

Submission to Southern DHB on Models of Care for Queenstown from Queenstown Medical Centre Ltd

This submission is made by Queenstown Medical Centre Ltd (QMC) on behalf of all QMC doctors and with their full knowledge and support.

The recommendations of the Models of Care paper have also been discussed with Drs Milliken and Thompson from Wakatipu Medical Centre who were supportive of an enhanced primary /secondary care model, recognised the unsustainable nature of the current arrangements and are comfortable with QMC's desire to be involved in broader care provision.

Background:

As a major stakeholder QMC has been consulted by Cranleigh Health Consulting and in the past by previous DHB administrations on our views on future health structures in rural communities.

The health service in Queenstown including the medical staffing of Lakes District Hospital (LDH) was provided by co-operation of local general practitioners until 2004.

The Southland District Health Board (SDHB) administration of the time then decided to provide medical staffing for Lakes District Hospital "in-house" which has had an increasingly significant effect on the sustainability of general practitioner out of hours services since that time.

It is also notable that the cost of medical cover at LDH has increased during that same time from \$240,000 per annum in 2003 to well over \$2,000,000 in 2010. This nearly tenfold increase is grossly out of line with the growth of Queenstown and has to be appreciated on the background of static in-patient care activity.

It has been of great concern to QMC that its comprehensive primary care service, at the forefront of quality and accessibility in New Zealand, has been significantly adversely affected by the provision of "first contact care" in an inefficient manner from a publicly funded and increasingly expensive, secondary care facility which has not, in fact, broadened significantly the secondary medical services it provides during this time.

The recent release of the "Models of Care" document for Queenstown, whilst incorporating all the right steps to a sustainable health service, has become a rallying point for various community groups most particularly the unelected health pressure group the Wakatipu Health Trust (WHT). Whilst we acknowledge the need of the local community to be involved in the future of their health provision we do not believe that the status quo has served Queenstown well nor that its preservation is a worthwhile or sustainable goal for the long term. It also appears that the LDH staff in general have identified the WHT model of "business as usual just with more funding from SDHB" as their most preferred outcome preserving staff positions, current service divisions and entrenched

practises.

Rural communities have long been served well by their general practitioners' care, level of expertise and breadth of practice but have perhaps looked with envy towards city hospitals providing ever more primary/general practice level care for free.

It is difficult to achieve an understanding within the public domain that episodic "free" care delivered by hospital Emergency Departments (EDs) is not only inappropriate and inefficient but significantly more expensive to the health system as a whole than the appropriate triaging of patients with a restriction of "free" emergency medical care to the seriously ill and injured patients that the emergency department system was developed for.

Lakes District Hospital is currently seeing over 6500 ED attendances of which >70% are triage categories 3, 4 and 5. This is work that is well within the capabilities of general practice in Queenstown and is still delivered, at a high standard, to patients attending general practices and in particular on an immediate access basis, at the QMC Accident and Medical (A+M) unit at 9 Isle Street. As patient numbers at this unit have barely increased from 2003 and bed numbers at LDH have remained static it is obvious that the increase in primary care attendances at Lakes District Hospital is the single factor driving the current medical staffing levels there.

A commonly made argument by the proponents of DHB funded EDs has been the safer environment of hospital systems, improved clinical outcomes and efficiency and greater patient satisfaction. Increasingly world experience and the available research has shown the opposite to be true and there is no evidence that the recent Queenstown situation is different.

The faults in the system of acute health delivery in New Zealand have been recognised and district health boards are moving to work together with primary care providers to shift patient loads into more appropriate environments where high quality care can be provided away from the episodic and poorly integrated care of emergency departments. This is enshrined in the principle of "better, sooner, more convenient health care" of current government policy and is at the heart of the push towards the development of "Integrated Family Health Centres" (IFHCs) as the main vehicle for such improvements.

Examples of primary care leadership in the provision of acute care are found in the majority of rural hospitals in New Zealand. Within the southern region Dunstan Hospital, Maniototo Hospital and Balclutha Hospital are all operating on a GP triage system for access to their intervention areas and Gore Hospital is currently moving towards such a system.

The Wakatipu Health Trust consistently refers to Oamaru Hospital as a desirable model for Queenstown. However, this particular facility is situated outside any reasonable funding parameter and has pursued a course of secondary care leadership at great cost to the public purse. It is clear in this context that Southern DHB will need to take decisive steps in bringing the Waitaki District in line with its other rural areas.

It is our contention that adopting a model with such a financially unsustainable

construct for service delivery is not in the current or long term interests of Queenstown.

