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Australian Journal of Primary Health, 2009, **15**, 188–192

Partnership approaches, regional structures and primary health care reform

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Partnerships are essential for reform of the primary health care system in Australia according to discussion papers produced in 2008 by the reform initiatives. Building on the foundation of patient–provider relationships, partnerships are needed between health care providers, between governments and between health and other sectors. Partnerships will feature in the regional structures that are being proposed to develop, resource and network private, public and state-based primary heath care services. This paper considers the potential for Divisions of General Practice to undertake the role of these regional structures.

While primary health care in Australia delivers a great deal of value, reform is needed to address considerable inequities in care and outcome, as well as many current and future pressures. Years of tinkering at the edges of the system have resulted in an increasing proliferation of narrowly targeted programs and funding arrangements, and growing complexity and inflexibility for health care organisations, professionals and consumers (Australian Government 2008). This paper considers the role of partnerships in a reformed system.

Partnerships generally start because some tasks cannot be achieved by a single individual, discipline or organisation. By providing extra capacity, partnerships can enhance opportunities and resources, and improve outcomes. Through partnerships, different health care organisations can combine their own attributes, skills, and contacts to achieve a common purpose with mutual benefit. Partnerships work on a continuum from relatively informal interpersonal networking through to formalised cooperation, coordination and collaboration (Victorian Health Promotion Foundation undated).

A partnership can be conceptualised as:

> *a joint working arrangement where otherwise independent bodies cooperate to achieve a common goal; this may involve the creation of new organisational structures or processes to plan and implement a joint program, as well as sharing relevant information, risks and rewards* (Dowling *et al*. 2004).

Evidence about the factors associated with successful partnerships abounds: the level of engagement and commitment of the partners; agreement about purpose and need for the partnership; high level of trust, reciprocity and respect within the partnership; favourable environment in terms of financial climate, institutional and legal structures; accountability arrangements; and leadership and management. However, the definition of success of partnerships is sometimes problematic, and systematic reviews reveal little evidence about the outcomes of successful partnerships in terms of outputs, service delivery or health (Dowling *et al*. 2004). Though the costs and difficulties are acknowledged by many, there is also very little evidence about the cost effectiveness of partnerships (Dowling *et al*. 2004).

Partnerships are needed in a reformed system

Fundamental to a people and family-centred system is the quality of relationship between patients, their carers and their health professionals. A good relationship at this level recognises an individual's role in their own health care through shared decision-making, self-care and monitoring. Ambivalence in the health care relationship and poor understanding of their condition can clearly weaken patients' confidence and ability to engage with recommended treatment. Effective communication and education is crucial (Cass 2008).

There are numerous references to partnerships in discussion papers addressing health reform in 2008, including the National Health and Hospital Reform Commission (NHHRC), the National Primary Health Care Strategy Reference Group, the National Preventative Strategy taskforce, and the Council of Australian Governments. Partnerships within health, within government and between health and other sectors are needed to develop and implement innovative approaches, strategies and products in a reformed Australian health system.

(1) Partnerships across providers and care settings (Australian Government 2008) are needed for high quality coordinated comprehensive care. This set of partnerships encompasses multiple disciplines and professions, multiple sectors including public, private and non-government organisations (NGO), and multiple settings of care including home, community, hospital and residential care. Putting people and their families at the centre of health care, the first service design principle of the national Health and Hospital Reform Commission (National Health and Hospitals Reform Commission 2008), is arguably the only way of achieving common purpose and alignment among the numerous players in the health care system, despite the competing demands of

10.1071/PY09007 1448-7527/09/030188

workforce, professional rivalries, management, efficiency, and accountability within the health care industry. A key enabler of partnerships between providers and across settings is effective health information exchange and referral supported by functionality, interoperability and security standards to protect privacy of patient information (Australian Government 2008).

