



# Regionalisation of health services: Benefits and impact

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Primary Health Care Research & Information Service (PHCRIS)  
June 2016

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ISBN 978-0-9941874-9-9

**Acknowledgements**

PHCRIS would like to thank Associate Professor Gawaine Powell Davies of the University of New South Wales for his valuable insights and comments on a draft of this report.

**Suggested citation**

Bywood PT, Erny-Albrecht K (2016). *Regionalisation of health services: Benefits and impact*. PHCRIS Policy Issue Review. Adelaide: Primary Health Care Research & Information Service.

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## Abbreviations

|        |  |
|--------|--|
| AC     | Autonomous Community (Spain)                                 |
| AHS    | Alberta Health Services (Canada)                             |
| ACCCHS | Aboriginal Community Controlled Health Service               |
| ALT    | Alliance Leadership Team (NZ)                                |
| AMS    | Aboriginal Medical Service                                   |
| ARS    | Regional health agencies (France)                            |
| ASL    | Local health authority (Italy)                               |
| ATAPS  | Access to Applied Psychological Services                     |
| CCG    | Clinical Commissioning Group (UK)                            |
| CHO    | Community Healthcare Organisation (Ireland)                  |
| DDKM   | Danish health care quality programme (Denmark)               |
| DGP    | Divisions of General Practice                                |
| DHB    | District Health Board (NZ)                                   |
| DMP    | Disease management programmes                                |
| ED     | Emergency department   |
| EU     | European Union   |
| GGD    | Municipal health services (Netherlands)                      |
| GPs    | General practitioners  |
| HEDIS  | Health Effectiveness Data and Information Set                |
| HSCB   | Health and Social Care Board (Northern Ireland)              |
| HSE    | Health Service Executive (Northern Ireland)                  |
| IRPES  | Inter-Regional Performance Evaluation system (Italy)         |
| LHN    | Local Hospital Network                                       |
| LRA    | Local Regional Authority (Europe)                            |
| MAHS   | More Allied Health Services program                          |
| MBS    | Medicare Benefits Schedule                                   |
| ML     | Medicare Local   |
| MPS    | Multi-purpose services                                       |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| NHS    | National Health Service (UK)                                 |
| NSW    | New South Wales  |
| NT     | Northern Territory   |
| NZ     | New Zealand  |
| OECD   | Organisation for Economic Co-operation and Development       |
| PHCRED | Primary Health Care Research Evaluation and Development      |
| PHCRIS | Primary Health Care Research and Information Service         |
| PHN    | Primary Health Network                                       |
| PHO    | Primary Health Organisation (NZ)                             |
| PIP    | Practice Incentive Program                                   |
| PREMs  | Patient Reported Experience Measures                         |
| PROMs  | Patient Reported Outcome Measures                            |
| RHA    | Regional Health Authority (Canada)                           |
| RRMA   | Rural, Remote and Metropolitan Areas                         |
| SALAR  | Swedish Association of Local Authorities and Regions         |
| WA     | Western Australia  |
| SHI    | Statutory Health Insurance (France)                          |

|     |  |
|-----|--|
| SIP | Service Incentive Payments             |
| SNS | Spanish National Health system (Spain) |
| UK  | United Kingdom                         |
| US  | United States of America               |
| VHI | Voluntary health Insurance (France)    |

## Executive summary

Providing a well-integrated, cost-effective, quality health care system that meets the needs of the population is challenging for governments worldwide. In Australia, this challenge is complicated by a geographically and culturally diverse population; and complex funding and responsibilities across different levels of government. Regionalisation in health care is about enabling appropriate allocation and integration of resources according to the local population health needs, and community engagement and quality improvement to optimise delivery. From a governance perspective, control and accountability for allocation of resources and delivery of services may be centralised, decentralised, or a mixture of both. This review examines the different approaches that have been used in Australia; and assesses what is known of their effectiveness in terms of: patient health outcomes and experience, cost containment, economies of scale, accountability, citizen participation in decision-making, integration of services, and quality and equity of care. An overview of the current global trends in regionalisation is also presented.

## Policy context

Through the *Building a 21<sup>st</sup> Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (Commonwealth of Australia, 2010), the Commonwealth government specified regional integration as a key building block for a strong integrated primary health care system. They acknowledged the importance of improving access and reducing inequity, improving chronic disease management, increasing the focus on preventive care and improving the quality, safety, performance and accountability of the health care system. A more recent review, the *Reform of the Federation Discussion Paper* (Commonwealth of Australia, 2015), proposes that the Commonwealth and States/Territories share the responsibility for delivering health care services to defined populations through regional health entities. At the jurisdictional level, Area Health Services (AHS, or similar) have been established, with the primary aim to “promote, protect and maintain the health of the residents in its area” (e.g. Area Health Services Act NSW, 1986). In each area, AHS functions include: managing hospitals and other health services, assessing population health needs, planning development for future health needs and setting priorities relevant to those needs.

## Key findings

Over the past 25 years, Australian Commonwealth governments have implemented several types of regional health care entities as meso level mechanisms to identify community needs, engage with relevant providers and facilitate coordination of effective, efficient and equitable health care. Starting in 1992, there have been three models of mainstream Primary Health Care Organisation (PHCO): Divisions of General Practice (DGP); Medicare Locals (MLs); and Primary Health Networks (PHNs). As PHNs were only established in July 2015, it is too early to determine their performance to date. For the DGP and MLs, there has been incremental improvement in integration across different parts of the primary health care sector (e.g. allied health, Indigenous health services) and between different levels of the health system (e.g. primary, secondary and tertiary sectors). There has also been improvement in accessibility due to implementation of a broad range of targeted programmes and services. At each transformation, successive PHCOs have changed in scope and focus and built on the work of the previous regional entity.

Although not examples of regionalisation *per se*, a number of organisations have been established to facilitate tailoring of health care services to local/regional needs. These provide useful insights that may be applicable to broader, population-level reforms such as health care regionalisation. These regional health care organisations include: Aboriginal Community Controlled Health Services

(ACCHS) and Multi-Purpose Services (MPS), which targeted Indigenous health and rural and remote communities, respectively; co-localised organisations, such as GP Super Clinics, which bring together a range of services into one location; and specific state/territory entities (e.g. HealthOne and GP Plus). Table 1 provides a summary of the benefits and impacts of regionalisation in Australia.

**Table 1 Summary of benefits and impacts of regionalisation in Australia**

|   |   |
|---|---|
| <b>Patient health outcomes and experience</b> | Overall, the extent to which regionalisation has improved patient health outcomes and experience is limited by the lack of appropriate indicators and poor reporting on patient-level data. For the most part, inferences can only be drawn from evidence that demonstrates the range of programmes and services supported by PHCOs to address the community’s needs (e.g. flexible hours and locum services, chronic disease management programmes, targeted services for vulnerable populations).<br>For Indigenous health, although evaluations showed no significant difference between ACCHS and mainstream services, patients indicated increased demand and a strong preference for ACCHS; thus, improving access enables more opportunities for health care delivery. |
| <b>Cost containment</b>                       | Although there has been increasing focus on improving efficiency, there is little available data to demonstrate cost savings in any particular regional entities.   |
| <b>Economies of scale</b>                     | Economies of scale are difficult to demonstrate due to context-specific characteristics that may not feasibly scale up or be transferable to a different context.   |
| <b>Accountability</b>                         | The unique governance structure of ACCHS ensures that each ACCHS is accountable to the local community.   |
| <b>Citizen participation</b>                  | Citizen participation in decision-making is best demonstrated in organisations that are controlled by the local community and focus on the needs prioritised by them (i.e., ACCHS and MPS).   |
| <b>Integration of services</b>                | Each PHCO built on the integration efforts of the previous model. However, some barriers persist, such as the complex network of responsibilities between the Commonwealth and States and Territories, poorly linked and inadequate data, difficulties with information-sharing across providers, inter-professional differences, and poor alignment of incentives to encourage integrated care.  |
| <b>Quality and equity of services</b>         | Variability across PHCOs remains problematic.   |

Internationally, there is considerable variability in the approaches to regionalisation, which span the centralisation-decentralisation continuum, and countries are shifting in both directions. Table 2 summarises the trends, but also provides a snapshot of the responsibilities of the different levels of government and regional health entities. For example, Australian PHNs are responsible for commissioning services, but have no authority over budget control; whereas the Clinical Commissioning Groups (CCGs) in the United Kingdom (UK) and Alliance Leadership Teams (ALTs) in New Zealand (NZ), which also commission services, do have budget control. A lack of levers and incentives to facilitate change was a barrier to MLs in Australia; and in Canada, lack of budget and organisational control for primary health care has impeded attempts by the Regional Health Authority (RHA) to better align services. In all countries apart from Australia and Canada, a regional agency has responsibility (sometimes shared) for both primary and secondary care, and this is generally coupled with some budgetary control. In contrast, responsibility for aged and long-term care varied from national (Australia, Germany), to regional (Spain, Ireland, Canada, New Zealand),



local (Italy, Sweden, Denmark, Netherlands, France) or a mix of agencies (UK). The role of national authorities was largely for distribution of funds to regions and control of policy development and quality improvement measures; and often public health and prevention programmes. In terms of patient experience, available data were typically by country, rather than regional. Where data were available, it was variable across regions (and countries) and cannot be reliably attributed to any particular model of regionalisation. Some good examples of well-functioning regional health entities that had positive impact on patient outcomes and experience were identified (e.g. Jönköping County Council, Sweden).

**Table 2 Summary of Australian and international regionalisation characteristics**

| Country   | Organisation       | Budget control | Policy/ quality improvement/ guidelines | Primary health care | Hospital care | Public health/ prevention | Aged care/ long-term care | Service contracting/ commissioning | Trend   |
|-----------|--------------------|----------------|---|---------------------|---------------|---------------------------|---------------------------|------------------------------------|---|
| Australia | Federal            |                |   |                     |               |                           |                           |                                    | Move to some decentralisation through PHNs, but retaining central oversight |
|           | State              |                |   |                     |               |                           |                           |                                    |   |
|           | PHN                |                |   |                     |               |                           |                           |                                    |   |
|           | ACCHS              |                |   |                     |               |                           |                           |                                    |   |
| Italy     | National           |                |   |                     |               |                           |                           |                                    | Highly decentralised  |
|           | ASL                |                |   |                     |               |                           |                           |                                    |   |
|           | Districts          |                |   |                     |               |                           |                           |                                    |   |
| Spain     | National           |                |   |                     |               |                           |                           |                                    | Highly decentralised  |
|           | ACS                |                |   |                     |               |                           |                           |                                    |   |
|           | HCC                |                |   |                     |               |                           |                           |                                    |   |
| Sweden    | National           |                |   |                     |               |                           |                           |                                    | Decentralised   |
|           | County Councils    |                |   |                     |               |                           |                           |                                    |   |
|           | Local authority    |                |   |                     |               |                           |                           |                                    |   |
| Denmark   | National           |                |   |                     |               |                           |                           |                                    | Decentralised, but moving toward centralised planning                       |
|           | Regional           |                |   |                     |               |                           |                           |                                    |   |
|           | Municipal          |                |   |                     |               |                           |                           |                                    |   |
| Germany   | G-BA               |                |   |                     |               |                           |                           |                                    | Decentralised but centralising some financial and care elements             |
|           | Länder             |                |   |                     |               |                           |                           |                                    |   |
|           | Corporatist bodies |                |   |                     |               |                           |                           |                                    |   |

|              |  |  |  |  |  |  |  |  |  |
|--------------|--|--|--|--|--|--|--|--|--|
| Netherlands  |  |  |  |  |  |  |  |  |  |
|              | Insurers   |  |  |  |  |  |  |  |  |
|              | GGD  |  |  |  |  |  |  |  |  |
| UK (England) | NHS  |  |  |  |  |  |  |  | Isolated cases of decentralisation                                     |
|              | CCGs   |  |  |  |  |  |  |  |  |
|              | Local Government Authorities                                   |  |  |  |  |  |  |  |  |
| France       | National   |  |  |  |  |  |  |  | Centralised but ongoing deconcentration of responsibilities            |
|              | SHI  |  |  |  |  |  |  |  |  |
|              | ARS  |  |  |  |  |  |  |  |  |
|              | General Council  |  |  |  |  |  |  |  |  |
|              | Local delegates  |  |  |  |  |  |  |  |  |
| Ireland      | Directorate  |  |  |  |  |  |  |  | Centralised but moving to greater decentralisation of planning         |
|              | CHOs   |  |  |  |  |  |  |  |  |
|              | Primary Health network   |  |  |  |  |  |  |  |  |
| Canada       | National   |  |  |  |  |  |  |  | Decentralised but in state of flux                                     |
|              | RHA  |  |  |  |  |  |  |  |  |
|              | First Nations and Inuit Health Branch of Health Canada (FNIHB) |  |  |  |  |  |  |  |  |
|              |  |  |  |  |  |  |  |  |  |
| New Zealand  | National   |  |  |  |  |  |  |  | Decentralised but ALT aims to better coordinate through centralisation |
|              | ALT  |  |  |  |  |  |  |  |  |
|              | DHB  |  |  |  |  |  |  |  |  |
|              | PHO  |  |  |  |  |  |  |  |  |
|              | Maori & Pacific providers                                      |  |  |  |  |  |  |  |  |

This table is based on available published literature but the reader is advised to confirm information from relevant health authorities in the individual countries

## Policy considerations

Finding the ‘sweet spot’ along the centralisation-decentralisation continuum remains a challenge for governments worldwide and, even if identified, it is likely to vary according to local context. Although there is a compelling argument for ensuring that local contextual factors are considered in policy decisions that impact on the local community (i.e., “no decisions about me, without me”<sup>1</sup>), there is also a strong imperative to achieve this with fiscal responsibility (efficiency, economies of scale) and ensuring quality, safety and equity of health care services for all. In developing policy to meet these needs a number of observations from real-world experience provide useful guidance.

### Take-home messages

- A ‘one-size-fits-all’ approach to health service delivery is not feasible for Australia, where there is considerable geographic and cultural diversity.
- Some elements of health care may suit a centralised approach (e.g. quality standards of care), while others may benefit from regional control (e.g. integration of services). Assuming responsibility for these elements is important for their meaningful delivery, and also depends on availability of levers and incentives to guide implementation (e.g. financial incentives and strategic authority).
- Flexibility to adapt to changing needs, advances in health care, workforce fluctuations and social/environmental factors needs to be embedded in the health care system.
- Ongoing support and buy-in across macro, meso and micro levels is essential for developing and sustaining partnerships and collaborations that will endure through economic fluctuations and changes in policy and politics.
- Cross-sectoral collaborations need to be supported by coherent policies that are aligned across macro, meso and micro levels of the health system. For example, a common barrier at the regional level is a mismatch between the requirement to collaborate across sectors to improve integration and the lack of authority to control budgets or allocate resources to do so.
- Community involvement and local cohesiveness are key enablers to regionalisation.
- Aboriginal Community Controlled Services (ACCHS) and Multi-Purpose Services (MPS) are good examples of regional entities that demonstrate improvements in access to services, involve the community in decision-making, and prioritise the needs of the local community. Similar community-controlled organisations in Canada and NZ have also shown improvements in patient health outcomes and experience, but are challenged by funding arrangements that do not consider the local context.
- Appropriate measures of patient experience need to be developed; this may be facilitated by better data collection and improvements in data linkage technologies. However, the potential influence of factors beyond the health system’s control also needs to be acknowledged.
- Experiences with regionalisation are very context-specific. Therefore, examination of local or regional approaches as distinct from country-level experience is likely to be informative, but not necessarily transferable.

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<sup>1</sup> (NHS, 2010)

## Background

### Australian context

Australia's health care system is complex, with responsibility and funding arrangements for different parts of health care split across levels of government (Commonwealth or State/Territory). A mixture of public and private health care services are provided in a variety of settings, including general practice, hospitals, specialist clinics and community health centres, by a wide range of providers (e.g. general practitioners, nurses, allied health professionals, specialists). Although Australians generally experience good quality health care under these arrangements, there are some persistent problems with accountability, inefficiencies, fragmentation of care and variability in the access to, and quality of, care. This is further exacerbated for frequent users of the health system (e.g. those with chronic and/or complex care needs), and vulnerable populations (e.g. socioeconomic disadvantaged, minority groups).

### Basis for regionalisation

*Organizations with multiple hospitals and other facilities spread over a large region can rightly call themselves health systems only if they have effective coordination of clinical services across their service areas (Fink, 2014, p 80).*

Internationally, it is accepted that well-integrated services, with primary health care playing a central coordinating role, is what underlies effective, efficient, evidence-based and patient-centred health care (Oliver-Baxter et al., 2013d). Implementation of this goal is challenging and various forms of regional structures have been established as delivery mechanisms to meet the needs of diverse communities. Leutz (2005, p 9) suggested that: "All integration is local". That is, all efforts to integrate care need to consider the local environment (geographic, systems, workforce, resources); and that local leadership and trusted relationships are essential, rather than forcing top-down, standardised or structural solutions on a local problem.

Effective and efficient integrated care needs to be addressed at all three levels of the health system: macro (system level funding, governance, performance), meso (organisational level collaboration) and micro (patient-level services) (Duggan, 2015, Oliver-Baxter et al., 2013a, Oliver-Baxter et al., 2013b, Oliver-Baxter et al., 2013c, Oliver-Baxter et al., 2013d).

*Achieving a transformation of this kind requires greater alignment at macro, meso and micro levels, starting with governance arrangements for both primary and secondary care and cascading through federal, state and local government systems and national and local health care organisations including primary care, ultimately there has to be successful engagement of local communities and neighbourhoods (Duggan, 2015, p 19).*

Regional organisational structures operate at the meso level of the health system, but they cannot operate alone. In Australian primary care, the meso system is represented by primary health care organisations; originally Divisions of General Practice, then Medicare Locals, and more recently Primary Health Networks (Abou Elnour et al., 2015). The Australian Government Department of Health is the macrosystem and the clinical microsystem comprises clinicians and care provider teams.

With a large land mass and a relatively small population, delivering good quality health care equitably to Australia's economically, geographically and culturally diverse population is challenging. The Australian government, like many others globally, is looking to optimise the governance

arrangements, make better use of available resources and improve the efficiency and quality of health care services. At different times, governments have alternated between centralised and decentralised governance structures, or a mix of both. Getting the optimal mix is a major challenge.

