



What is the answer to the challenge of multimorbidity in New Zealand?

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J PRIM HEALTH CARE
2020;12(2):118–121.
doi:10.1071/HC20028
Received 2 April 2020
Accepted 21 May 2020
Published 15 June 2020

ABSTRACT

The increasing prevalence of multimorbidity, a growing ageing population and lack of success in addressing the negative effect of socioeconomic and cultural determinants of health are major challenges for New Zealand's primary care sector. Self-management support strategies, personalised care planning, integrated care and shared health records have all been proposed as mechanisms to address these challenges. The organisation of the health system, however, remains largely unchanged, with limited accommodation and few funding concessions made for the requirements of these different approaches and tools. As a result, the primary care system is no longer a good match for the population it serves. With one in four New Zealanders reporting multimorbidity, and people aged >65 years predicted to double in number by 2050, this article argues that over the next decade, New Zealand requires a health system focused on incorporating self-management support, personalised and integrated care and shared health records. This will require further educating of not only health professionals, but also patients in the purpose behind these approaches. In addition, it will mean transitioning to a primary care system more suited to the needs of people with long-term conditions. The key gain from a radical redesign will be a more equitable health system focused on a broader range of health needs.

KEYWORDS: Multi-morbidity; primary care; chronic care model; person-centred care; equitable healthcare

Introduction

New Zealand (NZ) has an ageing, increasingly diverse population and a health system that is challenged to maintain appropriate levels of care due to increased demand from people with multiple long-term conditions or multimorbidity.¹ While multimorbidity increases with age, generally, it is experienced at an earlier age by Māori and people burdened with socioeconomic deprivation.¹ This means that people with the highest needs are often the least well-served by the current health-care system, and equity remains an elusive aspiration for the health system.²

There are some excellent long-term conditions programmes around NZ, but these tend to be

regionally specific, with no nationally consistent effective model of care for people with multimorbidity. The Chronic Care Model, an American model of care developed by Wagner,³ has been promulgated globally as a way for health systems to meet the needs of people living with long-term conditions.⁴ As the worldwide prevalence of multimorbidity increases, the adaptability of this model – originally developed for single condition care – is being reconsidered. A recent systematic review and thematic synthesis found that implementations of the Chronic Care Model have largely aligned with goals of health-care systems, disease-specific outcomes or health-care utilisation.⁵ A focus on patient work, or the burden of treatment,

was largely absent. Consequently, health systems have been largely ineffective in actioning the Chronic Care Model to provide patient-centred care.

Person-centred care incorporates individuals' preferences, values and beliefs.⁶ In NZ, this also needs to incorporate concepts of whānau (family) and whānaungātanga or connectedness.⁷ Recent NZ research has emphasised the need to focus on the biopsychosocial issues that frequently accompany multimorbidity.⁸ The existing business model of primary care, which is usually based on ~15-min consultations and designed to address acute presentations, leaves little space to effectively use a person-centred approach to meet the needs of people living with multimorbidity.

New Zealand in 2020: the good, the bad and Care Plus

In July 2004, the NZ government introduced Care Plus, a funding stream to help primary care providers to address increasing levels of people presenting with long-term conditions.⁹ Primarily, it enabled general practice nurse-funded time to support improved patient self-management of their conditions. Implementation of Care Plus was largely disconnected from the pillars of the Chronic Care Model, with limited use of the theory of self-management support.⁹ Subsequent research into the effect of Care Plus in NZ indicated that general practices struggled to use this funding to implement more self-management strategies for people with long-term conditions.¹⁰ Worldwide, it was becoming clear that long-term conditions care, with a focus on self-management support strategies, works best when associated with some or all of the key pillars of the Chronic Care Model.¹¹ Many small practices in NZ did not have the resources, support or understanding required to deliver care based on the Chronic Care Model,¹² and many practices used Care Plus to fund patient appointments, effectively removing some of the cost barrier to primary care. Consequently, the key purpose of Care Plus was often completely invisible to patients and was usually incorporated into the existing acute model of care in primary care practices.² Care plus remains simply a funding stream for long term conditions care. Thus, the Chronic Care Model has not been fully realised in NZ, neither has a sustainable model

of funding coupled with a model of care that is person and whānau centred.

The failure of Care Plus to positively affect patients' experiences of long-term conditions care was described in the 2007 NZ National Health committee report.¹³ This report highlighted New Zealanders' need for improved communication with their health-care professionals and greater involvement in managing their own health. The report also recognised that New Zealanders with long-term conditions wanted help navigating the health system and acknowledgement of the importance of their cultural and social contexts and their lifestyle. In addition, the need for improved understanding of the links between mental and physical health and an acknowledgment of the effect of health-care costs on families was communicated.¹³

The socioeconomic and cultural determinants of health are significant in the development of long-term conditions and multimorbidity. For people with low incomes, access to primary care in NZ is problematic.¹⁴ Although NZ has a very low-cost access scheme targeted at practices serving specific populations, it is estimated that 44% of people with high needs are not enrolled in one of these practices and are therefore not receiving the benefit in their own general practice.¹⁴ Sheridan *et al.* suggests that multimorbidity, poverty, minority status and increasing age leads to powerlessness and a compounding jeopardy of health and social issues, which further affects the health of the most vulnerable people in NZ society.²

