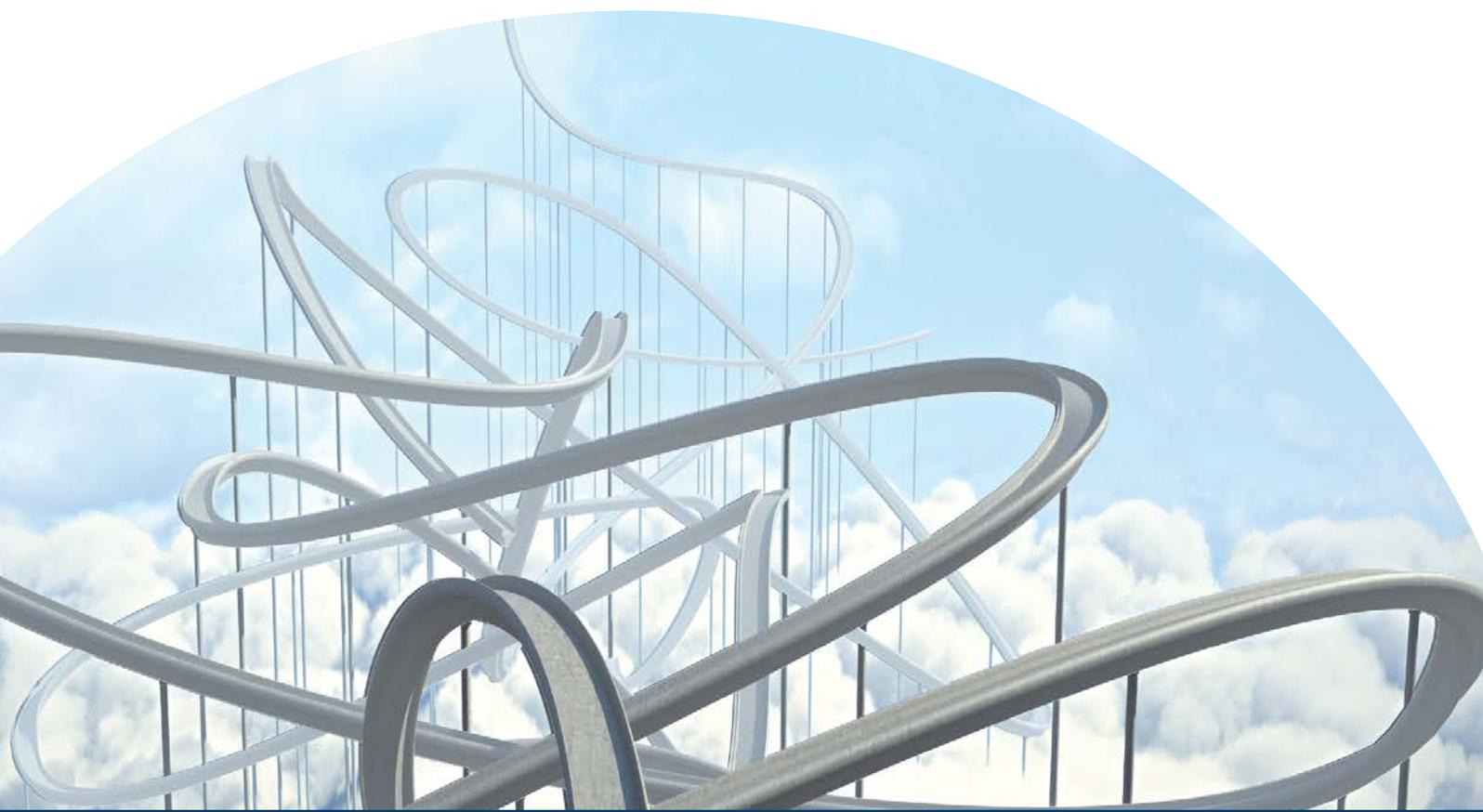




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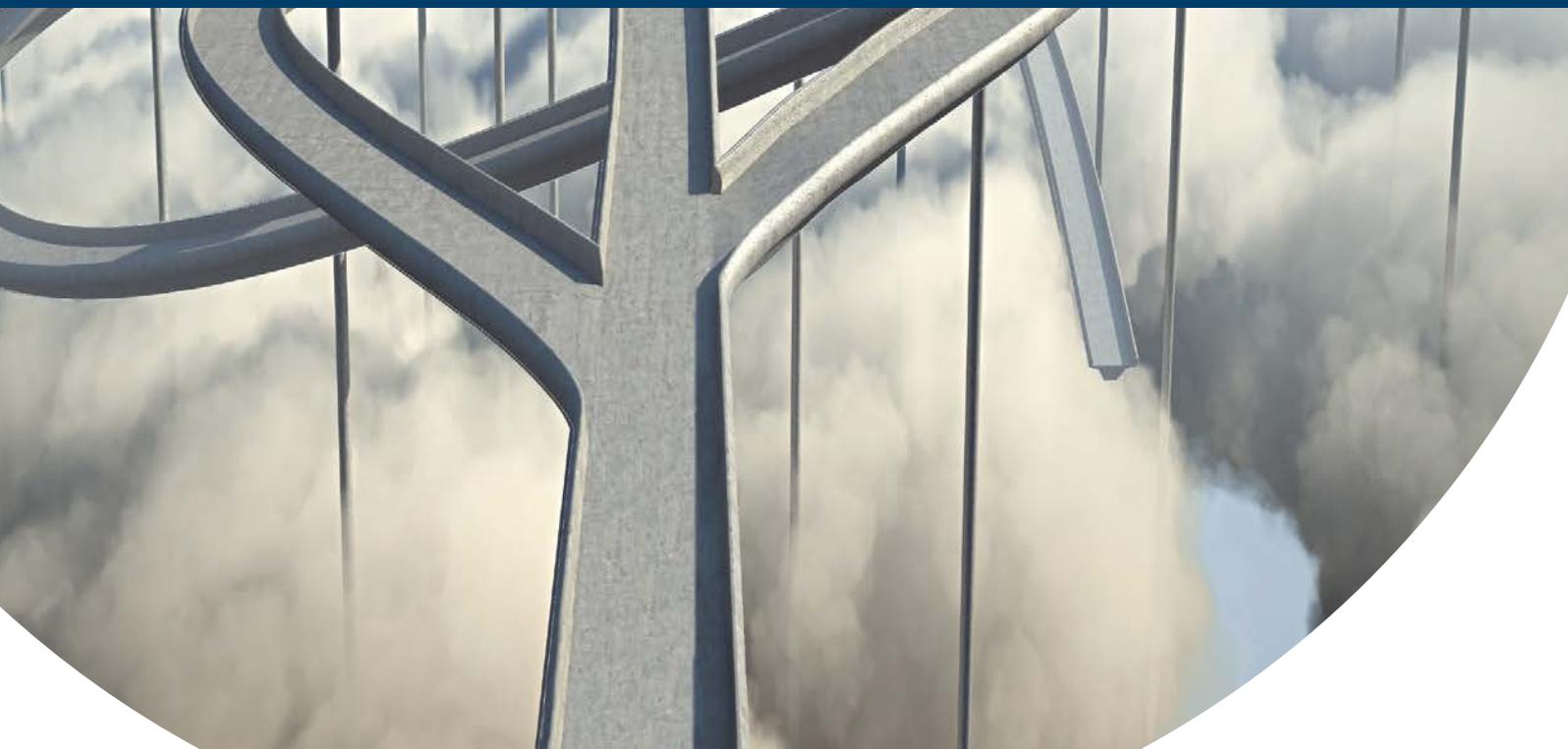
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An Australian Government Initiative



AUSTRALIAN HEALTH CARE REFORM: CHALLENGES, OPPORTUNITIES AND THE ROLE OF PHNs

FEBRUARY 2016



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MPCN acknowledges the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

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Health system reform – where to from here?

Australia's health system is one of the best performing in the world. However, the system evolved in the 19th and early 20th century to provide episodic care for infections and injuries, and the nature of health care need has changed significantly over time. Approximately 85 per cent of the burden of disease and 85 per cent of overall health care costs in Australia are now attributable to chronic conditions¹ resulting in vastly different demands and pressures on the health system than a century ago.

The current system is particularly poorly equipped to:

- deal with mental health as a leading chronic disease and comorbidity, the effects of which cost the Australian economy up to \$40 billion a year in direct and indirect costs and lost productivity;² and
- provide equity for vulnerable minority groups such as Aboriginal and Torres Strait Islander Australians, culturally and linguistically diverse populations, and people living in rural and remote Australia. These communities are affected by disproportionately high levels of chronic disease and poorer overall health.³

