TO	Community and Public Health Advisory Committee
FROM	Project Manager Funding Division
DATE	20 June 2006
SUBJECT	ELECTIVE SERVICES SPOT PURCHASING – EVALUATION

Memorandum

1. INTRODUCTION

The purpose of this paper is to provide an evaluation of the elective services spot purchasing project that has been running since August 2005. A total of $2.5m has been approved by the Board for phases 1 and 2 of the project, with a further $1.0m approved in March 2006.

The paper will cover both quantitative and qualitative aspects of the project and will set the context for some further work in the elective services area. It also aims to present a view of the issues that have arisen during the course of the project and therefore includes the perspective of both the private hospitals and MidCentral Health.

2. HAS THE PROJECT ACHIEVED WHAT IT SET OUT TO DO?

2.1 Aim of the Project

The objective of this project was to invest surpluses held by the Funding Division, from prior years, directly into patient outcomes by offering services to patients that had been waiting greater than 6 months for treatment. Some of the patients, particularly those on surgical active review, may not have otherwise received treatment in the public system.

The project has certainly achieved this objective, as the statistics in Appendix 1 highlight. To the end of May 2006, a total of 630 patients have received surgery whilst another 1700 first specialist assessments, diagnostic and minor procedures have been carried out across a range of specialties.

The sum of $2.3m has been invested in the project between July 2005 and May 2006. By year end 30 June 2006, the majority of the $2.5m allocated by the Board will have been invested directly into patient care. The only exception is the sum of $55,000 provided to MidCentral Health for project management.

2.2 Insights into the capacity of the total 'system'

The most significant learning to come from the project is that it has tested the capacity of the 'total system', that is, public and private capacity combined, to meet demand for publicly funded surgical services within a competitive pricing regime. Appendix 2 details the surgical activity between July 2005 and May 2006 and compares this to waiting list statistics.

The table tracks, by surgical specialty:

- The number of patients referred onto elective surgery waiting lists each month;
- The total number of patients provided with elective surgery each month, including those under the spot purchasing project;
- A breakdown of activity into MidCentral Health "business as usual", MidCentral Health Spot Purchasing volumes and patients treated by either of the private hospitals;
- Number of elective surgery patients waiting at the end of each month, in total;
- Number of elective surgery patients waiting greater than 6 months for treatment at the end of each month.

The table also calculates the volumes done under the spot purchasing project as a "percentage of total volume throughput" for the period from July 2005 to May 2006. Of significance is that Gynaecology volumes under the spot purchasing project represent 32% of total public sector patient activity over the given period. This is followed by Dental (24%), Urology (23%), ENT (16%) and General Surgery (5%). The Gynaecology percentage is high because both private hospitals have been working simultaneously in this specialty. The other specialties have been delivered by one or other of the private hospitals, with the exception of Urology, which Southern Cross commenced but was unable to complete due to unforeseen resource constraints. This work was subsequently picked up by Aorangi Hospital.

The table also highlights the fact that in all surgical specialties under this project, the number of patients being referred for treatment still exceeds the numbers than can be offered treatment as part of 'business as usual' and 'spot purchasing' combined.

It is acknowledged that if additional funding had been available under phase 1 and 2 of the project, Aorangi may have had spare capacity to undertake Dental, ENT and General Surgery, alongside Southern Cross, in addition to Gynaecology and Urology volumes. However, this spare capacity would only be available to the extent that the 2 private hospitals were not competing for the same surgeon and anaesthetist time.

For Gynaecology and Urology it seems that the current 'system' is at its capacity to treat publicly funded patients within the district, in the absence of any additional incentives for specialists to allocate either additional time or time normally spent in their private capacity. This also assumes there are no vacancies within MidCentral Health that result in the hospital being unable to meet funded elective surgery volumes. At present, MidCentral Health is in the process of recruiting a 4th Urologist.

2.3 Impact on the Waiting Lists

Surgical Procedures

The table in Appendix 2 tracks the elective surgery waiting list status by month from May 2005 to May 2006. It shows both 'total patients waiting' and 'patients waiting greater than 6 months'.

