Series title: Towards integrated primary health care
Integration within primary health care and between primary health care and other sectors

Integrated care: What policies support and influence integration in health care in Australia?

Report 1

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Financing and incentives: Commonwealth and shared policy perspectives on integration
Revenue collection
Fundholding
Purchasing

Financing and incentives: State and Territory policy perspectives on integration
Delivering services—selecting and delivering the best services
Delivering Services: Commonwealth and shared policy perspectives on integration
Access
Coordination
Continuity
Financing
Delivering Services: State and Territory policy perspectives on integration
Common factors promoting integration in States and Territories
Different approaches to promoting integration in States and Territories
Integrated service delivery

Summary
Conclusions
References
Appendix A
Macro level integration: Key considerations SWOT analysis
Appendix B
# Tables and Figures

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Summary of common and varying approaches across the Commonwealth /shared and State/Territory policies, by health system function</td>
<td>3</td>
</tr>
<tr>
<td>Table 2</td>
<td>Definitions of integration and integrated care</td>
<td>8</td>
</tr>
<tr>
<td>Table 3</td>
<td>Information sources</td>
<td>17</td>
</tr>
<tr>
<td>Table 4</td>
<td>Summary of policy elements supporting integration across four functions of health systems</td>
<td>44</td>
</tr>
<tr>
<td>Table 5</td>
<td>Roles and responsibilities for funding and delivering health care services</td>
<td>56</td>
</tr>
<tr>
<td>Table 6</td>
<td>Commonwealth and shared policies that influence integration by means of a stewardship function</td>
<td>57</td>
</tr>
<tr>
<td>Table 7</td>
<td>State and Territory policies that influence integration by means of a stewardship function</td>
<td>62</td>
</tr>
<tr>
<td>Table 8</td>
<td>Commonwealth and shared policies that influence integration by means of a creating resources function</td>
<td>86</td>
</tr>
<tr>
<td>Table 9</td>
<td>State and Territory policies that influence integration by means of a creating resources function</td>
<td>88</td>
</tr>
<tr>
<td>Table 10</td>
<td>Commonwealth and shared policies that influence integration by means of a financing and incentives function</td>
<td>91</td>
</tr>
<tr>
<td>Table 11</td>
<td>State and Territory policies that influence integration by means of a financing and incentives function</td>
<td>94</td>
</tr>
<tr>
<td>Table 12</td>
<td>Commonwealth and shared policies that influence integration by means of a service delivery function</td>
<td>96</td>
</tr>
<tr>
<td>Table 13</td>
<td>State and Territory policies that influence integration by means of a service delivery function</td>
<td>100</td>
</tr>
<tr>
<td>Figure 1</td>
<td>Key stakeholders involved in integrated care</td>
<td>7</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Typology of health care integration</td>
<td>10</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Relations between functions and objectives of a health system</td>
<td>19</td>
</tr>
</tbody>
</table>
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABF</td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td>ABHI</td>
<td>Australian Better Health Initiative</td>
</tr>
<tr>
<td>ABM</td>
<td>Activity Based Management</td>
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<tr>
<td>ACAI</td>
<td>Aged Care Access Initiative</td>
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<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>AGPN</td>
<td>Australian General Practice Network</td>
</tr>
<tr>
<td>AHCA</td>
<td>Australian Health Care Agreements</td>
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<tr>
<td>AML Alliance</td>
<td>Australian Medicare Local Alliance</td>
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<tr>
<td>ANPHA</td>
<td>Australian National Preventive Health Agency</td>
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<tr>
<td>AR-DRG</td>
<td>Australian Defined- Diagnosis Related Groups</td>
</tr>
<tr>
<td>CDM</td>
<td>Chronic Disease Management</td>
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<tr>
<td>CHIME</td>
<td>Community Health Information Management Enterprise</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CPHC</td>
<td>Comprehensive Primary Health Care</td>
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<tr>
<td>CSF</td>
<td>Clinical Service Framework</td>
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<tr>
<td>DHE</td>
<td>Digital Health Enterprise</td>
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<tr>
<td>DGP</td>
<td>Divisions of General Practice</td>
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<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>GPII</td>
<td>General Practice Immunisation Incentive</td>
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<tr>
<td>HACC</td>
<td>Home and Community Care</td>
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<td>HiAP</td>
<td>Health in All Policies</td>
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<td>HWA</td>
<td>Health Workforce Australia</td>
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<td>ICC</td>
<td>Integrated Care Centres</td>
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<tr>
<td>ICDM</td>
<td>Integrated Chronic Disease Management</td>
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<tr>
<td>IPaCH</td>
<td>Integrated Primary and Community Health</td>
</tr>
<tr>
<td>LCG</td>
<td>Lead Clinicians Group</td>
</tr>
<tr>
<td>LHN</td>
<td>Local Hospital Networks/Local Health Areas in some jurisdictions</td>
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<tr>
<td>LHHN</td>
<td>Local Health and Hospital Network</td>
</tr>
<tr>
<td>ML</td>
<td>Medicare Local</td>
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<tr>
<td>MPS</td>
<td>Multipurpose Services</td>
</tr>
<tr>
<td>NCDS</td>
<td>National Chronic Disease Strategy</td>
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<tr>
<td>NEHTA</td>
<td>National E-Health Transition Authority</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<tr>
<td>NHHN</td>
<td>National Health and Hospital Network</td>
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<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<tr>
<td>NHPAC</td>
<td>National Health Priority Action Council</td>
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<tr>
<td>NHR</td>
<td>National Health Reform</td>
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<tr>
<td>NPA</td>
<td>National Performance Authority</td>
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<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>NT</td>
<td>Northern Territory</td>
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<tr>
<td>PCP</td>
<td>Primary Care Partnerships</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHCOs</td>
<td>Primary Health Care Organisations</td>
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<td>PHCRIS</td>
<td>Primary Health Care Research &amp; Information Service</td>
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<tr>
<td>PHCP</td>
<td>Primary Health Services Plan</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>QLD</td>
<td>Queensland</td>
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<tr>
<td>RACF</td>
<td>Residential Aged Care Facility</td>
</tr>
<tr>
<td>RPHS</td>
<td>Rural Primary Health Services Program</td>
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<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>TAS</td>
<td>Tasmania</td>
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<tr>
<td>VIC</td>
<td>Victoria</td>
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<tr>
<td>WA</td>
<td>Western Australia</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WSRGP</td>
<td>Workforce Support for Rural General Practitioners</td>
</tr>
</tbody>
</table>
Executive summary

Without integration, all aspects of care can suffer. Patients can get lost in the system, needed services fail to be delivered or are delayed or duplicated, the quality of the care experience declines, and the potential for cost-effectiveness diminishes (Kodner and Spreeuwenberg, 2002).

