PHO Alliance

He huinga ratonga hauora

A time to act:

Implementation solutions

22 May 2015

Introduction

In February 2015 we published *A time to act: 7 actions which will help sustain the New Zealand health service for future generations**.

We shone a spotlight on 7 key actions members of the PHO Alliance believed would, when combined, help deliver a sustainable, effective and patient centred health and care system for the future.

We were confident of our proposed actions, but what we weren't quite expecting was the volume of support for our publication which subsequently arrived from all parts of the sector.

I would like to thank everyone who took the time to respond so positively. We found that particularly reassuring because the challenge of creating a sustainable health service is one which we believe we can only solve collectively with bold leadership and sector-wide engagement.

Among those messages of support we also received a challenge. A challenge from the Ministry of Health, who asked for our help to establish a further tier of practical steps required to implement our actions.

Happy to respond to that challenge, we put in place a process of engagement which included discussions with stakeholders alongside a sector wide workshop to develop the implementation solutions which we now set out in this new publication. Once again, I must thank those partners from across the health system, who attended and contributed to the success of that workshop.

For us, the overwhelming message from that process of engagement was that IT is an essential enabler for virtually every action. We need to see greater national leadership and development in this area rather than repeatedly reinventing the wheel and being left to the whim of commercially savvy vendors in each and every locality.

What we also heard was a repeated message that we need to do more to facilitate all of our vital health care professionals to work at the top of their scope of practice.

In this publication we set out solutions which require implementation at a national level as well as others that are within the current scope of local stakeholders.

There is inevitably some overlap between the proposed solutions as the gap in some enablers (e.g. IT) covers a wide range of proposed activity.

The final issue I wish to address as an introduction to this publication, is that of 'winners and losers'. We are aware of an on-going debate regarding targeting of resources and addressing unacceptable inequalities. Our message is simple; to address inequality we must refocus resource from those who need it least to those who need it most. The cost that may cause to the most privileged members of our society will be negligible compared to the on-going cost endured by those whose whanau are unfairly suffering more years of chronic illness and ultimately being taken from them years before their time. Doing nothing in response is not an option.

Having responded to the challenge we look forward to seeing these sector-wide recommendations reflected in the forthcoming refresh of the New Zealand Health Strategy and enabling us to deliver a lasting legacy for our future generations.

John Ayling
Chair, PHO Alliance

** A time to act: 7 actions that will help sustain the New Zealand health service for future generations – available from the PHO Alliance website www.phoalliance.org.nz/publications*

Our overarching actions to optimise the health sector

Reprioritise funding and services

1. Prioritise more services and funding to those most in need
2. Abandon health targets that do not have an evidenced link to patient outcomes
3. Support IT systems which directly underpin patient centred integrated care

Remove the barriers to access and eliminate perverse incentives

4. Make all primary care consultations affordable
5. Give patients the choice about who they would like to address their health concerns
6. Remove the barriers to diagnostic services
7. Divorce the conflicted relationships which DHBs have as controller of local health service funds and managers of secondary care hospitals

Our recommended solutions

Reprioritise funding and services

The health sector is facing possibly its biggest ever challenge. The New Zealand population is getting older and is living with more long-term conditions.

Not everyone is affected equally however. There remains an unacceptable gap for both health outcomes and life expectancy between Maori and non-Maori.

That we live with such inequality and inequity in the 21st Century in a developed society needs to be the prime focus of health care improvements. If we can reduce health care disparities then all New Zealanders are going to benefit from the changes we make.

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1. Prioritise more services and funding to those most in need

There is no debate that the health status of Maori, Pacific Islanders and those New Zealanders living in the most deprived communities is unacceptably worse than the rest of the population.

We say the only fair way to address such inequalities is to seek the same outcomes for all, and to achieve that will require more targeting and resources for those most at need.

We also say that the biggest health gains for New Zealand will be made by focussing on those most at need.

The current system of universal capitation funding is failing those who need it most and the formula for allocating health dollars across both primary and secondary care services needs an overhaul to be targeted for best effect.