The interesting point to note, when comparing the situation in May 2006 with that 12 months ago, is that despite the immediately evident improvement in the numbers of patients waiting greater than 6 months across all specialties, the improvement in "total waiting list numbers" is much smaller and in fact, is worse than 12 months ago in General Surgery. The Spot Purchasing Project has therefore provided a 'quick fix' which will be long forgotten in 6 months time when the numbers of patients waiting greater than 6 months for treatment revert back to historical levels.

Another factor to consider, is that part of the immediate improvement in the raw waiting list numbers for patients waiting greater than 6 months, is as a result of the 'cull' of

waiting lists that occurred during the spot purchasing project. On average, for every 100 patient files sent down to the private hospitals for surgery, an average of 35% did not proceed to surgery at all.

Reasons ranged from:

- Patient had moved out of the district;
- Patient had died;
- Patient no longer wanted treatment;
- Patient had opted for private treatment whilst on the public list;
- Timing was not convenient.

Between 5% and 10% of patients were not suitable for treatment in the private hospitals on the grounds that they had complex medical and/or physical problems preventing them from having surgery at the present time. Many of these patients were patients on active review with a high number in the Urology specialty. Patients were referred back to MidCentral Health for case management/referral to the appropriate service.

The project has therefore had an expected benefit – a 'cull' of the waiting list numbers for reasons other than re-prioritisation.

Medical Services and First Specialist Assessments

Spot purchasing of Dermatology, Cardiology and Neurology volumes was designed to clear the backlog of patients that had resulted from periodic vacancies in these specialties within MidCentral Health. The spot purchasing has assisted in providing a 'clean slate' on which MidCentral Health can build capacity to meet ongoing demand from here on.

Over the next few months, spot purchasing will continue to work on Cardiology, Dermatology and Endoscopy. Neurology resource may be more difficult to secure and was sourced from overseas for the duration of the spot purchasing effort which is now complete.

Urology continues to be an area where resource constraints across the district have made it difficult to make significant headway, particularly for First Specialist Assessments.

2.4 The problem with measuring 'demand'

The ESPI (Elective Services Patient Indicator) system of elective surgery reporting was designed by the Ministry of Health as a tool to measure the clarity, timeliness and fairness of the systems that District Health Boards have in place, rather than measure throughput and total demand for services. A number of performance indicators have been established to measure clarity and timeliness. These assess how well a hospital manages the *patient flow* through the system.

Prior to the introduction of the ESPI system, patients were placed on waiting lists with no certainty of when they would receive treatment. Waiting lists did not always operate fairly, with many patients treated in order of their length of wait instead of their level of need compared with other patients.

Over a period of years this situation has changed to one where:

- there is acknowledgement that resources are insufficient to meet all needs;
- all patients have the right to know whether or not they are likely to receive treatment; and
- all patients assessed by hospital specialists are now prioritised and then given a status that reflects both the capacity of a DHB service to treat patients and that patient's priority relative to others who are assessed.

Whilst the ESPI system of reporting meets the Ministry of Health requirements around clarity and transparency, it is not an effective tool for management of elective services. Changing referral thresholds in response to the District Health Board's ability to manage referrals and deliver elective volumes mean that it is almost impossible to measure real demand from looking at the ESPI waiting time statistics, or comparing them from year to year. Good waiting list statistics can result from returning routine referrals to primary care practitioners.

2.5 Performance of the private sector

The overall performance of the private sector under this project has been excellent. The private hospitals were asked to report a number of Key Performance Indicators under their contract. The combined statistics for both hospitals are reported below:

Key Performance Indicators	
Transferred back to MidCentral Health post surgery	3/529 surgical patients
Return to theatre / readmission to private hospital	6/529 surgical patients
Patient complaints	2 resolved 1 unresolved (pursued through Health & Disability Commissioner)

These statistics provided some assurance, as MidCentral Health was concerned there would be an increase in admissions back to the public hospital during the course of this project. The rate of complications and adverse events is also very low.

3. DIFFERING PERSPECTIVES

3.1 Private Hospitals Perspective

The private hospitals were asked to provide their perspectives on the project and the feedback below is a reflection of both the direct feedback received from them and discussions that occurred during the course of the project.

