

Clinicians in the Driving Seat!

Dr Paul McCormack,
GP and Independent
Commentator
Christchurch, NZ



Drivers Seat?



Drivers Seat?



What is Primary Care?

Barbara Starfield:

- First contact
- Continuing [Longitudinal]
- Comprehensive
- Integrated [or coordinated]

-> whole of health system view

An Environmental Scan

International Trends:

- Increased role for nurses
- Changed roles for doctors
- Capitated funding [as well as FFS]
- Enrolled population
- Community involvement
- From central control to devolution, and back!
- From bureaucracy to innovative / entrepreneurial

England

- GP fund holding in late 1980s were among the first networks in primary care
- “General practice led health system” 1996
- Policy Cauldron:
 - Shifting the Balance of Power
 - Leading Local Change
 - World class Commissioning
 - High Quality care for All
 - Doctor Led hospitals

Trailblazing hospital – **Medics in Charge**

- Doctors and nurses are to be put back in charge of running a hospital in a major shake-up which could have huge implications for the NHS.
- Telegraph UK
- 2nd July 2010

NHS shake-up

“hands funding powers to GPs”

- GP practices are set to be handed responsibility for most health services a radical shake-up of the NHS in England.
- Health Secretary Lansley believes GPs are best placed to understand patients' needs and to decide where money should be spent.
- 9 July 2010

Australian General Practice Network (AGPN)

- First Divisions of General Practice established in 1992
- AGPN was established in 1998 [as ADGP]
- Currently, a network of 110 local organisations (general practice networks) along with eight state based entities
- Divisions funded by Federal Government with some State Service contracts

A HEALTHIER FUTURE FOR ALL AUSTRALIANS

FINAL REPORT JUNE 2009



National Health and Hospital Reform Commission

2010 Budget Australia

- \$290 million to establish a new network of **primary health care organisations**, to be known as **Medicare Locals**, to coordinate and connect health services - **essentially re-branded and expanded Divisions of General Practice**
- Opportunities and threats

NZ Primary Care Development:

4 Phases:

- Pre 1990 – limited coordination, poor integration and poor communication
- 1992 – 2000 – IPAs [or GP Networks]
- 2001 – 2009 – PHOs - community governance
- 2010 – Clinical networks responding to BSMEC policy

1992 – 2001: IPA Era

- GPs surprised sector by their reaction to health reforms of 1991 – “organised themselves”
- GP networks - ProCare, Pinnacle, Rotorua, WIPA, South Link Health, Pegasus and others
- Strong clinical leadership ... and followership!
- Evolution to involve nursing colleagues

1992 – 2001: IPA Era

- Delivery across two main areas:
 - Primary care management / infrastructure
 - Clinical quality / clinical governance
- General practice demonstrated themselves to be the most adaptable group in the sector
- Strong achievements
- Variable in culture and direction

2001 – 2009: PHO Era

- Govt policy to achieve community governance – Alma Ata – and address health inequalities
- Built on achievements of IPAs, HCA, & MPOs
- Substantial govt investment in decreasing access costs for patients
- Local areas of excellence – when based on IPA
- Wide variation in culture and performance

2010: Clinical Networks

- Networks of clinical networks and PHOs responding to BSMC opportunities
- Focussed on:
 - Urgent care
 - Older persons care
 - Care of people with long term conditions
- Taking whole of health system approach
- Clinically led decision making

