Home & Community Health Association

Putting the Case

Improving the viability, delivery and outcomes of New Zealand's Home and Community Support Services: A national casemix delivery and contracting framework

In this paper the HCHA puts the case for two service elements that it believes are essential to enable the vision of the NZ Health Strategy and the Healthy Ageing Strategy to be applied to home support for older New Zealanders. The two elements are the use of casemix service delivery, and a fairer contracting framework.

Older New Zealanders should have their needs assessed and services allocated in a way that is consistent across the population. Health services need to be more closely targeted to client need and health providers need to work together, alongside the client and funders. Clients need more choice in supports and more control over their own health. Funders need services where value and performance can be better measured. Those are the key elements of home support casemix.

Providers need a service contracting environment where fair contracting incentivises quality, innovation and collaboration, and where alliances, data and sound modelling are used to share risk. Those are the features of a fairer contracting framework.

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Executive Summary

1) HCSS providers, support workers, allied health professionals, and funders are increasingly aware that current service delivery and funding models are inequitable for older clients, and unsustainable for Home and Community Support Services (HCSS) providers and support workers. A range of issues contribute to this situation, primarily the rapidly increasing demand including an ageing population, consumer demand, fragmented funding and inconsistency.

2) The current funding and delivery challenges indicate a need for change. This change needs to occur at a national and system level to improve the viability, delivery and outcomes of HCSS across the sector, and in all regions of New Zealand. In this paper, the Home and Community Health Association seeks implementation of Recommendation 3 of the Director-General's Reference Group in 2016, and specifically the elements regarding the application of a national case mix assessment methodology to all contracted Home and Community Support Services for older people and the alignment of that case mix with funding and alliance structures.

3) In a casemix model, clients can be assessed to identify their needs and then be allocated accordingly to receive a suite of services that will best meet these needs. Services can be funded according to the identified needs of a population grouping, while retaining an appropriate degree of tailored service provision, without needing to develop a bespoke service offering for every client.

4) The casemix model offers several benefits. It promotes a consistent approach towards support allocation. When aligned with a funding framework and a good contractual or alliancing arrangement it promotes more professional discussions and risk sharing. It enables risk reduction and management through the establishment of appropriate and safe care pathways. It helps to cut hospital admissions and speed up discharge for non-acute patients. It is cost effective but not at the expense of client care or outcomes.

5) A casemix model also supports public policy goals set out in the Ministry of Health *Healthy Ageing Strategy* (2016). It can be built alongside, or be underpinned by whānau ora approaches, and by models that place more choice and control in the hands of the consumer.

6) There are casemix models already in place in New Zealand that can form the core building blocks for a new national funding framework that incorporates consumer choice and restorative care.

7) Ongoing, open and transparent dialogue between all parties is needed to agree a way forward and co-design a solution. Funders, providers and clients need to understand and leverage the significant work completed to date. The solution could take several forms. However, a useful foundation is a casemix funding model, that can then be aligned with consumer choice, restorative care and an evidence-based funding structure.

Current state healthcare

8) New Zealand's healthcare sector has recently seen a shift in focus towards delivering care that results in improved client outcomes (rather than delivery of outputs) and is more sustainable for funders, providers and the healthcare workforce. Within this context, policymakers, funders and providers are working to identify and scale effective healthcare models that meet a range of client needs, including those clients with high need and costly care.

9) Approaches to the delivery of healthcare must also increasingly be responsive to supporting greater consumer control over health, access to health information and health supports with a population keen to exercise their agency in health matters. These shifts in delivery of healthcare have also shaped the way the Home and Community Support (HCSS) sector provides care for older people.

10) In recent years, care for older people has reoriented around the home and community. Instead of spending extended (potentially unnecessary) periods in hospital or moving older people into a residential care home, the sector has engaged in significant developments that support people to recover from injury or manage impairment, and maintain or regain independence, while living in their own homes.

11) In order to successfully support older people to maintain their health and wellbeing in the home and community, HCSS services are working to identify client needs early and meet those needs with delivery of an appropriate suite of services. Key to the clients success is responsive and flexible service provision that accommodates the dynamic nature of each client's condition and situation.

