

Pro-equity prioritisation

Situation

Pro-equity prioritisation after clinical prioritisation is essential to ensure equity when we have waiting lists.

Currently pro-equity prioritisation has been implemented partially in some district wait lists but is far from consistently applied and the methodology is variable.

There is a need to increase AND standardise pro-equity prioritisation.

Background

Pro-equity prioritisation will not solve Te Tiriti or equity issues as the system is still required to remove barriers to access e.g. Navigators, community supports, patient focused booking mechanisms etc. as well as exploring unconscious biases which may impact communication approaches or list ordering. However, pro-equity prioritisation is a way of compensating for some of these system elements and has been shown to enhance equity.

There are significant differences between proposed booking order from waiting lists/equity adjusters and the final booking order (particularly for theatre bookings). Many of these changes are understandable and justified, whether because of patient availability or clinical considerations. But we know many of the drivers for these changes do not apply equally across patient groups e.g. patient availability/access is strongly influenced by ethnicity, deprivation and remoteness. This means all the hard work of equity adjustor tools can be easily undone in the final booking order. We consider it essential therefore to run improvement work in parallel to these adjustment tools to look at the drivers of booking order and reduce inequitable variance where possible.

Pro-equity prioritisation has been implemented in a number of methodologies and these have been investigated recently in Te Toka Tumai and discussed regionally with a group of planned care leaders including appropriate Māori leadership. The main options are included in the table below.

The model being proposed is the most complex of the options considered as simplified models haven't rectified obligations to Te Tiriti or done enough to ensure equity. We think this is justified based on the pros and cons of each model. As region is looking for a common approach, then all districts need to consider whether they can operationalise this same model based on their systems and workflow.

Assessment

We need to progress pro-equity prioritisation regionally rapidly.

Optimal methodology is complex and will likely take time to implement across all of planned care.

We may need to accept an imperfect staged approach.

Recommendation

1. Rapidly understand ability to apply algorithm to existing wait lists across Northern Region – suggest report back in 1 week.
 - a. We anticipate feasibility of implementation will be much higher in procedural waitlists.
2. That an algorithmic approach includes Māori, Pacific ethnicity, Dep score
3. If initial feasibility is low in procedural waitlists we will need to consider
 - a. Alternative methodology
 - b. Accept different methodologies across region
4. If initial feasibility is low in non-procedural wait lists (FSA and Diagnostics) – we will need to reconsider methodology used.

Approach to equity adjustment	Pros	Cons
<p>One up – moving all Māori and Pacific patients up one priority band i.e. P4 to P3. In practice this was limited to the lower bands, P3s were not moved to P2 and P2s were not moved to P1.</p>	<ul style="list-style-type: none"> • Simple • Intuitive 	<ul style="list-style-type: none"> • Initial data analysis suggested this caused some inequity within Māori and Pacific groups. Long waiting P4s moved into the P3 band were effectively jumping ahead of P3 Māori and Pacific patients already there due to higher days waiting. Even if P3s were allowed to move to P2, the same would happen in this band. • No finer adjustment possible. May over or under adjust.
<p>Adding additional days waiting for Māori and Pacific patients – e.g. adding 30 days to the waiting time of Māori and Pacific patients so they are pushed higher up the list within their priority band.</p>	<ul style="list-style-type: none"> • Simple • Intuitive • Some evidence it may impact equity (though there were other confounding variables in the data) • Has some level of adjustment (by adjusting number of days added) 	<p>This likely works well in higher priority bands but may leave patients stranded in lower bands. Frequently, resource constraints result in the lowest priority band patients never being reached as the new influx of higher priority patients fill the limited number of slots. Adding additional days waiting to these patients does not make them any more likely to be seen. Data only looking at average waiting times may give an impression of overall improvement but some groups may be left behind.</p>
<p>Algorithm based approach (as per the Urology tool described in this paper) i.e. assign and order patients according to an adjusted risk score determined by priority, days waiting and ethnicity. Different priorities and ethnicities accumulate points at different rates to accelerate Māori and Pacific patients higher up the booking order as they wait longer.</p>	<ul style="list-style-type: none"> • Some evidence it may impact equity (though there were other confounding variables in the data) • Patients can effectively jump priority bands if they have waited long enough so they can't be stranded • You have control over the settings to determine the level of adjustment required to achieve the desired impact (this will likely vary by service) 	<ul style="list-style-type: none"> • Complex • Requires building of tools for Bookers and Schedulers incorporating the algorithms • Requires an operational process to review and adjust parameters to achieve desired result