Nature of the "public patient"	The private hospitals were not prepared for the amount of time they would need to dedicate to ensuring patients attended scheduled treatments, including the surgery itself. Many of the patients had complex social needs and the private hospitals were required to respond to these challenges in innovative ways. This included liaising with General Practitioners, other Government Agencies and Maori Health Providers. Some patients, despite having been on waiting lists for 12 months or more, declined treatment because it was not convenient. Further investigations often found that there were simply barriers for the patient, including lack of transport and family support where there were children to look after.
Patient Complexity	A high proportion of patients had significant medical and physical complexities, particularly in Urology.
Administration Burden	The private hospitals underestimated the amount of

	time they would need to spend on administrative matters. This is partly due to the fact that MidCentral Health did not allocate a dedicated resource (outside business as usual) to the project as was originally agreed. Because so many files had to be reviewed by the private hospitals in order to obtain surgical and clinic lists, a special fee had to be negotiated to compensate the private hospitals for the time spent by their surgeons reviewing files that did not proceed to surgery.
"Certainty"	The private hospitals noted that they prefer 'certainty' of work flow over a given period as opposed to performing short term catch ups which require them to acquire additional resources. They indicated they would welcome discussions about their ongoing role in assisting the Board to meet elective surgery targets into the future.

3.2 Public Hospitals Perspective

At the outset of the project, MidCentral Health raised a number of concerns about the project with the Funding Division.

To alleviate these concerns, the Funding Division negotiated a Memorandum of Understanding with MidCentral Health. The elements of the Memorandum of Understanding were then incorporated into the service contracts between MidCentral DHB and the private hospitals.

Reduced availability of Surgeons and Anaesthetists
Contracts included the requirement that the private hospital must act in 'good faith' where clinical staff are shared between the public and private sector. This meant scheduling within current timeslots or after hours. MidCentral Health has noted that accessing locums has been more difficult during the course of this project, although this was difficult to quantify.

Patients not suitable for treatment in private hospitals
About 5 – 10% of surgical patients files were returned from the private hospitals because they were 'unsuitable for treatment'. This was particularly evident in Urology where the patients tended to have complex medical and physical issues. Although the private hospitals were acting within their contractual rights under this project, the public hospitals do not necessarily have the privilege of exercising this discretion. A proportion of these patients will receive treatment in the public hospital whilst others may not be suitable for surgery until their complexities can be managed.

Increased pressure on Support Services
Contracts included prices for community nursing and allied health in some cases, in the event that MidCentral Health could not meet demand for these services. These services were not required from the private hospitals during the course of this project which suggests that MidCentral Health was able to meet this demand within current resourcing. The Funding Division agreed to fund MidCentral Health for any additional volumes over and above those in the Price Volume Schedule for these services.

Clinical Responsibility
All contracts between MidCentral DHB and the private hospitals outline clinical responsibilities and requirements.

The detail relating to these responsibilities is included in the Memorandum of Understanding between MidCentral Health and the Funding Division.

Understandably, it is fair to say that the project worked best where the surgeons were shared between the public and private hospital. There still seemed to be concern on the part of MidCentral Health clinicians about ultimate clinical responsibility for the patients. This was of particular concern where surgeons working in the private sector did not have "admitting privileges" with MidCentral Health.

3.3 Credentialing

Concerns were raised that some surgeons participating in the spot purchasing project are not 'credentialed' by MidCentral DHB.

The standard applied in evaluating preferred providers under the spot purchasing project requires the following standards:

- Surgeons to be registered medical practitioners;
- Attached to hospitals with relevant accreditation;
- Compliance with recognised health sector standards.

Both private hospitals within the MidCentral District have accreditation and meet the minimum standards required for contracting with ACC. Both private hospitals also have their own 'credentialing' process.

The concern arises largely from a recent case in the Bay of Plenty which resulted in the Health and Disability Commissioner recommending that the 'bar' is raised in the credentialing process. The report noted, among other things, that the Health Practitioners Competence and Assurance Act [2003] has some gaps relating to the sharing of information between registration authorities and private hospitals. The Commissioner said that hospitals should ensure they consult with relevant registration authorities and coordinate their actions with other hospitals.

