Discussion document
Primary/Secondary care integration

The purpose of this document is to stimulate discussion and hopefully give us a better understanding of primary/secondary care integration occurring concurrently with a wide range of initiatives to “work differently” and developing “new models of care” while secondary services are asked to “move upstream”.

Fact:
1. We continue to need an effective and well staffed secondary care services across the country. Secondary care services and staff continue to work under increasing demands and pressures.
2. Primary health care and preventative health initiatives are the way forward and should be supported but it will not reduce the need for secondary care services for some time to come.

Disclaimer:
I am writing this at a time that I am particularly frustrated with the slow or even lack of progress in reshaping the health services in New Zealand.

Any criticism in this document is not aimed at any individual or organisation. Any criticism would also be aimed at myself. I am part of the health care system and as such have shared responsibility to improve it.

This represents my personal views and not that of the ASMS

I do not claim to have had any training in Planning and Funding or Health Administration.

Relevant back ground:
I am employed as a Secondary Care Public Hospital Senior Medical Officer (Paediatrician)

I have been involved or are still involved in the following:
Clinical Director Woman, Child and Youth
Tairawhiti DHB Operations and Performance Team
Tairawhiti DHB Leadership Team
Tairawhiti Integration Committee
Tairawhiti Integration Forum and E Tipu E Rea (conception to 5 years)
Tairawhiti Rheumatic Fever Champion
BSMC Midland Health Network Alliance Leadership Team
Midlands Planning and Funding Alliance Leadership Team
Midlands Child Health Action Group (regional clinical network)
Midlands Regional IS Clinical reference/governance group
National Maternity IS Clinical reference group

I still find integration, regionalisation, alliancing, funding and contracting of services etc. very confusing.
Searching the MOH website:
“Integration” delivers 225 documents. These documents cover a wide spectrum of health care activities from IT to Telemedicine to the day to day delivery of health care.

Some of the following information are directly copied and pasted from the MOH website

New Zealand Health System:

Overview of the health system

Health and disability services in New Zealand are delivered by a complex network of organisations and people. Each has their role in working with others across the system to achieve better health for New Zealanders.

A complex system, working together

The Minister of Health (with Cabinet and the government) develops policy for the health and disability sector and provides leadership. The Minister is supported by the Ministry of Health and its business units, and advised by the Ministry, the National Health Board, Health Workforce New Zealand, the National Health Committee, and other ministerial advisory committees.

See attachment

Primary Health Care:

Primary health care relates to the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, pharmacist or other health professional working within a general practice.
Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening.

Public Hospitals are owned and funded by DHBs:

Objectives and roles of DHBs

The New Zealand Public Health and Disability Act 2000 created DHBs. It sets out their objectives, which include:

• improving, promoting and protecting the health of people and communities
• **promoting the integration of health services, especially primary and secondary care services**
• seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
• promoting effective care or support of those in need of personal health services or disability support.

There are currently 20 DHBs in New Zealand. They are required to plan and deliver services regionally, as well as in their own individual areas.
Other DHB objectives include:

- promoting the inclusion and participation in society and the independence of people with disabilities
- reducing health disparities by improving health outcomes for Māori and other population groups
- reducing – with a view toward elimination – health outcome disparities between various population groups.

DHBs are expected to show a sense of social responsibility, to foster community participation in health improvement, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

There are 20 DHBs and 34 Primary Health Organisations

See attachment

Non-governmental organisations

Non-governmental organisations (NGOs) receive significant funding (in the order of $2–4 billion per year) from both the Ministry of Health and district health boards. Many are non-profit, and along with providing services to consumers they are a valuable contact at community level.

Public health units

Regional public health services are delivered by 12 district health board-owned public health units (PHUs), and a range of non-government organisations. District health board-based services and non-governmental organisations each deliver about half of these services.

Health alliances

Health alliances are nine networks of primary health care providers and district health boards that are implementing the Government’s ‘Better, Sooner, More Convenient’ care initiatives. These initiatives will provide services closer to home, make New Zealanders healthier and reduce pressure on hospitals.

Improved primary health care involves doctors, nurses, pharmacists and other health professionals working together having access to specialist diagnostic testing, working in teams combining different disciplines, and playing a more proactive role in managing chronic conditions, avoiding illness and providing some safe appropriate services traditionally delivered in hospitals.

Primary health organisations

Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO.

