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Funds pooling in Australia: could alliance contracting hold the key?

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background

International health reform is currently driven by a number of common platforms. Whether it be the United Kingdom's National Health Service (NHS) *5 Year Forward Plan* (NHS England, 2014), the United States' Commonwealth Fund *Designing a high performing health care system* (The Commonwealth Fund, 2017) , New Zealand's *Better, Sooner, More Convenient health care in the community* (New Zealand Ministry of Health, 2011) or Australia's *Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding, Schedule 2* (COAG, 2016), approaches to caring for an aging population with high cost and complexity are uniform. Key features include:

- whole-of-system planning, funding and service delivery;
- linking incentives with desired structure and function;
- strong integration across health and social care sectors;
- advanced care delivery access within the community; and
- innovative use of e-health.

In April 2016, Australia's Council of Australian Governments (COAG) agreed to establish bilateral agreements to provide flexibility for each jurisdiction (state and territory) to work with the Commonwealth Government to determine the best model of care for Australians with chronic and complex diseases.

The Commonwealth undertook to establish enabling infrastructure, governance arrangements and systems to support a pilot of a Health Care Homes model in primary health care, consistent with the advice provided by the Commonwealth Department of Health's Primary Health Care Advisory Group.

The states and territories, working with the Commonwealth Government, committed to focus on, in selected regions:

- coordinated planning and collaborative commissioning of services between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs);
- arrangements for the sharing of patient information; and
- implementation of collaborative funding arrangements to support better coordination of care for patients at risk of avoidable public hospital admission.

The results of these activities are to be comprehensively evaluated and brought back to COAG for further consideration of a joint national approach, including joint or pooled jurisdictional funding arrangements (COAG, 2016). Six of eight states and territories are currently signed up to the 2018 Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform (COAG, 2018).

key questions

Pooled funding across state and territory jurisdictions has the potential to progress universal health coverage and minimise fragmentation in risk-sharing mechanisms. However, pooled population-based health funding at scale would be new, challenging and potentially confronting to Australian health and hospital providers, traditionally funded individually for deliverables based on activity. Key questions to ask before recommending changes include:

- What international evidence or experience in successfully pooling funds between primary healthcare provided in the community and acute care sectors could guide the jurisdictions in this endeavour?
- Which international models bests align with our own health system, service delivery arrangements, deliverables and culture?
- What governance mechanism could bring such diverse organisational and jurisdictional groups together in successful partnership?

health financing for universal coverage

Funds pooling: an international context

While many OECD (Organisation for Economic Cooperation and Development) countries are exploring forms of funds pooling, there is little formal evidence of impact at scale. Indeed, an international review of integrated funding for health and social care, that explored thirty-eight schemes from eight different countries, found a universal inability to isolate elements such as funds pooling from care delivery (Mason et al., 2015).

The United Kingdom has focussed on NHS service or clinical commissioning to influence care purchasing decisions for regional patient care, but this does not involve pooling of community and acute care funding.

The most relevant model from the United States is the accountable care organisation (ACO), which creates a single funding source for a mix of community and acute care services across an insured population. An ACO is usually an association of hospitals, healthcare providers and insurers in which all parties together assume financial and medical responsibility for patient care (Lewis et al., 2017). The focus in the United States, however, is chiefly across health fund membership, rather than regional geography.

In the absence of established evidence, the model which might most closely meet the need to deliver a population-based primary / acute care funds pool relevant to the Australian health system lies much closer to home.

Alliance Contracting in New Zealand

Since 2010, the New Zealand government has invested in 'alliances' between the country's twenty publicly-funded District Health Boards (DHBs) and thirty Primary Health Organisations (PHOs).

The DHBs own public hospitals and commission other regional services, while PHOs coordinate DHB-funded primary care and general practice services which are mostly privately-provided. Historically, DHBs and PHOs have largely coexisted, despite working with the same local populations.

Alliance contracting, compulsory in New Zealand from 2013, aims to create a mechanism that brings together clinical and management leaders from DHBs, PHOs and other regional allied services with a focus on collaborative 'whole of system' service design and delivery.

