Co–production in Health Management: An Evaluation of Knowing the People Planning

A thesis presented in partial fulfilment of the requirements for the degree of

Doctor of Philosophy
in Management

at Massey University, Palmerston North, New Zealand.

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2010
Abstract

Treating chronic health conditions consumes a significant portion of the health care resource. Two-thirds of UK hospital admissions consist of people with chronic conditions (Singh, 2005). To date, health management has tended to focus on service redesign, rather than focusing on the patients, as a way to facilitate improved outcomes and control costs. Typically, these management approaches are premised on the patient as a consumer/end user.

An alternative view to the patient being a consumer is that of the patient being a co-producer of the service. Co-production recognises the client (patient) as a resource, in that value cannot easily be created or delivered, unless the patient actively contributes to the service (Alford, 1998). Patients gain health value when they are well and are independent of the health care system and its costs. Health care organisations gain economic value, when chronic patients require less health care.

This thesis examines co-production, in the context of contemporary patient involvement and health services management. ‘Knowing the People Planning’ (KPP), an innovative health management method, is evaluated for its patient management co-production potential. KPP is based on ten key features of service provision. Four of the key features relate to the patient, whilst the remaining six features relate to the organisation. It is the management of these patient and organisation features that better facilitates chronic long-term mental health patients as co-producers.

The empirical findings, from this evaluation of KPP provide evidence for the efficacy of co-productive health management theory and practice. Patient health value and health care organisation economic value are created, when both the organisation and the patient co-produce the health service.

KPP was initially implemented by eight of New Zealand’s 21 District Health Boards. Socio-ecological action research methodology was used to evaluate KPP — by taking a ‘people-in-environments’ approach. The evaluation covers
fourteen action research cycles for 2,021 chronic long-term patients over four years. Measurements include the amount of time these long-term patients spent in hospital and employment rates. The integration of the action research cycles, using the socio-ecological method supported the generation of (what I have called) ‘co–productive health management theory’.

Analyses of secondary data, across organisational and patient domains, supplement the action research findings, in order to assess for confounding factors. The organisation outcomes relate to costs and staff turnover. Patient outcomes relate to service utilisation measures, for approximately 60,000 adult patients per year, who access New Zealand’s secondary mental health services.

A pivotal finding of this research was that, as the rate of patients with treatment plans increased from 50% to 90%, inpatient bed use decreased by 26%. However, increased funding for mental health services had only a minor impact on decreasing inpatient bed use. Patient employment rates increased, whilst the number of patients who required access to general practitioners and changes to their housing situation, decreased.

The patient management co–production view offers a significant opportunity for health care managers and researchers to significantly improve both patient and organisation value. Co–production views the patient as a resource, who contributes to her/his health outcome, rather than a person who simply consumes services. The better patients can co–produce their health outcome the better their health, and the lower their demand for health services.
Acknowledgements

Firstly, I wish to thank my family who have been party to the trials and tribulations that led me to undertaking and completing this research.

I also wish to extend a debt of gratitude to David King, since without him KPP would not have been developed.

My thanks go to the District Heath Boards that have implemented KPP and allowed me to use their data for this thesis. Thanks also to the Ministry of Health — my employer — and in particular to my colleagues Heidi Browne and Jesse Kokaua for their analytical support. I also thank my secondary supervisor, Dr Jan Lockett-Kay, for her knowledge and support.

My special thanks go to Professor Ralph Stablein, for his interest, knowledge and expertise, when supervising this thesis.
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