

SOUTH ISLAND HEALTH SERVICE PLAN

CONCEPTUAL FRAMEWORK

Introduction

The Chief Executives and Chairs of the South Island District Health Boards (DHBs) have requested that a framework be developed to support planning for clinically and fiscally sustainable health & disability services for the future in the South Island.

This framework will provide direction for the type and level of health services that will be required to best meet the needs of the South Island population, while allowing discussion and debate about how services can be configured and organised.

In considering the future there are concepts that must be agreed to enable individual DHBs and providers to plan and move forward without waiting for the South Island Health Services Planning process to be sufficiently advanced to provide detail for each service and related activity including service delivery specifics required for facility developments.

The goal is to have a regionally coordinated system of health service planning and delivery of health services that will see lasting improvements in the sustainability, quality and accessibility of clinical services. Initially this will be largely focused on hospital services however over time it must incorporate the development of primary and community based health care to provide the essential base for any changes to hospital services.

The 'New Zealand Health Strategy' sets the foundation for the government's action on health along with other key strategies such as He Korowai Oranga: Maori Health Strategy 2002 and the Primary Care Strategy, 2001. District Health Boards are charged with improving the health of their populations and reducing health inequalities. The recent WHO report strongly supports these underpinning strategies and states that more than ever there is a need for a well coordinated primary care.

Background

The current model of hospital services is not sustainable from a fiscal or a clinical perspective. Available future funding will not meet the current cost structures of providing secondary and tertiary (hospital) services in the current way; capital requirements for investments in new facilities and equipment are greater than the available level of funding.

Clinical sustainability issues are present in all District Health Boards (DHBs) now. Currently these vary between DHBs but include where there are not enough clinical staff to provide basic medical and surgical services, insufficient number of specialists for the population they service. The South Island also has a number of small, vulnerable clinical services deployed across the region providing to small populations.

The South Island DHBs agree that access to timely and accessible health and disability services, of a high quality, is a right that all New Zealanders have regardless of where they live. Services will only be accessible if they are sustainable. Services will only be sustainable in the medium to long term if they are of a high quality reflecting contemporary evidence based practice. These two issues create a counterbalancing effect when considering the configuration of health and disability services across the South Island, and indeed across New Zealand. This dichotomy ultimately results in a balancing between local provision of services and centralisation of services.

Increasingly some services within the South Island are facing key sustainability issues. More than ever regional approaches are required to ensure the population of the South Island have access to services and the ensure health resources are utilised in a manner that provides equitable access.

This conceptual framework outlines the:

- The key challenges facing the South Island health services
- Why we need to plan South Island health services
- Underpinning principles of the health services planning approach
- The planning approach to be undertaken
- Going forward
- What the future may look like.

Challenges of the South Island

Significant challenges are expected in the provision of health and disability services over the next 20 years including:

- Population growth, redistribution and ageing
- Increasing risk and prevalence of long term conditions
- Reducing health inequalities
- An international shortage of skilled healthcare workforce
- Effective utilisation of the available workforce
- Increasing sub-specialisation
- Managing within an affordable funding path
- Effective application of technological advances and
- Rising consumer expectations.

Within the South Island we know:

- We have inequity across the South Island e.g. access to elective services, health status for Maori
- Chronic conditions are the major cause of life expectancy disparities between Maori, Pacific and other New Zealanders
- Our Maori & Pacific Island populations are increasing by 38% & 48% respectively compared with 7% for the remainder of the population
- Our population is ageing - by 2021 one in five of our population will be aged 65 years or over, compared to one in eight in 2009
- Older people have higher rates of use of health services and population ageing drives health expenditure
- The prevalence of chronic conditions is predicted to increase due to obesity and ageing
- International evidence indicates 75-80% of health budgets are spent on managing chronic conditions
- Chronic conditions account for approximately 30% of acute admissions to hospitals
- Our four largest cities make up 58% of the South Island population which remains relatively constant through to 2026, with Christchurch City expected to grow at the fastest rate, 14% and Invercargill population expected to decrease by 7%
- Our rural population is relatively stable
- The geography & population spread in the South Island challenges standard models of care and service configurations
- Most of our hospitals have a number of services that are at risk due to shortages of skilled workforce
- Some hospitals are providing services at a level not supported by their population base
- Some of our community health services are at risk due to workforce issues
- Primary health care services do not have sufficient capacity to meet the demands of an ageing population and increasing levels of chronic disease
- Our DHBs and funding structures create artificial boundaries when designing health services.