The rise of chronic disease, caring for an ageing population, and the cost of new medical treatments and technologies are driving increases in the cost of health care in Australia at a rate higher than the increases in Gross Domestic Product (GDP).⁴ The average annual growth rate in health expenditure has been five per cent between 2003-04 to 2013-14, compared with 2.84 per cent for GDP.

Despite increasing costs and government expenditure, the care that is provided is not always achieving the outcomes the community expects. Less than one third of general practice patients with high blood pressure attain satisfactory control,^{5,6} while less than half of those living with diabetes achieve recommended levels of blood pressure, blood sugar and cholesterol control.⁷

A key challenge for the health system is to close the gap between evidence based practice and the real world health system in a sustainable way. However, there are a number of structural and funding based barriers which prevent that from occurring, including the ongoing challenges posed by the Commonwealth Government funding primary and community care and the states and territories funding acute care.

The Australian health landscape is therefore ripe for reform. Current moves by government to address these challenges include, but are not limited to:

- the Australian Government's Medical Benefits Schedule Review;
- various iterations of primary health care reform, most recently the establishment of Primary Health Networks (PHNs);
- the work of the Primary Health Care Advisory Group;
- the Reform of the Federation White Paper;
- the National Review of Mental Health Programmes and Services; and
- the Review of the Personally Controlled Electronic Health Record.

