Centre for Health Systems and Technology (CHeST)

Why alliance governance is more viable than the alternatives, and what we know about alliance performance

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AllianceSouth
Better health together

Why alliance governance is more viable than the alternatives, and what we know about alliance performance

Robin Gauld
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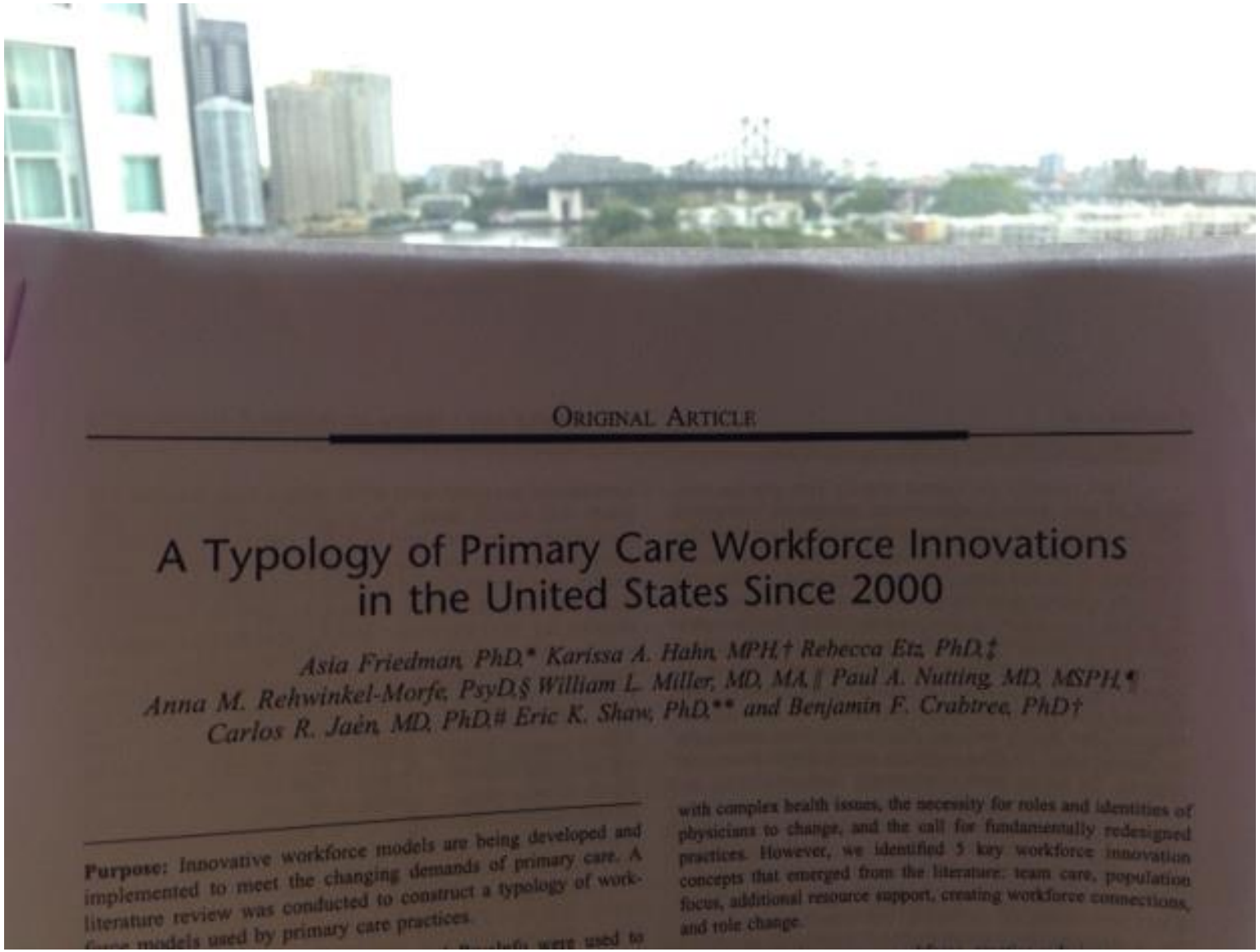
Some take home messages

- New Zealand has experimented widely with different forms of governance and service organisation, including:
  - top-down approaches aimed at: 'competition', 'national purchasing', 'devolved democratic governance'
  - bottom-up approaches via GPs; these demonstrate that clinical leadership makes a difference
- Present sentiment settling around partnership and network planning and service delivery models in a 'whole of system' paradigm; this is a top-down/bottom-up hybrid
- There are limits to competing with one another; efforts are better focused on partnering to share and leverage off different actors' skills, investments and experiences
- An 'alliance' governance model is supporting this