(2) Partnerships at government level – within and between federal, state and territory governments – are arguably the most critical to the success of reform efforts to establish and implement a coherent primary health care strategy. The existence of multiple jurisdictions, accountabilities and funding sources is one of the major causes of fragmentation of the primary health care system in Australia. Federal Labour pre-election policy committed to achieving national health care reform in partnership with state and territory governments, by embarking on a cooperative, systematic national reform process to improve services to the community, to reduce cost and blame shifting and to recoup by way of efficiencies the billion dollars currently lost by way of duplication and overlap (Rudd and Roxon 2007). The reform processes initiated in 2007–08 reflect this intention. The purpose of partnership at government level is to drive change, and put support structures in place to establish and maintain other necessary partnerships (National Preventative Health Taskforce 2008). A new form of National Partnership payments will be one mechanism used to fund specific projects, for example in preventative health, to facilitate the states and territories delivering on nationally significant reforms (COAG 2008).

(3) Effective partnerships with sectors outside health are required at local, regional and national levels to promote public health, since health is shaped and influenced by factors in the environment. These sectors include transport, education, housing and employment departments, schools and universities, local councils, employers, business and industry. For example, to build an adaptable workforce capable of interprofessional learning and practice in the future strong partnerships will be needed between education and health (National Health and Hospitals Reform Commission 2008). The National Preventative taskforce proposes a National Prevention Agency to establish partnerships and coordinate them, and also proposes partnerships between the National Health and Medical Research Council, the Australian Research Council and jurisdictional health promotion foundations to coordinate the investment approach for research and evaluation into preventative strategies (National Preventative Health Taskforce 2008).

Regional structures

The enduring need for regional partnerships and structures between health services for integration and coordination is evident from many previous initiatives. Local community services forums are common, to encourage networking and sharing of information. More formal Primary Care Partnerships exist as geographically based bodies in Victoria to improve planning, innovation and coordination across primary and community services; they have improved service coordination and increased the use of care plans for intensive service users (Australian Institute for Primary Care, quoted in McDonald *et al*. 2007). Other initiatives to provide integrated care at the local provider level in high need areas are the recent federal initiative 'GP Superclinics', 'HealthOne' in New South Wales, 'GP Plus' in South Australia, and 'Connecting Healthcare in Communities' in Queensland. These initiatives operate alongside 'Divisions of General Practice', which support general practice and assist integration of general practice with other primary care and hospital services in their catchment areas (Smith and Sibthorpe 2007).

As well as partnerships, the need for regional organisations that sit between local providers and government featured prominently in NHHRC discussion papers and consultations. The diverse set of private, not for profit and government agencies that currently provide primary and community care has little capacity to develop the service system independently (Swerissen 2008), leaving an opportunity for establishing regional organisations to develop, resource and network primary health care services. Such organisations will be built on existing and new partnerships.

Currently a big issue in the reform of primary health care is the lack of an integrated plan for the development, resourcing and networking of all primary health services – state-based, general practice and other private or non-government primary health services (National Health and Hospitals Reform Commission 2008). Diverse suggestions can be found in current reform discussion papers. Dwyer and Eagar (2008) suggest regional health funding authorities, which would plan and commission services to enhance coordination and integration of comprehensive health service delivery, including primary health care. The size of regions and their relationship to state boundaries would vary according to whether the states or the Commonwealth were responsible for governance and financing of the systems. Others (Harris *et al*. 2008; Jackson and O'Halloran 2008) propose a single regional governance structure that aligns Commonwealth and state public- and private-funded services around integrated service delivery within a region, with involvement of consumers and community members. The structure would be responsible for and have authority to plan service development, ensure access to primary medical care, govern access to allied health and provide recall and outreach to patients for primary, secondary and tertiary preventive activities, and be accountable for chronic disease management.

Complementing these regional funding and/or governance structures, some form of primary health care hub is called for to achieve integrated service delivery and access at the level of local providers (Harris *et al*. 2008; Jackson *et al*. 2008; Wenck and Watts 2008). Humphreys and Wakerman (2008) propose

a regional model for rural and remote Australia, identifying that 'appropriate centralisation of some service functions (for example, recruitment and financial services) may inevitably be necessary, while decentralisation of service delivery to meet access requirements of consumers can be maximised'.