Internationally, other health systems are grappling with the same or similar challenges, and there are many opportunities to learn from experiences in the United Kingdom (UK), New Zealand (NZ) and the United States of America (USA).

At the same time, private health insurers are also exploring ways to reduce their costs, and may offer insights into innovative approaches that are being implemented for their members.

This paper explores some of the key challenges facing the Australian health care system, and some of the opportunities which are particularly relevant to the remit of PHNs.

1 AIHW (2014). Australia's health (2014). Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

2 Australian Government (2015). Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response

3 AIHW (2014). Australia's health (2014). Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

4 AIHW (2015). Health expenditure Australia 2013-14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

5 Huang, N., M. Daddo et al (2009). "Heart Health-CHD Management Gaps in General Practice." Australian Family Physician 38(4): 241.

6 National Heart Foundation of Australia (2010). Improving cardiovascular outcomes in general practice.

7 Wan, Harris, et al (2006). Quality of diabetes care and coronary heart disease absolute risk in patients with type 2 diabetes mellitus in Australian general practice. Quality and Safety in Health Care 15(2): 131-135.

The challenges

Funding and incentives

Payments for health care in Australia are largely based on a “fee for service” model which involves paying a provider for an episode of care.

The Commonwealth Government spent approximately \$5.7 billion in 2014-15 through the Medicare Benefits Schedule on general practice services and programs to provide access to primary health care.⁸ There is very limited opportunity to use MBS to support access to allied health and alternate providers such as nurse practitioners.

The vast majority of Medicare funding is linked to individual patient consultations, with only around five per cent of general practice payments being associated with specific actions or processes of care, through the Practice Incentive Payments (PIPs) and Service Incentive Payments (SIPs).⁹ There is some evidence that these incentive payments are associated with changed clinician behaviour, but it is unclear whether this translates to improved outcomes for patients.¹⁰

Funding of hospital services is also predominantly based on activity, which fails to provide a financial imperative to plan and deliver services that align to community need, demonstrate improved patient outcomes or integrate care across settings. Similarly, out of hospital specialist care is funded through Medicare on a fee for service basis, which does not incentivise coordination of care or multidisciplinary approaches.

Outside of the primary and acute sectors, primary and secondary prevention programs delivered in the community setting are often funded on a historical basis and may not necessarily be:

- delivering evidence-based models;
- effectively targeting their services to reach those most at need; or
- demonstrating value for money.

Disease management

Disease management programs are designed to improve the health of persons with chronic conditions and to reduce health care service use and costs associated with potentially avoidable complications, leading to emergency department attendances and hospital admissions.¹¹

Existing Australian disease management programs, such as New South Wales (NSW) Health’s chronic disease management program and the Victorian Government’s Health Independence Program, tend to target a subgroup of patients at high risk of hospitalisation based on past experience, chronic conditions, and other risk factors¹² Other hospital based programs target locations, diseases or specific population sub-groups.

A consistent, evidence based approach to disease management, and coordination of existing programs to promote population level health improvements is lacking, and represents a lost opportunity in terms of achieving an efficient and effective response to chronic disease.

Effective disease management programs take a population based approach and stratify the intensity of their interventions by patients’ risk of illness and hospitalisation. For example, Kaiser Permanente automatically enrolls patients with chronic conditions in a disease management program which proactively engages patients to achieve health outcomes and tracks program costs to drive efficiency and value for money.¹³

Given the rising prevalence of complex patients with multimorbidity, it is also important to develop models which are flexible and patient-centric rather than highly specified or disease focused.

8 Australian Government Department of Human Services (2015). <http://medicarestatistics.humanservices.gov.au/>

9 Willcox, S., G. Lewis and S. Burgers (2011). Strengthening Primary Care: Recent Reforms and Achievements in Australia, England, and the Netherlands. New York City, The Commonwealth Fund.

10 Urbis Public Policy (2014). Literature Review - General Practice Accreditation Report. Prepared for the Australian Commission on Safety and Quality in Health Care

11 Bodenheimer, T. (1999). Disease management—promises and pitfalls. *New England Journal of Medicine* 340(15): 1202-1205.

12 NSW Government Department of Health (2015). “Chronic Disease Management Program.” from www.health.nsw.gov.au/cdm

13 Kaiser Permanente (2010). Kaiser Permanente’s programs focusing on chronic and high-cost conditions.

Pressure on the acute sector

Preventable hospitalisations are costly, expose patients to unnecessary risks and are very often not in line with patient desires regarding their health care. There were more than 600,000 potentially preventable hospitalisations in Australia in 2013-14, accounting for 6.2 per cent of all hospital admissions.¹⁴

The Australian Institute for Health and Welfare (AIHW) reports that Victoria has rates of potentially preventable hospitalisations which are comparable to the Australian average, and that chronic disease is a key contributor (refer Figure 1 below).

