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This report is part of the final evaluation report on Care Net Illawarra, one of the Australian Coordinated Care Trials based in the Illawarra. Each of the national trials addressed the same primary hypothesis:

Coordination of care of people with multiple service needs, where care is accessed through individual care plans, and funds pooled from existing Commonwealth, State and joint programs, will result in improved client health and well being within existing resources.

A summary of the key elements of the Care Net Trial is contained in Appendix 1 of this report.

There are 10 reports in this evaluation series:

Report Number 1	The Care Net Trial – What it was and How it was Managed
Report Number 2	The Care Net Intervention
Report Number 3	Care Coordination in the Care Net Trial
Report Number 4	The Use of IT in the Care Net Trial
Report Number 5	Client Experiences in the Care Net Trial
Report Number 6	The Care Net Trial – Impact on General Practitioners
Report Number 7	The Care Net Trial – Impact on Health and Community Care Providers
Report Number 8	The Care Net Trial – Impact on the Wider System (this report)
Report Number 9	The Care Net Trial – Value for Money?
Report Number 10	The Care Net Trial – The Evaluators Conclusions

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Report Number 8

The Care Net Trial - Impact on the Wider System

8.1	<i>Introduction</i>	1
8.2	<i>Hypotheses, Methods and Types of Data</i>	1
8.3	<i>Findings – The Impact of Care Net on the Wider System</i>	2
8.3.1	Care Net Aims within the Wider System	2
8.3.1.1	Care Coordination.....	2
8.3.1.2	Care Planning.....	2
8.3.1.3	Service planning and substitution.....	3
8.3.1.4	Who carried risk?.....	3
8.3.1.5	Funds pooling and community care agencies	4
8.3.1.6	Community care and the development of IT systems	5
8.3.1.7	System change aims	5
8.3.2	Local Stakeholder Views on the Trial	5
8.3.2.1	Illawarra Area Health Service	5
8.3.2.2	The Illawarra Division of General Practice.	8
	IDGP initiatives running in parallel with Care Net.....	8
8.3.2.3	Community Care Agencies.....	10
8.3.2.4	Private providers.....	12
8.4	<i>Discussion – Implications for Mainstream Services</i>	13
8.4.1	The main achievements in the wider system	13
8.4.1.1	Changing relationships	13
8.4.1.2	Community participation in Care Net.....	13
8.4.2	Barriers to making an impact on the wider system	14
8.4.2.1	Issues of scale	14
8.4.2.2	Issues of equity.....	14
8.4.2.3	Issues of integration	15
8.4.3	The next generation – the 1999 Care Network proposal	15
8.5	<i>Conclusion</i>	17
	<i>Appendix 1:An overview of the Illawarra Coordinated Care Trial</i>	18
	<i>Appendix 2:Hypotheses and Data Sources</i>	19
	Data Sources.....	21
	Framework for semi-structured interviews	22
	<i>Appendix 3:Policy Context</i>	23
	<i>References</i>	24

8.1 Introduction

The national evaluation framework for the trials proposed a number of thematic reports and the impact of the Care Net trial on the wider service system is the topic of this report. By the wider system we refer to the context of the trial, including the history and views of its sponsoring organisations and its impact on other stakeholders who are not directly covered in other reports in this series. Impact is discussed in terms of issues of integration.

The Council of Australian Governments' (COAG) original aims were to build a system that encouraged better and more flexible services at the local level and to do this the first step was to concentrate on the interface between health and community services (COAG, 1995). Section 8.3 of this report covers the history and policy context of both strategic planning and individual projects in the Illawarra region. These have both prepared the groundwork for the Care Net trial and also contributed to some of the barriers to achieving the original COAG aims and the local versions of those aims as interpreted by different stakeholders.

The findings in this report are organised under the headings of Care Net's aims within the wider system in the Illawarra, and the views of the trial sponsors and other stakeholders. The discussion section draws out the implications of the trial's evaluation findings for the wider service system in terms of the main achievements, the barriers, and opportunities for improved integration. This is followed by a description of the key points in the 1999 Care Network proposal. Care Network was planned by a steering committee including Care Net management committee members in response to the request by the Commonwealth for a continuation proposal after the closure of the Care Net trial.

8.2 Hypotheses, Methods and Types of Data

This report primarily covers material relevant to National Hypothesis 9: *“That the primary results can be achieved without detriment to other key areas of government policy, particularly in regard to equity of access and privacy, including any impact on clients outside the trial”*.

The methods used included semi-structured interviews based on a framework of strategic change and policy analysis (Pettigrew, 1992) and used in the trial's Mid Term Report (Eagar et al., 1998). The current report also uses the framework described by Leutz in terms of the five laws of integration (Leutz, 1999) to analyse the impact of the trial on the existing services and the wider system at the local level.

This report draws heavily on the conclusions of related reports and their associated data sources – the interviews, surveys and focus groups with GPs, the care coordinators' questionnaire and group interviews, Care Net staff interviews and documentation.

Other related hypotheses, and a description of the data sources used, are contained in Appendix 2. Quotations from interviews or other sources are presented in the text as indented and in italic. Where not otherwise attributed, their sources are from the list of interviewees and respondents.

8.3 Findings – The Impact of Care Net on the Wider System

8.3.1 Care Net Aims within the Wider System

8.3.1.1 Care Coordination

Care coordination is not one function. The elements already exist in the wider system and include information and referral; assessment; care planning; and purchasing and monitoring.

For information and referral the GP-based IT system clearly pointed in the right direction, bringing GPs into the wider information environment of community care. More might have been done by care coordinators (compared to what other mainstream services do) to include information on the role of carers. The lack of an agreed reporting format from the care plans to GPs meant that assessment data on functional deficits were not consistently translated into information the GPs could use.

The system of assessments of client need was planned with a view to creating a data set that could function for managing care plans and transferring key information between coordinators, GPs, hospitals and other providers. This was only partially successful and the reasons for this conclusion are described in Report Number 2. There was no direct evidence of reductions in the number of assessments undertaken by other agencies.

Assessment data were not used systematically inside Care Net, and when the wind-down process began, a new round of assessments using a newly-devised triage-type tool was undertaken, rather than using the existing Care Net information system.

Assessment lacked some clarity on the criteria used, and the skills and experience of those doing the assessment was variable compared to other agencies doing similar things.

The tools have other uses beyond providing a more thorough assessment:

- they provide a systematic approach across all clients;
- they allow the Trial to do research studies and describe the population;
- they allow for the measurement of change over time;
- they can be used to plan interventions, although caution has to be used because a score does not automatically correspond to a set of services.