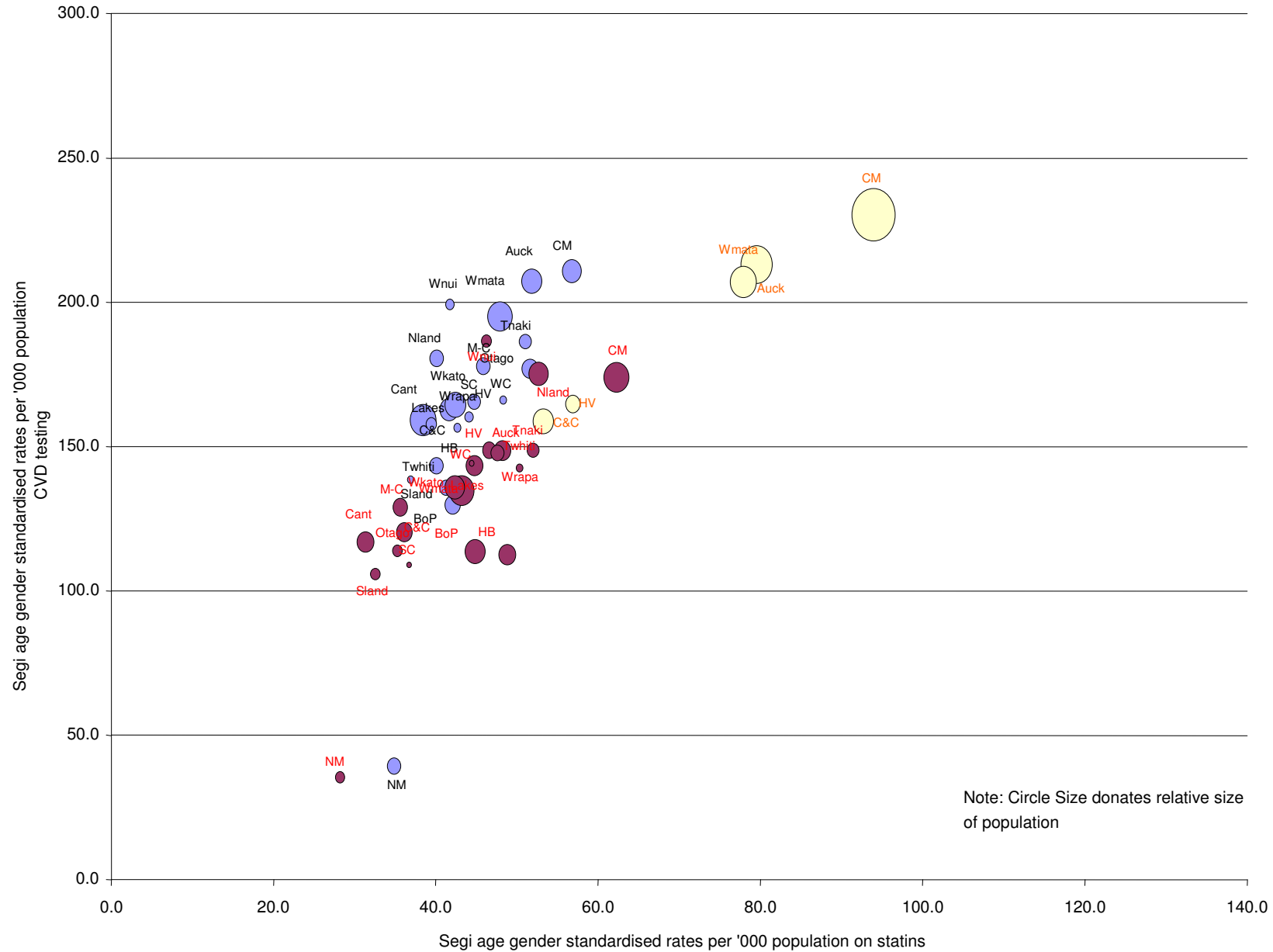
What we have learned? Incentives

- Incentives matter!
- How we fund health care has more impact than how much we fund
- Interventions work best when they are clinician led and management supported – but we need both!

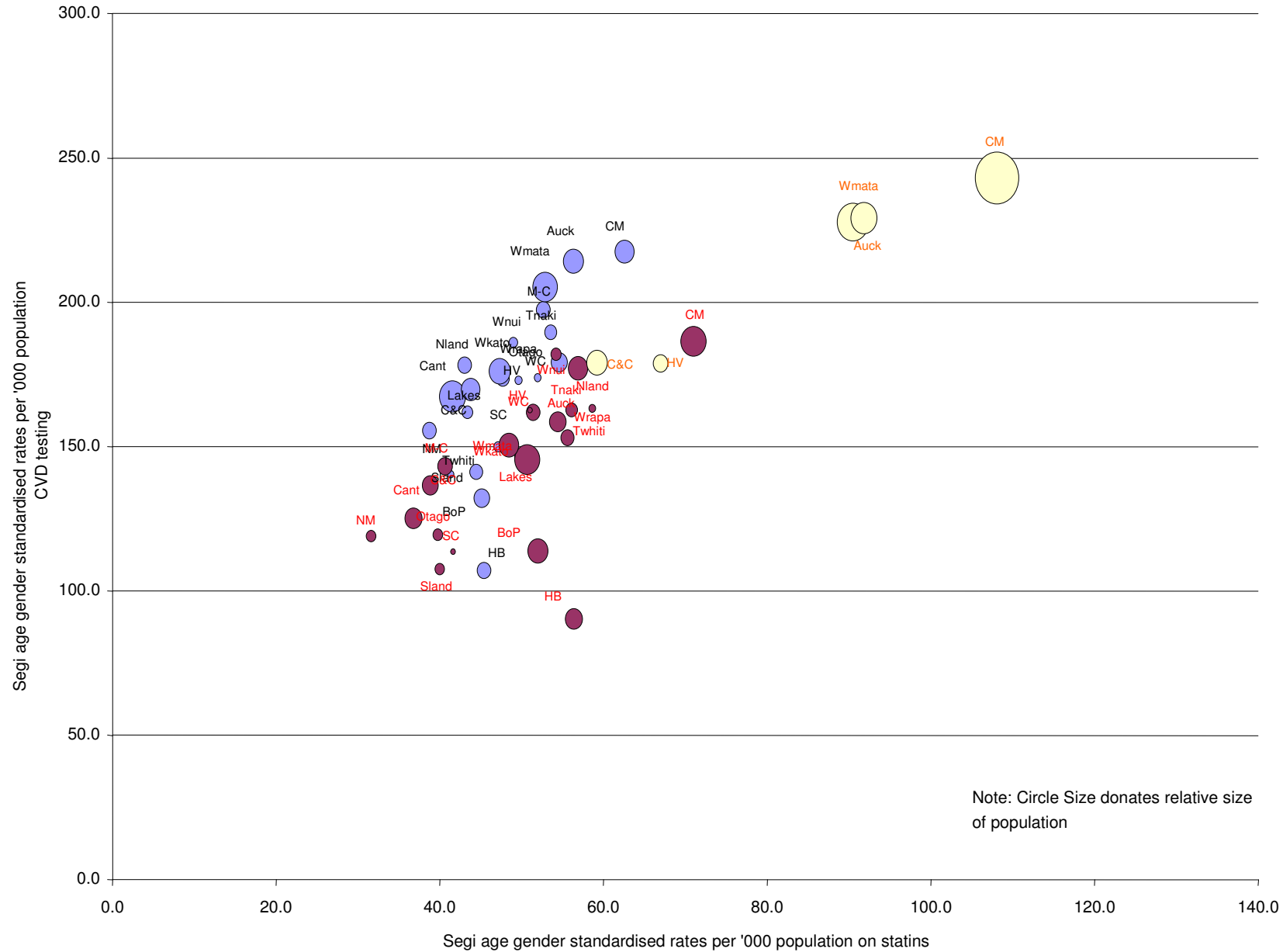
Are we making any progress?