12) As more people-centred care approaches are adopted to address a client's physical, emotional, practical and material needs, the types of services that enable older people to remain in their own homes continue to evolve. Services now extend beyond personal and home care and support.

Challenges with current HCSS arrangements

13) Among HCSS providers, support workers, allied health professionals, and increasingly funders, there is a growing awareness that current service delivery and funding models are inequitable for clients and unsustainable for HCSS providers and support workers. A range of issues are contributing to this situation, including:
    - An ageing population generating workforce pressure
    - The need to respond to a new generation of clients who want choice and control
    - Fragmented funding
    - Inconsistent assessment periods and service allocation
    - Inconsistent take-up and reporting on models and tools to understand which HCSS models work best for different client groups

14) New Zealand is facing significant demographic change, with the number of people aged 65 and older expected to nearly double as a percentage of the population in the next 20 years. To meet

the anticipated increase in demand from this group of HCSS users, the personal carer workforce would need to more than double in size, from 35,600 currently to 73,000.

15) Care in the home and community support sector must be provided by a suitably skilled and paid workforce that is supported to utilise collaborative working approaches. Recent initiatives such as guaranteed hours, travel time payments and pay equity have addressed some of these issues, but the challenge of growing the workforce and their productivity remains.

16) Clients are becoming increasingly aware of their rights and entitlements, are seeking health information, and are unwilling to accept poor quality or disjointed care. Providers are faced with needing to improve the quality and availability of services for clients, manage expectations and counter misinformation.

17) HCSS services are not delivered under a national contract. Funding arrangements currently vary between the 22 funders (Ministry of Health, Accident Compensation Corporation and the 20 DHBs). Funding for the same services vary considerably, which makes it difficult for providers to reliably forecast their income. The unpredictable nature of funding has an impact on providers' ability to cover operational overheads, maintain service standards and adequately pay their workforce. An unreliable source of income limits providers' ability to fund staff skill development and improve their pay and working conditions, which in turn makes it difficult to maintain service standards and retain staff. Multiple funding arrangements also results in significant administrative burden for both funders and providers, who must maintain multiple record keeping processes.

18) Currently, New Zealand does not utilise a standardised model or tool to guide the delivery of HCSS. DHBs have adopted different approaches and implemented these at different points in time. Variable uptake of effective models and tools means for many HCSS users and providers supporting more older people to remain in their homes and communities continues to be a challenge. Also, clients receive unreasonably variable service allocations across New Zealand.

19) The absence of a standardised national model and tools means New Zealand has a limited and inconsistent dataset to measure client outcomes and service performance. Consequently, it is difficult to determine what works best for different client populations. Without reliable data, it is difficult to know how to combine services around the needs of a client population group. The opportunity to efficiently connect clients to appropriate services and operate more cost-effective services may be missed.

Time for change – a national framework for HCSS

20) The challenges with current arrangements for funding and delivering HCSS indicate a need for change. This change needs to occur at a national and system level to improve the viability, delivery and outcomes of HCSS across the sector and in all regions of New Zealand.

21) The call for change is not new. In 2014, the need for system level change was highlighted as part of the *In-between Travel Settlement*. As part of this settlement, all parties, including MoH and the 20 DHBs agreed on a timeline for achieving the 'regularisation' of the HCSS workforce. The features of regularisation included:
    - guaranteed hours for support workers
    - training
    - wages in line with training level
    - a casemix mechanism to ensure the fair and safe allocation of clients within the DHB environment.

22) Further to this, in 2015, the Ministry of Health's Director-General's Reference Group for Home and Community Support Services (DGRG) identified the need for best practice care models for HCSS, and recommended the creation of national service standards; a national pricing model; a national casemix assessment methodology; and a regularised workforce, among other recommendations.

23) Whilst guaranteed hour have been implemented, and pay equity legislation has set in place a tenure and qualifications progression for staff, further action is still required on the aforementioned components of the In-between Travel Settlement, as well as the DGRG recommendations. In addition to this, it is increasingly apparent that all parties involved in the HCSS sector need to collaborate and develop an integrated national model that can fund and deliver services that are respectful of both clients and the workforce.

