



**AUSTRALIAN PRIMARY HEALTH CARE
RESEARCH INSTITUTE**

UNIVERSITY OF NEW SOUTH WALES

**APHCRI STREAM 7
TRAVELLING FELLOWSHIP REPORT**

Gawaine Powell Davies

March 2008

ACKNOWLEDGMENT

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.

Australian Primary Health Care Research Institute (APHCRI)
ANU College of Medicine and Health Sciences
Building 62, Cnr Mills and Eggleston Roads
The Australian National University
Canberra ACT 0200

T: +61 2 6125 0766
F: +61 2 6125 2254
E: aphcri@anu.edu.au
W: www.anu.edu.au/aphcri

UNSW Research Centre for Primary Health Care and Equity
University of NSW
NSW 2052

T: +61 2 9385-1547
F: +61 2 9385 1513
E : cphce@unsw.edu.au
W: www.cphce.unsw.edu.au

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INTRODUCTION

In 2005, the Australian Primary Health Care Research Institute commissioned a set of systematic reviews on issues of importance to Australian policy makers (Stream Four funding). The Centre for Primary Health Care and Equity was funded to review *Coordination of Care within primary health care and with other sectors*. In 2007 APHCRI funded a number of travelling fellowships (Stream Seven) to examine how the findings of these reviews applied in other health systems. This report describes the results of a travelling fellowship undertaken to investigate coordination of care in the Netherlands.

As requested in the contract, this report includes reflections on the linkage and exchange process for Stream four, details of the activities undertaken during the international visit and a comparison of the results of the Stream Four project, set in the international context.

REFLECTION ON THE LINKAGE AND EXCHANGE PROCESS

HOW DID THE LINKAGE AND EXCHANGE PROCESS WORK FOR THE SPOKE?

Although the Stream Four reviews were clearly intended to be relevant to policy and the *information for applicants for Stream Four* referred to 'interactions between researchers and policy advisers', the element of linkage and exchange was initially given less emphasis than in later funding streams. It evolved as the work developed, and our team found itself focusing more on the complexities of carrying out a systematic review within a limited time frame than on the interchange with policy advisers.

We undertook some limited consultations at the stage of conceptualising the issue, particularly with informants from other comparable countries, and held a consultation workshop at a primary health care conference. We also did a hurried but very useful consultation with bureaucrats late in the review which strongly influenced the synthesis of results. However we did not use the consultations as strategically as we would have wished, and found it difficult to time them to best advantage.

The Stream Four workshops were very effective for exchanging ideas with other researchers, but less useful for exchanges with Department staff. There are a number of reasons for this: there was a loss of continuity as different Department staff attended different workshops, and those who attended sometimes appeared to find it difficult to link researchers' presentations to their work. Researchers' presentations were of work in progress, and these tended to focus more on the methods of the review rather than findings or policy implications. The Department staff may not have found the research questions directly relevant to their work, and there may have been a mis-match between the very focused approach required for research and the broader sweep that public servants tend to deal with. Most of those who attended were involved in program implementation and management, while the lessons from the reviews may have been more useful to those working at a more strategic level. Finally, the fact that they

had no part in commissioning or shaping the reviews may have reduced their personal stake in the process¹.

However, there were some good elements to the linkage and exchange process. It was a useful discipline, reminding us that the reviews were intended to support policy, and that the results needed to be applied. Some of the input from those with whom we consulted was very valuable. The discussion of preliminary results with policy makers strongly influenced our synthesis of the results and presentation of the findings.

HOW COULD THE PROCESS HAVE BEEN IMPROVED?

Systematic reviews may not have been the most appropriate ways of addressing the questions on which Stream Four was based. The methodology encourages use of a relatively narrow range of literature, and tends to discourage use of evaluation and grey literature. A less systematic approach might encourage the use of a wider range of information and provide findings which more directly address the interests of policy makers.

This relates to the balance that Stream Four struck between academic activity with some application to policy and evidence based support for policy makers, with an appropriate stiffening of academic rigour. It may be that researchers and policy makers were seeking different resolutions of this creative tension, which could perhaps be usefully addressed early in another similar process. This discussion could have been the start of a structured process of reflection that monitored the differing needs and expectations of the different parties. Ideally this would start at the beginning of the program, continue throughout the process and be reviewed at the end.

It appeared difficult to engage staff from the Department in this work. As suggested earlier, it might have been advantageous to engage more senior staff with a stronger focus on strategy and policy development rather than implementation, to involve a mixed group representing different levels in the Department, with senior staff engaged at the start and the finish and others throughout.

