CHIEF EXECUTIVE OFFICER'S REPORT

RECOMMENDATIONS:

That the Board:

a. **Approves the establishment of a new PHO to include providers in the Otago DHB and Southland DHB regions.**

b. **Approves the appointment of a PHO Transitional Board to provide governance to the transition for the current 9 PHO configuration to a single new PHO.**

c. **Approves notices of exit to all PHOs in Otago and Southland once a timeline for establishment of the new PHO is confirmed.**

d. **Rejects the proposal from South Link Health to establish a PHO.**

1 INTRODUCTION

The vision for Primary Health Organisations (PHOs) to deliver on the Primary Healthcare Strategy (PHCS) remains unchanged since the strategy was introduced in 2001. However, a look at what has been achieved to date across New Zealand suggests there is still a long way to go.

The Minister of Health has recently made statements that indicate changes to PHOs are required.[1]

" we are committed to the PHCS … we want to achieve the rest of it … the multidisciplinary teams, co-locations, and better integration between primary and secondary".

"it is going to get harder for smaller standalone PHOs to step-up to the opportunities".

Treasury have also recently publicly released a discussion document on primary care that states *"limited progress has been made with the longer term objectives such as services that improve population health, keep people well, and coordinate their care".*[2]

[1] Hon. Tony Ryall, Minister of Health, speech at PHO Alliance meeting, Wellington, 5 June 2009

[2] How can primary health care contribute better to health system sustainability? A Treasury perspective.

Otago and Southland have a total of 9 PHOs with varying sizes and configurations. There have been some very good achievements by PHOs, but these have tended to be in certain areas or for specific groups of people, and have not been universal across the region.

The Minister clearly indicated a number of themes that the primary health sector should be considering.

- PHOs should be partnering DHBs to deal with the needs of the population
- PHOs will need to build capacity to step-up to the challenges; good governance, good managers and strong clinical leaders
- Fewer PHOs and less bureaucracy; seeking greater value for money by removing administrative overheads (see Appendix 2)

One of the most significant weaknesses of our current configuration of 9 PHOs across Otago Southland is the high degree of duplication. Recent Treasury forecasts (see Appendix 3) clearly indicate the seriousness of the financial situation the country is facing and the urgent requirement for all government sectors to show financial restraint. We all have a responsibility to reduce costs and duplication wherever possible. In Health this will require greater emphasis on doing more with less through increasing efficiency in all areas of service delivery.

The application in March 2009 to establish the Network PHO, and the messages coming from the Minister and the Ministry pre-empted a planned review of primary care and PHOs in Otago and Southland.

However, since the receipt of the Network PHO proposal, the DHBs have undertaken significant work in conjunction with existing PHOs and South Link Health to gain clarity among all parties as to the desirable requirements and purposes of a PHO. Much of this work was encapsulated in the Marwick report which was presented to the Boards in July.

The DHBs have considered further the organization or arrangement of PHOs which can deliver on the Boards' requirements for a PHO and this paper summarises Management's views in this regard.

2 OUR VISION FOR HEALTH SERVICE CONFIGURATION IN OTAGO SOUTHLAND

Our Environment and Future Trends

By New Zealand standards we have a highly dispersed population over a large area with about a third of our community living in rural areas. Otago and Southland share first world trends of an aging population, bringing with it an increasing chronic disease burden and increasing costs of healthcare service delivery. We are in competition with the rest of the world for skilled healthcare professionals who can apply ever expanding technology and innovation. Our total population is forecast to increase only marginally across the region with only Dunedin and the Central

Otago/Lakes regions predicting low and medium growth respectively over the longer term. Forecast declining population growth in many areas, but particularly in Invercargill, Oamaru, Gore and Balclutha will bring real challenges in healthcare service reconfiguration. The utilisation of Population Based Funding (PBF) (i.e. equitable average funding as a proxy for need) as our primary funding mechanism is not predicted to change, and as such our service access will trend to national average levels of access and quality unless we can achieve better than national average service delivery efficiency. We will be challenged to respond with health service delivery changes in response to the changing demographics and rurality of our region.

