Questions from stakeholder hui 7 May 2024

How can medication management be improved to ensure impact of poly pharmacy does not cause further harm to older patients?

The current review of the Aged Care funding and service model is taking a systems view to design better ways of supporting older people to remain at home. Medication management and innovative models of pharmacy are being considered in a series of workshops underway across New Zealand to ensure older peoples medication management is optimised and the impact of poly pharmacy is reduced. Further information about the review is available through Health NZ website: link.

If you wish to be part of the review you can provide feedback through this survey. (survey closes 10 June).

How can we help people age well and safely?

Public health promotion is high on our work programme to ensure that our population can recognise conditions through self-management, positive lifestyles and activities of engagement with telehealth services, primary care, community care and local pharmacy.

Will there be an equivalent view on Specialist Palliative Care availability in the community at both model of care and funding perspectives?

Palliative care is being considered in the Aged Care funding and service model review.

It's great to see a clear picture of the growing demand emerging. What role do you see demand prevention playing in enabling more sustainable alignment of forecast demand and health system resources?

Prevention is vital. For example, the best care when discharged from acute hospital is important for people to be as independent as possible long-term. As I mentioned there are some very good examples around NZ that should be deployed throughout the motu.

How do we use organisations like Age Concern to help support the elderly population?

They have input into policy development and deliver funded community services. They are contributing to the current review and have been invited to workshops.

How can we meaningfully input not just into funding formulas for aged residential care and home and community support but models of care, can you share early thinking re these models?

Further information about the Aged Care funding and service model review is available through Health NZ website: link.

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How do you envisage changing the view across the system for aged care providers to be seen as part of the wider health system rather than just a recipient of funding (noting not all are listed companies)?

The current review of the Aged Care funding and service model is taking a systems view to design better ways of supporting older people to stay well and age well. This approach is considering the older persons journey across the health system, including primary, hospital and community care and aims to develop integrated pathways of care across care settings and home.

I read the review on aged care funding, but was surprised it did not look at the number of aged care beds in NZ, as opposed to just the funding being allocated to the sector. NZ has a very large aged residential care (ARC) bed base and does this mean we have underdeveloped better alternatives, is this being looked at?

The number of aged care beds that need to be available to provide support in the future are part of the modelling being undertaken in the Aged Care funding and service model review.

NZ is currently paying millions to various agencies to send care workers into homes daily for medication oversight. In Christchurch I have been involved in trialling remote management with real-time monitoring. Everything went well with the small trial, but care workers don't want to refer clients into the service because then they will have one less visit on their books. The organisation employing them is funded per visit rather than per patient managed. This is a ridiculous waste of money.

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Where does community support sit within living well as it ensures people can live well in their own homes?

Community Support is an integral part of living well and delivers the support people need to live independently at home. Community support includes home and community support and wider community based support systems.

Nurse Practitioners and other health professionals can take some of the GP workload. How will they be supported to join primary care teams?

We recognise the role of an interdisciplinary primary care team, including GPs, nurses, nurse practitioners and other roles such as paramedics, pharmacists and physiotherapists. A team based approach is an opportunity to build on the varied skills in order to provide enhanced care for people. Nurse practitioners in particular, are already well embedded in a number of practices and providing vital access to health care.

GP is a much less attractive proposition now. What is planned to keep GPs in primary care?

Building a sustainable GP workforce is an important consideration and focus for Health NZ. There are a range of immediate and longer-term initiatives underway to ensure we can increase the number of GPs in the sector. This includes:

- Establishing an International Recruitment Centre, to recruit and support international health professionals (including GPs) to move to Aotearoa New Zealand
- Working with the Royal New Zealand College of General Practitioners to increase the number of GPs trained each year to 300 by 2026
- Closing the pay gap between first-year GP registrars and hospital registrars, removing one of the barriers for young doctors going into general practice.

When you keep issuing pharmacy licenses you dilute the pool of available community pharmacists that are the health professional seen most often and the only one available on a walk-in basis.