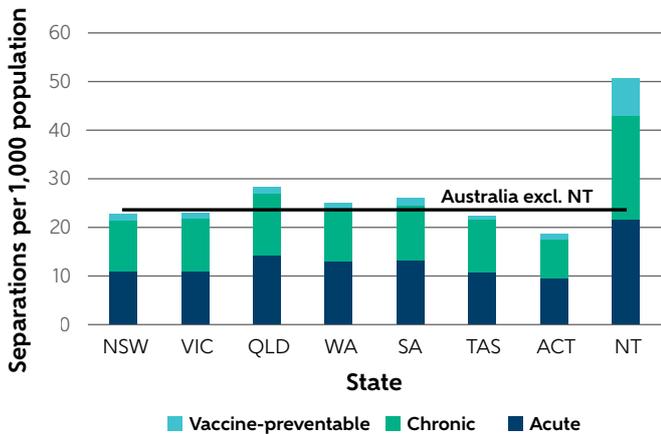


Figure 1: Potentially preventable hospitalisations in Australia 2013-14.¹⁵

In northwestern Melbourne, the key chronic conditions of Chronic Obstructive Pulmonary Disease (COPD), cardiac failure, iron deficiency anaemia and diabetes contribute to 74 percent of all potentially preventable hospitalisations (PPHs) (refer Figure 2 below).

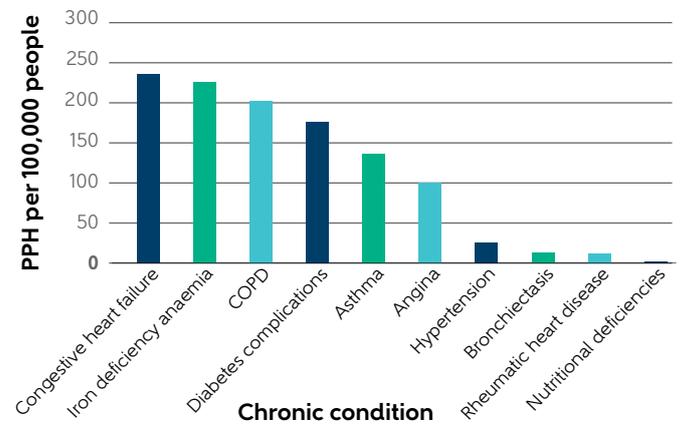


Figure 2: Potential preventable hospitalisations in the North Western Melbourne PHN region 2013-14.^{16,17}

As pressure on hospital beds has increased, health services around the world have sought to understand patterns of hospital admission and opportunities to prevent at-risk patients from deteriorating health and inappropriate presentation at hospital.

Studies of hospital admissions have found a significant proportion of hospitalisations could be prevented through more timely access and more appropriate provision of primary and community based health care.¹⁸

Chronic disease complications are a common cause of preventable hospitalisation, and strongly associated with suboptimal access to primary health care. Programs most likely to have an impact on reducing preventable hospitalisations are those that focus on chronic disease, and include: early intervention; care coordination and multidisciplinary approaches; and the promotion of equity and access.¹⁹

Preventing avoidable hospitalisations requires a strong system level focus on coordinated and integrated primary health care, which can reduce demand on hospitals and overall costs.

14 AIHW (2015). Admitted patient care 2013-14: Australian hospital statistics. Health services series no. 60. Cat. no. HSE 156. Canberra: AIHW.

15 AIHW (2015). Admitted patient care 2013-14: Australian hospital statistics. Health services series no. 60. Cat. no. HSE 156. Canberra: AIHW.

16 Adapted from data National Health Performance Authority (2015). Healthy Communities: Potentially preventable hospitalisations in 2013-14.

17 Potentially Preventable Hospitalisations per 100,000 people (age-standardised).

18 Primary Health Care Research and Information Service (2012). Potentially avoidable hospitalisations in Australia: Causes for hospitalisations and primary health care interventions.

19 Ibid.

Data and insight

A large amount of health data are routinely collected by governments and providers in the ordinary course of health service delivery, reporting on national health priorities, and notification of priority health concerns. The data represent a rich source of information about the health experiences of Australians across community and acute settings over time, but have not been routinely used to analyse the outcomes and experience of care, often due to institutional barriers and privacy concerns.²⁰

However, many health systems do routinely use and analyse rich data sets to improve patient care. Primary care providers in both the UK and the USA report on a large set of clinical indicators relating to evidence-based care.

The USA's National Committee for Quality Assurance (NCQA) has developed the Healthcare Effectiveness Data and Information Set (HEDIS) which is used by more than 90 per cent of American health payers. The HEDIS data set measures more than 80 clinical indicators of quality, encompassing both process measures (such as recording blood pressure) and outcome measures (achieving good blood pressure management).²¹

The UK's Quality and Outcomes Framework (QOF) is a voluntary program through which general practices can enrol to report against over 80 clinical indicators that are linked to incentive payments. Around 7,779 practices (almost 99 per cent) reported data in 2014-15. The collection of this data set, and the associated incentives for achievement, provides a nationally consistent way to enhance quality of care and standardise the delivery of primary health care.

