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Integrated healthcare: Policy pathways and pitfalls

Executive summary

Over 80 health leaders participated in an Integrated Care Simulation hosted by the Australian Healthcare and Hospitals Association (AHHA) on 23 October 2014, working through three health policy initiatives to understand their likely impact on health services and system integration.

These policy initiatives included:

- ✧ The introduction of bundled care packages for chronic diseases
- ✧ Private Health Insurers financing primary care services
- ✧ The transition from Medicare Locals to Primary Health Networks (PHNs)

The objective was to provide a realistic but stage-managed environment for participants from the public, private and not-for-profit sectors to gain insight into how these current policy considerations might play out across the health sector.

The overarching question emerging from the Simulation was ‘what do we want our health system to be?’ with much discussion centred on equity, choice and respect for the individual.

Another key theme that emerged during the three scenarios was how disconnected the various parts of the system are. It was observed that, when a broad change was proposed to the system, each stakeholder was mainly concerned with how it affected them, rather than the patient, or the system as a whole.

Themes of communication and collaboration also dominated the discussions, suggesting that broader consultation is required when developing health policy and planning for its implementation.

The top 10 recommendations to be taken from the Simulation were:

1. Health policy needs to have clear goals, be evidence-based and well-thought through, taking account of all potential consequences, and specific on details for all elements of the system, including providers and patients.
2. While financial sustainability of the health system is critical, policy makers must not lose sight of consumer interests – these must be central to health policy.
3. People working within the health sector need to engage regularly with policy makers at all levels in government to highlight any perverse or unintended consequences of policies, as well as to offer alternative solutions.
4. Healthcare cannot operate in isolation from social supports and care, and policy and planning should be undertaken together where possible.
5. Integrated care strategies and models could work well for people with high health care needs, however more research is required to better support health promotion and illness prevention strategies, including for generally well people.
6. The Australian healthcare system needs a greater focus on inter-professional leadership, requiring all areas of the health sector to actively collaborate and engage.

7. Australia should invest in the foundations of health system integration enablers, including funding, data collection and sharing, coordination capability in primary care, shared systems such as electronic records, and addressing parts of the health system not funded by Medicare.
8. There needs to be a stronger focus on ensuring informed decision making in health, especially among consumers—work must be undertaken to improve health literacy.
9. Evaluation criteria for health policies and programs should focus on quality and outcomes.
10. When developing policies, data strategies must be developed as an important first step to ensure any change can be measured and assessed to improve future implementation. Consideration must be given to data availability and consistency as well as data linkage and sharing. In particular, improved access to, and use of, granular MBS and PBS data must be supported by Government, in order to ensure a robust evidence base for health policy development.

The Simulation Project

Integrated care is care that crosses boundaries between primary, community, allied health and hospital care and extends beyond health into social care and support too. Providing integrated care is a goal of health systems around the world and is a way of optimising the outcomes for patient, provider and system.

According to the WHO, integrated service delivery is *'the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money'*.

Currently, health systems in Australia face challenges in delivering care that is well integrated. This problem is not new nor is it novel to the Australian context; governments and healthcare providers the world over are looking to solve this problem through, for example, changes in governance and structure, financing and payments, clinical governance and scope, models of care and mix of services to name some approaches.

Testing health policies in a simulation environment is not something routinely or commonly done in Australia in the health sector, however it is often one of the preferred methods used when testing readiness for security threats or in implementing new software or IT products.

Using the principles of the NHS/Kings Fund Rubber Windmill¹ experience in the UK as a guide, the AHHA developed a Simulation which allowed participants to test policies and structures and provide an insight into outcomes that may result.

The Simulation drew directly on the experience and judgement of participants, all of whom were currently working within the health system. All participants were provided with briefing material to support their engagement and participation at the Simulation, and team leaders were provided with additional information to steer their groups when needed. This material was intentionally broad and non-prescriptive so as to allow as much freedom of thought and ownership from participants as possible. Participants and team leaders alike were generous with their contributions, resulting in the ten key recommendations and analysis contained in this report.

¹ Windmill 2009 – NHS response to the financial storm, King's Fund

Will bundled care assist in managing chronic disease burden?

The chronic disease burden is much talked about, and policy solutions to this modern-day health challenge are being developed across health systems globally. With reviews ongoing of the Chronic Disease Management items under Medicare, the simulation explored how chronic disease management could be better funded and/or incentivised in the primary care sector so as to contribute to broader policy development in conjunction with the Government's review.

Scenario tested: The Simulation tested the introduction of bundled care packages for chronic diseases to be managed within the primary sector. An annual, capped, allocation would be made to each patient for the purposes of managing all needs associated with their particular chronic disease (i.e. including primary care, pharmaceutical care, allied health and pathology/diagnostic care).

