals from Kaitaia to Invercargill – and the critics are asking where the spending increases have gone.

We're in the process of rolling out affordable doctor's visits for all New Zealanders with a $2.2 billion seven year investment in primary health – and the National Party says there's been no improvements in health care under Labour.

We provided an historic pay increase to build and maintain our workforce of nurses and other health professionals we employ in public hospitals – and the questions about where the investments have gone continue.

We undertook the largest mass-immunisation campaign in New Zealand's history and have already lowered new cases of meningococcal B by 57 per cent – and we still get asked why more hasn't been achieved in health over the past six years.

And even in secondary care, where the National Party is trying to paint a crisis, we've seen huge increases in hospital activity. Public hospitals are handling 20 per cent more medical cases and a 12 per cent increase in case-weighted elective surgery discharges. And that doesn't count the increase in surgical outpatient procedures.

The flipside of the myth, that it has all been spent on bureaucrats, also needs to be exploded. About 1.5 per cent of health expenditure goes to the Ministry of Health; the other 98.5 per cent goes to those who deliver services. The number of bureaucrats in the Ministry of Health has remained virtually unchanged from six years ago.

National: Brash, Ryall and the crisis syndrome

So, what do we make of the National Party, the key purveyor of myths like the crisis syndrome.

First of all, Dr Brash has been honest. He said without embarrassment that he was putting politics ahead of sound, reasonable policy. In a press statement in October last year when he replaced Dr Paul Hutchison with Tony Ryall, Don Brash said that "sometimes a person who would make an outstanding Cabinet Minister in government is not the best suited to an attack role in opposition."

So a person who understands the health system, but who is not aggressively or acrimoniously misleading has been replaced by another with the opposite attributes. The crisis syndrome follows effortlessly.

Others seem almost unable to resist joining in. A couple of weeks ago two senior medical figures described the public health system as, respectively, "in need of a complete review" and "rotten to the core". Under questioning it became clear that their concerns were limited mainly to prioritisation and efficiency in elective services, a point with which I agree.

Why is National attacking New Zealand's public health system? Nine long years in opposition is one answer.

But the second is that National innately dislikes a public service working well. They have an underlying instinct to privatise or part privatise both the funding and provision of services. So they occasionally stress that the private sector should be used more, for the sake of it, or that part-charging has merit, or that a dominant role for public provision is somehow not the future, or that universality is wasteful.

