ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

24 June 2015

Dr Murray Horn
Health Funding Review
Ministry of Health
PO Box 5013
Wellington 6145

Attention: Philippa Bascand and Don Gray, please forward to Dr Murray Horn

Dear Murray

Review of Health Funding Arrangements

While the Review of Health Funding Arrangements does not include a consultation process, the Association of Salaried Medical Specialists (ASMS) wishes to draw your attention to a number of points about the current funding arrangements in relation to the review's stated aims.

First, we recognise that all funding models of national health services have strengths and weaknesses and, given that health services are constantly evolving, the efficiency and effectiveness of health funding needs to be continually monitored and assessed.

We support the stated aims of the review.

There are two aspects of the review which we believe are fundamentally flawed, however: the bypassing of a consultation process with the sector, and the exclusion of "consideration of what is the 'right' amount to allocate to health spending" in the review's terms of reference.

Sector consultation

On the first point, we note comments made by the Ministerial Review Group:

> *The past is peppered with reforms, designed along varying philosophical lines, and implemented by various government agencies. These reforms have generally been top-down and have had mixed levels of success. None, however, have been led by clinicians, even though the resulting changes have often had significant effects on clinical practice. This was particularly the case during the 1990s, when reforms were occurring against the background of the need for a substantial reduction in public expenditure. Health managers have also been asked to implement reforms without the mandate or co-operation of the clinicians who would be key to making them successful.*[1]

Whether in the context of 'reform' or 'review', the above observations apply equally when the changes being imposed affect the way clinical services are delivered. Our reading of the current review's terms of reference suggest the review's outcome may well have an impact on decisions about clinical services, including the way those services are delivered. The result, therefore, may well be the same scenarios where health managers are required to implement measures without the mandate or agreement of the clinicians who are the key to their success.

1 Ministerial review Group. *Meeting the Challenge*, Annex 2: Terms of reference: Clinical Leadership and Quality, July 2009.

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We note, for example, the suggestion that funding arrangements may include measures to "incentivise improved health outcomes", etc. If this is an allusion to some form of payment for performance, it is important to recognise that the literature on payment for performance, in its various guises, raises more questions than answers and that such approaches can carry significant clinical and financial risks. Financial incentives have also been shown to be highly divisive.[2]

Public hospital clinicians are already highly incentivised to do the best for their patients and any moves to impose more incentives or programmes involving targets could be counter-productive. To take full advantage of the skills, expertise and dedication of our public hospital clinicians, the best things to do would be to (a) enable clinicians to lead the services they provide, and (b) provide adequate resources to do it – which brings us to our second point.

Health expenditure

The quantum of health spending is inextricably linked to the quality of health spending. We are not aware of any health funding arrangements that work effectively irrespective of the amount of funding allocated. Our members could provide numerous examples of lost opportunities to provide more cost-effective and better quality service, through clinical leadership, due to inadequacy of resources.

There is now a strong body of evidence showing comprehensive clinical leadership can achieve what New Zealand's successive attempts at health reform have failed to achieve: significant improvements to the effectiveness and efficiency of our public hospitals across the whole spectrum of services (not just the selected few targeted by Government) while managing the increasing costs of health care.

Indeed, given the health indicators for the coming decade, our health system's ability to meet the growing demands placed on it may well rest on the extent to which comprehensive clinical leadership is established in practice.

Successful clinical governance, as envisaged by the Government's *In Good Hands* policy statement and by the *Time for Quality* agreement between the ASMS and the country's district health boards (DHBs) requires distributive leadership, embedded at every level of the system. But clinical leadership requires specialists' time – which can be found only when entrenched specialist workforce shortages are addressed.

Sustainable funding policies

The review's terms of reference say: "The Government … is looking for health funding arrangements that [are]… affordable short-term and sustainable longer-term."

As you know, government health expenditure has been falling as a proportion of gross domestic product (GDP) since 2009/10, so in purely fiscal terms there appears little question that government health spending is affordable in the short term. Health spending has also fallen in real terms, when cost increases and demographic changes are taken into account. However, there are many anecdotal indicators that being 'affordable' is not the same as being cost effective in terms of New Zealanders' health and wellbeing and in terms of the health of the broader economy.[3] [4]

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2 ASMS 2013. *Health Dialogue: Waitemata District Health Board's 'Package of Care Elective Surgery Model: A costly experiment?* Issue 8, August 2013.

3 ASMS 2014. *Health Dialogue: Reality Check: The myth of unsustainable health funding and what Treasury figures actually show*. Issue 9, August 2014. Available at http://www.asms.org.nz/wp-content/uploads/2014/08/Reality-Check-health-funding-paper-Final-21-August_162107.6.pdf

4 NZCTU 2015. *Working Paper No.14 Did the 2015 Budget Provide Enough for Health?* An analysis of the allocations in the health budget for 2015-16. Available at http://union.org.nz/sites/union.org.nz/files/Did%20the%20Budget%20provide%20enough%20for%20Health%202015.pdf

It is now recognised there is a substantial and growing unmet health need in the community, the cost of which is unmeasured. There are also signs of district health boards deferring capital maintenance and investment.

We do not believe that imposing new ways of funding services is going to address these issues in the long or short term. In fact, they may make them worse if they are not supported by the clinicians who deliver the services.

A public debate on health funding is overdue. There are certainly issues about the lack of transparency in the funding of DHBs and, in turn, the funding of services by DHBs. There is also an alarming lack of evaluation of health policy initiatives, in terms of cost-effectiveness and unintended consequences. Similarly, there has been no broader economic analysis or social impact assessment of the effects of current health spending policies. We strongly believe it is this bigger picture that requires urgent attention before any consideration is given to the need for a review of funding arrangements.

Kind regards

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