Why plan for the South Island

Individually and collectively DHBs face a number of challenges that relate to access, quality, sustainability and affordability.

Clinical and financial viability has increasingly and will continue to become more difficult to maintain and with the continual drive to higher quality services there is a need for a well coordinated planning process to develop plans that provide certainty of services, inform sensible investment and to ensure survival of small DHBs.

In undertaking South Island Health Service Planning, the concept of provision as close to the patient / clients home as possible is an underlying principle to be aspired to. It is recognised that some services, particularly lower volume and more specialised levels of care, will not be able to be undertaken at all locations.

Whilst, the health service plan initially is focusing on secondary and tertiary services consideration of the broader environment such as primary, community and NGO sectors and aged care sector is vital and there is a need to incorporate representatives in the development of service plans.

In understanding the challenges, the South Island DHBs recognise the following key drivers for health services planning:

Sustainability of health services is an increasing problem. There are inequalities in access, utilisation and outcomes of services as well as geographic (metropolitan vs provincial and rural vs urban), demographic and ethnicities. Thus the health status of our population is influenced by where people live, their ethnicity, and their level of affluence. There is recognition that the majority of South Island DHBs cannot be clinically or financially sustainable in isolation.

Demand will continue to put pressure on current resources and is expected to be a major challenge going forward for health. The current model of care for people with chronic conditions is not sustainable and the demand will far outstrip the health systems ability to provide care and treatment therefore it is essential that a more effective model is required to manage these conditions whereby people are not required to have frequent hospital admissions thus their care is provided within the community utilising primary and community providers and supported by the specialists services within the non acute environment.

Future Investment decisions regarding investments in services, workforce, facilities and technologies are required. Certainty in service demand and revenue is important in cases where facilities and/or technologies are highly specialised such as tertiary services and require a certain minimum rate of use to justify the financial investment.

Patient Satisfaction – factors that influence include waiting times; service quality; poor integration between services, providers and regions; transport and poor coordination between aspects of the 'patient journey'.

The key objectives of the South Island Health Services Planning are to:

- reduce inequalities in access to health services across the South Island
- enhance the quality of health services across the South Island
- enhance the sustainability of all health services for the South Island population that are appropriately delivered in the South Island
- engage with key stakeholders to ensure understanding and acceptability of South Island Health Services.

Principles

The principles for all of the South Island Health Service Planning are shown below. It was agreed that these principles would form the basis for all service planning that determines health service configuration and models of care.