The *Reform of the Federation White Paper* (Commonwealth of Australia, 2015) discusses the function and purpose of the current Federation and how it fits with the key objectives of equitable, efficient, affordable health and welfare. One of the options proposed is for the Commonwealth and the States and Territories to “share responsibility for all health care through Regional Purchasing Agencies” (Commonwealth of Australia, 2015, p 40). This is one form of ‘regionalisation’, which has been defined as “the creation of an intermediary administrative and governance structure (often referred to as a regional health authority or board) that assumes responsibility for organizing and delivering health care services to a defined population” (Simpson, 2011, p 237).

In this report, the Primary Health Care Research & Information Service (PHCRIS) examines the regionalisation of health services in Australia. In particular, the focus is on Australian examples of regionalisation including its impact on patient health, costs, accountabilities, efficiency and equity. An overview of the international trends in regionalisation of health care is also included.

## Aim

The aim of this Rapid Response is to identify available evidence relevant to the regionalisation of health services in Australia.

Specific questions and areas to be addressed include:

- What approaches have been used to establish regional health care entities in Australia?
- What services have been brought together?
- How effective are these arrangements in achieving the main aims of regionalisation?
  - Improved patient health outcomes and experience
  - Cost containment
  - Economies of scale
  - Greater accountability
  - Increased citizen participation in decision-making
  - Better integration of services (efficiency)
  - Reduced variability in care and greater care equity.
- What are the barriers and enablers of regionalisation?

Additionally:

- What are the current global trends with respect to regionalisation of health care services? (Canada, New Zealand, United Kingdom, Scandinavia, and Europe).

## Methods

This report follows a 'rapid review' format. Rapid reviews are short literature reviews that focus on research evidence with a view to facilitating evidence-based policy development (Grant and Booth, 2009). Given the 8-week time frame for this review, the searches and appraisal were pragmatic rather than systematic. A thorough review of Australian and international literature was undertaken through a search of academic and grey literature sources including, but not restricted to: PubMed (using the PHC Search Filter), Trove, Google Scholar, Scopus and relevant websites (e.g. [www.australia.gov.au](http://www.australia.gov.au); European Observatory on Health Systems and Policies: <http://www.euro.who.int/>).

Keywords applied in the searches included combinations of one or more of the following terms: health care AND regionalisation OR regionalization; health care AND decentralisation OR decentralization. Searches were restricted to English language, publication period 2011-March 2016, and the following settings: Australia, and for the international overview the United Kingdom (UK), Canada, New Zealand (NZ), Europe and Scandinavia as these countries have some similarities to Australia in their health care systems. Relevant systematic reviews identified in the searches were appraised for quality using the AMSTAR literature rating scheme (Shea et al., 2009). Snowballing of references within publications captured through searches was applied to identify additional publications of potential relevance.

### *General caveats*

Schemes identified in European and Scandinavian countries during the search process were included but specific searches on individual countries were not undertaken.

The governance structure/infrastructure of the health care system is but one element to consider in parallel with other elements that impact on health care, including funding/payment arrangements and workforce demographics and distribution (beyond the scope of this review). See previous PHCRIS reports for more details on financial incentives and payment models (Oliver-Baxter, 2013, Oliver-Baxter, 2014, Oliver-Baxter et al., 2014).

### **Patient satisfaction and patient experience**

It is relevant to note that despite widespread use of satisfaction to rank health care systems and reflect patient experience, some debate remains as to the appropriateness of this measure (Fenton et al., 2012, Sanchez-Piedra et al., 2014, Manary et al., 2013). For more details, see page 46 (Appendix).

For the purposes of the following report, patient experience is presented based on the Organization for Economic Cooperation and Development criteria of patient experience (OECD, 2016a):

- 1 Waiting time of more than 4 weeks for getting appointment with a specialist
- 2 Consultation skipped due to costs
- 3 Medical tests, treatment or follow-up skipped due to costs
- 4 Prescribed medicines skipped due to costs
- 5 (Regular) doctor spending enough time with patients during the consultation
- 6 (Regular) doctor providing easy-to-understand explanations
- 7 (Regular) doctor giving opportunity to ask questions or raise concerns
- 8 (Regular) doctor involving patients in decisions about care or treatment.



These criteria are useful for the purpose of international comparisons and are supplemented in this report with additional material where available, including measures of patient ‘satisfaction’. Further, since health care systems comprise all of primary, secondary and tertiary care, and dissatisfaction with one sector may overshadow satisfaction with another, patient experience or satisfaction with individual health care sectors is noted, where possible.

## Findings

The findings from this review are organised into two main sections:

- Australian perspectives: different approaches to regionalisation (services provided; impact on effectiveness, efficiency and equity of access; strengths and weaknesses; patient outcomes)
- International perspectives: overview of trends related to regionalisation.

### Australian perspectives on regionalisation

*Regionalisation is a complex task, involving elements of merging services, scaling up services and a change in management and governance control (Commonwealth of Australia, 2012, section 5.5.8).*

At the macro level of the Australian health system, regional integration was specified as one of the five key building blocks underpinning a responsive and integrated primary health care system going forward in the 21<sup>st</sup> Century (Commonwealth of Australia, 2010). The building blocks are expected to support the Australian Government's four priority areas for change:

- Improving access and reducing inequity
- Better management of chronic conditions
- Increasing the focus on prevention
- Improving quality, safety, performance and accountability.

At the meso level, the key mechanism to deliver these changes is some form of regional organisation that has the capacity to identify the needs of the local community, engage with relevant stakeholders and coordinate appropriate health care services effectively, efficiently and equitably.

Before the introduction of Australia's first regional Primary Health Care Organisations (PHCOs), the Divisions of General Practice (DGP) in 1992, most of the general practice sector comprised independent practitioners, with little connection to the broader health care system (CHERE, 2015b). Overall, it was recognised that there was a need to support general practice to link with other health care practitioners; encourage better communication, information sharing and coordination of services; and improve the quality of care using an evidence-based approach.

Over the past 23 years, Australia's health care system has seen multiple iterations in the structure of regional PHCOs from approximately 112 (100-123) Divisions of General Practice (DGP, 1992-2010), through 62 Medicare Locals (MLs, 2011-2014), to 31 Primary Health Networks (PHNs, 2015–current). There have been some criticisms of the political influences underpinning these transitions. For example, "... the replacement of Divisions of General Practice by Medicare Locals, and they in turn by PHNs were disruptive changes, but there was little attempt at reframing or promoting the opportunities arising from the change while minimising the costs of transition" (CHERE, 2015b, p 6). Similar changes in the secondary care sector aimed to improve cost-effectiveness by devolving responsibility to Local Hospital Networks (LHNs, or similar<sup>2</sup>; see page 19 for more details) (Hall, 2010). As well as addressing local concerns about hospital emergency department access and long waiting times, the LHNs were expected to improve coordination of the patient journey between hospital and primary health care by partnering with MLs (and later PHNs).

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<sup>2</sup> Across jurisdictions, the names of LHN units vary: New South Wales has 'Local Health Districts', Queensland has 'Hospital and Health Services', South Australia has 'Local Health Networks', and 'Tasmanian Health Organisations' are in Tasmania (AIHW, 2013).

Despite the criticisms, the changes are consistent with some of the global trends in transforming regional health care organisations along the decentralised-centralised continuum (see page 30 for current International perspectives). Due to Commonwealth/jurisdictional funding arrangements and the split responsibilities for different aspects of health, Australia's current health care system is partly centralised and partly decentralised. In this respect it shares some structural similarity with other international systems (see Table 9 for typology of health management systems in the European Union, Appendix).

### *Divisions of General Practice (DGP)*

First established in 1992, the DGP aimed to "improve health outcomes for patients by encouraging general practitioners (GPs) to work together and link with other health professionals to upgrade the quality of health service delivery at the local level" (Commonwealth of Australia, 2000, p 210). The Australian General Practice Network (AGPN) was the national peak body for the DGP.

Over the period of their operation (1992-2010), numbers of Divisions fluctuated due to amalgamations and closures. In 2010-11, there were 111 Divisions<sup>3</sup>, servicing general practices (and GPs) within a defined catchment area and encompassing an average population of approximately 200 000 people (ranging from <20 000 in remote NSW to >650 000 in metro Queensland); 7 035 practices (average 63 practices/Division); and 24 720 GPs (average 222 GPs/Division) (Carne et al., 2012). The objectives of the Divisions were supported by various incentive programmes to encourage evidence-based care, including the Practice Incentives Program (PIP) and Service Incentive Payments (SIP). However, evidence suggests that the complex and time-consuming administrative burden of claiming the benefits often discouraged practices from claiming payments (Kecmanovic and Hall, 2015, Australian National Audit Office, 2010). There was also a range of different Commonwealth-funded programmes to support better access, integration and multidisciplinary care, and to focus on chronic disease management and preventive care (Russell, 2013a). Examples of these programmes included: Access to Applied Psychological Services (ATAPS), Aged Care GP Panels Initiative, Australian Primary Care Collaboratives Program, More Allied Health Services program (MAHS), Better Outcomes in Mental Health Care programme, and the Nursing in General Practice programme. Each programme represented a way of leveraging practices and practitioners to focus on the government's priority areas, reduce pressure on the acute care sector, and maximise use of limited resources. See Russell (2013a) for a detailed discussion of the Divisions' programmes.

A review of primary health care (Powell Davies et al., 2006) suggested that the Divisions had made a contribution to building capacity in discrete initiatives within general practice (e.g. asthma, diabetes), care coordination for individual patients with chronic illness, and improving access to allied health professionals. In contrast, there was less focus on population health and limited capacity building in other areas of primary health care, except for some training across professional boundaries through the Primary Health Care Research Evaluation and Development (PHCRED) strategy (Commonwealth of Australia, 2014a). However, it was also recognised that most of the coordination of services within different parts of primary health care or between sectors relied on voluntary efforts, commitment and capacity at the local level. Although this was supported by local Divisions through memoranda of understanding, evaluation of the Divisions suggests that weak linkages between general practice and other health care sectors made it difficult to access multidisciplinary care (Powell Davies et al., 2009b). Relationships between general practice and hospitals were also variable and influenced by

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<sup>3</sup> According to the Rural, Remote and Metropolitan Areas (RRMA) classification: (4 remote, 13 rural/remote, 33 rural, 11 metro/rural, 50 metro).

several factors, including the quality and interoperability of information systems, organisational and administrative capacity within general practice and the strength of relationships developed at the local level (Powell Davies et al., 2009b). While many Divisions had developed good connections across the health care sector, supported by Commonwealth-funded programmes and Medicare Benefits Schedule (MBS) items to encourage best practice, Powell Davies et al. (2009b) suggested that there was “still no consistent approach to linking general practice with community health” (p 6).

In a critique of the Australian Divisions, Smith and Sibthorpe (2007) assessed their performance against six key roles of PHCOs:

- **Improving health outcomes:** Evidence from the last Annual Survey of Divisions (2010-11)<sup>4</sup>, which all 111 DGP were required to complete, indicated that most Divisions provided immunisation or diabetes programmes (99%); and mental health programmes (96%); and most (>90%) also provided programmes or activities targeting women, children/youth and Indigenous Australians (Carne et al., 2012)
- **Managing demand and controlling costs:** Divisions did not have a role in fund-holding or commissioning of services
- **Engaging primary care physicians:** The Divisions were led by GPs, with high levels of membership (>90% of GPs were members of a Division); however, active participation in the Division’s activities (e.g. board membership, participation in training opportunities) was described as ‘patchy’
- **Enabling greater integration of health services:** Evidence indicates that many Divisions made progress in this area by developing a range of different programmes, including: structured shared care programmes between GPs and various specialists (e.g. mental health, antenatal, diabetes, aged care); programmes to improve GP-hospital interactions; and programmes to enhance integration with community health care providers
- **Developing more accessible services in community and primary health care settings:** Divisions were involved in a range of activities in this area, including: after-hours care, locum services, links with residential aged care facilities and Aboriginal Community Controlled Services (ACCHSs). Through the MAHS programme funding, Divisions also supported access to a range of allied health services (e.g. psychologists, dietitians, podiatrists, social workers, physiotherapists and mental health nurses)
- **Enabling greater scrutiny and assurance of quality of primary health care services:** In contrast to other types of PHCO, which have been involved in clinical governance activities, such as reviewing prescribing practice and monitoring standards of care (e.g. Independent Practitioner Associations in NZ; Primary Care Trusts in the UK), Division’s participation in this area was primarily through encouraging activities for accreditation (98%); upskilling practice staff (99%); development of practice teamwork (81%); cultural awareness training (74%); and implementation of new clinical procedures (60%) (Carne et al., 2012).

In terms of **patient experience** and outcomes, there is little empirical evidence and it is difficult to draw reliable conclusions about the influence of Divisions or other regional health care organisations at the patient level (Scott and Coote, 2007). This is partly due to the strong focus at a local level and the high variability across Divisions, not only in the specific characteristics and challenges of their catchment areas, but also in their different structures, mechanisms, activities and capabilities. Scott and Coote (2007) used a linear regression model to isolate the effect of Divisions on several measures, by controlling for many of the different characteristics (e.g. remoteness, population, practice characteristics). Although the findings from this study showed that Divisions influenced primary health care activity and performance in their local areas on a range of variables related

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<sup>4</sup> Updated data to replace 2004-05 data reported in Smith and Sibthorpe (2007).

primarily to participating in PIPs and SIPs<sup>5</sup>, overall, Divisions had minimal influence on clinical practice and how their activities impacted on patients' experience was not reported. However, some activities, such as practices providing long consultations and after-hours care could be explained by Divisions' activity (38% and 40%, respectively) and these may have impacted on patients' access to care and quality of interactions with their GP.

Overall, many Divisions across Australia performed their functions very well, improving in areas of accessibility, comprehensiveness, coordination of care and population health outcomes, while others performed below average compared to equivalent peer Divisions (Carne et al., 2012, Powell Davies et al., 2006). The main barrier to achieving better outcomes was in the weakness of their connections across sectors, which impacted on their ability to support integrated care.

### *Medicare Locals (MLs)*

Following a review of the health system, the National Health and Hospitals Reform Commission (NHHRC, 2009) recommended restructuring regional level PHCOs. First established as an initiative of the Labor Government in 2011, 61 MLs were funded to reduce fragmentation of primary health care services within local communities. Building on the foundations of the Divisions, the transition to MLs was expected to have a stronger focus on integrating health care services by enhancing engagement with the broader primary health care sector (e.g. allied health care, ACCHS, community health) and the acute care sector (through aligning with the boundaries of Local Hospital Networks, or similar). In contrast to Divisions that served general practices and GPs, the MLs were population focused; GPs were an important contributor, but not central to the approach. MLs were expected to focus on population health planning and needs assessments relevant to their local community. In short, the MLs assumed most of the roles undertaken by Divisions, but their catchment areas were larger, their governance structures and accountability arrangements were different, and there was a shift away from general practice as the central focus towards a greater representation of all health care providers. The Australian Medicare Local Alliance (AMLA) was the national peak body for MLs.

In the short period of their existence (the first MLs commenced mid 2011- all MLs ceased operation mid 2015), several evaluations and reviews of MLs were undertaken (Horvath, 2014, Javanparast et al., 2015, Robinson et al., 2015, Ernst & Young et al., 2014); and findings varied, depending on the terms of reference and performance indicators applied.

A 2014 review of MLs suggested that they had failed to appropriately engage GPs and lacked clear objectives (Horvath, 2014). These factors and the variability in their performance were the key reasons underpinning ten recommendations to change the name, the governance structure and the focus of MLs to reflect better integration of services. The Horvath report has been criticised for its lack of transparency, inadequate terms of reference and limited use of available information to inform the recommendations<sup>6</sup>.

In contrast, a comprehensive review, which triangulated data from several sources, the *National Evaluation of Medicare Locals* (Ernst & Young et al., 2014) reported that, despite the fact that MLs were still in the process of establishing their organisations and developing networks, they had built on the work of the Divisions by maintaining clinician engagement as well as incorporating primary

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<sup>5</sup> Percentage of total variation in performance that could be explained by DGP activities ranged from 19% to 64% (Scott and Coote, 2007).

<sup>6</sup> See <https://newmatilda.com/2015/06/15/coalition-spending-millions-reshuffle-deckchairs-and-shed-health-jobs/>

health care more broadly. The review also acknowledged that at this early stage of their development, MLs were not yet working as a “cohesive national network”.

*... overall Medicare Locals had succeeded in establishing their organisations and partnerships, were making good progress towards their five strategic objectives, and were broadly on track towards becoming effective Primary Health Care Organisations, within the constraints of the Australian health care system (p 1-2).*

In terms of patient-level outcomes, evidence indicated that most MLs were improving the patient journey by implementing different programmes (e.g. chronic disease management, after-hours access, Partners in Recovery mental health programme) and integration strategies; and many had been developing connections with other organisations (e.g. LHNs, non-government organisations and Indigenous health care organisations). In general, MLs had made good progress in improving patients’ “access to better quality chronic disease care and to services not otherwise available (e.g. psychological and allied health services); and care coordination for people with complex conditions” (Ernst & Young et al., 2014, p 3).

A survey of all 61 MLs in 2013 evaluated their performance in terms of population planning and system integration; and engagement with stakeholders (Response rate = 70%) (Robinson et al., 2015). The authors reported that there was substantial variability across MLs in terms of their form (e.g. structure of Boards, workforce composition) and function (e.g. needs assessments conducted in-house or outsourced). Stakeholder engagement also varied and reported barriers to engagement included: a “perceived lack of policy direction from the Commonwealth government and lack of connectivity between MLs” (p 5), and lack of levers and incentives to facilitate change.

Although ML activity reflected local needs, evidence provided to the Senate Select Committee on health policy, administration and expenditure in 2014 demonstrated that some services and programmes were commonly provided by most MLs (Table 3). All of the 13 ML examples provided were active in primary health care (general practice and allied health), particularly with respect to establishment of after-hours services; and specialist service provision was also widely supported, although this generally related to mental health services. The Senate Select Committee was informed that 73 per cent of Partners in Recovery Regions (national mental health programme) had MLs as their lead agency (Australian Government, 2014). Community care was also supported by most of the 13 MLs, with strong support for vaccination and Indigenous health programmes. In contrast, services and programmes specific for aged care were nominated by approximately half of the MLs, and acute care was generally limited to Health Pathways programmes (in collaboration with LHNs). However, it should be noted that MLs were tasked with meeting unmet needs; therefore, lack of ML services or programmes might indicate that adequate arrangements were already in place.

