"DHB-PHO alliances – making them work"

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SHIFTING CARE CLOSER TO HOME: HOW DO WE TRANSFORM?
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The topic of the session is "making alliances work" but it is worth taking a little time to ponder just what is an alliance and what is the work we want it to do.

The health sector's adoption of alliancing through the 'Better Sooner More Convenient' initiative in 2010 signalled the Ministry of Health's support for a collective approach to addressing the challenges of integrating health services. At the time it was stated that "the Ministry's overall goal in using alliances is to promote clinical leadership in the health system, with aligned clinical and financial accountability and supporting clinically led decision making"[1]. Alliancing required an approach:

- That accommodates the DHB's dual roles as an alliance partner and as the statutory body obliged to deliver health and disability services;
- That recognises that the district alliances are positioned within a complex system involving multiple organisations and professions; and
- That is sufficiently flexible for districts to change their alliance's scope and establish new service groups in response to the unique needs of their populations.

Carolyn and Tom Love did the policy work to design a vehicle to support the "Better, Sooner, More Convenient" business case process. There were 9 alliances established in 2010.

These alliances are an application of the general concept of "collective impact" in the relevant literature. The best-known name associated with this literature is Elinor Ostrom, who won a Nobel Prize in economics for a lifetime of research and theoretical work around voluntary arrangements aimed at achieving a common goal and/or managing a common resource such as water.

Under collective impact arrangements multiple parties engage together to provide services that integrate their separate contributions into an integrated service that creates synergy between providers aimed at better outcomes for those receiving the services. Such arrangements can take many different forms. They can be captured in formal contracts, incorporated entities or be informal agreements between people to work together on common goals.

The literature shows an enormous variety of applications of collective impact designs and case studies. There is no blueprint but there are numerous checklists drawn from the

[1] Love, Ehrennberg, and Esplin (2014, p.3)

literature on the conditions that are associated with success. From Ostrom's research she drew up a list of features of collective impact practices associated with success.[2] The Stanford Social Investment literature has similar insights boiled down to five criteria for success, while in health there are lists of critical success factors in the work of the King's Fund.

Thus, the topic of this session "making alliances work" comes down to applying these and other insights to being successful in creating an arrangement which brings together multiple parties, organising them to integrate their services into a bundle that from the point of view of the recipient is seamless, appropriate and successful in meeting performance requirements for the combined service, rather than its individual components. And amongst those performance requirements will be the topic of this conference, which is to bring services "closer to home".

A lot of the work that was done in the name of social investment in recent years is relevant to the design and functioning of alliances in health. There is not time here to elaborate, but anyone interested might look at the paper on Governance of Social Investment produced by a committee which Carolyn and I were on in 2016 and explores how social services can be delivered through decentralised collective impact vehicles, while still providing for formal accountability back to the government and the parliament.

The essence of integrated service delivery is to get the collection of service providers, which necessarily have strong vertical lines of accountability and control, to enter collaborative relationships that are necessarily horizontal and have potentially competing lines of accountability. This is an essential conclusion of the recent Productivity Commission report on social services, which identified the proliferation of central government contracts for narrow lines of service as inimical to collective interest arrangements

While service integration and social investment is relatively new in some areas of social policy there is nothing new about it in health, where the integration of services has been a subject of interest for decades. The Canterbury Clinical Network, which is in effect an alliance, was in place years before the term came into use. And while there are numerous examples of integrated health services in New Zealand, overall it has been a rather dreary story of isolated areas of progress brought about by local leadership that did not diffuse through the system.

Why has it been so hard? The structures have not helped, but no structure will ensure better integration. The checklist of success factors is not dependent on structures although, that said, if you wanted to drive the integration of primary, secondary and community care your first choice of structure would not be what we have today. 20 District health boards in the country with our population strikes most outside observers as distinctly odd and is surely a source of difficulty in getting the system to promote better integrated services.

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[2] www.onthecommons.org/magazine/elinor-ostroms-8-principles-managing-commmons
Collective Impact, By John Kania & Mark Kramer, Stanford Social Innovation Review, Winter 2011

Funding systems have not helped the cause of integrated health care either. By abolishing the Health Funding Authority, the government surrendered powerful means of influence over the system as a whole. Population based funding offers little assistance to the cause of integration and is tolerant of parochial and provider driven interests.

It is essential to design an overall architecture which facilitates alliances and collective impact arrangements more widely. The so-called Integrated Performance and Incentive Framework – or IPIF for short - was one such attempt. It not only focused on integration of primary and secondary care but included space for NGOs, private and community providers, other social services and the citizens themselves within the alliances at the conceptual level. Systemwide outcome goals were to be established and contributory performance indicators developed by clinicians through which to assess contributions to achieving the wider goals. These contributory indicators were developed and are in operation today, although most other aspects of the architecture were blocked from further development by the ministry backed by ministerial indifference.

No doubt there are other potential architectures, which can promote better outcomes through service integration, but experience shows that none of these are simple and all will require sophisticated policy analysis, successful engagement through the health sector, new capabilities and skilful change management. This is not just at the centre but throughout the health services system. Experience shows that these arrangements grow incrementally and reflect local conditions. While Canterbury has done exceptionally well in building its model, other areas of the country are on different paths and trying different things in different circumstances and with different priorities. This is as it should be. The Health Care Homes in Wellington seem promising, while Axford Scholar Amy Downs' recent criticism of the PHO system[3] sees the Midland network as an exemplar of quite a different kind. The Canterbury clinical network is expanding to cover more of the South Island while Auckland, as is commonly the case, will need to develop its own unique responses. The bulk of the action will not be at the centre but around the country, which is the way integrated care has largely developed.

For those at the centre working with alliances will present challenges to the way they do their business. They will need to give effect to new systems of vertical accountability for policy and funding that promote innovation in service design and delivery closer to the citizens. This means that public officials will need to participate in collaborative arrangements over which they do not have complete control of funding and accountability. The Treasury has developed some models for doing this that are included in the paper on the governance of social investment. But they have yet to be put into practice

New Zealand's experience in better integrated health care and outcome focused delivery systems shares much in common with other countries, especially the United Kingdom. The international evidence is that service integration is not easy and the arrangements are vulnerable to changes in leadership and other circumstances. However the evidence is also

[3] http://www.fulbright.org.nz/wp-content/uploads/2017/09/DOWNS-From-Theory-to-Practice-The-Promise-of-Primary-Care-in-New-Zealand-.pdf

that these approaches to better healthcare can produce better results. And I would add that with the necessity for us to find new systems for engaging with and delivering services to people in the long tails of disadvantage these approaches are essential, as the Productivity Commission report emphasised.

With the changing of leadership in the cabinet and the ministry I will conclude by emphasising how crucial it is for making these system changes to have a Minister and a Director General for whom this is a top priority. This has not generally been the case in the past. [4]

[4] For a well-researched view of this point, Amy Downs observes that "However, these innovations to expand access to primary care have been driven more by the vision of local health care leaders as opposed to health policies championed by the government. Because of this, institutionalising reforms can be challenging."