On the future of psychiatry in New Zealand

Professor Des Gorman BSc MBChB MD PhD
The National Health Board
Health Workforce New Zealand
The University of Auckland
The background to future mental health services in New Zealand

• New Zealander’s expectations of their health services.

• A global mismatch between the demand for health services and the supply and affordability of those services.
  – Projections of demand.
  – Likely workforce growth.
  – Possible funding increases.
NZIER (2005)
NZ Population Projections by Age Cohort (Assuming medium population growth)
Demand, supply and affordability

- On the basis of extant feminisation, part-time work, career choice, migration and retirement, and using a head count of the practitioners and trainees in 2010, none of the medical disciplines will have enough practitioners by 2021 to meet NZIER’s best case scenario.
- Some workforces are already in critical shortage and this has adverse personal and societal impact.
Proportion of the working age population receiving different main benefits, 1960-2010

Source: MSD Statistical Reports
Note: Population 18-64 years. The count of benefits excludes individuals receiving a benefit as a partner.
Figure 20: Māori and non-Māori life expectancy, by gender, 1950–2000
A terrible but liberating conundrum

• An informed, but conservative guess of the growth in demand for health services is for a doubling between now and 2021.

• At best, it may be possible to increase the health workforce by about 40% over this period.

• If increases in health funding are to be linked to growth in GDP, then the likely increase in health funding will also be about 40%.
A terrible but liberating conundrum

• The solution to the conundrum is to both reduce the demand for health care and to reduce the cost of meeting that demand.
A terrible but liberating conundrum

• Consequently, we will need to do many if not most things differently and this will necessarily require a reform of service configurations and models of care. This recognition leads to the adoption of the following core design principles: an inclusive intelligence; disruptive innovations as business as usual; and, clinician leadership.
A terrible but liberating conundrum

- There is a general acceptance among OECD nations that a key response is to slow down the rate at which hospitals are being built and the rate at which hospital specialists are being recruited, trained and employed.
Managing health funding— an exercise in investment and disinvestment

The status quo
- Hospital based specialists and dislocated small business model of community providers

Up-skilling community providers
- Community based health provider networks
- Integrated care and corporatisation

Fewer hospitals and specialists
- Home based and patient directed care
Increased cost and reduced independence

Hospital based care

Care in community based residential facilities

Care at home with and without special assistance

What is necessary to shift care in this direction?
A terrible but liberating conundrum

- It follows that there will need to be a shift in the site of patient care from hospitals to community networks, and into the home, and to do this, the following will be essential: (1) a shared care record; (2) a different form of funding services and of rewarding providers; and (3) a fit-for-purpose community based health workforce.
An illustrative vignette: Aunty and her poor diabetes control

• The status quo.
• A virtual version of the status quo.
• A reformed model of care involving an advanced care pharmacist.
• A reformed model of care involving an diabetes nurse prescriber.
• Barriers to reformation.
Aunty is unwell

Fourteen week duration and six provider contacts; three days off-work for daughter; and, two hospital admissions.

** = Daughter off-work to drive Aunty to appointments

Three month wait and two hospital admissions for falls
Aunty is unwell

Blood test unit in car – tests and uploads results on Auntie's health face book page and sends phone text to GP

One hour duration and one provider contact. No days off work for daughter. No hospitalisations.

District Health Nurse

Physician

Pharmacy

Family Doctor

Uses password Aunty provided to go online and look at her results - texts diabetes specialist and sends results to them by phone.

Looks at results on their phone - rings family doctor and nurse and emails new insulin regimen to pharmacist.
Aunty is unwell

District Health Nurse

Advanced practice pharmacist
Aunty is unwell
Patient centred approach

Current provider centred approach

Mobile test units and electronic record

Reward system

Increased convenience, speed and safety; reduced cost to system, Aunty, her daughter, her daughter’s employer.

Health workforce planning

• It is probable that the only truism in health workforce planning is that we will inevitably get it wrong.

• This recognition can either be seen as an excuse to give up and resort to serendipity and to rely on the vagaries of the market place or as a stimulus to adopt principles that enable planning under conditions of uncertainty.
Health workforce planning

• Planning must be based on a dynamic intelligence.

• Most of the health workforce needs to be able to be flexibly employed, and quickly re-trained and re-deployed (e.g. a generic rehabilitation clinician).

• Slow to train and expensive health workers need to be employed in as general a scope of practice as is possible and must work “at the top end of their licence”.
EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

Quality rank

1
26
51

General practitioners per 10,000

1 2 3 4 5

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

EXHIBIT 6
Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000

Quality rank

1
26
51

Specialists per 10,000

18 19 20 21 22

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000
7,000
6,000
5,000
4,000

General practitioners per 10,000

1 2 3 4 5

NOTE: Total physicians held constant.

EXHIBIT 7
Relationship Between Provider Workforce And Medicare Spending: Specialists Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000
7,000
6,000
5,000
4,000

Specialists per 10,000

18 19 20 21 22

NOTE: Total physicians held constant.
On the future of psychiatry in New Zealand

• The concept of criticality of medical disciplines and service loads as the basis of training funding.

• How do psychiatrists contribute to the Government’s health targets?

• How vulnerable is the discipline of psychiatry?

• What is the role of psychiatrists in the future New Zealand mental health service?
The Government’s ‘clinical’ health targets

• **Health Target One:** Better, sooner, more convenient health services.

• **Health Target Two:** Improving service, reducing waiting times, and increasing the volume of elective surgery.

• **Health Target Three:** Achieving health targets relating to cancer, smoking, immunisation, diabetes, cardiovascular health, and the performance of emergency departments.
The Government’s ‘clinical’ health targets

• **Health Target Four:** Delivering services closer to home in local community settings.

• **Health Target Five:** New systems and services to safely and effectively respond to the health needs of older people, including prevention.
Proportion of the working age population receiving different main benefits, 1960-2010

Source: MSD Statistical Reports

Note: Population 18-64 years. The count of benefits excludes individuals receiving a benefit as a partner.
The vulnerability of psychiatry

- Total non-trainee workforce = 489
- Trainee to specialist ratio = 0.38
- Proportion of non-trainee workforce that is not vocationally registered = 16%
- Proportion of non-trainee workforce that are IMGs = 57%
- Average age of non-trainee workforce = 51 years (for both NZ graduates and IMGs)
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• What is the role of psychiatrists in the future New Zealand mental health service?