**Table 3 Health services provided by a sample of 13 Medicare Locals**

| Health service area | Medicare Local |   |   |   |   |   |   |   |   |    |    |    |    |
|---------------------|----------------|---|---|---|---|---|---|---|---|----|----|----|----|
|                     | 1              | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| Primary care        | ✓              | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓  | ✓  | ✓  | ✓  |
| Aged care           | ✓              | ✓ |   |   | ✓ |   |   |   | ✓ | ✓  |    |    | ✓  |
| Acute care          | ✓              |   | ✓ |   |   |   |   | ✓ |   |    |    |    | ✓  |
| Specialists         | ✓              | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓  | ✓  | ✓  | ✓  |
| Community care      | ✓              | ✓ | ✓ | ✓ |   |   | ✓ | ✓ | ✓ | ✓  | ✓  | ✓  | ✓  |

Source: Data are based on the Senate Select committee report on health policy, administration and expenditure (Appendix 8 in Australian Government, 2014).

Closure of all MLs in 2015 and the absence of programme evaluation reports preclude detailed investigation of how services/programmes were integrated or delivered across MLs. However, an early stage evaluation of five ML/LHN partnerships demonstrated successful use of the *HealthPathways* programme to foster structured collaboration between GPs and hospital specialists, and highlights the central role of MLs in bringing stakeholders together (Boughey, 2014). A qualitative investigation of ML/LHN interactions in South Australia described data sharing, joint community consultation sessions, programme evaluation and joint training activities as key collaborative approaches to joint ML/LHN population health planning (Javanparast et al., 2015). However, this study also noted the challenges that MLs faced due to the lack of formalised collaboration strategies, the different priorities of state and federal agencies, and the difference in focus of LHNs (sickness) compared to MLs (population health).

There were little data on the impact of MLs on patient experience or outcomes, which may reflect the limited opportunity to achieve significant improvements in a short timeframe (Robinson et al., 2015); and a lack of reporting of patient-level data. While acknowledging the appropriateness of differences in the ways MLs operated to meet the local needs, the authors also suggested that “some of the divergence was unnecessary and detrimental to their establishment” (p 7). Evidence from this study also showed that MLs had made progress towards population-based planning and stakeholder engagement. This was confirmed in a recent qualitative study (Javanparast et al., 2015), which showed that MLs had made substantial contributions to improving health in their areas through a range of activities including: building trusted relationships with stakeholders in their regions (including LHNs); needs assessment and population health planning; data sharing; community consultations; training and programme implementation; and evaluation.

### *Primary Health Networks (PHNs)*

On July 1<sup>st</sup> 2015, 31 PHNs took responsibility for the coordination of health care services in their regions (Booth et al., 2016). Like the MLs before them, PHNs are expected to work closely with the State and Territory LHNs (or similar), general practices and broader primary health care service providers in their region to improve the access to care and integration of health services for individuals. They are also expected to address the health needs of the local population they serve, focusing on effectiveness, efficiency and quality of care. A key aspect of PHNs’ role is to get the right balance between working within a “nationally consistent framework” (Booth et al., 2016, p 2) to maintain standards and quality of care and services; and at the same time, ensuring the right services are available to meet the specific population needs at the local level.

The smaller number of larger catchment areas (compared with MLs and Divisions) is expected to create economies of scale, with greater leverage for influencing change, greater purchasing power, and potential reductions in administrative costs and duplication of effort (Commonwealth of Australia, 2014b). Apart from the size of the region, the main points of difference for PHNs, compared with MLs, is the reinstatement of general practice in a central role in primary health care (e.g. GP-led Local Clinical Councils<sup>7</sup>), with other health care providers as complementary; and the commissioning of services. PHNs have also been assigned a clear focus to target six key priority areas rather than the entire scope of primary health care: mental health, Aboriginal and Torres Strait

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<sup>7</sup> Clinical councils and Community Advisory Committees are expected to contribute clinical and consumer-related information for the PHN Board <http://ahha.asn.au/events/forming-effective-clinical-councils-and-community-advisory-committees-0>

Islander health, population health, health workforce, e-Health, aged care. Unlike MLs, PHNs' roles are predominantly as facilitators and purchasers of services, not providers, except in the case of market failure (i.e., inadequacy or absence of relevant services), and all such arrangements remaining from the ML period are expected to transition to a purchasing arrangement in the first year of operation (Commonwealth of Australia, 2014b).

With the transition to PHNs, the Australian government has signalled its commitment to commissioning of health care services as part of its aim to improve integration of services appropriate to regional population health needs and to improve quality and cost-efficiency (Booth and Boxall, 2016). Given that this is a considerable change in approach, Australia could learn from the long-standing international experience of commissioning, which was first introduced in England and NZ in the 1990s (Edwards, 2015, Cumming, 2016). For example, commissioning in England has changed substantially over time from GP-fundholding, through Primary Care Trusts and Clinical Commissioning Groups; and potentially more changes are on the horizon (Edwards, 2015). Recent reports have also discussed the value in moving towards 'place-based systems of care'<sup>8</sup> (Ham and Alderwick, 2015); 'integrated commissioning' (Humphries and Wenzel, 2015) and development of measures to evaluate the performance of local/regional health systems such as clinical commissioning groups (Ham et al., 2015). A full exploration and evaluation of the advantages and disadvantages of different models of commissioning in the Australian setting is beyond the scope of this review. However, in terms of regionalisation, a recent review of the evidence on commissioning of services stated that: "Despite prolonged attention to a commissioning agenda, there is little evidence to demonstrate that it has made a significant change to the activities of providers or the health status of local populations" (Robinson et al., 2016, p 13).

PHNs may act as 'integrator' organisations, as described by the Institute for Healthcare Improvement (IHI, 2015); that is, organisations that take responsibility for the overall health of the population in their region by undertaking needs assessments, service design and commissioning/coordinating a range of resources to improve population health.

Given that PHNs are newly established, there are no evaluations of their performance to date. However, it would be useful to bear in mind the key roles of PHCOs described by Smith and Sibthorpe (2007) (see above). PHNs are in a good position to address most of these where appropriate services are available, and to assess, monitor and report on potential gaps in services within their region.

Reminiscent of the Divisions' performance data gathered through the Annual Survey of Divisions, the PHNs are expected to communicate monitored activity data to providers and patients, using a web-based dashboard (Ernst & Young et al., 2015). This ongoing data collection is expected to enable PHNs to monitor the health outcomes of the population and the quality of care delivered in their catchment areas. These data may be used to underpin any performance-based incentive payments aligned with the primary aim of improving population health.

At the micro level, PHNs are expected to monitor the quality of patient care. Different measures of quality have been developed, with increasing attention focused on the use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)<sup>9</sup> (Weldring and Smith, 2013); and measures of clinical outcomes (e.g. US-derived Health Effectiveness Data and

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<sup>8</sup> For example, 13 Total Place pilots have been established in the UK, with the aim of reducing waste and duplication by encouraging organisations and local authorities to work together to deliver relevant services (Alderwick et al., 2015, Ham and Alderwick, 2015, Humphries and Gregory, 2010). Early evaluation indicates positive outcomes and efficiency savings.

<sup>9</sup> [http://www.aci.health.nsw.gov.au/\\_data/assets/pdf\\_file/0003/253164/Overview-What\\_are\\_PROMs\\_and\\_PREMs.pdf](http://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0003/253164/Overview-What_are_PROMs_and_PREMs.pdf)



Information Set (HEDIS) measures) (NCQA), which include effectiveness data as well as consumer experience of care.

### *Local Hospital Networks (LHNs)*

In 2011-12, as part of the National Health and Hospitals Network agreement, responsibility for hospital governance was devolved to state-based LHNs (NHHN, 2010). The aim was to establish LHNs comprising a small group of public hospitals with the capacity to benefit from economies of scale while providing a range of hospital services responsive to local needs. Incentives to adopt LHNs were contained in the National Health and Hospitals Network Agreement, and included increased Commonwealth responsibility for hospital funding (moving from a 35:65 split to a 60:40 split), agreed performance targets, and funding increases where emergency and elective surgery service targets are met (Kirby, 2010, Haas, 2010). LHNs are funded by the states and territories.

There are currently 137 LHNs across Australia: 124 'metropolitan' LHNs, grouped based on geography; and 13 state-wide networks, grouped according to function including specialised hospital services (Oliver-Baxter et al., 2013b). Essentially, LHNs manage public hospital services and funding, as well as being accountable for meeting performance standards (NHPA, 2015). Leadership within LHNs is provided via a professional Governing Council and a Chief Executive Officer. The former includes local health, management and finance professionals, who work with local clinicians to manage and drive hospital performance, and also work with local primary health care and aged care providers to ensure continuity of care beyond the hospital.

No evaluation reports on LHNs were located. In NSW, where eight Area Health Services were replaced with 15 LHNs (Haas, 2010), the Agency for Clinical Innovation supports implementation and evaluation of Health Pathways strategies (ACI, 2013) involving LHNs and MLs. In Victoria, LHNs replaced local hospital boards.

## **Regional approaches to service provision**

The following examples illustrate focused primary health care responses to local need, although they do not have the population-level responsibilities of regional authorities. These arrangements demonstrate flexibility in governance and funding that can facilitate the partial decentralisation of responsibility. In the Australian context, PHNs would benefit from working with the following service providers for innovative coverage of service gaps and to prevent duplication of services.

### *Multi-purpose services (MPS)*

The MPS model is a meso level response to address the unique challenges of communities in rural and remote areas of Australia. The MPS model is a joint government initiative to support cost-effective, flexible delivery of aged care and health care services in rural and remote regions that do not have the capacity to support stand-alone hospitals or residential aged care facilities (Department of Social Services, 2015a). Often these regions have small populations (from 1,000 to 4,000 people) distributed across large geographical areas; they experience hospital closures, dispersed health care services, and difficulty sustaining a workforce (AHHA, 2015, NSW Government, 2015, Hoodless and Evans, 2001). First developed in the early 1990s, currently there are more than 175 MPS distributed throughout Australia (except in the ACT) (Department of Social Services, 2015a); and they are supported by pooled funding arrangements from the Commonwealth's aged care packages (Department of Social Services, 2015b) and the state/territory Government's hospital and community services budgets. The diverse composition of funding allows for flexible use of budgets according to community needs and facilitated streamlining of services across traditional jurisdictional

boundaries (AHHA, 2015, Malone and Anderson, 2015). The services themselves are administered by state/territory health departments, often through LHNs (Department of Social Services, 2015a). This integrated care model was designed to promote continuity of care for patients, to more effectively meet the needs of particular communities and to redress the limited resources available in some regional areas (Department of Social Services, 2015a).

Each MPS is informed by the needs of the specific community, with community consultation a key feature (Malone and Anderson, 2015). MPS include residential care facilities and a combination of complementary primary health care, community services, transport, allied health (including oral health), acute care (including emergency) and subacute care (e.g. respite, palliative care) all within a local centre (NSW Government, 2015, Malone and Anderson, 2015). While some MPS use a 'one-stop shop' co-location model, others save costs by using existing buildings that may be some distance apart (Malone and Anderson, 2014); and this has potential implications for staffing, resources and economies of scale (Anderson and Malone, 2014).

Key enablers of successful MPS include not only the pooled funding approach but also maintaining strong relationships with communities, establishing close ties with adjacent health services and having a single organisational and governance structure (Anderson et al., 2011, NSW Government, 2015). Identified barriers relate to conflicting requirements of aged and acute care services, accessing ongoing funding (including the capacity to apply for grants), recruitment and retention of staff, and administrative processes that overwhelm already burdened management (Malone and Anderson, 2014, AHHA, 2015). Citizen participation is usually encouraged through formation of steering groups, comprising community members (with or without health care expertise) and health care workers (Anderson and Malone, 2014). However, mismatch between community perception of service needs and actual usage may create conflict and dissatisfaction in a resource-limited setting.

The MPS model has been successful in NSW, with investment of over \$400 million in 2015<sup>10</sup> for the redevelopment of 64 facilities (NSW Government, 2015). A qualitative study exploring the perceptions of community members and staff involved in developing a MPS in rural NSW reported that trust was important for enabling collaboration. The participants described how the lack of trust, or suspicion related to the loss of power, can lead to coexistence, rather than coordination, between services (Anderson et al., 2011). Successful MPS sites relinquished their focus on aged care and offered a more holistic view, with multi-skilled staff shared across services. Participants engaged with these sites described positive outcomes, including improved communication across care providers and improved services for patients. The NSW government has recently initiated a collaborative project to identify strategies to promote individual person-centred care and a caring culture for aged residents living in MPS (Preece, 2015).

### *GP Super Clinics*

The 2009 national review of the health system (NHHRC, 2009) identified the need for greater focus and investment in primary health care. GP Super Clinics were introduced to better manage the increasing prevalence of chronic illness by co-locating a multidisciplinary team of health care professionals, including GPs, practice nurses, and allied health care providers; and partnering with medical specialists to deliver integrated care to local communities (Russell, 2013a). An audit of a sample of 18 (of 29 established) GP Super Clinics (Australian National Audit Office, 2013) reported that most of the operational clinics had made good progress towards achieving some of their prescribed performance indicators. In particular, 78 per cent provided a range of health care services,

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<sup>10</sup> Funded predominantly through the NSW Government's Rural Hospital and Health Service programme.

78 per cent had shared electronic health records, 67 per cent addressed future workforce training and 72 per cent had a bulk billing policy. However, recruitment and retention of staff was reported to be a key challenge, which impacted on their capacity to provide a range of services; and problems related to financial viability were reported in half of the sample audited. The audit also revealed high variability across Clinics in the number of patient presentations per month (<1,000 to 10,000). The extent to which the GP Super Clinics have improved patient health and wellbeing has not been rigorously evaluated.

### *Aboriginal and Torres Strait Islander health care services*

One of the longest established examples of regionalisation in Australia is associated with improving the health of Indigenous Australians. Australia has several organisational models that address Aboriginal and Torres Strait Islander health, which is significantly worse than non-Indigenous Australians' health. The main organisations are the Indigenous Primary Health Care Service and the Aboriginal Community Controlled Health Service (ACCHS)<sup>11</sup>. The Indigenous Primary Health Care Service is a mainstream organisation funded by the Commonwealth government to deliver health programmes to Aboriginal and Torres Strait Islander peoples (Alford, 2014). In contrast, the ACCHS governance model is unique in that the organisations are located in, and accountable to, the local Indigenous community, with predominantly Indigenous representation at every level from the board (elected by the local community) to the workforce (AHMRC, 2015).

Recognising that mainstream health care services did not adequately meet the needs of Australia's Indigenous peoples, the ACCHS was first established in the early 1970s (AHMRC, 2015). Using a model of self-determination<sup>12</sup>, and with a strong focus on the concept of community as active participants in the "planning and implementation of their health care" (from the Declaration of Alma-Ata, 1978), there are now 150 ACCHSs around Australia which aim to provide a comprehensive model of primary health care to address the health and wellbeing of the local Indigenous community in a culturally safe manner. In a review of primary health care in Australia, Hurley et al. (2010) identified ACCHSs as the main settings for comprehensive primary health care<sup>13</sup>. The National Aboriginal Community Controlled Health Organisation (NACCHO) is the peak body for ACCHS.

**As each ACCHS aims to reflect the specific needs of the local community, there are differences in services provided, workforce, infrastructure and resources. ACCHSs may undertake a range of different functions and activities depending on contextual factors, but they also have some characteristics (**

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<sup>11</sup> Also referred to as Aboriginal Medical Services (AMS) (Govil et al., 2014).

<sup>12</sup> Self-determination is acknowledged in the *United Nations Declaration on the Rights of Indigenous Peoples* (2007), which was ratified by the Australian Government in 2009 (Commonwealth of Australia, 2012).

<sup>13</sup> Comprehensive primary health care, as described in Alma Ata, incorporates not only the treatment and preventive care provided at the first point of entry to the health system (i.e., primary health care), but also "the other key elements of equity of access, collaboration across sectors beyond health and consumer and community empowerment and participation in the services" (Hurley et al., 2010, p 148).

Table 4) (AHMRC, 2015, Tilton and Thomas, 2011).

**Table 4 Functions and services of ACCHSs**

| <b>Common features of ACCHSs</b>   | <b>Examples of services provided</b>  |
|--|---|
| Community engagement, control & cultural safety                          | cultural awareness training   |
| Holistic approach to health and wellbeing                                | family violence, child protection, anger management, counselling  |
| Focus on health promotion and illness prevention                         | immunisation, nutrition, physical activity, oral health   |
| Specific population health programmes                                    | child and maternal health, men’s health, chronic disease management, sexual health, mental health, alcohol and drug use services, aged care and disability services |
| Support services   | accommodation for homeless, outreach services, transport services, pharmaceutical dispensing services   |
| Advocacy & Aboriginal knowledge  |   |
| Employment & training  |   |
| Team-based multidisciplinary care  |   |
| Integration across sectors (hospital, specialist, aged care, disability) |   |

A key goal of ACCHSs is to improve Indigenous access to health care services and evidence indicates that Indigenous Australians show a preference for ACCHSs compared with mainstream services (Alford, 2014, Govil et al., 2014). For example, studies exploring the use of sexual health services and drug and alcohol services reported a preference for accessing these services through ACCHSs and high levels of satisfaction with the care received, particularly in terms of culturally appropriate and integrated services (AHMRC, 2015, Ward et al., 2013).

A NACCHO review reported a 6.3 per cent annual increased demand for services provided by ACCHSs (Alford, 2014). The 2015 report card on ACCHSs reported an overall improvement in 10 of 16 key performance process of care indicators (e.g. maternal and child care, immunisations, chronic disease management), whereas other indicators showed no change (e.g. chronic disease tests, cervical cancer screening, influenza vaccination) (AIHW, 2015).