- NZ MoH work assessing progress in primary care adoption of the evidence for CV risk assessments and statin usage
- Unpublished, Dr Sandy Dawson, 2010

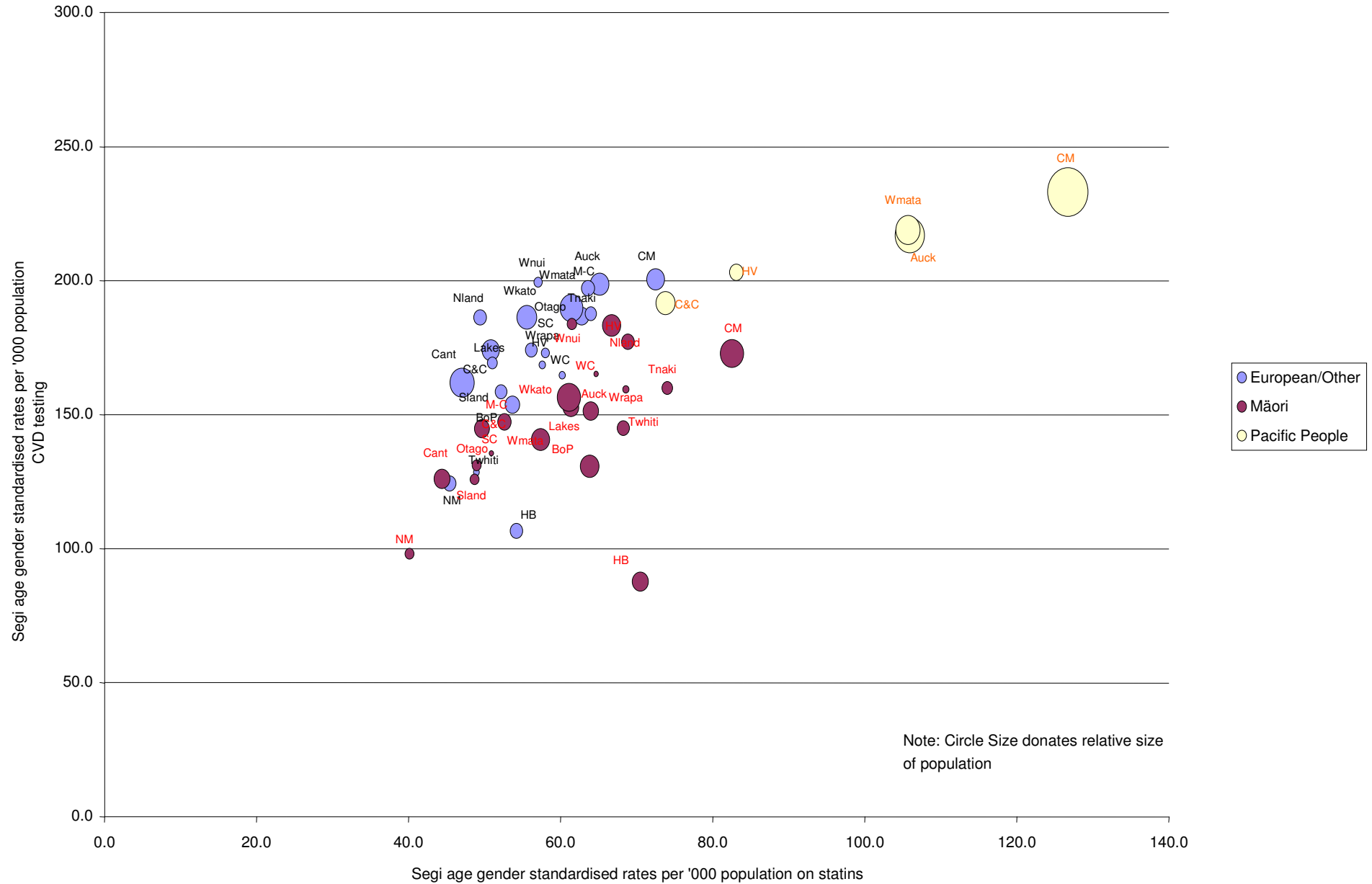
Age standardised rates for the YE Feb 2008



Age standardised rates for the YE Feb 2009



Age standardised rates for the YE Feb 2010



*Primary
Health
Care*

*Better,
Sooner,
More
Convenient*



Better
Sooner
More Convenient

Govt Policy:

Better, Sooner, More Convenient

- Govt bottom lines – “Living within our means”, achievement of six national health targets, no structural form change
- Need to prepare for near future challenges
- Looking for functional change
- **Clinically-led and patient-centred**
- **Intended to bring doctors, nurses and other health professionals to decision making tables**

Govt Policy: Better, Sooner, More Convenient

- Reducing pressure on hospitals
- Making Kiwis healthier
- Decreasing bureaucracy
- Consolidating structures
- Shifting funds to health professionals at the frontline
- Devolution from hospitals to community

BSMC EOIs

- Sept 2009 - 78 EOI applications
- March 2010 - 9 mandated to proceed to business case, involving 60% of NZ population
- From 1st July, these groups are being launched
- Using an alliance based agreement form adapted for NZ Health System : good faith, best for patients, open and transparent, no disputes

Better, Sooner, More Convenient

- Clinically led service development
- Patient focussed - closer to home
- Informed and supported by community
- Informed and supported by Iwi [NZ indigenous people]

Better, Sooner, More Convenient

- Focus on urgent care, care of people with long term conditions and of older people
- New service models and more delivery pathways - nurse walk in clinics, pharmacists delivering new roles
- Multi-disciplinary team delivery – medical/nursing/pharmacist/allied health
- Extended opening hours

Better, Sooner, More Convenient

More services in local communities

- support to provide more urgent care
- easy access to X-rays and other diagnostics
- first specialist assessments
- outpatient follow-ups
- minor surgery

