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New Zealand primary healthcare and health system change: thoughts from an academic and Alliance Chair perspective

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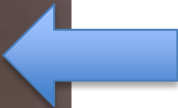
ORIGINAL ARTICLE

A Typology of Primary Care Workforce Innovations in the United States Since 2000

Asia Friedman, PhD, Karissa A. Hahn, MPH,† Rebecca Etz, PhD,‡ Anna M. Rehwinkel-Morfe, PsyD,§ William L. Miller, MD, MA,∥ Paul A. Nutting, MD, MSPH,¶ Carlos R. Jaén, MD, PhD,# Eric K. Shaw, PhD,** and Benjamin F. Crabtree, PhD†*

Purpose: Innovative workforce models are being developed and implemented to meet the changing demands of primary care. A literature review was conducted to construct a typology of workforce models used by primary care practices.

with complex health issues, the necessity for roles and identities of physicians to change, and the call for fundamentally redesigned practices. However, we identified 5 key workforce innovation concepts that emerged from the literature: team care, population focus, additional resource support, creating workforce connections, and role change.



Friedman A, Hahn K, Etz R et al, Medical Care, 52(2): 101-111; 2014.

THE FUTURE FOR PHC AND HEALTH SYSTEMS IS IN…

“Experimental governance”

Instead of a top-down, hierarchical rule-based system where failures to adhere are sanctioned, or unregulated market-based approaches, the new governance school posits a more participatory and collaborative model of regulation in which multiple stakeholders, including, depending on the context, government, civil society, business and nonprofit organizations, collaborate to achieve a common purpose. In order to encourage flexibility and innovation, “new governance” approaches favor more process-oriented political strategies like disclosure requirements, benchmarking, and standard-setting, audited self-regulation, and the threat of imposition of default “regulatory regimes” to be applied where there is a lack of good-faith effort at achieving desired goals.

Klein, A. Judging as nudging: new governance approaches for the enforcement of constitutional social and economic rights, *Columbia Human Rights Law Review*, 39, 2008, cited in Fierlbeck, K. The changing contours of experimental governance in European health care, *Social Science and Medicine,* 2014;108(1):89-96.

Old and new governance compared

Old governance

- Substantive
- Rigid
- Prescriptive
- Demanding of uniformity
- Stable and lasting
- Hierachical control

New 'experimental' governance

- Procedural
- Flexible
- Informative
- Accepting of diversity
- Provisional and revisable
- Alliance

Overview

1. Brief history of PHC change in NZ
   – WHO goals and PHC performance
2. Institutions do matter
3. Current developments: Alliances, ALTs and SLATs
4. Reflections on Alliance performance and prospects
5. Experimental governance: what prospects?

1. PHC REFORM IN NZ: QUICK HISTORICAL RECAP

PHC change in NZ

- Early 1990s: IPAs develop
  - ca 80% of GPs are members by late-1990s
  - IPAs were: budget holding; facilitating comparative effectiveness research; building strong networks across PHC; embracing IT; engaging in population health
- Early 2000s: Primary Health Care Strategy and PHOs launched
  - Alma Ata vision…

PHOs…

- Government sought to subsume IPAs and GPs within PHOs
  - GP resistance; a lost opportunity
  - IPAs remain an organisational force
- PHO policy never properly thought through; they were an ‘add on’
- Early 2000s also saw DHBs installed as regional infrastructure for planning and funding local health services, and owning public hospitals

But PHOs meant…

- Considerable new funding available for PHC
- Enrolment with a GP
- Reduced patient fees and new services for:
  - Patients with chronic conditions
  - Services to improve access
  - Health promotion
- Development of PHC infrastructure and focus on a population

PHOs and Primary Care Strategy also meant

- New Zealand was closest in our 2010 evaluation to delivering on the WHO 2008 PHC goals:
  - Universal coverage: to promote equity, end exclusion, promote social justice
  - Service delivery reforms: to reorganise services around primary care
  - Public policy initiatives: integrating public health services into PHC; 'inter-sectoral collaboration'
  - Leadership reforms: promoting policy dialogue with multiple stakeholders

Gauld R et al, The WHO Report 2008 – Primary Health Care: how wide is the gap between the agenda and its implementation in 12 high-income health systems?, *Healthcare Policy*, 7,3;2012.

2. INSTITUTIONS MATTER

Present institutional arrangements

- 20 District Health Boards:
  - Plan and fund services for a geographic population
  - Each with embedded infrastructure
- ~30 PHOs
  - Provide local PHC infrastructure and services
- DHBs fund PHOs but the two are parallel systems, working with a common population and depend on one another
- Health service and system improvement requires a joint planning mechanism

3. CURRENT DEVELOPMENTS: ALLIANCES, ALTS AND SLATS

‘Better, sooner, more convenient’ care

- 9 pilot BSMC business cases commissioned in 2010
- Diversity of regions and focus but some commonalities
- Each featured an ‘alliance’ structure
- An ‘alliance leadership team’ was core governance/decision making/accountability mechanism

What is an alliance?