ORIGINAL ARTICLE

A Typology of Primary Care Workforce Innovations in the United States Since 2000

Asia Friedman, PhD, Karissa A. Hahn, MPH,† Rebecca Etz, PhD,‡ Anna M. Rehwinkel-Morfe, PsyD,§ William L. Miller, MD, MA,‖ Paul A. Nutting, MD, MSPH,¶ Carlos R. Jaén, MD, PhD,# Eric K. Shaw, PhD,** and Benjamin F. Crabtree, PhD†*

Purpose: Innovative workforce models are being developed and implemented to meet the changing demands of primary care. A literature review was conducted to construct a typology of work-

with complex health issues, the necessity for roles and identities of physicians to change, and the call for fundamentally redesigned practices. However, we identified 5 key workforce innovation concepts that emerged from the literature: team care, population focus, additional resource support, creating workforce connections, and role change.

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Friedman A, Hahn K, Etz R et al, *Medical Care*, 52(2): 101-111; 2014.

Today's menu

1. Four governance models
2. New Zealand's health system and underlying institutions: why alliances are important
3. Current NZ developments: Alliances and 'whole of system' planning
4. Some conclusions

CORPORATE GOVERNANCE (VERTICAL)

Corporate governance: ‘old governance’

- Performance oriented
- Hierarchical control
- Appointed membership, with specific skill sets
- Operates in secrecy
- Public consultation limited to certain decisions or points in decision making cycle
- ‘us’ and ‘them’

DEMOCRATIC GOVERNANCE: DISTRICT HEALTH BOARDS (VERTICAL)

NZ's elected board model…

- Unique to NZ
- Does not satisfy international benchmarks for 'representative democracy'
  - Elected and appointed members are accountable to the government, not voters
- Engenders limited voter interest
  - 'major local campaigns' might be needed to show people how to get involved (UK Health Commission 2008)
- Does not necessarily produce a skill-mix or knowledge-base required to drive high-performance of large, big-budget and complex organisations
- A lot of 'governance' happens beyond the DHB Boards
- Questions over how many elected members there should be

CLINICAL GOVERNANCE (HORIZONTAL)

Clinical governance: origins and definition

"… a system through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

Scally G, Donaldson L. Clinical Governance and the Drive for Quality Improvement in the New NHS in England. *British Medical Journal* 1998;317(7150):61-65.

‘Clinical governance’ in practice

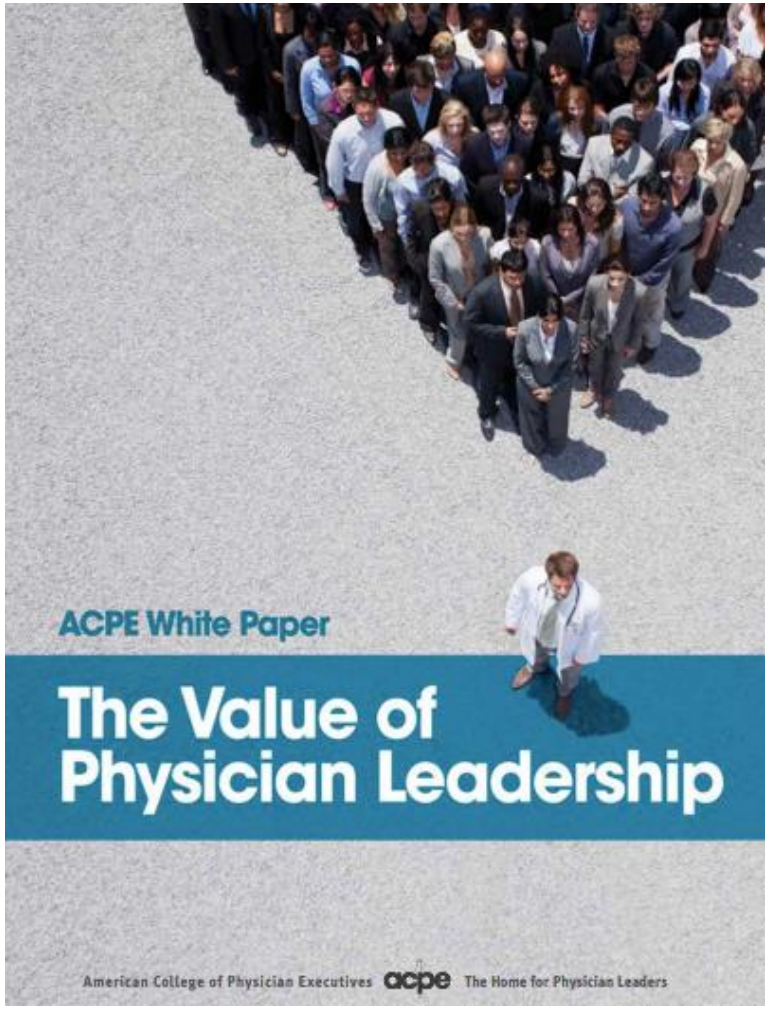
- The idea that:
  - ‘everyone in this health organisation has two jobs: improving the system of care as well as providing care’
- Clinical governance is the organisational fuel for health care quality and health system improvement
- Aims include partnership with management, building trust across the organisation, reducing clinical variation, standardising processes where possible, placing patients at centre of service design etc
- Expect to see:
  - Involvement of health professionals (clinicians) in leading and improving the system for organising and delivering care;
  - Leadership by clinicians, including clinicians stepping into leadership positions as well as leading by example and leading change;
  - A clinical workforce who are engaged and committed to service improvement in their organisation and to better patient care;
  - Clinical oversight of the organisation