Data from the assessment about a heart condition, for example, won't immediately give rise to a treatment regimen, and an adverse score on a cognitive assessment tool should give rise to further investigation, not necessarily an intervention. A general instrument (like the GHQ) is not part of the Trial's assessment tools, but could be used as a cue and prompt device. Some tools won't be able to be used alone because they won't separate changes that are due to the interventions and those that are due to the natural progression of people's conditions.

8.3.1.2 Care Planning

Care planning also received a mixed score card from informants in the local system. The performance of the care coordinators was generally judged to be excellent, with GPs and other providers being very happy with the quality of the work done in the role.

The criticisms that were made of the care coordinators were in terms of the extent to which the role did not reach out to existing service networks, but rather created new arrangements built on the new service culture that was encouraged within Care Net.

Care planning can be criticised as too inward looking, based on the knowledge of the care coordinators, so other quality services were ignored in the planning. In particular there was unhelpful confusion in the trial about the roles of HACC service providers.

8.3.1.3 Service planning and substitution

Service purchasing (or commissioning) also received a mixed appraisal from the wider system informants. The lack of defined budgets linked to client needs and the apparently ad hoc tendering arrangements were seen as problems in the wider system.

Purchasing and monitoring by the care coordinators is a good idea and they were well positioned to do it – especially for one person in the role. The drawback was in not have a defined budget limit, so that raised ethical questions about allocating resources.

Another point of difference in the model was the absence of specified contracts. There were preferred providers, but on what basis were they preferred?

Council is very familiar with the rules around tendering and purchasing. We offered to 'lend' Care Net the systems. There was no response to the offer so Care Net did not have a real EOI and contracts management process. Transparency and clarity were missing. It wasn't clear whether tender assessment panels were set up, the documentation for tenderers wasn't adequate, and we were asked to provide unit costs, rather than prices. These processes are normally all covered by a set of legal requirements.

The model of substitution of services to encourage private community care providers at the expense of encouraging more flexibility within the services provided by the trial sponsors, was also criticised.

There are other elements of community health (other than community nursing) that would be useful for the Trial but don't get called upon - psychosocial services, health promotion, support groups, stress management, exercise groups.

8.3.1.4 Who carried risk?

Financial risk for the trial was carried by the Commonwealth, the State and the IAHS. Financial risk at the local level was borne completely by the IAHS, and in particular by community health services within IAHS, which had pooled a budget component based on historical patterns of service use, yet did not have a guarantee of buy-back. Further, community health funds had been pooled (as were other service funds) on the basis of full average costs but the trial could purchase funds from other providers at marginal prices (see Report 7).

Other local providers had little financial risk attached to their involvement:

- GPs were not expected to lose income, and they gained access to information and got PCs on their desks.
- Home Care Service negotiated arrangements centrally and directed local branches to be involved on the basis of an agreement for a 100% buy back of the services represented by their pool contribution.

- Private providers whose services were purchased as part of the care plan received additional work and income and bore no risk.

8.3.1.5 Funds pooling and community care agencies

(Leutz, 1999) describes his law number 4: "You can't integrate a square peg and a round hole."

At the early stages of Care Net it was unclear what existing or new service types would be needed. Clearly the whole HACC service sector did not need to be engaged, and with relatively small amounts of funds and large numbers of agencies, their involvement was not manageable. Unfortunately this turned into an "us and them" negotiation, which broke down. A better arrangement would only have involved key providers like the HCS, transport and MOW, and projects such as Community Options, with the majority of other agencies being dealt with through an information strategy.

The pressures these small agencies experienced from attempting to respond to unmet demand on the community care service system, made them wary of what changed funding arrangements through the pool might involve, and sceptical of what a new layer of care coordination could achieve.

(Pooling) isn't necessary to achieve better service coordination. The small funds contribution would not make enough difference in terms of increasing the flexibility of care plans.

It is clear that on the one hand small community focussed agencies don't need to contribute to part of a larger pool to do a good job. For example, meals on wheels can offer alternatives like frozen meals, outings or communal dining. The main problem that may arise without participation in the pooling arrangements might then be one of gaining more accountability if that individual service is not what the client wants. There might equally be a problem if the pooling arrangements lead to supporting a large monopoly service provider.

We have a relatively fragile services system and if small agencies were required to pool funds it could spell their demise. It is not useful to see them all as simply separate agencies with separate roles. We have to acknowledge how they all fit together to sustain a viable infrastructure within the community sector.

No. It's not feasible for, say, something like a neighbour aid coordinator who may work part time. What is important is how they all participate in a network of services, as part of a larger package, not funds pooling per se.

The different levels of work on community care have to be acknowledged and pooling funds won't always help. A successful trial would involve partnership at a variety of levels in different organisations. We haven't seen Care Net building those different types of partnerships. For example the work on CIARR and the NSW assessment framework are good examples of building a common approach and achieving progress on difficult issues without pooling funds.

(All quotes are from community care service providers and administrators)

In this context the impact of the trial was to increase the choices for consumers by giving improved access to existing services, direct purchasing of a range of new interventions and service types, and giving more information to GPs. It had been planned that these services would be provided at no additional cost as they would substitute for existing services (PBS, MBS and acute care and community health services provided by IAHS). In reality, these were additional services as outlined in Report 9 on the financial result.

8.3.1.6 Community care and the development of IT systems

There were clear gains in the area of GP computerisation, the use of email messages and the use of computers in care planning. However, the main concern in the wider system was the uneven distribution of these benefits. The proposed extension of the IT capabilities to the community care sector through the trial did not occur as intended by the original submission. The detailed analysis of what was achieved is discussed in Report Number 4 on IT.

The IT issue has been controversial in terms of the resources going into one sector and being left out in the others. This was a strategic error because it made the HACC sector feel they were being treated as second rate.

IT is an example of the aims being consistent but the practice falling short. Council's IT Division had already made investments which would help small agencies by using a cooperative model and Council's 14 community development workers.

Care Net signed up about 100 GPs and the 100 or so other services, would not really have been feasible to sign up and support separately. So the plan was to have the three LGAs as bases with Care Manager and connect to Care Net via modems. That could have run not only Care Manager but also accounts, transport and the CIARR. It made a lot of sense to have all that connected with GPs.

Unfortunately nothing happened – the hypothesis that the IT would help community services was never tested. The Care Net manager, as the only one with the authority to make it happen, never got back to us. What we ended up with was a fax-based system for service orders and the posting of client files, even though e-mail was available.

