Memorandum

Options for improved planned care delivery and the private sector

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To:	Hon Simeon Brown, Minister of Health		
From:	Health Workforce and System Efficiencies Committee		

Contact for telephone discussion

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Purpose

1. This memorandum provides you with the Health Workforce and System Efficiencies Committee's (the Committee) advice on various opportunities to improve planned care surgery delivery, as well as noting potential unintended consequences and mitigations of these, in relation to Planned Care Surgery and Private provision of service.

Background

2. Outsourcing of public work has been a long standing and necessary component of planned care delivery in many districts. This has predominantly involved diagnostic and surgical services. Done well, outsourcing is patient-centric with significant advantages for patients, providers, funders, and clinicians.

3. The Committee stresses there is no reason to delay outsourcing whilst mitigations are established, but the Committee advise that Health New Zealand should expeditiously work with relevant stakeholders to further develop and embed risk-mitigation strategies.

4. The Committee emphasises a collaborative approach with stakeholders is essential to maximising opportunities to deliver Planned Care for the benefit of patients.

5. The Committee notes that some outsourcing involves activities other than surgery, but this paper focuses on Planned Care Surgery. Use of outsourcing varies across the country and in some districts the use is traditionally high. This reflects, in large part, historical public capacity limitations in human resources and infrastructure, in turn reflective of historical investment decisions.

6. Whilst "outsourcing" formally refers to the delivery of public work in private facilities by clinicians in their private time, there are also additional "private-like" arrangements in use. There is, therefore, a spectrum of activity with various levels and types of "staff purchase". The spectrum of arrangements include:

    a. **Outsourcing** to private providers with work provided by clinicians in Private time

    b. **In-sourcing of additional procedural lists** often at agreed sessional rates of remuneration (especially in weekends) but also in evenings, public holidays in some districts.

    c. **"Package of Care"** whereby staff in their private time use public facilities with the private clinical provider carrying out all aspects of care without reliance on "public medical staff" such as RMOs. Note this model appears to only be used in the Waitemata District

    d. **In-sourcing within normal planned care** sessions under various contractual arrangements (for example, urology contracting in some districts)

    e. **"Wet leasing"** whereby Public fully resources a Private operating room with roles performed by staff in the public system, during public time.

7. The Committee notes that Health New Zealand hold these various contracts and could provide more information to you on request.

8. Perceived advantages of a public-private collaborative model include:

   a. Improved timeliness and choice for patients

   b. Increased total production (often mischaracterized as "productivity")

   c. Retention of public staff especially under "private like" arrangements

   d. Potentially some cost reduction, noting that the private sector likely has a lower cost base due to its:

      i. Freedom from acute work

      ii. Freedom to select its case breadth

      iii. Ability to reject high needs patients or high costs patients/activities

      iv. Ability to transfer patents with complications or high needs/complex discharge needs to public post operatively

      v. Likely higher overall revenue base due to insured and fee for service patients.

9. However, there are important caveats:

   a. Maximal production is likely only achievable by utilization of both public and private facilities. Any degradation of the ability to maintain staffing in public will significantly threaten overall production and hospital flow, including for acute work. Destabilisation of public resources reduces both public productivity and production, not necessarily pro-rata to private production.

   b. A collaborative model only exists if labour is not transferred to the private sector as a net loss to the public sector.

   c. Case-mix suitable for private will be predominantly of lower-complexity, shorter stay cases in most specialties, therefore especially if outsourcing also leads to a loss of staff, the waiting times for cases not suitable for outsourcing will likely increase. This results in perverse queuing where next in line is not necessarily next treated.

   d. Costs may not truly be lower as the current funding structure for public cases includes revenue specific to the health status of the patient and variables such as the facility in which a procedure occurs, any needs requiring an Intensive Care Unit admission and so forth. This revenue is broadly determined by the Weighted Inlier Equivalent Separations (WIES) system. Therefore, it is important the negotiating process recognises the revenue of cases suitable for outsourcing may well be below "average WIES revenue" received for all patients having the same procedure in public.

   e. There must be national consistency regarding clinical decision-making in all aspects of planned care, but especially in relation to acceptance for specialist review and entry to a planned care waiting list. The Committee believes this is necessary to maintain proper stewardship of public money and to avoid actual or perceived conflict of interests in regard to clinicians obtaining personal benefit from potential waiting list expansion.

Risk of distortion

10. Whilst tempting to see private as an immediate option for speedier reduction in public waiting times there are risks from sudden, "significant distortion" of existing volumes and arrangements.