The big advances in reducing inequalities come when bold decisions are made about funding priorities.

As well as the core funding formulae, the myriad funding silos which span Ministry of Health Programmes and each DHB need considering as a whole and targeted more appropriately. The emerging Integrated Performance and Incentive Framework must make a significant impact upon inequalities locally, or it will fail an otherwise great opportunity.

Implementation solutions for national action

1. *Re-target capitation (esp. VLCA) funds at individual patient level rather than practice level. One way this could be achieved is to reintroduce a community services card type system administered at the practice level.*

2. *Update and strengthen the primary care capitation formula to include weightings for deprivation, need, rurality and ethnicity. (as a minimum, establish a second age:cost curve to recognise that the challenges of old age and end-of-life come many years earlier for Maori, PI and high-needs population).*

3. *Introduce DHB and IPIF targets to reduce inequalities (variation in life expectancy between white European Kiwis and that of Maori, and Pacific Islanders).*

4. *Recognising the variation in existing regional disparities, incorporate a significant weighting to IPIF reward funding to acknowledge the high-needs population component of PHO enrolled numbers.*

5. *Reduce the number of funding silos and processes by including SIA, CarePlus and Health Promotion streams within an overarching primary care weighted allocation formula (in line with 2. above).*

Implementation solutions for local action

6. *Combine more DHB and PHO funding streams through consistently understood Alliance arrangements to secure greater collective benefit and targeting at high needs.*

7. *Review all financial commitments being made from the 'Services to Improve Access' (SIA) funding stream, to ensure best outcomes and benefit being secured for high need population alongside other local funding streams.*

2. Abandon health targets that do not have an evidenced link to patient outcomes

We say more about perverse incentives and unintended consequences later, but nowhere is this more evident than the misalignment between health policies based not on the needs of our communities but on easily measured "widgets" which make good media releases.

Setting a maximum six hour waiting time for ED does not ensure that we have a high performing health system. It fails to ensure a better alternative is put in place before admitting patients to costly hospital wards causing further anxiety to them or their loved ones.

And a six hour waiting time for ED certainly doesn't ensure that optimal multi-disciplinary care and support is provided to those who are most vulnerable to enable them to live independently and happily with their families and Whanau.

Setting DHBs targets for the numbers of patients receiving elective procedures while clearly of individual benefit reinforces a disease focused approach and does nothing to incentivise providers to prevent the onset of illnesses or find alternatives for referrals to secondary care.

We believe there would be benefit in greater use of patient reported outcome measures (PROMs) rather than singular activity based measures. PROMs are a means of collecting information on the effectiveness of care delivered to patients as perceived by the patients themselves. Such measures are becoming more established overseas and include the Aberdeen Varicose Vein Questionnaire and the Oxford Hip Score.

The PHO Alliance recognises that improvement projects such as multidisciplinary pathway development have made a useful contribution of encouraging and supporting primary care practitioners to assume greater clinical responsibility for patients, with a consequent reduction in unnecessary referrals into secondary services and more localised care for patients. This is as it should be. However the reluctance to recognise the financial implications of changing patient flows so that patients can remain within the primary care domain risks compromising these gains.

Implementation solutions for national action

8. *Introduce a national independent expert panel to develop and oversee a single dashboard of locality health targets with a focus on outcomes covering inequalities, deprivation, ethnicity, co-morbidities, rurality, and mental health status.*

9. *Introduce an independently developed and collated suite of Patient Reported Outcome Measures, building on the work already being developed nationally by the Health Quality and Safety Commission.*

10. *Introduce a hospital quality of care measure incorporating readmissions, medication errors and PROMs as an alternative to existing volume and time based measures which add little to clinical outcomes.*

11. *Introduce clinically accepted school based childhood obesity targets incorporating waist measurements, physical activity, nutrition. Support with legislation banning unhealthy food and drink being sold within/nearby schools.*

12. *Introduce targets at DHB level measuring reductions in inequalities (e.g. life expectancy gap).*

13. *Abandon volume based hospital activity targets (e.g. elective and FSA volume target).*

3. Put integrated IT platforms in place

We agree with the vision of the National Health IT board and believe we need to do more to make it a reality.

