STATES OF JERSEY

AFFORDABLE ACCESS TO PRIMARY CARE SCHEME

Lodged au Greffe on 23rd December 2019
by Deputy G.P. Southern of St. Helier

STATES GREFFE

PROPOSITION

THE STATES are asked to decide whether they are of opinion –

to request the Minister for Health and Social Services, in consultation with the Council of Ministers, as appropriate, to devise a scheme which improves on, and removes potential barriers to, access to primary care for patients who are financially, clinically or socially vulnerable, by –

(a) identifying and prioritising which vulnerable groups are most in need of affordable access to primary care;

(b) reducing the patient co-payment for G.P. consultations from its current level for patients, while ensuring that such patients have ready access to a multi-disciplinary team to include pharmacists, practice and community nurses, physiotherapists, mental health workers and community support workers, all with expanded roles; and

(c) identifying the appropriate sources for the funding of such improved services;

and to bring a proposition for debate by the Assembly in the third quarter of 2020, in order that such a scheme can be implemented from 1st January 2021.

DEPUTY G.P. SOUTHERN OF ST. HELIER

REPORT

In the extensive debate of the Government Plan 2020–2023 (P.71/2019): amendment, despite the Council of Ministers' in principle support –

> *"The Council of Ministers supports the overall aim of the amendment to reduce the costs of primary care to well-targeted groups."*.

The amendment was defeated by the relatively small margin of 25 to 19. The narrowness of this rejection, along with the overwhelming support I have received, both at the time and since, from members of the Public, has encouraged me to re-visit the issue with this similar standalone proposition.

The Minister for Health and Social Services ("H&SS") made much in the debate of the briefing paper that had recently introduced for consultation, the Jersey Care Model ("JCM"), which contains extensive plans for improving health service delivery, especially primary care, for the Island. It is an impressive document, but one which is largely concerned with high-level ambition, vision and intent. Close examination of the primary and intermediate care sections (pages 15 to 22) shows that very few of the plans for change are complete, and in place, despite first being outlined in P.82/2012.

There is total agreement over the need to reduce the numbers of patients in receipt of (expensive) secondary and tertiary hospital treatment in place of primary and intermediate care in the community, close to home. Without this critical change, with its associated emphasis on monitoring and prevention, leading to early diagnosis and treatment, our ageing population will be increasingly expensive to care for.

Given the glacial progress of the Care Model, my main concern in the proposals put forward by the Minister for H&SS, is one of lack of urgency. The fact is that today there are already many patients who put off seeing their G.P., or simply refuse to seek treatment, because of the cost. This undoubtedly has higher treatment costs in the longer term, following later diagnosis. These additional costs will continue to place a burden on the health budget by increasing the amount of hospital-based secondary and tertiary care required.

This proposition expands on the words contained in the Government Plan: *"We will deliver new models of primary care including ... The development of a model to support access to primary care for financially vulnerable individuals"*, and the words given in the response to Written Question 546/2019 *"with delivery targeted for 2021"*.

As Members will be all too aware, "targets" are often missed.

Not only does my proposition ensure that all 3 groups of vulnerable patients, those in financial, clinical and social need, are included, but it gives a clear and practical date by which action is to be expected. We are informed that the external health professionals who have been engaged to cost and stress-test the Care Model, have been commissioned to report by June 2020. It is perfectly reasonable to expect the Minister for H&SS to bring his refined scheme to the Assembly by the third quarter with a view to delivering more affordable access for some groups by 1st January 2021.

