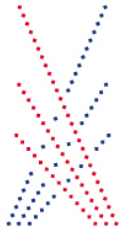

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Title: The Enablers of Stakeholders Engagement in Health Policy Development: The Case of Western Australia Health Networks

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Summary: The health sector is challenged by limited resources, demographic changes, costly innovation, and the burden of chronic diseases. Health networks are a collaborative platform for multidisciplinary stakeholders' engagement aiming for the co-production of health policies and standards of care.

Western Australian (WA) health networks are presented as a case study on stakeholders' engagement in policy development. WA has chronic understaffing and a low population density. The case study follows a qualitative methodology which includes document analysis, observation, and interviews. We identified two issues that might negatively influence the networks' effectiveness, (1) lack of equal participation by all the stakeholders; and (2) limitations in the representation of stakeholders.

We identified the main limitation of the case study is measuring the extent to which health networks are used in disease management in a low population density area.

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In high-income countries, the effective management of the health sector is challenged by limited resources in an environment characterized by demographic changes (ageing population), the proliferation of costly technological innovation, and the burden of complex chronic non-communicable diseases (Gandjour et al. 2005; Smith et al, 2009; Prince et al, 2015). Furthermore, the health ecosystem is heavily affected by the quality of good governance and performance in other sectors like education, employment, housing and the welfare system. Despite these challenges, good societal health and wellbeing is fundamental for economic development.

Health networks serve as a collaborative platform for multidisciplinary stakeholders' engagement and consumer participation with the aim of the co-production of health policies and standards of care. The co-production of health policies potentially yields more effective care (Waibal et al., 2015; Turakhia & Combs, 2017) that is better value for money (Kerkemeyer et al, 2018). Within health networks, medical and administration competencies of service providers are brought together and then linked to patients' reported needs. Although the premise of health service co-production seems promising, there are several hurdles to its implementation including information asymmetry between stakeholders, paternalism, and conflicting interests (Barile et al., 2014; Sharma et al., 2014; Bergdahl et al., 2013).

A conceptual framework of stakeholder engagement is proposed to evaluate health networks' contribution to health systems. Western Australian (WA) health networks are presented as a critical case study, specifically as one 'least likely' to show evidence of the relationship being investigated (Flyvberg 2006). Its 'least likely' status arises from the challenges associated with chronic understaffing, one of the lowest population densities of any state in Australia with 1.0 person per square kilometre (ABS, 2015), and the high levels of chronic ill-health in some of the most remote communities, all of which make the effective provision of health services extremely challenging. The case study presents two issues: improving the meetings dynamics of WA health networks; and examining the impact of WA health networks on the health outcomes of individuals.

An Overview of the WA Health Networks

In 2005, the Health Reform Implementation Taskforce recommended clinical networking to help provide "a new focus across all clinical disciplines toward prevention of illness and injury and maintenance of health" (WA Department of Health, 2005). In 2006, the WA Health Networks was established as a collaborative mechanism that connects WA Health and other service providers across systems of care together with the people who receive the care. The Networks bring together these groups as partners to share their collective clinical and health system knowledge and experience. Through supporting the Networks, the Health Network Directorate supports WA Health priorities for, Prevention and Community Care Services, Health Services, Chronic Diseases Services and Aboriginal Health Services.

By 2016 the Department of Health had established twelve Health Networks. They focus on health priorities across the whole health spectrum from the prevention of illness and maintenance of health, through to the management of illness and palliative care. The Networks are: Cardiovascular; Child and Youth; Diabetes and Endocrine; Disability; Falls Prevention; Infections and Immunology; Musculoskeletal; Neurosciences and the Senses; Renal; Respiratory and Women's and Newborns. Although there are other Networks within the Department of Health (e.g. Genomics, Aged Care, Cancer and Palliative Care, Primary Care, Mental Health and Injury and Trauma), they are managed by a distinct division, and therefore

have been excluded from our analysis. The Health Networks listed above fall under the Health Networks Directorate, System Policy and Planning in the Division of Public Health.