Context

Integrated health care has been a focus of national health reform in Australia and internationally. In Australia, this has culminated in the National Health Reform Agreement (NHR Agreement; August 2011) to deliver reforms to the organisation, funding and delivery of health and aged care. Over successive health reform agreements since the National Healthcare Agreement of 2008, there has been a concerted effort to promote integration at the macro level between governments. The NHR Agreement sets out the shared intention of Commonwealth, State and Territory governments to work in partnership to improve health outcomes for Australians and ensure the sustainability of the Australian health system.

More recently, the Commonwealth has worked closely with states and territories and primary health care (PHC) stakeholders to develop a National Primary Health Care Strategic Framework (Standing Council on Health, 2013).

Aims

This report, which is the first of a series on integrated PHC, examines integration at the macro level. It maps out the policies, agreements and other documents that explicitly refer to integrated care.

This map forms a baseline/foundation document of PHC integration in Australia. The key aims are to:

1. identify relevant policies that focus on integration and PHC services at the Commonwealth, State/Territory and local levels
2. identify the common (agreed) areas and differences in policies across the levels
3. examine evidence of effectiveness of macro level strategies to improve integration of PHC (e.g. general practice, allied health and community health)
4. identify strengths, weaknesses, opportunities and threats related to macro level integration in the Australian context.

Scope

This report focuses on integrated care at the macro level, specifically where PHC plays a role. The term ‘policy’ refers to any official statements or views articulated by policy-making bodies on external matters (as distinct from internal policies and procedures) that are publicly available. Sources are varied but typically include: agreements, policy directives, position statements, submissions, discussion papers, options papers and briefs. There may be overlap between policies (Commonwealth, shared, and State and Territory).

While the ultimate aim of integration is to link together service providers and organisations to deliver appropriate, comprehensive and coordinated care to individuals and families (Queensland Government, 2000), this report explores the policy documents that provide an overarching vision for integrated care; and those that underpin the governance, funding and strategies to deliver integrated health care services.

1 Macro: For the purposes of these reports, macro level integration refers to activities that drive integrated care at the policy level, both nationally (Commonwealth or shared policies) and within States/Territories. Macro, meso and micro levels are defined on page 13.
Findings
A large number of health policy-related documents (Commonwealth, State and Territory) were identified that mentioned ‘integration’, ‘integrated care’ or related terms, indicating that an integrated health care system is an aim of multiple government policies. For the most part, these documents provide an overarching vision and specify integration as a key direction or objective, but give little or no detail on what is meant by integration, the processes or mechanisms underlying integrated care, the stakeholders or roles required to implement policies or how it is intended to be implemented. In addition, while evaluation is mentioned in several documents, there is little detail on what criteria would be used or how evaluations would be undertaken.

The focus of these documents often varied, not only according to the jurisdiction, but also by the type of policy lever (e.g. regulation, financial incentive) and function (e.g. strategic direction, distribution of health care workforce). Therefore, the documents have been organised into categories based on the WHO health system performance framework (WHO, 2000). This framework was established to evaluate health systems across the world. The WHO identifies a health system as a structured set of resources, actors and institutions related to the financing, regulation and provision of health actions that provides health care to a given population (WHO, 2000).

Given the broad scope of this field and the multiple perspectives, levels and approaches to policy on integrated care, the material has been organised according to the following four functions of a health system, as described by WHO (2000):

- **Stewardship**: How is the health and wellbeing of the people protected? This function defines the overarching vision and direction of health policy to establish a fair and optimal health system through governance, information dissemination, regulation and advocacy. Stewardship strongly influences the other functions.
- **Creating resources**: What resources are needed? This function is about investment in skills, training, facilities, equipment and maintenance to ensure a balanced mix of inputs (human resources, physical capital, consumables) across geographical areas.
- **Financing and incentives**: Who pays for the system? This function is about fair distribution of payment; strategic purchasing to improve the health system outcomes and avoid waste (duplication, redundancy). It includes revenue collection, purchasing and pooling resources.
- **Service delivery**: This function is about choosing the most effective ways to deliver high quality services equitably, with the ultimate aim of improving health.

For the Commonwealth/shared policies and State/Territory policies, there were several key common elements that related to the four functions, and a number of varying approaches. This reflects both a concerted focus on integration through National Health Reform, with the Commonwealth and jurisdictions working together on improving integration, along with unique approaches or varying areas of focus among the different jurisdictions. Table 1 summarises the common factors and varying approaches extracted from Commonwealth/shared and State/Territory policies and organised by health system function.

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ii ‘Actors’ refers to the people who perform the tasks required to make the health system work – from Ministers and policy-makers to local health authorities and providers. Patients are also actors in terms of being involved in their own health care.
Analysis

PHC integration at the macro level presents a number of strengths, weaknesses, opportunities and threats. While integration enables implementation of reform, collaboration, consistency, and clear objectives, measures and targets; it may also result in varying approaches to reform in jurisdictions and a lack of evaluation of policies. There are opportunities for improved care pathways and the sharing of resources; however there can also be challenges around differing definitions of integration or ascertaining funding responsibility in relation to policy implementation. A SWOT analysis of macro level integration is provided in Appendix A.