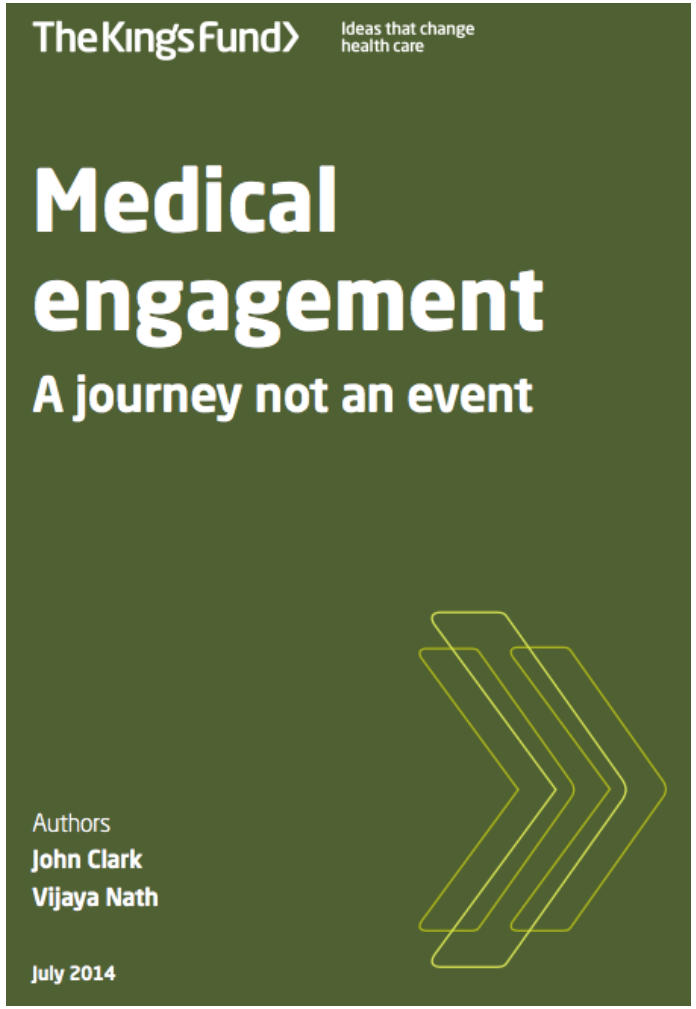
Clinical governance evidence-base

- 2010 McKinsey/LSE research shows hospitals with clinically-trained leadership are more likely to have standardised processes in place, and better patient outcomes
- 2011 study of US hospitals backs this up

S Dorgan et al, 2010, Management in Healthcare: Why good practice really matters. London: McKinsey/LSE
A Goodall, 2011, Physician-leaders and hospital performance: is there an association? Soc Sci Med, 73, 535-9

Clinical governance evidence-base





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EXPERIMENTAL GOVERNANCE (VERTICAL AND HORIZONTAL)

“Experimental governance”

Instead of a top-down, hierarchical rule-based system where failures to adhere are sanctioned, or unregulated market-based approaches, the new governance school posits a more participatory and collaborative model of regulation in which multiple stakeholders, including, depending on the context, government, civil society, business and nonprofit organizations, collaborate to achieve a common purpose. In order to encourage flexibility and innovation, “new governance” approaches favor more process-oriented political strategies like disclosure requirements, benchmarking, and standard-setting, audited self-regulation, and the threat of imposition of default “regulatory regimes” to be applied where there is a lack of good-faith effort at achieving desired goals.