Finally, there is not a strong culture supporting exchange between universities and the Department. Few people move between research and policy, and staff change jobs frequently in the Department, making it difficult to form lasting relationships or sustain capacity once it has been developed. Active support for staff to move between the two would be valuable, as is the use of those who have worked in both sectors as cultural interpreters.

WHAT ADDITIONAL STEPS COULD BE INCORPORATED IN SUBSEQUENT PROGRAMS?

The following steps might be incorporated into subsequent programs.

- Supporting a specific process of consultation between applicants and policy makers while submissions are being developed, and including policy makers or knowledgeable observers such as Robert Wells in any briefing sessions for potential applicants.

¹This contrasts with very productive discussions we had previously held with a policy advisor who had sought information relating to an immediate problem in his current work.

- Asking applicants to identify the specific parts of government or health services which would be interested in learning from the results, and providing some guidance for this.
- Building a carefully planned process of reflection into workshops, as suggested above.

HOW DID THE 1:3:25 REPORT APPROACH GO? HOW EFFECTIVE WAS IT?

This was a difficult format to adjust to, particularly as the project was so dominated by the complexities of the systematic review. The challenge in writing the report was to ensure that it focused on results and policy implications rather than being dominated by initial questions and methods. This was particularly acute for the one and three page summaries. However using the 1:3:25 format provided a very useful discipline.

This format is in becoming widely used. The danger that this will become a formula that is applied indiscriminately. Twenty five pages can be too short or too long to do justice to the research (although clever use of appendices can often get around the problem); a one paragraph summary may be more useful than a page. More critically, it is probably more important for researchers and policy makers to discuss the intention of the research and how it should be reported early in the research.

HOW ELSE COULD THE EVIDENCE BE MADE AVAILABLE TO RELEVANT AUDIENCES?

The results have been presented and used quite widely. They have been written up in a paper that has been accepted for publication and presented at three national conferences. They were the basis of a request to address a workshop at General Practice Victoria, to discuss government policy on primary health care with staff from the Minster's office. They have informed our thinking about the issue of coordination, and will influence our future research, in particular the evaluation of the HealthOne NSW program.

The results of the review are directly relevant to current developments in health services integration at regional level through the Council of Australian Governments program. There is scope for working with those who are designing and implementing the program to make sure that a system focussed approach is taken rather than a series of useful but disconnected initiatives. This may be best pursued at state/territory level, in association with state/territory health services and State Based Organisations for general practice.

There may also be opportunities for further developing the work at an academic level: the Commonwealth Fund has suggested that we apply for funds to develop and present the work further, and Professor Martin Roland from the National Primary Care Research and Development Centre in the UK has suggested involvement in a paper for Health Affairs, in association with an Anglo-American working group.

DETAILS OF ACTIVITIES UNDERTAKEN DURING THE INTERNATIONAL VISIT

The aims of the international visit were:

- to assess how the strategies identified in the systematic review fit with Dutch approaches to care coordination within primary health care;

- to compare Australian national policies and programs supporting coordination of care with those used in the Netherlands;
- to describe the ways in which research contributes to developments in policy and practice in the Netherlands, and in particular any systematic approaches taken by government, research and professional organisations (with an emphasis on primary health care);
- to articulate what Australia might learn from the Dutch experience in coordination of care and in linkage and exchange in this area;
- to identify opportunities for further collaboration with Dutch researchers.

The visit itself took place over a three week period between October 22nd and November 16th 2007, with a program largely devised by Professor Guus Schrijvers from the Julius Institute at the University of Utrecht. The first four days were spent as a guest member of the Faculty for a European Health Leaders' tour looking at health service integration in different countries: this provided an excellent introduction to the Dutch system and how it deals with health services integration, as well as comparisons with other European health services. The remaining time was spent in meetings with academics and policy makers, and in attending seminars. This provided a useful combination of perspectives, as well as the opportunity to hear issues being debated in public and academic forums. The program is attached as Appendix A.

A COMPARISON OF THE RESULTS FROM THE STREAM FOUR PROJECT SET WITHIN THE INTERNATIONAL CONTEXT

The Stream Four Four review identified the strategies used to coordinate care at patient and provider level, and assessed their effectiveness. Two main types of strategy were found: those relating to communication and individual support for service providers and patients, and those which involved providing systematic support for coordinating care. Details of the strategies are provided in Appendix 2. The former were more closely associated with improved patient satisfaction, the latter with improved health outcomes. The report identified opportunities for strengthening support for care coordination within the Australian health care system.