8.3.1.7 System change aims

The systemic change/community development agenda of the trial was explicit from the start (Report Number 1) and the range of community development activities was considerable. The difficulty for the evaluation is in attributing any changes to the specific activities of the trial, given the various complementary change agendas that were already in progress in the Illawarra area. This is a problem that is common to evaluating any broader systemic change interventions.

There has been 10-15 years of growth driven through Commonwealth and State structures, giving a degree of fragmentation and a large number of independent service providers now underpin a generally good system. Into the 1990s we have begun to see a consolidation phase and the question now is how to rework the system. So a Trial to target high needs clients makes sense - the basic philosophy is sound.
(Public providers, September 1998)

However, as described in Report Number 1 on the organisational model and in Report Number 5 on clients, the establishment of a separate service and new service culture, coupled with relatively low numbers of clients specifically needing the care coordination functions, meant that wider changes would inevitably be somewhat marginal in their effects.

In terms of service coordination generally, it is not the case that Care Net was accepted by all services. For example, community health did not accept assessments from the Care Net care coordinators. They saw them as another service level, not as a coordinating point.

8.3.2 Local Stakeholder Views on the Trial

8.3.2.1 Illawarra Area Health Service

Leutz's second law of integration - "Integration costs before it pays".

The key local stakeholder (in that they were the local organisation bearing financial risk) was the Illawarra Area Health Service (IAHS). In practical terms Care Net sat within the Area structure, constituted under the Area Health Service's enabling legislation.

In supporting the Care Net Trial at the highest level, the IAHS executive demonstrated a strategic approach to the issues raised by the trial, rather than a narrow focus limited to its financial implications. Without this level of support it was unlikely that Care Net could have started and, without the continued support of IAHS, it is unlikely it could have continued.

Support for Care Net from the IAHS perspective was seen as strategically useful because:

- *The trial was worthwhile from the perspective of improving care and getting a better continuum of care, in line with IAHS historical efficiency measures and strategic objectives.*
- *Many of the bigger changes that the trial was part of were being driven independently by changes in technology.*
- *Care Net was part of the longer term process that was 'raising the bar' on access to hospitals – examples included:*
 - *bed management strategies,*
 - *hospital in the home-type treatments,*
 - *innovations in community health services post acute care and increased ambulatory care,*
 - *the ability to 'trace' patients across service and institutional boundaries using an electronic health record.*
- *The trial represented a small proportion of the IAHS total budget.*

There was also another strategic consideration that made support for Care Net an attractive proposition. Under the NSW funding agreements, the IAHS should have been stemming outflows to Sydney hospitals and seeking additional resources for extra work done within the Area, as of July 1998. It was on the basis of this timetable that the Area had some confidence that it could minimise its exposure to risk if the trial was successful in reducing hospital admissions.

In this scenario the trial's success in reducing admissions and outflows would free up inpatient capacity and, allowing that flow reversals could be negotiated, the flow reversal would be accompanied by additional budget.

This cross border flow arrangement did not happen in the life of the trial and consequently any reduction in hospital admissions as a result of the trial would have created inpatient capacity that the Area did not have the budget to use (because it had been contributed to the pool). Even though NSW Health did not follow the expected timetable, Area self-sufficiency was reinstated on the financing agenda in the Health Council's Report in March 2000 (NSW Government, 2000).

Due to the relatively small-scale impact of the trial, the Area did not have to contemplate strategies to close beds as a result of the Care Net interventions. The ongoing budget constraints due to the relative disadvantage of the Illawarra also confounded any attempt to attribute change to specific elements of the trial. Furthermore, there were clauses in the trial agreements where risk was jointly shared between the NSW Health Department and the IAHS.

There were also different levels of awareness of the Care Net trial within the different facilities and services of the IAHS:

- General Managers across the IAHS were acutely aware of the trial because the IAHS contributions to the trial were levied from hospital and community budgets and shown in each budget as a transfer of funds to Care Net.

- Acute Inpatients - a flag was proposed to be attached to the records of Care Net clients, but the volume of activity was very low relative to the total throughput of the hospitals, so the level of awareness was correspondingly low.
- The Emergency Departments were aware of the trial and some were actively developing their own projects with similar aims to Care Net - for example the Area's bed management policy and the Area-wide emergency services plan.
- Rehabilitation and Geriatrics were very interested and involved, in part through a history of projects on falls prevention, for example at Port Kembla Hospital and in community health.
- Community nursing was very relevant to the trial and community health management was familiar with the rationale for service substitution.

The perception of the trial from the community health perspective was that the contract between the Area Health Service and Care Net specified too few services to be purchased from community health.

Further, there was concern that it did not take advantage of the capability of community health services, particularly on the prevention and group intervention side. Because the number of clients in the Care Net population, and those referred to community health, was relatively small there was not enough specific information from Care Net sources, or from community health data, to satisfactorily sort these issues out.

The years 1998/99 and 1999/2000 were difficult for the IAHS in terms of its budget problems, with a number of restructuring and service delivery changes being implemented, including the closure of hospital wards and an emergency department and relocations of services.

The long-term significance of the trial in encouraging new ways of organising services is likely to be offset by the immediate problems of budgets within IAHS. For example, the Area as a whole is supportive of community health building an ambulatory care team, but because there were no enhancements to support it, there is no initiative built, and then Care Net won't be able to purchase these type of services from community health.

The impact of this pressure on the trial was to increase the perception of special treatment of trial participants. One outcome was that Care Net was perceived by community health and community care providers to be relatively over-managed, and providing additional services to a relatively small number of low need clients. In the context of widespread budget restraint, there was a perception that the cost of the Care Net infrastructure might be better deployed by being spread among existing community care providers. This outside perception co-existed with the sense that the Care Net care coordinators worked very hard.

Management in IAHS were very conscious of the danger of small Home and Community Care (HACC) agencies being overwhelmed by the trial and losing their independent identity. This represented an acute awareness of the fifth of Leutz's laws of integration - that:

"the one who integrates calls the tune" (Leutz, 1999).

For small HACC-funded agencies, the scale of the trial, the funds pooling arrangements and the role of GPs and care coordinators appeared to threaten a diminution of role for community management and an increasingly dominant role for the IAHS. It was felt this was undesirable in the context of building local trust and better coordination, and this in turn led to less direction and control of the activities of the trial by the IAHS. This point is discussed in more detail in Report Number 1 on the organisational model.

