Reforming primary healthcare

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The starting point of this editorial is an acceptance that a substantive reform of primary healthcare is necessary in almost all OECD nations, New Zealand included. It is also reasonable to conclude that the Institute for Healthcare Improvement (IHI) Triple Aim is a sound template to evaluate putative reforms[1] and that disruptive, rather than sustaining innovations are needed.[2] To illustrate the need for transformation, based on European Union (EU) surveys, increasing the number of doctors and or the overall health budget, in isolation, would not reduce the level of unmet health need arising in most EU countries from affordability, accessibility, availability and acceptability factors.[3,4]

In OECD nations, the core-operating healthcare model for some time has been transactional, reactive, and both doctor-led and hospital-based. This model was sensible, but is ill-suited to the disease burden of 2018. The model's longevity is a result of powerful forces that have blunted innovation.[5]

It is probable that a tipping point of health system sustainability and fitness-for-purpose has been reached in most jurisdictions and that long overdue innovative disruptions are occurring. The core operating model is rapidly transforming into what is aptly described as "participatory" healthcare.[6] Kaiser Permanente reports that 52% of their >100 million annual member encounters with company physicians now occur virtually.[7] At the forefront of this technological disruption are the AI-variant Babylon phone application,[8] the well-established and successful nurse-practitioner-led Minute Clinics in the US,[9] and dispensing robots.[10]

A credible analogy exists in the reduced 'value' of London taxi drivers' 'knowledge' consequent to Google Maps (let alone autonomous taxis).[11] Although there is no likelihood that general practitioners (GPs) will become redundant, the challenge to all primary healthcare providers will be to identify how they add value in a "participatory" and self-management healthcare milieu.

This is the background to the necessary reform of primary healthcare.

The situation in New Zealand is typical of that in most nations who have devolved governance to local healthcare entities - in New Zealand, District Health Boards (DHBs). Although such devolutions, and some form of population based funding and primary care capitations, are probably best practice,[12] the following points describe commonplace and disconcerting findings:

- Despite devolution of governance to district healthcare entities, most central agencies (usually ministries or departments of health) continue to operate in a 'command and control' manner;
- Most health funding mechanisms are relatively weak; desirable regional behaviours are consequently 'discouraged' and central agencies' role in monitoring activity and financial performance, and not value, is promoted;[12]
- Regardless of any benefit that health targets have on productivity, 'activity targets' promote activity-monitoring roles for central agencies and undermine the primary responsibility of district healthcare entities, which is to identify and address local health need and to 'live within their means';
- Having uniform district healthcare entity autonomy, regardless of performance, is problematic, as is the identification of what would be rewarding for entity best practice. This illustrates why real co-development is an essential feature of any devolved governance system;
- As cited, and as a direct consequence of weak funding mechanisms, most regional healthcare 'structures' are not fit-for-purpose and are casual alliances rather than being either accountable or robust;[13] and

J PRIM HEALTH CARE
2018;10(1):3–5.
doi:10.1071/HCv10n1_ED2
Published online 29 March 2018

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- In New Zealand, there is role confusion between primary health organisations (PHOs) and DHBs.[14]

Whatever the original rationale for PHOs, it is likely that any value arises from risk-sharing, which requires reasonable size. Desirable change is underway. Again, the problem is exaggerated by weak funding mechanisms. In retrospect, and notwithstanding the merit of its ideological base, the primary healthcare capitation programme in New Zealand was flawed from the outset and has been corrupted.

Since capitation, New Zealand Medical Council and Ministry of Health survey data show a high level of unmet health need (16% of respondents per annum) arising from a progressive reduction in GP availability and a significant shift in after-hours illness and injury burden to urgent care clinics and to hospital emergency departments.[15,16]

What can be learned from past and current primary healthcare reforms?

First, devolved governance systems can work well, some element of population based funding is effective, and capitated funding of primary care is probably preferable to salaried providers and superior to a 'fees for service' (or other activity-based funding) approach.[12,17–19]

Second, a process of inclusive sector co-development is essential and instead of some discrete outcome, it is better to create an environment in which drivers of reform are set in play such that effective system evolution is ongoing.

Third, for positive reform of primary healthcare, broader systemic shortcomings need to be addressed.

From a tactical perspective, these steps are recommended:

- Transform central health agencies so that there is a functional, if not actual, separation of policy and system administration functions (the English NHS and New Zealand's ACC are good structural role models);
- Significantly upgrade the ability of central agencies to operate as sophisticated healthcare purchasers and commissioners;
- Develop a common health intelligence unit to underpin health investment by all interested Government agencies;
- Substantially reform health funding mechanisms to best practice in behavioural economics,[12] and allow these mechanisms to generate the evolution of regional and district 'structures', and non-Government healthcare providers, to the most efficient size, number, function and so on; and
- Co-develop a performance matrix for devolved governance healthcare entities, and a related reward scheme.

In regard to the fourth of these bullet-points, an uplift of the New Zealand primary care capitation will require at least the following:

- Embedding performance indices into capitation contracts (eg the maximum time allowable for someone to be seen by a suitable provider after contacting the organisation they are enrolled with, details about after-hours care, and how care is to be provided for enrolled people in rest homes, etc.);
- Co-development of provider outcome measures (and a voluntary process where enhanced capitation can have a proportion that is at risk against achieving these outcomes);
- Publication of both performance indices and outcome measures for each contractor so that consumers can make a choice about who they enroll with - this was supposed to be a key feature of the capitation programme from the outset; and
- The adoption of a process to make sure the money allocated for high needs enrollees follows the choices that the enrollees make. This is administration-heavy, but will ensure that such funds address their targets and, along with published indices and measures, will provide an ongoing stimulus for positive system evolution.[12]

Many reforms of primary healthcare are under way, but most are relatively early in development. An appropriate application of user-requirement

based planning, co-development and design thinking will help ensure success.[20]

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