Submission

ASMS | TOI MATA HAUORA

Submission on the draft report of the Productivity Commission on more effective social services

CONTENTS

INTRODUCTION

This submission concentrates on issues that affect medical specialist services (and, consequently, New Zealand's health system), including:

- social impact bonds
- commissioning
- patient 'choice'
- integrating services
- incentives for improvement.

We have also commented on two matters critical to improving outcomes and value in health service delivery: evidence-based policy development and evaluation, and the adequacy of government health funding. A third critical issue – distributive clinical leadership – is discussed in our previous submission (2 December 2014).

BACKGROUND

The Association of Salaried Medical Specialists (ASMS) is a union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members. We now represent more than 4,000 members, most of whom are employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all public hospital senior doctors and dentists eligible to join the ASMS are members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. They are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

SUMMARY AND KEY POINTS

As per our initial submission, the ASMS wishes to reiterate our concerns with any moves to implement new policy that is not premised on rigorous research, sound empirical evidence and supported by on-going monitoring. We continue to advocate for the development of evidence-based policy initiatives that can guarantee better patient outcomes and better value for money than the status quo.

We wish to restate our support for the following features of the current health system:

- a largely single-payer funded system (through general taxation), which enables cohesiveness and continuity, and relative fairness, as well as avoiding the administrative costs associated with privately funded systems. [1] [2] [3]
- a health workforce with standards of practice second to none.
- a district health board model which provides a framework for the integration of services.[4]
- an ability to institute changes and best models of practice more rapidly and effectively than most other larger countries.

We agree, however, with the characterisation of the health and social services system as under-performing (due, in our view, to lack of funding) and under pressure. Key facts that require attention include addressing inequities in access to, and delivery of, health services in New Zealand[5,6], the increasing incidence of unmet need, combined with ever-increasing workloads and difficulties in implementing potential service improvements due to barriers to change.

Perhaps most significant, however, is the pressing need to address a chronic underfunding of the health sector as a proportion of the growth in Gross Domestic Product (GDP). As detailed in a recent analysis of the 2015 budget, the accumulated funding shortfall in government health expenditure for 2015/16 compared to 2009/10 is estimated at more than $1 billion. And the Health Vote in the 2015 Budget is an estimated $245 million behind what is needed to cover announced new services, increasing costs, population growth and the effects of an aging population.[7]

Concurrent with this push for adequate funding of the health system is the view of the ASMS that the current funding and purchasing arrangements intrinsic to the system lack transparency, both nationally through the Population Based Funding (PBF) formula, and locally through the DHB 'purchasing arms'.[8] Those shortcomings, along with a lack of good data, especially in relation to unmet need and quality of services, means there is poor accountability.[9,10,11] In addition, purchasing and funding arrangements seem overly complex

(and costly) for a population of 4.5 million, involving about 10,000 contracts annually between service providers and either the Ministry of Health or DHBs.[12]

We continue to assert that introducing new arrangements involving more contestability, more provider diversity and payment for performance would exacerbate the current weaknesses in the wider system, as well as failing to address the primary need for better resourcing.

Comments on specific findings and recommendations are detailed in this submission.

NEW IDEAS IN NEW ZEALAND AND ELSEWHERE

One of the key findings in this section of the draft report pertains to the use of social impact bonds (SIBs) as a tool to stimulate innovation and better outcomes in the health and social services sector. The ASMS is highly concerned with the SIBs discussed in this section of the draft report and also alluded to as a possible model for new approaches to purchasing and/or contracting social and/or health services.

Our main concern is the apparent willingness to roll out this tool given the current dearth of robust empirical research into SIBs, especially given uncertainties about how well they are likely to function in the New Zealand context. We note as a consequence that a report prepared for the Department of Internal Affairs does not recommend SIBs as a practical option for New Zealand to explore in the short term.[13] We further highlight our concerns at the risks associated with SIBs both in terms of the likelihood of achieving rates of return to investors, potential savings to the Government and being able to accurately measure the success of a SIB programme.[14] As is widely recognised in the literature concerning SIBs, they involve complex policy arrangements and may require concurrent commissioning of new information management systems which may have implications for costs around establishing successful SIBs as well as impacting upon the potential cost savings that a SIB may provide.[15] [16]

Further, given that the initial SIB proposed by the Government is focused on a particularly vulnerable social group, we wish to register our concern at the lack of detail provided about the possible unintended consequences, ongoing monitoring plans and how outcomes will be defined and assessed. It remains unclear from both the broad model of SIBs discussed in the draft report, as well as in the specific programme planned by the Government, who has responsibility if and when things go wrong. It is not clear whether there will be a gap in service provision if the SIB fails, and who has responsibility for defining and assessing outcomes which will have ramifications for both the social group involved and future service provision under a SIBs model.