The lack of routinely collected health data to support health care providers and researchers to improve chronic disease prevention and care is a limitation of the Australian health system.²² Both the UK QOF and USA HEDIS data sets are used to drive improvements in the quality of care, target improvements in population health, and monitor performance of health care providers.

Primary health care data from general practice are not routinely or systematically analysed. Existing programs, such as the Australian Primary Care Collaboratives Programme²³, demonstrate how the collection, analysis and reporting of clinical data can drive improvement, but such programs are limited in scope and operate on an opt-in model.

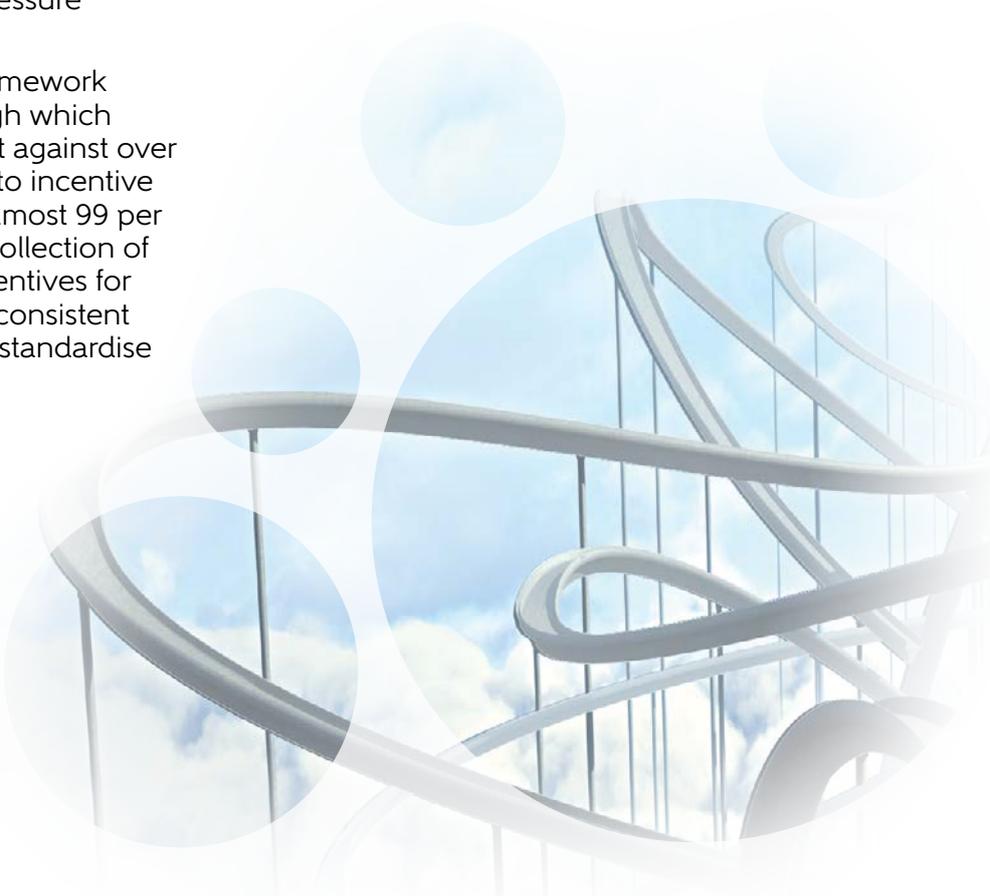
Australia's lack of consistent routine data collection and analysis creates a gap in understanding local health needs and services. Closing this gap requires establishment of a primary health minimum data set, and routine collection, analysis and feedback of performance data to funders, providers and communities to support best practice and well targeted health interventions.

20 Jorm, L. (2015). Routinely collected data as a strategic resource for research: priorities for methods and workforce. *Public health research and practice* 25(4).

21 National Committee for Quality Assurance (2015). *HEDIS 2015 measures*. Washington, D.C.

22 Jorm, L. (2015). Routinely collected data as a strategic resource for research: priorities for methods and workforce. *Public health research and practice* 25(4).

23 Australian Government Department of Health. (2015). Australian Primary Care Collaboratives Programme (APCCP) from www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programs-apccp-index.htm



The options and opportunities

While much can be written about the challenges facing the Australian health care system, it is more important that the possibilities and opportunities to achieve change are examined and understood. In thinking about the possibilities for the primary care system, it is useful to think about those relevant to governance and financing, consumers, health professionals and systems and processes (refer Figure 3: Primary care model elements (McKinsey & Company). below).

These four key components do not operate in isolation, but are synergistic in increasing value to the payer and consumer in delivering improved outcomes and efficiencies. The mix of interventions required for a health care system (or a PHN) will vary based on the specific needs of the community and providers.

