Innovation and experiences of care integration in Australia and New Zealand

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Clinical integration remains the unfulfilled dream of most health systems globally, although pockets of success exist. In Australia and New Zealand there has been a rush to emulate the success of the Canterbury District Health Board 'Pathways' developed in the Christchurch area, featured in this issue of Future Hospital Journal. Whether this success represents an exportable commodity, or is the result of a unique coming together of circumstances that allowed clinical integration to be implemented in Canterbury, remains unclear.

A World Health Organization report on integrated health services published in 2008 did not identify a unified or commonly agreed conceptual model for the integration of health systems.[1] However, the American Medical Association statement describing clinical integration as 'the means to facilitate the coordination of patient care across conditions, providers, settings and time in order to achieve care that is safe, timely, effective, equitable and patient focused' is probably as good a definition as any,[2] although a number of authors[3–8] agree that effective information technology, physician leadership, quality and performance monitoring, and funder and consumer engagement are essential prerequisites. Second, divorcing 'ownership' of the patient or their disease from a particular physical or administrative location (eg primary or secondary care), through a recognition that an integrated system serves the patient's healthcare needs in a safe and efficient manner relative to the point in the disease progression, is a mindset requirement.

There is general agreement that effective IT with sound governance is the most important tool in the integration box. Critical to this is the ability to share clinical information in real time among all involved in decision making and care delivery, including the patient themselves and their carer(s). However, even the Australian IT platform (personally controlled e-health record) has failed to deliver so far in this regard, in large part because it was introduced via an opt-in rather than opt-out process.[7] In addition, technical deficiencies around remote broadband and investment in implementation (both from a hardware and change management viewpoint) exist, hence impacting adversely on the integration process. Progress is being made in other regions of Australia with the introduction of unique identifiers and e-health records that are stable across multiple platforms. In the Canterbury area of New Zealand, the destruction of other IT-based practices by the loss of infrastructure in the 2010 earthquake enabled the adoption of the single electronic shared care record view.[9,10] The importance of the information links of the Transalpine Health Services and their District General Hospital to Christchurch were key in this success.[10]

In considering barriers to clinical integration, professional culture, leadership and trust are central issues. Indeed, many will acknowledge that environments resistant to change require data and evidence to gain acceptance of the need to modify systems. The behaviour of leaders both appointed and natural in respecting the practice of colleagues in other clinical disciplines is key to integration, coupled to what might be termed effective followership by all involved in patient care, wherever it is delivered. This view is clearly endorsed by many writing in this issue of FHJ and is supported by a King's Fund review.[7,9–11]

Acknowledgement of the importance of other societal aspects of integration is also vital; examples being transport infrastructure and interprofessional learning, both of which are easier to achieve in small rural and regional tertiary campuses.[7]

The next key aspect of successful clinical integration is monitoring; that is, the collection of data to evaluate efficiency, effectiveness (with respect to outcome) and safety, as well as assessing the impact of system redesign. Data showing reductions in admission and increased admission avoidance go hand in hand with decreased length of stay. However, those demonstrating falls in admissions from residential care homes – a marker of keeping people well in their own environment – is perhaps the most interesting[11] and could drive system change elsewhere.

In Australia, the relationships of provider organisations with the funder and funding models remain an obstacle to integration; a situation compounded by the presence of multiple tiers of government and governance. Currently, there are at least four different funding paradigms in play within Australia, all of which include a component of taxpayer-funded government contribution. These models are most obvious in the medical arena but also impact on the work of the allied health professional and, to a lesser extent, nursing sectors. They range from uncapped fees for service models seen in community ambulatory practice, and funded by the national government, to rationed block-funded service provision in the individual state-run acute hospital sector. These models do not

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necessarily align with direct benefits for patients; those with complex disease, regardless of their financial status, may have to journey across these capped and uncapped models, which brings inevitable implications for waiting lists. In Australia the funding models enhance the natural divides of professional culture with respect to primary care and the acute hospital sector. In New Zealand, the model is more sympathetic to an integrated care system and, although there is a private sector which is growing, the district health boards are effectively fund holders across the entire primary, ambulatory and the acute hospital sectors, thereby reducing incentives for cost shifting. The capacity of the New Zealand system to deliver an integrated care service is therefore greater than in Australia. However, there is a trend towards trials of a more diversified funding model in Australia, particularly for the multi-morbid patient with chronic disease, the so called 'frequent flyers'. Such trials of capitation-based funding for managed care of enrolled populations are in their infancy but in theory incentivise health maintenance.

Patient pathways are evolving with the successful examples of Canterbury[11] and elsewhere driving this change. However, the 'one size fits all' and 'we want one of those in our health service' approaches should be resisted. Failures occur where pathways are not developed and adapted locally but are imported unmodified. Multidisciplinary approaches to integrated care have been adopted most commonly and audit and outcome measures are being incorporated into the process. While investment in clinical leadership has occurred, there remains a culture of physician scepticism that needs to be overcome. The Australian Commission for Safety and Quality in Health Care has mandated consumer engagement and shared decision making with this end in mind. Effective information sharing with a universal healthcare record remains an aspiration and Australia remains some distance away from aligned financial incentives.

Whether the apparently successful integration of care seen in Canterbury can gain traction elsewhere will depend, in part, upon cultural impetus for change and mutual trust among providers to start the journey. The unique circumstances of the tragic 2010 earthquake may have influenced the success of the process, but in any event, the trust and teamwork evident in their health system is inspirational. ■

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