Our Future Service Configuration
The DHBs will seek the establishment of a single Primary Healthcare Organisation (PHO) across Otago Southland, and over time, this PHO will assume responsibility for supporting and funding most community service providers. Such a PHO will require professional governance, but at the same time be able to maintain a connection with communities. As it would be impractical to have every community individually represented on the PHO Board, there would need to be sub-committees or advisory boards to represent communities of interest, e.g. Maori, rural.

Community service providers will continue to play an increasingly important role in maintenance of health and wellness. Greater emphasis will need to be placed on the non-medical workforce to manage wellness and particularly chronic diseases of the elderly in the community and in people's homes. "Integrated Family Health Centres" (IFHCs) will be established in the community, facilitated by the PHO for clinicians to lead delivery of integrated health services through multidisciplinary teams, sharing expertise and health information. Community nursing services in particular will play a major role in supporting IFHCs in management of chronic disease in the community and more particularly in the home. The development of IFHCs, particularly in main rural centres, will ensure continuity of care between community and hospital services.

Sustainable regional secondary and tertiary services will be achieved through reconfiguration of services between hospitals in our regions and other secondary and tertiary hospitals outside the Otago Southland region. Traditional referral patterns will need to change to be able to support quality service delivery. IFHCs may contain observation beds for short stays pending either discharge to the community or referral to one of the hospitals in the region. [NOTE: *Work is currently underway to inform future configuration of hospital services across Otago Southland*]

IFHCs will be strategically located to ensure geographic coverage of the region to enable good access to primary care. IFHCs will refer patients to hospitals based on defined criteria. Patients health information will be integrated and be able to be accessed by authorized healthcare providers at the point of care, irrespective of where patients present.

Aging in place, supported by community health workers, will be an importance feature of service delivery for the elderly. Aged Residential

Care homes will continue to provide access to those elderly people who, despite support services, cannot live independently.

3 EMERGING POLICY DIRECTION

It has become increasingly apparent through discussions with the Ministry of Health that policy change will be required to ensure that the Government's vision of "Better, Sooner, More Convenient Primary Health Care" is able to be achieved. Whilst this policy framework is currently under development, certain key principles are starting to emerge. These include:

- Maintaining universal subsidies for GPs;
- Moving some hospital services to Integrated Family Health Centres that provide a full range of services, including specialist assessments by GPs with special interests, minor surgery, walk in access, chronic care, increased nursing and allied health services, as well as selected social services;
- Specially trained nurses who are involved with chronic care patients engaged as lead clinicians for non-health agencies to support at risk families;
- Providing a much wider range of care and support for patients with greater incentives for PHOs and providers to coordinate the ongoing care of their patients;
- Devolve more treatment and diagnostic services to primary care, holding DHBs accountable for the devolution of services to general practice and Integrated Family Health Centres;
- Improved productivity, increased efficiency and reduced cost;
- Reduced bureaucracy and administrative cost in order to apply more resources to direct patient care by clinicians;
- Greater clinician involvement in decision making regarding delivery of health services;
- The need for local planning to take into account the geographical community of interest to ensure that health and social services are well integrated at the local level;
- Sufficient critical mass to ensure that the new models of care are viable and appropriate to the geographical location;
- Where primary care has a direct impact on demand for services provided by other providers, e.g. hospitals, delegated funding could be used to align clinical and financial accountability and inform clinical governance processes so that services are better aligned to evidence based delivery. Such approaches could include PHOs holding funds for first specialist assessments and other outpatient services, ED attendances, community pharmaceuticals and community laboratory services.

4 PHO VISION

The DHBs PHO vision is congruent with the Primary Health Care Strategy. After five years of PHOs the DHBs are now able to more clearly articulate

a vision for what a PHO should look like and how it should operate in the region.