In practice, an alliance facilitates clinically-led conversations between general practitioners, hospital specialists and others involved in service delivery, as well as shifting resources in the system to support alliance decisions. Emphasis in alliance activity tends to be on chronic disease and older patients who have regular contact with the health system, require well-integrated services, and whose care is amenable to primary care delivery.

Governance

Alliance membership is skill based and ground-up. It represents those with capacity to lead, influence and understand perspectives of service delivery. Members may include DHB and PHO chief executives and managers, general practitioners, hospital specialists, nurses, allied professionals, ambulance and aged care residential services, Māori and Pacific leaders and patients, and community representatives Timmins and Ham, 2013). Several New Zealand alliances have an Independent Chair.

The focus of an Alliance is to work in partnership to improve health and health services for their population by developing a 'whole of system' approach to service planning and delivery, with services provided in the best place as clinically agreed.

The patient is at the centre of all planning with a particular emphasis on care integration and reducing duplication between service delivery points.

Resources are allocated where they will best deliver on alliance goals and service need, requiring that alliance members work collaboratively and engage in challenging discussions around issues such as where services ideally should be based.

Members work to build cross-sectoral clinical leadership and engagement which is critical to discussions around effective service redesign.

This clinical leadership dimension of alliance governance is what sets the model apart from the more traditional corporate governance model that often characterises health care. Indeed, some alliances have created an opportunity to build strong clinical governance and leadership, and an expectation that health professionals will take up the opportunity to improve and redesign the health system.

The Alliance Charter

The 'glue' which binds New Zealand's alliances is the Alliance Charter. The Alliance Charter outlines rules for:

- engagement, committing members to act with honesty, integrity and with the goal of building trust in one another;
- working collaboratively, making decisions by consensus and resolving disagreements cooperatively;
- adopting a patient-centred, whole-of-system approach for making decisions on a best-for-system basis; and
- making the best use of finite resources in planning health services to achieve improved health outcomes for populations.

Alliances also focus on issues such as developing clinical treatment pathways across the health system. A common outcome is moving of particular services from a hospital to a community care setting, whilst ensuring that primary care and general practice providers are upskilled and supported to assume additional responsibility. In time, alliances are also expected to incorporate social services, and some have made progress in this.

Evaluation

Early evaluations of the alliance contracting approach are mixed. Longer term alliances have achieved new community rehabilitation and support services (Charles, 2017), while others show minimal change to traditional indicators (Lovelock et al., 2014). However, alliances are considered to have long-term potential as 'everyone is in the room' seeking to improve care systems for challenging patient groups (Charles, 2017; Gauld, 2017; Lovelock et al., 2017). The New Zealand Government and providers around the country remain committed to the model, arguably as, in the context of traditionally-separated hospital and primary care sectors, there is no appropriate proven alternative.

future of pooled funding

Australia, in company with all OECD nations, faces a future where traditional funding models, incentives and our siloed health cultures are no longer fit for purpose, as growing numbers of Australians require care shared across organisations, settings and care givers.

Care in the future will be, by necessity, increasingly patient and family centred, and leverage a growing awareness of the importance of patient engagement, continuity of care, digital access, and the under-recognition of social isolation and mental health as drivers in health care outcome.

A population-based governance model, which unites diverse organisations and professional groups around a single patient-focussed vision for local health need, is critically important to delivering the COAG reform agenda. It is also central to the universal health care system so valued by all Australians.

managing transition

The key to managing this transition lies in:

- Harnessing and coordinating the myriad players at the local level, in a new, shared patient-centred approach to delivering the best-possible health outcomes.
- Ensuring a governance framework and key performance indicators which facilitate this, including a shared commitment to relevant population-based funding and service redesign priorities, and efficient service delivery.
- Understanding that implementing such a model requires significant cultural change and new forms of clinical and executive leadership. This includes a commitment to working together to create a local health system that is accessible, high quality and contemporary in delivery.

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