Table 1  Summary of common and varying approaches across the Commonwealth /shared and State/Territory policies, by health system function

<table>
<thead>
<tr>
<th>Function</th>
<th>Common factors</th>
<th>Varying approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stewardship</td>
<td>• Addressing health reform priority areas</td>
<td>• Models of care, Memoranda of Understanding etc.</td>
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<tr>
<td></td>
<td>• Medicare Locals and Local Hospital Networks (LHNs) working together</td>
<td>• How access is addressed</td>
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<td></td>
<td>• Partnerships across sectors</td>
<td>• Emphasis on technology</td>
</tr>
<tr>
<td></td>
<td>• Addressing health reform priority areas</td>
<td>• Focus on linking specific government sectors vs. linking agencies relating to</td>
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<tr>
<td></td>
<td>• Medicare Locals and Local Hospital Networks (LHNs) working together</td>
<td>patient groups</td>
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<td></td>
<td>• Partnerships across sectors</td>
<td>• Emphasis on workforce</td>
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<td></td>
<td>• Partnerships across sectors</td>
<td>• Emphasis on workforce</td>
</tr>
<tr>
<td>Creating</td>
<td>• Multidisciplinary programs</td>
<td>• Context-dependent resource requirements</td>
</tr>
<tr>
<td>resources</td>
<td>• Information transfer/e-health</td>
<td>• Resource availability</td>
</tr>
<tr>
<td></td>
<td>• Matched human resources/demand for services</td>
<td>• Emphasis on acute vs. PHC setting</td>
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<td></td>
<td>• Importance of communication between stakeholders</td>
<td>• Social factors vs. business factors</td>
</tr>
<tr>
<td>Financing and</td>
<td>• Incentive payments to practitioners</td>
<td>• Timing of new financing models</td>
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<tr>
<td>incentives</td>
<td>• Reflecting regional demographics</td>
<td>• Formalised financial policy plans</td>
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<tr>
<td>Delivering</td>
<td>• Implementing activity-based funding</td>
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<tr>
<td>services</td>
<td>• Promoting access through co-location</td>
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<td></td>
<td>• Patient-centred care</td>
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<td></td>
<td>• Community engagement</td>
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<td></td>
<td>• Improving the patient experience and continuity of care</td>
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<td></td>
<td>• Right services, right time, by right people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Composition of primary health care organisations (PHCOs)</td>
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<td></td>
<td>• Patient emphasis or practice emphasis</td>
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<td></td>
<td>• Financing plans</td>
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Conclusions

Integration policies that support Australian health reform have a strong focus on encouraging alignment, collaboration, consistency, and clear objectives, measures and targets. Coherence across Commonwealth, State/Territory and shared policies provides opportunities to improve efficiency by sharing resources and, ultimately, improving patients’ experience of their care pathway. The WHO framework is a useful way to organise many diverse policy-related documents and make sense of their key objectives; and to identify potential policy levers for change. Many different approaches to integration policies used by the Australian States and Territories reflect contextual differences related to population density, distances to services and local community factors. Evaluation of policies is needed to determine their effectiveness in achieving not only integration, but also the

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iii LHNs are also known as Local Health Networks, Local Health Areas, Area Health Services and Local Health Districts in some jurisdictions.
longer term effects of an integrated care approach. The challenge for the future is to strengthen the commitment to change, and remove the barriers related to both the ‘will’ and the ‘means’ to implementing integrated health policies.
Background

Integrated health care has been an integral element of health reform in Australia and internationally. The human and financial cost of fragmented care is an important challenge for health care systems worldwide.

*Fragmentation adversely impacts quality, cost, and outcomes. Eliminating waste from unnecessary, unsafe care is crucial for improving quality and reducing costs – and making the system financially sustainable (Enthoven, 2009, p S284).*

There is a growing evidence-base to indicate that fragmented care is costly not only in terms of financial inefficiency for the practice and the health system, but also for patient health outcomes (e.g. delays or lack of appropriate care) (Davies, 2012, Enthoven, 2009).

*Fragmentation leads to well-intentioned actions that sometimes have the unintended consequence of making things worse (Stange, 2009, p 101).*

Stange (2009) identified several consequences of fragmented care including: inefficiency, ineffectiveness, inequality, commoditisation, commercialisation, depprofessionalisation, depersonalisation, despair and discord. A survey of eleven countries (Schoen et al., 2011) showed that more than 20 per cent of Australians with complex care needs experienced some form of fragmented care (2009-2011). For example, 12 per cent of Australian health care providers failed to share important information with each other; and test results/records were not available or duplicate tests were ordered for 19 per cent of patients.

It is widely acknowledged that “treating patients for one condition without recognising other needs or conditions” is likely to undermine the “overall effectiveness of treatment” (Lloyd and Wait, 2006, p 7). Increasingly, evidence suggests that integrated health care is an effective way to optimise the efficient delivery of services and improve patients’ outcomes and experiences (Enthoven, 2009, Kodner, 2009). PHC is frequently the first point of contact with the health system and has been identified as the cornerstone for connecting patients to appropriate health care services (Starfield et al., 2005).

Primary health care in Australia

Primary health care (PHC) refers to:

*...socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation (Commonwealth of Australia, 2009c, p 22).*

PHC in Australia is currently provided by a complex mix of agencies, which includes State and Territory government-managed community health services, publicly and privately funded providers, and government and non-government agencies. The PHC sector operates at a number of levels in the context of Australia’s system of government and the broader health system. Broadly these levels can be grouped into three categories:
• **Macro** (system) level governments and agencies are responsible for national and/or state level policy, funding strategy and enabling infrastructure. In addition to the Commonwealth, State and Territory governments, examples include the Australian Medicare Local Alliance (AML Alliance), National Lead Clinicians Group (LCG) and the Australian National Preventive Health Agency (ANPHA).

• **Meso** (organisational) level agencies are positioned between the macro and micro levels, often have a regional role and may act as commissioning, linking, enabling agencies for the local and regional PHC sector, such as Medicare Locals (MLs) and Local Hospital Networks (LHNs).