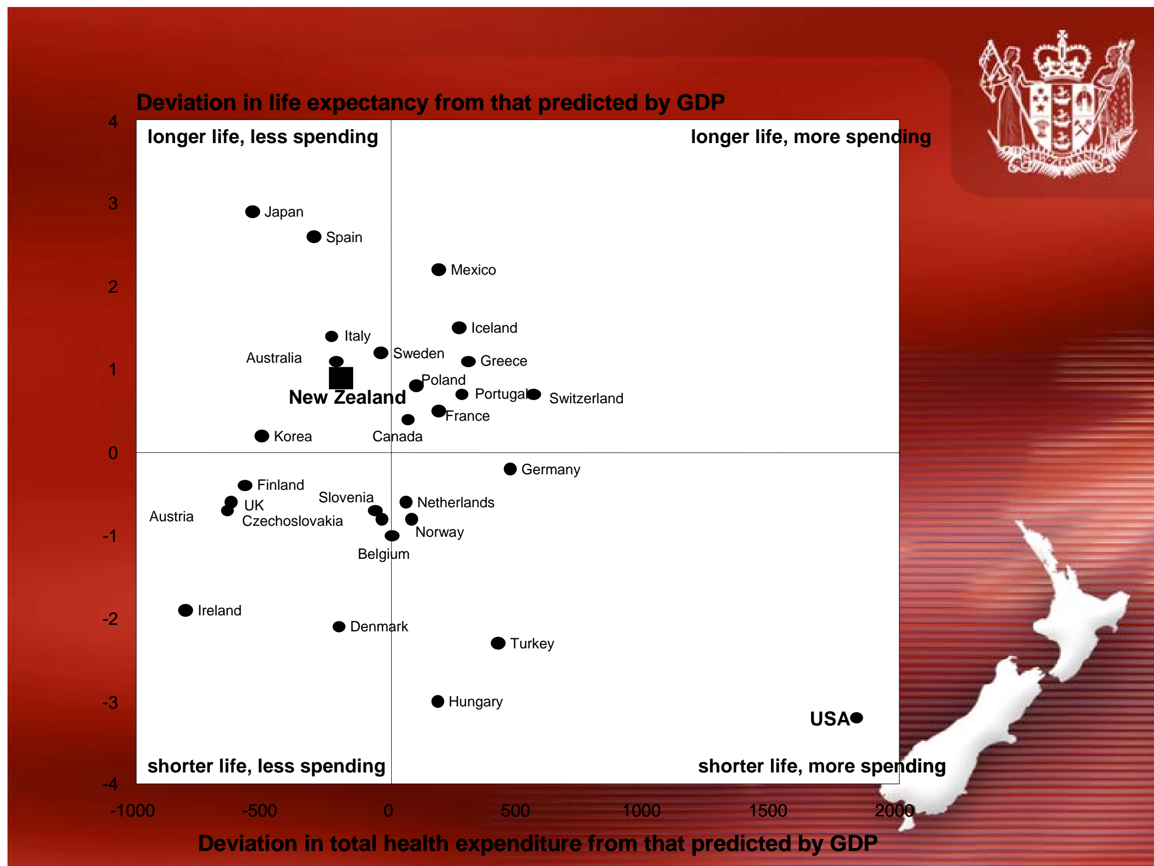
That instinct is not openly aired and for good reason. We tried all that in the nineties. They were unhappy times for both the health system and the then government. National got through five Health Ministers in nine years, and more associates & crown health enterprise ministers than I can recall.

I find it just weird that a party with nine recent years in government and now 6½ years in opposition still hasn't worked out how not to run a health system. The least cost-effective system in the western world can be found in the US, yet it is towards that end of the health policy spectrum that National instinctively glances. Other like-mindeds, for example Australia, simply don't waste their time.

Cost-effectiveness

I won't waste any more of our time either. Let's turn to cost-effectiveness; the question not of how much we spend, but how well we spend it.

The starting point is a paradox. From some public commentary you wouldn't think so, but New Zealand already has a cost-effective system. That is, we spend less and live longer. Take a look at this graph. The caveat is that international comparisons are often inexact, but the top left hand quadrant is the right place to be. The US is miles off to the bottom right and the graph has had to be expanded to fit it in.



So we can be pleased about that. But we must shift New Zealand further towards the top, or top left, over time.

What to do?

Well, what not to do is to ask doctors or nurses to run faster down corridors. That approach was tried in the nineties and didn't work. Resentment and loss of morale are very costly to any health system. The workforce is the system. It is human, it is clever, and it must be valued.

But opportunities for improved cost-effectiveness abound and I want explore a few of them.

Firstly, and perhaps most self-evidently, is dear old government procurement. We buy drugs through Pharmac, and in doing so save about 7 per cent of our entire health budget. That is a huge gain. But we don't buy consumables or

motorcars or communications the same way, and probably we should. Actually we have just begun. With insurance. DHBNZ, the body that DHBs have established to do things that all DHBs want done, has just gone into the market for insurance product that all DHBs may want. It is early days yet, but one can foresee useful gains as a programme of procurement gathers momentum.

At another level cost-effectiveness can be improved, not by less health service, but by more. There is a sentence to be found in the Ministry of Health which reads:

> *Simple, highly cost-effective interventions, for common uncomplicated long-term conditions are not happening dependably.*

I hope you like it. It means, perhaps, that we should ensure we always give a statin to someone who needs it, or improve further our use of retinal screening in diabetes, or improve further our immunisation rates, or our attention to polypharmacy issues.

In short, this sentence reminds us that many of the gains in health are simple. The reasons they don’t occur dependably are complex; they don't occur because to err is human, because systems need continual improvement, because information technology can be better deployed, because we need to continually update clinical guidelines and so on. It is a sentence that is true all around the world, but it is an area we can make further progress faster than many other countries because of our size.