This section focuses on opportunities including potential funding mechanism opportunities such as flexible and blended payment models, risk stratification (consumer segmentation) and medical home models. Consideration of integrated care and needs based commissioning approaches are also included as these solutions are closely aligned with the key remit of PHNs.

Figure 3: Primary care model elements (McKinsey & Company)²⁴



²⁴ McKinsey & Company (2015). Improving Primary Care.

Re-thinking health funding and incentives

While fee for service and activity based funding models can be effective in driving efficiency at a unit cost level, these models are less suited to driving efficiency at a system level.

Many health systems use blended payments consisting of a mix of fee for service and incentive (or pay for performance) models to drive desired behaviours and models of care, or particular health outcomes, such as well controlled blood pressure, cholesterol and blood sugar levels in patients with diabetes.²⁵

Compared with the UK, where performance based payments to general practitioners comprise approximately 25 per cent of GP payments, Australian general practice incentive payments (PIPs and SIPs) comprise only about 5 per cent of total payments to general practitioners.²⁶

Commonwealth and state governments are beginning to explore innovative funding models which seek to break down traditional barriers to improved care and provide a patient centric approach to funding and service delivery - one such example is the Victorian HealthLinks program.

HealthLinks aims to enable more proactive care for patients with chronic, complex conditions to prevent unnecessary hospitalisation and improve patient outcomes. It does this by allowing more flexible use of existing funding sources to treat chronic conditions and their complications. The goal is to remove the financial barrier of episodic health care funding to enable health care providers to provide more effective and timely chronic disease care.²⁷

Evidence from the implementation of blended payment models from the UK and the US suggests that gradual introduction of blended payment schemes, strong leadership and clinician engagement, and support for evaluation and evolution of blended payments are key elements of success.²⁸

Risk stratified care

Risk-stratification provides a mechanism to understand different patient groups and respond with an appropriate and targeted level of care to reduce their primary and secondary risks, and minimise disease progression. Risk stratification can consider both the presence and state of disease, and social issues which can greatly impact on an individual's capacity to effectively manage their health (refer to Figure 4 below).

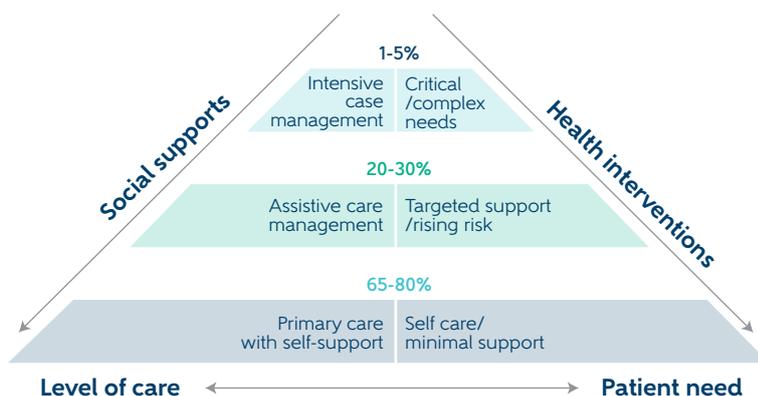


Figure 4: The risk stratification and response triangle.

Risk stratification approaches can facilitate population level interventions which are targeted and appropriate, and therefore efficient and affordable.

25 Health Affairs (2012). Pay-for-performance. Washington, D.C.

26 Willcox, S., G. Lewis and S. Burgers (2011). Strengthening Primary Care: Recent Reforms and Achievements in Australia, England, and the Netherlands. New York City, The Commonwealth Fund.

27 Department of Health and Human Services (2015). HealthLinks, Presentation to Preventable Hospitalisation Forum that was held at NAB Docklands on Thursday, 15 October 2015

28 Campbell, S. M., A. Scott, et al (2010). Implementing pay-for-performance in Australian primary care: lessons from the United Kingdom and the United States.

Kaiser Permanente (an integrated managed care consortium based in California with close to 10 million members), uses the risk stratification pyramid to guide the intensity of care provided to patients with chronic disease in primary care.

1. **Primary care with self-care support** – for the 65-80 per cent of patients with chronic conditions responsive to lifestyle modification and medications. General practitioner time is conserved, with a multidisciplinary team providing much of the patient interaction and follow-up.
2. **Assistive care management** – for the 20-30 per cent of patients with chronic conditions whose diseases are not under control in the primary care setting, and who require assistance to manage comorbidities and complex medication regimens. A care manager supports the primary care team to ensure the patient receives interventions such as self-management education and referrals to exercise or smoking cessation programs.
3. **Intensive care management** – for the one to five per cent of patients with advanced chronic disease and complex comorbidities. These patients receive intensive interventions, such as cardiac rehabilitation for patients with heart failure. A nurse manager provides telephone support for up to six months to help patients make lifestyle changes and adhere to their medication regime, while primary care and specialist doctors provide guided medical management as part of a multidisciplinary team.