Health care in the Netherlands has many similarities to Australia: it serves a similar size population (16.5m in 2006), involves similar levels of expenditure (9.2% of GDP in 2005, compared to 9.5%), has a strong primary health care sector, based largely on private general practice, with other providers operating from a wide range of different provider organisations, mostly of which are private not for profit organisations. Unlike Australia, patients register with a particular general practitioner, who is paid a small capitation fee and then by fee for service. GPs act as gatekeepers to hospitals and specialist services, and provide medical care in nursing homes. Population satisfaction with core aspects of primary health care is generally higher than in Australia (Schoen 2007).

The Netherlands has a system that is funded through health insurance rather than direct government funding. Health insurance has long been virtually universal and closely regulated. It has supported relatively equitable access to services, and this is underpinned by the strong value placed on social solidarity and mutual responsibility. However the lack of

direct government funding leaves the government with a smaller direct role in health services than in Australia, although it is involved in monitoring and accrediting hospitals².

However major changes were introduced into the health insurance system in 2006 (Netherlands Ministry of Health Welfare and Sport 2005). These establish diagnosis and treatment related groups ('DBC's') as the basis for funding and allow insurance companies to compete on price, and to choose which health services they will cover with their insurance rather than cover all providers. At the same time, competition law forbids collusion between insurance companies or between service providers. This introduces a strong element of competition that was previously absent.

Proponents of the new arrangements hope that it will lead to increased efficiency and encourage better quality care as insurers set the terms for covering services from particular providers. They note the tentative emergence of 'chain DBC's' which cover comprehensive care for complex conditions from a number of different providers. Detractors believe that the restrictions on collusion will undermine collaboration and lead to greater fragmentation, reducing the quality of care as insurers compete for business on price rather than quality of care. They see the reforms as a shift towards a more market driven health system dominated by for profit rather than not for profit organisations. It is too early to tell the impact of these changes on the health system, but there were many signs of service providers and provider organisations preparing themselves for a more organised approach to service provision.

Coordination of care has long been seen as a problem in the Netherlands (Smeenk, de Witte et al. 2000). As in Australia, but unlike the United Kingdom, there is no single authority with responsibility for coordinating primary health care services, either locally or nationally. One response to the problem of fragmentation has been the development of programs of transmural care. Transmural care is comparable to shared care in Australia, brings together providers who agree to coordinate elements of care within a framework of shared procedures and standards. This has been supported by the development of an extensive range of standards for care, many focusing on the roles of different providers. Transmural programs have arisen from a variety of sources, some in primary care, some hospital and some supported from universities or other external organisations. In some cities service providers have pooled funds to set up organisations to establish transmural care programs: for example the Foundation for Transmural Care in the Hague.

More recently, the language of 'integrated care' and 'chain care' has been adopted. Although usage varies, 'integrated care' suggests stronger integration and more complete care than 'transmural care': for example, there are proposals for developing integrated child health services in Amsterdam. However much of the activity relating to developing 'integrated care' seems to be concerned with specifying the details of the care that is required rather than with developing the organisational infrastructure that allows the care to be provided across organisational boundaries³. The

² Indicators are currently being developed for coordinated care. These include the existence of agreed guidelines, written responsibilities, a single point for patient follow up and a single complaint authority.

³ This may in part reflect the very limited role of the government in health service provision. Funding for service providers comes largely through health insurance companies that, until recently, have had little incentive to influence the organisation of service delivery, and are provided in

terminology of 'chain care' has been adopted widely in Europe, and is used more generally to describe approaches to linking elements of care across providers. In the Netherlands it appears that this will become the language for care coordination for the purposes of health insurance, through the 'chain DBCs' (diagnosis and treatment groups).

Care coordination is supported in a number of ways.

In many places there are regional associations of health care providers who meet to support service development and coordination at local level. These are voluntary, usually without an external mandate, and so tend to operate rather like inter-agency groups in Australia. Their reach and impact varies, but some have long histories.

As noted, in some places service providers have pooled funding to establish organisations that will promote transmural or chain care across their organisations. This can include both vertical integration (between primary health care and hospitals) and horizontal integration (within primary health care). The Foundation for Transmural Care in the Hague had a staff of five, and programs in diabetes, dementia, bed sores and palliative care.

There are professional organisations devoted to promoting more integrated care: for example Sensor⁴. These tend to work through professional education and consultancy, and through seminars such as one on competition and cooperation that I attended in Utrecht.