24) The Home and Community Health Association wants to see the implementation of the recommendations of the MoH's Director-General's Reference group, specifically Recommendation 3 as follows: It is recommended that a national agreement become the foundation for service provision for HCSS. The agreement will:
    - be person centred, as demonstrated and measured through client experience
    - identify national service-level standards
    - have a national pricing structure based on an agreed costing methodology
    - have a national minimum base price that is reviewed and negotiated annually
    - have an agreed national casemix assessment methodology
    - enable flexibility to reflect individual population need
    - require regularisation of the HCSS workforce as per the approach proposed in recommendation 8 be reviewed annually.

    (noting that only the last bullet point has been partly achieved)

25) An appropriately designed, managed and funded case mix model could usefully form the basis of a national funding framework for HCSS service provision as outlined in the Recommendation above.

A casemix assessment, funding and delivery model

26) A casemix funding and delivery model involves clients being assessed to identify their needs and then being allocated accordingly to receive a suite of services that will best meet these needs. Through a casemix model, services can be funded according to the identified needs of a population grouping, while retaining an appropriate degree of tailored service provision without needing to develop a bespoke service offering for every client.

27) This approach to funding and delivery of care enables funders to allocate funding based on anticipated population group needs. Providers are able to receive equitable funding for the services they deliver and forecast the needs of their population based on a growing body of data from their own previous assessments and allocations. Clients can be assured that their needs are being assessed appropriately and being met in an equitable manner regardless of where they live in New Zealand.

28) While the casemix funding model has a long history of use in hospital settings, it is only in recent years that it has been deemed suitable for use with home and community based care. The identification of a casemix in a hospital is based on diagnosis, which is less applicable in the community where client need, rather than diagnosis becomes more important. However, the comprehensive use of assessments focused on home and community care now supports the use of a case mix funding model for HCSS.

Leveraging current funding and delivery models to develop a national contract framework utilising a casemix model

29) Many of the core building blocks necessary for an integrated national model of HCSS have already been developed in New Zealand for the local setting and population. There is an opportunity to leverage these building blocks that could support a national casemix funding and delivery model. These include:
    - Home and Community Casemix model (versions) currently operating in seven DHB regions
    - Restorative/responsive Home Support Delivery Model
    - interRAI assessment
    - Other relevant national integrated services such as ACC's Integrated HCSS contract funding and delivery model.

30) HCSS casemix has already been built and variations of it are operating in seven DHB regions. These are set out in Table 1. Table 2 shows the funders that are still using the fee for service model

Table 1: Current New Zealand homecare casemix application in DHBs (health of older persons)

Funder	Date	Features	No. providers	Service volume (hrs)*
Auckland DHB	2010	Combined with bulk funding and restorative service model DHB maintained funding and service for lower casemix levels. Six non-complex levels and eight complex. Providers undertake interRAI contact assessments for non-complex and more recently for stable complex using the interRAI Home Care Assessment and actively case manage these clients. Support programme around goals and needs led by RHP.	Four	674,857
Canterbury DHB	2011	Combined with bulk funding and restorative. Providers undertake interRAI contact assessments. Separate, CREST model focuses on intensive post-acute support.	Three	773,157
Southern DHB	2013	Combined with bulk funding and restorative service model. Providers undertake interRAI contact assessments. Support programme focussing on goals and needs, led by RHP. Rehabilitative and restorative approach. Training requirements. Providers also deliver support services to the DHB under Mental health, Chronic Health, Personal Health, Palliative contracts: these are delivered under a Fee for service model.	Three	723,622
Hawkes Bay DHB	2014	Restorative. Care cluster interdisciplinary approach. Provider RHP undertake contact assessments. Not bulk funded.	Two	374,956
Bay of Plenty DHB	2016	Combined with Fee for Service (FFS) and Responsive model cluster groups developed by the DHB to reflect client needs based on interRAI Home Care, CAPS and associated assessment tools including the Chess and Maple. Clients are identified as non-complex or one of 8 complex clusters. All FFS clients transitioning to the Responsive model over a period of 2 years – currently half way. Provider RHP do not currently undertake contact assessments but a pilot is underway to assess the effectiveness of this. The DHB does not call this a casemix model, however there are synergies with other models and is bulk funded and funding has been maintained for all non-complex clients.	3 Lead Providers with 8 providers in total	960,300
Capital and Coast & Hutt Valley	2016	Bulk funded restorative. Quality targets, incentives, specified training. Providers undertake interRAI contact assessments. Long term conditions included.	One	692,913
Nelson-Marl DHB	2017	Casemix, bulk funded restorative model of care, also using the Calderdale Framework principles (workforce development and collaboration tool). Providers undertake contact assessments.	Two	389,213
				4,589,018