Equity of Access	Clinical engagement	Quality & safety	Clinical sustainability
<p>Planning will be based on the health needs of our constituent communities</p> <p>Historical demand and service provision will not determine future needs.</p> <p>Planning for health services relates to recognising and planning for changing demand and providing an equitable level of service for the population catchments with a continuing focus on reducing inequalities in health status.</p>	<p>Clinician input, through active clinical leadership, into the planning and decision making process is recognised as a critical component of the success of the SIHSP</p>	<p>The health consumer is the primary focus of any model of health care quality management</p> <p>Health treatment and care is based on the best available evidence with appropriate monitoring and evaluation.</p> <p>All health care providers have access to systems that enables outcomes of care to be assessed</p> <p>Quality of care systems that focus on: safety, access, effectiveness, efficiency, acceptability, appropriateness, and consumer participation.</p>	<p>The identification of future need and supply of clinical skills.</p> <p>Design of service delivery models that allow appropriate access, meet credentialing requirements, support evidence based practice, and are consistently delivered to a high standard of quality & safety.</p> <p>Clinical education and ongoing training for all health care providers must be considered to ensure quality service delivery</p>
	<p>Patient centred consumer involvement</p>		
	<p>Health care services will be co-designed with service users including the patient.</p> <p>This will be a collaborative process allowing a sharing of perspectives and experiences.</p>		
Māori health service needs	Community engagement	Continuum of care	Fiscal sustainability
<p>We recognise our commitment to partnership with Maori</p> <p>We recognise that Māori in our communities do not have equal access to health care or equal health outcomes.</p> <p>We aim to reduce health disparities by planning for services to address these</p>	<p>The Community will be informed and involved so that they have an awareness of the SIHSP, the drivers of sustainable health services that may result in changes to health service configuration and can accept the outcomes as being in the long term best interest of the population</p>	<p>SIHSP will consider the full continuum of care</p> <p>Continuum of care refers to services and integrating mechanisms that guide & track patients/clients over time through a comprehensive array of services spanning public health through to tertiary & including supports required to enable service delivery</p>	<p>Acknowledgement that efficient and effective use of resources will be required across the SI.</p> <p>Resources include workforce, facilities and infrastructure (including: information systems, clinical equipment, and transport) to deliver the models of care within the allocated funding system.</p>

Planning Model

What does it look like

WHOLE OF SYSTEM – HEALTH SERVICE PLANNING

Principles								
Equity of Access	Maori Health Service Needs	Clinical engagement	Patient centred consumer involvement	Community acceptance	Quality & safety	Continuum of care	Fiscal Sustainability	Clinical sustainability

Clinical service plans

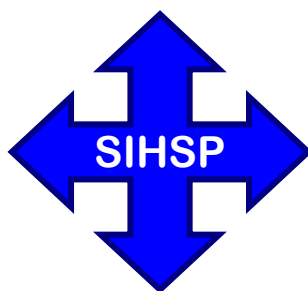
e.g. Neurosurgery, Child Health, others TBA

Regional Services

e.g. Health South, Electives initiative, others TBA

Health Networks

E.g. SIRMHN, SCN, others TBA



Clinical service developments

Non-clinical service developments

Enablers						
MoH Tools	Funding Options	Demand forecasting	Technology	Human Resources	Transport & Accommodation	Communications Plan

The planning model is supported by three prioritisation tools:

1. Health Equity Assessment Tool¹ - addresses inequities.
2. Decision Matrix² - plots amenability of addressing the problem i.e. is it feasible to implement, against the impact of the solution on outcomes.
3. Whānau Ora Health Impact Assessment³ –a tool to support Health Impact Assessment on policy decisions aimed at reducing inequalities.

¹ Ministry of Health. 2004. *A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health*. Wellington: Ministry of Health <http://www.moh.govt.nz/moh.nsf/pagesmh/3968>

² Kletchko S. Assessment of Health Status Problems NMDHB 2008

³ Ministry of Health. 2007. *Whānau Ora Health Impact Assessment*. Wellington: Ministry of Health. <http://www.moh.govt.nz/moh.nsf/indexmh/whanau-ora-hia-2007>

Going Forward

“The nature of health problems is changing dramatically; urbanisation, globalization and other factors speed the worldwide spread of communicable diseases and increase the burden of chronic disorders...”

In the face of all this, business as usual for health systems is not a viable option.”
World Health Organisation (WHO)

Life expectancy is increasing and as people live longer they are also living with one or more long-term conditions. Healthy life expectancy is not increasing as fast as life expectancy. Previously fatal conditions are now treatable but may last or recur for many years. The combination of demographic and lifestyle changes [increasing obesity, reducing activity, poor diet, ageing of smokers] means that the risks of long-term conditions are increasing, and are likely to be major burdens on the health system in the future [and disproportionately so for disadvantaged groups, contributing to increasing health inequalities].

There is no option of the Status Quo. Doing nothing is not sustainable as it will lead to needing more hospital beds, more doctors, nurses and other health professionals.

Hospitals provide an important back-up and a setting for highly specific care, and their importance to a preventative health system is paramount. However, a preventative health system would be primary and community-care led, also recognising home and community as the preferred place for provision of health services. This approach has been promoted by the World Health Organisation (WHO).