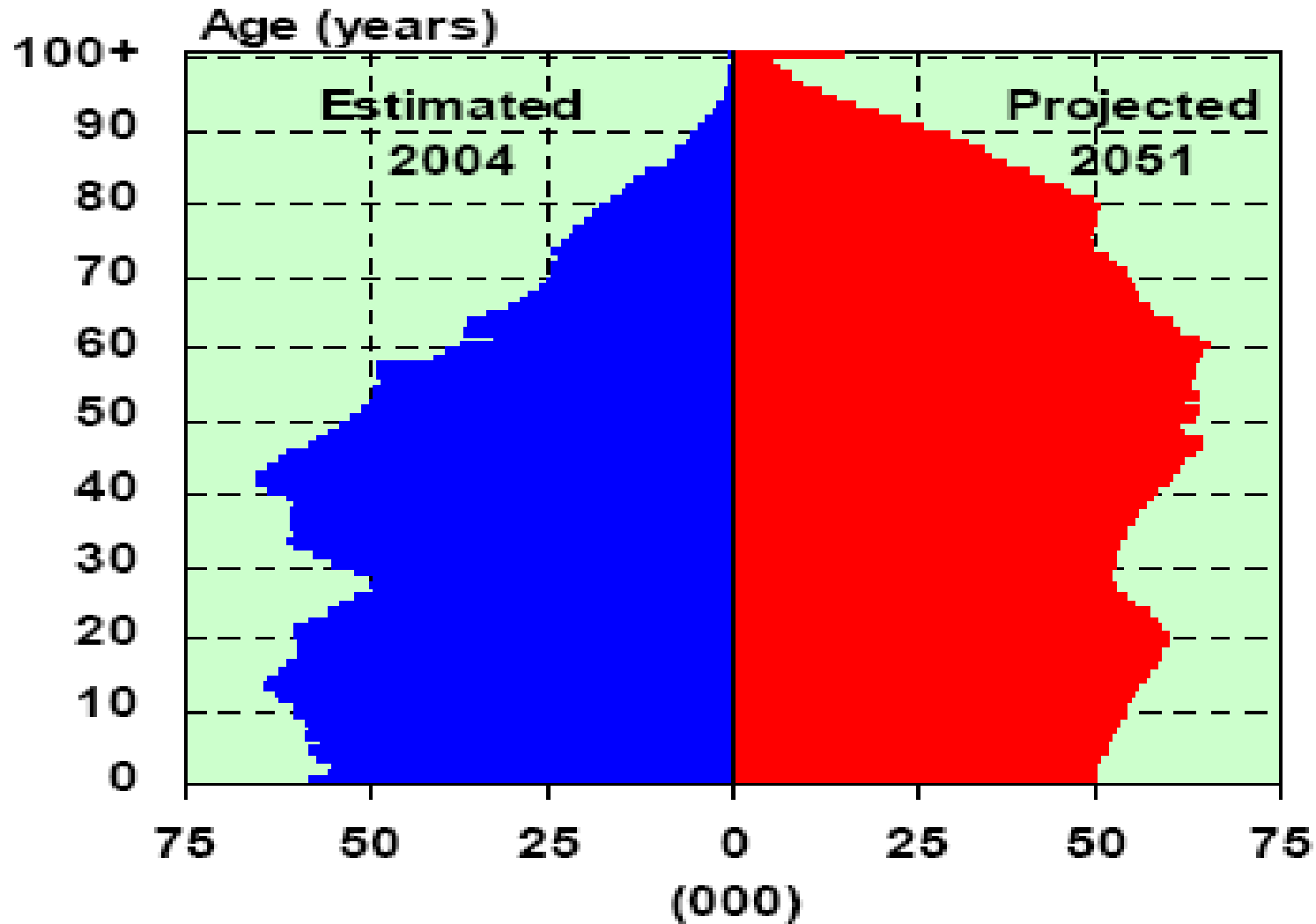
Why do we need to change?

- Demography
 - Population is aging
 - Health work force is aging
- Govt funded health system infrastructure largely hospital based
- Focus on structures – not functionality
- Established health system behaviours

What are the problems?

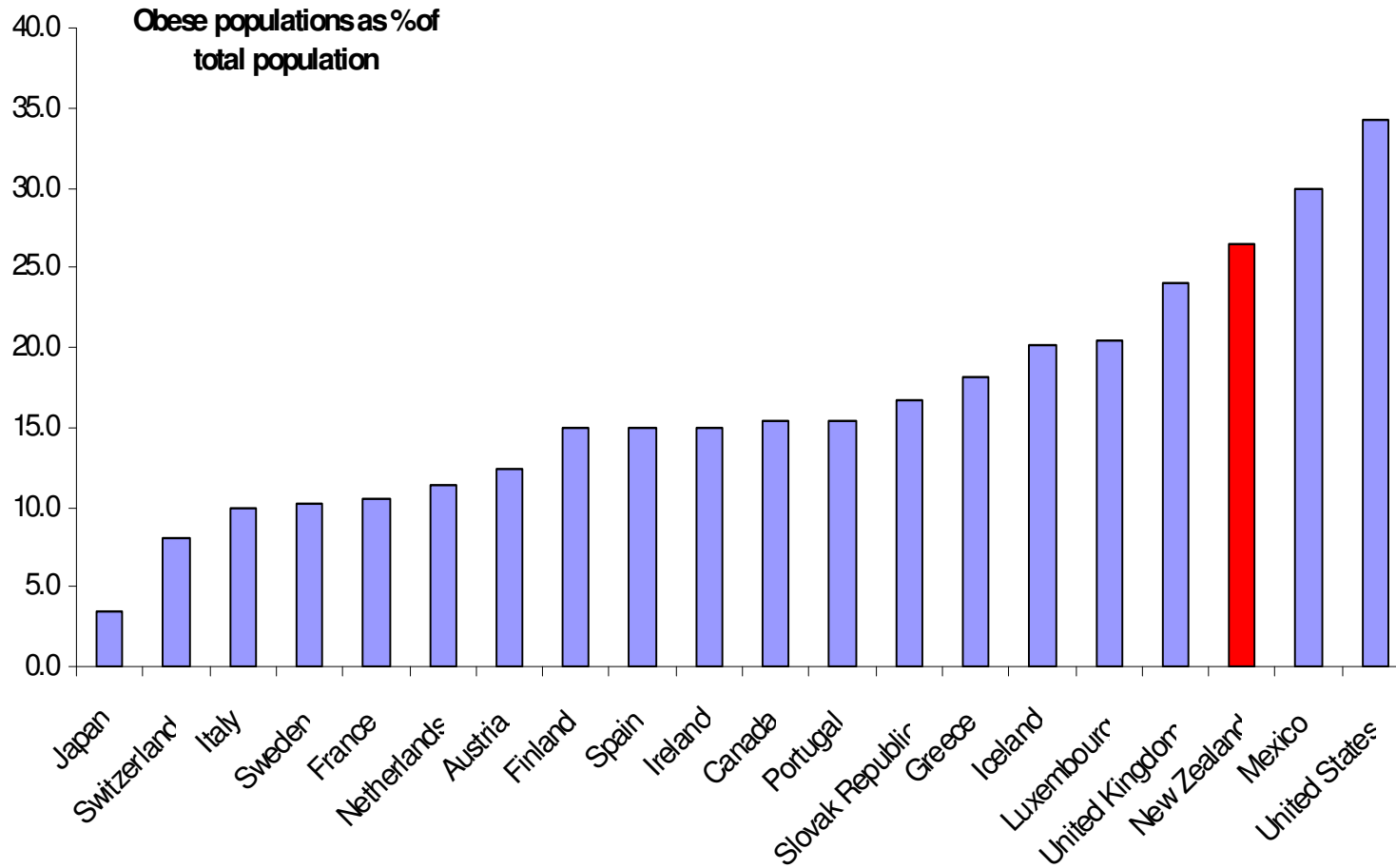
- Variably connected health professionals
 - Disengaged health professionals
 - Limited development of teams
 - Immature systemic clinical governance
-
- Limited ability to deploy more of GDP into health