Klein, A. Judging as nudging: new governance approaches for the enforcement of constitutional social and economic rights, *Columbia Human Rights Law Review*, 39, 2008.

NZ’S HEALTH SYSTEM

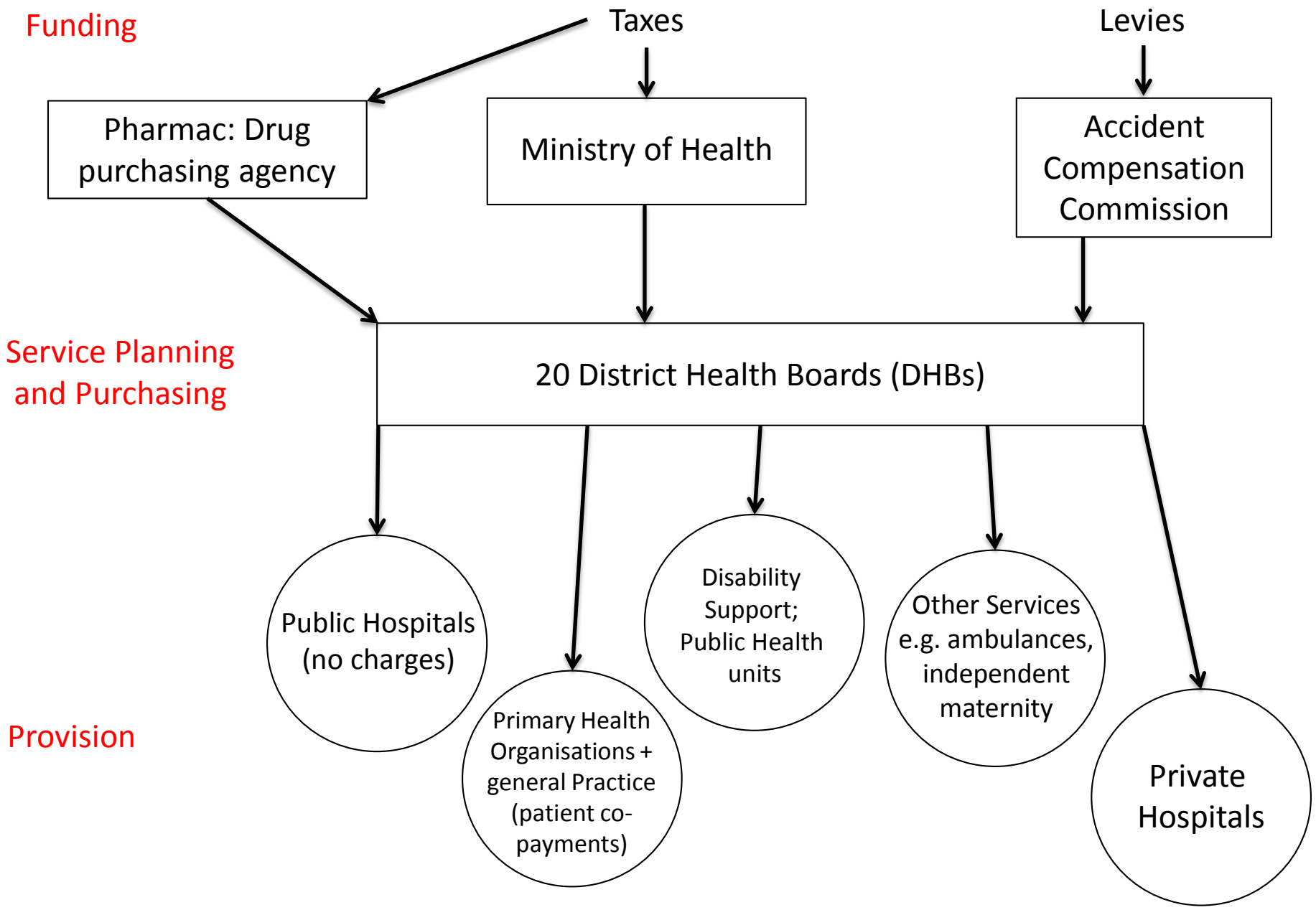
NZ health system

- Founded in 1938 Social Security Act – world's first 'national health service'
- Public hospitals free; charges for primary care (private General Practitioners subsidised by government)
- Strong GP gatekeeping; focus on family practice
- Single payer (Government); mixed public-private delivery; dual practice
- Tax-based public funding approx 83% of total
- THE=10.2% GDP vs 9.3 OECD average
- History of democratic governance (only country with elected governance model)
- Considerable restructuring since 1980s but relative stability since 2000s