A review that focused on Indigenous health in mothers, babies and young children reported that “a number of ‘promising’ initiatives have been identified that may contribute to improved outcomes and/or ways of building good relationships to facilitate health improvement” (Bywood et al., 2015, pp 26-27). Examples include the ACCHSs’ Mums and Babies programmes, which have led to improvements in antenatal attendances and better health outcomes for mothers and babies (Bywood et al., 2015); and cardiac rehabilitation programmes provided by a metropolitan WA Aboriginal Medical Service (AMS) (Dimer et al., 2013) and a Tasmanian ACCHS (Davey et al., 2014), which led to improvement in cardiovascular risk factors and healthy behaviours in Indigenous participants.

Qualitative evidence from focus groups and interviews reported “marked health improvements seen due to the establishment of Aboriginal medical services in their communities and the importance of the AMS’ role in addressing the negative effects of discrimination on Indigenous health” (Baba et al., 2014, p 56). Participants linked ACCHSs with improvements in seeking health care services and better mental and physical health and wellbeing in their communities.

At the micro level of service provision, there are also examples of community-level, patient-centred, multidisciplinary health care targeting Indigenous health problems. One such example is the Brisbane South Complex Diabetes Service, which is delivered by a large general practice (Inala Primary Care) in an area of substantial disadvantage (Hepworth et al., 2013, Jackson et al., 2010). A comprehensive exploration of the benefits of such services at this local level is beyond the scope of this report. See Oliver-Baxter et al. (2013c) for more detail.

Wise (2013) suggests that localisation of programmes (i.e., early childhood development) leads to interventions that facilitate aligned activities among partners, address local determinants of early childhood development, consider local service environment constraints, strengthen local legitimacy and credibility, maximise community strengths and skills, share resources and funding, and empower Indigenous communities. For Indigenous Australians, “remote, regional and urban communities are different contexts but the key challenges are common” (Empowered Communities, 2015, p 8). ACCHSs represent one example of empowering Indigenous development through regionally-specific governance arrangements and the core principle of subsidiarity<sup>14</sup>.

The contextual diversity that exists across ACCHSs and the populations that they serve may contribute to the lack of robust formal evaluations. Moreover, this diversity makes it difficult to scale up promising initiatives that are context-specific and not necessarily generalisable in other settings. A recent study analysing the clinical audit data from over 100 ACCHSs and Indigenous health centres reported substantial variability in the quality of preventive care provided (Bailie et al., 2016). Exploring the differences in health centre characteristics, higher quality care was related to location (Northern Territory, urban and smaller service centres) and client factors (female, regular attendees, aged 25-34 years). For the most part, clients received basic preventive care tests; however, there was often poor follow-up when needed. Overall, there was no significant difference in the quality of preventive care provided by ACCHSs compared with government-controlled Indigenous-specific health services.

When comparing performance of ACCHSs and mainstream services, the evidence is mixed. In particular, studies have shown that patients’ experiences are consistently more positive in Indigenous-specific health services (such as ACCHS and AMS) compared with mainstream health services (Govil et al., 2014, Jowsey et al., 2012). For example, even long waiting times were perceived more favourably in ACCHSs compared with mainstream services (Jowsey et al., 2012), as patients valued the informal social interactions with their peers in a culturally respectful place, with less emphasis on following rules and processes required of a ‘good patient’.

*The whole journey through these services and not just health professional encounters contributes to patient satisfaction, empowerment and engagement in managing their health (Jowsey et al., 2012, p 203).*

In contrast, an evidence review reported inconclusive results for Indigenous clinical outcomes overall (Mackey et al., 2014), due mainly to an absence of good quality, well-designed studies. For example, evidence showed that ACCHSs were no more or less effective at providing immunisation services compared with mainstream services in WA, NT and far-west NSW (Bailie et al., 2009). However, there are discrepancies between studies regarding the immunisation status of Indigenous Australian children, which may be related to problems in the accuracy and reliability of available data (Bywood et al., 2015).

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<sup>14</sup> Principle of subsidiarity means that “authority for deciding or acting should rest as close as possible to the people affected by the decision or act” (Empowered Communities, 2015, p 22).

Integration of services within and across sectors is a key focus of ACCHSs. Formal partnerships between ACCHSs and hospitals or other health and social care services has led to improvements in service delivery for Aboriginal and Torres Strait Islander patients (Knoche et al., 2012). Some studies of ACCHSs have measured health care utilisation; and increased access to health care services is associated with improved health outcomes (Dwyer et al., 2011 in AHMRC, 2015). ACCHSs reduce some of the barriers to accessing health care services, by providing:

- culturally safe environment
- Aboriginal staff
- reduced costs
- flexible approach
- transport
- informal child care
- continuity of care
- trusted relationships
- clear, appropriate information
- family-centred services (AHMRC, 2015).

By improving access to health care, ACCHSs are in a unique position to address and advocate around non-health issues, such as unemployment, inadequate housing, domestic violence and other social determinants of health and wellbeing. An evidence review of the impact of ACCHS reported positive benefits in several areas (AHMRC, 2015).

A critical element of the ACCHS model of care is the recruitment and retention of health care workers (Indigenous and non-Indigenous) to work in rural and remote areas. These factors may impact on the capacity of ACCHSs to deliver services. For a discussion of the multiple challenges in addressing the problems of recruiting and retaining appropriately trained health care professionals, see Bywood et al. (2015).

### **Regionalisation in rural and remote areas**

Regionalisation is of particular importance to remote communities that have limited infrastructure, high levels of morbidity, higher costs of health care delivery and chronic workforce shortages (Commonwealth of Australia, 2012). For example, in remote areas of the Northern Territory (NT), primary health care is delivered by Aboriginal health workers and Remote Area Nurses in small community health centres, whereas larger communities may also have a resident GP. In contrast to the ACCHSs, which are funded by the Commonwealth and locally managed and administered through their elected Boards, health care services that are managed through the NT Department of Health and Families have some centralised administrative functions, including payroll and recruitment.

Increases in funding and remote area health workforce have enabled more preventive care services to be provided; however, there is limited information on the effectiveness, efficiency, appropriateness and sustainability of specific initiatives delivered through regional services for Indigenous people living in remote areas of NT (Commonwealth of Australia, 2012). Evaluation data, which were available for the Child Health Check Initiative, suggested that this initiative may not be an appropriate response to the needs of the local community; inefficiencies in administrative processes and follow-up services were identified; and there was uncertainty about long-term funding and resourcing to sustain the initiative.

The Child Health Check Initiative evaluation report (Commonwealth of Australia, 2012) identified several barriers that may have contributed to some of the problems associated with this initiative:

- short funding cycles gave partners insufficient time to adequately scope, plan and implement a programme to increase community control and establish appropriate regional Aboriginal primary health care services
- a lack of clear policy direction meant the partners did not share the same vision
- inconsistent communication between partners caused confusion
- there were no activities to involve the community or to empower Indigenous people in remote communities at the beginning of the initiative
- lack of adequate resources and capacity to fulfil responsibilities in some areas.

### **Limitations of available evidence on regional Indigenous health services**

Overall, there is a limited evidence base, with many gaps in the published literature in some areas of Indigenous health, particularly related to multimorbidity and holistic aspects of health care services (Lawless et al., 2014). Common limitations of many programmes to improve Indigenous health include: small sample sizes; variability in approach, scope, quality; time and context-specific; and often short follow-up assessment, which means it is unknown whether initial improvements can be sustained, or positive outcomes could emerge after a longer period. Many studies recruit participants through ACCHSs, which may also introduce sampling and information biases (AHMRC, 2015).

### **Parallels with international Indigenous community-controlled organisations**

A shift from centralised governance in Manitoba (**Canada**) to regionalised local community control of health services led to a 30 per cent reduction in potentially avoidable hospitalisations (Lavoie et al., 2010). In addition, the longer the health care services had been in community control, the lower the reported rates of potentially avoidable hospitalisation. An examination of equity-oriented primary health care services for disadvantaged populations in Canada showed that integrated care that addressed the social determinants of health and included high levels of community participation were most effective for improving population health, meeting the needs of disadvantaged populations, enhancing trust and engagement with patients, and reducing health inequities (Browne et al., 2012).

Since its inception in **Alaska** in 1982, the Southcentral Foundation (SCF) Nuka model of care (Gottlieb et al., 2008, Southcentral Foundation, 2016, Southcentral Foundation, 2012) has been building a strong Alaska Native-owned and operated health care system to service the physical health and wellbeing needs of the Alaskan Native and American Indian people in the community. This model is based on sustained partnerships with regional health care providers, under tribal governance and management. Significant improvements have been demonstrated, including: better access to primary care services; reduced hospital activity (36% fewer hospital days, 42% fewer emergency care services, 58% fewer specialist visits); improved performance on HEDIS measures; and higher customer satisfaction (Gottlieb, 2013).

Similarly, in **NZ**, evidence showed better access and fewer potentially avoidable hospitalisations in populations served by Māori-controlled health care providers (Carr and Lee, 2009).

Given the variability in health systems, regional approaches and the cultural differences across Indigenous communities, it is difficult to identify which specific elements of the international regional models contributed to better health outcomes amongst their Indigenous peoples compared to Australia. As shown in the evaluation of the Child Health Check Initiative (Commonwealth of Australia, 2012), to some extent, this may be due to a combination of factors, including: lack of



robust evaluation data, insufficient time/resources for planning and engaging with the community, lack of flexibility in funding arrangements and administrative/governance structures that do not facilitate good communication across relevant agencies. However, although evidence indicated that patient health outcomes for those attending Indigenous-specific health care services compared with mainstream services were not statistically different, there was a clear preference for Indigenous-specific services; consequently, improving accessibility to health care.

### *Sub-regional organisations*

Several States and Territories have addressed the problem of fragmented services by establishing specific sub-regional networks to improve integration. The best known are the **28 Primary Care Partnerships (PCPs)** in Victoria. PCPs focus on improving coordination of services, chronic disease management and integrated preventive care through alliances between approximately 600 partnership organisations, including: hospitals, community health services, mental health services, drug and alcohol services, disability services, local government and PHNs (and MLs before them) (Victoria State Government, 2015). Evaluations of PCPs suggest that they significantly improve care coordination overall, particularly across services funded by the Victorian government; however, there has been substantial variability across PCPs in engaging with general practice. Apart from some health promotion, there has been little effect on integrating services (Powell Davies et al., 2009b). In a review of primary health care service integration, Powell Davies et al. (2009a) suggested that the PCPs lacked authority and structure to enable effective integration.

**HealthOne** (NSW, N=26) and **GP Plus** (SA, N=14) are state government initiatives that were established to promote collaboration across different sectors at a local level. One of the main challenges to the operation of these regional organisations has been in collaborating across different funding and accountability systems to develop an agreed governance model (Powell Davies et al., 2009b). HealthOne at Mt Druitt is one example of a successful regional model. It uses a virtual hub-and-spoke model to improve coordination and integration of services in a socially disadvantaged area of Western Sydney, particularly targeting their older population, with high prevalence of chronic and complex illness (McNab and Gillespie, 2013). Services include: general practice, community pharmacy, allied health and Aboriginal health services. An evaluation of this model demonstrated better communication and information exchange between patients and different health care providers as well as fewer ED visits and shorter hospital stays, and improved patient experience. GP Plus health care centres in SA offer a range of services (not including GPs) to complement general practice, including: nursing and midwifery; allied health services (e.g. physiotherapy, podiatry, social work); Aboriginal health services; dental services; drug and alcohol services; community mental health; child and youth services; and specialist clinics (SA Health, 2008).

## **Summary of Australian perspectives on regionalisation**

Several different types of regional health care entities have been established in Australia in different locations and at different times. Although a common underlying purpose of regionalisation is to improve the quality of health care and the overall health outcomes for the community in a particular region, the scope and focus of regional organisations has evolved over the past 25 years. Starting with the **DGP** in 1992, their main role was to encourage GPs to work together with other health care practitioners and to improve the overall quality and standard of health care. Over the 18-year period of operation, and with the support of a range of incentives, most Divisions supported practices in their catchment area to deliver a range of programmes to improve health outcomes, improve accessibility to services, and enable integration of services. However, there was substantial variability in the performance across Divisions. In terms of efficiency and economies of scale, it is unclear how Divisions performed as they did not have authority to control funds; and no data were available.

**MLs** built on the work of Divisions and broadened their scope to integrate with wider primary health care services as well as the acute care sector. In their brief lifespan, MLs made good progress towards developing networks and improving integration with different parts of the health care sector; and made further improvements to the patient journey through a range of targeted programmes and services. As with Divisions, there was variability in the performance of MLs, which were at different stages of development. No data were available to determine whether efficiencies or economies of scale could be attributed to the MLs.

In the more recent transformation to **PHNs**, the focus on integration across health care remains, with general practice in a central role; however, the key changes are in the governance structures, with separation of purchaser (PHNs) and provider (commissioned services) roles. No evaluation data on PHNs are available at this time.

Partnerships between **LHNs** and MLs were emphasised in the 2011 National Health Reform Agreement. However, despite evidence of some collaboration, a lack of system-level strategies and several changes in policy impeded progress (Javanparast et al., 2015). It is hoped that the establishment of LHNs, and alignment of PHN boundaries with clusters of LHNs, will lead to improved inter-sectoral collaboration.

Key differences between the different regional authorities are summarised in Table 5. While it is expected that variation in responsibility and local needs would require different approaches, it is important to note that evaluation and data collection to inform strategic decisions are largely absent from all but the Divisions of General Practice remit.

**Table 5 Summary of differences between regional authorities**

|   | Secondary sector        | Primary sector                |                          |                          |
|---|-------------------------|-------------------------------|--------------------------|--------------------------|
|   | Local Hospital Networks | Divisions of General Practice | Medicare Locals          | Primary Health Networks  |
| <b>Number of units nationally</b>         | <b>137</b>              | <b>111<sup>#</sup></b>        | <b>61</b>                | <b>31</b>                |
| <b>Funding</b>                            | State                   | Federal                       | Federal                  | Federal                  |
| <b>Framework</b>                          | Yes                     | No                            | Yes                      | Yes                      |
| <b>Budget control</b>                     | Yes                     | No                            | Yes                      | Yes                      |
| <b>Priority setting /Planning</b>         | Yes                     | Yes via member input          | Yes via Needs assessment | Yes via Needs assessment |
| <b>Service provision</b>                  | No                      | Yes                           | Yes                      | No*                      |
| <b>Service management</b>                 | Yes                     | No                            | No                       | No                       |
| <b>Commissioning/contracting services</b> | Yes                     | No                            | Yes                      | Yes                      |
| <b>Quality accountability</b>             | Yes                     | No                            | No                       | No                       |
| <b>Data collection</b>                    | No                      | Yes                           | No                       | No                       |
| <b>Required GP involvement</b>            | No                      | Yes                           | No                       | Yes                      |
| <b>Required Consumer involvement</b>      | Yes                     | No                            | Yes                      | Yes                      |
| <b>Intersectoral collaboration</b>        | Yes                     | No                            | Yes                      | Yes                      |

<sup>#</sup> Based on average; \*Except in case of market failure

Acknowledging the specific challenges that are unique to vulnerable communities, **ACCHS** and **MPS** have been established to address Indigenous health and aged care, respectively. ACCHS are unique in the way that the health care priorities are community-driven and accountable to the community. This is similar to the state-funded Victorian Community Health Centres operating a social model of health to ensure access and support for those with, or at risk of, poorer health (Vic Health, 2015). At the micro level of service delivery, the ACCHS is a good example of bringing together the appropriate services that play a role in Indigenous health and wellbeing (health and non-health). The comprehensive primary health care model uses an empowerment approach and encompasses a holistic view of health care, including social determinants and equity issues. Although there is no significant difference in clinical outcomes for those attending ACCHS compared with those attending mainstream services, patients show greater preference for, and health care utilisation is higher in, ACCHS. MPS uses a flexible funding model and strong relationships with the community to deliver integrated care for aged populations living in rural and remote areas. Like ACCHS, the combination of health care and social services are tailored to meet the community's needs.

Other models of regionalisation include co-localised or hub-and-spoke service models, such as national GP Super Clinics, Victorian PCPs and SA's GP Plus. Each of these models has demonstrated improvements in some indicators, but comparison across different approaches is not meaningful as they differ on too many variables. For all models, irrespective of their governance structure, funding, roles and responsibilities, a key barrier to better integration of services is a lack of strong and enduring relationships between providers and service organisations.

Better integration of services is an ongoing challenge and takes time to develop. At the meso level of PHCOs, there has been increasing emphasis on supporting integration of services to reduce fragmentation and improve efficiency in health services. There is an assumption that "collaboration across public services would deliver better value for citizens than organisations working independently of each other" (Ham and Alderwick, 2015, p 29). However, cross-sectoral collaborations and partnerships need strong leadership and clear goals; and Ham and Alderwick suggest that real shared decision-making is rare; and that most interaction relates to sharing information and joint needs assessment, which limits the impact.

**Table 6 Patient experience of health care services in last 12 months, % of persons aged 15 years and over**

| Patient experience criteria                           | 2009<br>% | 2010-11<br>% | 2011-12<br>% | 2012-13<br>% | 2013-14<br>% | 2014-15<br>% |
|---|-----------|--------------|--------------|--------------|--------------|--------------|
| <b>Wait times longer than acceptable<sup>a</sup></b>  |           |              |              |              |              |              |
| Wait for GP appointment                               | 18        | 15           | 27           | 20           | 23           | 21           |
| Wait for specialist appointment                       | 21        | 21           | 25           | N/A          | 25           | 24           |
| <b>Cost barriers</b>                                  |           |              |              |              |              |              |
| Delayed/skipped prescriptions                         | 9         | 9            | 9            | N/A          | 8            | N/A          |
| Delayed/skipped GP consultation                       | 6         | 8            | 7            | 5            | 5            | 5            |
| Delayed/skipped specialist consultation               | 10        | 12           | 8            | 8            | 8            | 8            |
| <b>Sufficient time in consultation (always/often)</b> |           |              |              |              |              |              |
| GP consultation                                       | N/A       | N/A          | N/A          | N/A          | 89           | 89           |
| Medical specialist consultation                       | N/A       | N/A          | N/A          | N/A          | 90           | 93           |

<sup>a</sup> OECD criteria for wait times = waiting > 4 weeks for appointment; N/A: data were not available for time period. Source: (ABS, 2010, ABS, 2015).