Some 'integrated care' organisations have been set up that bring a range of health services into a single organisation. Two that I visited as part of the European Health Leaders' network were Almire, which brings together aged care, community health and general practice services, and Rivas, which includes hospital, aged care, community health and home care but not general practice. Both organisations had extensive systems for coordinating care and arrangements for comprehensive service development. These are private not-for-profit organisations which have identified an opportunity and developed a network of services that suits their local opportunities⁵. There is currently a move in Amsterdam to create integrated care organisations to provide health care for young people from 6 months to 16 years⁶. However current competition policy would probably make it impossible now to set up integrated care groups like Rivas.

Some entrepreneurial clinicians are setting up more integrated approaches to care, taking advantage of opportunities arising from the new health insurance arrangements. I met a GP who had left 26 years of solo practice to form a group practice, with nursing and allied health staff, and a residential aged care medical specialist⁷ who had formed a consortium to provide integrated health care under contract to residential aged care facilities.

fragmented, largely private and not-for-profit sectors where there is little capacity for coordinated development.

⁴ www.integratedcare.nl

⁵ However I was told that current competition policy would preclude setting up such organisations now.

⁶ Interestingly, there appeared to have been little thought about the dis-integrating effect of such organisations as they take young people's health care out of the context of family health care through general practice.

⁷ Medical care in residential aged care is a recognised specialty in the Netherlands

The Institute for Health Care Improvement (CBO) is developing guidelines for integrated or chain care

As noted above, some insurance companies are starting to contract with service providers for 'integrated care', particularly for people with chronic disease. It is too early to tell how service providers will respond in the relatively unstructured environment of health care, and in the face of strong competition laws⁸.

Some developments in integrated care have been funded as trials: for example the health research and development funding organisation Zon MW has funded trials of diabetes care and integrated chronic disease management.

There has been sustained support for integrated care from academic quarters, through champions such as Prof. Guus Schrijvers and the Integrated Care Network⁹.

LESSONS FROM THE VISIT

I drew a number of lessons from the visit relating to integration and care coordination in Australia.

The visit reinforced the view that 'all integration is local': that is, to deliver better coordination of care, integration needs to work at the practitioner/patient and service organisation levels. Here local history and context are important, and external solutions need to be adapted to local circumstances. This was born out by the very different approaches to service integration between the two integrated care organisations that I visited, each with its own strengths. It means that system reform alone is unlikely to achieve good care coordination, although it will provide the framework for developments at the patient/provider and organisational levels.

The fact that similar problems of service integration and care coordination arise in such a different system reinforces the view that these reflect problems inherent in providing consistent care over time within complex and specialised health services. This suggests that ongoing and significant investment is likely to be required to achieve good care coordination in the face of such difficulties, either at the patient level (through care coordination) or service level (through service development) or system level (through infrastructure development).

The Dutch experience highlights two issues which are also significant in Australia. One is the lack of infrastructure to support sharing of care – for example, shared health records, consistent assessments or standard referral forms. In both countries these limit opportunities for sharing care across providers and increase the cost and difficulty of doing so. The second is that there are frequently no clear lines of authority and responsibility for developing more coordinated systems of care and improving care coordination, particularly across different services and sectors. This has become evident in the Netherlands as services struggle to assemble groups that can develop programs of care that will meet the increasing demand for integrated care. Progress in these two areas would support the development of care coordination and coordinated service development.

⁸ One prediction was that many services would amalgamate to permit coordination within a larger organisation, which is permitted by law.

⁹ www.ijic.org

The changes to health insurance in the Netherlands appear likely to create powerful new incentives for improving efficiency and effectiveness of health services. This highlights the lack of such levers in Australia, where there is little incentive for quality (including well coordinated) care, either in fee for service medicine or in direct state funded services or through private health insurance. This raises the question of where the drivers for effective care coordination will come from in Australia, particularly as the schedule of incentive payments for general practice becomes increasingly complex. At the same time, Australia would do well to note anxiety in the Netherlands about destroying collegial and collaborative arrangements for health care, and take care to 'first do no harm'.

In the Netherlands, health service arrangements are underpinned by a strong set of values, based on solidarity and consensus decision making. Some expect that these will help maintain cooperation and coordination in the more competitive environment that is emerging. It is not clear that there is such a strong set of shared values underpinning the Australian health care system. It may be worth actively exploring and developing the values underlying Australian health care, to create a firm foundation for any future shift to a more competitive or market driven system.