I'll touch on just one other area of cost effectiveness before moving on. It can be called service configuration. In many areas of health New Zealand needs just one of something, or a network of provision across several DHBs, or an agreed approach to avoid a Tower of Babel in information technology. Duplication and inefficient deployment of resources is the enemy.

This is about sensible cooperation, and it is the antithesis of the nineties when the name of the game was not to cooperate, but to compete. Roughly, a more market approach to health reduces cost-effectiveness, as the US so graphically demonstrates. Testing the market certainly has its place; there are thousands of contracts in the health system. Similarly cooperative models need careful attention to pricing and inter-district flows. But generally cooperation improves cost-effectiveness over competition. If you want a one-liner it is that in health the market is a good servant but a bad master.

Electives

Let's now turn to electives, except that I'll begin with acutes. Here is a surprising figure. There are about 620,000 discharges from our public hospitals each year, or one seventh of our population. Leaving aside things like maternity, which is counted separately, about three quarters of the work is acute and about one quarter is elective.

Acutes are all those cases that can't wait – heart attacks, an urgent geriatric assessment, surgery for cancer, respiratory disease, acute psychiatry, a serious infection, a stroke, appendicitis, and all the many follow ups that occur after the initial event.

My first point is to say the New Zealand health system handles acute services brilliantly. Never perfectly, but brilliantly nonetheless. New Zealand is not awash with stories about hospitals turning away patients in need of acute care, or 'ambulance bypasses' as they are euphemistically referred to in other countries. My response is to say thank you to the hospital workforce in New Zealand. They deserve recognition and praise.

But now electives, the other quarter.

The news of recent weeks is that people have been returned to their GP, sometimes in large numbers, because they will not get to see a specialist or have their surgery within the six month target the government sets.

This means prioritisation has not adequately occurred at the outset and that expectations have therefore been raised unfairly. We have to fix that. It is not how the booking system was designed to work. Most DHBs seem to have the right systems in place, but a significant minority do not.

Having said that, there is an assumption gaining ground that sending someone back to their GP must be a bad thing. The opposite is the case. A person who has been transparently returned to their GP knows where they stand, can be assessed by their GP afresh. If their condition deteriorates they can re-enter to the booking system. Many do.

But here is where the surprises start to arrive. Quite a few don't deteriorate. They get better. Because of good exercise or good nutrition or good GP care. Indeed some clinicians are now advising me that about a quarter of all GP referrals can be treated this way. They assert that the key is to further improve the primary/secondary interface. They say that it is often appropriate for specialist opinions to be provided over the phone, or email or from medical records.

In other words you and I may have a vision of a GP referral being a person with serious pain, difficulty walking and in early need of hip surgery. Many people <u>do</u> fit that image but the <u>whole</u> truth is a good deal broader. It also includes a person for whom the GP who would just like a second opinion or perhaps some written specialist advice.

Now of course this direct communication between GP and specialist often happens, but it does not happen optimally. GP liaison staff are amongst those who hold the key to improving this interface and they have begun to make startling progress in some areas.

But the other more obvious reason that referral back to a GP is a good thing is that before the booking system came in they weren't referred anywhere! This was the old waiting list system and people just sat on it. I know of a man who

waited twelve years for his knee replacement. Perhaps that is where the word patient comes from! Putting someone on a list and leaving them there, un-reviewed and unconnected to their GP is not an acceptable way to run an elective service. That is why, under National as it happens, the booking system was introduced, complete with a process to refer people back to their GP if they are not a high enough priority.

What has come to public attention recently is that people haven't been returned to their GP early enough. They were not prioritised at the outset. They were told yes, then later they were told no.

Prioritisation is a necessity whenever there is a resource constraint. We have a resource constraint. It is called a health budget. There will always be a health budget and so there will always be a constraint. Labour has been accused of putting too much money into health, because it frustrates the plans of our opponents to fund tax cuts. We had an election about that just eight months ago, and I am glad for our health system that we won.