To achieve high quality health care and improve patient safety, New Zealanders need a core set of personal health information available electronically to them and their treatment providers regardless of the setting as they access health services.

We need to find information solutions which allow patient centred integrated care. These systems need to be interoperable, share data and be accessible to not only health providers but patients. For this to occur there has to be strong national and regional leadership to make unified decisions about how to progress towards the NHITB vision statement. This should be driven by the needs of patients and clinicians not by IT vendors.

Implementation solutions for national action

14. *Establish a single national 'clearing house' through which all developments (including PMS developments) are agreed, negotiated and commissioned from vendors (to shift commercial balance-of-power) with agreed standardised outputs and electronic reporting*

15. *Establish a single national health IT forum encompassing, MoH, DHBs, PHOs, providers and patients to develop and implement national policy covering*
    - *Usage requirements (user, system, levers)*
    - *Data sharing / privacy / data protection / patient created access rights*
    - *Data standards*
    - *Shared care portals*

16. *Stop the duplication across New Zealand's 20 – 30 localities in respect of workload and resources underpinning IT development, negotiation, commercial contracting and training.*

17. *Mandate the requirement for 100% e-referrals as a patient safety measure (e.g. lost faxes) across all providers (e.g. growing role of pharmacists, allied health practitioners and NGO providers).*

Remove the barriers to access and eliminate perverse incentives

We constantly give advice to patients and colleagues about making the right decisions to get the best outcomes and to most successfully navigate around the myriad components of our health system.

It would therefore be reasonable to expect that our health system and those organisations within it, are configured in a way which supports those same patients and health professionals to make the right choices, first time and every time.

Yet ask any health professional and most patients about their experiences and many are likely to reflect on irritating and seemingly illogical barriers in the system which have prevented them from doing the right thing.

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4. Make all primary care consultations affordable

If we are serious about encouraging patients to visit their GP rather than ED, and if we are serious about ensuring all women receive cervical screening when appropriate, then we should make all such appointments and associated consultations affordable.

To allow patients to attend ED with its immediate access to diagnostics and its high-tech facilities with no co-payment, yet have financial barriers to see their GP is perverse.

It is also a significant barrier to access for those very same vulnerable high needs patients for whom we want to encourage greater health engagement to reduce the unacceptable health inequalities we face in New Zealand.

There is a bundle of international evidence about the whole system benefits of a strong primary care sector. We believe removing the barriers to accessing ours will improve outcomes but also save money as we reduce demand upon high cost secondary care services and ED.

The current Very Low Cost Access (VLCA) capitation funding formula is failing. There are 590,000 non-high needs patients receiving the benefit of VLCA funding. We need to have a funding formula that is targeted to the need of the individual patient.

Implementation solutions for national action

18. *Recognising that affordability is also about being able to access services at a convenient location and a convenient time, ensure that IT enablers are in place for patients and practitioners (see section 3 above).*

19. *Remove all patient co-payments for essential screening and population health programmes (e.g. cervical screening).*

20. *Re-target capitation (esp. VLCA) funds at individual patient level rather than practice level. One way this could be achieved is to reintroduce a community services card type system administered at the practice level.*

Implementation solutions for local action

21. *Optimise the 'health care home' multi-professional team, ensuring services are supported by pathways and funding frameworks incorporating:*
    - *Nurse practitioners*
    - *Allied Health practitioners*
    - *Pharmacy care for common ailments*
    - *Pharmacist only meds*
    - *Mental health*
    - *Optimisation of triage/ reception*

22. *Increase patient education to optimise navigation and self-management.*

5. Give patients the choice about who they would like to address their health concerns

We believe, that for many reasons, a GP may not always be the best health professional for patients to see when they turn to the health system for support or assistance. If we moved towards an integrated, multidisciplinary team approach in primary care, we consider that patients would be able to make their own decision about when to see the dietitian, the podiatrist, the physiotherapist, the nurse, or the counsellor for instance.