* Service Volumes drawn from 2017 OIA, relating to the year ended 31 March 2017. Some of the volumes include DHB Under 65 chronic conditions support and some exclude them. For some DHBs (eg where bulk funding applies) DHBs have derived hours from provider information, or contracted providers have given data directly to HCHA.

* Providers often hold related contracts, such as Under 65 chronic conditions support, District Nursing, ACC home support and community nursing, mental health and needs assessment.

Table 2: Current home support funders using fee for service

Funder	Hours Delivered
Northland DHB	691,124
Counties Manukau DHB	715,042
Waitemata DHB	1,082,740
Waikato DHB	805,000
Lakes DHB	290,267
Tairawhiti DHB	105,843
Taranaki DHB	235,127
Whanganui DHB	233,693
Mid Central DHB*	523,245
Wairarapa DHB	93,143
South Canterbury DHB	173,156
West Coast DHB	34,319
ACC **	
Ministry of Health DSS ***	
	4,459,977

* Mid Central DHB is currently re-tendering on fee for service basis (restorative)
** ACC has commissioned the development of a casemix model to be used as part of its 2018 service review. This will be based on a specific ACC injury needs assessment tool, not on the InterRAI assessment.
*** The Ministry of Health DSS is now engaged in the transformation project which will encompass many of its funded services over the next several years.

31) A number of DHBs utilise the Restorative Home Support (RHS) model to deliver HCSS. The RHS model includes:
- targeted assessments of clients with high and complex, as well as non-complex, needs;
- supporting clients to identify and realise personalised goals;
- helping clients to perform functional exercises to give them muscle strength to carry out everyday activities;
- training and enhanced supervision for support workers;
- care management tailored to client need; and
- health professional coordinators to provide supervision, carry out more specialised tasks, such as non-complex assessments, and to maintain links to staff and services across their locality.

32) For its targeted assessments the RHS model uses the International Residential Assessment Instrument (interRAI). The interRAI Home Care Assessment is utilised for clients with high and complex needs and the interRAI Contact Assessment for clients with non-complex needs. interRAI use in homecare was piloted in 2003, and in 2012 New Zealand was the first country in the world to mandate the assessment for older community living citizens. The interRAI data set now holds over 200,000 homecare assessments, and is one of the biggest ageing datasets in the world. (interRAI New Zealand Annual Report 2016/17)

33) The interRAI assessment can usefully support a casemix funding and delivery model because it helps to group clients by need and identify the suite of services that would work best for them. While the interRAI assessment offers its own casemix system, namely Resource Utilisation Groups – RUG III/HC, it groups clients into population groupings that are too broad for the New Zealand setting. These broad groupings limit capability to confidently determine and meet needs accurately and adequately.

34) All DHBs are required to use the interRAI assessment for clients aged over 65 years. This national coverage means the interRAI assessment tool is familiar to providers across the country and may be more readily received by providers and DHBs as part of a national contracting framework for HCSS.

35) In 2008-2009, Auckland DHB and the University of Auckland developed a casemix system for the New Zealand setting and population. The system is called the Home and Community Support Services Case Mix System (HCSS CM), which can be used to inform both types of interRAI assessments performed under the RHS model.