8.3.2.2 The Illawarra Division of General Practice.

Cooperative arrangements amongst Illawarra GPs have a long history, beginning with the Wollongong After-Hours Medical Service 23 years ago. There has been a local sub-Faculty of the RACGP, and GPs were also organised under hospital based Medical Staff Council arrangements. A number of past and current projects have also included work with the University of Wollongong.

Since the advent of the Illawarra Area Health Service in 1986, there has been a Division of General Practice within the Area management structure. This has helped the Division members to develop more “cost conscious” attitudes and dovetail the issues of GPs with those of the IAHS. Formal liaison between the Division and the IAHS Executive takes place through a bi-monthly meeting. The Chair of the IAHS Board of Directors is a GP. The long history of active engagement with the IAHS made GP involvement in Care Net relatively straightforward.

Federal funding has been available since 1992 under the Divisions and Project Grants Program as part of the General Practice Strategy. The Division now covers 85% of Illawarra general practitioners.

In the education and training area, the IAHS has long funded a local GP training unit (now based at Port Kembla Hospital) which is intended to support the integration of general practice education and training in the Illawarra. Wollongong Hospital is in process of becoming a teaching hospital and the educational activities, which have been undertaken for many years, have been recognised in the NSW Health Council Report [NSW Government, 2000 #703], and will be funded to become part of the core activity of IAHS.

The various projects that the Division had undertaken (and continues to support), have dovetailed well with the aims of Care Net.

IDGP initiatives running in parallel with Care Net

IT Support

The General Practice Strategy Review in 1998 recommended allocating resources for information technology infrastructure through the Practice Incentives Program and the national General Practice Computing Group. This also included support through Divisions for projects that could develop standards in areas of data quality and decision support (Ellis and Kidd, 2000).

At the State level there have been many complementary initiatives sponsored by NSW Health in areas such as primary care information systems, Area-based data warehousing, and new hospital based information systems built around improving pathology reporting.

As a result of these sources of support, the Illawarra area has been host to a number of developments in the areas of general practice information management and technology. The “patient information notification and retrieval project”, more commonly known as the “Docmail project”, aimed to improve the continuum of care of patients facilitating hospital discharge by providing patient hospital information to the appropriate GP via email. This has been one project that has dovetailed with the interventions of Care Net Illawarra, which saw the computerisation of up to 100 Illawarra GPs.

This uptake of computerisation in general practice led the executive of both the Illawarra Area Health Service and the Illawarra Division of General Practice to make a joint decision to work

towards shared patient information between the GPs and hospitals. This progress saw the implementation of the Docmail project.

The Division's goal of improving computer literacy among GPs has involved the employment of its own IT support person, once again building on, but independent of, Care Net and its interventions. The improved IT component under Care Net (the intranet and access to hospital diagnostic and treatment data), while not made fully operational, was perceived by the Division to be worthwhile in and of itself regardless of other outcomes. This is because the Division perceived it to have the potential, in the longer term, to reduce the duplication of services. It could thus save money that could then be released for funding prevention activity.

A detailed description and evaluation of the achievements of the IT component of the trial is contained in Report Number 4 on the IT system.

Community Pharmacy

The pharmacy issues dealt with by the trial built on considerable background work already done through the Medication in the Ethnic Elderly project which has been documented elsewhere as an example of GP integration with the wider health system.

“The project has two major components. The first is to work directly with patients and teach them how to use a medication management card. The second is community education through local ethnic organisations and health workers.” (Centre for General Practice Integration Studies, 1997)

The pharmacy issue is a good example of the trial context providing a means of doing more systematic work where a lot was already known and already achieved in the local system. Community nurses had already been involved in doing medications audits (reviews independent of the prescribing doctor), including over-the-counter medicines, and advice on how to take medicines. The community liaison pharmacist role was already well established as helpful in dealing with a range of medications issues such as the use of a medications card and the medicines review process.

Growing out of the work of the earlier medication projects, the Division employed a community pharmacist who worked in conjunction with Care Net and was then employed again by the Division at the end of the trial. The Care Net connection enabled a more directed approach involving GPs and the key issue for evaluation purposes would have been the systematic application of what was already known, and an assessment of the additional value that could have been added within a care coordination framework. This shortfall in making optimum use of the trial context led to difficulties in making sense of the disjointed, but catalytic impact of the trial. This is covered in more detail in Report Number 2 on the Care Net interventions.

Community health issues

The Division and the Community Health Executive meet bi-monthly and this liaison includes the management of other joint projects such as the use of asthma educators, and considering strategies for addressing other (especially chronic) diseases and health problems.

Illawarra Physical Activity Project

The Heart Foundation (NSW Division) and the IAHS Health Promotion Resource Unit directed a project between 1995 and 1998 with Commonwealth funds that included GPs from the Illawarra Division in a survey of the awareness of physical activity. The project used TV radio and print commercials to "improve health by promoting opportunities for involvement in moderate-intensity physical activity" (National Heart Foundation (NSW), 1999).

Illawarra Target 2000

This is a media-based strategy to raise funds for the promotion of health, developed as a joint venture with IAHS, the Illawarra Health Fund, Healthy Cities Illawarra, Wollongong Council, University of Wollongong and interested business groups. It was part of the IDGP's broader strategy of seeking investments in prevention and connecting GPs through the Division to wider community interests.

As was described in the trial's mid-term report, the historical involvement of the Illawarra Division in its various collaborative projects suggests that a number of background factors served to reduce the level of threat to GPs who were involved in Care Net (Eagar et al., 1998).

The trial also presented a strategic opportunity for the Division to address health policy deficits in primary care, which generally has not supported the 'bigger picture' approach to health problems - that is a lack of support for paying for investments in prevention up front, for screening, for risk assessment. In advance of the new enhanced primary care MBS items introduced in November 1999, Care Net presented an opportunity to move practically in this direction.

The improved IT component with the Care Net intranet, the potential for access to hospital results and better medication information were felt by GPs to be a bonus. The assumption was made that if Care Net reduced the duplication of services, then resources might be freed up for a better mix of services and for more investment in prevention.

8.3.2.3 Community Care Agencies

"You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people." (Leutz, 1999)

The Home Care Service of NSW (HCS) was a trial sponsor and was centrally directed in encouraging the local involvement of its branches in the trial. This meant that, for services representing about 50% of the Home and Community Care (HACC) Program's funds in the Illawarra, agreement to participate in the trial was negotiated centrally at a level beyond local control.