INSTITUTIONS MATTER

Present institutional arrangements

- Several national agencies and advisory boards
- 20 District Health Boards:
  - Plan and fund services for a geographic population
  - Each with embedded infrastructure
- 30 Primary Health Organisations
  - Provide local PHC infrastructure and services
- DHBs fund PHOs but the two are parallel systems, working with a common population and depend on one another
- 12 regional Public Health Units
- Multiple contracted disability support and allied health services
- Health service and system improvement requires a joint planning mechanism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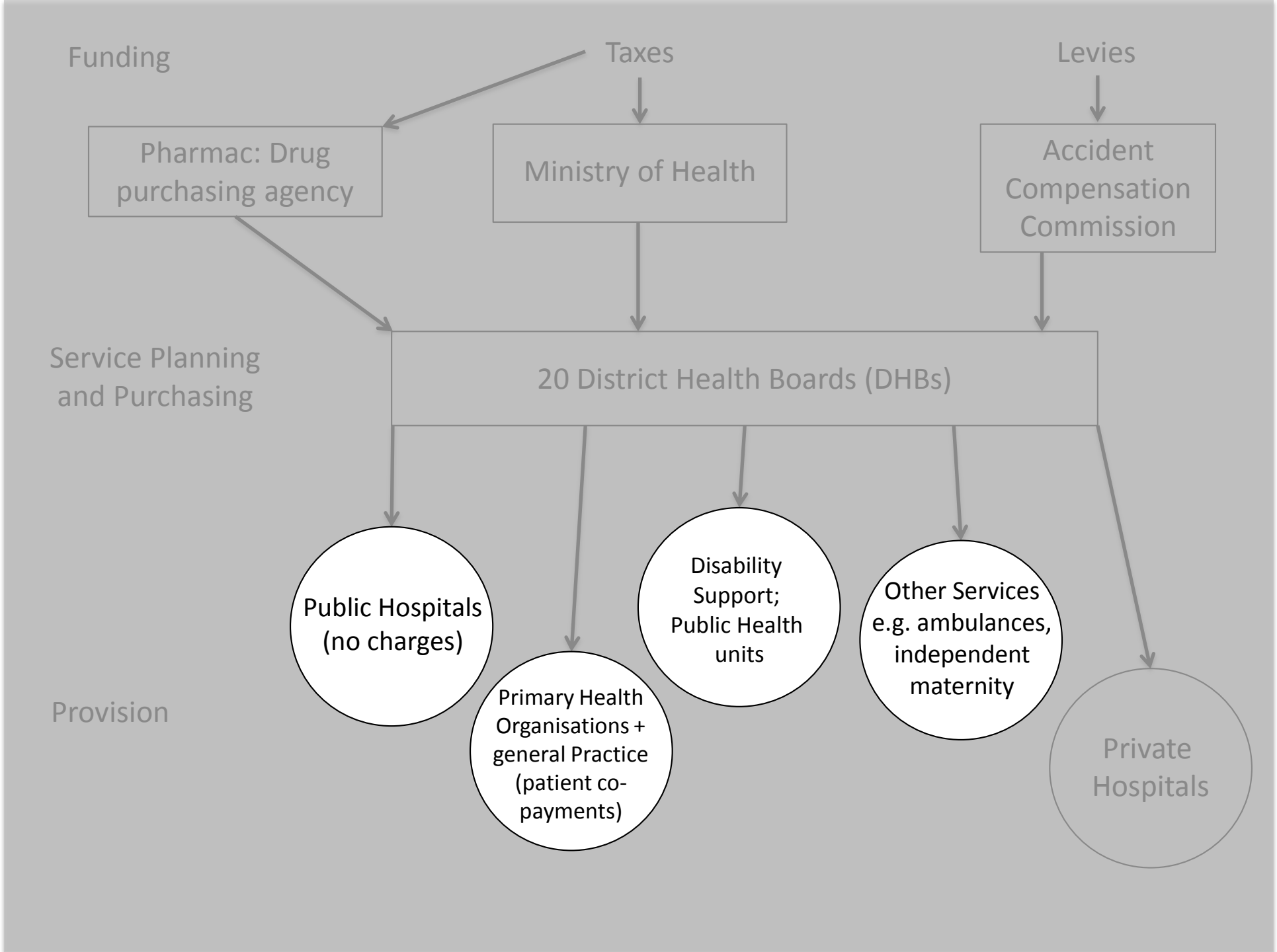
Taxes
Levies
Pharmac: Drug purchasing agency
Ministry of Health
Accident Compensation Commission