But the constraint, at whatever level it is set, still exists. And so we must prioritise people with a greater need ahead of those who do not have as great a need. If we fail to do that then too many people crowd through the front door, the system jams and belatedly some people are sent back to their GP. That is what has been happening recently, and it is not OK.

But it isn't out of hand. One of the recent clutch of 'crises' has been that 8,000 people were returned from elective surgical lists back to their GP, across New Zealand, over a year. For those 8,000 people that is bad news and they are entitled to feel annoyed. But in that same year, another 107,000 people did receive their surgery.

On behalf of those who work in the health sector and who are talking with their patients every day, it must be stressed that prioritisation can be difficult. It is difficult partly because the prioritisation process is hard to achieve accurately, no matter how many tools are developed. But inaccurate

prioritisation is better than none at all and the accuracy has improved over recent years.

Then there is the question of ethics. A health professional may understandably feel it is unethical to prioritise, and ethical only to achieve the best for all their patients no matter their priority. The New Zealand Medical Council disagrees with that view saying, "acting…on ethical principles in an environment of resource limitation will involve health professionals making and communicating prioritisation judgements to the patients…for whom they have duties of care."

The Health and Disability Commissioner holds the same view and said so in a Southland urology case last week. Among the commissioner's findings was that DHBs and individual clinicians have an obligation to prioritise.

So prioritisation matters and failure to prioritise means that sick people miss out.

But that is not the whole story in the public's mind and nor should it be. The public needs to know if we are doing 'enough' elective surgery.

An honest answer is that there is no such thing as 'enough'. In the same way as there are never going to be 'enough' teachers or police. Demand exceeds supply throughout the Western World. The stand out exception is the US where priority is accorded, not on need, but on willingness or ability to pay.

So if we are not getting 'enough', are we getting 'more'? The answer is 'yes', no matter which way you look at it. The only way you can get to 'no', as the National Party has, it to exclude all medical activity, all acute surgical activity, all case-weighting and all outpatient surgical activity. It takes real effort to turn a 'yes' into a 'no', but that is what crisis makers set out to do.

Here is what 'yes' looks like. Since the change of Government, total hip replacements are up 24 per cent, knees 52 per cent. Bypass grafts are down

0.5 per cent, but that is because they are being partly superseded by angioplasties, up 75 per cent. Cataracts are down 17 per cent over our first three years, but up about 12 per cent over the past three years and will rise about another 40 per cent over the next couple of years as the cataract initiative is fully implemented.

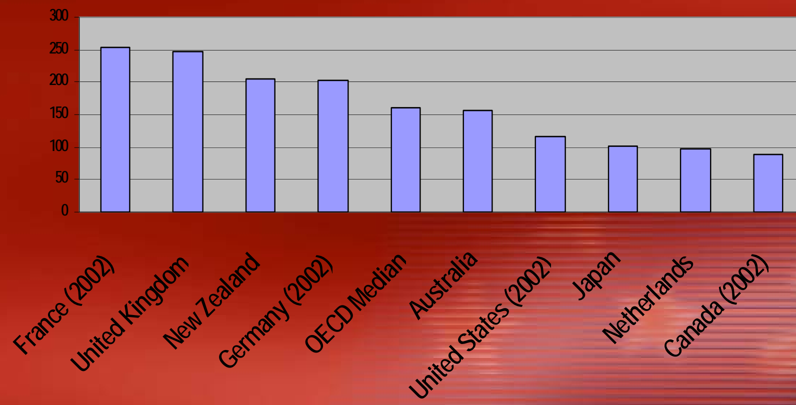
So there is more activity, a lot more. Minor surgery has moved out of hospital theatres over recent years but our information systems haven't tracked it. From 1 July we will progressively be able to add the increasing number of outpatient surgical procedures to the totals.

But even though we know electives volumes are up a lot under this Government, it still doesn't answer the question "how do we compare internationally"?

One way to try to answer this is to look at international comparisons courtesy of the OECD. International comparisons in this area of health are notoriously difficult so the safest comparator is total hospital activity, as measured by the OECD.

