Medical Leader	
Medical Expert	•
Communicator	•
Advocate	☐
Scholar	•
Professional	
Collaborator	•
Manager	•

Managing Equity In A Time Of Fiscal Constraint

2014 Day 2 – Q4 (Choice)

The New Zealand Public Health and Disability Act 2000 in section 22 (e) and (f) requires District Health Boards (DHBs):

- *to reduce health disparities by improving health outcomes for Maori and other population groups:*
- *to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:*

Assume this legislation applies to your own jurisdiction.

District Health Boards fund the full spectrum of publicly funded health care via contracts with a variety of providers. This includes primary care and prevention services.

A recently published report analyses the impact of economic constraints on one particular DHB's investment in strategies to reduce health outcome disparities. It makes the point that ministerial directives and other national policy requirements which are mandatory have left DHBs with a reducing proportion of their budget over which they can exert direct control. For this reason, both primary and preventative care spending is disproportionately affected by cost containment measures.

In light of this report, your CEO asks you to prepare an outline paper for your local governance Board, outlining the ways in which your effectiveness in working to reduce inequalities can be measured, in general terms, and what areas should be protected when implementing cost containment.

What information will you seek in preparing this report, and what strategies might you recommend to maintain the maximum investment in reducing inequalities when cost containment is required?

Censor's Notes

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Measurement of effectiveness/information required:

- Need baseline information about health status of overall population and the various subgroups known to have higher levels of deprivation. Candidates must refer specifically to Maori/indigenous Australian populations. A good candidate will note that M/IA peoples typically present late in the course of an illness, which creates an unknown burden of unmet need within their communities. *Examiners can ask about this and how to assess if not mentioned.*
- Data sources: Census information, health service use data from primary and secondary care, notifiable disease notifications and surveillance (eg influenza), *consider initiating sampling surveys within specific communities, if information is not available*
- Review literature generally, and in particular to establish what indicator conditions may be reliable measures of poor health outcomes for these communities, with emphasis on ambulatory sensitive (avoidable) hospitalisations.
- Review information available on time trends in rates of overall morbidity and mortality in your community, if possible comparing rate changes for the least deprived with the most deprived communities.
- Review as above, but looking specifically at ambulatory sensitive conditions
- Look for benchmarks, eg Health Round Table, talk with colleagues, particularly in health provider organisations with similar demography, including public health providers.

What areas they should try to protect when implementing cost containment.

The answers to the above come from answers to the first question, and can be expanded with specific examples, particularly around ambulatory sensitive admissions.

Strategies:

- Initiating or improving surveillance – given time frame would need to ensure some conditions with short lead times were included – injury, communicable diseases, obstetric and neonatal outcomes etc
- Reviewing organisation's policies around prioritisation of first specialist appointments and waiting lists to ensure more deprived communities and indigenous peoples are not being systematically disadvantaged; if possible auditing their effectiveness. Consider including living in a highly deprived community and indigeneity as weighting factors for prioritisation.
- Partnership with primary care; seek their advice. Ensure their organisational goals are aligned with the funding organisation's statutory duties around reducing inequalities, that they are made aware of the demonstrated potential for perverse outcomes from some ministerial

priorities, that they are monitoring ambulatory sensitive conditions, and especially, that their information gathering systems align with hospital coding. In NZ primary care uses Read Codes, which do not align with ICD10 used by hospitals. Examiners can pose this question – what if you find this situation? Consider using indicator practices, get statistician advice about valid sampling, highlight longer term need to enable health outcome data to be reliably amalgamated or linked.

- Partnership with identified communities where people experience health inequalities. Find out how these communities view their health status and their experience with obtaining health care, improvements they can suggest. Build and maintain genuine partnership over the long term, consider consumer representation. From an Australian National Health Service Standards point of view they should mention the need to partner with consumers in identifying health needs and service delivery options
- Look into short and longer term strategies for improving health, roles of other agencies in contributing to health outcomes – housing, income protection, education etc. Partnership with public health agencies.
- A good candidate might venture into the political aspect; of ensuring that the political dimensions of this issue are appropriately brought to the attention of their Board via their CEO.

COMPETENCIES

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