Foresight Future of an Ageing Population - International Case Studies

Case Study 6: Integrated Care in New Zealand

Foresight Theme: Adapting health and social care systems

This case study will look at Canterbury Clinical Network (CCN) which focuses on establishing collaborative relationships as a platform for integrated service delivery. The 'Health of Older People' work stream within CCN aims to enable older people to live at home for as long as possible.

Context and History

The population of New Zealand

In the census of 2013, New Zealand had a population of 4.2 million, over half a million of whom live in Christchurch and the surrounding Canterbury region on the South Island. [Figure 1]

Nationally, 0.6 million New Zealanders (14%) identify themselves as Māori and this is projected to rise to 22% by 2051. The Māori population has higher levels of smoking and obesity and consequently poorer life expectancy and healthy life expectancy than the population of European origin.

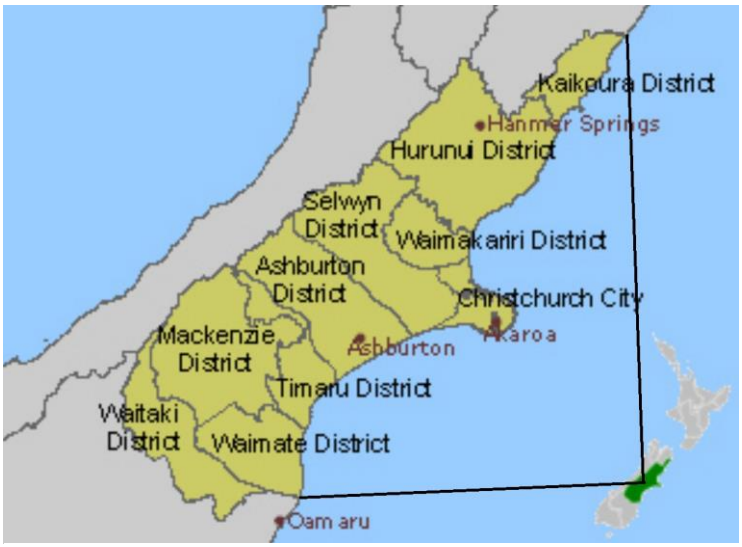

Figure 1: The Canterbury region of New Zealand

The population of the city of Christchurch fell by 2% following the devastating earthquake that hit the city on 22nd February 2011 but it has since recovered and been more than offset by a rise in the population of the surrounding area.[1] In its2014 annual report, the District Health Board reported a 35% increase in new patients for psychiatric emergency services since 2011, and a 40% increase in the demand for child and youth community mental health services.

New Zealand has an ageing population. In 2014 650,000 New Zealanders (14%) were aged 65 and over and this is projected to reach 1.2 million (22%) by 2034. Between 1994 and 2014 the number of people aged 80 and over increased by 80% to 160,000 and this is expected to more than double again to 368,000 by 2034.[1]

Integrated Care

Integrated care means different things to different people but it generally includes the avoidance of gaps in care provision between primary and secondary health care, health and social care, physical and mental health care and could also include the avoidance of any hiatus experienced during

[1] Statistics New Zealand

transitions between and within social care and mental health services that are organised by age group. The patient perspective is at the heart of integrated care. Achieving integrated care requires those involved with planning and providing services to impose the patient's perspective as the organising principle of service delivery.[2] Integrated care is service delivery that provides a 'smooth and continuous' transition between services, with co-operation and collaboration across services and a 'seamless' journey for service users.[3] Integrated care does not necessarily imply integration of the organisations providing care. "Organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care".[4]

Healthcare in New Zealand

From the 1980s to date, health care in New Zealand has undergone major structural reform five times.[6] This included an experiment with an internal market and purchaser-provider split in the 1990s. In 2000 the New Zealand Health and Disability Act established District Health Boards (DHBs) with responsibility for planning and purchasing or providing services for their region. The DHBs are, for the most part, locally elected and, since 2008 are supported by a National Health Board, advising the Minister of Health, to plan and fund national health services, and a Shared Services Agency (SSA) to undertake administrative and support services on behalf of the DHBs.

