The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

EDITORIAL

Health policy: articulating the vision and how to get there

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Policy in any domain is half-baked if it is not clear about what it aims to achieve, how this vision will be accomplished, and is acceptable to people who are affected by both the process and the outcome. Health policy sits alongside policy in every other social domain so it is always a vexed mixture of what we would like to do, what we can afford to do and what is possible.

I think that for most of the 7.8 billion people in the world today, 2020 is going to stand in our memories for a long time, for our needs for new and different health policy in the face of a pandemic no one had ever faced before in real life. Ultimately, the vision for Covid-19-related policy in every country was to save lives. To do that it must also save livelihoods, health systems, and entire social systems. There were many possible pathways to achieving that vision. The policy choice varied by geography, history, political and economic resources, and many other elements. No policy could be convincingly presented to everyone affected by it because of the absence of our prior experiences of pandemics of the magnitude of Covid-19 – and this time last year we had no idea what that scale would be.

As a previous public health professor, I knew of the choices and justifications but doubted our ability to do all that New Zealand has done in the last year or achieve all that we have achieved. I thought that the many countries choosing to follow a 'learn to live with it' strategy were making a choice that was justifiable in New Zealand – but our policy-makers made much bolder choices. Now, due to those choices, and our geography, history, political and economic resources, we are moving into a time of reflection and learning and it behoves us to weigh strategic possibilities, other than the one we have implemented, for dealing with this and future pandemics. 'Covid Plan B' was developed by a multidisciplinary group of academics to consider the impact of alternative responses to the pandemic. The social contribution unique to academics comes from their responsibility to think differently and to question accepted 'truths'. In this issue the Plan B group make an argument against 'lockdowns'[1] and we publish a rebuttal from Dr Ian Town, the Chief Science Advisor at the Ministry of Health.[2]

Most of the articles in this issue are about health policy, one way or another. Considering practice-level policy, Lillis and Lack used a Medical Protection Society structure for assessing risk in repeat prescribing to develop framework for general practices to use when developing their repeat prescribing policies.[3] We also have research signalling policy vacuums,[4,5] successes, failures,[6] and policy revisions.[7,8]

In the first category Chatindiara and colleagues report high levels of malnutrition and frailty among patients entering residential aged care facilities.[4] Most people might imagine that malnutrition is quite rare in New Zealand, making these results somewhat startling and suggesting that policy relating to nutrition for vulnerable people in the community might be valuable. There is much evidence of ethnic inequalities in New Zealand but difficult to make policy in the myriad specific areas contributing to this situation. We publish a database linkage study showing that Maori filled their prescriptions for diabetes treatment less often than people of other ethnicities despite equality in being prescribed these medicines.[5] This deserves further investigation to discover why and whether greater diabetes-related morbidity among Maori might be amenable to new policies.

Policy failures may contribute to the increasing rates of sexually transmitted infections (STIs) in New Zealand. A systematic review in this issue uncovers specific health service changes that could change this trend, including attention to implementing the existing policy requiring comprehensive STI testing in pregnancy.[6]

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Policy revisions include addressing the ambiguity in the capacity and capability funding policy in primary care and reconsidering addiction care teams to specifically include community pharmacists.[7,8] Interviews with 50 people from District Health Boards (DHBs) and Primary Health Organisations (PHOs) in 19 DHBs found widespread confusion about the Systems Levels Measures funding and how it should be used.[7] Community pharmacists are a mainstay of the methadone delivery service but they feel disengaged from the hospital Addiction Services that assume overall responsibility for the care of these people and their role is poorly considered in relevant policies.[8]

Clinical practice guidelines are not policy but recommended best practice. A second database study in this issue shows that most people prescribed dabigatran had the recommended renal tests on commencement of the drug but only a minority of patients prescribed it for a year had the recommended annual follow-up check.[9] Further research is needed to investigate reasons for this drop off.

We do, of course, have an array of clinically-oriented papers, including a report of random blood glucose testing in supermarkets and malls[10] and an audit of general practitioner (GP) referrals to a dermatology service,[11] GP referrals to specialist services are always appropriate because they are made when GPs recognise uncertainty about making clinical decisions and then best practice is to seek advice: responding to GP requests is the responsibility of services specialising in relevant areas (and therefore dealing only with matters relevant to the referral). If you have recently made a referral for advice about subungual discolouring you will probably find this paper valuable.

We also have two Improving Performance papers.[12] The first comes from the Canterbury Initiative, a group working in the Canterbury DHB to address problematic areas of health services. This report addresses the problem of getting timely physiotherapy for patients referred from general practice when all funded physiotherapy services were provided in DHB hospitals. This paper describes massive improvements in access, timeliness, transparency and equity achieved by engaging community physiotherapists instead. The second paper comes from the National Hauora Coalition, a Maori PHO in Counties Manukau.[13] It is about a fono to try to figure how to better manage rampant rheumatic fever among Pacifika peoples in the region. This is a classic Improving Performance paper, with the problems clearly articulated and the process of finding solutions well explained.

Arthritis is an increasingly common condition as our population ages. The case report in this issue is about a rare presentation of arthritis.[14]

Without a doubt 2020 has been an unusual year across the planet. Whether good, bad or indifferent for you we send our very best wishes to our readers for a peaceful and relaxing end to the year. As Editor-in-Chief I also most sincerely thank the Associate Editors, publishers and the Royal New Zealand College of General Practitioners for the unreserved support you have all provided to the Journal throughout this eventful year. And thank you also to all our authors who have challenged, inspired, and sustained us by your engagement throughout 2020. May we all meet again in the New Year refreshed and ready to tackle the challenges and enjoy the delights of 2021.

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