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Partnerships and collaborative advantage in primary care reform

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policy issue

Interest in partnerships and collaboration in primary health is growing. Primary health reforms globally have embraced ideas about partnerships, collaboration and alliances, indicating a shift from individual care models to systems thinking. The literature uses the terms *collaboration*, *partnership*, *alliance*, *coalition* and *joint-working* inter- changeably.[1] Partnerships between professionals, across sectors and including consumers, strengthen the capacity of organisations to improve both individual and population health and reduce health risks.[2]

Partnerships provide organisations, and individuals within them, with opportunities to create stronger impact and produce results that they could not have produced alone, and this in turn strengthens their core purpose. Collaborative advantage is achieved by a partnership when:

- the synergy and method of working between partnering organisations drives the delivery of outcomes;
- each organisation, through the collaboration, is able to achieve its own objectives better than it could by working in isolation.[3]

The evidence about mechanisms for effective partnerships is sound. However, outcomes in terms of individual or population health are difficult to measure because of the multiple factors involved in partnerships and in how better health outcomes are achieved. Because it is difficult to show causal relationships between partnerships and outcomes, it is critical that partnerships are established on evidence-based approaches to ensure that they produce desired results.

Collaborative advantage is conceptualised at two levels in the literature:

- the interprofessional teamwork at the primary care service delivery level where providers work together on a patient's care planning;[4]
- a systems level where partnerships are formed to change community or population level outcomes.[5,6]

The interprofessional level requires support at the level of policy and systems if it is to be effective and sustainable,[7] and the policy and systems level requires the

service delivery sector to work in partnerships in order to deliver reforms.
The World Health Organization has called for effective interprofessional collaboration to deliver high quality health care.[8] Since the landmark Alma-Ata Charter on Primary Health Care (WHO 1978), intersectoral collaboration has been a cornerstone of effective primary health care, and primary health care strategies fundamentally call for multisectoral collaboration on issues such as school health, health literacy, and environmental health.

The involvement of consumers is supported in the literature with growing evidence of the benefits with models emerging at four levels (individual, service, network and system) and across five elements (information, consultation, involvement, collaboration and empowerment) of engagement.[9]

what does the evidence say?

The characteristics of effective partnerships include collaborative planning, an agreed common agenda and the pursuit of common goals, organisational capacity, partnership competencies, leadership commitment, and sound communication practices to keep people engaged.[10]

These key elements are needed to create an environment that has the capacity to manage a partnership relationship over the time it takes to produce results. The literature also identifies that organisations need to assess their capacity to partner before committing. Private providers run their businesses to generate profit while partnerships in primary health are generally about producing better health outcomes. Indeed, fee-for-service systems of remuneration are a deterrent to working in partnerships.[11] There is undoubtedly a need for incentive mechanisms to create opportunities for the primary care sector to work in partnership. Reforms in the primary care sector at the level of governance and funding would provide a stronger base for effective partnerships, including interprofessional collaboration for care coordination.[12]

The literature is clear that partnerships are more likely to deliver results when they use logic models and theories of change to drive their structure and function.[13] The literature says that without both a logic model and a theory of change, partnerships flounder. Indeed, in 2013, the Commonwealth Department of Health commissioned McKinsey Australia to develop a framework that sets out a logic model intended to provide structure and function to drive outcomes in primary health care collaboration.[14]

The Peninsula Model for Primary Health Planning[15] has used the McKinsey logic model as its service development framework. The Peninsula Model is a practical example of partnership between health, hospitals and local government that demonstrates how collaborative advantage arises when actions are structured and coordinated across levels of influence and between a wide range of sectors, in a local catchment. An evaluation conducted in late 2014 of the Peninsula Model[16] showed that critical success factors include:

- robust core structures, processes and common agenda;
- backbone resourcing particularly for the necessary breadth and depth of engagement;
- commitment from partners despite impact of external reforms;

- continuous communication of the vision and 'wins' more broadly;
- investment in resources and skills (direct and in-kind).

Another strong partnership has been developed by Inner North West Melbourne Medicare Local (INWMML), two Community Health Services and Melbourne Health, a major Local Hospital Network (LHN) in Victoria.[17,18] Their partnership aims to improve patient care, outcomes and pathways for their shared community.

Both the Peninsula Model and the Inner-North West Melbourne collaboration use a structured partnership as a basis for assessing, prioritising and planning for services to best meet local health care needs. Both partnerships are closely connected to their Local Hospital Network through Primary Care and Population Health Committees. Both partnerships have collaborated effectively on health care pathways, advance care planning, chronic disease management, integrated mental health services, after-hours access, and information technology developments. Through partnerships, they strive to find the best solutions to strengthen access to primary health care services, reduce avoidable hospitalisations, and keep people well, in ways that they could not achieve as single services working alone.

Two theories of change attracting attention from partnerships and collaborations are Results-Based Accountability, and Collective Impact. Both have structured methodologies that are designed to achieve coordinated collaboration and drive transformative change in the way organisations work together to solve complex problems. History has shown that no single organisation can create large-scale, lasting social change by working in isolation of others. In areas such as vulnerable children and families, or alcohol and drug issues, cross-sector partnerships that include primary care and a wide range of other agencies are essential to strengthen responses to prevention as well as integrated service delivery. In other words, partnerships and collaborations are mechanisms for organisations and multiple sectors to look beyond individual programs showing success with limited populations to where results can be improved on a larger scale.

