

How do we embrace quality clinical partnership which achieves high performance and accountability?

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It can be quite a daunting prospect to try to embrace something which can have the qualities of a freshly picked chestnut. Anyone unfamiliar with this beast is confronted with a viscously prickly pod which requires cautious handling with thick gloves. Once the armour is removed the glossy brown kernal is revealed, success!?! not yet. It must be carefully scored and cooked for 20 min then double peeled whilst painfully hot, finally yielding a delicious versatile interior which few people know what to do with and you need dozens the little beggars to make something useful. Even if you do know how to use them to their full potential, it still requires lots more work and careful choice of accompaniments.

Based on this, there are some basic principles about partnerships which are worth revisiting.

- There needs to be a clear purpose for the partnership and what potential players might get out of it.
- Partnerships are about mutual benefits, all partners seek to have their needs met within the context of the partnership.
- Partnerships need understanding, trust and respect.
- Partnerships do not flourish where there is a power imbalance.
- Partnerships need to be entered into because all partners really want to be there. Gunshot weddings don't often produce good long-term relationships.
- Partnerships are not purchaser/provider relationships although these arrangements may occur within the context of partnerships arrangements.
- Partnerships need ongoing work and lots of it.
- Partnerships need renegotiation from time to time.
- Expectations of partnerships are different to the expectations of many other relationships. Implying the prospect of genuine partnerships when all that intended is ongoing communication, contracting of services or setting up advisory committees is likely to lead to disillusionment.
- The word "Partnership" is frequently overused and misapplied.

In the context of Medicare Locals partnerships between general practice and allied health practitioners, consumers and other parts of the health system and community groups have been mandated into the landscape (the father of the bride is holding the shotgun).

For some this is a journey which has already been embarked upon because it was seen to make good sense without the need for prodding, for others this is a brave and, at times, confronting new world.

Most are familiar with the rhetoric of right practitioner, right place, right time for consumer centred care but realizing this vision can be complex. Developing partnerships to achieve this will require some examination of long held beliefs and positions as well as some give and take to achieve workable partnerships. Whilst most express philosophic al support for and recognize the potential

value for the consumer, this happy outcome is far from being the only driver. Successful partnerships require exposure of and solutions to deal with elephants hiding behind the curtains.

Potential partnerships are coming from various positions of power, entitlement and expectation. The opening address of the conference discussed the issues of dealing with change and the grief associated with the loss of the established and familiar. This is perfectly understandable but it is equally important to understand that many of those with whom partnership is sought feel no such grief or loss.

For those who have seen outside the tent for so long, hope burns bright when such change offers real possibilities to step in from the shadows.

Nicola Roxon noted this morning that in the early 1990s GPs felt disconnected and dissatisfied before the advent of Divisions. That is how many other primary health care professionals and consumers feel now. Community health has always been between a rock and a hard place and is still confused as to where they may be going. All sides of this process need to be handled really well to ensure that the end result is not mass disillusionment.

Aggressive public discussions about who rules the roost are unhelpful in partnership building. The consumer, for whom these partnerships are most important, actually doesn't care. They want the best outcome for their particular problems with the least expense and fuss.

The government has placed a great deal of importance on developing strong partnerships but has not necessarily provided equivalent support for various players to effectively engage and make these partnerships work.

Ensuring right practitioner, right place, and right time is made much more complex when some providers are well supported and others entirely lack support for strong clinical engagement. We are trying to form partnerships on a wildly canting deck. Expecting team based collaboration is difficult when some are paid to be engaged and others are expected to do it for love.

E-health is going to have a significant impact on good clinical partnerships but again, some have been well supported to increase capacity to embrace e-health and others have had no support whatsoever.

Despite working alongside each other for many decades it never ceases to amaze me how little each profession and indeed each of the various silos of the wider health system understands the role and clinical value of the others.

Partnerships will struggle unless that understanding and, with it, trust improve. Partnerships do not thrive when everyone is jockeying for position and jealously guarding their own kingdom with bewildered consumers caught in the crossfire.

This is well evidenced at present with at least some ML's and Divisions struggling to locate and engage those with whom they wish to partner. The temptation is to stick with those you know because developing understanding and trust takes time and effort. Already overworked practitioners can be forgiven for being overwhelmed with even the thought of the effort required.

So..... is it all too hard?

Should we give up or are quality clinical partnership possible?

Yes we should keep trying, but it will not be easy unless some of the underlying issues and basic foundations of partnerships are addressed.

Some of these things can be addressed directly by Medicare Locals and are already mooted in the structures:

- Ensuring a wide range of professionals and consumers are effectively and equally engaged in clinical governance and adequately supported by locals.
- Time is invested in networking exercises to build understanding and trust.
- Early adoption of joint CPD activities both in primary care with other sectors.
- Strong support for early adoption of e-health initiatives by all players and advocate for support to achieve this.
- Genuine engagement with stakeholders that has time for slow commitments.
- Clear continuing communications with all those who need to be engaged.
- Advocating to government for funding and structural changes will remove the inequities which are barriers to partnerships.
- Maintaining the focus on the consumers.
- Developing data collection to support the system that do not put excessive burdens on anyone.
- Ensuring support of evidence based practice for best consumer outcomes.

If the climate is right clinical partnerships can flourish and good consumer outcome can be realised.