36) HCSS casemix systems, such as the HCSS CM, offer the ability to:
- benchmark against best practice;
- compare practice at both the national and regional level;
- use nationally consistent quality frameworks;
- and develop nationally applicable pathways in collaboration with other HCSS casemix system users.

ACC's National Integrated HCSS Contract

37) ACC's integrated HCSS contract provides a useful example of a national contract and the way a procurement process can be used to bring about change in delivery of services. ACC is a key HCSS funder, spending about $193 million a year on the provision of care for about 15,000 clients. Several years ago, ACC identified an opportunity to improve the services it funds through greater service integration. Whilst this model has yet to achieve its full potential, it has made significant progress with the relationships with key suppliers of these service. As part of the commissioning cycle ACC used a procurement process to direct those improvements.

38) The integrated contract helped to realise ACC's goals:
- increased client satisfaction;
- greater consistency in service delivery and client experience, supported by a quality framework;
- improved engagement between ACC and suppliers;
- collaborative working approaches to solve problems and resolve issues together; and
- better qualified providers.

39) The ACC model shows that there is an opportunity for the HCSS sector (suppliers, regulators, trainers, workforce and funders) to develop a national HCSS funding and delivery model and contract drawing on the tools and experience already in place through the RHS, interRAI, HCSS CM and ACC's national HCSS contract.

Case Mix and Whanau Ora service delivery

40) Concerns have been raised that a casemix model limits client choice, precludes individualised care, and cultural and regional variation. In particular, questions have been raised as to whether a casemix model can be responsive to the specific needs of Māori and whānau.

41) While a casemix model that groups services around specific client segments or populations, does not offer unlimited client choice, individual, cultural and regional variations can inform casemix service offerings. In New Zealand all service offerings for all client segments could include, or even be underpinned by, whānau ora approaches, which seek to involve a client's family, whānau and community to develop an agreed care pathway. The HCSS sector and funders, along with other complementary sectors, which should include Māori service users and providers, could develop a casemix model together that reflects New Zealand's cultural and regional diversity.

42) Ideally the casemix would be informed at a local level through a locally administered assessment. An effective assessment would ensure the voices of individual client's their family and whānau are heard and wherever possible acted upon. Findings from this assessment would then guide decisions about the most suitable service offering for the client, and in this way can accommodate the needs of Māori and whānau.

43) For Māori, a casemix model can offer a number of benefits. It can help to:
- integrate Māori health providers and local marae into a wider mix of services;

- recognise Māori health providers and local marae as important agencies for connecting with individual Māori, whānau, hapu and the wider community;
    - promote the provision, increased availability and uptake of services that are culturally relevant and safe for Māori;
    - remove inequalities arising from differential access, assessment and treatment, which can particularly affect Māori; and
    - ensure Māori cultural responsiveness requirements are built into contracts, service standards and operational guidelines, requiring service providers to be trained and skilled to deliver culturally responsive services and/or to have standing relationships with Māori health providers and local marae to deliver those services and/or provide cultural guidance.

44) At its core, a casemix model promotes a consistent standard of care. When applied nationally, the standard of care for clients and their family and whānau becomes more equitable regardless of where people live. Clients are connected to the services they need, when they need them, and these services are delivered by service providers working to a contractual and monitored standard.

Self-directed support within a casemix model

45) In line with demand for information, health supports and access to particular services from a generation of clients who are more aware of their rights and entitlements as health consumers has come a move to offer self-directed care in the HCSS sector. In essence, self-directed support is designed to increase user's choice and control, enabling them to self-direct care services to meet their changing needs.

46) Approaches to self-directed care vary in accordance with the degree of scope afforded to the client. In some initiatives the client has choice and control over their care arrangements, including decisions about what care to purchase and from whom. In other initiatives clients are supported to participate in decisions about their care and what services will best meet their needs but do not control decisions about their care or the purchase of services to meet their needs.