In terms of the impact of regionalisation on patient experience, there were limited data that demonstrated an association between patient experience and particular regional health entities. Using Australian Bureau of Statistics (ABS) data<sup>15</sup> that were similar to the OECD patient experience criteria, Table 6 shows some fluctuations over time from 2009 to 2015 (ABS, 2010, ABS, 2015). For example, the proportions of survey respondents who reported having to wait longer than acceptable to get an appointment to see a GP or specialist have increased over time since 2009; whereas the cost barriers have remained stable or decreased slightly overall. Compared with OECD data (Table 7, Appendix), a high proportion of Australian patients reported that they ‘always’ or ‘often’ had sufficient time allocated for a consultation with the GP or medical specialist.

Given the problems related to using patient experience as a measure of health system performance, caution is needed in interpreting these outcomes or attributing changes to any single factor. Although longitudinal data collections are valuable for monitoring performance over time, inconsistencies in the way survey questions are worded and/or gaps in data when questions are removed/added make it difficult to reach reliable conclusions. Better alignment of Australian data with international datasets (e.g. OECD patient experience criteria) would provide more consistent and comparable information.

Some system-level challenges faced by MLs and the Divisions before them still remain for PHNs (CHERE, 2015a). These include:

- **Jurisdictional complexities:** enduring barriers remain between the acute care and primary health care sectors, due to split responsibilities across Commonwealth and state/territory boundaries. For example, states/territories are responsible for hospital care and the Commonwealth is responsible for primary health care and aged care. This can lead to cost-shifting and lack of coherence in policy and practice across sectors.
- **Rising costs of health care:** the combined effects of an ageing Australian population, a shift in the burden of disease towards multiple chronic and complex conditions and advances in medicine and technology have contributed to increased demand and higher expectations of quality health care.
- **Poorly targeted financial incentives and funding structures:** Existing incentive schemes for practices and practitioners (e.g. Fee-for-service) may lead to unintended consequences (e.g. over-use of MBS items) and do not support better integration of services across sectors. There is poor alignment of incentive structures across different parts of the health system, including general practice, allied health and other health care providers, hospitals, health insurance, health care managers and administrators.
- **Inter-professional barriers:** differences in training, registration, funding, accountabilities and rewards impact on effective multidisciplinary team care.
- **Poorly linked and inadequate data:** routine collection of clinical, process and performance data at a regional level; and information sharing across health care providers to inform practice and population health planning is lacking.

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<sup>15</sup> Patient experience survey data were collected from a representative sample of Australian households (e.g. 7,124 in 2009).

## Current international perspectives and trends

In the following section, a brief overview of health care system decentralisation/centralisation status and trends is provided for a selection of countries within the UK, Europe and Scandinavia, and for Canada and NZ. It should be noted that many of the countries included here are in a dynamic phase of health system reform with ongoing pressure for governments to act; in part due to a perceived need for economic austerity, but also increasing patient expectations and the public perception of politicians' accountability for health sector performance (Jakubowski and Saltman, 2013). The following overview is based on the literature available at March 2016 and the reader is encouraged to refer to the individual references for more detail; in particular, two reviews (Jakubowski and Saltman, 2013, Progress Consulting S.r.l. and Living Prospects Ltd, 2012) are recommended. Details on specific countries are provided in the Appendix (from page 49) and organised by the type of health management system (decentralised to centralised) described in Table 9 (Appendix).

### *Summary of trends*

Decentralisation of health care has for many years been widely supported in Europe, particularly in the Nordic countries of Norway, Denmark, Sweden and Finland (Saltman et al., 2012). In all systems examined in this report, decentralisation was associated with clear delegation of areas of responsibility. For example, local authorities often assumed responsibility for prevention, long-term and elderly care, home nursing and social services, whereas regional centres often governed hospitals and primary care, and the State (or national) authority distributed funding and regulated health care through guidelines and quality improvement initiatives. However, overall indications are that there is current movement towards greater centralisation in many of the countries examined; and although driven by common concerns about quality, safety, and efficiency issues, the approaches to this vary.

In some countries, there has been a mix of measures resulting in some control being centralised to the national level, while other areas are further decentralised to local agencies (Jakubowski and Saltman, 2013). Moves towards centralisation often take the form of evidence-based guidelines and performance safety and quality measures implemented through national agencies, or specialist centres (e.g. Denmark, Germany) (Jakubowski and Saltman, 2013). Specifically, Jakubowski and Saltman (2013) report that, while many central governments are looking to gain greater control of their decentralised health care systems, there is “no clear uniform direction for the resulting shifts in responsibilities. In a number of countries, recent reforms have centralized certain areas of decision-making or regulation but decentralized others – although the former has been more prevalent” (p xvii).

On the basis of its early and enthusiastic adoption, Canada is often highlighted in discussions of health care regionalisation/decentralisation (Marchildon, 2015). Canada has strongly favoured a **decentralised** model; but there is movement towards greater centralisation in some provinces, more decentralisation in others; and even cases (e.g. Alberta) where the change in direction has been partially reversed as problems were encountered with increased centralisation (Marchildon, 2015). However, a lack of evaluation studies has made it difficult to determine the impact of the different models of decentralisation across the country.

NZ also represents a **decentralised system**; but in response to recent system level difficulties, there has been a move to centralise coordination of agency activities and services. NZ's regional District Health boards (DHB) have responsibility for hospitals and allocation of funds to Primary Health Organisations (PHOs) which are, in turn, responsible for planning and funding of primary care (Gauld, 2014a). More recently, an Alliance Leadership Team was established to better coordinate the DHBs

and PHOs and to share resources (through a flexible funding pool), which are used where needed to finance cross-sectoral service integration (Gauld, 2014b). Early evidence suggests that this approach is yielding positive outcomes with respect to reducing rates of emergency hospitalisation (Gauld, 2014b). Finding the correct balance and scale of authorities has also proven difficult elsewhere, with the decentralised Danish system significantly reducing the number of units while the centralised French system moved to increase the number of regional entities. In each case, there has been a need for flexibility in responding to changing needs and unforeseen short-comings of previous policies. A time-course analysis of patient satisfaction and the process of decentralisation in Spain revealed little if any interaction between the two; and in Italy, the impact of decentralisation has been shown to be highly context-specific (Anton et al., 2014, Toth, 2014).

Other shifts towards decentralisation include: Ireland, which is in the process of moving from a highly centralised system to decentralisation of planning; while the centralised system of England is piloting full decentralisation in the Greater Manchester region (Darker, 2013, Health Service Executive Ireland, 2014, Vize, 2016). Therefore, models of regionalisation vary considerably between and within countries, and there does not appear to be a dominant model or a strong consensus in terms of movement towards one of either centralisation or decentralisation.

### *Financial responsibility*

Financial responsibility has also been subject to change in response to unmet needs and spiralling costs; but again in no single direction. In the highly ranked<sup>16</sup> centralised English system, a new initiative sees the Greater Manchester regional authority take autonomous control of a £6.2 billion budget and responsibility for health and social care. In contrast, in the Netherlands a competitive market dominates with health insurers given major responsibility for health care finance and provision (Jakubowski and Saltman, 2013, van den Berg et al., 2014, Vize, 2016). Meanwhile, the Italian national government has brought in measures to centralise financial control by requiring traditionally decentralised regional authorities to submit budget plans; and Germany has moved to centralise health insurance funds and increase fund regulation in what is seen as a move away from decentralisation (Jakubowski and Saltman, 2013, Toth, 2014). Recently, Canada has been criticised for failing to give regional authorities adequate control over primary health care delivery or budgets for physicians, resulting in a truncated version of regionalisation that hampered alignment of responsibility and accountability (Marchildon, 2015). Sweden stands apart in that even local municipal authorities are able to levy taxes to pay for health care; and there is no evidence that this highly decentralised system is likely to undertake major change in the future (Jakubowski and Saltman, 2013).

### *Patient experience*

Based on the eight OECD criteria for patient experience, where data are available, it is evident that patient experience varies across countries included in the current report; but there is no clear correlation according to degree of centralisation/decentralisation (Table 7, Appendix)<sup>17</sup>. It is also relevant to note that, while many countries rank highly in terms of quality and coordination of care, they often score poorly in terms of patient-level outcomes of access and equity (Davis et al., 2014, Government of Canada, 2015) (See Table 7 and Table 8, Appendix). From an analysis of responses to the 2010 Commonwealth Fund International Health Policy Survey, Papanicolas et al. (2013) concluded that overall satisfaction represents something different in different health systems; and it

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<sup>16</sup> The UK consistently ranks highly in terms of quality of care, access to care and equity compared with other OECD countries (Davis et al., 2014) (see Table 8, Appendix)

<sup>17</sup> For more details on patient experience for different countries see [http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH\\_HCOI](http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_HCOI)

is likely that between-country variation is related to factors outside of immediate health system control. However, in a number of countries, poor affordability and effectiveness of care, together with less interaction with one's regular doctor were associated with poorer overall ratings of a health system (Papanicolas et al., 2013). Based on the Commonwealth Fund survey, the lowest levels of satisfaction were reported in Australia and the US, and the greatest satisfaction in the UK (Papanicolas et al., 2013). The 2013 Eurobarometer survey indicated generally high levels of satisfaction, but also variation. While respondents in all countries indicated that well-trained medical staff and treatment that works were the main criteria of high quality health systems, the importance of choice of doctor varied (e.g. rated as important by 10% of UK respondents vs 28% in Germany).

Overall, in most of the countries examined, patient experience of, and satisfaction with, health care is generally good to high (except in southern Italy, where it is low (Toth, 2014)), although high out-of-pocket costs were a common area of dissatisfaction across most systems (Table 7, Appendix), irrespective of whether they represented a more centralised or decentralised model. An exception to this was the centralised English system, with high levels of patient satisfaction and low impact of out-of-pocket costs.

Despite the high levels of patient satisfaction in the UK, major changes towards decentralisation are currently being piloted in the Greater Manchester region of England, reportedly to enable greater integration between health and social services, and to better respond to local needs (Vize, 2016). Reporting of patient satisfaction and experience is becoming more common; and while the use of OECD indicators is useful for international comparisons, there is need for restraint in drawing conclusions on this basis, as many different factors may influence patient satisfaction (Papanicolas et al., 2013). Further, outcomes from Germany suggest a need to measure this separately for the different health care sectors because in that setting, satisfaction with health care overall did not mirror the primary health care sector where patients reported greater dissatisfaction. In view of the increased importance being placed on primary health care in all of the systems examined, an increased focus on patient experience in this sector is likely to be useful, including collection of nationally representative, longitudinal data based on consistently applied questions and rating schemes. Finally, analysis of the differing regional governance models in Italy using the Inter-Regional Performance Evaluation system (IRPES) including patient satisfaction and experience outcomes, suggests at least two measures potentially leading to improvements: public disclosure of data and external benchmarking between regions in the Italian setting (Nuti et al., 2016).

## Summary and discussion

One of the key purposes of regionalisation is to consider local contextual factors in decision-making in order to improve the health of the local population through better access to quality health services that fit the needs of a local community. The downside of this goal is that the regional variability in needs and potential diversity of approaches limits opportunities for standardising approaches or scaling up effective programmes for wider implementation. However, although a ‘one-size-fits-all’ approach is unlikely, there are lessons that can be learned, shared and adapted from ‘case studies’, then shared and adapted again.

We examined the impact of regionalisation in Australia and internationally, based on the key functions and responsibilities of a regional organisation: supporting quality care to improve health outcomes, managing costs, engaging primary health care practitioners and the community, enabling better integration of services, and improving accessibility to services in the community.

The key barriers and enablers of effective regionalisation that emerge from the findings are:

- **Flexibility:** to achieve ‘functional integration’ (Valentijn et al., 2013), a flexible approach is needed. That is, rather than more centralisation or standardisation of care, greater focus is needed on developing strong and enduring partnerships that have the flexibility and capacity to adapt to changes. For example, changes in the regional demographic profile, advances in health care, technological improvements, workforce fluctuations, social and environmental factors impact on the prioritisation and selection of services, and how they are provided, measured and monitored to ensure quality and effective care is provided efficiently and equitably.
- **Cross-sectoral collaboration:** levels of the health system need to be aligned. At the macro level of policy, population-level data can inform planning, with population-level budgets to align incentives. Meso level organisations can target specific population needs, engaging with the community to manage and design local services. Micro level services that are aimed at individual health outcomes, with integrated health records and multidisciplinary care teams require enablers at the macro and meso levels (Alderwick et al., 2015).
- **Clear definition of responsibility and flexibility of funding** are important contributors to effective decentralised systems. Flexible funding to respond to local community needs was central to the success of MPS in rural Australia, and capitation based on population needs and characteristics has enabled the NZ PHOs to tailor services, despite having no overarching financial authority. In contrast, a lack of levers and incentives to facilitate change was a barrier to MLs in Australia; and, in Canada, lack of budget and organisational control for primary health care has impeded alignment of the system by the regional RHA.
- Although an area of considerable interest, patient experience is a difficult outcome to measure, particularly where it is used to gauge health system performance; and may reflect aspects not related to the health care system.
- Out-of-pocket costs are a major source of patient dissatisfaction across all systems, with the exception of the UK; but access to well-trained medical staff and treatment that works were of greatest importance across Europe.



## Conclusions

Achieving an optimal balance in delivering good quality, fiscally-responsible and appropriate health care that meets the needs of Australia's diverse population is a challenge. Although evidence-informed decision-making is needed to ensure quality and effectiveness of care, flexibility and adaptability are essential to obtaining a good fit.

Flexibility and context-specific implementation of services at a regional level is important not only for the current health care needs, but also looking forward to what may be needed in the future as a population's burden of disease changes (e.g. lower rates of infection, higher rates of chronic illness, increasing multimorbidity and disease complexity).

Whichever PHCO variation is implemented, it needs to be supported across all levels of the health system from macro to micro. Moreover, strong and sustainable partnerships and networks that can transcend changes of governments, and are adaptable to changes in population and health care advances, may reduce the disruption and costs associated with continuous system re-design.

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## Appendices

### Measures of patient satisfaction and patient experience

In a detailed literature review of patient satisfaction versus patient experience, Kalucy (2009) identified a number of problems with the measurement of **patient satisfaction** including:

- ambiguity of the concept of 'satisfaction' which is a multidimensional construct, though often measured as if it were unidimensional
- the lack of definition of the term satisfaction
- patient level biases, including a tendency for patients to treat medical professionals uncritically as experts, and a disinclination to be critical because of their gratitude or not wanting to jeopardise their treatment
- satisfaction being determined largely by factors other than the care an individual receives, including age or educational attainment
- satisfaction being related only marginally to experience, and more to public events like media portrayals, the opinion of political leaders, and even national events that are not directly related to health
- findings from satisfaction surveys being too non-specific to use to improve the quality of care delivered.

It has been acknowledged that **patient experience** indicators such as process measures (did the right thing happen at the right time?) and outcome measures (i.e., patient functional status) are preferable to 'satisfaction', which can differ widely between individuals and across socioeconomic status (Hibbert et al., 2013). However, reporting of patient experience outcomes in those terms is often absent (Russell, 2013b).

**Table 7 OECD criteria for patient experience, by type of health system and country**

| Proportion of respondents reporting on criteria (% , range) |                     |                        |                       |                  |                       |                                    |                          |                                 |  |
|---|---------------------|------------------------|-----------------------|------------------|-----------------------|------------------------------------|--------------------------|---------------------------------|--|
| Country   | Type of healthcare  | 1. Wait times >4 weeks | 2. Consultation costs | 3. Medical costs | 4. Prescription costs | 5. Sufficient time in consultation | 6. Adequate explanations | 7. Opportunity to ask questions | 8. Patient involved in decision-making |
| Australia   | Mixed               | 17.5 (16.9-18.0)       | 3.2 (2.9-3.5)         | 7.8 (7.4-8.2)    | 46.2 (43.3-49.0)      | 82.9 (81.4-84.3)                   | 85.9 (84.5-87.2)         | NR                              | 86.0 (84.7-87.3)                       |
| Italy   | Decentralised       | 4.8 (0.7-9.0)          | 3.1 (-2.2-8.5)        | NR               | 54.3 (51.8-56.7)      | NR                                 | NR                       | NR                              | NR                                     |
| Spain   | Decentralised       | 0.1*                   | NR                    | 5.5*             | NR                    | NR                                 | NR                       | NR                              | 62.1*                                  |
| Finland   | Mixed/decentralised | NR                     | NR                    |                  | NR                    | NR                                 | NR                       | NR                              |  |
| Sweden  | Mixed/decentralised | 3.6 (2.9-4.2)          | 2.4 (1.8-2.9)         | 4.1 (3.5-4.8)    | 48.7 (46.1-51.4)      | 78.3 (76.8 - 79.8)                 | 81.8 (80.4-83.2)         | NR                              | 80.5 (79.1-82.0)                       |
| Denmark   | Mixed/decentralised | NR                     | NR                    | NR               | NR                    | NR                                 | NR                       | NR                              | NR                                     |
| Germany   | Mixed/decentralised | 7.9 (6.7-9.0)          | 5.6 (4.6-6.5)         | 9.6 (8.4-10.8)   | 27.2 (25.3-29.1)      | 88.2 (87.0-89.5)                   | 90.7 (89.5-91.9)         | NR                              | 87.7 (86.4-89.1)                       |
| Netherlands   | Mixed               | 12.5 (11.2-13.7)       | 16.6 (15.2-18.0)      | 8.3 (7.3-9.3)    | 22.6 (19.9-25.4)      | 85.1 (83.8-86.3)                   | 86.8 (85.6-88.0)         | NR                              | 83.9 (82.6-85.3)                       |
| UK  | Mixed               | 2.2 (1.7-2.6)          | 2.5 (1.9-3.1)         | 2.1 (1.6-2.6)    | 18.3 (15.6-20.9)      | 86.3 (84.9-87.7)                   | 89.5 (88.2-90.8)         | NR                              | 88.0 (86.7-89.4)                       |
| France  | Mixed/centralised   | 9.0 (7.9-10.0)         | 9.5 (8.5-10.5)        | 7.8 (6.8-8.8)    | 49.3 (47.2-51.3)      | 80.0 (78.6-81.4)                   | 83.7 (82.4-85.1)         | NR                              | 78.8 (77.3-80.2)                       |
| Ireland   | Centralised         | NR                     | NR                    | NR               | NR                    | NR                                 | NR                       | NR                              | NR                                     |
| Canada  | Decentralised       | 5.4 (4.9-5.8)          | 5.6 (5.1-6.1)         | 8.5 (7.9-9.1)    | 62.1 (60.7-63.6)      | 79.3 (78.4-80.2)                   | 85.4 (84.6-86.2)         | NR                              | 83.0 (82.1-83.8)                       |
| New Zealand   | Mixed               | 14.3 (13.5-15.1)       | 11.8 (10.2-13.3)      | 6.1 (5.6-6.6)    | 44.1 (41.1-47.1)      | 88.4 (87.0-89.8)                   | 89.5 (88.0-91.1)         | NR                              | 89.8 (88.3-91.4)                       |

1. Waiting time of more than 4 weeks for getting appointment with a specialist; 2. Consultation skipped due to costs; 3. Medical tests, treatment or follow-up skipped due to costs; 4. Prescribed medicines skipped due to costs; 5. (Regular) doctor spending enough time with patients during the consultation; 6. (Regular) doctor providing easy-

to-understand explanations; 7. (Regular) doctor giving opportunity to ask questions or raise concerns; 8. (Regular) doctor involving patients in decisions about care or treatment.