• **Micro** (practice) level includes agencies and individuals who provide direct PHC to clients/patients such as general practice, community health services, private nursing or allied health providers (AMLA, 2012, p 3).

Figure 1 illustrates the key stakeholders involved in integrated care, their perspectives and their main focus at the different levels. In some cases, the distinction between levels is not always clear and stakeholders play a role in more than one level.
The main actors at the **macro** level are: Government agencies and policy advisors at national and regional levels. This is a high level ‘big picture’ perspective. Focus is on stewardship, funding, incentives, creating resources and selecting best services for delivery.

The main actors at the **meso** level are: PHCOs, allied health and community health organisations, medical specialists and hospitals. Arms-length bodies also play an important role. This is a middle level, regional perspective. Focus is on partnerships with similar organisations and those in other relevant sectors to facilitate integrated care.

The main actors at the **micro** level are: health care professionals across all organisations, patients and the local community. Focus is on patient-centred health service delivery and implementation of programs.

**Figure 1** Key stakeholders involved in integrated care
Funding and responsibilities: Public—Private Mix

Health care in Australia is a mix of publicly and privately funded health care providers. Australian health care is funded primarily through tax revenues, with approximately one-third funded privately through insurance or patients’ out-of-pocket payments (Foley, 2008). Of the total expenditure, one-third occurs in the public sector (e.g. public hospitals, community health services, public health); and the remaining two-thirds occurs in the private sector (e.g. general practice, specialists, private hospitals, allied health, dental care, pharmacy). Private services have a variety of governance arrangements, including private practice, group practice, for-profit and not-for-profit organisations.

Prior to the recent health reform efforts there was a separation of responsibilities for health between the Commonwealth and State/Territory governments. This arrangement sometimes resulted in uncoordinated and fragmented care. That is, the Commonwealth was responsible for PHC services delivered through Medicare general practice funding, while the States/Territories were responsible for community health care funded via Medicare block grants (Commonwealth of Australia, 2009c). Specifically, the Australian Government funded the majority of general practice services, through both Medicare and the Department of Veterans’ Affairs (SCRGSP, 2011). The Australian Government also provided funding for general practice services under initiatives such as the Practice Incentives Program , the General Practice Immunisation Incentive Scheme (GPII) and Divisions of General Practice (DGP; funded til December 2012). State and Territory governments have also provided funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for general practitioners (such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas) or education and support services for public health issues. In 2008-09, government expenditure on community and public health was $7.5 billion, of which State, Territory and local governments provided 74.6 per cent, and the Australian Government 25.4 per cent (AIHW, 2010).

Integration and integrated care

The terms, ‘integration’ and ‘integrated care’ mean different things to different people. This is not surprising as integration occurs between different levels of the health system (vertical integration), such as between PHC and acute care organisations; and across health care providers at the same level (horizontal integration), such as between general practitioners (GPs) and allied health professionals. Consequently, there are many definitions of integration. Some definitions focus on the organisation of services across different sectors, while others focus on the provision of a broad range of health and/or social care services (Table 2).

Table 2 Definitions of integration and integrated care

<table>
<thead>
<tr>
<th>Original term/Author</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Integrated care (Øvretveit et al., 2010)</td>
<td>The methods and type of organization that will provide the most cost-effective preventative and caring services to those with the greatest health needs and that will ensure continuity of care and co-ordination between different services.</td>
</tr>
<tr>
<td>Integration (Leutz, 1999)</td>
<td>The search to connect the healthcare system (acute, primary medical and skilled) with other human service systems (e.g. long-term care, education and vocational and housing services) to improve outcomes (clinical, satisfaction and efficiency).</td>
</tr>
<tr>
<td>Integrated care (Gröne and Garcia-Barbero, 2001)</td>
<td>A concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion ... [as] a means to improve the services in relation to access, quality, user satisfaction and efficiency.</td>
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</tbody>
</table>
Integrated care (Kodner and Spreeuwenberg, 2002)  
A coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors ...to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex problems cutting across multiple services, providers and settings.

Integrated care (WHO, 2008)  
The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.

Sources: (Kodner, 2009, WHO, 2008)

The differences in definitions may reflect the multiple ways in which the terms are used. The WHO (2008) describes six main usages of integration, which are not mutually exclusive, and which may operate across the macro, meso and micro levels:

- **one-stop-shop**: individuals in a specific target group (e.g. people with diabetes) receive all the appropriate care in a streamlined, coordinated manner
- **multi-purpose service delivery**: a range of services that are provided at one location for a catchment population (e.g. GP Superclinics)
- **continuity of care**: integration of care over a period of time, such as through the course of a chronic illness, or across the stages of life
- **vertical integration**: integration of care across different levels of service, such as referrals between public and private providers
- **integrated policy-making and management**: policy decisions and support across different parts of the health system and across different government portfolios
- **inter-sectoral integration**: integrating health services across different sectors, such as linking health with education and social services.

Fulop et al. (2005) also distinguish four different dimensions of integration:

- **functional** integration occurs at the macro level of a health care system, for example through mainstreaming of the financing and regulation of cure, care, prevention and social services (integration of non-clinical support and ‘back-office’ functions)
- **organisational** integration occurs at the meso level of a health care system, for example in the form of mergers, contracting or strategic alliances between health care institutions (formal structure)
- **service** integration occurs at the meso and micro level of a health care system, for example in the form of alliances between health care professionals to integrate services within and between organisations
- **clinical** integration occurs at the micro level of a health care system, for example continuity, cooperation and coherence in the primary process of care delivery to individual patients (clinical team using a shared care pathway).

As shown in Figure 2, these dimensions exist within two additional factors to support coordination and collaboration:

- **normative** integration: shared values
- **systemic** integration: coherent set of rules and policies.
Integrated care: What policies support and influence integration in health care in Australia?