A PHO is an enabler and facilitator of services for providers in primary care and the community. Strategically a PHO should:

- Provide leadership on issues affecting primary care
- Foster clinically led planning and service delivery through strong clinical leadership and governance
- Introduce models of care that deliver better health, better utilise the available skills and improve sustainability of providers
- Promote innovation from health care providers and communities
- Recognise and meet the needs of different communities
- Be accountable for improving health outcomes
- Develop capacity and capability of the primary health workforce
- Operate cost effective service delivery and management services (value for money).

5 REQUIREMENTS AND CAPABILITIES OF PHOs

Management have developed a schedule of "Requirements and Capabilities of PHOs" (see Appendix 1), informed by emerging policy direction and our vision for community care service delivery, to assist us in determining what PHO configuration would best support achievement of our objectives. Whilst many of the requirements could be achieved by a configuration of multiple PHOs across Otago Southland, our view is that some of the requirements would at worst not be able to be achieved by multiple PHOs and at very best would be very difficult or not possible to be achieved by multiple PHOs.

It is our view that a single PHO across Otago Southland would be the best option to successfully achieve "Better, Sooner, More Convenient Primary Health Care". In particular we believe the following requirements are best met by a single PHO:

Good Governance

- Facilitating innovation, e.g. replicate examples of innovation and good practice through an innovation fund
- Provides leadership and advocacy for community care (and not just single provider groups)
- Capability to attract high calibre staff

Health Service Planning and Delivery

- Equitable access to health services e.g. specialist (low FTE) services can be managed in the community
- Available PHO funding is applied to the areas of highest need e.g. prioritise SIA funding across the region to maximise equity of health outcome

- Patients have the ability to move around the region to access funded services, i.e. they are not financially penalised because of which provider they access funded services from
- Reduced fragmentation of services, e.g. public health, community nursing, diagnostic services, primary mental health, Needs Assessment and Service Coordination
- Ability to build capacity and capability in primary care to manage services devolved from hospital settings, e.g. first specialist appointments (FSAs), diagnostics, public health, community nursing, ED, etc.
- Introducing new models of care for service delivery, e.g. IFHCs.
- Provider training and development
- Using technology to improve access to health services or address workforce and resource issues e.g. Telehealth, ePrescribing, electronic bookings, online services.

Value for Money

- Cost effective delivery of both clinical and management services, i.e. no unnecessary duplication
- Economies of scale to leverage opportunities for new/additional health services, e.g. multiple part-time FTEs can be pooled into full-time FTEs
- Minimise transactions costs in the sector, e.g. between the DHBs and PHOs and between the PHOs and providers
- Economies of scale for management services, e.g. Finance, Contract management, Project management, Procurement, Auditing, Payroll, Human Resources, Information Technology
- Introducing technology to better utilise resources or improve outcomes

Financial Risk Capacity

- Ability (through incentivising providers for example) to manage devolved budgets and risk for demand driven services such as pharmaceuticals, community laboratory tests, ED admissions, etc.

Information Technology

- Comprehensive capability in Information Technology, e.g. robust systems, secure management of data and reporting, supporting practice management systems and decision support tools etc.
- Supporting best clinical practice and benchmarking
- Innovation e.g. Telehealth, ePrescribing, electronic bookings, online services
- Sufficient scale for appropriate disaster recovery, IT redundancy, personnel coverage and backup.