In the Australian private health insurance environment, some insurers have designed a suite of tailored health programs which provide targeted interventions for:

- their healthy members (primary prevention);
- those with diagnosed chronic disease and initial hospitalisations (secondary prevention); and
- integrated care programs for members with chronic and complex conditions and a pattern of high use of health care.

Medical homes

The Patient Centred Medical Home (PCMH) model promotes care which is patient centred, physician guided, cost efficient and aimed at achieving agreed long term health goals.²⁹

The model introduces the concept of accountable care, where a single provider or group of providers (usually general practice) becomes the central coordination point for a patient, and accepts a level of accountability for their outcomes.

The PCMH model aims to provide tailored and coordinated health care via a multidisciplinary care team using health data, disease management, and appropriate payment structures to encourage and reward best practice.^{30,31}

Commonly accepted features of PCMHs are:

- **Patient-centered:** A partnership between practitioners, patients, and families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organised across all elements of the broader health care system, including specialty care, hospitals, home health care, community and social services and supports.
- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.
- **Committed to quality and safety:** Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.³²

The term 'medical neighbourhoods' is also sometimes used to describe an optimal model which closely links patients in with allied and specialist care through a highly integrated model centred around general practice.

Medical home models have been found to lead to a number of benefits including increased access to appropriate care and decreased use of inappropriate services, improved access to preventative medicine, improved patient experience and reduced costs of care.³³

The Royal Australian College of General Practitioners (RACGP) has published its 'Vision for general practice and a sustainable healthcare system' (the Vision) that describes an approach to reforming health care which is based on the PCMH model.³⁴

Patient enrolment (compulsory or voluntary) is a critical component of a medical home model. The RACGP Vision recommends introducing voluntary patient enrolment to support the establishment of a PCMH concept. Benefits may include establishment of more stable relationships between patients and GPs and a better understanding of the practice population to enable needs based planning.³⁵

A key concern about the model is that it may create 'gatekeepers' and 'bottlenecks'. Certainly appropriate access to general practice would be necessary to ensure the success of the model, particularly for those vulnerable populations who are most likely to benefit from it.



29 Ernst and Young (2015). A model for Australian General Practice: The Australian Person-Centered Medical Home.

30 Health Affairs (2010). Health Policy Brief: Patient-Centered Medical Homes.

31 Patient Centered Primary Care Collaborative (2007). Joint Principles of the Patient-Centered Medical Home. Washington, D.C., American Academy of Family Physicians.

32 Patient Centered Primary Care Collaborative (2015). <https://www.pcpcc.org/about/medical-home>

33 The Royal Australian College of General Practitioners (2015). Vision for general practice and a sustainable healthcare system.

34 Ibid.

35 Ibid.

Integrated, patient-centred care models

Fragmentation of care between community and acute health care settings is a recognised problem in many health systems, including Australia's. Providing integrated care that is patient-centred, seamless across health care settings, and well supported by systems to support sharing of patient information is recognised as key to improving the prevention and treatment of chronic disease.³⁶

Better integration may be achieved through the implementation of single solutions or programs, such as shared patient information platforms or patient pathways, or through more comprehensive and multifaceted care programs.

The Canterbury integrated care model in New Zealand provides a good example of integrated care. The model aims to:

- keep people well and in their own homes and communities;
- provide services which enable people to take responsibility for their own health; and
- provide timely and appropriate access to complex care (refer Figure 5 below).



Figure 5: The Canterbury District Health Board's model of integrated care.

³⁶ Standing Council on Health (2013). National Primary Health Care Strategic Framework. Canberra, Australian Government Department of Health.

There is strong evidence that integrated care programs can impact positively on individual and system level outcomes, and patient and provider experiences:

- It is estimated that the Canterbury model saved more than 1 million bed days in its first few years of operation, averting many avoidable hospital admissions.³⁷
- A 2015 review of the evidence base by McKinsey & Company found that integrated care programs may result in an average 19 per cent reduction in hospital admissions when compared to standard care practices, and were also associated with improved clinical outcomes (HbA1c level in diabetes).^{38,39}
- A review of integrated care experiences in Germany, the Netherlands and England demonstrated moderate and mixed improvements for patients (clinical outcomes, use of hospital care, care processes and experience), and inconsistent results from integrated care in relation to cost per patient per year of usual care. The most consistently positive outcome was improved provider experience.⁴⁰
- Figure 6 below summarises the evidence supporting the success of various integrated care interventions, demonstrating that self-empowerment and education and multidisciplinary teams currently have the strongest evidence base, but may not necessarily be the interventions which can deliver the greatest impacts.