Such direct access would make better use of all our health professionals' skills and significantly free up GP time for those patients who really need them or for when the patient's needs are just too complex for them to make their own decisions.

Once again, we believe removing the funding barriers and better co-ordinating access to all our primary care health professionals will not only improve outcomes but also save money as we optimise the skill mix for the primary care workload and reduce demand upon high cost secondary care services and ED.

Implementation solutions for national action

23. *Facilitate all health professionals working at the top of their scope by ensuring that IT enablers are in place for use by patients and all practitioners.*

24. *Amend the Medicines Act & GMS Regulations (to enable allied health and pharmacy to become integrated into 'Health Care Home' team).*

Implementation solutions for local action

25. *Transition to a materially higher patient:GP ratio through increasing multi-professional skill mix within health care home.*

26. *Give all patients with 1 or more long-term conditions, the choice of a nominated low-cost direct access 'care manager' from the wider health care home multi-professional team (e.g. physiotherapist, pharmacist, dietitian, mental health practitioner).*

27. *Optimise clinical pharmacists practicing through PHOs in support of the health care home*

6. Remove the barriers to diagnostic services

We recruit and fund a highly qualified, highly experienced and highly capable multi-disciplinary team based in primary care and aligned to the medical home which is general practice. We expect them to manage risk on a daily and patient-by-patient basis. We look to them to manage demand for secondary and specialist care so as to ensure high cost acute services are utilised appropriately.

Why then do we prevent those same practitioners and professionals from accessing probably the most important decision tool available to them?

Failure to provide access to the full suite of diagnostic services to our vital primary care workforce results in delays to diagnosis, anxiety for patients, duplication of costs through outpatient appointments and an overwhelming failure to provide the right care at the right time in the right place.

Empowering and mandating the primary care teams to utilise the traditional secondary care domain of diagnostics and we believe referrals will reduce, duplication of costs will reduce, and, most importantly, more patients will receive earlier interventions and support to live independently in the community without the need for avoidable hospitalisations.

Implementation solutions for national action

28. *Through a single national IT forum, develop, commission and mandate the uptake of single specification telemedicine solutions on a single national platform.*

29. *Develop regional respositories as a component of the national clearing house recommended in section 3 above.*

30. *Further develop scope of training practices – to incorporate more on-site diagnostic equipment and attract trainees through a programme of structured placements.*

31. *Enable and optimise vocational registration extended scope for GPs, nurses and allied health professionals (as emerging to facilitate rural access).*

7. Divorce the conflicted relationships which DHBs have as controller of local health service funds and managers of secondary care hospitals

We already know a strong high quality primary care sector is vital to a strong high quality wider health sector which is financially sustainable and which delivers better outcomes for patients.

Such a vision requires investment in primary care capability, capacity and infrastructure. In New Zealand, we feel investment in primary care has continually been eroded over recent years rather than increased.

We believe this will not change whilst we have financial pressures at the same time that DHBs have the unenviable task of controlling those investment decisions locally and simultaneously being held robustly and publicly to account for the performance of secondary care acute hospitals. Very few Directors or Executives the world over could rationally increase the risk to their own bottom line by investing in another sectors growth and capacity.

We need to look again at the purchaser/provider split without creating an industry of accountants and contract managers unwittingly diverting health funds away from real patient care.

Implementation solutions for national action

32. *Mandate/legislate for DHBs to facilitate the shift of specific services from secondary to primary care management, recognising that is where the primary skill set is already established. A simple re-location does not achieve the change required.*

33. *Mandate the establishment of DHB level strategic investment funds to pump prime primary care infrastructure and service developments.*

34. *Mandate that one DHB Board Director position is filled by a primary care selected member of each local PHO Board.*

35. *Mandate that each DHB executive leadership team includes the chief executive of each local PHO.*

About the PHO Alliance

The PHO Alliance is a consortia of member PHOs working together to share learning, share best practice and support better outcomes for patients.

Our member PHOs encompass some 1.2 million New Zealanders living in some of the most deprived communities from Cape Reinga to Bluff. Our reason for being is to improve community health and the enrolled populations of our members.

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