Every year the WHO provides an annual report on the status of health care and health care systems. As 2008 was the 30th Anniversary of the Alma Ata Declaration it is not surprising that the report would focus on Primary Health Care. The underlying premise of the report, Primary Health Care – Now More Than Ever⁴, is that an aligned systems wide approach is required to transform the health system and achieve the core WHO values of making health systems more equitable, more inclusive and fairer.

The Report explores the need to combine four sets of reforms (universal coverage, service delivery, public policy and leadership) in a way that reflects a convergence between the values of primary health care that requires that health systems to “put people at the centre of health care”, the expectation of the people as to what they find desirable for themselves and their society and common challenges facing health systems world-wide.

The Report clearly places primary health care in the pre-eminent place in the future health system as the guardian of a person-centred system. Consistent with general practice themes over time it recognises explicitly the role of primary health care in delivering comprehensive, continuous and integrated care, providing a regular point of entry to the health system that builds trusting relationships with individuals. In addition, the Report recognises the danger of specialisation, hospital centric systems and complex fragmented services driven by a disease rather than a person focus. It notes frequently the need to move services closer to the person and supports the development of primary care networks and multi-disciplinary teams.

There is a strong theme to support primary care taking responsibility for a defined population and being supported to coordinate care for that population from hospitals, NGOs and specialised services. As part of this approach the Report suggests that primary care providers should have their role as coordinator strengthened by giving them administrative authority and purchasing power.

⁴ World Health Organisation 2008 The World Health Report 2008: Primary Health Care – Now More Than Ever. Geneva, World Health Organisation. http://www.who.int/whr/2008/whr08_en.pdf

South Island Health Services Planning Conceptual Framework

The Report explicitly recognises that Primary Health Care is not a cheaper option but a more cost effective option and identifies this as one of the misconceptions that has led to failure to implement the vision of primary health care.

A core theme of the Report as a whole is that health systems do not naturally align with the values of Primary Health Care. It has to be a deliberate and planned reorientation of a health system around a single point of continuity based in the community and an explicit move away from fragmented specialised care to a more holistic person centered model.

What the future may look like

The challenge for health professionals is that they will need to work differently, in different settings, across different sectors to coordinate patient care and ensure smooth transition for patients to appropriate levels of care. Secondary and tertiary services in the future need to exist within DHB structures but be provided across a number of DHBs. Most health professionals do not work in a linear structure they work in professional teams, collegial networks, across teams and in the future this will be the way that secondary and tertiary services will need to operate in particular across DHB boundaries providing services to local, sub-regional and regional populations.

A strong and highly developed primary care infrastructure is the required foundation for all South Island DHBs. More health care will be provided at home and in the community for long term conditions and rehabilitation. It needs to be noted that the future of the health services being able to meet the future demands on health services achieving the objective of a highly developed primary care sector is fundamental without which it is unlikely that secondary and tertiary services will be able to be sustainable. This is supported by WHO's annual report 2008.

Clinical networks will provide a forum for clinical leadership, and a partnership between management and clinicians across the service continuum to support delivery of a quality health service. For this networks are likely to have a more formal place in the health system and be accountable for agreed outcomes.

The traditional labels for facilities that align with the levels of service delivered i.e. primary, secondary and tertiary, are now and will continue to blur as services are delivered in a variety of places, including the home. Models of care, clinical networks and new technologies are changing to support service delivery in different environments to those traditionally recognised. However, there will always be a need for facilities where specialised services will be delivered and coordinated from. The labels primary, secondary and tertiary are used in this document to reflect the core level of services delivered from the facility.

With these changes the current configuration of facilities across the South Island will need to evolve. The traditional DHB boundaries and patient flows across the South Island will need to be challenged to ensure the services across the South Island are supported in a sustainable manner.