We recognise the important role of community pharmacy and they play a vital role in timely access to care. We have developed a national interim pharmacy provider policy, which has been established to provide a framework related to the issuing of an Integrated Community Pharmacy Services Agreement (ICPSA).

Will there be work undertaken to look at all of the different telehealth services? There are so many!

We are carrying out a telehealth review that will inform a broader telehealth service plan and options for any changes that may be required in services across the country. The review will look at the range of services being provided currently and a pathway to a more planned approach to delivery to ensure we have the right services in place across the country.

The MESO level service assumes that we need primary health organisations (PHOs). Has there been a cost to benefit analysis done as some of the PHOs receive large sums of money that may be better used for frontline services?

The purpose of the meso-level design project is to develop a discussion document on the future functions of the meso-level primary and community organisations that will support improved and sustainable future health outcomes. In this work we are looking at the current offerings of PHOs, but we are not looking to determine the final make up, function or number of PHOs in this work. We are also thinking broadly and there are no assumptions related to the current PHOs.

Is the scope of the primary care development programme really broad enough to fix primary care? Are others outside of GP included?

The scope of the primary care development programme is to improve priority areas across primary care, urgent care, pharmacy and rural care. The goal will be to focus on strategic change to improve health outcomes, which will require thinking broadly and about different approaches to health care delivery. We will not fix everything, but planning to make some significant improvements.

Where do Non-Government Organisations (NGOs) sit in this space as community/primary care providers? Disappointing that they are not mentioned at all as essential services in this space and a number of whom are funded by Health NZ. The burden on GPs would be significantly higher without them.

NGOs do play an important role in the health system. Aspects of their work are being captured in the meso-level design work where the benefits of having NGO better connected in with the system has been raised.

Can you say a bit more about the health needs index if this is going to be used in the capitation re-weighting? Is multimorbidity calculated based on hospital admissions and pharmaceutical data? If so, how do you ensure it takes into account people who have long term conditions but are not severe enough to use medicines or go to hospitals yet?

The capitation re-weighting project will be looking at options to better target capitation and multimorbidity will be one factor that is likely to be considered. The actual metric to determine the weighting related to multimorbidity is to be worked through with the advisory group.

Great to see these updates. I would like to know how we are connecting these life streams together in terms of workforce foundational training, so workforce can go between life streams as needed?

The primary care team are working in partnership with the national workforce team and regional teams to support workforce development and implementing workforce funding that will be targeted to the primary and community care workforce, who may support people across any life course.

What is the role of consumers in meeting some of the increasing demand (not just whānau and caregivers, but patients as well)?

Consumers have a very important role in health care. The opportunities that self-management brings to people as well as the system still needs to be fully realised. Tools, such as Healthify, are one way that we are supporting this valuable option for consumers to be drivers of their own care.

How many GP practices are disability accessible, ie: include hoists to enable some disabled people onto examination tables?

We do not have this information in a consolidated form, but this information is available through HealthPoint and through local primary practice websites.

Where a GP practice is not disability accessible, do they tend to use home visits as an alternative and if so do they charge full price?

We do not have this information in a consolidated form and this will likely vary from practice to practice.

What is being planned in primary care to address incidence of cancer being diagnosed after admission into ED? NZ have one of highest rates in OECD.

We are supporting the sector with health pathways for a number of cancers. These pathways provide guidance for primary care on appropriate assessment, referral and management of conditions.

How do you see Primary care coming together to ensure a whole-of-population approach is taken? Eg: for un-enrolled people and those geographical areas with access challenges.

The scope of the primary care development programme will take a whole of population approach, and there are regional health plans in development that are taking into account the needs of the population across its geography. We will also be working with regional teams and partners to focus on activities to support enrolment. The enrolment of newborn babies is a current focus for us.

Are there any updates on the Regulating the Physician Associate profession under the Health Practitioners Competence Assurance Act 2003?

This work is being led by the Ministry of Health. We understand that progress has been made.