Rationale and approach for this series

Given the multiplicity of definitions, dimensions, perspectives, levels and objectives of integrated care, we will examine these different aspects in more detail in a series of reports, with a particular focus on the role of PHC.

The first report in this series examines integration at the macro (policy) level. Future reports include integration at the meso and micro levels.

<table>
<thead>
<tr>
<th>Report</th>
<th>Level</th>
<th>Title</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Macro</td>
<td>Integrated care: What policies support and influence integration in health care in Australia?</td>
</tr>
<tr>
<td>2</td>
<td>Macro</td>
<td>Integrated care: What policies support and influence integration in health care across New Zealand, England, Canada and the United States?</td>
</tr>
<tr>
<td>3</td>
<td>Meso</td>
<td>Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level?</td>
</tr>
<tr>
<td>4</td>
<td>Meso</td>
<td>Medicare Locals: A model for primary health care integration?</td>
</tr>
<tr>
<td>5</td>
<td>Micro</td>
<td>Integrated care: What can be done at the micro level to influence integration in primary health care?</td>
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</tbody>
</table>

In reality, there is overlap between levels and across jurisdictions; and in practice, some policy initiatives cross the different levels and/or measure impact at the different levels. Moreover, the macro, meso and micro levels are also interdependent. Initiatives implemented at the meso or micro levels are unlikely to be effective unless they are enabled at the macro level by policy. That is, integrated care that is delivered by a team of health care professionals (micro level integration) requires support and leadership across the different provider organisations (meso level integration);
and both are enabled by macro level integration policies. For example, integrated care for the elderly patients in Torbay (UK integrated care pilot) improved significantly due to the establishment of “locality-based health and social care teams that aligned with general practice” (Curry and Ham, 2010, p 44). The integration of providers was the driving force behind service improvement. However, this arrangement was facilitated by policies that allowed the care teams to use pooled budgets to align incentives appropriately. In this case, “organisational integration was a consequence rather than a cause of work to improve outcomes” (Curry and Ham, 2010, p 44).
Aims of this report—macro level integrated care

This report is a review of Australian policies which promote integrated care that is relevant to PHC, including delivery of health care services within PHC and between PHC and other related areas. The overall objectives of the current report are to provide a map of policies that are relevant to integration in Australian PHC; to discuss vertical integration in the Australian health system; and describe how macro level policies may influence integration. This map forms a baseline/foundation document of PHC integration in Australia.

The key aims are:
1. To identify relevant policies that focus on integration and PHC services at the Commonwealth, State/Territory and local levels
2. To identify the common (agreed) areas and differences in policies across the levels
3. To examine evidence of effectiveness of macro level strategies to improve integration of PHC (e.g. general practice, allied health and community health)
4. To identify strengths, weaknesses, opportunities and threats related to macro level integration in the Australian context.

The second report in this series (Integrated care: What policies support and influence integration in health care across New Zealand, England, Canada and the United States?) will examine macro level integration in other countries, and discuss how international integration efforts relate to the Australian setting.
Scope of the report

This report focuses on integrated care at the macro level, specifically where PHC plays a role. The term ‘policy’ refers to any official statements or views articulated by policy-making bodies on external matters (as distinct from internal policies and procedures) that are publicly available. Sources are varied but typically include: agreements, policy directives, position statements, submissions, discussion papers, options papers and briefs. There may be overlap between policies (Commonwealth, and State and Territory). Shared policies in this report refer to intergovernmental agreements and arrangements (e.g. Council of Australian Governments (COAG)).

While the ultimate aim of integration is to link together service providers and organisations to deliver appropriate, comprehensive and coordinated care to individuals and families (Queensland Government, 2000), this report explores the policy documents that provide an overarching vision for integration; and those that underpin the governance, funding and strategies to deliver integrated health care.

Limitations

Due to time constraints, the timeframe for inclusion of policies for this report was limited to the most recent policies that aim to influence integration in PHC. However, to give context to the recent reforms, prior health reform policies are discussed where relevant. In addition, we have included recent initiatives that may be in effect during a transition phase. For example, some initiatives relate to Divisions of General Practice while others reflect recent transitions and address the newly formed primary health care organisations, Medicare Locals. Time constraints also limited searches to publicly accessible documents that were indexed by the search terms ‘integration’ or ‘integrated’. Therefore, this report does not provide an exhaustive list of policies, particularly for the States and Territories. Instead, this report represents a scoping exercise which selected a broad subset of policies targeting integration of health services. Some documents are directive in their focus on the delivery of integrated care whereas others are broad (i.e. cross-sectoral). Whilst careful consideration has been given to produce a report which is engaging and useful, broad judgements and observations were at times required in order to get the balance between the breadth and the depth of policy directed towards integrated health care.
Methods

This report followed a ‘rapid review’ format. Rapid reviews are pragmatic literature reviews that focus on research evidence, with a view to facilitating evidence-based policy development. In order to obtain the most relevant material quickly, search terms varied across different databases. Consequently, replication of this review may result in a different literature base.

Table 3 lists the information sources used to identify relevant literature for this rapid review. While some articles were located in the peer-reviewed literature, most of the relevant information for this report was located by searching the grey literature, including from government or organisational sources, evaluation reports and organisational websites. Once relevant material was located, a snowballing approach was used to identify additional material. Where possible the information was triangulated (Hansen, 2006) in order to confirm sources.

Table 3   Information sources

<table>
<thead>
<tr>
<th>Electronic bibliographic databases</th>
<th>E.g. PHC Search Filter, MEDLINE, CINAHL, PsycLIT, ISI Web of Science, PubMed, AUSTHealth</th>
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<tbody>
<tr>
<td>Websites</td>
<td>Commonwealth and State/Territory Departments of Health</td>
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<td>PHCRIS</td>
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<td>Australian Policy Online</td>
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<tr>
<td>Grey literature</td>
<td>Google, Google Scholar, Open Grey, TROVE</td>
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Findings

A large number of health policy-related documents (Commonwealth, State and Territory) were identified that mentioned ‘integration’, ‘integrated care’ or related terms. For the most part, these documents provided an overarching vision and specified integration as a key direction or objective, but gave little or no detail on what was meant by integration, the processes or mechanisms underlying integrated care, the stakeholders or roles required to implement policies or how it was intended to be implemented. In addition, while evaluation was mentioned in several documents, there was little detail on what criteria would be used or how evaluations would be undertaken.