Simulation findings: The possible introduction of bundled care packages for people with chronic disease raises a number of concerns about the ability to meet the needs of the majority; because of the potential focus on the 'high-need' few, problematic delivery to rural and regional populations and the challenge of integrating care between private and public health services.

The health system is often described as operating in silos and implementing a bundled care package policy would have limited impact on this unless it was patient-centred. This includes creating a mutual understanding with patients about how and why the introduction of bundled care packages might best suit their needs. Patient information and informed decision making would need to be central in the development and implementation of such a major health policy change, in particular if patients were to be more involved in managing their care through choice of provider, service and in managing funding provided for these choices.

This issue of patient autonomy however is problematic: while we should seek to empower patients in taking control of their own healthcare decisions, they may not be able to make a truly informed decision without the assistance of medical and health professionals. This is further complicated when considering the delivery of bundled care to rural and regional populations, Aboriginal and Torres Strait Islander (ATSI) and Culturally and Linguistically Diverse (CALD) communities, where resources can be scarce and communication/information needs different.

Consideration would need to be given to who would manage any proposed 'bundled care' arrangements—GPs, care coordinators or the patients themselves.

One option would be to give patients the ability to choose whether they want to participate in a bundled care package scheme. Use of care coordinators could be a cost-effective approach and assist with addressing health literacy issues, but would such an approach introduce another layer of complexity into an already complex system? Would the value contributed by care coordinators offset the associated administration costs? Similarly, the cost-effectiveness of GPs as coordinators would need to be considered.

Lessons for care coordinators in the health sector could certainly be learned from the phasing in of the National Disability Insurance Scheme into Australia.

Funding specifics for a policy of this kind would also need to be worked through, ensuring a bundled care program provides an adequate level of support relative to the complexity or intensity of particular chronic diseases. It is likely that an annual cap would need to be factored into the model, raising issues around where to set the limit and whether this would meet the needs of patients. Consideration would need to be given to 'frequent flyers' as well as better management of out-of-pocket costs arising from additional services, and appropriateness of safety nets. Furthermore, the lack of clarity about responsibilities between Federal and State Governments, as well as between primary and acute health services would need to be addressed.

In attempting to develop truly integrated care, it is also important to acknowledge that some chronic diseases are currently put in the 'too hard' basket. For example, the complex needs and often episodic nature of mental illnesses may mean these are overlooked in the development of bundled care strategies. Safeguards must be put in place to ensure these patients are not disadvantaged.

To overcome these issues, the evidence behind the arrangements for bundled care programs would need to be strong and well-articulated. There is a tension between experiments in pilot programs and scalable, broad implementation of health policy. As such, consideration must be given to how a policy can be scaled for complex and future needs, as well as how it can be modified and adjusted along the way to remain flexible to changing needs and patterns of disease burden. It may be possible to pilot this work through identifying current 'frequent flyers' or those at risk of multiple hospitalisations for a particular chronic disease and then working out what would help reduce their admissions. Such a project could provide valuable data and be expanded to include other chronic diseases.

Data and research are integral to support risk stratification, pathways of care, the role of technology and, in particular, identifying those groups that may not be accessing care. Significant steps need to be taken to ensure unintended consequences are identified and avoided in the implementation of such a policy, such as clinicians competing for a share of the budget, an increasing burden on hospitals or the focus on chronic disease cases resulting in neglect for the needs of the broader population and a drift away from non-chronic disease health care.

In summary, bundled care packages would require strong investment in ensuring ongoing integration of care, not just service delivery. This needs to occur through solid and well researched policy development of funding, patient and clinician education, and relationship management across providers, services and funders. While there are potential benefits of the introduction of bundled care packages for chronic disease, attention would need to be paid to ensuring underlying policy settings are robust and the appropriate capabilities are in place.

In summary

- ✧ Bundled care packages hold potential but would require sufficient evidence, data and funding to support the diversity of needs
- ✧ Informed patients and supported decision making would be central to success
- ✧ Bundled care packages hold potential to integrate service delivery, however the integration of health care requires considerable commitment from Government, providers and patients alike.

A role for Private Health Insurers in primary care?

In its February 2014 report, the National Commission of Audit² proposed that consideration be given to allowing private health insurers to expand coverage to primary care. In May 2014, the Federal Health Minister³ signalled his interest in the Commission of Audit's plan, particularly in incentivising GPs to focus on chronic disease and for greater involvement of private insurers in creating care plans to keep people out of hospital.

Scenario tested: The Simulation tested an amendment to the *Private Health Insurance Act 2007* to allow private health insurers to provide rebates for certain items that attract an MBS fee for out of hospital services, specifically primary care services.