- The idea of an Alliance is derived from the construction industry:
  - Different businesses/interests work collaboratively to ensure achievement of common goal: to complete a project successfully and on time, within budget. They help one another and, where relevant, share resources

Health alliances

- From mid-2013, each PHO is required to enter into an Alliance with its respective DHB
- Each PHO-DHB alliance is a governance arrangement (or mechanism) aimed at:
  - Working in partnership to improve health and health services for their population
  - Developing a ‘whole of system’ approach to service planning and delivery
  - Improving the patient journey, with the patient at the centre of all decisions
  - Allocating resources where these will best deliver on alliance goals

Alliance aims

- Build on strengths of DHB and PHO
- Build system-wide approaches to service delivery
- Integration/coordination, with focus on timely service provision and services designed with patient experience at centre
- Deliver services in best place, as clinically agreed
- Allocate resources to support service design
- Reduce duplication across local health system
- Clinical leadership

Alliance membership

- Health professional and managerial leadership
- Skill based
- Have capacity to lead/influence/understand perspectives of professional colleagues (e.g. General Practice; nursing; hospital specialty)
- Members may include:
  - PHO CEO and professional leaders
  - DHB CEO/COO, P&F, professional leaders
  - Måori/Pacific leaders
  - Patients/community representatives
  - Support staff

ALLIANCE SOUTH:
AIMS, STRUCTURE, ACTIVITIES

Alliance South is

- A collaborative leadership aimed at improving the health of our Southern population

Why?

- To provide a whole of system experience of care for our Southern people, provided at the right place and right time by the right person

Alliance South aims

- Create a Southern health system: integrate/coordinate care
- Health professionals lead decision making
- Systems that make sense to patients and health professionals: ‘best for patients, best for system’
- Encourage and support innovation; transform the health system
- Consistency across the region
- Whanau ora

CEO
Southern DHB

Alliance South leadership team

Programme Manager

Service Level Alliance Teams

Community & Hospital Pharmaceuticals	Rural Health	Outpatients	Acute Care & Demand	Diagnostics

SOUTHERN PATHWAYS

Each SLAT will…

- Assess needs of the population
- Promote and facilitate district service planning, and clinically/financially sustainable services
- Integrate service development
- Support/assist the DHB and PHO to make clinically-led service development decisions based on '**best for patient, best for system**' basis
- Provide leadership within the health community
- Allocate resources to support service design
- Balance focus on highest priority areas in our communities, while ensuring appropriate care across the entire Southern population
- Advise on development, delivery and monitoring of health services

Flexible funding

- Pooled DHB-PHO resources, largely from pre-existing ring-fenced allocations
- Alliance has local flexibility to allocate these to agreed services and initiatives

Building a culture of co-creation in researc

...t should governance for integrated ...are look like? New Zealand's alliances provide some pointers

Multidisciplinary leadership teams and flexible approaches are helping streamline New Zealand's health care system

Robin Gauld

While the search continues for governance arrangements that support health system and service integration,[1,2] developments in New Zealand provide useful new insights. New Zealand presently has 20 district health boards (DHBs) planning and funding regional hospital and other services, and around 30 primary health organisations (PHOs) that plan and fund elements of general practice and primary care for enrolled patients. These two sets of arrangements have functioned largely separately from one another, despite DHBs funding PHOs and both having common populations.[3] New Zealand's policymakers and health care providers have

Alliance goals variously include shifting services hospitals to primary care or creating new arrange combining elements of both service domains to, for ple, reduce avoidable hospitalisation or improve c condition management. The key, as noted, is to fo and work towards what makes best sense in the con integration to the players in the local health system

All DHBs now have an alliance leadership team membership of which is determined by the DHB an and evolves as an ALT sees fit. Members are likely to doctors, nurses, allied health professionals, others fro pital and primary care settings, and those with res

4. ALLIANCE PERFORMANCE: WHAT DO WE KNOW? HOW TO MEASURE THIS?

Better, Sooner, More Convenient – Primary Health Care

Research Team:

Robin Gauld, Kirsten Lovelock, Greg Martin, Jackie Cumming

Funded by the Health Research Council of New Zealand in partnership with the Ministry of Health

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Aim

- To evaluate whether the business cases:
  - led to integrated and co-ordinated care across the different systems of care;
  - improved patient experience; and
  - Produced efficiencies and cost reductions through reduced ED admissions and ASHs and greater co-ordination of service delivery.

Methods

- Collaborative with BSMC sites
- Pragmatic mixed method case study design:
  - quantitative and qualitative data;
  - routine data/survey data;
  - site visits, interviews;
  - document analysis

Findings

- Goals and targets were too ambitious
- Too many new initiatives were rolled out simultaneously
- Considerable pressure on front-line staff
- Alliances had a rocky start:
  - Leadership questions
  - ALTs too big
  - Clinical involvement/disillusionment
  - Dominance of planning and funding representatives
- The BSMC cases have commenced a process of steering the ship in a new, important direction

TO CONCLUDE: EXPERIMENTAL GOVERNANCE FOR THE FUTURE?

- Alliancing offers an important road-map
- The idea has yet to be fully tested, but the journey has only begun
- This is an age of ‘experimental governance’: beyond hierarchical forms of control and silos to ‘harmonisation’ of interests of different actors in the health system
- Much of the ‘old’ hierarchical infrastructure remains in New Zealand, including reporting and financial mechanisms
- A complex mix of vertical and horizontal governance arrangements is emerging
- It’s messy but critical in a complex world when seeking to build clinically-led ‘whole of system’ approaches
- The pending ‘Integrated Performance and Incentive Framework’ (IPIF) should galvanise Alliances and their activities

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