NZ was one of the first countries in the world to attempt to establish a universal tax-funded national health service, with a vision of an equitable health service for all New Zealanders and with a focus on preventive health care and integrated hospital services.¹⁵ Opposition from the medical profession more than 80 years ago meant this did not fully occur.¹⁶ Consequently, the funding model for primary care in NZ currently balances service provision with a combination of user-pays and public funding. This is one reason why implementing the Chronic Care Model has been problematic in NZ. Notably, the pillars that support effective integration between primary and secondary care and a proactive primary care system that puts patients at

the centre of long-term conditions care remains elusive in NZ.

Is the Chronic Care Model the answer?

In NZ and around the world, health funders and planners in primary care have looked towards the Chronic Care Model to guide better person- and whānau-centred responsive policies to meet the needs of people living with long-term conditions. Although there are multiple versions of the Chronic Care Model, the approach is centred on improving quality of life and enhancing self-efficacy for people with long-term conditions.¹⁷ Much of the research on the Chronic Care Model has been in single disease care, but it is thought that the basic tenets of the model are transferable to multimorbidity care. It is considered especially so if the constructs of minimally disruptive medicine, reducing patient work and improving patients' capacity, are embraced.^{5,11}

Initiatives in Canada, Australia and the United Kingdom (UK) to improve the care of people with multimorbidity have aligned with more recent iterations of the Chronic Care Model proposing proactive rather than reactive primary care.¹⁸ The National Health Service in the UK has suggested a whole-of-system approach based on the analogy of a house of care. It is committed to providing a partnership model of collaborative care focused on holistic and patient-centred care.¹⁹ Shifting practice in primary care to an integrated patient-centred model as envisioned by the Chronic Care Model, and the UK's House-of-Care approach requires considerable change management, as well as health and business re-organisation. Patient-focused and integrated strategies using chronic care principles that consider physical, psycho-social, cultural and deprivation needs have the potential for excellent outcomes in terms of adherence to medication regimes, better engagement, better patient experiences and ultimately health and quality-of-life improvements.^{20,21} Importantly, for people living with multimorbidity, the health system needs to ensure that it does not continually increase the patient workload associated with ever-more complex treatment regimes and disparate single conditions advice from multiple providers. Although the system is generally good at providing information, practical resources to enhance self-management are

rarely offered.⁵ Neither does it support patients with multimorbidity to re-evaluate their life or assist them in finding and engaging with a supportive social network.⁵ Furthermore, the user pays, bio-medically focused model of care that remains has led to a lack of engagement by the people most in need of health care, exacerbating and further widening health inequity in NZ.^{2,16}

The way forward

Nearly 20 years ago, The World Health Organization and the United States Institute of Medicine declared long-term conditions the health-care challenge of the 21st century.^{22,23} Well over a decade ago in NZ, Bycroft and Tracey suggested that major systemic change was needed to cope with the increasing burden of long-term conditions on our morbidity and mortality statistics.²⁴ Today in NZ, despite long-term conditions making up 80% of primary care presentations, and the current long-term conditions strategy increasingly focused on primary care, most general practices continue to be organised around meeting episodic acute presentations, largely due to their private business focus.²⁵

Francis *et al.* suggest that the Chronic Care model cannot function effectively in health systems that are not person-centred or integrated.⁸ Despite funding initiatives like Care Plus, the current structure in NZ primary care is unable to provide a model of care that would remedy inequity in health care for the most vulnerable members of our society.^{8,10,14} Combining the key principles of the Chronic Care Model with minimally disruptive medicine would mean that patient work and the complexities of living with multimorbidity are front-and-centre in primary care consultations.⁵

Conclusion

Multimorbidity is common in NZ, with one in four New Zealanders living with multiple long-term conditions. People with multimorbidity are among the highest users of the health-care system.¹ Consequently, health-care providers in NZ and around the world have looked towards the Chronic Care Model to redesign health systems with a more person-centred and multi-modal approach.^{2,8} Internationally, health-care organisations in similar

jurisdictions to NZ are moving away from acute biomedical disease-focused models of care to person- and whānau-centred approaches that encompass a biopsychosocial cultural approach to health.⁵

Person- and whānau-centred care should be the new catch-cry in NZ long-term conditions care. Successful and culturally safe person-centred care means that health expertise is shared between interprofessional health-care teams, patients and their whānau in supportive and collaborative relationships.¹⁰ The social determinants of health are recognised as contributing to the earlier development of long-term conditions, yet for people on low incomes, access to a user-pays primary health-care system remains problematic. Adequately funded person- and whānau-centred care that is embraced by patients and health professionals requires a cultural and systemic change within NZ's primary care institutions, and for people with multimorbidity in our society. The question remains as to why New Zealanders in 2020 continue to wait for a consistent nationwide approach to long-term conditions care and universal health-care coverage.

Competing interests

The authors declare no competing interests.

Funding

This research received no specific funding.

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