Finally, we believe applying business models to the resolution of social issues is inappropriate. People who require health and social services should not be framed as mere statistics. Instead, we highlight the importance of recognising such people as socially-embedded individuals with complex and intersecting needs.[17]

COMMISSIONING

As discussed in detail in our original submission, the ASMS does not accept the assertions contained within the draft report that managed markets, in which providers compete for market share of the social and health sector, are likely to stimulate better performance. Market policies, which aim to promote competition among providers in the hope of decreasing cost and improving efficiency and quality, have not been proven to bring about beneficial outcomes.[18] The predictions within classical economic theory do not readily translate into provider responsiveness to patients and purchasers, large-scale cost reduction or innovation in service provision. Evidence of the impact on quality of care is mixed, and while there have been some signs of improved access for patients and increased provider efficiency, confounding factors (such as simultaneous increases in funding and pressure from enforced targets), along with weak monitoring strategies, make attribution to market policies alone doubtful.[19]

We note that the draft report recommends that social service commissioning organisations should shift more emphasis toward outcome-focused contracts. While intuitively this appears a common-sense and welcome emphasis, we would register caution with this discursive shift in the absence of rigorous research and sound empirical evidence. It is well established within both the literature and the wider sector that outcomes in health and social service provision are notoriously hard to define and measure, and require careful planning, sound evaluation strategies and detailed and ongoing monitoring.[20] An outcomes-based approach to assessing performance is in principle a more sensible approach than measuring relatively crude outputs. However, linking outcomes to funding carries a high risk of unintended consequences where there is inadequate public accountability (as occurs in commercial arrangements) and where the outcomes are not well defined and shown to be directly linked to the services provided. We therefore remain wary of any moves to use this emphasis on outcomes to increase the contracting out of services to private providers (whether via SIBs or other mechanisms).

As discussed in our initial submission, we assert there is little robust evidence available on the cost-effectiveness of private health providers compared with public services, due in part to variations in the services provided, the way data is collected and measured, and a lack of openness due to commercial sensitivity of some basic information. Given the emphasis on the need for better data and analytical systems within the draft report, we would caution against adopting systems (whether outcomes-focused or otherwise) that are likely to lead to further issues with both access to and transparency of information. In the context of SIBs, for example, it is noted that commercial sensitivity around details of contracting arrangements

are unlikely to foster collaborative approaches to establishing sound measurement systems and data collection protocols.[21] These concerns about protecting private investments in such systems may also lead to difficulties with accessing information about outcomes and service provision which is currently provided for in New Zealand under the Official Information Act (OIA).

CLIENT CHOICE AND EMPOWERMENT

As discussed in our original submission, the ASMS has reservations about further attempts to cement a competitive market-oriented approach to New Zealand health services. As other commentators have asserted, health care is rarely consumed 'for the sake of it' [22] thus raising questions about the appropriateness of applying market principles to services that should not be at least in principle motivated by profit and governed by rules of economic supply and demand.

The increased emphasis on patient choice and competition between providers heralded in the draft report is argued on the basis that it will improve efficiency and effectiveness as well as having the capacity to increase the quality of service provision. We question the claims in the draft report that increasing client direction leads to a decline in the quality of services. The evidence is limited and not robust. And the evidence that having greater 'choice' actually leads to gains in efficiency, improved health outcomes and greater patient empowerment is, at best, mixed.[23]

On the other hand, we note that 'marketising' health systems can result in perverse effects concerning efficiencies and economies of scale. As discussed in our original submission, increasing competition and "choice" between public health providers can often result in increasing costs, greater administrative burdens due to the need for new and more complex information systems, and, as discussed in the previous section, a reluctance to share best practice guidelines due to concerns about intellectual property.[24]

In this context, we wish to reiterate the importance of attending to current shortages of general practitioners and medical specialists in New Zealand, many of whom are approaching retirement age.[25] Virtually all medical specialties, including general practice, are on New Zealand Immigration's skills shortage lists.[26] With clinical resources spread thinly across much of the country, there is no capacity, both in terms of the clinical workforce and existing information systems, to offer any real choice.