47) Just as the case mix-model can be developed to accommodate engagement with Māori and whānau and the assessment used as a tool to guide decisions about the most appropriate suite of services for an individual, it can also be developed to accommodate self-directed care. During the development of a casemix model the HCSS sector and those it consults, including older people could debate the potential for some services within a case mix to be offered as self-directed and the extent to which these could be self-directed (i.e. engagement in care planning, control of who to purchase a service from, decision-making on budget spend on a service). Consideration would also need to be given to the circumstances within which it would be advantageous to support a client with self-directed support options and what support the client may need to achieve the most from a self-directed services model.

48) Even if decisions were taken not to include a role for the client in purchasing services, the case mix-model can support clients to make decisions about their own care, albeit within the parameters of client segment determined by their assessments results. Within a casemix model, there is significant engagement and consultation with the client, from the assessment through to the selection and receipt of services. The assessment is intended to be a dialogue between the client and provider to work through the client's needs. Dialogue with the client continues beyond an assessment to setting personalised goals and developing a care management plan. It is in the best interests of both the client and the provider that the client feels ownership and responsibility for their care and outcomes.

49) In the casemix model, the suite of services available to the client may be based on their client segment or population, however, a variety of services are available for the client to select from that suite. Through proactive engagement and education, the client is supported to select the right services for their needs. The client can also be reassured that they are selecting services that are proven to deliver positive outcomes for people with similar conditions and in similar situations.

Benefits of a casemix model for providers and funders

50) Among the most important benefits of a casemix model for providers and funders is its risk reduction and management function. By assessing a client upfront and determining which client segment they fit within, the client can be placed on an appropriate and safe care pathway. The assessment will highlight risk areas and the care pathway will include mitigations for those risks. The care pathway will have been developed based on evidence of what works best for that client segment to keep them safe, aid their recovery or prevent their deterioration, and realise the best possible outcomes for them.

51) Casemix models for HCSS help to cut hospital admission and speed up discharge for non-acute patients, for whom evidence suggests the best possible outcomes are realised in their homes and communities, rather than in hospital or residential care settings. As a result, hospital based health expenditure is reduced in favour of more cost effective home and community based health expenditure, but not at the expense of the client's care or outcomes.

52) Furthermore, a case mix model supports public policy goals, including those laid out in MoH's Healthy Ageing Strategy (2016), which aims to foster infrastructure, resources, approaches and attitudes that enable older people to live as independently and actively as possible in their own homes and within their own communities.

Funding a casemix model

53) At the heart of any contract, integrated or otherwise, is agreement on the way in which payment is to be made by one party to another. Determining what to pay for, and when and how to pay for it, is a critical component of any contract development. Ideally, all parties should have some involvement in determining those parameters to ensure transparent, smooth subsequent contract negotiations.

54) The funding model set out in a contract can either encourage or inhibit the desired service delivery and outcomes. A case mix model needs to be funded to maximise the benefits of the model: providing client-engaged, coordinated and outcomes-focused suites of services to the people that need them, when they need them. Such comprehensive service provision cannot be well supported by funding models that seek to overly control or devolve purchasing decisions and payments for services. For example, a fee for service model, whereby a provider receives a separate payment for each service delivered, does not encourage coordinated and connected services or empower clients and providers to take ownership of planning for and realising outcomes. Similarly, placing all funding and purchasing power in the hands of an individual client not only risks putting significant decision making pressure on the client, it can also create uncertainty about what services will need to be provided and when and affect providers ability to plan and budget.

55) A population-based model, whereby funding is allocated to a provider based on the number of clients within an assigned geographic area, places a larger block of funding in the hands of the provider to share out across their services to the needs of clients in their area as those needs arise. However, as population-based models often allocate funding based on generic assumptions about the needs of the population as a whole, this does not encourage targeting services at client segments to maximise client outcomes and service efficiencies. Instead, providers are left to guess how best to juggle their clients, services and funding. Similarly, a capitation model funds the provider a set amount for each client on their books, often irrespective of the client's condition, situation and needs. Again, while this gives the provider a larger block of funding to work with, it does little to help them direct that funding.

56) A middle ground between the above-mentioned models is the bundled payment model, whereby a provider is funded for the overall care for a condition. The bundled payment would cover the full set of services to deliver end to end care for the condition. This model aligns itself directly to the case mix model, as both segment clients by condition and deliver services tailored to achieve the best possible outcomes for that condition.