The focus of these documents often varied, not only according to the jurisdiction, but also by the type of policy lever (e.g. regulation, financial incentive) and function (e.g. strategic direction, distribution of health care workforce). Therefore, we have attempted to organise the documents into categories based on the WHO health system performance framework (2000). This framework was established to evaluate health systems across the world. The WHO identifies a health system as a structured set of resources, actorsiv and institutions related to the financing, regulation and provision of health actions that provides health care to a given population (WHO, 2000).

Furthermore, health systems aim to achieve three fundamental objectives:
- improved health (e.g. better health status and reduced health inequalities)
- enhanced responsiveness to the expectations of the population, encompassing respect for the individual and client orientation
- financial fairness on both sides with protection from financial risks resulting from health care.

Figure 3 shows the relationship between the functions and objectives of a health system, as outlined in the WHO report (2000).

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iv ‘Actors’ refers to the people who perform the tasks required to make the health system work – from Ministers and policy-makers to local health authorities and providers. Patients are also actors in terms of being involved in their own health care.

v Source: (WHO, 2000, p 25)
The level of attainment of these goals ultimately reflects the performance of the system as a whole. Rather than a destination in itself, integration is considered a function of good policy leading to improved health service delivery. Hence for this report, these categories provided a sensible way to identify how the policies attempt to influence integration of health services. The four key functions include:

- stewardship
- creating resources
- financing and incentives
- delivering services.

These functions can be applied to the whole health system of a country with specific sub-characteristics for primary care, or to primary care only. For this report, we have used these functions to define the mechanisms of policies targeting integration that involves PHC.

**Integration mapped across health system functions**

A macro level perspective on integration relates to the establishment of partnerships between Commonwealth and State/Territory governments, and between intrasectoral organisations (public and private) working together on shared priorities. Many policies and agreements explicitly refer to integration across jurisdictions, providing vision, objectives and specific integration elements. Within these documents, there is often reference to integration between the public and private sectors and across other sectors. Given that PHC providers work predominantly in the private sector, integration with the private sector is implicit in many policies involving integrated care. One example of specific policy involving integration with the private sector relates to the establishment of GP Super Clinics, which will be discussed in more detail below in the Delivering Services section, and in Report 5 in this series (*Integrated care: What can be done at the micro level to influence integration in primary health care?*).

The tables (4 to 11, Appendix B) summarise the key aspects of Commonwealth, shared and State/Territory policies that focus on integration for PHC in each of the four different functions. The overall vision and specific elements that relate to integration are provided for each document, including an electronic link to the documents in the tables. For each of the functions (stewardship, creating resources, financing and incentives, and delivering services), we have identified the common and divergent factors affecting integration across the jurisdictions.

**Stewardship—protecting public interest**

Stewardship is about the “careful and responsible management of the well-being of the population” (WHO, 2000, p viii). As the ‘steward’ of national resources, the government is responsible for establishing the “best and fairest health system possible” (p 118). Stewardship is an overriding function (broader than regulation) in that it oversees all basic health system functions, having direct and indirect effects on the outcomes of a health system.

*Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy and collecting and using information (WHO, 2000, p 118).*

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vi Shared policies refer to those that have explicit agreements between the Commonwealth and States/Territories regarding each jurisdiction’s specific roles, responsibilities and funding arrangements.
Stewardship covers three main aspects:
- setting, implementing and monitoring the rules for the health system
- assuring a level playing field for purchasers, providers and patients
- defining strategic directions for the health system as a whole.

Stewardship can be further divided into six sub-functions: overall system design, performance assessment, priority setting, regulation, intersectoral advocacy and consumer protection (Murray and Frenk, 2001). In short, stewardship deals with: governance, information dissemination, coordination, and regulation of the health system at various levels. Stewardship is the dominant function that influences the other functions and “percolates through all levels of the health system” (WHO, 2000, p 129).

**Stewardship: Commonwealth and shared policy perspectives on integration**

Through an incremental process, the Commonwealth, with the states and territories, have been working to promote integration among different sectors in the health system. This has been primarily achieved through the NHR agreements. The current NHR Agreement fosters integration and stipulates shared responsibility for health outcomes. The Commonwealth has full funding and program responsibility for aged care (except where otherwise agreed) and has lead responsibility for general practice and PHC; whereas the States/Territories provide public health, community health, aged care services, public dental services and immunisations via health promotion programs (Commonwealth of Australia, 2009c). Table 5 (Appendix A) provides a summary of the roles and responsibilities of the different jurisdictions for funding and delivery of health care services. Despite differences in funding arrangements and governance structures across the jurisdictions, the Commonwealth, States and Territories appear committed to sharing responsibility for health and placing patients’ needs at the centre of the health system.

The establishment of MLs, as a leading role in striving for integrated PHC, is a fundamental platform across Commonwealth and shared policies (Australian Government Department of Health and Ageing, 2011, Commonwealth of Australia, 2010a). MLs are expected to work across Commonwealth and State/Territory policies and are in a position to facilitate and strengthen networks and partnerships. Other ML functions, such as identifying and addressing service gaps, influencing the behaviour of PHC providers, and supporting integrated care initiatives, operate at the meso level and will be addressed in Report 3 in this series (*Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level?*).

The Commonwealth and shared policies in Table 4 provide a snapshot of the national plans to promote collaboration and integration as a way of addressing the nation’s key health needs. They incorporate the stewardship roles described above (WHO, 2000). Specifically, the policies indicate that primary health care organisations (PHCOs) such as MLs, should work together with LHNs to achieve the common aims related to equity, chronic disease management, health prevention and improving practice (Commonwealth of Australia, 2012).