Methods

The case study follows a qualitative methodology which includes document analysis of both internal and formal documents; observation, including of the operation of the networks' meetings; and interviews with network staff. Furthermore, we propose a conceptual framework to measure WA health networks contribution to WA health system based on literature findings.

Findings

The case study results are presented through three dimensions (1) diverse health networks leadership, (2) shared knowledge and (3) policy implementation. On leadership, we find the professional background of the networks' leads are diverse. Some leads are physicians in the tertiary care level, GPs, allied health professionals and nurses. Regardless of the diverse medical backgrounds, there is a common denominator that is focused on expertise, individual social capital, professional experience and understanding of the system. Furthermore, clinical leads' social capital, reputation, and influence are key dimensions for championing to bring positive change and implement Health Networks' recommendations.

On knowledge sharing, the networks' core operations are primarily driven by the experiential knowledge of their network members and evidence-informed policy, although there is some referral to specific published studies or scans of the literature. At network meetings, members receiving briefings and provide feedback on policy initiatives and new policy, typically with the network leads prominent in discussions. There is additional informal communication and working groups are created if there is a specific topic that requires further discussion and analysis. The degree to which individual network members participate is varied; and there was minimal participation from health consumers. Moreover, representation at network meetings does not include some key stakeholders, or relies heavily on personal experience in place of broad expertise. Furthermore, consumers' profile was often limited to their disease conditions. Often single consumers have a limited understanding of the breadth of disease conditions and the experience of people of different gender, age, socio-economic and cultural backgrounds.

As for policy implementation, WA Health Networks are tasked with developing policies and disseminating information that promotes best practice rather than implementing policies. They also have no budget to be dedicated to the transformational changes recommended in its models of care, protocols, frameworks, and guidelines. Furthermore, the diffuse ownership and accountability for implementing the policies has led to distinct levels of implementation of the policies, with 50% of the models of care and policy frameworks being partially implemented, and 27% being substantially implemented (Department of Health WA, 2015). To summarize, we identified two main issues in the network dynamics that might negatively influence the effectiveness of health networks, (1) lack of equal participation by all the stakeholders; and (2) limitations in the representation of stakeholders. Both factors point to the challenges of creating and sustaining an effective model of shared leadership and knowledge sharing.

Limitations

Furthermore, we identified one significant limitation of the case study is measuring the extent to which health networks are used in the management of long-term conditions. The limitation

stems from the fact that health networks are mechanisms for policy production and dissemination rather than policy implementation. To overcome this limitation data will be collected that allows an examination and differentiation across networks.

Whilst networks consist of formal and informal interactions between individuals, Ugyel (2019) argued that informal networks have not gained much attention in public administration and management and concomitantly there is a need to focus on informal networks particularly in developing countries where formal networks are lacking. We argue that informal networks may also be of particular relevance in developed countries. For example, geographical isolation in a developed country may limit the effectiveness of formal networks and health professionals in the management of long-term conditions. By using WA with its low population density, we aim to extend this case study by gathering new evidence of the role played by informal networks in the management of long-term conditions. Using a social network approach outlined by Rogers et al. (2011), the case study will be extended using a qualitative framework to assess the extent and effectiveness of the use of informal networks (both non-health professionals such as traditional healers, and personal communities such family, friends and the community (Ugyel, 2019), in managing long-term conditions relative to the geographical isolation of the individual. The qualitative analysis will be questionnaire based and include selected WA individuals with either heart disease or type 2 diabetes. Questions will relate to the socioeconomic and demographic background of the individual as well as medical information regarding their condition and their use of informal networks. In this analysis we aim to identify and profile the types of informal networks used, and how they are used in the management of long-term condition relative to their geographical isolation. The outcome of this analysis will help inform policymakers of the current state of play in the use of informal networks in self-managing long term conditions for patients that are geographically isolated. It may also point to ways in which formal health networks needed to be redesigned to better integrate with these informal ones.

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