Age Distribution of Population



Statistics New Zealand, March 2006

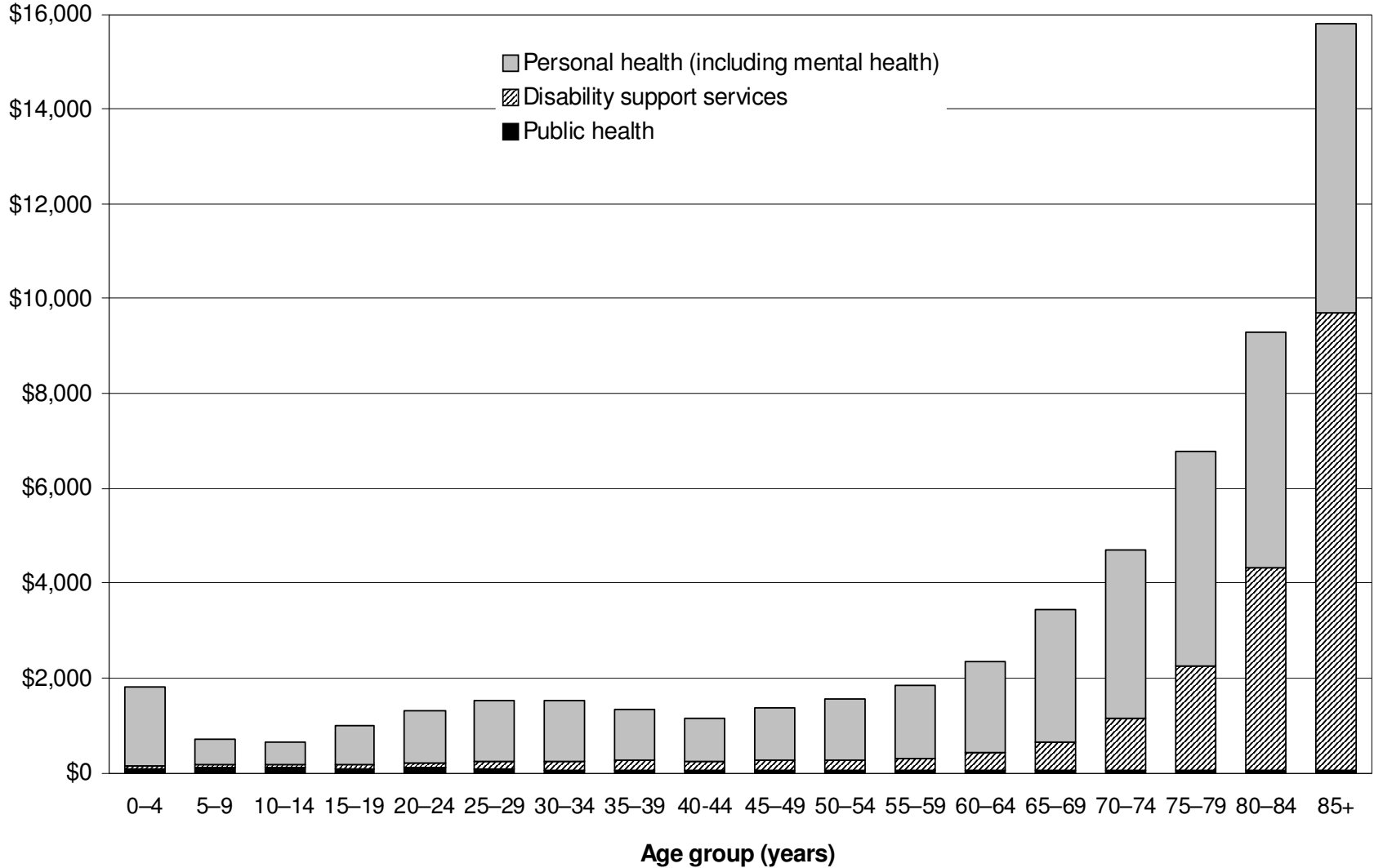
Obesity OECD Data



Data: OECD Health Data 2006-2008

Health Expenditure per capita per year

by age and service group, genders pooled, 2001/02



Why do we need to change?