Simulation findings: Since the Commission of Audit's report, there has been much interest and speculation across the health sector in the potential for Private Health Insurers (PHIs) to fund primary care services. The Simulation identified risks associated with such a policy; including the creation of a two-tiered system for the insured and the uninsured. While the uninsured are predicted to be the major losers from this potential policy initiative, PHIs are also concerned about how their shareholders would fare.

This policy proposition appears to be based on an assumption that private insurance cover for primary care would boost better integrated care for insured patients and reduce demand for hospital care, and thus provide budget savings. Those opposed to a greater role for PHIs in primary care content that it could fragment and weaken care for the uninsured, incentivise workforce provision away from public patients and dictate to physicians who should be getting what treatment. The issue of workforce distribution is of particular concern when considering this policy's potential impact in rural and remote areas, with a real danger of increasing geographical and social inequities.

One of the advantages to come from this potential policy initiative would be better datasets, which could support better needs analysis, planning and funding if commercial considerations about data ownership and access were overcome. However if the Medicare and PBS data collections were reformed to allow for similar granular level collection, the same data could be gathered to realise this benefit.

Debate is urgently required on how the private system can better interact with the public system and what the optimal relationships and funding arrangements should be. A voluntary and mutual partnership approach may help enhance the management of chronic and complex disease, and better integrate care through seamless transitions across the public and private sectors.

An alternative could be to provide additional funding for activities in primary care, not just via private health insurance incentives, but for anyone else in the system—State, Federal, non-for-

² *Towards Responsible Government, National Commission of Audit Phase One Report, February 2014*

³ *Address to the George Institute for Global Health, Minister Dutton, 1 May 2014*

profits—with the universal goal of reducing hospitalisations and readmissions. Increasing funding, through incentives or payments, could encourage the development of more integrated models of care.

Ideas such as allowing PHIs to reduce premiums for people who have accessed preventative health services are also worthy of investigation, and others around incentivising and generating interest in self-management, behavioural change, and the maintenance of good health would also generate significant efficiency to the whole health system.

As such, while there is much scepticism and uncertainty around this policy, simulation of the issue shows that, when fear is cast aside to make way for pragmatism, there is potential for PHIs to support better integrated care for patients through well developed and researched policy decisions. There appears also to be potential for private sector innovation to influence and lead the same across the public sector.

Overall any policy change in this area should ensure that universality remains unaffected, so that all Australians can enjoy good health and access timely care to avoid complex and costly disease.

In summary

- ✧ Policy development in this area should focus on how the public and private sectors can better integrate for the seamless transition of care, and for collection and reporting of more comprehensive health data
- ✧ Any change to private health insurance needs to ensure that people without insurance are not disadvantaged.

Can Primary Health Networks drive integrated care?

In 2014, the Federal Government announced that it would be replacing the network of 61 Medicare Locals with Primary Health Networks responsible for organising primary care for their communities.

Scenario tested: the Simulation asked teams to consider the upcoming process to form Primary Health Networks, including who should bid or be part of a bid, and how that involvement would be managed.

Simulation findings: A clear articulation of Primary Health Network (PHN) objectives is needed if they are to drive integrated care, with concerns around a potential lack of performance goals and patient consultation. The development of robust KPIs will help avoid 'tinkering' later on, providing PHNs with an understanding of what they are meant to achieve and guiding their activities accordingly.

It will be important for PHNs to engage relevant stakeholders—including patients—in the process, as well as to ensure there is a focus on outcomes and quality. There is also a need for strong engagement with sectors outside the narrowly-defined clinical and medical care sector. For instance, it may be appropriate in some instances to direct health savings to non-health areas, such as housing, to achieve health gains. Additionally health professionals from across the sector must have buy-in to ensure that care is properly integrated and directed from holistic and well-considered planning for local needs.

PHN partnerships across health and social sectors would also benefit further from relationships and collaboration with the research sector, and through joint activities that continually improve planning, service delivery arrangements and needs assessments.

An abundance of research on the impacts of social determinants on health demonstrates that healthcare cannot operate in isolation from social supports and care. Policy and planning should be undertaken together for this reason, with the PHNs having significant potential to drive these connections. While the PHN model has the potential to go some way towards addressing integration across public and private, and acute and primary care sectors, its success depends upon service coordination and integration, capacity building, robust governance and diverse partnerships, as well as how well it can manage relationships and competing interests.

In taking a structured and consultative approach, the PHNs have the opportunity to make financial savings in the long term. They can do this by including illness prevention as a key objective, as well as disease management. This will help ensure the broader healthcare needs of all people, including those with chronic diseases, are not overlooked.