Queenstown Medical Centre Proposal

In view of the public consultation and the clearly articulated wish by the community to gain input into the future of their health provision, it would be insensitive and publicly unacceptable for QMC to bid for a tender encompassing all of LDH services.

However, the model we believe to be currently favoured by the Wakatipu Health Trust, that of a continuing secondary care focus for local “public” health delivery is unacceptable to the Queenstown providers given its inherent flaws and lack of sustainability.

Any Queenstown solution will require the support of all providers to ensure the viability of the future health system in the long term. A publicly funded trust creating a competing health system on the basis of outmoded and failed policies is not a structure Queenstown providers are able to support.

QMC therefore proposes a “Dunstan Hospital” model i.e. provision of secondary care services from the “public hospital” with hospital admission through general practice/primary care or directly for triage categories 1, 2 (and appropriate 3) but that the model is enhanced through the co-location of all health care providers on one site and in particular a primary care A+M unit.

The work currently categorised as triage 3-5 is clearly within the capabilities of general practice in Queenstown and will be treated by local general practices. The populist argument that the Queenstown public should have access to free ED services for all ailments is ignoring financial reality, government policy and evolving medical care models.

Triage category 1 and 2 (and some 3) will remain to be treated free of charge under the public ED contract.

Therefore, to streamline services, a variation to the “Models of Care” paper should be considered for the Queenstown hospital .

1. General Practice, Accident and Medical (A&M), District Nursing services and Out Patient clinic provision are all at the core of Primary Care.

This block should therefore be considered as a unit under the leadership of a proven provider-Queenstown Medical Centre Ltd - who would provide general practice and accident and medical services on site , provide district and community nursing and co-ordinate and administrate out-patient clinics.

2. Higher emergency care (triage 1+2), inpatient care including end-of-life/hospice and respite care are bundled into a second “community contract” resting with a proposed “Queenstown Health Trust” contracting to the Southern District Health Board.

This would enable the community to become involved in donations, fund raising and support of the Queenstown Hospital without any commercial limitations through the involvement of a private operator.

It seems apparent from comments by WHT that anything but the replacement of the SDHB by WHT and “business as usual” is unacceptable to the leadership of the trust, it should however be acknowledged that WHT is neither elected, nor has the unequivocal support from the Queenstown community.

A compromise bundling the core “secondary care type functions” together under the leadership of a board of governance incorporating representation from WHT would go a long way in achieving community acceptance.

An experienced health administrator should therefore lead the proposed “Queenstown Health Trust” which would include local health provider, DHB, iwi and community representatives as well as co-opted expertise as required.

This “Dunstan Model” in reducing ED attendances and consequent unnecessary clinical load and fiscal burden has been shown long term to be clinically safe, politically acceptable and supported by the communities of other areas in Otago/Southland.

A co-located primary care facility incorporating an A&M unit interfacing directly with the Queenstown Health Trust run ED and the hospital itself will be supported by all providers in Queenstown and help to reinvigorate viable 24/7 GP services that have struggled since 2004. Most importantly this would be an integrated care centre in which true primary/secondary and private/public partnership would exist and result in significant enhancement of patient care while both clinical and fiscal efficiencies would be forthcoming.

Such an integrated centre would not only best serve patient care but also provide for the possibility of further services including surgical intervention, support current services such as maternity provision, be the ideal base for health professional teaching and training, enhance staff morale and help their retention, look to integrate other current medical services such as mental health and could provide a vehicle for a wide variety of community support organisations likewise integrating on one site. The possibilities are endless and the concept sound.

As a first step and a show of good faith QMC would like to renew its offer of accommodating the care of triage category 4 and 5 patients from June 2010 to reduce the workload on LDH and avoid another staffing crisis.

The SDHB Medical Division update from 11/11/2009 also states this as one of the options to address a perceived “unsafe situation” at LDH ED.

Despite QMC offering this interim solution to SDHB management staff in November 2009 it appears that instead a further staff increase at LDH was favoured by the SDHB medical division.

We are aware that our submission differs in many aspects from the current proposed models of care discussion document.

However, after discussions with our community and Lakes District Hospital staff we feel that a forced amalgamation of all the various current service providers will lead to unnecessary confrontation and loss of public support.

We are currently investigating the co-location options that will allow commercial viability of high quality, easily accessible primary care services whilst offering public ownership of the hospital facilities and services.
These options would significantly reduce the required public investment into Queenstown allowing a true private-public partnership delivering high quality services.

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