There is growing evidence that the current health systems of nations around the world will be **unsustainable** if unchanged over the next 15 years.

Globally, **healthcare is threatened** by a confluence of powerful trends – increasing demand, rising costs, uneven quality, misaligned incentives.

PWC, HealthCast 2020: Creating a Sustainable Future, 2005

Commonwealth Fund – June 2010

Exhibit 3. Overall Ranking

	AUS	CAN	GER	NETH	NZ	UK	US
Overall Ranking (2010 edition)	3	6	4	1	5	2	7
Overall Ranking (2007 edition)	3.5	5	2	n/a	3.5	1	6
Overall Ranking (2006 edition)	4	5	1	n/a	2	3	6
Overall Ranking (2004 edition)	2	4	n/a	n/a	1	3	5
Health Expenditures per Capita, 2007*	\$3,357	\$3,895	\$3,588	\$3,837	\$2,454	\$2,992	\$7,290

* Expenditures shown in \$US PPP (purchasing power parity). Netherlands is estimated.
Data: OECD, *OECD Health Data, 2009* (Nov. 2009).

Exhibit ES-1. Overall Ranking

Country Rankings	
	1.00-2.33
	2.34-4.66
	4.67-7.00



	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Clinicians in the driving seat.....

..... require a **vision** for the future

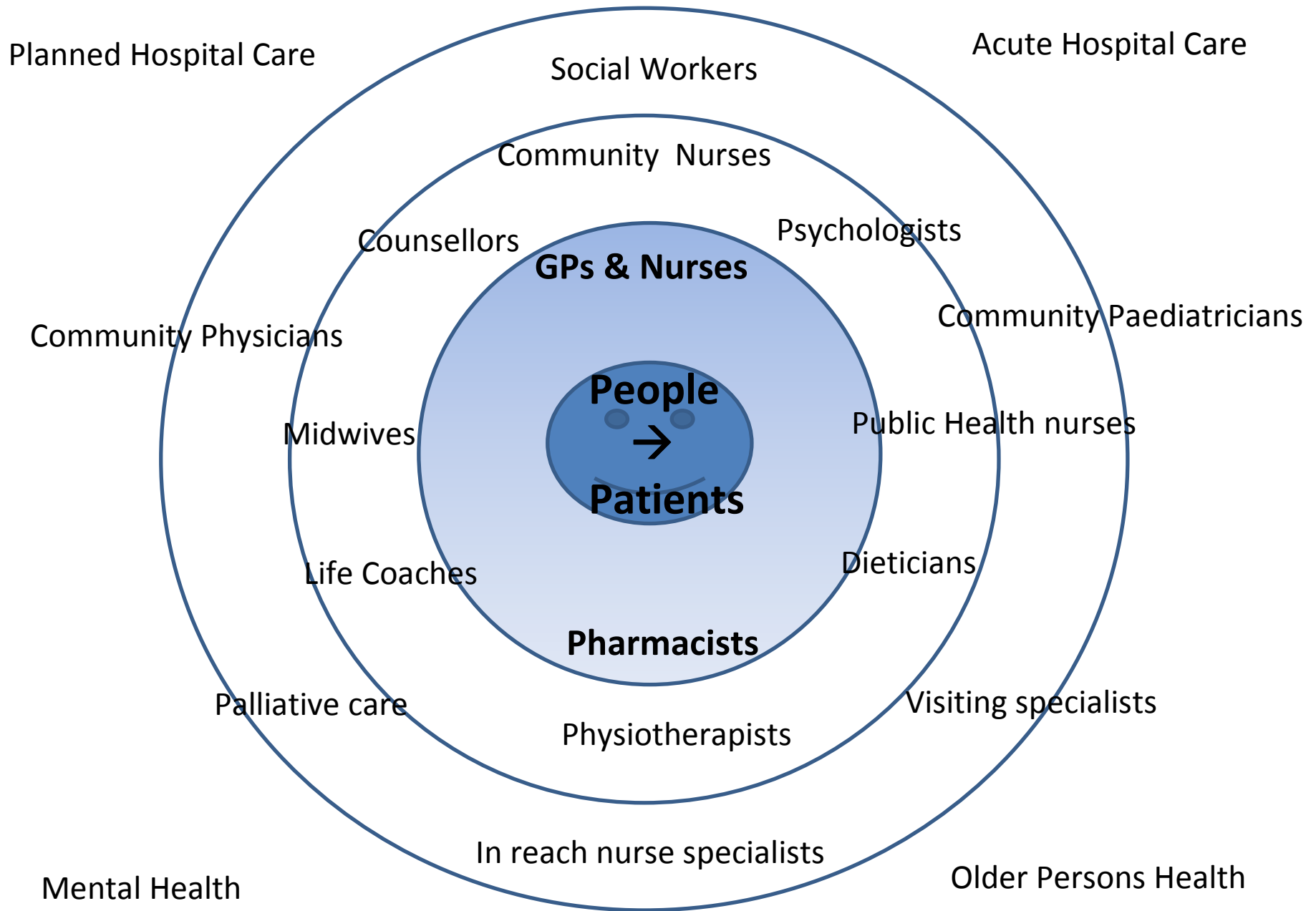
and a network as a delivery platform!

