

POLICY OPTIONS

Integrated primary–secondary health care governance for Australia

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Nicholson C,^{1,2} Jackson C,¹ Hepworth J,³ Marley J¹

¹The University of Queensland, ²Mater Health Ltd, ³Queensland University of Technology

Policy context

KEY ELEMENTS EFFECTIVE AND SUSTAINABLE INTEGRATED PRIMARY–SECONDARY HEALTH GOVERNANCE MODELS

In 2009 Australia's National Health and Hospitals Reform Commission Report first recommended significant governance change as an important element in increasing the effectiveness and efficiency of health care delivery. In turn, regional service integration was one of the five key building blocks in Australia's First National Primary Health Care Strategy. Federal and State government reforms created new meso-level organisations – Primary Health Networks (PHNs), previously Medicare Locals (MLs), from 1st July 2015 and Local Hospital Networks (LHNs), in some jurisdictions Local Hospital Districts/Health and Hospital Services, from June 2011. For the goals of health reform to be realised these organisations must work together to achieve co-ordinated and integrated primary healthcare services, however an integrated governance model was never developed.

The Primary Health Care Advisory Group (2016) stated that, "Care within the Health Care Home is supported by better integrated community and acute care within the broader health system ... will require Primary Health Networks (PHNs) to work with Local Hospital Networks (LHNs) to strengthen and promote regional collaboration in commissioning services to support local and out of hospital health care. PHNs should collaborate with LHNs, Private Health Insurers (PHIs) and providers to develop or build upon locally relevant hospital admission and discharge approaches or protocols, including locally relevant patient health care pathways".¹ At the COAG meeting, 1st April 2016, the Heads of Agreement between the Commonwealth and the States and Territories on Public Funding states that 'all governments have a shared responsibility to integrate systems and services'.² Given the priority placed on effective governance frameworks to deliver clear roles and responsibilities to both funders and providers of health care, what is the governance vehicle best suited to achieving our national reform outcomes, and how is it best crafted in the current Australian health care reality?

Research previously undertaken in the Centre of Research Excellence in Primary Health Care Microsystems (<http://aphcri.anu.edu.au/aphcri-network/research-completed/improving-quality-and-sustainability-integrated-phc-governance>) identified ten governance elements linked to successful primary/secondary health care integration,

- > Joint planning: Governance arrangements included formal agreements such as memoranda of understanding (MOUs), joint board memberships and multilevel partnerships in the planning process.
- > Integrated information communication technologies, particularly, a shared electronic health record, and systems that link clinical and financial measures.
- > Effective change management, requiring a shared vision, leadership, time and committed resources to support implementation.
- > The importance of shared clinical priorities, including the use of multidisciplinary clinician networks, a team-based approach and pathways across the continuum to optimise care.
- > Aligning incentives to support the clinical integration strategy, includes pooling multiple funding streams and creating equitable incentive structures.
- > Providing care across organisations for a geographical population, required a form of enrolment, maximised patient accessibility and minimised duplication.
- > Use of data as a measurement tool across the continuum for quality improvement and redesign requires agreement to share relevant data.

- > Professional development supporting joint working allowed alignment of differing cultures and agreement on clinical guidelines.
- > An identified need for consumer/patient engagement is achieved by encouraging community participation at multiple governance levels.
- > The need for adequate resources to support innovation to allow adaptation of evidence into care delivery was acknowledged.

Building on this previous work evidence from the reform environment suggests some progress in some elements; however others remain ad-hoc or non-existent.³

- a) Meso-level organisations are making progress in the following areas together,
 - > Joint planning is documented in agreements at both federal and state level and there is evidence to support it a key objective in both strategic plans.
 - > ML–LHN MOUs currently identify agreed shared clinical priority areas based on local need.
 - > At local level, ML–LHN MOUs have documented evidence of commitment to patient, consumer and community engagement.
 - > Federal and State health departments and authorities produce documentation on the health of their populations, and MLs and LHNs must focus on population health service planning as part of their reporting.
- b) Areas still to operationalise,
 - > Policy direction requires “e-health tools to link providers and improve quality of care”. The report from the review of the My Health Record (titled 'Personally Controlled Electronic Health Record Review Report') was released 19th May 2014. The findings of the review supports the ongoing operation of the My Health Record system and made several recommendations aimed at making it more functional and usable and able to provide “access to more health information, creating a more efficient system, making continuity of care easier and improving treatment decisions”. Federal support for the rollout of the My Health Record is articulated although this is not reflected in state plans.
 - > Federal and state governments “will ... look to improve quality and accessibility of data to inform planning and service delivery with a ‘whole of system’ view”.
- c) Areas still to evolve,
 - > There is little in current policy documents to incentivise integrated care. International models employ governance frameworks that create the funding and business rules to better incentivise care models across the interface contracting to create joint incentives to manage cost. The Commonwealth is to support the piloting of Health Care Homes later in 2016.²
 - > There is no documented evidence that LHNs or MLs have currently committed resources to jointly manage the change required to working collectively across the interface. This can be complex, challenging and resource intensive.