11. Risks of a sudden distortion include:

    a. Loss of technical staff from public as occurred when our borders re-opened post-Covid. The exit of medical professionals (particularly anaesthetic and medical imaging technicians) to private was considerable as the private sector dramatically enhanced salaries to attract staff. Consequently, public performance was degraded for both planned and acute care and ultimately costs rose as the public sector had to meet increased remuneration expectations.

    b. Loss of specialist surgeons and anaesthetists. Most consultants with either part-time or full-time private practices are consistently "fully booked" for their private activity most weeks, therefore, unless the contracting processes establish clear safeguards, a sudden dramatic increase in Private contracting risks loss of full time employment (FTE) and expertise from public. The effects of this will not only be on timeliness for complex planned care not suitable for private, but also on acute flow as the same consultants performing planned care also cover acute care 24/7.

    c. Disproportionate worsening of access for those cases not suitable for outsourcing. These are generally patients with complex heath conditions and needs, who in turn are disproportionately from lower socioeconomic groups or are those requiring complex surgery, particularly cancer surgery.

    d. Degradation of training of Resident Medical Officers (RMOs) to become specialists, thus further embarrassing the specialist pipeline and workforce available for both sectors in the future.

12. The Committee notes there are mitigations to avoid these unintended consequences:

Seeking the right balance

13. A collaborative approach with the private sector is required. It is vital those establishing contracts recognise there are clinical obligations and responsibilities in the public sector that must not be weakened by outsourcing. Health New Zealand should consider such risks in the contracting process.

14. The Committee advises:

    a. Health New Zealand to establish improved certainty and duration of contracts to allow better investment by Private providers and better planning by Public. These contracts must clarify:

        i. Case selection

        ii. Roles and responsibilities especially around management of complications

        iii. Follow-up requirements

        iv. Audit and reporting of outcomes and complications.

15. A phased/coordinated approach to any significant uplift in public volumes transferred to private to allow risk mitigation. This would ideally be linked to ongoing recruitment

of FTE in the public sector and would be designed to ameliorate the risks of a sudden distortion.

16. Access to most outsourced work should be made contingent on the clinicians involved maintaining at least a public equivalent commitment.

17. The Committee recognizes that continuity of care, especially for the management of complications is clinically and medicolegally highly desirable for achieving the best patient outcomes, again reinforcing a view that contracting of surgical cases should be to staff with a public role and commitment. Involvement of non-public clinical staff should be assessed by the district and region on the basis of other contributions to Public such as in education and training. Full credentialing and a commitment to active participation in Audit are also essential to maximize patient outcomes.

18. Establish and maintain agreements on the roles of private in education and training. This should cover all staff types involved in the outsourced activity.

    a. Technical staff

    b. Nursing staff

    c. Specialist trainees

    Note: An investment in specialist RMO trainees will be necessary to backfill the role of trainees in the public facility when they are receiving training in an outsourced environment, otherwise both acute and planned public work will be adversely affected. This requires recognition, planning and funding by Health New Zealand.

19. Analysis of the various in-sourcing and "private like" models to assess cost-effectiveness and applicability to districts not using such arrangements. This is particularly relevant for any district lacking access to private facilities without gross patient inconvenience.

20. Consideration of Public-Private partnerships to invest in resources on public sites to increase capacity and productivity.

21. Review of employment options/contracts for staff with the intent of maintenance of public commitment for those staff benefiting from outsourcing

22. Construction by Health New Zealand of Governance arrangements to ensure nationally consistent policies and procedures for matters such as:

    a. Regular assessment of outcomes to ensure maximal patient benefit.

    b. Public staff taking annual leave or using non-clinical time to perform outsourcing. (The Committee believes this is necessary for ensuing Health New Zealand's responsibilities under Health and Safety legislation are observed).

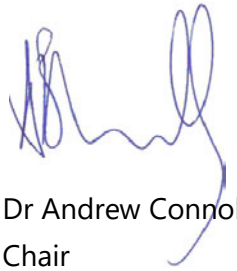
23. Consideration of employment contracts whereby public staff are also contracted to provide out-sourced production in a shared employment model.

24. Review of extent of outsourcing from First Specialist Assessment through to and including follow-up

    a. Explore if some scenarios may best be managed by outsourcing of whole pathway from acceptance of referral or by outsourcing of a proportion (for example the operation itself).

    b. In the longer term avoid partially outsourcing activity without establishing capacity for the outsourcing of the entire healthcare event from end to end.

25. Establishment of credentialing processes of private providers contracted for public work.



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Health Workforce and System Efficiencies Committee
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