Ultimately all integration is local, according to the fifth of Leutz's Laws of Service Integration (Leutz in Dwyer and Eagar 2008, p. 5). In setting up the proposed regional and local structures, the perils of a one-size-fits-all model must be avoided. Frontline health workers taking part in the NHHRC public consultations argued that from their experience a local focus is necessary in health planning and delivery to ensure health programs are customised to the unique needs and opportunities of specific areas (Elton Consulting 2008). Success requires local flexibility in implementing common design elements, as 'HealthOne', 'GP Superclinics', 'Connecting Healthcare in Communities', and earlier integration programs (Fine 2001) have found. Partnerships need to make it possible for the aspirations of local clinicians, managers and communities to fit with the realities of national policy makers, health organisations and bureaucrats (Jackson 2008).

Divisions of general practice and regional structures

The core design elements for these organisational structures are likely to include experience with similar work, existing partnerships and networks, skills in planning, commissioning and purchasing, and excellent governance, with involvement and engagement of consumers and primary health care team members from private, public and NGO sectors. The structures need sufficient establishment and maintenance funding to be sustainable, and need to be allowed to undertake their work without constant restructuring because of changes in government and/or policies at state or federal level. Regional structures are unlikely to be effective unless the divided responsibility for primary health care and the system of payments for primary health care services is also addressed (McDonald *et al*. 2007).

Could the regional organisations referred to above be built on existing Divisions of General Practice and state based organisational structures, as Hal Swerissen (2008) suggests? After 16 years Divisions are embedded as geographical-based planning and development organisations within the Australian primary health care system (Smith and Sibthorpe 2007).

Several attributes favour the Divisions. First, they are established organisations with a defined catchment area, extensive local knowledge, and are present in all parts of Australia rather than in isolated pockets of high need. Second, they have experience, skills and capacity developed through working with many different partners and networks since their establishment in 1992. They relate to general practitioners (GP) and practice staff, other primary care professionals and services, local communities, NGO, area health services, state governments and many other bodies. Ninety-eight percent of Divisions in 2006–07 reported having formal agreements to work collaboratively with other organisations, a total of 2315 agreements (Hordacre *et al*. 2008). Formalising partnerships through memoranda of understanding and service agreements has assisted in clarifying aims, delineating roles and sharing resources, along with other strategies for effective collaboration (Centre of General Practice Integration Studies 1999). Third, Divisions have developed planning, commissioning and purchasing skills, through programs such as the More Allied Health Services program in rural areas and Better Outcomes in Mental Health Care Initiative. While their capacity is variable, North and West Queensland Primary Care shows the potential for a Division to organise and deliver broad primary health care services in a very large rural and remote area (Battye and McTaggart 2003; Harte and Symons 2008), while also illustrating the flexibility of the Divisions model to respond to local needs.

However the capacity of Divisions is uneven (Commonwealth of Australia 2003) and their focus is on general practice with limited involvement from the broader health sector. Perhaps the greatest drawback is that at present Divisions (and also primary care networks and primary care partnerships) 'have neither the scope of responsibility nor the authority to take a comprehensive approach to ensure access to primary health care service coordination and addressing population health needs', compared with primary care organisations in Great Britain and New Zealand (McDonald *et al*. 2007).

If Divisions were to have an expanded role in a publicly funded health system, with partnerships across providers and care settings, they would need much greater involvement from consumers and other members of the primary health team in their governance, planning and management consistent with trends in international Primary Care Organisation development (Smith and Sibthorpe 2007; Harris *et al*. 2008). Strong engagement of GP, nurses, other primary care professionals and the public would all be necessary if Divisions were to operate as fully functioning primary care organisations that could both engage professionals in developing primary care services and also account properly to the public and communities they serve.