Under simulation, the PHN model does appear to hold potential for innovative ideas on integration of care, and in developing models of care to suit community needs. The Community Advisory Committees and Clinical Councils have the potential to contribute to innovation

through effective governance of those structures and meaningful engagement with their respective groups. However this will require the support and guidance of clearly articulated KPIs.

While there are concerns that the PHN model appears to be vague in terms of objectives, performance measures and targets, it may be more rigorous than the Medicare Locals (MLs) model in terms of process. Greater rigour in objectives and measurement, coupled with a less detailed approach to process, would help provide the clarity and flexibility required for a high-performing and well-integrated primary health system.

In summary

- ✧ With clearly articulated and evidence-based performance indicators, Primary Health Networks hold great potential to integrate both health and social care for their communities
- ✧ Primary Health Networks also hold potential to deliver financial savings into the future, by ensuring a dual focus on disease management and illness prevention in their activities
- ✧ Primary Health Networks should be afforded the required flexibility needed to organise and plan a well-integrated primary health sector as part of a high-performing national health system.

Health Policy - experiments or evidence-based?

The Integrated Care Simulation demonstrated that, when broad change occurs, each part of the health system often busies itself looking out for what it will mean for them, rather than focusing on the patient or the system as a whole. Furthermore, when patient consultation does occur, it can be fragmented or superficial, and at times is not done in a way appropriate to the patient's levels of health knowledge.

There are currently logistical, technical, legal and privacy constraints with data sharing across the sector, as well as an overall lack of data from MBS and PBS sources on activity and services at a granular level. This is a particular impediment to evidence-based health policy. Better integration of the public and private sectors would give rise to better opportunities to collect and share data that would, in turn, drive more effective and targeted health policies. However, this requires appropriate structures and agreements to be in place prior to activity.

As identified in the Simulation, development of pilot programs may assist in understanding the impact of a proposed policy, with necessary consideration given to how a system or policy can be scaled for complex and future needs. This may require a 'work backwards' approach in identifying a particular 'at risk' group and working out what would help reduce their admissions. Conducting these pilots at the community level would also ensure that services and models of care could be implemented appropriately for the specific groups they are to benefit. Taking this evidence-led approach would help save time and money in the longer term, as the particular policy is amended, enhanced and/or expanded to include other chronic disease cases and patient and community needs.

The Simulation identified a clear interest across all areas of the health system to develop policy that results in positive outcomes. This common motivator could serve to drive health reform if policy makers engage broadly with stakeholders, rather than via narrow interest-based consultations.

Where to from here?

While the Simulation made obvious a number of challenges inherent in the health system, such as the funder-provider divide, it also demonstrated the potential for 'game-changing' thought and collaboration.

In challenging health leaders from across the system, including academics, healthcare providers, insurers and consumers, to think about positive changes to develop better integrated care, it became clear that thoughtful leadership in the national conversation about our health system was needed.

The project helped shine a light on the importance of evidence to inform health policy development, and of well-planned implementation to ensure purposeful change and anticipate and mitigate any unintended consequences. Many participants commented that the Simulation reinforced the need to tackle issues collaboratively engaging all stakeholders. It was also noted that, at times, those high level talks forget the most important stakeholder in the system—the patient.

Much discussion about each of the topics centred on equity, choice and respect for the individual, with participants generally being in agreement that these values are central to an optimal health system.

Another key theme that emerged during the three scenarios was the disconnection across the various parts of the health system, with many competing interests and therefore areas of focus within the system. A breakdown of historic silos is critical for successful reform or change within the sector. The Simulation experience highlighted that while there is an assumption that policy makers work in the best interest of patients, not much consultation occurred with them when work began. Broader consultation, better communication and collaboration were seen as being integral to better policy planning and implementation.

Conditions required for success include:

- ✧ Comprehensive health data development, better availability and access for researchers, policy makers and health service managers;
- ✧ Pilot programs that are locally planned and managed, and amenable to change;
- ✧ Research and broad stakeholder consultation to achieve greatest buy-in across the whole health sector;
- ✧ More information and support for decision making whether for patients or clinicians;
- ✧ Better engagement with policy makers from all areas of the health sector;
- ✧ Investment in efficient and effective programs that meet performance indicators; and
- ✧ Clearer articulation of what we want our health system to be now and in the future

At the centre of all discussions was the universality of healthcare, and taking a genuinely patient-centred approach in developing and implementing health policy. As became evident, these core values can become clouded when other competing priorities are considered, ultimately at the expense of patient satisfaction and undue costs in the long term. The commonality is that we want a high-performing health system that looks after us all. The challenge lies in meeting that expectation.

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