A well-developed capacity to create and sustain fruitful collaborations also gives health care organisations a significant competitive advantage, and builds capacity for future collaborations. Partnerships require a dense web of interpersonal connections and internal infrastructures that enhance learning and drive outcomes,[19] but they only function successfully when structured appropriately.

what is the quality of the evidence available?

At the level of partnerships for primary care service delivery, few studies of outcomes have used designs capable of producing high-level evidence, so overall, the strength of evidence is moderate rather than definitive.

No randomised controlled trials of collaborative advantage or health outcomes have been found for this brief. One study[20] developed a multi-methods design involving reviews, environmental scans, qualitative studies, and multiple case studies conducted consecutively, to explore the structures and processes required to build and sustain effective collaborations involving the primary health care and public health sectors.

A systematic review of the coordination of care in primary health and with other sectors used a narrative synthesis to describe outcomes, in the absence of higher

level evidence being available[21]—this approach is typical of the literature on partnerships for integrated primary care.

A second systematic review[22] included experimental or quasi-experimental designs to assess different aspects of collaborative partnerships, also including papers that used multiple measurement systems and varied study designs to capture different aspects of partnership functions and outcomes.

Nonetheless, there is agreement between these reviews about the key elements of an effective partnership on both patient-related outcomes and system level change.

The evaluation of the Peninsula Model also used multiple methods (survey, focus groups and interviews) to develop findings. While this evidence may be considered low-quality, there is agreement that partnerships show improvements in many aspects of professional and organisational functioning from their partnership work.

Overall, the quality of evidence on health outcomes is insufficient to draw generalisable conclusions. However, it is relatively early days to show change in health outcomes, but over time, we should anticipate health outcome data to show successful 'needle moving' change[1] that gathers momentum with sustained efforts.

In relation to consumer engagement, there is emerging evidence about the influence of consumer engagement on health care organisation. The Australian Council on Safety and Quality in Health Care (ACSQHC) has noted emerging evidence albeit from California, linking consumer engagement with reduced hospital costs and utilisation of services, and improve the quality and safety of health services and individual health care.[23,24] If these types of improvements can occur in LHNs, then similar improvements can surely occur in the context of primary care reforms.

what does this mean for policymakers?

Increasingly, partnerships and collaborations are becoming more common, and they will continue to do so because they provide for a strategic approach to the development of common agendas and pooled resourcing, to improve health outcomes. The Peninsula Model for Primary Health Planning is a good example of this approach, using the Commonwealth's commissioned logic model, while the Inner-North Melbourne partnership is also a response to the desire of local organisations to improve systems and health care delivery.

Partnerships and collaboration need to be deliberate, with planned actions based on a logic model and theory of change. With deliberative processes rather than ad hoc approaches, partnerships can change the way organisations and individuals work, but they require incentives and mechanisms of support to enable involvement over the period of time necessary to achieve change.

Private industry primary care providers are unlikely to make a long-term commitment to broad collaborations driven by public sector agencies focused on social-health change, so mechanisms to engage them, where appropriate, need to be built into the partnership's framework.

Increasing research capacity to measure collaborative advantage will reduce the

[1] Needle-moving is about a 10 per cent plus change on an indicator that is a clear standard for success. While 10 per cent may not seem ambitious, it can represent enormous savings

nature of inconclusive evidence and is likely to improve the practice of partnerships, coalitions and joint working in health and human services. Similarly, the evidence on consumer participation in primary care partnerships is promising in hospital quality—particularly in reductions to adverse events.

In relation to primary care systems and primary care reforms, benefits to consumers from primary care reform are yet to be shown.[25] Yet there are promising practices in consumer engagement that will inform Australia's Primary Health Networks. Structured approaches should include monitoring and accountability for benefits to consumers, and over time, of outcomes from consumer input to the reforms, particularly those that affect safety and quality.

Partnerships and collaboration are about creating new value together rather than mere exchange. They are about obtaining a desired result or return on investment (such as, achieving better population health outcomes or maximising procedural efficiencies) for the amount of time, funding and effort an organisation invests in the process. For private industry providers to become involved in partnerships, the common agenda and desired outcomes need to be carefully worked-out and agreed upon in advance. This ensures that all partners share a common purpose and commitment to the partnership and its goals throughout the time required to achieve these outcomes. This means that the partnership needs to carefully orchestrate a collaborative culture and purposefully facilitate collaborative action to achieve collaborative advantage.[26]

Policymakers, researchers and practitioners need only look to Australian best practices, such as The Peninsula Model and the Inner-North Collaborative Framework among others, for models on how to develop effective partnerships and collaborative advantage to accelerate primary care reform. These models are showing improvements in many aspects of professional and organisational functioning from their partnership work. The work they are doing in the development of strategies for streamlined care, embedding of efficiencies, and reductions in avoidable hospitalisations, is just being realised. Continuing financial and policy support for them is likely to bring tangible economic, consumer, and health system quality benefits to primary care reforms.

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