Primary Healthcare

Within each DHB region, primary health care services are provided by a number of Primary Health Organisations (PHOs) funded on a per capita basis by the DHBs to ensure the provision of primary health care services. This is mostly carried out through general practices. As in the UK, GPs in New Zealand are self-employed, but in New Zealand they join together, formerly in Independent Practitioner Associations (IPAs) and now in the Primary Health Organisations (PHOs), into which individual patients can voluntarily enrol usually through their GP practice.

In January 2016 93% of the population of Canterbury region (94% of over 65s) were enrolled with a PHO as were 94% of all New Zealanders (97% of over 65s) nationally.[5]

In the Canterbury region there are three PHOs, Pegasus Health (Charitable) Ltd, the largest with 380,000 enrolled patients and over 85% of City of Christchurch GPs, Christchurch PHO and Rural Canterbury PHO.

Co-payments in Primary Care

New Zealand health care is primarily (83% in 2009-10) financed from public funding.[6] For over 75 years, since the Social Security Act of 1938, public hospital care and maternity care have been free at the point of use, but service users have continued to make payments towards the cost of General Practitioner (GP) based primary care. [3] Typically a patient pays 50% of the cost of a GP's consultation

[2] Goodwin and Smith (2011) *The evidence base for Integrated care*; The Kings Fund and the Nuffield Trust – Developing a national strategy for the promotion of integrated care

[3] Cumming J (2011) *Integrated care in New Zealand*, International Journal of Integrated Care vol 11, Nov 2011

[4] Goodwin et al (2012) *Integrated care for patients and populations: improving outcomes by working together.* The Kings Fund and The Nuffield Trust

[5] New Zealand Ministry of Health (January 2016), *http://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrolment-primary-health-organisation*

[6] Cumming et al (2014) *New Zealand Health System Review*, Asia Pacific Observatory on Health Systems and Policies

fee but individuals and families with low income can apply for a Community Services Card (CSC) providing care at a reduced rate or no charge, and individuals who need to visit the GP more than twelve times in one year for the same illness can apply for a 'High User' health card. If referred to a specialist, an initial consultation fee starts at NZ$150 (£70).[7] Co-payments make up around 50% of General Practice income.[8]

Secondary and Community Healthcare

District Health boards have full responsibility for public hospital services in their area and have contracts with community providers of district nursing services, counselling, palliative care, home care and other specialised services delivered in the community.[9]

Social Care

Unlike in the United Kingdom, District Health Boards in New Zealand are also responsible for most social care. The budget covers both care in people's own homes and residential and nursing care, subject to a needs assessment. Residential care is means tested and also dependent on assets held. Personal care at home (washing and bathing) is free but subject to resources being available, while domestic care (cleaning and shopping) is means tested and charged for.[8]

Figure 2: Integrated health and social services in Canterbury

The need for action

Faced with responsibility for so many aspects of health and social care, but with separate, unco-ordinated systems in place for the implementation and management of the different aspects of that care, the District Health Board for the Canterbury region was facing difficulties. In 2007, the main hospital in Christchurch was regularly 'gridlocked' with patients backing up into the emergency

[7] Pegasus (2014) *New Zealand's Health Care System*

[8] Timmins and Ham; The Kings Fund (2013*) The quest for integrated health and social care: A case study in Canterbury, New Zealand*

department and facing long waits as the hospital ran out of beds, and the system as a whole was NZ$17m in deficit on a turnover of NZ$1.2bn.[8] If nothing changed the Canterbury region would have needed an additional 500+ hospital beds, 20% more GPs and practice nurses and a 50% increase in the number of residential care beds by 2020, a situation deemed unaffordable.[8]

Implementation

The Canterbury Clinical Network (CCN) was established in 2009 to bring together the various health and social care systems, to work together towards common goals that have as a primary focus the health and wellbeing of the patient, avoiding the constraints and conflicts dictated by the processes of the individual and separate care systems.

The Canterbury Clinical Network provides a platform for clinical leadership and demonstrates the principles of an alliance across the Canterbury Health System. The CCN leads the development of services across the sector where innovation and transformational change is required.

The Canterbury Clinical Network consists of: The Alliance Leadership Team (ALT); The Alliance Support Team (AST); The Programme Office; Workstreams and other work groups and Service Level Alliances (SLAs).

