World Health Care Networks
Pre conference policy-research roundtable 21.07.10
Meeting Summary

Attendees:
A list of attendees is provided at the end of this summary.

Purpose of meeting:

1. Discussion of international evidence and experience regarding primary heath care (PHC) networks and health reform from Canada, the USA, New Zealand, the UK and Australia
2. Sharing key lessons from different countries' experience of PHC reform
3. Identifying the research policy interface: where/how research can assist in the policy process – and current evidence gaps

1. International evidence and experience
Presentations/country overviews were provided as follows:

- Brenda Hefford* and Brian Evoy (Canada)
- Richard Bohmer (USA)
- Harry Pert* (New Zealand)
- Judith Smith (UK)
- Robert Wells* (Australia – General Practice Network focus)
- Rosemary Huxtable* (Australia - Commonwealth Government)

All five countries are at different points along the PHC reform process. Networks have been used variably within this process in each country and mean different things to different people in different countries.

Canada: (see also PowerPoint presentation attached) is just starting out with broader "networks" of GPs with their Divisions of family practice. This is evolving from a situation where, similar to other countries, GPs (or "family doctors") own their own practice and are paid by fee-for-service directly from the Government, but negotiate, each though their own Provincial medical association, their contract with government. Details about how this previously strained GP/Medical Association/health authority/government relationship is improving through more collaborative working, as well as benefits to care provision and outcomes is elaborated on in the presentation.

USA: Works more in business ecosystems including lifestyle coaches, online health (Google health) and the like. As such there is more of an "anti-network" in the USA which has, instead, a miasma of retail and commercial agencies filling health service gaps.

* The Powerpoint presentations provided by these speakers are attached. Where PowerPoint's were provided at the roundtable, few additional notes are provided here.

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As a result in the USA there is a move away from a continuous ongoing relationship with a primary care practitioner organisation. Commercial agencies in these business ecosystems tend to take the simple and easy to treat/manage groups. The danger is that as a result, PHC practitioners are/will be left underpaid to deal with the complex cases. The problem though is that we are not training the medical professionals coming through for this kind of environment.

New Zealand: (see also PowerPoint presentation attached) Reform has gone through several stages. The initial Independent Practitioner Associations (IPAs – GP member funded organisations which grew from the ground up) moved from a member support focus to management quality and clinical governance support then onto an organised care focus with the advent of primary Health Organisations (PHOs – top down government funded structures)

UK: Reform has also moved through a spectrum of phases. It has covered GP fund holding and GP commissioning (early 1990s) with a view to general practice becoming more collectivised – about 50% general practices were fund holders under this approach (which was voluntary). The UK then moved to primary Care Trusts (PCTs - similar to district health Boards [DHBs] in NZ, and to the state role in Australia). Under the Blair government (1997 – 2007) the focus in the UK became access and targets. A major result of this focus was significantly improved access to GP care (ie most UK patients can now see a GP on the same day instead of having a two week wait.) There is also more freedom of choice for consumers in the UK now regarding which GP they can see.

There has been further significant change on the provider side. Now the UK have GP federations. 20 – 30% of GPs are in groups/consortia for commissioning purposes. These consortia hold a "notional" budget and commission services for their given populations. The GP federations are similar to accountable care organisations in the USA. Ideally GP Federations:

- give patients better access to services with change being championed locally by GPs, rather than through 'one-size fits all' plans from central Government
- can attain 'economies of scale' they could not achieve individually, by sharing back-office functions and directly employing managers and nurses to provide new services.

A new White Paper was realised earlier in 2010 in the UK re GP fund holding. It has raised some concerns regarding the GP again having a purchaser-provider role.

Australia: (See also the two PowerPoint presentations attached from the General Practice Network and the Commonwealth Government Department of Health and Ageing). There has been an evolution since before the 1990s from "cottage industry" general practice, to divisions of general practice (support organisations – early 1990s) to the idea of PHC organisations which are more like PCTs/PHOs in the UK/NZ. (PHCOs are not yet implemented in Australia and their future is dependent to a degree on the outcomes of the upcoming Australian federal election)

2. Lessons and ideas arising from the country overviews on PHC reform

Financing/funding:

- Health reform (particularly in the USA – but also elsewhere) is really financing reform. The new PHC world in the USA may include some kind of bundling payments. Expect similar bundled "packages" of care payments may also form part of the Australian general practice/PHC reform

- Pay for performance (P4P) is another funding stream that has been introduced in some countries (egNZ, UK) but there are issues around P4P – because often it is restricted to paying for what we can measure. As this is seldom outcomes, P4P is often diluted to pay for participation.

Ideas around integration:

- It is time to abandon the artificial divide between primary and secondary care. In the end it is really about integrating care within the whole system and building the required system around that so that we can operate as a whole system.

- Maybe we need to look at how we integrate the care rather than integrating the system/structure. Elliott Fisher's work provides more detail on this approach.