The Commissioners latest ruling places additional responsibility on all hospitals, public and private, to demonstrate they have fulfilled their obligations under the Act.

Representatives from MidCentral Health and the 2 private hospitals in the MidCentral district have recently met to discuss this particular issue with a view to forming common standards for credentialing. The recommendation for future tenders issued by MidCentral DHB is that applicants are specifically requested to provide information relating to their credentialing process and that this information is used in the evaluation of tenders.

4. WHERE TO FROM HERE - OPPORTUNITIES FOR SERVICE DEVELOPMENT

The elective services spot purchasing project has identified at least 4 areas for further service development.

4.1 Efficiency and Effectiveness

The Cardiology work undertaken by Southern Cross as part of the spot purchasing project has provided a benchmark for service delivery in Cardiology. Southern Cross is offering many patients a 'one stop shop' that includes a First Specialist Assessment and the relevant diagnostic tests in one clinic. A patient moving through the MidCentral Health Cardiology service can be on as many as 3 waiting lists at one time and is likely to receive separate appointments for the First Specialist Assessment and associated diagnostics.

Is the private hospital working more efficiently or is MidCentral Health merely constrained by funding arrangements and lack of physical space?

Current funding arrangements impose certain requirements the hospital must meet to receive the funding for each discrete part of the patient's journey. The use of nurse clinics and nurse practitioners is also not strictly within the current DHB purchase unit and funding framework, however, MidCentral Health is currently holding nurse led clinics in both cardiology and respiratory services. Bottlenecks are created in the system where patients must attend a First Specialist Assessment before they can be referred for some diagnostic services. A recent project led by the Funding Division allows General Practitioners to refer directly into the CT Scanning service for patients presenting with headaches.

Lack of physical space imposes severe constraints on improving efficiency, particularly for cardiology where there is no physical department to work from.

It is time for District Health Boards to adopt a 'population' approach to funding their hospital providers through the Price Volume Schedule. A revamp of the way our hospital providers are funded, presents some challenges within the current Inter-district Flow environment, but would mitigate some of the current disincentives to improving efficiency and effectiveness. There are also opportunities to explore community based locations for many services.

4.2 Improved Waiting List Management

The project has identified significant opportunities to improve the 'processes' around management of the waiting lists and incorporate a nursing case management model to actively manage patients with complex needs from the beginning of the referral process and provide a communication link with General Practitioners and Primary Care providers.

At the present time there are insufficient resources allocated to 'active management' of the elective services waiting lists. This is demonstrated by the high number of patients 'removed' from the lists during the project for reasons that have nothing to do with 'reprioritisation'.

Early in 2005 the Funding Division agreed to fund 3 Full Time Equivalent Nursing Case Management positions from accumulated surpluses. Unfortunately the nursing case managers were initially deployed into discharge planning roles in non-elective services specialties. It was not until January 2006 that the MidCentral Health Nursing Case Managers began actively working with the Elective Services Project Manager on waiting list management.

4.3 Workforce development from a sector perspective

Much debate is ensuing nationally on the value of private provision of publicly funded services. However, this project evidences that, for the MidCentral district at least, we have fundamentally 'one' market for services with much of the workforce shared between the public and private sector.

Workforce development should therefore be viewed from a 'total sector' perspective in order to secure the best resources for the district.

4.4 Making the most of available physical resources

Two things are apparent – MidCentral Health is constrained by lack of physical space whilst the private hospitals have considerable excess capacity. During the course of this project, both private hospitals have expressed an interest in having further discussions on a number of possible options.

5. CONCLUSION

The elective services spot purchasing project has identified that:

- The spot purchasing project has achieved what it set out to do by investing $2.3m directly into patient outcomes between July 2005 and May 2006;
- The project has tested the capacity of the 'total system' to meet demand for publicly funded services;
- The number of elective patients treated during the project represents a significant percentage of total elective public throughput over the period;
- There are currently spare human and physical resources within the MidCentral district that could be utilised to deliver elective services to our population within a competitive pricing regime;
- There is essentially 'one market' for services so the public and private sectors need to work together to find innovative solutions, including collaboration on workforce development and common clinical standards for the sector.

6. RECOMMENDATION

It is recommended:

that this report be received

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