NR = not recorded; \* data missing.

**Table 8 Overall ranking of selected health care systems for 2011-2013**

|                        | Australia | Canada | France | Germany | Netherlands | NZ | Norway | Sweden | Switzerland | UK | US |
|------------------------|-----------|--------|--------|---------|-------------|----|--------|--------|-------------|----|----|
| <b>Overall ranking</b> | 4         | 10     | 9      | 5       | 5           | 7  | 7      | 3      | 2           | 1  | 11 |
| <b>Quality of care</b> | 2         | 9      | 8      | 7       | 5           | 4  | 11     | 10     | 3           | 1  | 5  |
| <b>Access to care</b>  | 8         | 9      | 11     | 2       | 4           | 7  | 6      | 4      | 2           | 1  | 9  |
| <b>Equity</b>          | 5         | 9      | 7      | 4       | 8           | 10 | 6      | 1      | 2           | 2  | 11 |
| <b>Efficiency</b>      | 4         | 10     | 8      | 9       | 7           | 3  | 4      | 2      | 6           | 1  | 11 |

Adapted from (Davis et al., 2014)

## International trends, by country and type of health management system

### *Europe and Scandinavia*

#### **Overview**

Health systems across Europe and Scandinavia cover a spectrum between centralised and decentralised forms. This variation across Europe was documented in a detailed report for the European Committee of the Regions (Progress Consulting S.r.l. and Living Prospects Ltd, 2012) and formed the basis for proposing a new typology comprising five distinct types of health management system. The five types are distinguished based on the degree of decentralisation of functions, consideration of the funding source and level compared to the EU average, potential for direct spending by the local regional authority (LRAs), as well as the LRA power and responsibility for health-related legislative, planning and implementation functions, and health care facility ownership/management (see Table 9). Although many European countries have actively pursued transformation within their health care systems since publication of that report, the proposed typology provides a useful framework with which to compare the individual health care systems.

For all EU member nations in 2012, most countries were employing models positioned away from the extremes of decentralisation and centralisation, but a larger number tended towards decentralisation (see Table 10, Appendix).



**Table 9 Proposed typology of health management systems in the European Union**

| <b>Health management system type</b>                                | <b>Definition</b>  |
|---|--|
| <b>Type 1 (decentralised systems)</b>                               | Regional health management systems, with regulation, management, operation and some funding delegated to regional authorities or States. Funding through sub-national budgets is above the EU average; and sub-national authorities own and manage health care facilities.   |
| <b>Type 2 (partially decentralised systems)</b>                     | Health management systems where local and regional governments are responsible for several planning and implementation functions, besides funding; and they own and manage health care facilities. Sub-types are distinguished by the level of funding from subnational budgets (above or below the EU average).   |
| <b>Type 3 (operatively decentralised systems)</b>                   | Health management systems where local and regional authorities (LRAs) have operational (implementation) functions, including owning health care facilities; funding from sub-national budgets is limited. The Netherlands have an 'operative' function, but differ in that they are centralised regarding hospital governance; and LRAs have a role in planning and implementation, including limited funding contribution from the sub-national budget. The UK also differs, as each of its four constituent countries (England, Scotland, Wales, and Northern Ireland) has its own 'National Health Service' but within each constituency the prevailing type refers to a system that is 'centralised but structured at the territorial level'. The UK is type 3 due to the 'operative' function of the four constituencies. |
| <b>Type 4 (centralised but structured at the territorial level)</b> | Health management systems that are centralised to the extent that most responsibility lies with the central government even if implementation is at the territorial level through bodies representing the central administration. Apart from Portugal, LRAs may also manage health care facilities.  |
| <b>Type 5 (centralised)</b>   | Health management systems are centralised in full.   |

*As presented in (Progress Consulting S.r.l. and Living Prospects Ltd, 2012).*

**Table 10** Distribution of European Union countries in 2012, according to the new health system typology

| Type 1  | Type 2         | Type 3      | Type 4   | Type 5          |
|---------|----------------|-------------|----------|-----------------|
| Italy   | Lithuania      | Latvia      | Portugal | Malta           |
| Austria | Hungary        | Slovenia    | Greece   | Ireland         |
| Spain   | Estonia        | Luxembourg  | France   | Republic Cyprus |
|         | Poland         | Bulgaria    |          |                 |
|         | Denmark        | Netherlands |          |                 |
|         | Finland        | Romania     |          |                 |
|         | Sweden         | UK          |          |                 |
|         | Germany        | Slovakia    |          |                 |
|         | Belgium        |             |          |                 |
|         | Czech Republic |             |          |                 |

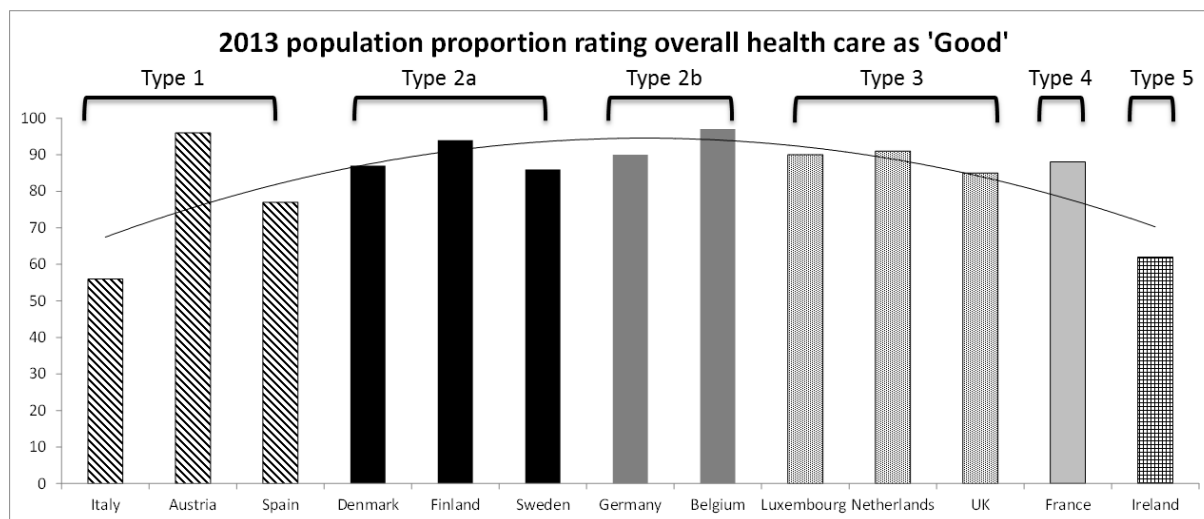
Source: (Progress Consulting S.r.l. and Living Prospects Ltd, 2012).

### Patient outcomes and experience

In 2013, a European Commission Eurobarometer survey on health care safety and quality for almost 28,000 people included a section to gauge perceptions of, and information about, the quality of health care (European Commission, 2013b). Respondents were asked to answer the question ‘How do you rate the overall quality of healthcare in your country?’ Based on five possible responses (‘very good’, ‘good’, ‘bad’, ‘very bad’, ‘don’t know’) (European Commission, 2013b), results indicated wide variation in patient satisfaction with the overall quality of health care in their country. Respondents in the northern and western European countries were more likely to rate health care as ‘good’ or ‘very good’ compared to those living in southern and eastern Europe. However, even among western European countries there was variation, with 30 per cent or more respondents in Belgium, Netherlands, Austria and the UK rating the health system as ‘very good’, compared to less than 20 per cent of respondents in Ireland, Spain and Italy (European Commission, 2013b, pt 3).

When data for selected northern and western EU countries were reviewed according to the type of health management system described in Table 9, there was an apparent trend towards greater satisfaction (as reported by the Eurobarometer) with mixed systems that lie between centralised and decentralised models (Figure 1). However, there are also obvious exceptions (e.g. Austria), and caution is advised when interpreting these data due to the use of ‘patient satisfaction’ as a key variable<sup>18</sup>. Well trained staff and treatment that works were the dominant hallmarks of quality health care among Eurobarometer respondents.

<sup>18</sup> See discussion on patient satisfaction as an outcome measure (page 54).



**Figure 1** Proportion of residents rating the overall quality of healthcare in their country as 'good' (highest rating possible)

Source of health care system rating: (TNS Opinion & Social, 2014); Type 1 = decentralised; Type 2a = partially decentralised with high funding level; Type 2b = partially decentralised with low funding level; Type 3 = operatively decentralised; Type 4 = centralised but structured at the territorial level; Type 5 = centralised.

It is interesting to note that a 2012 survey of approximately 3,000 patients using primary care services in seven European countries found that overall 77 per cent were satisfied with primary care received (Sanchez-Piedra et al., 2014). However, in Germany the corresponding value was 60 per cent, compared to 64 per cent in Finland, 66 per cent in Spain, and 74 per cent in Italy; and this despite a lower proportion of patients in Germany reporting chronic disease and a higher proportion having had their weight, cholesterol and blood pressure measured in the last year. These outcomes contrast with the Eurobarometer findings for the health system overall, where higher rates of satisfaction were demonstrated among German respondents; and also emphasises the importance of distinguishing between levels of satisfaction in individual health care sectors as opposed to overall satisfaction with the health system.

## Trends in decentralisation/centralisation and corresponding patient experience

### Type 1 models: decentralised

Both Italy and Spain have a long experience with decentralised health care. Based on the Eurobarometer data presented above, satisfaction with health care is relatively low.

*Italy (Ferré et al., 2014, Progress Consulting S.r.l. and Living Prospects Ltd, 2012, Jakubowski and Saltman, 2013)*

- Highly decentralised, the 19 regions and two Autonomous Provinces of varying size and population organise and deliver health care.
  - The Ministry of Health is responsible for public health at the national level, quality control and allocation of national funds to the regions, and has exclusive authority in setting the core health benefit package (Livelli Essenziali di Assistenza – LEA). Ministry of Health specifies that 50% of funding should go to community health care.
  - Regional agencies (mainly northern Italy) provide technical and scientific support to local health authorities (ASLs) and hospitals

- In each region, geographically-based ASLs are responsible for primary, secondary and specialist care (either directly or via hospitals or private providers), preventive medicine, public health and care of the elderly.
- Each ASL is divided into Districts, and these are responsible for local public health, community health services, and primary care.
- Citizen or consumer involvement lacks a systematic strategy. It varies widely despite statements of principles in the founding law of the State health system
- Universal coverage is mostly free of charge for residents and citizens
- Public financing comes from national and regional taxation; most regions depend on transfer of central funds to compensate for regional income variation
- Mixed service provision – public and private, but predominantly public
- Basis of region definition is geopolitical; therefore wide variation in population, geographical size and economic development exists
- Population estimated 62 million.<sup>19</sup>

### Trends

Decentralisation of health care occurred in Italy in the 1990s. Toth (2014) suggests that this was influenced by more economically advanced regions tiring of the fiscal burden of less disciplined regions; and the government at that time preferring regions to take on unpopular decision-making relating to health care (e.g. out-of-pocket costs). It was also expected that competition would encourage less advanced regions to follow the practices of more successful regions. Regional ASLs deliver primary and secondary health care services, set reimbursement rates, allocate public funds and set any additional quality standards beyond those set at the national level (Jakubowski and Saltman, 2013). A national solidarity fund was used to equalise regions through subsidies (Jakubowski and Saltman, 2013). However, the combined effects of increased regional healthcare spending, regional deficits, regional fragmentation of health care services, political instability and the 2008 financial crisis have stalled completion of the intended process of decentralisation begun in the 1990s (Ferré et al., 2014). The current national government is playing a greater role in regional economic decisions, including a strategy whereby regions submit budget balance plans; and failure to operate within budget requires them to increase local taxation and risk entering trustee administration (Toth, 2014, Jakubowski and Saltman, 2013). Recovery plans have been implemented for a number of regions and inter-regional collaboration has been very limited. According to Jakubowski and Saltman (2013), this setting favours national government intervention via increased centralisation as the future solution to health care service variability, rather than the alternative of strengthening regions through collaboration.

In Italy, there are strong differences between the northern and southern regions with the north being more developed and affluent in terms of per capita income (Toth, 2014). However, as noted above, national policy aims to equalise delivery of resources to all 22 regions. Where the regions differ is how that funding is utilised. Southern regions outsource to private entities for specific services and this accounts for approximately 39 per cent of the public regional health care spending; in the north, the corresponding level is less than 35 per cent (Toth, 2014). Northern regions have also reduced hospital beds by closing hospitals or repurposing them for long-term care facilities, rehabilitation centres and palliative care (Toth, 2014). This is reflected in a greater proportion of the northern region's budget being spent on local care (as opposed to hospital care) compared to the southern region (Toth, 2014). Recent analysis of the differing regional governance models and outcomes using the Inter-Regional Performance Evaluation system (IRPES) suggests that the 'choice and competition' model was not associated with sustained performance improvement; but public

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<sup>19</sup> July 2015 <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2119rank.html>

disclosure of data can lead to improvements, as can external benchmarking (Nuti et al., 2016). IRPES comprises six dimensions of: population health, regional strategy compliance, quality, patient satisfaction and experience, staff satisfaction, efficiency and financial performance. Another analysis of the Italian health care system suggests that decentralisation that includes fiscal processes (e.g. 1998 granting of regional power to impose tax levies) can improve inequalities in health outcomes in affluent regions, but not for less developed regions. This suggests that there may be a need for greater central government intervention; and the benefits of decentralisation may be very context-specific (Di Novi et al., 2015).

#### Patient experience

Satisfaction with the Italian health care system is also divided along the north-south border. In 2009, approximately 49 per cent of northern Italian respondents were very satisfied versus 23 per cent of southern Italians (Toth, 2014). The Northern value is in line with the Eurobarometer findings for 2013 (TNS Opinion & Social, 2014). In 2009, 168,000 Southern Italian residents went to the North for treatment, compared to just 31,000 in the opposite direction (Toth, 2014). Incomplete OECD data for patient experience in Italy possibly reflects limited availability of data for that set of indicators<sup>20</sup>. Nevertheless, available OECD indicator data show that patient access to care was good in 2013, whereas the cost-burden of prescriptions was very high compared with other countries (Table 7, Appendix). Sanchez-Piedra et al. (2014) reported that 87 per cent of survey respondents in 2012 were satisfied with primary care received, and 74 per cent had had weight, cholesterol and blood pressure measured in the past year, suggesting good levels of patient management within primary care. However, it was not indicated whether the respondents were from the northern or southern regions. Movement towards an integrated primary health care system has reportedly been very slow in Italy.

*Spain (Anton et al., 2014, García-Armesto et al., 2010, Jakubowski and Saltman, 2013, Progress Consulting S.r.l. and Living Prospects Ltd, 2012)*

- Highly decentralised since 2002
  - National Ministry of health coordinates the Spanish National Health System (Sistema Nacional de Salud, SNS), and distributes funds to 17 Autonomous Communities (ACs)
  - ACs are accountable only to the regional parliaments
  - Important role of regional authorities (ACs) for planning and organisation, policy development, delivery and expenditure related to health including hospitals and primary care
  - Primary care is delivered through public Health Care Centres (HCC)
- Citizen involvement has been effectively discouraged by the technical (professional) bodies, but is increasing through patient lobby groups who are gaining recognition in regional politics
- ACs have responsibility for public health spending (92% in 2010)
- Universal coverage mostly free of charge
- Public financing out of general taxation, including regional taxes
- Mixed service provision – mainly public and some private
- Basis of region definition was political
- Population estimated 48 million.

#### Trends

The Sistema Nacional de Salud (SNS) was established to provide universal health care to those with Spanish citizenship. The process of decentralisation to 17 ACs occurred over a period extending from

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<sup>20</sup> IRPES data including patient and staff satisfaction results for 2012 is available in Italian (<http://www.meslab.sssup.it/>)

1981 to 2001 (Anton et al., 2014). This highly decentralised system was defined based on political considerations rather than health care needs, but provides universal coverage that is largely free of charge (Anton et al., 2014). ACs are generally responsible for, and regulate, the insurer, purchaser and provider health care functions for their population (García-Armesto et al., 2010). ACs are also responsible for other sectors including education (Jakubowski and Saltman, 2013). Decentralisation within regions varies considerably across Spain. Typically, separate executive organisations for primary and specialist care (ambulatory and hospitals) are in place, although some regions have a single management structure for integration of these areas. AC authorities can extend insurance benefits (set by the national government) to meet local preferences and criteria of need and priority (García-Armesto et al., 2010). Decentralisation has reportedly led to improved health outcomes such as life expectancy and mortality rates at a relatively modest cost (Jakubowski and Saltman, 2013). However, it has also led to marked regional differences in health outcomes and has not addressed intra-regional geographical inequity problems, as well as failing to foster inter-regional connectivity through information systems (Jakubowski and Saltman, 2013).

### Patient experience

A recent review of the Spanish Health Barometer cross-sectional survey results for 1996 to 2009, found that decentralisation was not associated with an improvement of citizens' satisfaction with health care; and in fact may be associated with a small negative impact on satisfaction (Anton et al., 2014). OECD survey data for patient experience indicators in the Spanish setting is generally lacking, but for 2013 approximately 62 per cent of respondents indicated that their regular doctor involved them in decisions about care or treatment (Table 7, Appendix). This proportion was substantially lower than reported by other comparable countries. In contrast, Sanchez-Piedra et al. (2014) reported that approximately 79 per cent of respondents were satisfied with primary health care services received in 2012. Given that 37 per cent of Spanish survey respondents included in the EUprimecare survey reported having a chronic disease, and 66 per cent had weight, cholesterol and blood pressure measured in the past year, respondent interaction with the system was considerable (Sanchez-Piedra et al., 2014).