**Chronology of Health Reform**

In summary, the (reverse) chronology of significant health reform documents relevant to PHC integration is as follows:
- *National Primary Health Care Strategic Framework (2013)* and bilateral plans with states and territories under the NHR Agreement
- **NHR Agreement**: Council of Australian Governments (COAG) agreement that sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for Australians and ensure the sustainability of the health system.

- **Building a 21st Century Primary Health Care System - Australia’s First National Primary Health Care Strategy** (2010): recognises that a strong PHC system is critical to the future success and sustainability of the health care system.

- **National Health and Hospitals Network Agreement** (NHHN; April 2009): agreement by COAG, with the exception of Western Australia, to deliver health and hospital reform (superseded by NHR Agreement).

- **A Healthier Future for All Australians** (June 2009), National Health and Hospitals Reform Commission: made recommendations about Australia’s health care system, including that Australia adopt primary health care organisations.

- **National Healthcare Agreement 2008**: focused on funding of health care through revised federal financial relations.

**Strategic directions, vision and governance**

Through successive NHR agreements, integration has been promoted by:

- delineating roles and responsibilities
- identifying shared responsibilities between governments
- streamlining funding arrangements and promoting common objectives and outcomes between levels of government.

The *NHR Agreement* provides an overarching model for improving the health system, responding to the population’s expectations and promoting equity (Commonwealth of Australia, 2012). In terms of stewardship, the *NHR Agreement* defines the vision of health policy, priority areas and strategic directions of the health system. The *NHR Agreement* also sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the health system.

The *NHR Agreement* also represents an opportunity for the Commonwealth and States/Territories to set goals together, and address the same building blocks, constructing holistic plans for the health system. By stipulating that Commonwealth officials will work closely with State/Territory parties, the agreement itself promotes integration and provides an example of the macro level of linkage and coordination required for an integrated health system. Similarly, the individual *Australian Health Care Agreements* (AHCAs) (Australian Government Department of Health and Ageing, 2010) between the Commonwealth and each State and Territory provide further evidence of such macro level integration (Table 5, Appendix B).

Providing strategic directions for the health system as a whole supports the concept of integration with a push towards shared aims among different organisations. This is exemplified in the Commonwealth initiatives that cover a broad range of PHC-related issues such as community health, Indigenous and rural health, mental health, chronic disease, cancer and immunisation.

The establishment of the *Australian National Preventive Health Agency* (ANPHA) (Commonwealth of Australia, 2010a) is a specific example of targeting a health reform priority area. ANPHA provides governance for dealing with issues related to chronic disease, which is one of the key priority areas for PHC (Commonwealth of Australia, 2010a). Further, the *National Chronic Disease Strategy* sets the
rules and priorities in a stewardship role and provides the States and Territories with frameworks for tackling chronic disease management (National Health Priority Action Council (NHPAC), 2006).

The National Strategic Framework for Rural and Remote Health (Australian Government Department of Health and Ageing, 2012b) is also a good example of integration as it was developed through a partnership between the Commonwealth, and State and Northern Territory governments. Moreover, this framework covers not only the vision, strategic directions, governance and development of collaborative partnerships as part of the stewardship function, but also addresses issues related to delivering services (access, models of care), and creating resources (sustainable workforce).

**Equity and advocacy**

Similarly, one of the key aspects of stewardship is to assure a level playing field. This is demonstrated by the Commonwealth government’s acknowledgement of the importance of consulting not only with the States/Territories, but also with MLs, clinicians (e.g. through the National LCG) and other key stakeholders in developing a health system “fit for the future” (Commonwealth of Australia, 2012, p 3, COAG, 2011a). For example, the NHHN Agreement specifies the roles and shared goals of the MLs and LHNs in their collaborations (COAG, 2011a). Consideration of local needs (e.g. through needs assessments) and linkages between communities and health professionals are embedded in the functions of MLs. The NHHN Agreement is also expected to enable intersectoral advocacy and consumer protection by ensuring that patients’ perspectives are heard by the different services involved in their care. Further, this agreement speaks to funding and addresses the health system’s need to ensure financial fairness (COAG, 2011a).

**Evaluation and performance assessment**

One of the more challenging aspects of stewardship relates to performance assessment. There has been little evaluation around the efficacy of policies given the difficulties in measuring health care performance. However, the successive health reform agreements have a concerted focus on increasing accountability of governments and health care organisations in improving health outcomes through implementation of performance assessment frameworks:

- The NHR Agreement acknowledged the importance of accountability with the establishment of the National Health Performance Authority (NHPA).

While these do not specifically measure government performance around promoting integration, they do promote a shared vision of the Australian health care system.

The National Health Performance Authority Performance and Accountability Framework outlines three domains to assess the performance of service delivery: equity, effectiveness and efficiency. This framework is targeted to address key national health policy objectives. One of these objectives is specifically aimed at improving integration between the PHC sector and hospital sectors (National Health Performance Authority, 2012). This policy document outlines responsibilities of MLs and LHNs as well as initial performance indicators towards future benchmarking and comparisons between organisations. Prior to this document, other policies included recommendations related to evaluation. For example, the National Chronic Disease Strategy (National Health Priority Action Council (NHPAC), 2006) described the need for an evaluation plan. This proposed plan incorporated process indicators to investigate whether processes had been enacted to implement the strategy’s directions, and outcome indicators that assessed whether the specified objectives had been achieved. Another example, the National Health Priority Action Council indicated the importance of
using evidence-based, validated measures in evaluation, with assessments addressing both short and long-term outcomes and taking place at the level of implementation of the policy (i.e. state, region, community) (National Health Priority Action Council (NHPAC), 2006). These policies have been superseded, yet the ideas could readily be applied to investigate the efficacy of a range of policy models now and in the future.

**Stewardship: State and Territory policy perspectives on integration**

While many aspects of integration are subsumed in the Commonwealth and shared policy documents, others are specific to the State/Territory jurisdictions. Table 5 lists the State and Territory policies that use a stewardship function to influence integration. We have identified some of the common factors that appear in the State/Territory policies, some examples of those that are specific to particular jurisdictions, and what is planned in terms of monitoring and evaluation.