Benefits of Networks:

- Networks able to manage resources more effectively so can be really useful mechanisms in reform processes from that perspective.

- A bottom up approach is important in reform. In New Zealand, GPs had to believe in the change in order to sell it to them. This bottom-up "buy-in" helped a lot with GP engagement and bringing GPs along during the transition. Clinical governance was a coincidental benefit of this process. It attained prominence without there being a specific focus on it. Networks can also be useful in promoting/facilitating a bottom-up approach.

Health professional roles in policy:

Another important part of policy (and associated research) is being able to distinguish where it is best for policy-makers to make decisions and where decisions are best left to health professionals. Bill English (NZ deputy PM) was good at this.

Doctors (and other health professionals) play an important part in policy especially around health system design. Ideally doctors' roles are:

- Occasional clinical provider
- Statesman
- Leader
- System design consultant
- Human rights advocate

3. Policy-research interface and evidence gaps

- Governments get confused between policy and management. Policy is too blunt an instrument to drive change in clinical practice/clinical management. Better questions and approaches are needed such as: What is the nature of the policy environment required to enable clinicians to do their best work? Asking a question like this would help in developing workable policies, instead of policy-on-the-run and the "muddling through" approach that we often see now. Researchers and policy makers together can also play a role in helping formulate the right questions.

- What research methodologies do we need to bring to the issues we're tackling currently in PHC systems? Multiple research methodologies are required. Workforce, consumer focus, the role of government in health service policy and change etc - all these factors need to be considered. Hence we need a multi-method approach to encompass the range of factors and timeframes that different sectors are working to.

- Another problem with policy research is that is we usually frame the question the wrong way. Instead of asking what do we need to make this work/get the system needed to make this work, we look at the resources we currently have and ask what's the best we can do with the current resources? This is where we can learn from organisations who run and evaluate innovations all the time as part of an ongoing Quality Improvement (QI) process.

Many of these companies also use rapid reviews and rapid appraisal methods as they too, like politicians, cannot wait 3+ years for research results. Not for profit academic centres in the USA have some application to this area and this type of approach. The flip side of this approach, however, is that it may be too idealistic. In reality, finite resources are available and governments are unlikely to go in for complete system overhauls. A more pragmatic approach is to determine how to get the best outcomes whatever the system/resources available and work with that. Further, in health care where ultimately system failures can be fatal, can we really take this approach – or does it fail to take into account sufficiently "the shroud of those who die"? Research-policy approaches in health care need to learn how to tackle this so that we can get the right balance between CQI approaches, system efficiencies and the consumer perspective.

- In terms of research in health care and health care policy we also need to move more towards pulling together the research and practice team – and supporting/promoting the role of the practice team in research (eg team based research that can feed into College guidelines etc.)

WHCN policy research roundtable attendees

Toni	Ashton (Co Chair)	AUS/NZ	A/Professor in Health Economics. Centre for Health Service Development, University of Wollongong.
Richard	Bohmer	USA	Professor of Management Practice. Harvard Business School.
Petra	Bywood	AUS	Research Manager. Primary Health Care Research and Information Service (PHC RIS)
Brian	Evoy	Canada	Executive Lead of Divisions of Family Practice. General Practice Services Committee (GPSC)
Brenda	Hefford	Canada	Physician Executive Lead for Primary Care Development. Fraser Health Authority
Rosemary	Huxtable	AUS	Deputy Secretary. Department of Health & Ageing (DoHA)
Libby	Kalucy	AUS	Director. PHCRIS
Marjan	Kliakovic	AUS	Professor/Director. Academic Unit of General Practice. Canberra.
Michael	Lamont	NZ	CEO. Mangere Community Health Trust.
Paul	McCormack	NZ	Independent Health Consultant
Russell	McGowan	AUS	Non-GP Board Member. Australian General Practice Network (AGPN)
Luccio	Naccarella	AUS	Policy Analyst and researcher. General Practice Victoria
Di	O'Halloran	AUS	Chair. Went West general practice Network.
Bev	O'Keefe	NZ	Executive Chair. General Practice New Zealand. (GPNZ)
Jim	Primrose	NZ	Chief Adviser. New Zealand Ministry of Health
Harry	Pert	NZ	President. Royal New Zealand College of General Practitioners (RNZCGP)
Judith	Smith	UK	Head of Policy. The Nuffield Trust
Fiona	Thomas	NZ	Deputy Executive Officer. GPNZ
Karen	Thomas	NZ	Chief Executive. RNZCGP
Les	Toop	NZ	Director. Pegasus Health
Bob	Wells	Aus	Director. Australian Primary Health Care Research Institute (APHCRI)
Liesel	Wett (Co Chair)	AUS	Deputy CEO. AGPN
Rachel	Yates	AUS	Director Policy. AGPN