### **Type 2 models: partially decentralised**

The Nordic models of health care, which have long been decentralised, have recently started to shift towards increased centralisation. Although driven by common concerns about quality, safety, and efficiency issues, change is occurring more rapidly in Norway and Denmark than in Sweden and Finland (Saltman et al., 2012).

#### *Sweden (Jakubowski and Saltman, 2013, Saltman, 2015)*

- Highly decentralised, regional authorities (21 county councils) assume greatest role in practical and financial terms, with assistance from local authorities (290 municipalities responsible for elderly care)
  - State is responsible for legislation on health, regulatory control of health and medicines, including integration of services and data collection
  - Consultation between the State and regions/municipalities is via the Swedish Association of Local Authorities and Regions (SALAR) representing the county councils and municipalities, as well as the largest employers in Sweden (Jakubowski and Saltman, 2013)
  - Eight national agencies have evolved over the past decade and through measures such as practice guidelines and drug regulations, central-level influence on health policy has increased; a development criticised by SALAR (Jakubowski and Saltman, 2013)

- County councils have responsibility for health care planning, service provision and contracting, and hospitals. They also have the authority to levy proportional income taxes and to raise taxation levels
- Some county councils are divided into health care districts (usually one hospital and several primary care units) and in 2000 there were 370 districts (Saltman et al., 2007)
- Municipalities are responsible for planning and funding of care of the elderly, discharged patients and people with disabilities
- Universal coverage with a nominal fee at the point of use
- Public financing of health care largely via regional and municipal taxation (but also national), with care mostly free at point of contact with a capped variable co-payment, and out-of-pocket costs also apply for medications
- Mixed service provision – public and private
- Basis of region definition is geopolitical
- Population estimated 9.8 million.

### Trends

Despite attempts in the 1980s and again in 2007 to partially centralise the county-based structure of the Swedish health system, it remains decentralised and virtually unchanged (Saltman, 2015). Similarly, the public nature of service provision has changed little with very slow movement of private providers into the hospital sector. The Vardval (Care Choice) initiative of 2010 granted patients free choice of provider between private and public centres, and primary care has gradually moved to a mixed public/private provider base with counties increasingly contracting out services to private providers (50% of all primary care visits in Sweden in 2012). Using a capitation model for each signed-up patient, payments are doubled for those over 65 years of age (Saltman, 2015). Although counties and municipalities have retained the potential to increase local taxes to cover increases in health costs, the potential negative impact of this within electorates has acted as an incentive for counties to identify more effective cost-containment policies and measures, sometimes leading to underinvestment (Jakubowski and Saltman, 2013). However, Saltman (2015) suggests that, like most European economies, Sweden is facing a number of health care challenges that have prompted calls for a more flexible and efficient<sup>21</sup> structure of service delivery; but in a stable/static system, addressing these may be difficult.

### Patient experience

Patient choice of provider has also been a very slow development in Sweden, and was partly facilitated by European Union court rulings on patient rights to 'timely' care (Saltman, 2015). OECD reporting for 2013 indicates Sweden had good access to care and high levels of equity in care (Table 8, Appendix), whereas interaction with a person's regular doctor was lower when compared to other western European countries (Table 7, Appendix). In terms of out-of-pocket costs, while Sweden performed better than most on consultation costs (2.4% skipped consultation due to cost), prescription costs were problematic for 48.7 per cent of respondents. Large national patient surveys across different health care settings conducted in Sweden in 2009-10 found that, while patients were satisfied in terms of 'respect', a substantial proportion were not satisfied with information received about their conditions (one third), information about possible warning signs (two thirds), involvement in decision-making (one third), or planning of their health care (two thirds) (Kandelaki et al., 2016). Variation between counties in terms of health care access were apparent but how much can be attributed to governance structure is unknown (Jakubowski and Saltman, 2013).

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<sup>21</sup> Sweden's health system ranks highly (#2) in terms of efficiency compared to other selected health care systems (Table 8, Appendix).

Waiting times for specialised care and inter-county variation in access and quality of care are substantial problems (Jakubowski and Saltman, 2013), but also highlight the importance of looking at individual regional efforts for examples of greater efficiency. Described as one of the world's 'high performing healthcare systems' where responsibility for health has devolved to the regional level, the Jönköping County Council has developed integrated health and preventive care services to help people navigate services across settings (Baker and Denis, 2011, Baker et al., 2008, Davies, 2008). Based on a fictional elderly resident ('Esther') and a long-term commitment to training and development, this 'whole of system' approach focuses not only on healthy living, but also on social aspects that impact on health (e.g. alcohol and drug use, crime, truancy, education outcomes etc.), with targeted strategies for children and young people, people with mental illness and older people. The Jönköping County Council has consistently performed well on a range of health and wellbeing indicators, including: reduced hospital admissions, improved access to specialist care, shorter length of stay and shorter wait times for specialist appointments (Alderwick et al., 2015).

#### *Denmark (Mainz et al., 2015, OECD, 2013, Jakubowski and Saltman, 2013)*

- Decentralised, although the 2007 reform imposed greater centralisation to form a three layered health system with less units, State (national), five regional (formerly 15 counties) and 98 local (municipal, formerly 275) authorities having a major role
  - State distributes tax-based funding to regions (80% as block grants), and municipalities (20%, according to socioeconomic differences and population size) to co-finance hospitals and primary care (Jakubowski and Saltman, 2013)
  - Regions run and own hospitals, and are responsible for contracting self-employed GPs, specialists, and dentists, as well as being responsible for distributing block funding from the state (Mainz et al., 2015, Progress Consulting S.r.l. and Living Prospects Ltd, 2012)
  - Municipalities are largely responsible for home nursing, long-term care, disease prevention, local administration of primary health care, social services and health promotion (Mainz et al., 2015), but also have a financial stake in the funding of hospital services (OECD, 2013)
- Formal involvement of consumers is limited and not compulsory (OECD, 2013)
- Universal coverage largely free at point of contact for acute and community care; but out-of-pocket costs for pharmaceuticals, dental care, physiotherapy and eye products
- Public financing through taxation
- Mostly public service provision
- Region definition is geographical
- Population estimated 5.6 million.

#### Trends

Although traditionally a decentralised system, 2007 reforms resulting in reduced number of regions and municipalities together with more recent introduction of national standards for publicly-funded health system providers via the Danish Health care quality Programme (DDKM) (IKAS, 2015) has contributed to a move toward a more centralised planning model (Olejz et al., 2012, dmc healthcare, 2016, Jakubowski and Saltman, 2013, OECD, 2013). Specifically, centralisation via national clinical guidelines, disease management programmes and patient pathways was established in Denmark to standardise the delivery of health care (Mainz et al., 2015). Objectives of the 2007 reform included economies of scale and reduced duplication of services (Jakubowski and Saltman, 2013). Regions are increasingly encouraged to outsource to cost-effective private providers where there is a shortage of public providers; and removal of their power to levy taxes has further centralised funding to the State level (Jakubowski and Saltman, 2013). Hospital sector improvements



prior to 2009 were supported by extensive inclusion of clinicians in decision-making and led to specialised services being offered within a smaller number of major hospitals (OECD, 2013). Removal of incentives to take up private insurance in 2011 has negatively impacted the private health insurance sector.

Integrated home and community care for the elderly is a cornerstone of the Danish system, assisting people to live independently. The original programme (Skævinge) has expanded to include those requiring long-term care. The current programme focuses on supporting self-care and independent living with access to community nurses and allied health care services; and, despite increasing numbers of patients, overall costs for care have decreased (dmc healthcare, 2016). However, primary and secondary care sectors are not well integrated and GP engagement with disease management programmes has been poor, even with financial incentives (OECD, 2013).

#### Patient experience

The National Danish Survey of Patient Experiences (LUP) has been conducted on behalf of the five regions and the Ministry of Health since 2000. While LUP surveys of patient experience are implemented within hospitals and the questionnaire is largely focused on hospital care, participation is voluntary within primary health care and municipalities (OECD, 2013). Outcomes are published in Danish, but the Region of Hovedstaden announced in 2014 that there was greater than 90 per cent satisfaction with hospital treatment. This is consistent with 2013 Eurobarometer survey results indicating that 87 per cent of respondents were satisfied with overall health care in Denmark (TNS Opinion & Social, 2014). Similarly, the Danish Patients Evaluate general Practice (DanPEP) survey has been completed by 80,000 people, and shows generally good satisfaction levels (OECD, 2013). Specifically for the period 2002-2005, DanPEP questions relating to OECD criteria 5-8 about patient interaction with the doctor showed good levels of satisfaction among 78 per cent or more of patients, but satisfaction with accessibility was much lower depending on the question (48-74%) (Vedsted and Heje, 2008). More recent details of DanPEP have not been widely published in English, but all practices must contribute to DanPEP at least once every three years (OECD, 2013).

#### *Germany (Busse and Blumel, 2014, The Economist, 2015, Jakubowski and Saltman, 2013)*

- Decentralised (but moving towards increased centralisation), with activities of the Federal Joint Committee (Gemeinsamer Bundesausschuss, or G-BA) and the 16 state level Länder being clearly separated. Länder in turn delegate to ‘corporatist bodies’ comprising payer (associations of sickness funds) and provider members (regional associations of physicians, dentists or single hospitals)
  - G-BA has a shared responsibility for public health, long-term care, hospital budgets and regulatory decision including which services are covered by Statutory Health Insurance (SHI)
  - Länder are responsible for hospital care, planning and financing, as well as public health activities and training of health physicians
  - Civil society organisations, sickness funds and doctor’s associations have a major role
  - Ambulatory care is provided through individual private practice or polyclinic-type centres, as members of either Regional or federal associations of SHI physicians (corporatist bodies), but is also supervised by the Länder
- Universal coverage through SHI coverage (accounts for 85% of the population; those on higher incomes can opt out by taking up private health insurance)
- Public financing through taxation, social insurance contributions financed through employee and employer payroll taxes, and private health insurance (The Economist, 2015)
- Mixed public – private service provision

- Geographical region definition at level of Länder
- Population estimated 81 million.

*Gesundes Kinzigtal* in Southwest Germany is a regional population-based integrated care approach, which involves collaboration between a national health management company, a regional health management company, a network of local physicians and two non-profit health insurers (Hildebrandt et al., 2010). *Kinzigtal* contracts with a range of health care providers and other industry organisations (e.g. gyms, support groups). Health care providers in this region receive financial incentives in four stages: 1) regular payments through SHI; 2) Fee-for-service (e.g. health check-up); 3) pay-for-performance (e.g. patients enrolled in Disease Management Programme); and 4) profit distribution through efficiency savings. *Kinzigtal* is responsible for the health care budget of the enrolled population; and where savings are made, the benefits are shared. Compared with those not enrolled, *Kinzigtal* has saved 16.9 per cent of the budget (2006-2010), mainly through lower ED admissions (Alderwick et al., 2015)

### Trends

The decentralised system of Germany has moved to a more central financial structure as a consequence of two major strategies: increasing the power of corporatist governance arrangements (e.g. centralisation of health insurance funds), and through strengthening of national-level regulation of some components of health insurance funding (e.g. standardisation of the contribution rate) (Jakubowski and Saltman, 2013). Establishment of the SHI fund in 2009 to centralise SHI contributions was a fundamental reform (Jakubowski and Saltman, 2013, Busse and Blumel, 2014). There has also been a move to centralisation of healthcare units specialising in particular diseases or procedures; and nationwide rollout of Disease Management Programs (DMPs) (The Economist, 2015, Fuchs et al., 2014). Germany ranks poorly in terms of efficiency of the health care system compared with other selected health care systems (Table 8, Appendix).

### Patient experience

OECD indicators indicate a high level of satisfaction with overall health care services in Germany (e.g. access to care, Table 8, Appendix), although some cost-related barriers to care appear to be greater than reported for other western European countries (Table 7, Appendix). The 2013 Eurobarometer survey found that 90 per cent of respondents rated the overall quality of healthcare in Germany as 'good' (9% rated it as 'bad'). In contrast, for primary health care, Sanchez-Piedra et al. (2014) found that 44 per cent of survey respondents in 2012 reported having a chronic disease, and although 81 per cent had weight, cholesterol and blood pressure measured in the past year, only 57 per cent were satisfied with the primary care received. The impact of centralised management of chronic diseases such as diabetes through DMPs has shown improvements in process parameters and satisfaction with care, but due to weaknesses in study design, effectiveness of DMPs is uncertain (Fuchs et al., 2014). Evaluation of the *Kinzigtal* initiative demonstrated improved health outcomes and better experience of care compared with those not enrolled with *Kinzigtal* (Alderwick et al., 2015).

### **Type 3 models: operatively decentralised**

*Netherlands (van den Berg et al., 2011, Jakubowski and Saltman, 2013, van den Berg et al., 2014)*

- Operatively decentralised, market-based system with delegation to various groups including municipal health services (GGDs), which are responsible for providing public health services, and insurers who contract service providers (primary and secondary)
  - Government ministry (4 agencies including Dutch Healthcare Authority) responsible for priority setting and determining the minimal amount that an insurer has to charge for standard cover, and generally has regulatory function
  - Insurers include for-profit and not-for-profit agencies and operate in a competitive market, where their responsibilities include contracting providers of primary care
  - GGDs responsible for providing public health services including funding and management of long-term care services, youth health care, mental health care and medical screening
  - Hospitals are mostly non-profit corporations, but pharmacies are largely public entities located within hospitals or general practice
- Patient organisations have a strong position, and employers have become intermediate agents between insurers and employees
- Almost universal coverage through compulsory health insurance and an income-based contribution; a mandatory deductible of €385 per year applies from 2016 (except for general practice and midwifery care)<sup>22</sup>
- Funded through compulsory income-related contributions and insurance premiums
- Private service provision (primary and secondary), regulated competitive market
- Basis of region definition is geographical at primary care level based on government requirement that GPs can only accept patients who live within 15 minutes of the practice
- Population estimated 17 million.

### **Trends**

Widely regarded as a well-functioning decentralised health care system, the Dutch system has undergone a number of transformations over the years, including introduction of a managed competition model in 2006, with health insurers playing a central role to optimise service delivery and achieve the goals of sustainability, quality, and efficiency of the system (van den Berg et al., 2014). In this decentralised model, insurers are obliged to contract sufficient providers to guarantee access to their insured clients and After-hours cooperatives must be located near a hospital to avoid unnecessary ED use. Health care organisations are obligated to include a client council and to take their advice into account when developing new policies or making decisions (Hegger et al., 2016). An important tool for assessing how the system is performing is the Dutch Health Care Performance Report (DH CPR), first published in 2006 and continually refined to meet needs (van den Berg et al., 2014). Faced with increasing health care costs, a 2013 McKinsey report (van Rooijen et al., 2013) suggested that the way forward in the Dutch health system should include greater emphasis on quality performance measurement and prevention, as well as exploration of the alternative financing models for cure (curative care) and care (long-term care including elderly, disability and chronic psychiatric care). Decentralisation of responsibility for funding of long-term care to local agencies (GGD) has not translated into measurable cost savings at the system level (Jakubowski and Saltman, 2013). Provider variation in quality of care is a challenge within the Dutch system (Jakubowski and Saltman, 2013), and recent increases in the annual deductible (from €220 to €350) may affect future access (van den Berg et al., 2014).

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<sup>22</sup> <http://www.zorgwijzer.nl/faq/health-care-insurance-in-the-netherlands>

### Patient experience

Based on OECD indicators, most of the Dutch population is satisfied with the level of care and interaction received from their doctor. However, compared with other OECD countries, the proportion of people indicating problems with respect to waiting times (12.5%) and out-of-pocket costs for consultation (16.6%) and prescriptions (22.6%) is relatively high (Table 7, Appendix). This is despite government policy that regulates provider supply with the aim of ensuring access; and obligatory insurance schemes that aim to ensure cost coverage (albeit with a sizeable deductible). Eurobarometer surveys of satisfaction with the health system overall indicate approximately 90 per cent of respondents are satisfied.

### *UK (OECD, 2016b, Bevan et al., 2014, Jakubowski and Saltman, 2013)*

- Decentralised to individual UK member countries, and centralised within those countries (i.e., England, Wales, Scotland, Northern Ireland), but organised and administered on a local basis
- Each country has its own publicly-funded National Health Service
  - England:
    - Department of Health has been responsible for public health policy and regulation, and central budget allocation. Recently, responsibility for public health has transferred to local authorities (Alderwick et al., 2015)
    - NHS England is independent of the government, oversees and allocates resources to Clinical Commissioning Groups (CCGs) and leads quality improvement measures via the National Institute for Health and clinical Excellence (NICE). They also commission primary care and specialist services at a national level
    - CCGs replaced Primary Care Trusts in 2013 (previously replaced Primary Care groups), and have responsibility to allocate funding to primary and secondary services, community and mental health services, as well as commissioning of local health care services
    - All general practices have to be members of a CCG
    - Health and wellbeing boards were established to strengthen health and social care relationships and work with local government authorities to promote integrated commissioning
  - Scotland:
    - Scottish Government Health Directorate is responsible for the NHS and policy development and implementation
    - 14 regional NHS boards oversee health and social service agencies that plan and provide services. These regional boards are supported by 7 special NHS boards and one public health body (quality and improvement) and must achieve 'Local Delivery Plan' targets and involve consumers in decision-making
  - Wales:
    - Welsh Assembly government is responsible for the NHS
    - NHS comprises 7 local health boards and 3 NHS Trusts responsible for planning and providing health care services
  - Northern Ireland:
    - Department of Health, Social Services and Public Safety (DHSSPS) has strategic oversight and delegate health and social service commissioning responsibility to the Health and Social Care Board (HSCB)

- The HSCB commissions services from 5 Health and Social care (HSC) trusts and manages annual funding received from the government. Five Local Commissioning groups (geographically aligned with health and social care trusts providing health social care) interact with the HSCB and HSC trusts to commission services and assess local health and social care needs
- Services managed and administered by HSC trusts include: hospitals, health centres, residential homes, day centres
- High level of citizen or consumer panel involvement through surveys, patient-reported outcomes, online feedback portals and involvement of patient and consumer groups, and NHS boards in some countries. Only in England does the patient have the right to choose their provider organisation; and in this case the money follows the patient
- Universal coverage free at point of service in all four health systems
- Mainly public financing through general taxation and national insurance contributions
- Mostly public service provision, but matching of health care services to need varies in each country according to structure (see above) but Northern Ireland differs in that health and social services are administratively combined
- Basis of region definition is geography
- Population estimated UK 64 million
  - England (population 50 million)
  - Scotland (population 5 million)
  - Wales (population 3 million)
  - Northern Ireland (population 1.7 million).