Without working through the more detailed planning to address the above issues, it is impossible to accurately predict or determine facility configuration and planning. There are also political and broader economic implications which need to be tested which reach far wider than the health sector. Examples of these policy settings include the impact that any changes to the configuration of tertiary services in Dunedin Hospital may have on the Education sector and in particular the University of Otago, and any broader economic impact on the wider community. The same would apply to populations such as Greymouth, and to a lesser extent Timaru on the consequential economic impact of any changes. These issues need to be addressed at a political level as they run the risk of derailing robust health service planning, or result in the focus of health service planning being centred around immovable assumptions / paradigms.

This being said a structure of facilities across the South Island is likely to be:

1. Integrated Family Health Centres – These centres will be primary led services providing a full range of multi disciplinary primary care services, including some services that have traditionally been provided through hospitals or District Health Board settings. These may include some outpatient activity; community based & district nursing, needs assessment. These will be provided in numerous settings and will be sized to take account of the population mass and distribution. Integrated Family Health Centres will be aligned with designated 'Base Hospitals', not necessarily along existing referral lines.

2. Community Hospitals – These centres may include services provided in other areas through Primary led Integrated Family Health Centres, however they will also provide acute stabilisation and transfer services, visiting secondary outpatient services, primary maternity care, sub acute care, rehabilitation for patients transferred from secondary and tertiary hospitals and appropriate day patient services including low level surgical activity.
3. Secondary Hospitals –will provide core Secondary Services for sustainable catchment populations. A number of these services will be provided in these facilities via In Reach Services from larger regionally based services. These facilities may develop areas of special interest but will be undertaken through regional planning rather than individual DHB generated initiatives. Some tertiary services will be provided in secondary hospitals through integrated service planning and delivery on behalf of the region
4. Tertiary Centre – Tertiary services will include robust outreach services, both from an outpatient, day patient, and where appropriate inpatient services, provided across the region..

The configuration of services can be summarised under different groups of clinical services:

Emergency care will need to be provided in the community and in all hospital facilities in the South Island (all current secondary care level hospitals). However, there is likely to be a requirement for enhancements to be invested into forming a coordinated regional service that is supported by telehealth (videoconferencing, real time transfer of clinical data/information and images) along with enhanced communication systems and transport systems.

Medical services will likely be provided by general medical services with visiting sub-specialist services provided at local hospitals, specialist outpatients services which could be provided at local hospitals or at 'integrated family health centres' and specialist outreach nursing services and home-based care. Major acute secondary and tertiary hospitals will provide a full range of medical subspecialties.

Surgical services will provide those and all other surgical specialties. These specialties will also provide visiting outpatient clinics and elective surgery at local hospitals. Some minor procedures such as skin lesions are likely to be provided in general practice and 'integrated family centres'. It is likely that there will need to be a move to regional booking systems to ensure optimal use of theatre capacity and equity of access.

Women's and Children's Services Secondary obstetric and paediatric services are likely to be provided in all local hospitals through sub-regional and regional services. Paediatric services are likely to be more focused on community paediatrics with more integration with primary and community providers. For tertiary paediatric services these are likely to be part of tier 2 or national service framework.

Conclusion

From the issues highlighted in the above sections there are themes that should underpin any changes in the way South Island provides health services and these are reflected in the principles described earlier.

Inevitably there will be concerns for individuals, communities and services as the changes are planned, debated and instituted. It will be critical to build partnerships locally across the health system that integrates planning and delivery of health services between all aspects of the system. Intersectorial partnerships will also be important both at a local but also regionally especially related to telecommunications and transport systems. Underpinning partnerships is the need to have joined up accountabilities and this will be important at the sub-regional and regional level.

Some DHBs have been considering changes for some time and are further ahead in their thinking and planning than others. However it is important that any changes are made in the context of the whole South Island.

It is also critical that we have active engagement at a political level to ascertain the extent of which change will be acceptable in the health sector, taking into account whole of government, and broader economic flow on implications.

Underpinning all of the decisions must be the goal of a fiscally and clinically sustainable health system in the South Island. This conceptual framework will now be utilized to guide and structure the approach taken through the South Island Health Service Planning processes, as well as a guiding structure for any localized or sub regional activity.