Clinical Integration

- Networks of networks!
- New core teams - doctors, nurses and pharmacists working with other health professionals – supported by a broad range of other health professionals and managers
- With involvement in decision making, clinicians will need to take responsibility and accept accountability

Funding

- Align incentives across health system for
 - Health system needs
 - Professional drivers
 - Clinical and financial accountability
- Funding: a blended model of base line capitation, FFS for activity and quality and performance payments



Planned Hospital Care

Acute Hospital Care

Social Workers

Community Nurses

Counsellors

Psychologists

GPs & Nurses

Community Paediatricians

Community Physicians

People

Public Health nurses

Midwives



Patients

Life Coaches

Dieticians

Pharmacists

Palliative care

Visiting specialists

Physiotherapists

In reach nurse specialists

Mental Health

Older Persons Health

People as Carers

- Self care
- Whanau ora
- Health promoters
- Routine care
- Expert patients
- Joint consultation
- Community education

Clinical Support

- Clinical Assistants to support doctors, nurses and pharmacists complete patient related care and administration
- Assisting to deliver the whole patient care episode with safe transfer of care as directed by clinical professionals
- Variety of models – enrolled nurses, medical assistant

Pharmacists

- Safe Accurate Dispensing [SAD] mandatory
- As clinical pharmacists and working with nurses and doctors, delivering:
 - Routine care as part of team
 - Monitoring; eg; INR, diabetes, thyroid
 - Medicine management
 - Patient coach
 - Health promotion

Nurses

Working with pharmacists and doctors:

- Patient coach
- Routine care
- Long term condition management
- Walk in advice
- Health promotion

- Nurse practitioner and clinical nurse specialist

Doctors

Working with nurses and pharmacists:

- Team coach, often team leader
- Complex care
- High acuity care
- Assessment
- Generalism valued
- Delivering virtual health care – 0900 GP, email consultations and/or disease state blogs

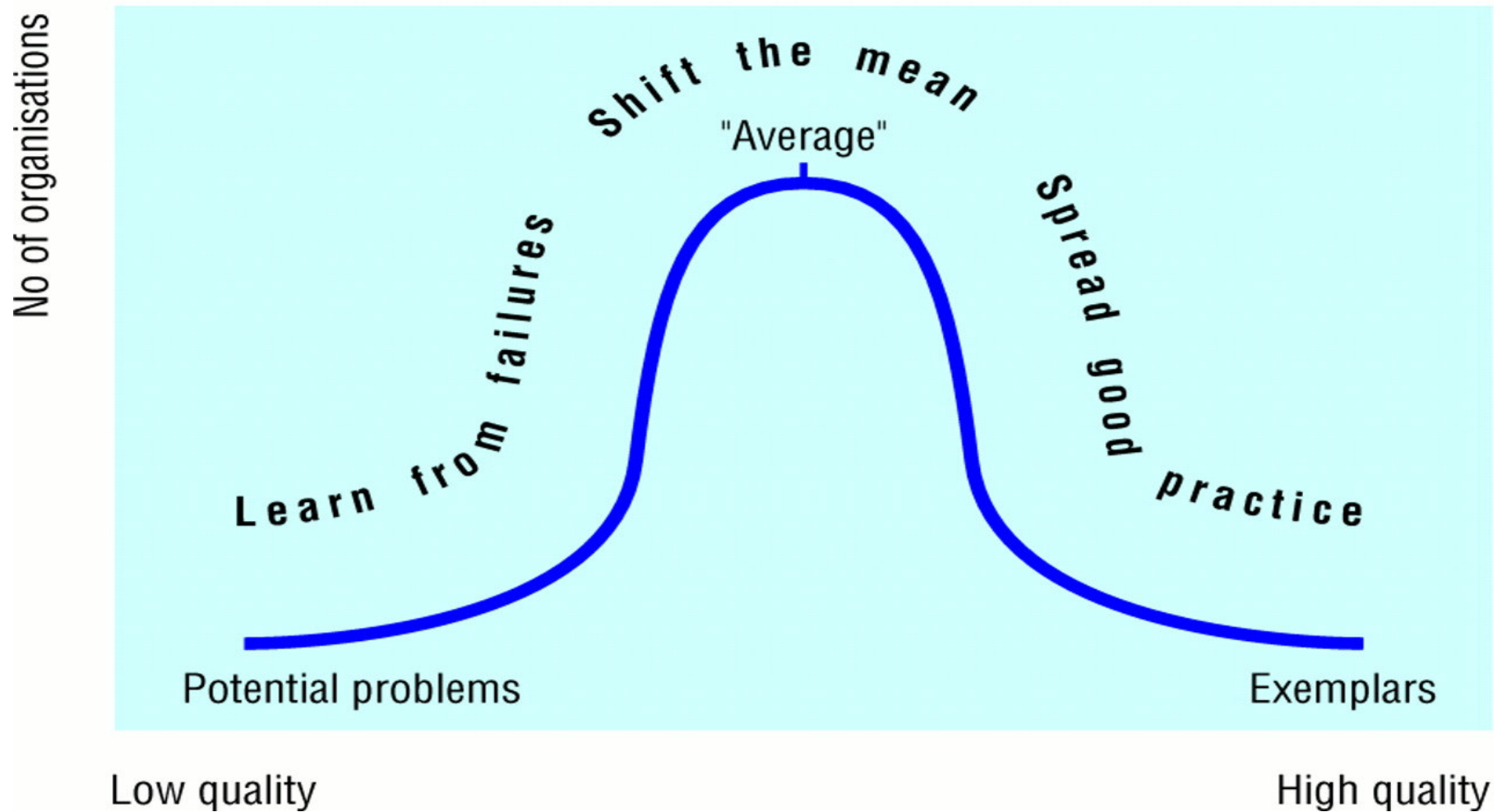
Work force - Networks

- General practice and primary care should be the preferred careers for new graduates
- New roles:
 - Community clinical nurse specialists - CDM
 - Community physicians
 - Community paediatricians
 - Family nurses [new scope of child health / district care / end of life care]

Clinical Governance - Networks

- A commitment to deliver high quality care should be at heart of everyday clinical practice
- Vehicle for continuously improving the quality of care and developing capacity to maintain high standards
- Local professional self regulation key to dealing with complex problems of poor performance among clinicians
- Donaldson, CMO, NHS, 1998

Clinical Governance



Clinical Governance - Networks

- Poorly performing health professionals are a risk to patients and the system
- Local professional regulation needs to be addressed -> timely and satisfactory solutions to these complex problems
- The Sir Donald Irvine challenge!
- Donaldson, CMO, NHS, 1998