This higher level agreement to participate at the level of funds pooling, albeit with a 100% buy-back guarantee, also overcame long standing industrial matters around personal care tasks in the HCS relationship with community nursing that might potentially have complicated local negotiations.

The rest of the agencies funded under the Home and Community Care Program did not pool funds in the trial, but did act as providers. More direct involvement was complicated by the nature of the funding program itself, with complex administrative arrangements that fund the operations of a large number of small agencies concerned with the frail aged, people with disabilities and their carers. In many cases this funding represents a contribution to the service costs, with voluntary

effort and client contributions making up the shortfall. Management of these services takes place through voluntary and local management committees, often with the support of local government.

In the Illawarra region there were about the same number of separate HACC agencies providing services to Care Net-type clients (older people with complex care needs), as there were general practitioners enrolled in the Trial (about 100).

From the HACC program viewpoint the trial managed to marginalise many community care providers, especially the smaller ones, but also including the NSW HCS, even though it was one of the sponsors.

The general consensus was that publicly-funded community care agencies, with the exception of Kiama Council's nursing agency which entered into a number of specific contracts, were marginal to the trial's new service activity. Even though marginal to the management and governance of the trial, they were net beneficiaries of the arrangements. The analysis of the performance of the funds pool shows that HACC agencies received an additional \$280,000 over the life of the trial.

The main ongoing trial structure was the management committee, which had a number of shortcomings. Firstly the trial was formally part of the IAHS, but had no direct connection to the Board level of the IAHS. Secondly the community sector services, particularly HACC, had no useful support at first from the funder (ADD) on how best to respond to the trial.

The NSW Ageing and Disability Department (ADD) centrally had been less actively involved in the local negotiations on the establishment of the Trial, leaving the local management of Care Net to negotiate around 100 or so HACC agencies' expectations and assumptions as best it could. Those expectations and assumptions were naturally very mixed because of the 19 different HACC service types, and the independence and localised nature of the management committees running the services.

For HACC services generally the Care Net model included familiar elements of reform. Improved assessment tools, the use of common information between agencies (eg the implementation of the Client Information and Referral Record or CIARR), and a single entry point to the community care system have all been promoted both centrally and locally (NSW Ageing and Disability Department, 1998).

In terms of specific lessons there is a lot already known about common assessment and care coordination – these are already a big part of the ADD agenda for change, so in that sense the trial operated in an environment of its own, while similar changes through the general experience of community care reform were going on around it. On the other hand, the wider context of change gave Care Net staff and their goals a degree of credibility.

There have been benefits in terms of the trials' impact on the new MBS items and the Carelink Centres – both will provide future incentives for greater participation by GPs in community care. However, the HACC and community health sectors were already doing care coordination, so the trial did not help much there.

Leutz's third law of integration says - "*Your integration is my fragmentation*".

When community service providers' views were documented in June/July 1997 there was already concern about the clientele being recruited to the trial because few of them were their existing clients. In the absence of assessment data on these early recruits, two alternatives were presented to explain this situation - either the trial was accessing a substantial population with unmet needs, or the clients were largely low need clients (Southon, 1997).

If Care Net opened up demand for additional services, in a context of scarce resources, it was not clear to community care providers where these new services could come from. If Care Net was recruiting low need clients, then this appeared to negate the purpose of the trial in helping those

with complex needs, and few savings would be likely to be made (and redistributed) from reducing acute care utilisation.

The objectively complicated nature of many of the issues raised by Care Net, and the lack of local structures that allowed HACC-funded providers to speak authoritatively and with one voice in their negotiations, made their involvement in the trial difficult to manage. Local HACC Forums are information sharing bodies and remain disconnected from the Program's administration and planning processes.

Consequently, the time factor involved in dealing individually with community-based management structures in the small HACC-funded agencies, meant that Care Net had inevitably to begin recruiting general practitioners and their clients before agreements with HACC providers could be negotiated.

The main lessons have been about GPs, not community care, and it doesn't look like there has been a lot of progress in bringing together the social and the medical sides. The GPs have some useful software and that has meant better reviews of medications, but not necessarily better coordination.

8.3.2.4 Private providers

The trial made extensive use of private services from outside the domain of the contributors to the funds pool (ie, in particular not IAHS community health and not Home Care). This was the local interpretation of the original National Evaluation Reference Group's National Hypothesis 2, that the success of coordinated care will be influenced by: *"the extent of substitution between services within a trial pool"*.

As discussed in Report 9 there was a net transfer of \$1m from the pool contributors to private community care providers.

Care coordinators were quite clear in their responses to queries about the reasons for private service utilisation:

Community health was inflexible in the type of staff available to attend a client. Community health only employed registered nurses who first, cost more than an AIN and second, would not do what Care Net requested.

Community Health's ... continuity of service provider was less than that provided through the private sector.

Community Health and Home Care could not guarantee an appointment time to the client. There was a one hour window on either side of the appointment time. This was a major inconvenience to some clients and the care coordinators, as their advocate, would seek to change the service.

The response time to a request for a service continued to be better in the private sector. Requests for services on a Friday afternoon, particularly on discharge from hospital, could not be responded to by Community Health. There were designated times for intake in Community Health.

All care coordinators had examples of the "better" and cheaper service available through the private sector. When asked to extrapolate from the Trial to possible improvements to mainstream services, one care coordinator suggested:

More flexibility, reliability and more pro-active response rather than reactive responses. Reduced price services – Home Care is 50% more expensive than private services – why is this so?

The views of the range of providers other than GPs, and the differences between their views, are discussed in more detail in Report Number 6. The issue of price differences between providers is discussed in Report Number 7.

8.4 Discussion – Implications for Mainstream Services

8.4.1 The main achievements in the wider system

8.4.1.1 Changing relationships

The building of improved relationships between a significant number of general practitioners and the wider community care system was clearly seen as the major achievement of the trial.

The biggest lessons are around the ways of getting GPs more involved. The earlier demonstration projects couldn't offer any incentives to GPs, but Care Net did. The main element of this was the IT component, using computers for helping the information and referral component of care coordination.

Other parts of the system had variable experiences. Community health it seems had very little involvement, whereas the ACAT played a large role, especially in the wind-down. There seemed to be a direct link between the perceived "inflexibility" of community health and the need to go to private providers.

Kiama Council was a notable exception to the problems experienced by Care Net with traditional community care providers. This was because their services were capable and willing to respond in more flexible ways.

In other cases Care Net encouraged changed practices and more responsiveness, for example with Kiama Council's community nursing services.