Hospital Discharges per 1,000 Population in 2003

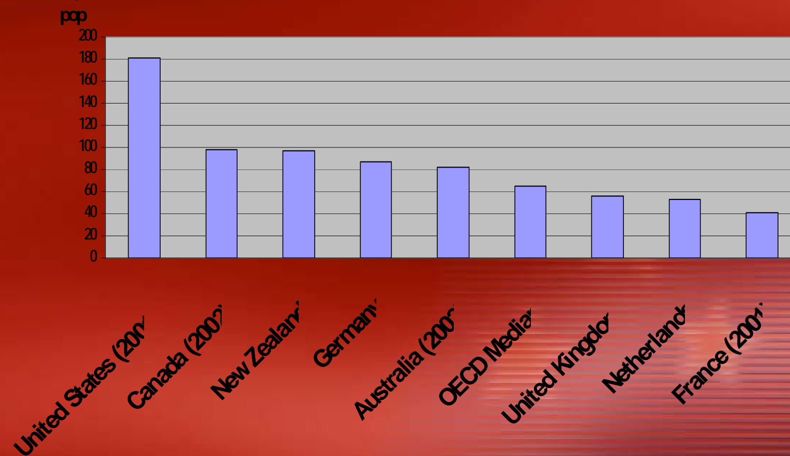
Discharges per 1,000 pop



Source: OECD
Health Data 2005

Coronary Bypass Procedures per 100,000 Pop. in 2003

Procedures per 100,000 pop



Source: OECD
Health Data 2005

This shows New Zealand with a lower level of activity than the UK and France, but higher than Germany, Australia, US, Japan and the Netherlands or Canada. We are 26 per cent higher than the OECD median. Such other data that exists, bypass grafts for example, shows us in an even better light, but we are reluctant to use it because it may not be accurate.

Tell me now where the crisis is. Tell me how this system is in failure, or how it is getting worse, or how we compare badly internationally.

Not that it is good enough yet. The issues of prioritisation must be resolved, capacity must be further increased and more efficiency secured.

There is a significant work programme in place, and each month progress is being made. The government intends to secure those gains one by one to further improve the levels of surgical interventions for New Zealanders.

One last point on electives. More and more hospital intervention does not always mean better and better health. To some extent a good health system can prevent heart surgery, or diabetes, or cancer, or respiratory disease or arthritis. One day a Health Minister will be able to declare a reduction in elective surgery as a good thing.

Priorities

My priorities for the next financial year, which I'm announcing today, are steps in that direction.

First, we must get ahead of the chronic disease burden. In particular, if we take no action on an issue like obesity, we will witness the first generation of children to die at a younger age than their parents. Every politician needs to be concerned about this issue – it is undoubtedly our greatest public health challenge.

Next, I'll be working on major child health initiatives including oral health services, hearing screening, and well child checks.

It will also be another very busy year for primary health. In two months time we will be rolling out cheaper doctor's visits for 45-64 year olds. We also have a lot of work ahead of us in further cementing a population health approach with our PHOs across the country.

Services for older New Zealanders become more important every year and deserve more attention from all of us. We will increase our investment in aged care in Budget 2006, especially in supporting the growing number of New Zealanders who want to stay in their homes for as long as possible.

You will be hearing more on cost-effectiveness in health as it is a priority not just for me, but for the entire government. You'll also be hearing more about what we can do to support and maintain our world-class New Zealand health workforce.

Finally, we will step up our efforts to improve the quality of our health infrastructure, especially information systems. This may seem like a technical issue, but it is central to our efforts to improve the quality of health care in New Zealand.

These issues are important and I'm very happy to have the advice and support of the three health spokespeople who are here today in addressing them.

Conclusion

This Labour-led government is not about to see the public health system or its workforce dishonoured by the opposition benches. I will take every opportunity to defend that system with the same determination that we bring to further improving it. And I will take every opportunity to thank our health workforce for their dedication.

Thank you for your attention and interest.

Contact: Jason Knauf, Press Secretary, (04) 471 9918 or (021) 71 9881, email: Jason.Knauf@parliament.govt.nz, http://www.beehive.govt.nz/hodgson