### Trends

Within the UK member countries, there is an increasing trend towards greater decentralisation. As England accounts for approximately 80 per cent of the UK population, this setting is particularly informative of current trends. Beginning with the introduction of Primary Care Trusts and then CCGs in 2012, the move away from the central NHS model in England has led to CCGs controlling 80 per cent of the NHS budget (Jakubowski and Saltman, 2013). The 209 CCGs are tasked with delivery of a sustainable health care system, to be achieved through collaboration with 152 health and wellbeing boards, 152 local authorities, seven commissioning support units, and four NHS England regional teams (Naylor et al., 2015). The new governance arrangement is still evolving and the King's Fund proposed ten priorities, suggesting how they might be addressed in the coming years (Naylor et al., 2015).

More recently, in the Greater Manchester region, health care and social services control is being transferred to the region to improve service integration for the population of 2.7 million people (Vize, 2016, McKenna and Dunn, 2015). This move was prompted in part by the NHS five-year forward view asserting that “England is too diverse for a “one size fits all” care model to apply everywhere” (NHS England, 2014, p 4); and partly in response to lower than national averages for health outcomes in the Greater Manchester region, despite substantial spending on health care (NHS England, 2014, GMCA, 2016). Under the new arrangements, Greater Manchester continues to be part of the national NHS and social care system, but the focus is on people and place. This involves integration of health and social care with other services including blue light services (e.g. ambulance, police), mental health, public health, health education and research and development (including the academic health science system, Health Innovation Manchester, HIM). The final governance model is due for release in April 2016, and will assume responsibility for the financial and clinical sustainability of health and social care across 10 boroughs. Greater Manchester has a population of 2.8 million, and the new combined ‘authority’ will have control of the £6.2 billion budget (Vize, 2016). However,

this development is controversial and is not without its critics (Vize, 2016). Currently, the UK ranks highly in terms of efficiency of the health care system (Table 8, Appendix).

#### Patient experience

The UK is at the top of global ranking of health care systems for 2011-13 (Table 8, Appendix); but limited data availability restricts comparisons between individual UK countries with respect to patient satisfaction with the health care system. However, recent OECD indicators of patient experience for 2013 indicate substantially better performance in the UK as a whole compared to many similar economies for patient access, out-of-pocket expenses, and satisfaction with doctor interactions (Table 7, Appendix). In England (2014), the NHS inpatient surveys also indicated a high level of satisfaction with hospitals (84%), with similarly high ratings for care and respect received, hospital conditions, staff competence and information received (Care Quality Commission, 2015). In comparison, earlier surveys based on the British Social Attitudes survey (2011) across England, Wales and Scotland, reported the proportion of patients satisfied with the NHS was between 50 and 65 per cent, while 65 to 80 per cent were satisfied with NHS doctors or GPs (Bevan et al., 2014).

#### **Type 4 models: centralised but structured at the territorial level**

*France (Chevreul et al., 2015, Jakubowski and Saltman, 2013)*

- Centralised with state Ministry of Health exercising strong control, particularly over financial and operational management, and more recently quality of care
  - SHI also shares responsibility with Ministry of Health
  - Local regional authorities contribute to support of the elderly and the disabled, and to a lesser extent to policy and health system regulation. In a move towards decentralisation, seven regional entities evolved with planning responsibilities; but in 2009-10, these were merged and 26 regional health agencies (ARSs) formed, although the Ministry of Health continued to be the main decision-makers.
  - “ARS has responsibility for ensuring that health care provision meets the needs of the population by improving articulation between ambulatory, hospital, health and social care sectors, while respecting national health expenditure objectives” (Chevreul et al., 2015, p 19)
  - Each ARS covers several departments (geographic areas) and, within each department, a local delegation is responsible for implementation of ARS policies, while services such as care of the elderly and disabled are under the General Council
- Citizen or consumer panel involvement has been criticised as inadequate, but forms part of the 2015 Health Reform Law
- Universal coverage for residents through SHI, and for the poorest, universal free medical coverage. This is supplemented by Voluntary health Insurance (VHI) which covers co-payments and supplements costs for medical goods and services not well covered by SHI
- Funded mostly through public financing by income-based contribution and taxation
- Mixed public and private service provision
- Population estimated 66.5 million.

#### Trends

Establishment of the ARS was a move towards planning decentralisation of this traditionally centralised system. However, “In the French context, decentralization was mainly a form of deconcentration, where policies and frameworks are defined at the central level and implemented at the local level, adapted to local situations” (Chevreul et al., 2015, p 158). Planned changes with the 2015 Health Reform Law are expected to increase State control of ARS governance, and also increase

consumer representation. Despite having a high standard of care and low out-of-pocket costs, the French system is currently challenged by the financial demands related to meeting the needs of people with chronic diseases and an ageing population. France ranks poorly in terms of efficiency of the health care system compared with other selected health care systems (Table 8, Appendix).

#### Patient experience

Based on OECD statistics, patient experience of health care in France is very good (approximately 80% reporting good interaction with their regular doctor), although overall out-of-pocket costs appear to be of more concern than in other western European countries (Table 7, Appendix); and they rank poorly in terms of access to care (Table 8, Appendix). Out-of-pocket costs account for 7.5 per cent of total health expenditure in France, and this is of particular concern in the area of residential long-term care services where this averaged almost €3,000 per month in 2012 (Chevreul et al., 2015). Eurobarometer data for 2013 indicated that 88 per cent of French respondents rated the overall quality of healthcare as good (compared to a 71% average for the 28 EU member countries) (European Commission, 2013a).

### **Type 5 models: centralised**

*Ireland (Darker, 2013, Health Service Executive Ireland, 2014)*

- Until recently, Ireland was highly centralised, with main responsibilities held by the Health Service Executive, HSE (comprising 3 divisions) and with a very limited (if any) role of local governments. Recent restructuring has decentralised planning and service delivery and now sees the Minister for Health overseeing an HSE Directorate headed by the Director General who is responsible for liaison with 8 National directors overseeing different aspects of health care including:
  - Acute Hospitals directorate –Hospital groups
  - Four separate directorates together oversee the 9 Community Healthcare Organisations (CHOs) – Primary Care, Social Care, Health & Wellbeing, Mental Health directorates
  - CHOs
    - Each of the 9 CHOs has a chief officer tasked with coordinating integrated care models, particularly with reference to interaction between community and acute hospital services, and in line with national frameworks
    - The CHO structure includes a head of primary care, head of social care, head of health & wellbeing, head of mental health, head of finance , head of human resources, head of corporate support services, GP Lead, and Lead quality & Professional Development unit
    - The CHO for health & wellbeing coordinates needs assessments
    - The CHO head of primary care oversees the Primary Care Networks and is the accountable budget holder
    - Each Primary Care Network has an identified accountable person who is responsible for service delivery to a defined local population
- Citizen or consumer panel involvement, but not indicated as part of new CHO structure
- Universal coverage for residents, but significant out-of-pocket costs apply for all except those with a Medical Card (low socioeconomic status or having long-term or severe illness) or GP visit card (income- and age-based)
- Public financing out of general taxation, with contributions from out-of-pocket payments and private health insurance
- Basis of region definition: geographical for newly proposed CHOs, population-based for Primary Care Networks
- Mixed public and private service provision
- Population estimated 5 million.

### **Trends**

While the HSE continues to lead, in 2014 the Irish Government backed a move towards greater decentralisation of service delivery with establishment of nine CHOs. In addition, 90 primary health care networks are to be established averaging a population of 50,000 people and responsible for coordinating care at the local level, including social care, mental health and health and wellbeing (Health Service Executive Ireland, 2014, Darker, 2013). The CHO populations are based on geographical boundaries, and vary between almost 390,000 to approximately 674,000 people; and encompass on average ten Primary Care Networks. The Irish government's move to establish CHOs and Primary Care Networks supports national health policy in relation to meeting future health needs, and can be viewed as decentralisation of planning. In the initial phase, key areas will be to develop primary care services and standardised pathways and models of care within community services, such as social care and mental health. In particular, a stronger emphasis on prevention,



early detection and health promotion and improvement is envisaged (Health Service Executive Ireland, 2014). A detailed account of expected governance structures of the CHOs and Primary Care Networks is available (Health Service Executive Ireland, 2014, Chapt 7), but due to the ongoing restructuring, it is difficult to identify final arrangements regarding structure and flow of funding at this time.

In 2014, reduced State subsidy of private health insurance resulted in younger people dropping private insurance until penalties were introduced in 2015 for those taking up insurance for the first time after the age of 34 years (Turner, 2015).

#### Patient experience

The OECD has no listing of patient experience indicators for Ireland; and the most recent survey of patient experience in Ireland was conducted in 2010. Further, the 2014 National Healthcare Quality Reporting System report stated that this measure had not been included because there was no standardised approach across services provided by the HSE that would allow comparison to be made (An Roinn Sláinte, 2015).

#### *Canada (Marchildon, 2013, Marchildon, 2015, Van Aerde, 2016)*

- Decentralised, main responsibilities held by provincial Regional Health Authorities (RHAs) who also have responsibility for a number of hospitals and long-term care homes (Ontario is an exception); and a legal mandate to plan the coordination and continuity of care across health organisations and providers.
  - Federal government has a ‘steering’ function via the Canada Health Act; compliance is required for Provinces to receive funding, but recently stated that provincial governments should decide their own health reform priorities and objectives (Marchildon, 2015)
  - RHAs are responsible for hospitals and long-term care
  - Generally RHAs do not have responsibility over primary health care, with private and decentralised delivery of physician services directly funded by provincial governments
- Citizen or consumer panel involvement is minimal or non-existent
- Funding from Health Ministry to RHAs for institutional care, but provincial governments did not transfer control of physicians’ payments to RHAs (Marchildon, 2015)
- Universal Medicare is free at point of access, but only for medically necessary hospital and physician services. Employment-based private health insurance covers prescription drugs, dental care and vision care
- Funding mainly from the general tax revenues at federal, provincial and territorial government level. While historically this was equalised across provinces, after 2014, distribution was on a per capita basis only. Equalisation is addressed through a separate transfer programme
- Mixed public and private service provision
- Basis of region definition is geography
- Population estimated 35 million.

#### Trends

Regionalisation of the Canadian health care system began in Quebec in 1989; and within 10 years most provinces had adopted a form of regionalisation based on a need to reduce costs and consolidate fragmented services. This largely took the form of devolution of funding from provincial government to the RHAs, and centralisation to RHAs of governance and administration responsibilities for the individual health care facilities and organisations (Marchildon, 2013).

However, after 20 years of regionalisation, it has been suggested that due to a lack of evaluation, “we don’t know whether regionalisation has resulted in better health, better health care or better value for Canadians” (Van Aerde, 2016, p 66); although Lewis and Kouri (2004) note that it has been associated with less system fragmentation, less duplication of hospital services, and improved pathways for long-term care. With political leaders questioning the efficiency<sup>23</sup> of regionalisation, there has been a general move towards greater centralisation in some provinces and toward further decentralisation in others (Marchildon, 2015); but this has not been a straightforward process. For example, to gain economies of scale, Alberta replaced nine RHAs with the single Alberta Health Services (AHS) unit; however, four AHS administrative zones then had to be established because of problems with over-centralisation (Marchildon, 2015).

According to some commentators, two major limitations of the Canadian regionalisation process to date have been the absence of clear goals and evaluation, and failure to include health care professionals (particularly physicians) and community members (specifically patients) in the process (Marchildon, 2015, Van Aerde, 2016). Originally, some consumer representation was achieved through election of board members to the RHAs, but now most members are appointed directly by ministers of health and provincial cabinets (i.e., there is no evidence for public input today (Marchildon, 2015)). Similarly, although RHA committees should reflect the population served, inclusion of First Nations and Inuit people is often absent; and indeed services on-reserve are sometimes outside of the province’s mandate (Lavoie, 2013). The First Nations and Inuit Health Branch of Health Canada (FNIHB) delivers community-based health services, but does not receive sufficient funding for reserve residents that only partially qualify (not registered under the Indian Act). There also appears to be varied and sometimes limited provision in some provinces for those living off-reserve. Lavoie (2013) criticises both federal policy framework and RHA provisions, but also recognises that rejection of pan-Aboriginal approaches has contributed to the fragmented and often inadequate health care provisions for National First Nations, Inuit and Métis people.

### Patient experience

Patient experience of the Canadian decentralised health care system has not been directly compared between provinces; and within-regions patient experience indicators are rarely used (Marchildon, 2013). Both the Commonwealth Fund surveys and OECD indicators (Health Council of Canada, 2011, Davis et al., 2014) rank Canada below comparable developed countries in terms of health care quality, access and equity (Table 8, Appendix); and out-of-pocket costs for prescriptions is very high (62.1% skip prescriptions due to costs). However, it is unwise to generalise for Canada due to the substantial variation in health care delivery between provinces. A 2010 Commonwealth Fund survey of Canadian satisfaction with primary health care found that 48 per cent of respondents were fully engaged<sup>24</sup> with their primary care; and overall most felt they had enough time with their physician (Health Council of Canada, 2011). However, nearly one in five were not at all engaged. In a 2015 report from the Advisory Panel on health care Innovation, it was noted that while there are some examples within the Canadian system where the gap between the rhetoric of patient-centred care and the experience of many patients and families is being successfully addressed, greater assistance is required with up-scaling of innovations (Government of Canada, 2015). Federal action to improve patient engagement and empowerment was one of the five areas forming the final recommendations.

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<sup>23</sup> Canada’s health system ranks poorly in terms of efficiency compared to other selected health care systems (Table 8, Appendix)

<sup>24</sup> Fully engaged was defined as a response of ‘always’ to the following questions: 1. How often are you involved to the extent that you want to be in decisions related to your care? 2. How often do you have enough time with your physician? 3. How often do you have the opportunity to ask questions about your recommended treatment?

### *New Zealand (Cumming et al., 2014, Gauld, 2014b)*

- Decentralised system, where the Ministry of Health (including the National Health Board) is responsible for health policy, and oversees and allocates funds to the 20 District Health Boards (DHBs). In turn, DHBs provide funding directly for hospitals and for 31 Primary Health Organisations (PHOs), private hospitals, and Māori and Pacific health care providers (via services agreements)
  - Ministry of Health directly funds public health and prevention services, and disability support services
  - DHBs own, plan and fund regional hospitals and other services based on a clinical governance model involving health professionals; they are also responsible for aged care, public health and prevention
  - PHOs plan and coordinate general practice and primary care for enrolled patients; and although there is a pay-for-performance quality framework, funding is based on population needs rather than a fee-for-service model, with capitation rates weighted based on age, rurality, gender, deprivation status of PHO enrollees and number of high-user people. PHOs have no financial authority and cannot commission services
  - Primary medical care is largely provided privately with government subsidies
  - Alliance Leadership Team (ALT) model was introduced in 2013 to coordinate DHB and PHO interaction
- Community participation including Māori members is required at the DHB level
- Universal coverage for all with co-payments
- Funded largely through general taxation, with supplementation from user payments, private health insurance (held by 38% of population) and non-profit organisations
- Mixed public and private service provision
- DHBs are based on geographical area; GPs decide which PHO they want to join and are funded based on capitation payments
- Population estimated 4 million.

### Trends

Since 2009, NZ has committed to a clinical governance model based on the UK NHS model, with the 20 DHBs and 31 PHOs taking a central role (Gauld, 2014b). Based on 2011-2013 data, NZ ranked highly in terms of efficiency of the health care system (Table 8, Appendix). In 2013, NZ moved towards increased centralisation via a formal alliance between DHBs and PHOs reportedly in response to the difficulties of a system with parallel structures lacking coordination (Gauld, 2014b). The ALT includes members from DHBs, PHOs, doctors, nurses, allied health professionals and consumer representatives, who agree to a 'whole of system' approach and creation of a 'flexible funding pool' to finance this approach (Gauld, 2014b). ALTs have flexibility to focus efforts where it is needed. Initial early evaluation suggests that there have been positive outcomes including reductions in ED admissions and more traditional hospital services being provided in the community setting (Gauld, 2014b). Gauld (2014b, p 567) suggests that important factors for successful alliances include members' requirement to:

- 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
- cast aside sectoral interests, work to assist one another
- take a whole-of-system approach to planning and decision-making based on what is best for the patient and health system.

### *Patient experience*

Patient satisfaction with their regular doctor is high, but cost-related barriers to care (e.g. prescription and consultation costs) are also relatively high compared with other similar countries based on OECD indicators (Table 7, Appendix). National patient experience surveys for public hospital inpatients and based on indicators covering communication, partnership, coordination and physical/emotional needs are regularly published and results for 2014 demonstrate high rates of satisfaction in most DHB regions<sup>25</sup> (Cumming et al., 2014). However, NZ ranks poorly in terms of equity compared to other countries (Table 8, Appendix).

One example of a regional entity that performs well is Counties Manukau Health (CMH), which is responsible for commissioning health care services in South Auckland, a low socioeconomic area of Auckland (Alderwick et al., 2015). CMH aligns networks of practices with hospital services, using capitated budgets allocated to PCOs and alliance agreements to share responsibility across partners. Services are tailored to local needs, based on population risk stratification, including prevention, lifestyle support and social care needs; and the emphasis is on supporting people to manage their own health. Early evaluation indicates positive trends, including improvements in: immunisation, cardiovascular risk assessment, smoking cessation support, acute care and care home utilisation rates. CMH also connects with social care partners that impact on health, such as housing programme and employment services.

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<sup>25</sup> <http://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/NEMR/patient-experience-survey-results-Feb-2015.pdf>