... there are projects like COPs and trials like Care Net that encourage working outside the guidelines and rules to better deal with individuals' needs. Other providers, if given the discretion to go outside the rules, could do a better job. It is a bit like a two class system where there are those who can and those who can't operate outside the rules.

8.4.1.2 Community participation in Care Net

Community participation in the Care Net Trial was addressed at four levels:

- Care Plans – consumer participation in the development and implementation of the individual participants' care plans (see Report Number 5)
- Care Net Management Committee - two consumer representatives were on the Care Net Management Committee Board
- Consumer Participation Groups – involvement in groups developed through the Trial (see Report Number 5)
- Community Development Activities – local media, Care Net newsletter etc

The main discussion of individual client issues is contained in Report Number 5. The client involvement in care planning is also covered in Report Number 3 which examines care coordination. The description that follows is based on interviews with Care Net staff and is concerned with the local participatory elements of the trial's activities.

The style of action research involved in the Care Net consumer and community participation work was not formally evaluated. For internal management purposes a style of reporting on this activity was used to summarise key points and this did not reach a more formal report stage unless requested by the Management Committee.

8.4.2 Barriers to making an impact on the wider system

8.4.2.1 Issues of scale

While the trial acted as a catalyst for various developments, notably in the IT field, the number of clients within the intervention group who required coordinated care was small and so the impact on mainstream services was correspondingly limited.

There has been no change to the amount of information available either to the ACAT or to hospital-based services. It may be that better information comes into the system, but it is not routinely available. The electronic flags attached to Care Net clients do not come up at the hospital level.

8.4.2.2 Issues of equity

The impact of the trial on issues of equity in the wider system is also discussed in Report Number 4 on the clients. Informants within the wider system mainly commented on the relatively generous distribution of resources for the active participants against a backdrop of unmet need.

More money to spend on services is likely to increase the satisfaction of clients and carers, and more care is likely to improve outcomes, if only because it is overcoming the neglect inherent in the regular under-resourced system.

This view was reinforced after the findings of the mid term evaluation had been considered, which showed a profile of the clients' needs. Care Net clients, while scoring worse than the general population, were seen as less dependent/in need than the regular clients of community health and community care services.

The most important concerns are the equity issues, which to a large extent can't be avoided within the context of a trial, but have to be considered in relation to the wider system. In general, in Care Net it looked like the participants were less sick and got more resources.

These would not be big problems as long as the substitution aims were achieved and there were additional resources as a result. For example, service substitution leads to better management (we don't know if that will be related to better outcomes), which leads to fewer prescriptions, which leads to savings in the PBS, which flow over to more resources in community care. But it seems we have not had so much service substitution as something more like provider substitution.

There were also other elements of Care Net's arrangements with providers that did not fit neatly, such as the existing agencies' fees policies and expected client contributions, leading to different expectations from clients who essentially receive similar services.

Also there are equity problems if there are no fees charged when normally fees would be attached to services.

8.4.2.3 Issues of integration

In relation to the specific issue of integration, an earlier version of the COAG proposals had been initiated but not implemented in what was called the Primary Care Initiative, instigated by NSW Health in 1994 under the work program of the Health Ministers' Forum. An Illawarra proposal for a Human Services Board was considered and rejected by local community care providers, as were a number of local expressions of interest for Integrated Community Care Demonstration Projects under the direction of the (then) NSW Office on Ageing (Fine, 1996)].

Not unexpectedly, an implementation debacle ensued, and negotiations among Illawarra stakeholders eventually broke off.

When the COAG Trials were proposed (Leigh et al., 1999), this local history contributed both to a reluctance for involvement from the community care sector, but also to an understanding of the issues involved in running a trial within the wider system.

In terms of the second Leutz law, "*Integration costs before it pays*" (Leutz, 1999), the Care Net model was expensive in terms of the infrastructure provided, and limited in its direct impact. However, the long-term effects on the wider system were judged to be beneficial (but expensive) by at least some informants.

Individual's care coordination has improved, and it is correct to say there have been changes to the local system, which wasn't flexible enough. The COPs model has worked well up to a point, but has not been as good as the trial because they were not able to be accepted as the only case manager. For example a person might be involved with four agencies and two of them would consider themselves as the case manager. The trial put the role clearly in one place and it was seen that way by the client.

Another indirect effect of the lessons learned through Care Net has been on the expressions of interest process for the use of new ADD and respite funds. The idea of tendering jointly for new projects has become more common and more attractive. There has been good collaboration especially through the three Councils.

The overall effect is that Care Net appears to be a new layer in the system, and more of the same. The deficiency in the infrastructure is not just Care Net's fault - there has been not enough time and not enough expertise in the setting up phase, so its potential is not being realised. For example, the timetable in setting up was too tight, recruiting started before the selection criteria were established and before the assessment tools were developed.

8.4.3 The next generation – the 1999 Care Network proposal

In late 1999 an Expression of Interest was developed by a Steering Committee for the next stage of Care Net, called Care Network. This constituted a new trial proposal, not a proposal for an extension of the Care Net trial. The Steering Committee aimed to build on the successes and to avoid the pitfalls of Care Net. In consequence, the Care Network model was fundamentally different to that of Care Net.

The assumptions behind the new proposal were that the Care Net trial indicated the benefits from linking GPs and community service providers in care planning. However the model adopted in the trial, while focused on meeting the needs of GPs and trial participants, was judged as doing little to bring community and health services providers into the care planning process. The effect of the Care Net design was that community-based health and support services were yet to bridge the gap between themselves and GPs and it was considered that, in many circumstances, this was still resulting in less than optimal client outcomes.

The Steering Committee also stressed the need for a 'lean' management organisation to ensure that any savings arising from the trial would be directed to the provision of care. The use of existing contracts, tendering process and management systems were expected to minimise expenditure on infrastructure and increase the resources available to underwrite the direct provision of care.

The community view of the 'success' of Care Net has resulted in considerable enthusiasm from consumers, GPs and service providers in the Illawarra and there is an expectation that recruitment in the proposed trial will be easier than was the case in the Care Net trial.

The model also means that small providers may have to amalgamate with other providers to ensure that they have staff with a range of skills to provide care in a 'package' format. ... In addition, it also provides the stimulus for providers to develop a more flexible and responsive approach to meeting the needs of consumers.

It is anticipated that some agencies would expand the range of services they provide in order to tender for some of the care packages, while others would form consortia or sub-contract others to provide for the functions they cannot provide themselves.

