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The Primary Health Care Win Win

Every year hundreds of millions of dollars are spent treating people in hospital who don't need to be there. If our primary health care system was functioning more effectively we would save millions of dollars and empty thousands of hospital beds.

In 2003, in just one of our 20 district health boards — Canterbury DHB — avoidable hospital admissions accounted for over 30% of admissions, costing nearly $100 million. Despite a big increase in primary health funding by the previous Government, avoidable hospitalisation rates did not reduce in the years to 2009 and increased in 2009/2010.

Up until 2009 reducing "ambulatory sensitive hospitalisations" (avoidable hospital admissions) was one of the Government's key "health targets". Why this important measure of the success of our primary health services was dropped is unclear.

We can reduce hospital admissions and doing so will save a lot of money. The success of our primary health system is the key to this "win win". So, why isn't it happening?

A University of Canterbury report on the actions required to reduce avoidable hospitalisations, found that no single intervention for individual patients held the answer. What does make a difference is the use of multidisciplinary teams, including nurses and a whole range of "allied" health practitioners, providing coordinated, comprehensive services across a range of settings. This approach was central to the last Government's primary health care strategy.

The present Government wants to push these policies along through its fledgling Integrated Family Health Centres. But while you can set up organisations to *enable* integration of services, real integration does not automatically follow. There are barriers to overcome, and lessons to be learned, which today's Government appears not to have heeded.

One barrier is the business model, built largely on GP-owned businesses. DHBs receive population-based government funding to cover the full range of publicly-funded health services for their districts, along with the financial risks. Part of that

funding is passed, with the financial risks, to PHOs and on to contracted private practices to provide primary care services.

GPs can mitigate the risks by shifting costs to patients via user charges, or by referring patients to other community providers or hospitals. This is prompted more by lack of capacity or incentives to move beyond the 15-minute GP consultation than deliberate under-servicing. Since doctors' fees comprise up to 40% of their revenue, they have little incentive to change their current business model to develop the much-needed broader, collaborative approaches.

Until we challenge this model, our avoidable hospital admissions will remain high. While 30% of New Zealand general practices routinely operate as multidisciplinary teams formally organised to discuss and make decisions about care of specific patients, in the UK, where the avoidable hospitalisation rate is less than half of New Zealand's, 81% do so.

The 30% of practices that are applying a team approach are more likely to be the minority of "Access" PHOs established by community organisations or unions. These PHOs, which commonly employ GPs on salaries, tend to be smaller and cover populations with relatively high health needs, have fewer management resources, and are at risk financially and from burn-out.

Although attempts have been made for decades to integrate our primary health care services with the rest of the system, there are now some encouraging signs. Many of the new generation of GPs, want to work differently and are opting to work for salaries instead of running a business.

The time is ripe for DHBs to offer new opportunities for employment of primary care practitioners— not just GPs but the whole primary health team. How much easier it would be to achieve the primary health model needed to reduce hospitalisation if GPs, nurses of all codes, hospital doctors and a comprehensive range of allied health professionals worked together unhindered by complex contracting arrangements, the constraints of employer-employee relationships or the demands of running a business. Health promotion and protection, primary health and secondary would be viewed as part of a continuum with a common goal of addressing disparities in health and access to health care.

A key barrier to achieving this could be removed if the whole health team were employed by a single employer — logically the district health boards. While achieving this will require a long-term approach, a good start would be a requirement on DHBs to provide new salaried employment options for primary health professionals as part of a more proactive effort to foster teamwork and collaboration across all relevant service providers and agencies. The evidence shows taking such measures would be a win win, in dollar terms and in improvements to the health of New Zealanders.