Service Planning and Purchasing
20 District Health Boards (DHBs)
Public Hospitals (no charges)
Primary Health Organisations + general Practice (patient co-payments)
Disability Support; Public Health units
Other Services e.g. ambulances, independent maternity
Private Hospitals
Provision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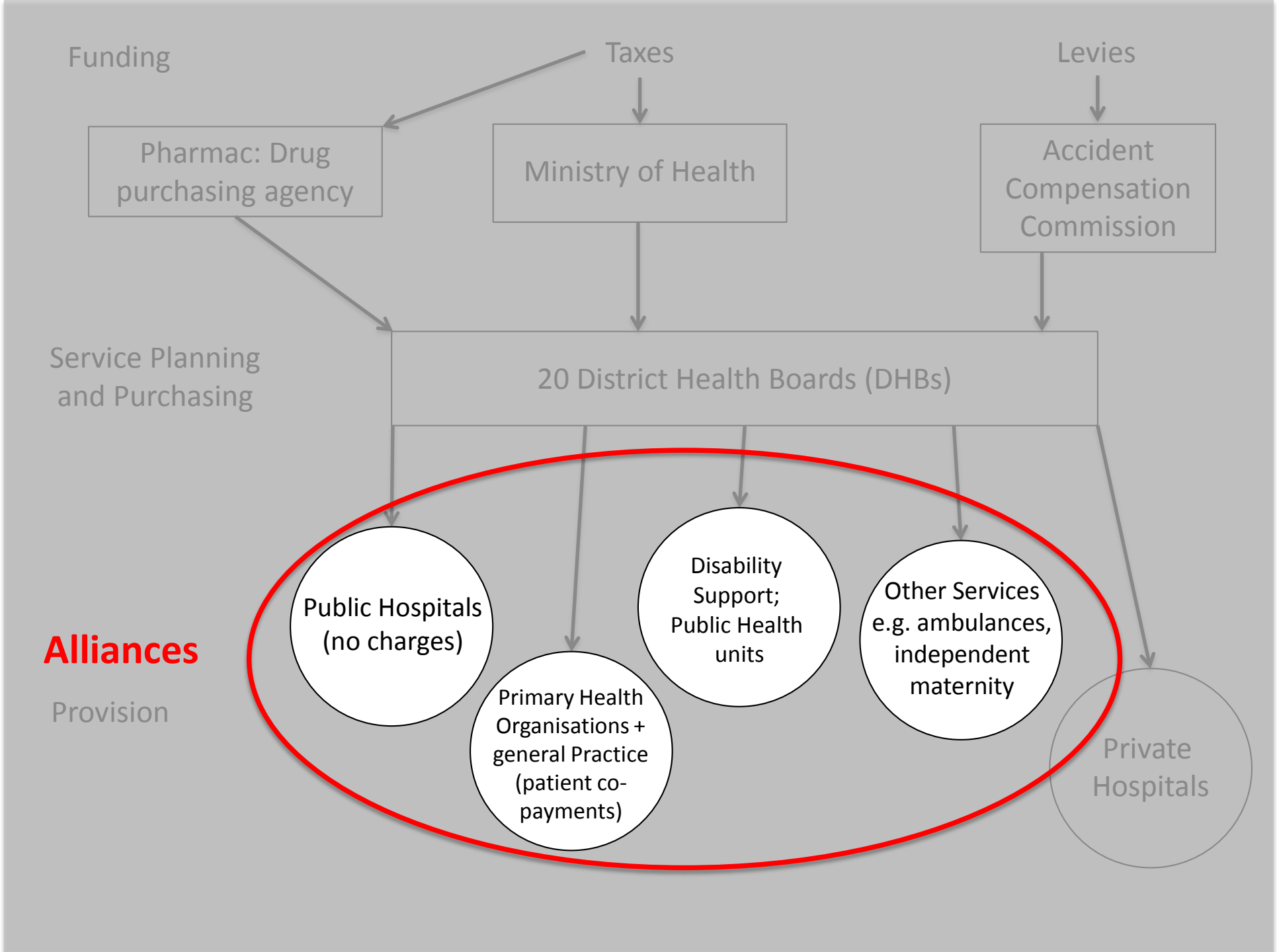
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CURRENT DEVELOPMENTS: ALLIANCES

New govt 2008: ‘Better, sooner, more convenient’ care

- 9 pilot BSMC business cases commissioned in 2010
- Diversity of regions and focus but some commonalities
- Each featured an ‘alliance’ governance structure

Ryall, T. (2008). *Better, Sooner, More Convenient: Health Discussion Paper by Hon Tony Ryall MP*. Wellington: National Party.