The implications for small HACC funded agencies in contributing to the pool will need to be discussed with those agencies and the Ageing and Disability Department. It may be the case that such agencies do not actually pool their funds, but enter into credit arrangements with the trial, whereby the trial accesses services up to an agreed threshold before having to purchase service from the agencies.

These extracts from the Care Network proposal indicate the impact of the trial on the wider service system. A number of important and specific lessons have been extracted from the collective experience of the trial.

8.5 Conclusion

This report has been primarily concerned with National Hypothesis 9: “That the primary results can be achieved without detriment to other key areas of government policy, particularly in regard to equity of access and privacy, including any impact on clients outside the trial”.

The Illawarra provided a good context for the trial having a history of cooperative projects and significant accumulated goodwill between the sponsors. In terms of the broader system, new links and new service types were introduced for the participants and the main shortfalls were in relationships with the smaller community care providers.

A number of informants pointed out the early limitations of the trial's structure that in turn limited the amount of systematic learning that could occur.

The trouble is that the design of the trial is not well enough thought through to clearly provide answers on these issues. Even if we learn enough from the exercise to design a more meaningful trial, then that will have been worthwhile.

What the trial lacks is a design based on epidemiological expertise, a strong reliance on evidence-based approaches, more rigour in terms of attention to the role of the control group, and more scientific questions built in and couched in terms that can be answered. One basic flaw is having GPs with both active and control patients, which is likely to confound the intervention of GPs having computers on their desks.

The actual research questions in the trial are not clear enough from the point of view of ... what is the main intervention? Is it the funds pooling, the care coordinators, or the IT/education dimensions?

There is an attribution issue for the trial in that a number of background factors are in place that the trial builds on, that these contribute to the effects of the intervention. How can the elements of the trial itself be separated from those background factors?

The analysis of clients' needs (Report Number 5) showed that relatively few required the type of care coordination to the extent that the full model that was implemented could provide. So in terms of the wider system, a lot of resources went to those requiring relatively little. In addition, there were questions raised as to whether the full coordination model would in fact be more appropriate for those with high needs, as compared to more specialised models and interventions.

The assumption in the trial that needs to be tested is that complex care coordination requires an administrative role. This may be true for the middle and lower level of needs, but not necessarily for those with complex medical needs and a higher level of consumption of services

From the point of view of aged and rehabilitation services, it may also be unlikely that putting the GP at the centre of the model in the trial will be adequate to deal with those clients with higher levels of medical needs, or needs related to functional impairment. These often need the input of rehabilitation and aged care services.

Appendix 1: An overview of the Illawarra Coordinated Care Trial

The Illawarra Coordinated Care Trial, or Care Net Illawarra, was established as part of a National series of demonstration projects that aimed to assess the benefits of coordinated care in the context of the Australian health care system. The primary hypothesis to be tested by the trials was that:

That coordination of care of people with multiple service needs, where care is accessed through individual care plans and funds pooled with existing Commonwealth, State and joint programs, will result in improved client health and well-being within existing resources.

Fund pooling was a key component of the coordinated care trials. The established, program-based organisation and funding of health care services was thought to be a principal factor in frustrating flexible service provision and service substitution. The way to overcome this issue was believed to be the pooling of funds from Commonwealth, State and joint Commonwealth-State programs (Pekarsky, 1999). Trials would be allocated a budget from which they could purchase services for clients, with funds for the budget coming from the finances of existing service providers. But there would be no additional money. A key Commonwealth requirement was for trials to be cost-neutral.

The Illawarra trial encompassed three local government areas: Wollongong, Shellharbour and Kiama, the area being located south of Sydney, NSW. Its principal stakeholders were the Illawarra Area Health Service (IAHS), the Illawarra Division of General Practice (IDGP) and the NSW Home Care Service.

The trial aimed to coordinate the care of people aged 65 years and over with either a risk of falling or who had complex medical or social problems that required multiple services from more than one health care service provider. During the 1997 planning phase of the trial, roughly 1800 eligible residents were referred to the trial by the 100 GPs participating. 1200 clients were allocated to an active group and would have their care coordinated by the trial, while the other 600 were allocated to a control group.

After the planning phase, the trial went live on 1 November 1997. It finished on 31 December 1999, a total period of 26 months over 3 financial years.

The coordination of care was undertaken by 15-16 care coordinators, in collaboration with the client's GP. The GP maintained control of the medical aspects of the client's treatment, while the care coordinator organised access to other services, purchasing services agreed to with the participant and GP. The care coordinators performed a systematic assessment of their clients initially every three months and subsequently in response to need. These assessments were intended to inform the creation of the clients' care plan that, among other things, included the goals of care for the client. Finally, a service plan was created that described the package of services to be bought by the trial in order to address the clients' goals was created.

Thus, the trial adopted a commissioning model of service provision. It secured services mainly from community care service providers, having access to both public services (those in the IAHS and the local HACC agencies) and private services. Medical (GP, specialist), pharmaceutical and hospital services were also within the funding pool, but these services were largely determined by GPs.

The trial used State and Commonwealth funds to develop an information system. Based on an intranet structure, the system supported email, client records, service utilisation, and financial data. This system did not support full communication between providers but significant steps included the increased use of computers by GPs.

Appendix 2: Hypotheses and Data Sources

The National Evaluation Reference Group established a primary hypothesis and a series of secondary hypotheses that represented the likely influences on whether that statement could be supported. The Care Net trial adapted that framework into a local set of hypotheses. The national and local hypotheses are listed below.

NH1 The primary hypotheses: Local Illawarra adaptation

<p>National Hypothesis 1:</p> <p>“That coordination of care of people with multiple service needs, where care is accessed through individual care plans, and funds pooled from existing Commonwealth, State and joint programs, will result in improved client health and well being within existing resources”.</p>	<p>Care Net Hypothesis 1:</p> <p>“if improved individual client health and well-being can be achieved within existing resources where an individual’s multiple service needs are met through an individual care coordinator, a single care plan and a single pool of funds”.</p>
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The extent to which this is achieved, will be influenced by:

NH2 Substitution services within the pool

<p>National Hypothesis 2: “The extent of substitution between services within a trial pool”</p>	<p>Care Net Hypothesis 4: “If improved health outcomes can be achieved with service substitution”</p>
	<p>Care Net Hypothesis 6: “If injury prevention can be achieved with service substitution”</p>
	<p>Care Net Hypothesis 9: “If care coordination and the purchasing of services from a central fund can reduce expected bed days in hospital. This will apply to both lengths of stay and re-admissions”.</p>