Human Resources

- Provide recruitment and retention services for providers
- Workforce development and support for providers,

- Provision of professional development, training and education
- Offer career pathways
- Locum services for providers (e.g. PHOs could provide a GPs and Pharmacy locums service)
- Roster management of some services delivered by providers, e.g. after hours
- Industrial and employment relations

6 CONCERNS ABOUT A SINGLE PHO ACROSS OTAGO SOUTHLAND

Over the past week management has canvassed a single PHO model at meetings with Chairs and CEOs of existing PHOs and with South Link Health. Whilst Chairs have stated that their views cannot be construed as being those of PHO Boards, their comments have nevertheless been useful in providing an alternate view to that of DHB management for the Board to consider. The majority of PHO Chairs can see some of the benefits of a single PHO but have significant reservations about a single PHO model for the following reasons:

- Local communities of interest would not be best served by an entity that is not closely associated with and does not have a special interest in and understanding of the needs and wellbeing of that local community
- Rural interests in particular will be not have an adequate voice on the PHO and will inevitably lose out to urban interests
- Bigger is not always better, and they would need to be convinced that the requirements of future PHOs could not be met through smaller PHOs or alliances of PHOs
- The requirements and timing of those requirements for PHOs across Otago Southland is not explicitly known and therefore the optimal structure to meet those requirements cannot be determined
- There is a concern that local goodwill and resources (human and financial) from which local structures currently benefit, would be lost if a single, large, remote entity was imposed.
- Larger PHO entities are unlikely to be as innovative as smaller more nimble PHOs and this will ultimately have an impact on patient outcomes.

The relevance and importance of these concerns is acknowledged. It would be essential for governance arrangements, funding mechanisms, operating processes and structures within a single PHO to mitigate these concerns. For example, sub-committees, advisory boards or other arrangements would have to be put in place to represent disparate geographic and demographic communities of interest. An actual physical local presence in rural areas may be part of the answer.

7 IMPLEMENTATION

Implementation of the new PHO for Otago Southland would initially be led by the DHBs. The first task in establishing a new PHO is to appoint a

Board to oversee the role of getting the PHO set up and operational. This Transitional Board would have specific tasks to complete before a permanent Board was put in place. The Transitional Board will not run the PHO and therefore the composition of this board will not reflect a traditional PHO Board. However, it will need to have specific skills required to establish a significant new entity in the current health environment. Key tasks for the Transitional Board would be:

- Recruit and appoint a Chief Executive and other management.
- Develop a business plan.
- Confirm a target "go live" date.
- Establish the ongoing governance structure.
- Develop the necessary infrastructure
- Commence operations

The Transitional Board would be appointed by the DHBs. Its sole purpose is the set-up of the PHO, and hence the board composition should reflect the necessary skills for the task. It would be essential that the Transitional Board have strong clinician representation as well as current PHO knowledge. The recommended composition of the Transitional Board is:

- Chair (1)
- DHBs Board Members (2)
- DHB management (1)
- Existing PHO Chairs (2)
- GP Providers (2), one from each of Southland and Otago
- Non-GP providers (2), one from each of Southland and Otago

It is proposed that the Transitional Board would be dissolved once the PHO becomes operational and is replaced by a permanent PHO Board. This will need to have representation from the community, Maori and providers.

While the changes arising from Management's recommendation will clearly have significant impacts for current PHOs, there will also be significant changes for the DHB both in terms of current DHB service delivery and the planning and funding of services. Consultation with staff and unions will be a prerequisite to any changes affecting staff.

8 COMMERCE ACT

The DHBs do have to be cognisant of the Commerce Act. Legal advice indicates that there is no reason why the DHBs cannot establish a single PHO; it is a policy decision that they are entitled to make. There is currently competition between healthcare providers and this will not change.

It should be noted that the Commerce Act precludes the merging of all existing PHOs into a single entity.

Brian Rousseau
Chief Executive Officer

07 August 2009

APPENDIX 1: REQUIREMENTS AND CAPABILITIES OF PHOs – STRUCTURAL OPTIONS

H:\Board Meetings\
PHO Options Matrix v

APPENDIX 2: NZ DOCTOR ARTICLE – 29 JULY 2009

20090731125344750
.pdf

APPENDIX 3: TREASURY FORECASTS

H:\Funding\2009_10\
THE TIGHT FISCAL E

H:\Funding\2009_10\
The Treasury - Tight