57) While focusing on the condition rather than the person may appear to be contrary to a people centred approach, the client would necessarily benefit from an outcomes focused approach to addressing their condition, and the services themselves can still be sensitive to and respectful of the client.

58) Targeted care of a condition, as upheld by both the case mix and bundled payment models, can further support:

- continuous improvement of the care provided for a condition, through the analysis of condition specific outcomes data;

- greater understanding of risk factors and how best to manage them, based on more concentrated learnings from the targeted care of a condition;
- collaborative, multidisciplinary care to address the condition;
- expanded client information, understanding and choice on how their condition can be best addressed; and
- cost efficiencies by providing targeted rather than generalist care, without needing to compromise on quality.

Challenges facing the adoption of a case mix model under a nationally integrated contract

59) While many of the building blocks to support HCSS delivery using a case mix model under a nationally integrated contract do exist, a number of challenges must be overcome to determine how these building blocks can be combined and applied to the New Zealand setting.

60) Despite its small size and population, much of New Zealand's health care provision is regionalised. People responsible for running health care in the regions prize locally led and run health care and may view a national contract as a form of centralisation with an implicit reduction of regional independence and decision-making power.

61) The case mix model requires providers to take on greater responsibility and accountability for case and risk management and outcomes. To achieve this funders would need to hand a significant amount of control over to providers. Both funders and providers may be wary about redefining their relationship along such lines.

62) Population based or capitation models are used to allocate most health care funding in New Zealand. Neither of these funding models supports a case mix model. It may be difficult to convince both funders and providers of the benefits of adopting a model that is unfamiliar to many or may require significant changes to administrative processes, procedures and information technology platforms.

63) Challenges to developing and implementing a national HCSS contract using a case mix model can be overcome through wide ranging engagement across the HCSS sector. This engagement would need to share the concepts and models and promote a partnership approach to designing a solution for New Zealand. Developing an understanding that a national contract is not about centrally dictating every care decision but developing mutual agreement about appropriate parameters for safety, consistency and measurability.

Key considerations for developing a national service delivery and funding model

64) If the HCSS sector and funders agree to develop a national HCSS service delivery and funding model, time will be required to scope the core components of the model, including establishing shared goals. Developing a model and contract simultaneously would help ensure collective consideration of and action to address the wide-ranging requirements of clients, their family and whanau, service providers, support workers, allied health professionals and funders.

65) A key consideration should be the delivery of high value health care to clients. It will be important to define 'high value care' that it is achievable and balances delivering outcomes that matter to clients with managing the associated costs. A case mix model, underpinned by integration of services is key to achieving that balance and delivering high value health care. Components of an integrated case mix model can include:

- segmenting clients based on conditions or care needs;
- bundling payments to providers to deliver end to end, wraparound services to a specific client segment;
- providers structuring themselves by having dedicated teams for each client segment, without limiting options for teams to work collaboratively and across disciplines as needed;
- providers being contractually responsible for end to end client care and outcomes;
- one stop shop care, where clients can access all of their care needs in one place;
- alternatively to or alongside the above, hub and spoke care, which meets core client needs and coordinates access or signposts to complementary or specialised care as needed;
- providers being incentivised to expand across multiple sites or geographic areas, or become affiliated with other providers across multiple disciplines;
- shared outcomes, measures and data, so they are standardised to maximise comparison, learning and improvement;
- shared tools and resources, such as client education and engagement, and intake and scheduling processes; and
- shared back office functions and information technology platforms, to help reduce administrative overheads through cost efficiencies and economies of scale.

66) Ongoing, open and transparent dialogue between all parties is needed to agree a way forward and co-design a solution. All parties need to have full awareness and understanding of the significant work that has been done to date, so it can be leveraged and the path ahead is made less daunting. The solution could take any number of forms. However, a useful starting point for a solution is consideration of:

- a case mix model, including:
- Restorative Home Support;
- interRAI assessment; and
- Home and Community Supports Services Case Mix System.
- an integrated contract; and
- a bundled payment funding model.

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