NH3 Services included and size of the pool

<p>National Hypothesis 3: “The range of services included in the trial and the size of the pool”.</p>	<p>Care Net Hypothesis 8: “If a financial system linked to care plans can provide budget forecasting suitable for advanced service”.</p>
	<p>Care Net Hypothesis 9: “If care coordination and the purchasing of services from a central fund can reduce expected bed days in hospital. This will apply to both lengths of stay and re-admissions”.</p>

NH4 Clients selected

<p>National Hypothesis 4: “The characteristics of the clients to whom services are provided”.</p>	<p>No corresponding local adaptation</p>
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NH5 Clinical and service delivery protocols

National Hypothesis 5: "The characteristics of the clients to whom services are provided".	No corresponding local adaptation
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NH6 Care coordination function

National Hypothesis 6: "The characteristics of the care coordination function"	Care Net Hypothesis 2: "If the allocation of care coordinators to general practice surgeries improves communication between GPs and other services available to provide necessary services for their patients".
	Care Net Hypothesis 3: "If the care coordinator in a role of patient/client advocate increase the patient's involvement in care planning processes".
	Care Net Hypothesis 8: "If a financial system linked to care plans can provide budget forecasting suitable for advanced service".

NH7 Administrative Arrangements

National Hypothesis 7: "The characteristics of trial administrative arrangements"	Care Net Hypothesis 7: "If an information system communication network containing the care plan and relevant clinical information can improve the cost-effectiveness of care coordination processes and outcomes"
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NH8 Consumer Involvement

National Hypothesis 8: "The extent to which health consumers are partners in the planning of the coordinated care trial, the development of care plans and empowered through the coordination process".	Care Net Hypothesis 5: "If consumer involvement in project management and policy development can improve the process and outcomes associated with care coordination".
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NH9 Wider System

National Hypothesis 9: "That the primary results can be achieved without detriment to other key areas of government policy, particularly in regard to equity of access and privacy, including any impact on clients outside the trial".	No corresponding local adaptation
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Data Sources

The main sources of data used to examine the hypotheses relevant for Report 8 are described below.

Sources of Data	Methods
Wider System semi-structured interviews	Interviews with key informants. See list below. The method used with the interviews included sending them to interviewees and seeking feedback from written notes (ie validation procedure)
Care coordinators questionnaire	Self-administered questionnaire to 15 CCs (see report#3)
GP focus groups and interviews	Two focus groups with IDGP. Interviews with key informants
GP survey	Analysis of written responses (see report #6)
Other provider questionnaire	120 distributed including 20 each to aged aged rehab services and community health. 55 replies. (see report #7)
Other quantitative and qualitative data	From the Care Net documentation including questionnaires and reports and analysis from data within the information system (see reports#5&9).

Wider System Interviews Informant List:

Illawarra Area Health Service:
CEO, Director of Health Services Development, Director and Deputy Director/CH Nursing Community Health, Director and Deputy Director, Aged Care and Rehabilitation.

Local Government:
Director Community Services, Director Community Services and Nursing Service.

Home Care Service:
Branch Manager.

Illawarra Division of General Practice:
CEO, Chair, Focus Groups with GPs.

NSW Ageing and Disability Department:
Program Manager, Regional Manager, Project Worker.

Care Net Illawarra:
Community Development, Hospital Liaison, Team Leader Care Coordinators, Group feedback sessions with Care Coordinators.

Framework for semi-structured interviews

Focus areas based on Pettigrew (1992):	Leutz (1999) five laws for integrating medical and social services:
1. The quality and coherence of 'policy'	You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people.
2. The availability of key people leading change	Integration costs before it pays.
3. Long term environmental pressure - intensity and scale	Your integration is my fragmentation.
4. A supportive organisational culture	You can't integrate a square peg and a round hole.
5. Effective managerial-clinical relations	The one who integrates calls the tune.
6. Cooperative inter-organisational networks	
7. Simplicity and clarity of goals and priorities	
8. The fit between the change agenda and its locale	

Appendix 3: Policy Context

The impact of the trial on the wider system will always be difficult to assess given that the changes that were instigated can be seen as part of a continuum of changes that have been occurring for some considerable time. It makes little sense to see Care Net as a 'stand-alone' intervention in a complex system. This point is also made in the discussion of how the trial fitted within what was already known and is now known, about care coordination, which is included as an Appendix in Report Number 3.

A useful starting point for reviewing this wider system context is the National Health Strategy, which began in 1990. Its various papers contributed considerably to raising the level of debate about reform. Of particular significance was the Australian Health Jigsaw (National Health Strategy, 1991), which drew attention to the problems of the multiple programs in health and community care, and overcoming the limitations created by their boundaries.

In the NSW social policy context under the Coalition governments of 1992-95 this theme was reinforced and incremental solutions proposed through a paper called Changing Care for Older People: Trialing New Ideas (Rubenstein and Sadler, 1994). The evaluation of the resulting demonstration projects showed both the progress that could be made in integrating local service systems short of "full integration", and the difficulties of attempting to implement a "budget-holder" model in community care settings (Fine, 1996).

Meanwhile at the Commonwealth level the Council of Australian Governments had published its aims to build a system that encouraged better and more flexible services at the local level. The first step to achieve this was to concentrate on the interface between health and community services (COAG, 1995).

The basis for changes in community care in NSW derived mainly from the HACC reform agenda (Commonwealth Department of Human Services and Health, 1995), which had also generated a NSW community care assessment framework (NSW Ageing and Disability Department, 1998). Corresponding concerns in the health sector revolved around issues of what services would best be able to respond to clients in need of post acute (McCallum et al., 1996).

At the time the trial was being developed the questions of the best ways to respond (to what were clearly acknowledged as emerging needs) were still being reviewed to assess the evidence on the effectiveness of community care interventions (Fine and Thomson, 1995). The health debate, meanwhile had moved on to consider the larger, more difficult questions of client outcomes (Eagar, 1998).

So by the end of the trial, much was already known in the literature about what was likely to work better for clients. The specific attributes of case management approaches were well understood from the many trials and demonstrations (Fisher and Fine, 1999). As Leutz pointed out in his framework of laws on integration (Leutz, 1999) "there is enough accumulated experience that policy makers, managers and clinical leaders can now call some of the tunes rather than having to encourage ad hoc initiatives indefinitely" p.100.

During the same period, the role of GPs in the wider system has been strengthened both within NSW (NSW Health Department, 1999) and from a number of Commonwealth initiatives arising from the increased support through GP Divisions (General Practice Strategy Review Group, 1998).

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