PHOs are one vehicle through which the Government’s primary health care objectives articulated through Better, Sooner, More Convenient Primary Health Care are
implemented in local communities. PHOs vary widely in size and structure, although all are not-for-profit organisations.

A PHO provides services either directly or through its provider members. These services should improve and maintain the health of the entire enrolled PHO population, as well as providing services in the community to restore people’s health when they are unwell. The aim is to ensure GP services are better linked with other primary health services (such as allied health services) to ensure a seamless continuum of care, in particular to better manage long-term conditions.

**Ministry of Social Development:**
Our Ministry is all about helping to build successful individuals, and in turn building strong, healthy families and communities.

**Supporting vulnerable children**
The Ministries of Social Development, Education, and Health are working together, alongside the Police and the Social Sector Forum, on three results that will support vulnerable children. They are:

**Result 2: Early childhood education:** In 2016, 98 per cent of children starting school will have participated in quality early childhood education.

**Result 3: Immunisation:** Increase infant immunisation rates so that 95 per cent of eight month olds are fully immunised by December 2014 and this is maintained until 30 June 2017.

**Rheumatic fever:** Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by June 2017.

**Result 4: Assaults on children:** By 2017, we aim to halt the rise in children experiencing physical abuse and reduce current numbers by five per cent.

**Integration:**

Integrate what?

We keep using words and concepts that are poorly defined and the interpretation can often be quite subjective. Your integration and my idea of integration can be very different, now multiply that by 20 DHBs and 34 PHOs and you get………

These concepts (like integration, regionalisation etc.) becomes buzz words that are used loosely within meetings and minutes and annual and regional plans. We develop support structures and working groups and administrative support and local and national travel and teleconferencing and video conferencing around these concepts but the vision of what successful integration would look like is not clear. We are trying to build a 10,000 piece puzzle but we have no picture available as a reference to what the finished puzzle should look like. We all know why we want to do this (or do we?) i.e. “to achieve high quality, affordable, seamless patient care” but we do not have a common vision or idea of what it would look like or how we will achieve this.

Conversations and questions asked to frontline staff in all sectors of the health service will quite often reveal how poor we communicate with them.
But alas integration does not happen in isolation (nothing in the health service ever does)

**Regionalisation**
Running parallel to integration we have regionalisation (and this has become an “industry” in its own right), regional service plans needs to be written and agreed and signed off by DHBs as well as primary care PHOs

**Health Alliancing:**
BSMC Alliances continues and have been since 2009. They have their own unique “blood supply” to access resources and receive “oxygen”. I have not seen any recent progress reports or updates as to outcomes or benefits. May be I have just had a boys look?

**Clinical Networks:**
Clinical networks are developing or being developed and some are quite mature already. Some has had a big positive impact on patient care but we should guard against clinical networks becoming an industry in its own right demanding more and more resource for less and less benefit.

**Ministry of Social Development:**
MSD Children’s Teams (protecting vulnerable children) and Gateway program require a high degree of cooperation between primary care, secondary care and MSD services. This is not a bad thing but again presents us with yet another level of integration that is resource hungry in a cost neutral environment.

**HBL**
……. enough said.

**Clinical pathway development:**
Map of Medicine
Canterbury Initiative

For each one of the above headings different conversations, meetings etc. etc. etc. needs to happen;

As an example: In the Midland region you have 5 DHB stretched out from coast to coast. Within this region you have several PHO to integrate with;

In Gisborne city (population 35000) we have 1 DHB, 5 GP practises spread over 3 PHOs to integrate and regionalise and get agreement……. is not an easy task……. enough said

**Vision?:**
The health system should look like a cut through the centre of an onion. No matter which way you cut it you see neatly arranged layers and levels of care. Moving from the outside to the centre, you should reach the centre and find a happy, healthy person. Should this person need to use the health service they should be able to move from the centre through
the layers of the health service seamlessly. The glue that keeps the layers together and bridge them should be our Information Services.

What we have at the moment is a “Health and disability services in New Zealand delivered by a complex network of organisations and people. Each has their role in working with others across the system to achieve better health for New Zealanders”.

Understanding this system is difficult and the “glue” of IS is quite often still being applied or absent and have come undone in places. From a patient perspective services are still all but seamless.

Is there a common vision/recipe or at least direction of travel? How do we effectively communicate with frontline staff and perhaps more importantly how do they communicate with us?

Attachments include some interesting or controversial documents.