As noted earlier, there appears sometimes to be a disjunct in the Netherlands between developing the specifications for integrated care and planning the organisational infrastructure that can deliver this. This fits the Dutch health system, where specifications can be promoted through a number of channels, including health insurance, consumer organisations and accreditation programs but where there is little direct external influence on service development. In Australia the role of the government as funder or provider of health services and the work of meso level organisations such as Divisions of General Practice make it easier to address issues of organisational infrastructure more directly. However specifications have their value, especially as the basis of performance indicators for monitoring coordination of care and health system performance.

APPENDIX 1: PROGRAM FOR STUDY TOUR

WEEK 1: European Health Executive's Program (EHEP) October 28 - November 4		
	MORNING	AFTERNOON
Sunday October 28		Arrival Biltstraat 196, Utrecht
Monday October 29	<u>Guus Schrijvers</u> : Welcome and introduction Tour of the hospital	Meeting with Viktoria Stein (Vienna) Meeting with International Journal of Integrated Care
Tuesday October 30		Orientation to EHEP Dinner at Indonesian Restaurant
Wednesday October 31	Ministry of Health, the Hague - Health Services Inspectorate - Health services research (ZON-MW)	Ministry of Health, The Hague - The role of patients
Thursday November 1	Site visit to RIVAS integrated care group in Gorkum	Site visit to Health Care group in Almere.
Friday November 2	EHEP summary discussion	EHEP summary discussion Dinner in Utrecht
WEEK 2: November 5 - November 11		
Monday November 5	<u>Mr Henk van Stel</u> , Julius Centre Integration in child health services	<u>Ms Els de Bruin</u> , Project secretary, Diabetes & Integrated Care, ZonMW, The Hague
Tuesday November 6	<u>Mr Jaap Trappenburg</u> , Julius Centre Integrated COPD care	<u>Mr John Verhoef</u> , Leiden University Medical Center (LUMC). Integrated care for rheumatoid arthritis
Wednesday November 7	<u>Mia van Leeuwen</u> , Foundation for transmural care in The Hague and specialised in management of Health Care,	
Thursday November 8	<u>Ms Mascha Berk</u> , Julius centre. The role of consumers	Seminar on competition in health services, Utrecht
Friday November 9	<u>Ms Nathalie Urbanus</u> , Julius centre Integrated child health care	<u>Mr Leo Kliphuis</u> , Director of Public Health, Ministry of Health. The Hague
WEEK 3: November 12- November 18		
Monday November 12	<u>Dr. Ravensberg</u> , ZON-MW and colleagues Health services research and dissemination of findings	
Tuesday November 13	<u>Prof. Guus Schrijvers</u> Final meeting	
Wednesday November 14		<u>Prof. David Hunter</u> : Lecture on public health, Utrecht
Thursday November 15	<u>Dr Robert Vereij</u> , <u>Dionne Kringos</u> . Nivel: Primary health care research	<u>Tjitske Binkhorst</u> CBO (Institute for Health Care Improvement): developing standards
Friday November 16	Seminar on innovations in primary health care, Julius Institute, Utrecht	Travel to Amsterdam to return to Australia

	Medical Centre	
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APPENDIX 2: STRATEGIES FOR COORDINATING CARE IDENTIFIED IN THE REVIEW

Strategy/strategy type
<i>Communication between service providers</i>
Case conference involving PHC
Other communication within PHC/between PHC and other providers
<i>Systems to support the coordination of care</i>
Shared care plan used by PHC clinicians
Decision support shared by PHC clinicians and other clinicians
Pro formas used by PHC clinicians
Patient held record used for PHC care
Information or communication systems used by PHC clinicians
Shared records used by PHC clinicians
Register of patients used to support PHC
<i>Coordinating service provision</i>
PHC consultations coordinated with those from other providers in/outside PHC, including joint consultations
Shared assessment
Priority access to a health service
<i>Support for service providers</i>
Support/supervision for PHC clinicians
Joint training/training on collaboration involving PHC
Reminders for PHC clinicians
Facilitating communication
<i>Relationships between service providers</i>
Co-location between PHC and other service providers
Case management
Multi disciplinary team (MDT) involving PHC
Assigning a patient to a particular PHC provider
<i>Support for patients</i>
Joint patient education/relating to sharing care involving PHC
Reminders for taking part in PHC care
Assistance for patients for in accessing care from PHC
<i>Joint planning, funding and/or management</i>
Joint funding including a PHC provider/service
Joint management involving PHC provider/service
Joint planning involving PHC provider/service
<i>Organisational agreements</i>
Formal agreement involving PHC organisation
<i>The organization of the health care system</i>
Change to funding arrangements impacting on PHC

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