In 2011 McKinsey & Company identified that successful integrated care programs shared three traits:

- a focus on patient cohorts with high need and high costs (such as patients with chronic disease);
- effective mobilisation of a multidisciplinary system around the patient which is supported by mechanisms such as protocols and shared care plans; and
- establishment of enablers including accountability and joint decision making, clinical leadership, effective information sharing, alignment of incentives and strong patient engagement.⁴¹

The evidence regarding successful integrated care models provides insight into how to progress the development of flexible and patient-centric approaches to manage chronic disease, and to alleviate pressure on the costly acute sector.

Intervention	Reviews finding a positive impact	Additional insight from evidence base	Average impact - reducing hospitalisations
Self-empowerment and education	83% (20 of 24)	Supported self-management has strongest effect on clinical outcomes of all integrated-care components when estimated at component level	25-30% (interquartile range)
Multidisciplinary teams	81% (13 of 16)	All reviews have concluded that specialised follow-up of patients by a multidisciplinary team can reduce hospitalization	15-30% (interquartile range)
Care coordination	57 % (8 of 13)	Interventions involving case management reduce HbA1c (in patients with diabetes) by 22% more than interventions without case management	~37% (average from 2 reviews)
Individualised care plans	64% (7 of 11)	Personalised approaches using tailored information influence health behavior more than uniform approaches	~23% (average from 2 reviews)

Figure 6: Review of findings from 34 systematic review of integrated care published in the last 10 years.⁴²

37 The King's Fund (2013). The quest for integrated health and social care: A case study in Canterbury, New Zealand. London, The King's Fund.

38 McKinsey & Company (2015). The evidence for integrated care.

39 Like all systematic reviews, the size of the effect of integrated care which McKinsey found is sensitive to both the literature search terms used, and the studies excluded (362) by the authors prior to final analysis of retained studies (43).

40 Busse, R. and J. Stahl (2014). Integrated care experiences and outcomes in Germany, the Netherlands, and England. Health Affairs (Project Hope) 33(9): 1549-1558.

41 McKinsey & Company (2011). What it takes to make integrated care work.

42 Adapted from McKinsey & Company (2015). The evidence for integrated care

Needs based commissioning

Commissioning is the planning and purchasing of health services to meet the needs of a population. Commissioning is used by health organisations to allocate funds to address community health needs, and to set and monitor performance expectations for health providers.⁴³

In England over 200 Clinical Commissioning Groups (CCGs) have been established to commission care for approximately 200,000 people each. CCG membership consists of general practitioners and other local health professionals responsible for the commissioning of most hospital and community services provided by the National Health Service (NHS).⁴⁴

CCGs evaluate the performance of commissioned services from local health care providers, while each CCG is itself evaluated on performance indicators in the NHS Outcomes Framework.

In NZ, Primary Health Organisations (PHOs) are responsible for the health of geographically enrolled populations, and focus on multidisciplinary care coordination and the reduction of health inequalities. PHOs commission and provide general practice services to those people that have enrolled in the PHO. PHOs receive capitated funding adjusted by the risk of their enrolled patients, to enable them to pursue innovative models of health care.⁴⁵

Commissioning provides an opportunity to provide needs-based, flexible, and tailored solutions to address the health needs of communities. While Australian national health priority areas set the agenda for the whole health system, regional commissioning of health services provides an opportunity for strategic and targeted spending to address the varied health needs of specific communities.

As regional commissioning bodies, PHNs therefore need to play a key role in linking national and state health priorities with local community health needs. The regional commissioning process provides an opportunity to engage local communities and local health providers in the strategic development of health services to address community needs. Commissioning also provides the mechanism for performance evaluation and accountability back to communities and to governments.

The challenge

The case for change is clear and pressing: the challenge for policy makers and the health sector is to progress a coordinated and purposeful reform agenda. The options and opportunities discussed above either directly or indirectly reflect the Commonwealth's remit for PHNs, and the expectations of stakeholders.

PHNs, including North Western Melbourne, are tasked with improving health outcomes by strengthening primary health care and connecting services across the system. This paper identifies a number of contemporary and emergent opportunities:

- Reflect best practice implementation of the current and evolving Commonwealth reform agenda by:
 - embracing our role as a meso-level organisation which can transcend the traditional Commonwealth and State divide to effectively plan and coordinate care in response to a deep understanding of regional level health needs and service system characteristics; and
 - implementing an approach to commissioning that promotes a central role for clinical and community input, and emphasises the importance of evidence based assessment of need, solution design and investment decisions.
- Demonstrate leadership by promoting and supporting initiatives which aim to reform the current funding and incentive models, which fail to support best practice care or integration.
- Test and implement integrated care models and risk stratification in North Western Melbourne.
- Build on success by progressing the development and uptake of evidence based patient pathways, which support best practice care and cross setting integration.

43 South Australia Health (2015). Clinical Service Commissioning. from www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/clinical+service+commissioning

44 National Health Service UK (2015). CCG Outcomes from www.nhs.uk/nhsengland/thenhs/about/pages/ccg-outcomes.aspx

45 Primary Health Care Research and Information Service (2013). Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level? Adelaide, Flinders University.