

Personal reflections

We work in a very complex health system. Discussions tend to confuse rather than clarify. Documents, including contracts, don't enlighten us. Despite that our health system is rated highly in all international studies. Doctors and nurses are rated highly by the public and these dedicated New Zealanders continue to deliver care in compassionate, effective and coherent ways despite the best efforts of the system to make it difficult to do so.

I have been asked by my chair, Dr Bev O'Keefe, to write this column before I depart from IPAC to take up my new role with the Southern Cross Group. She particularly asked that I draw on my 18 years in the sector and offer some of my thoughts about the past as a pointer for the future.

What I propose to do is look briefly at the last couple of health reforms and try to draw some conclusions from them that I think might help provide some insights to guide actions over the next few years.

The first reform I look at is the purchaser-provider reform of the 90's.

Despite trenchant criticism by some commentators there were some great advances during this period. The 90's was a time in which primary care was in the ascendancy and we saw the emergence of community governed organisations, mainly for high needs populations, and also new clinically led organisations (IPAs). These organisations were extremely innovative, had strong visionary leadership, and provided a unifying vehicle for what were previously isolated providers acting independently from one another.

Examples of developments during that time include budget holding and development of new community based services, electronic patient management systems, best practice guidelines, and new approaches to general practice education.

In my opinion the key enablers for these developments included consolidation of scarce management/planning resources into four purchasing organisations, a devolution agenda driving bottom up developments, strong action oriented leadership at many levels, and relationships built on respect and trust.

The second reform to consider is the 1999 reform with the launch of the Primary Health Care Strategy and establishment of 21 District Health Boards.

Central to this reform was the ideological drive to embed community governance in hospital and primary care structures and thereby distance the medical profession, and particularly general practice from decision making in the sector.

And despite government claims of great advances over the last 8 years the evidence is less compelling. Sure, the development of a Primary Health Care Strategy and the

reduction in the cost of access to general practice services and pharmaceuticals are significant gains.

There is no doubt we could find other advances during that time but this reform failed in many ways none the least of which was the failure to adopt even the most basic change management processes. The fixation on structure and the ideological 'one model fits all' approach has been a significant barrier to progress. Underpinning these failures was the top-down, command and control approach to implementation of the reform.

Sadly, many of the gains in primary care from the 90's have been eroded and innovation has slowed down during this period.

The change of government and the tight fiscal environment provides an opportunity for a new approach which draws on what we have learnt from the last two major reforms.

The 'motherhood and apple pie' bits of that include a clear political vision, shared sector goals and pathway to achieve the vision, and rebuilding of trust between government, provider organisations and general practice.

We also need less ideology and more pragmatism, less reports/papers/talk fests and more action, less top down and more bottom up, and recognition that contracts and structures are the end game and not the main game.

But in my opinion the most important change required to drive the sector forward involves DHBs. NZ is too small to expect 21 DHBs to have the strategic and relationship management capability to support a significant change programme.

We therefore urgently need to separate the funding and planning functions from the hospital arms of DHBs and consolidate these functions into fewer planning and funding entities.

There are some outstanding people in DHBs who are smart, have vision, understand change management, and recognise that DHBs can't be effective unless they bring providers and community along with them. Unfortunately there aren't enough of them so we need to pool their talents. If this does not happen then we will see little change in approach and attitude locally.

I have enjoyed the challenge of working at IPAC and I look forward to continuing my involvement with general practice in my new role.

Victor Klap