Finally, it is worth noting that although choice is generally perceived to be a good and important 'right' of individuals, research has suggested that in fact, people often value simply having access to high-quality service providers that they can rely upon greater than they value having a choice between many different providers.[27] For example, in a survey of users of the National Health Service (NHS) in the United Kingdom, the preference exhibited was for retention of the public and universal aspects of the health system rather than having a choice over the providers of their care.[28] The ASMS believes that emphasising the importance of choice in the health and social services system should not be at the expense of access to good quality, convenient and well-resourced services.

SERVICE INTEGRATION

The ASMS wishes to emphasise the importance of collaboration and cooperation through initiatives such as clinical networks, as critical to maintaining safe and viable services. In general, we are broadly supportive of efforts to improve integration, both within health and across health and the wider social sector, rather than fragmenting services through greater competition.

We are pleased at the recognition of the difficulties around service integration mentioned in the draft findings. As discussed in our original submission, we remain cautious of proposals to greater integrate health services unless it is clear how better integration of health services can improve cost-efficiency of service delivery. This is particularly the case given the difficulties involved with defining and evaluating integration and possible outcomes.
We further note that these shortcomings with integration make measuring and comparing the impact of integration on systems, providers and at patient level, a challenging proposition.[29] [30] [31]

It is pleasing to note in the recommendations that institutions and commissioning arrangements should provide opportunities for bottom-up integration. As we highlighted in our original submission, Canterbury DHB's incremental moves to better integrate hospital and community services over the past six years or so is, according to one analysis, one of 'a small stock of examples' where integration appears to have resulted in positive measurable change.[32] Notably, the process at Canterbury involved a number of different initiatives developed and implemented from within. Clinical leadership, in particular, was shared and distributed as a collective responsibility.[33]

As discussed in our original submission, however, it remains important to note that organisational integration does not necessarily lead to integrated care at the patient level, which is necessary when the aim is to improve patient health outcomes.[34] Instead, merging organisations can often led to greater conflicts and mistrust within the organisations concerned, particularly when top-down forced mergers are seen as simply attempts to cut costs.[35,36] We assert that integration is best viewed as a continuing process which is frequently challenging to implement, even when it is a 'bottom up' process as opposed to an imposed directive.

INCENTIVES FOR IMPROVEMENT

We note the draft report's emphasis on providing positive incentives for improvement. If this is about payment for performance approaches, discussion must focus on the robustness of the evidence collected to support the efficacy of this practice, difficulties with establishing how incentives are likely to be received according to health professionals and/or institutions, and the potential conflicts of interest that may arise as a consequence of this practice.

The question of whether explicit financial incentives can improve health services both in terms of their cost effectiveness and quality remains largely unanswered, despite their use over many years. We emphasise the high level of risk implicit within moves toward incentivising improvements vis a vis payment for performance. As discussed in our original submission, there remain significant unanswered questions about the robustness of studies to assess the benefits of this practice, key issues around confounding factors, and compelling evidence concerning the potential for conflicts of interest to arise. As a consequence, we continue to emphasise the need for rigorous evaluation of their use to determine their impact on health care quality and resource use.[37]

CONCLUSION

To reiterate our comments in our previous submission, effective decision-making depends on informed use of evidence both in developing policy and in evaluating its effect once implemented. The available evidence does not support the premise that health outcomes and value for money would improve by changing the current way public health services are purchased. The evidence does, however, indicate significant risks in some of the purchasing models and strategies discussed - directly or indirectly - in the inquiry report, including 'contestability', quasi-market approaches, public-private partnerships, personal health budgets, 'payment for performance' and NHS-style commissioning.

Since the failure of the market-oriented health reforms of the 1990s, successive governments have recognised the benefits of collaboration in delivering efficient and effective health services. The performance of our health system now compares well with other developed countries. The evidence indicates there are further gains to be made in further developing and refining collaborative models of health service delivery.

