# What should governance for integrated care look like? New Zealand's alliances provide some pointers

## Multidisciplinary leadership teams and flexible approaches are helping streamline New Zealand's health care system

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doi: 10.5694/mja14.00658

While the search continues for governance arrangements that support health system and service integration,[1,2] developments in New Zealand provide useful new insights. New Zealand presently has 20 district health boards (DHBs) planning and funding regional hospital and other services, and around 30 primary health organisations (PHOs) that plan and fund elements of general practice and primary care for enrolled patients. These two sets of arrangements have functioned largely separately from one another, despite DHBs funding PHOs and both having common populations.[3] New Zealand's policymakers and health care providers have concluded that it is no longer acceptable nor sustainable to operate a health system with parallel structures that lack coordination or a governance model that supports this.

In response, from mid 2013, New Zealand moved to implement a governance model across the entire country, aimed at integration by requiring an alliance between each DHB and corresponding PHOs. This followed investment in 2010 in nine pilots. The alliance concept derives from the construction industry, where independent companies collaborate, rather than compete, to ensure that large, complex projects are delivered on time and within budget. While the health alliances are forced by policy, they are an example of an experimental governance model[4] that, evaluations of the pilots suggest, provide considerable promise.[5] For example, alliances have helped drive important new initiatives that provide better support for complex patients in primary care settings by enabling general practitioners to work together with hospital specialists and other providers. While early days, there is some evidence of reductions in emergency department admissions and of more services traditionally provided in hospital settings being delivered in the community, such as specialist outpatient consultations, older people's health, and emergency response services that might otherwise require a hospital visit. Importantly, those involved in alliances believe it is a model that helps steer health system and service design in an important new direction.[5,6]

Some important factors underpin the alliances. Members should

- be clinical leaders from across the health system, with influence and respect among colleagues;
- have capacity to bring resources to the alliance table so decisions can be implemented; and
- very importantly, cast aside sectoral interests, work to assist one another, and take a whole-of-system approach to planning and decision making based on what is best for the patient and health system.

Alliance goals variously include shifting services from hospitals to primary care or creating new arrangements combining elements of both service domains to, for example, reduce avoidable hospitalisation or improve chronic condition management. The key, as noted, is to focus on and work towards what makes best sense in the context of integration to the players in the local health system.

All DHBs now have an alliance leadership team (ALT), membership of which is determined by the DHB and PHO and evolves as an ALT sees fit. Members are likely to include doctors, nurses, allied health professionals, others from hospital and primary care settings, and those with resources, such as the chief executives of the DHB and respective PHOs and consumer representatives. Each member signs a charter spelling out the rules of engagement and focus of the ALT, which then sets local priorities and plans how these will be met.

There is flexibility for how an alliance goes about its activities. Many ALTs are focused on developing service-level alliance teams (SLATs). These are work streams that include, again, a combination of clinical leaders and management. The Southern Health Alliance Leadership Team, of which I am Independent Chair, has chosen initially to create SLATs for acute service demand management; outpatient services; diagnostics; rural health; community and hospital pharmaceuticals; frail older people; and respiratory conditions. To illustrate how a SLAT functions, initial respiratory SLAT work involved a workshop including hospital emergency department and respiratory physicians, GPs, nurses and ambulance services. Resulting actions include identifying frequently hospitalised patients, providing nurse-led care plans for them and ensuring that the patient's GP and, where necessary, hospital services are involved in this, and developing primary care-based options for ambulance services. Development of web-based clinical pathways aimed at integration, involving health professionals from the primary and hospital sectors, is also governed by the ALT.

In the Canterbury region, where alliance development is more established, dozens of people from different parts of the health system are involved. With care design decided on advice of a SLAT, it is then up to the ALT and its member organisations to pool or shift resources to support new configurations. This process is being propelled by new flexible funding arrangements, whereby the PHO can use existing ring-fenced allocations in new ways as decided by the ALT. The DHB is expected to contribute to this pool which will grow with time, along with the level of joint risk sharing, as an alliance work program advances.

How alliance performance will be measured is an important question that the government is tackling. An impending

Online first 21/07/14

Integrated Performance and Incentive Framework incorporates a range of system-wide measures, including patient experiences with the system, requiring an effective alliance and integration in order to perform well.[7]

Like Australia and other countries, New Zealand's public hospitals and GPs work with quite different incentives and business models.[8] Yet, alliances have provided a powerful method of bringing health professionals together from different parts of the system and motivating them to work collaboratively on what services should look like from a patient and clinical perspective. Given their relatively embryonic state, the challenge now is to monitor closely how the alliances perform over time and consider lessons for policymakers elsewhere.

**Competing interests:** No relevant disclosures.

**Provenance:** Commissioned; externally peer reviewed.

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