What is an alliance?

- Alliance idea is derived from the construction industry:
  - Different businesses/interests work collaboratively to ensure achievement of common goal: to complete a project successfully and on time, within budget. They help one another and, where relevant, share resources

Health alliances

- Since mid-2013, each Primary Health Organisation has been required to enter into an Alliance with its respective District Health Board
- Each PHO-DHB alliance is a governance arrangement (or mechanism) aimed at:
  - Working in partnership to improve health and health services for their population
  - Developing a 'whole of system' approach to service planning and delivery, with services provided in the best place as clinically agreed
  - Improving the patient journey, with the patient at the centre of all planning (integration and reducing duplication)
  - Allocating resources where these will best deliver on alliance goals and service designs
  - Building cross-sectoral clinical leadership and engagement

Alliance membership

- Health professional and managerial leadership
- Skill based
- Have capacity to lead/influence/understand perspectives of professional colleagues (e.g. General Practice; nursing; hospital specialty)
- Members may include:
  - DHB and PHO CEOs and managers
  - GPs, specialists, nurses, allied professionals
  - Ambulance and aged care residential services
  - Māori/Pacific leaders
  - Patients/community representatives
  - Independent chair

Alliance Charter

- Outlines rules of engagement and commits members to:
  - Act with honesty, integrity and aim to build trust in one another
  - Work collaboratively, make decisions by consensus and resolve disagreements cooperatively
  - Adopt a patient-centred, whole-of-system approach and make decisions on a Best for System basis
  - Make the best use of finite resources in planning health services to achieve improved health outcomes for our populations

How much power and influence do alliances have?

- Potentially game changing
- Mandate to determine priorities locally; decide how services should be configured
- The local power including key organisations and professionals is in the room
- DHB can use reserve powers

WHAT WE KNOW ABOUT ALLIANCE PERFORMANCE

The Kings Fund

Ideas that change health care

Authors

Nicholas Timmins
Chris Ham

The quest for integrated health and social care

A case study in Canterbury, New Zealand

2013

SAGE Open Medicine
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Better, Sooner, More Convenient? The reality of pursuing greater integration between primary and secondary healthcare providers in New Zealand

Kirsten Lovelock[1], Greg Martin[2], Robin Gauld[3] and Jayden MacRae[4]

Abstract

Objectives: This article focuses on the results of evaluations of two business plans developed in response to a policy initiative which aimed to achieve greater integration between primary and secondary health providers in New Zealand. We employ the Consolidated Framework for Implementation Research to inform our analysis. The *Better, Sooner, More Convenient* policy programme involved the development of business plans and, within each business plan, a range of areas of focus and associated work-streams.

Methods: The evaluations employed a mixed method multi-level case study design, involving qualitative face-to-face interviews with front-line staff, clinicians and management in two districts, one in the North Island and the other in the South Island, and an analysis of routine data tracked ambulatory sensitive hospitalisations and emergency department presentations. Two postal surveys were conducted, one focussing on the patient care experiences of integration and care co-ordination and the second focussing on the perspectives of health professionals in primary and secondary settings in both districts.

Results: Both evaluations revealed non-significant changes in ambulatory sensitive hospitalisations and emergency department presentation rates and slow uneven progress with areas of focus and their associated work-streams. Our evaluations revealed a range of implementation issues, the barriers and facilitators to greater integration of healthcare services and the implications for those who were responsible for putting policy into practice.

Conclusion: The business plans were shown to be overly ambitious and compromised by the size and scope of the business plans; dysfunctional governance arrangements and associated accountability issues; organisational inability to implement change quickly with appropriate and timely funding support; an absence of organisational structural change allowing parity with the policy objectives; barriers that were encountered because of inadequate attention to organisational culture; competing additional areas of focus within the same timeframe; and consequent overloading of front-line staff which led to workload stress, fatigue and disillusionment. Where success was achieved, this largely hinged on the enthusiasm of a small pool of front-line workers and their initial buy-into the idea of integrated care.