This alliance approach is underpinned by the Canterbury Clinical Network District Alliance Agreement and the CCN Charter in which alliance members agree to collaborate and demonstrate a commitment to act in good faith and to reach consensus decisions on the basis of 'best for patient, best for system'. The funding and implementation of services is guided by the mantra 'One system, one budget'.[8]

The ten Canterbury Clinical Network members, who have signed the District Alliance Agreement, are the *District Health Board (DHB);* the three *Primary Health Organisations (PHOs); Access Homehealth* – who provide home-based healthcare and support; the *Canterbury Community Pharmacy Group (CCPG)*- who support community pharmacies; *Christchurch Radiology Group (CRG)* – a sub-speciality radiology group which owns and runs medical diagnostic imaging clinics; *Healthcare NZ Community Health* – a provider of home and community based support services; *Nurse Maud* – who provide nursing for home and community care and in-patient nursing in hospitals and hospices; and *Canterbury SCL (Southern Community Laboratories)* – who run New Zealand's largest network of diagnostic laboratories.

The overall guidance, direction and leadership framework for the alliance is provided by the Alliance Leadership Team (ALT). Led by an independent chairman, the team members represent a variety of differing perspectives including those of the DHB, PHOs, service users, secondary and tertiary health care, practice nursing and Māori.

The Alliance Support Team (AST) is the senior level working core of the alliance. The team is made up mainly of senior executives from the alliance member organisations. They provide advice and guidance on the prioritisation and funding of services and initiatives recommended to the Alliance Leadership Team (ALT) by Service Level Alliances and Workstreams. AST members attend ALT meetings as attendees and participate in discussions, providing advice and guidance as required.

The Alliance Support Team (AST) is supported by the Programme Office. Led by the Programme Director, who is also a member of AST, the Programme Office coordinates the activity of the alliance, and provides day-to-day operational support to the various Canterbury Clinical Network groups.