Care Management

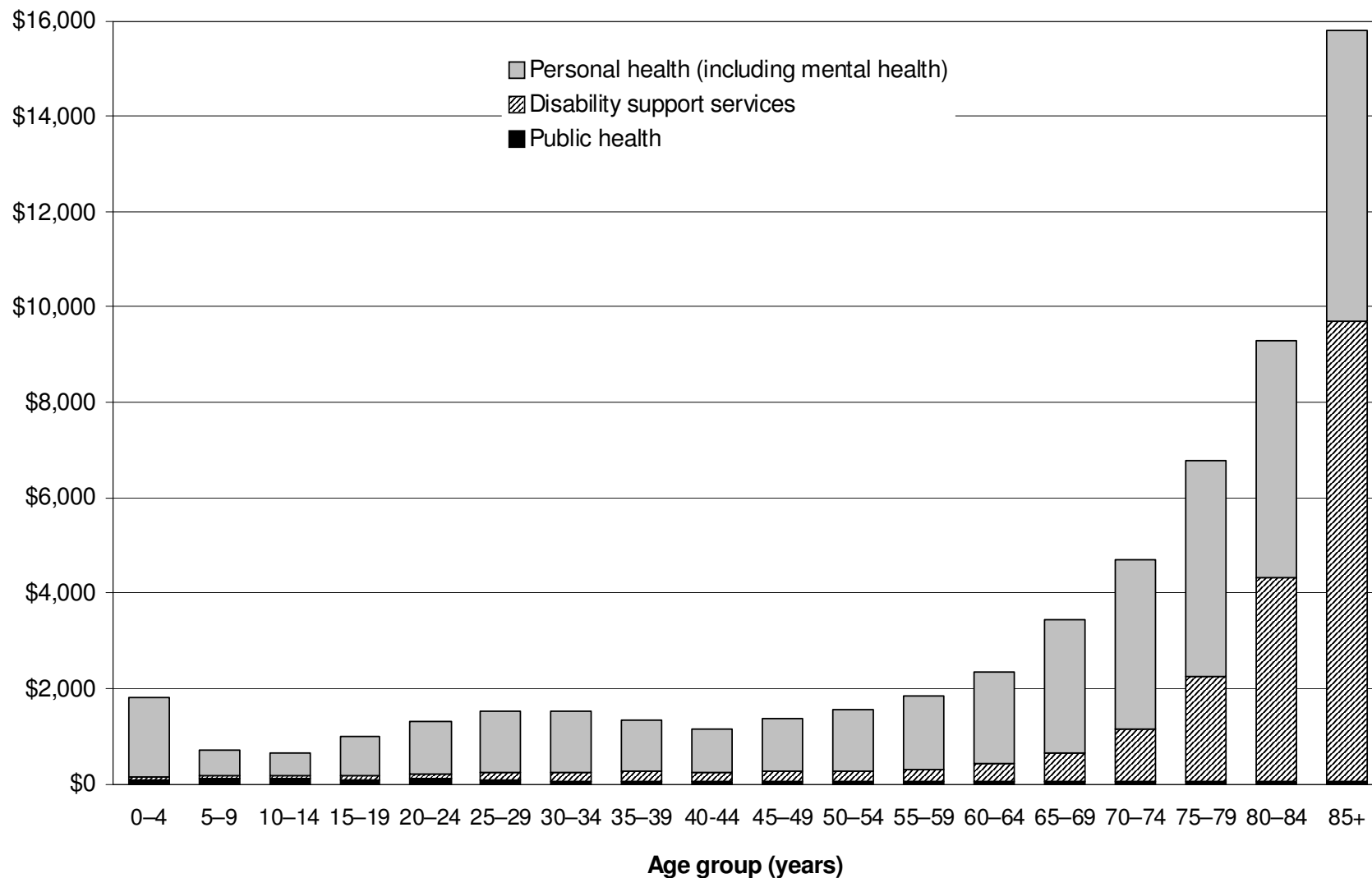
- Make use of Standard [Routine] and Custom [Complex] care model from Richard Bohmer
- Clinical team decide together who is best suited to provide elements of care
- Parallel care pathways, joining up and separating again

End of Life Care

- Community discussion – substantial % of health funds are spent in last year of life
- EOL care should more often be delivered in home
- We should ensure that we are kind and considerate in our treatment and care advice / decisions – focus on dignity, comfort and pain control

Annual per capita Health Expenditure,

by age and service group, genders pooled, 2001/02



Shared Health Record

- Electronic health record shared between health professionals
- Explicit informed patient consent [opt on] to shared health record characterised by
 - Access by clinical professionals on basis of need to know
 - Monitoring, auditing and reporting
 - Clinical governance over health information and systems

Health Governance

- New large, capable, community based health organisations delivering service integration
- Governors – highly capable, capable of accepting accountability for large amounts of govt health funding, focus on probity, and monitoring

Location

- New community based infrastructure – safe, acceptable, low cost, low tech alternatives to hospital and rest home care
- Health care will be provided in the community – unless it is required to be delivered in a hospital
- More diagnostics, outpatient, complex and acute care are provided in community facilities

Community Health Infrastructure

- Support for re-sizing practices for improved sustainability
- Range of new forms – IFHCs, CHHs, WOCs!! SCs, etc
- Diagnostic centres / observation centres / assessment centres
- Opportunity to share facilities with after hours cover

Clinical Leadership

- Clinicians should accept the responsibility of leadership
- Major focus – improving health and health care value for patients
- The right kind of competition: competition to improve results
- [Today's competition – one player's win is another's loss]

- Michael Porter, 2007

My World View

Health is all about people!

Health is about hearts and minds

There is no more money – now, we
have to be smart

Dr Paul McCormack

paul.mcc@xtra.co.nz