Evidence into practice

A study was undertaken to investigate the perceptions and experiences of those board members and CEOs currently working in meso-level organisations to explore if the elements from the literature are indeed being used to facilitate integrated primary/secondary health care governance or should be in the future. Whilst not all elements are currently in practice all stakeholders agreed that to promote integrated care for patients, particularly those at risk of poor health outcomes and those with chronic and complex health needs, across the health system all elements need to be included in PHN/HHS planning, service implementation and evaluation. Partners are required to move from an organisational focus to a system-wide perspective working together on meeting stakeholder needs, processes, sustainability and its people and culture. A Balanced Scorecard⁴ was developed to support stakeholders to develop measures to manage performance jointly to achieve the vision and strategy of the partnership (Figure 1).

Putting the scorecard into practice as a tool to facilitate PHN/HHS working together has included, in July 2015 seven PHNs in Queensland have agreed to use this as the basis of their planning with HHSs; and, in October 2015 it was endorsed by the Queensland Clinical Senate as a tool for PHNs and HHSs to use in Queensland in developing and implementing integration locally.⁵ Brisbane North PHN & Metro North HHS have used this in their Working Together agreement signed February 2016.⁶

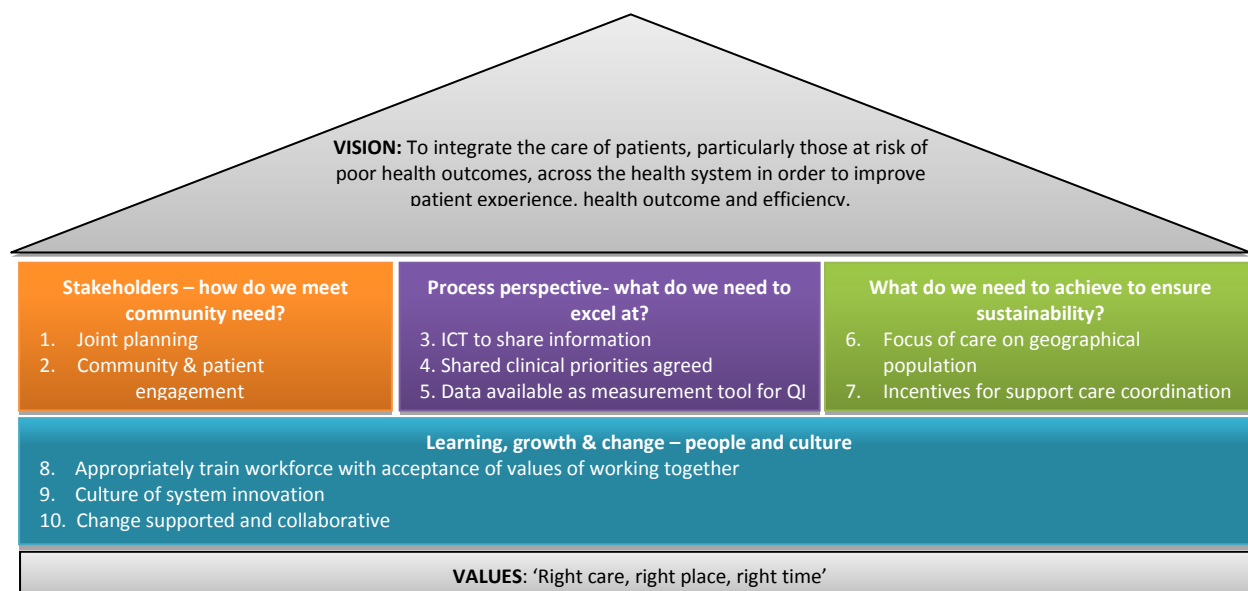


Figure 1: Integrated governance Balance Scorecard

Policy options

The process of transformation led policy has been underway for a number of years with the most recent being the COAG announcement in April 2016.² Specifically in Schedule 2, “Bilateral agreements will be signed off to provide flexibility for each jurisdiction to determine the best model of care”, and the “Commonwealth will establish any enabling infrastructure, governance arrangements, or systems to support a pilot of a Health Care Homes model of primary health care, consistent with the advice provided by the Primary Health Care Advisory Group”. The implications for this work are that it provides a tool to inform the development of such governance arrangements that can be used nationally and tailored locally.

As demonstrated by Brisbane North PHN and HHS the tool assists stakeholders to take a health system approach. This includes determining and agreeing a joint need and vision, agreeing shared responsibility for outcomes, and, in time aligning drivers and incentives. Key to this is leadership at clinician and executive locally and at policy level a reform agenda to support the change.

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