My concerns around the timing of the delivery of the Care Model are reinforced by the many links between the need for increased community care and the size of the hospital. It seems that neither can be delivered in isolation. In the words of the Minister, *"whole-*

system change is needed" if we are to deliver the Jersey Care Model. In the papers released by the Minister for H&SS recently on the terms of reference for the "Our Hospital Project" we find the following –

For the Heath Planner and Clinical Design Team –

> "3.6 Capacity Projections:
>
> *Critical to the sizing of the project at this stage will be the projections of whole system capacity requirements. The Health & Care Planner and Clinical & Professional Design Team must undertake a detailed review of forecast of future demand and consequent whole system capacity needs. The forecast must include all factors likely to influence demand (e.g. population, intervention rates, models of care etc), must be capable of showing the differential impact of each factor separately."*

The size of the hospital will be subject to a population debate due in 2020, as well as the success of the Care Model delivery, while the Financial Adviser will be operating to a different schedule, as shown here –

> "*B1.01 – The financial advisor will be required to act as editor in chief and lead on the development of the following cases of the business case. This will involve:*
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> *(i) Delivery of the Hospital Project Strategic Outline Case (SOC) by the end of March 2020 and the Outline Business Case (OBC) by the end of March 2021.* ***A deadline for delivery of the Full Business Case (FBC) will be discussed and agreed in due course.***"

Between the absence of a population policy and the absence of a deadline for a full business case, there appears to be ample room for drift in the delivery of the primary care model unless a tight and clear timescale is set.

In opposing my amendment to the Government Plan in December, the Minister for H&SS made much of whether the groups of vulnerable patients I identified and discussed were well-targeted and might require means-testing. For example, *"there would be no support for people of working age with a chronic condition"*. Despite my protestations that the examples given were not designed to be exclusive, but were only included to give a guide to what costs might be, the Minister insisted in treating these exemplars as part of the proposition.

Paragraph (a) of this current proposition leaves the selection and prioritisation of vulnerable groups completely in the Minister's hands.

Developing a multi-disciplinary workforce

A further critique was that my previous amendment focussed solely on consultations by doctors in primary care, and that I had concentrated on increasing the medical benefit paid from the Health Insurance Fund ("HIF") which can only be claimed for G.P. consultations, in order to reduce the patients' co-payment of around £45.

While continuing to value our G.P. workforce, it is the intention of the Minister for H&SS to move away from what he describes as this outdated model to a multi-disciplinary approach, with the patient at its heart. As formulated then, it was argued

that my amendment would have interfered with attempts to build multi-disciplinary teams.

Paragraph (b) of this proposition specifically includes this measure, which seeks to deliver easier and affordable access to services supplied by nurses, pharmacists and other allied health workers as part of the primary care package.

Funding

The level of funding required to deliver services at affordable rates under the Jersey Care Model will depend on the choices made by the Minister on which vulnerable groups and how many are to be covered. Nevertheless, there will be a cost for the delivery of services under the new system which the Minister for H&SS has already addressed, as follows –

> *"We will address the current funding mechanism to facilitate expansion of these services – including review of the potential to expand the use of the Health Insurance Fund to allow increased funding for a range of providers."*

Expanding the range of services paid for from the HIF is not new. In the years 2013 to 2015 an additional £14 million was directed to the Health Department for the delivery of primary care services in the hospital from the HIF.

The Minister for H&SS points out that funding for primary care services in Jersey is sourced from a combination of –

1. service user co-payments,
2. payments from the Health Insurance Fund ("HIF"),
3. payments from Health and Community Services (paid for by general taxation).

Increased provision of Primary Care services is likely to require extra funding, repurposing of current budgets, or reducing the spend on Secondary Care into the future.

Reconfiguration of current funding-streams

- Moving funds and resources from secondary to primary care with concomitant activity changes
- Combination/redistribution of the HIF and HCS budgets
- Ring-fenced budget for prevention and screening.

Potential new funding-streams

- Expand public contributions to social security or general taxation/ indirect taxes/ charges
- Prescription charges for some medicines.

It should be noted that there is the potential to access funds from the HIF on a one-off basis in order to offset double running costs in primary and secondary care during a period of transition.

Paragraph (c) of the proposition asks the Minister for H&SS to identify the sources of funding required to deliver the first steps of his Care Model.

Financial and manpower implications

The essential thrust of this proposition is to ensure that the initial stages involved in the delivery of the Jersey Care Model are in place, not just for the medium to long term (4 to 5 years) as advised to every household in the Island, but also in the short term (by 1st January 2021) to deliver affordable access to health services in the community.

Any financial and manpower costs will depend on the scope and size of the scheme chosen by the Minister.