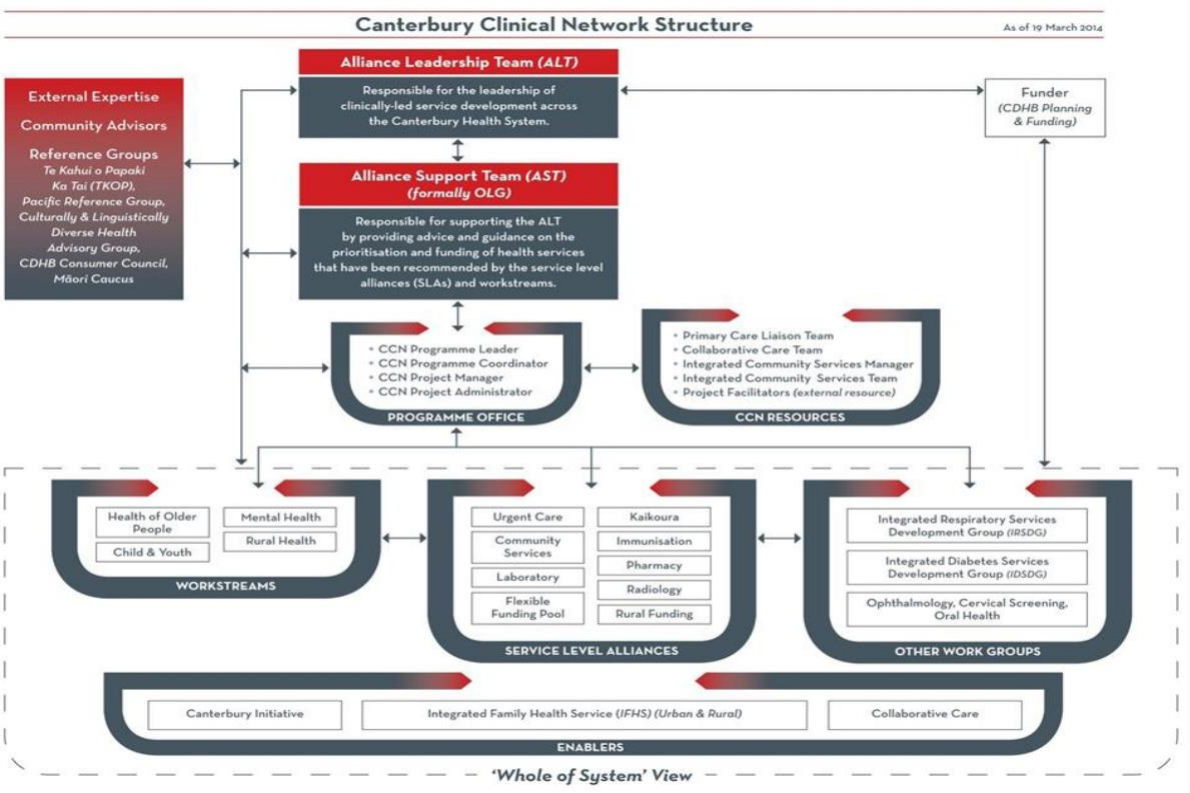

Figure 3: The Canterbury Clinical Network Structure

At an application level, the alliance is organised into 'Workstreams' that focus on a particular target population or area of work, and 'Service Level Alliances' (SLA) that lead on the transformation and implementation of services . The 'Workstreams' include 'Health of Older People' - enabling older adults to live well at home and in their community. The Workstreams and Service Level Alliances may set up 'Working Groups', usually responsible for delivering a specific short-term or finite body of work while CCN 'Programmes' are operational groups delivering ongoing or long-term bodies of work.

Achievements

It is argued that one of the principle achievements of the Canterbury Clinical Network is the buy-in at all levels to a more co-operative way of working and the re-empowering and re-engagement of clinicians and other staff.[8]

The Canterbury Initiative supports integration by managing a group of GP liaisons who work in various hospital departments assisting with triage and referral processes, bringing a primary care perspective to the table in decision making and taking information from specialist teams back to primary care. CI have also done substantial work on improving communication, referral quality, collaboration about clinical pathways and have set up an electronic referral management system to improve quality and timeliness of communication between primary and secondary care.[9]

[9] Rose Laing, CCN Health (2016), Personal communication.

The Electronic Request Management System (ERMS), launched in 2010, is an electronic referral system between general practice and other parts of the system and can be used to request tests, outpatient referrals, community assessments and specialist advice.[8,9] Designed by GPs and hospital specialist , ERMS was introduced with no financial incentives for use but has become heavily used.

An evolving integrated IT suite includes an electronic shared summary record. The electronic Shared Care Record View (eSCRV) acts as a portal that draws on existing hospital, GP and other data to provide a fairly full summary record.[8] This still has some limitations, since the hospital system uses paper records for inpatient notes and GPs have so far only been prepared to share classifications and medications with their hospital colleagues. Consultation notes remain hidden, but, as sharing becomes the norm, it is hoped that this stance will ease and it will progress to being a single electronic health record. Views of outpatient letters and discharge summaries, lab results and dispensing as well as a variety of administrative data sets are already shared. There is also a new agreement to securely send and share larger data sets to allow better evaluation of outcomes.[9]

The electronic Shared Care Record View (eSCRV) shares information across health care but does not yet extent to social care systems.

Another innovation is the development of shared care plans that can be created, read and updated by almost any clinician, regardless of location. Despite software problems, acute plans for patients highly likely to present to acute services and advance care plans for patients who need to document their wishes for care in the last phase of life, have been established. Personalised care plans for patients with long-term conditions which allow for goal-setting, collaboration between health care providers and recognition of the patient's day-to-day needs and aspirations, are in an advanced stage of development.[9]

Impact

An evaluation of the ERMS system, by the University of Auckland in 2011, concluded, even at that early stage, that the system had achieved 'substantial transformation of referral management in the Canterbury region'.[8]

An analysis commissioned by the Canterbury board has shown a substantial medium term shift of resources from acute hospital care to community care and arranged and elective hospital services. [8] Canterbury hospital now rarely experiences gridlock and the DHB has moved from a NZ$17m deficit in 2007 to a NZ$3m surplus in 2014.

The Canterbury Clinical Network (CNN) and other pilot alliances have proved so successful that, from mid-2013, New Zealand has moved to implement a governance model requiring alliances between local District Health Boards (DHBs) and the corresponding Primary Health Organisations (PHOs) in all regions across the entire country.[10]

[10] Gauld R (2014) *What should governance for integrated care look like? New Zealand's alliances provide some pointers*, Medical Journal of Australia 201 (3) S67-68