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Health Reform Monitor

Measuring and managing health system performance: An update from New Zealand☆

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ABSTRACT

In July 2016, New Zealand introduced a new approach to measuring and monitoring health system performance. This 'Systems Level Measure Framework' (SLMF) has evolved from the Integrated Performance and Incentive Framework (IPIF) previously reported in this journal. The SLMF is designed to stimulate a

2.1 *Ambulatory Sensitive Hospitalisations (ASH): 0-4 year old children* *"Keeping children out of hospital"*

Where are we now? Ambulatory Sensitive Hospitalisations Summary

Ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds in Southern DHB have been gradually decreasing since 2013, with a total and Māori rate below the national average. Southern DHB has the 5th lowest ASH rates for total population and 6th lowest ASH rates for Maori in New Zealand.

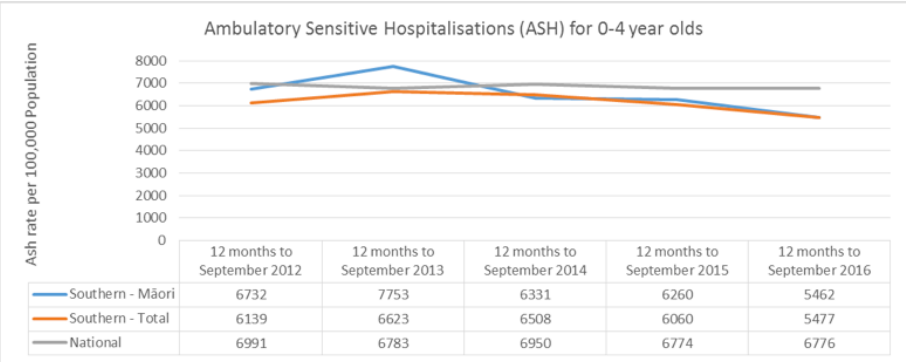
The most prevalent clinical conditions that contribute to Southern DHB's ASH rate include respiratory conditions (infections and asthma), gastroenteritis and dental conditions. Eight of Southern DHB's top ten ASH presentations are below the national average, with the exception of upper and ENT respiratory infections and GORD.

Measure description:

Standardised Rate per 100,000 as per non-financial quarterly measure – System Integration 1

Baseline Data

Five year trend to September 2016



	12 months to September 2012	12 months to September 2013	12 months to September 2014	12 months to September 2015	12 months to September 2016
Southern - Māori	6732	7753	6331	6260	5462
Southern - Total	6139	6623	6508	6060	5477
National	6991	6783	6950	6774	6776

Key contributing clinical conditions

Top 10 ASH conditions for 12 months to September 2016	ASH rate per 100,000			
	Māori	Other	Total	National
Upper/ENT respiratory infection	1,495	1,705	1,663	1,436
Asthma	1,332	1,029	1,089	1,335
Dental conditions	1,033	802	848	989
Gastroenteritis	625	809	773	1,099
Lower respiratory infection	190	241	231	420
GORD	299	194	215	68
Dermatitis & eczema	217	174	182	190
Pneumonia	136	167	161	588
Constipation	54	114	102	137

Where do we want to be?

Long term goal: To reduce and maintain ASH rate to fewer than 4,100 people per 100,000 population aged 0-4 years by 30 June 2022

Target for 2017/18: <5,190 per 100,000

Rationale: Aiming for a 5% annual reduction. *(MOH estimates ASH reduced by 25% in AP – liaise with Charlotte)*

How will we get there? (Contributory Measures)

Over the next five years, Southern DHB and WellSouth PHO will work progressively to achieving the long term goal through the development and implementation of key actions to reduce hospital admissions for children with a

2.1.1 Primary diagnosis of asthma or upper/ENT infection

2.1.2 Reduce ED attendance rates,

2.1.3 Increase GP utilisation,

2.1.4 Encourage newborn enrolment with WellSouth PHO and

2.1.5 Place a greater focus on equity for our priority populations.

I would say this, but…

- More research into alliance performance is badly needed…
- Studies that:
  - Investigate alliance structure and process questions
  - Evaluate the model
  - Link performance to various activities

TO CONCLUDE…

- Alliancing offers an important mechanism for cross-sector clinical leadership for integration and innovation
- It is an example of ‘experimental governance’
- Alliancing in NZ has yet to be fully tested, but the journey has only begun
- By getting ‘everyone in the room’, alliancing is facilitating clinically-led conversations about care design and delivery previously not possible
  - allowing us to look at how the system should function from a patient and professional perspective
- The process is messy but part of the transition to building clinically-led ‘whole of system’ approache


KEEP
CALM
AND
THANK YOU
FOR WATCHING