REFERENCES

1 Saltman, R.B., Busse, R., & Figueras, J. (Eds.). (2004). *Social health insurance systems in western Europe*. Maidenhead: Open University Press.

2 Carrin, G., & Hanvoravongchai P. (2002). *Health care cost-containment policies in high-income countries: how successful are monetary incentives?* Geneva: WHO.

3 E Nicolle, I Mathauer. *Administrative costs of health insurance schemes: Exploring the reasons for their variability*, WHO, Geneva 2010.

4 Treasury. *Briefing to the Incoming Minister: Health*, October 2014.

5 Ibid

6 Ministry of Health. *Briefing to the Incoming Minister*, November 2014.

7 Council of Trade Unions. *How much funding is needed in Budget 2015 to avoid the condition of the Health System worsening? Working Paper on Health Number 13*, May 2015

8 E Penno, R Gauld. 'How are New Zealand's District Health Boards funded and does it matter if we can't tell?' *NZMJ*, Vol 126, No 1376; 14 June 2013.

9 Treasury. *Briefing to the Incoming Minister: Health*, October 2014.

10 Ibid

11 Ministry of Health. *Briefing to the Incoming Minister*, November 2014.

12 Ministry of Health *Annual Report 2014*.

13 Philipson Consulting Ltd *The potential for Social Impact Bonds in New Zealand, A report prepared for the Department of Internal Affairs*, September 2011

14 S Tan et al. '*An evaluation of Social Impact Bonds in Health and Social Care' Interim Report* Policy Innovation Research Unit (PIRU)*,* March 2015

15 Ibid

16 E Disley et al. *Lessons Learned from the Planning and Early Implementation of the Social Impact Bond at HMP Peterborough* Ministry of Justice Research Series 5/11 May 2011

17 M Fotaki *What market-based patient choice can't do for the NHS: The theory and evidence of how choice works in health care*, Centre for Health and the Public Interest, March 2014

18 Ibid

19 L Brereton, V Vasoodaven. *The Impact of the NHS Market: An overview of the literature*, Civitas, October 2010.

20 S Tan et al. *An evaluation of Social Impact Bonds in Health and Social Care Interim Report* Policy Innovation Research Unit (PIRU), March 2015

21 Ibid

22 M Fotaki *What market-based patient choice can't do for the NHS: The theory and evidence of how choice works in health care*, Centre for Health and the Public Interest, March 2014

23 Ibid

24 S Tan et al. *An evaluation of Social Impact Bonds in Health and Social Care Interim Report* Policy Innovation Research Unit (PIRU), March 2015

25 ASMS. *Taking the temperature of the public hospital specialist workforce*, August 2014.

26 http://www.immigration.govt.nz/migrant/general/generalinformation/review.htm

27 M Fotaki *What market-based patient choice can't do for the NHS: The theory and evidence of how choice works in health care*, Centre for Health and the Public Interest, March 2014

28 Ibid

29 GD Armitage et al. 'Health system integration: state of the evidence,' *Int J Integr Care*. 2009 Apr-Jun; 9: e82.

30 R Atun et al. 'A systematic review of the evidence on integration of targeted health interventions into health systems,' *Health Policy and Planning* 2010;25:1–14, Oxford University Press, 2010

31 P Valentijn et al. 'Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care,' *International Journal of Integrated Care*, 22 March 2013 - ISSN 1568-4156

32 N Timms, C Ham. The quest for integrated health and social care: A case study in Canterbury, New Zealand. The King's Fund, London, 2013.

33 Ibid

34 N Curry, C Ham. *Clinical and Service Integration: The route to improved outcomes*. The King's Fund 2010.

35 S Choi, I Holmberg et al. 'Executive management in radical change: The case of the Karolinska University Hospital Merger. Scandinavian Journal of Management. 2011;27:11-23.

36 N Fulop et al. 'Changing organisations: a study of the context and processes of mergers of health care providers in England,' Social Science & Medicine. 2005;60:119-30.

37 BS Armour, M Melinda Pitts et al. 'The Effect of Explicit Financial Incentives on Physician Behaviour,' *Archives of Internal Medicine*, May 28, 2001, Vol 161, No. 10