Interventions such as formation of new regional organisations could have untoward effects. Changing the role and mandate of the Divisions could alter their relationship with members, thereby compromising their influence as member organisations (McDonald *et al*. 2007). While GP engagement is currently relatively strong in Divisions compared with primary care organisations in the UK and New Zealand, it could be compromised by extending and expanding the role of Divisions through a mandated shift to broader membership (Smith and Sibthorpe 2007). While the process of broadening the membership base of Divisions has commenced in line with the direction proposed by the Australian Government in 2004 (Commonwealth of Australia 2004), it has been a slow process requiring considerable change in culture and attitudes. In 2007, 54% of Divisions

reported having members who were not GPs, and 60% of Divisions had at least one Board member who was not a GP (Hordacre *et al*. 2008).

Primary health care is an example of a complex adaptive system, a densely connected web of independent but interacting people and organisations, each operating from its own schema or local knowledge, and with the capacity to learn from experience (Begun et al. 2003). Each element in the system affects all the other elements in sometimes unpredictable ways, and each element of policy, funding arrangements, skills roles and accountabilities comes as a linked aligned set (Dwyer and Eagar 2008). A complex adaptive system is dynamic as a result of the number of people and organisations involved, the connections between them, and the influence of external forces. It is possible to perceive but not predict the patterns that emerge in a complex adaptive system, despite the lure of 'retrospective coherence' (Kurtz and Snowden quoted in Martin and Sturmberg 2009). Turning this around: 'one cannot study repetition under constant conditions, because there *are* no constant conditions' (Evans 2009).

However, Kurtz and Snowden suggest that the way to work with a complex system is to use a 'probe' (such as a memorandum of understanding between two or more bodies), observe the emerging patterns and behaviours, then stabilise the desirable behaviours and destabilise the undesirable. In creating each local regional structure, it should be possible to identify and strengthen the existing local positive relationships and partnerships, and identify the structures which supported those relationships. Such structures and partnerships have been developed not only in Divisions of General Practice, but also in primary care partnerships in both Victoria and Queensland, and state-health area and regional health service structures.

Mandating the formation of regional primary health care organisations will not be successful without all those factors that make partnerships work – especially commitment, trust and mutual respect, skills, and authority. Finding common ground around the interests of people and their families provides a key to this, in the crowded and contested primary health care space. Through the knowledge and respect for each other's business that arises from a successful partnership, the areas of business overlap can be identified, along with the areas in which each party can work more effectively alone.

The proposed regional structures may be most effective if there is a choice of governance models. A recent systematic review found evidence for three potential models for integrated health care governance: separate organisations merging; developing a separate incorporated structure for areas of common business overlap; and coming to a common collaborative arrangement while maintaining separate independent governance and funding (Jackson *et al*. 2008). It is unlikely that any one of these models would fit all the diverse circumstances in Australia, but each has potential to address different barriers. The second model, for example, could make it possible for a Division to maintain its focus on supporting general practice, while being part of a separate incorporated structure for the functions of a regional organisation.

In summary, the reformed primary health care system will need strong robust partnerships at all levels, within and between governments, within and between health care, and with other sectors, as well as the fundamental relationships between providers, patients and their families. Without effective partnership between governments to address fundamental issues of divided funding and responsibility, partnerships at provider and patient level will not be sustainable, but will constantly be stymied by the structural barriers and conflicting accountabilities of both parties, contributing to ongoing fragmentation, which is anything but people and family focused. Divisions of General Practice have considerable potential to be regional structures in whole or part, if these are built on existing local relationships. The sustainability of the regional structures for planning and service delivery will depend on the robustness of the partnerships at all the other levels.

Acknowledgments

Primary Health Care Research and Information Service is funded by the Primary and Ambulatory Care Division of the Australian Government Department of Health and Ageing. I would like to thank my colleagues Ellen McIntyre, Ann-Louise Hordacre and Sara Howard for their suggestions and Louise Baird for her assistance in preparing the paper. The paper has been strengthened by the constructive suggestions of the reviewers.

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