*Common factors promoting integration in States and Territories*

Macro level integration commonly refers to partnerships (Queensland Government, 2000) and each state’s policies reflect this need. Similarly, each state has specific policies that represent the main stewardship functions related to setting, implementing and monitoring rules, assuring a level playing field and defining strategic directions. Furthermore, many of the sub-functions of priority setting, intersectoral advocacy, and consumer protection are addressed in terms of overall system design (WHO, 2000).

Described in detail in the ‘creating resources’ section below, the **alignment of resources** is reflected in stewardship functions across several State/Territory policies. These policies primarily focus on demand and supply of human/physical resources, and a planning and regulatory framework to ensure high quality service provision and consumer protection (Government of South Australia, 2010, Government of Western Australia, 2007a, Government of Western Australia, 2011b, Primary Health Victorian Government Department of Human Services, 2009, Tasmanian Department of Health and Human Services, 2007b, Victorian Government, 2008a, Victorian Government, 2011c, WHO, 2010). The policies often have specific target populations around which to create resources. For example, the **NSW Framework for integrated support and management of older** people focuses on aged care (NSW Department of Health, 2004a), and the NSW Chronic Care Program (NSW Department of Health, 2004c, NSW Department of Health, 2006b) focuses on chronic conditions, while SA’s ‘Stepping Up’ model addresses mental health (South Australian Social Inclusion Board, 2007). Other states have broad policies around the demand and supply of resources across the community as a whole, such as VIC’s **Demand Management Framework for Community Health Services** (Victorian Government, 2008a).

In terms of improving access to **create a level playing field**, location commonly emerges as a key component of integration. For example, the policy for developing **HealthOne NSW** services refers to a number of different location models which are appropriate for promoting collaborative efforts among health services (NSW Department of Health, 2012a). Some evidence suggests that co-location models can benefit rural and remote areas, while larger regional and metropolitan areas may benefit from ‘hub and spoke’ models with a central base and services spread throughout surrounding neighbourhoods. This may provide a platform for integration by way of strengthening health and other linkages, thereby maximising cohesion in the wider community (Wakerman et al., 2008). The third model is a virtually integrated service which seems to be most effective when treating simple conditions (NSW Department of Health, 2012a). Many State/Territory policies discuss the importance
of co-location where appropriate (ACT Government, 2008c, Government of South Australia, 2007b, Government of Western Australia, 2007a, NSW Department of Health, 2012a, South Australian Social Inclusion Board, 2007). It is clear that the location of services is vital to integration efforts as it serves to improve patients’ access to the support they need. For example, the WA policies refer to co-location specifically in terms of non-inpatient services where there is service or patient synergy (Government of Western Australia, 2007a).

In addition to partnerships, guidelines or setting of priorities and shared goals are also commonly described in the stewardship-type policies. For example, QLD’s Primary Health and Community Care in Queensland Health (2002) policy assists organisations to identify priorities by way of several guiding principles, namely collaboration and cooperation which are specific to influencing integration. In line with Commonwealth directions, the State/Territory policies have underlying themes that reflect the importance of equity, health prevention and chronic disease management (ACT Government, 2008a, ACT Government, 2009a, ACT Government, 2010, Commonwealth of Australia, 2012, Government of South Australia, 2011, Government of Western Australia, 2007a, Government of Western Australia, 2011b, NT Government, 2009, Tasmanian Department of Health and Human Services, 2007d, Tasmanian Department of Health and Human Services, 2007a, Victorian Government, 2008a). Strategic directions for the health system as a whole include highlighting the health reform’s priority areas, with specific policy directions for each of the states. For example, chronic disease management is important in models such as the WA Chronic Health Conditions Network (Government of Western Australia, 2011b).

Across the States and Territories, policy documentation sets the following priorities:

- improving access, continuity of care and transitions between community, PHC and the acute/hospital sector
- improving quality, safety, performance and accountability through technology in practice. The role of technology in integration is implied, with preliminary discussion in some states (e.g. VIC) around the concept of connectedness that is expected to be generated by e-health (Primary Health Victorian Government Department of Human Services, 2009). It is believed that technology will emerge as a greater focus for all jurisdictions over time. For example, in Tasmania there is a push for information and communication technology infrastructure (General Practice Tasmania, 2007) to enable communication between the public health system and GPs.

Intersectoral advocacy (WHO, 2000) is also a key component of health policy directions. There is consistent emphasis on integration involving a combination of appropriate leadership, high quality workforce and incorporating evaluation and monitoring to continuously improve the services provided (Table 5). State policies frequently refer to working partnerships, either formal or informal arrangements to promote multidisciplinary teamwork and improve communication between service providers, in addition to improving collaboration between government sectors (ACT Government, 2008c, Government of South Australia, 2007b, Government of Western Australia, 2011d, NSW Department of Health, 1999, NSW Government, 2012, Queensland Government, 2005, South Australian Social Inclusion Board, 2007, Tasmanian Department of Health and Human Services,
2007b, Tasmanian Department of Health and Human Services, 2007a, Victorian Government, 2011c). There is a suggested need to align non-government organisations (NGOs), industry, community, private and public health organisations, specialists, and non-health-related government agencies in health policy. For example, the Victorian Public Health and Wellbeing Plan 2011-2015 refers to primary care partnerships which will enable MLs and LHNs to work together effectively (Victorian Government, 2011c). Additionally, the Northern Territory Government 2030 Strategic Plan for promoting collaboration referred to a preventive health agency to link NGOs, communities, private industry and researchers (NT Government, 2009). In SA, the Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-12 employed clinical networking as an approach to improve multidisciplinary teamwork and shared operational protocols and practice (South Australian Social Inclusion Board, 2007). Interestingly, the ACT and the NT both mentioned researchers being involved in collaboration (ACT Government, 2008a, NT Government, 2009).

In terms of consumer protection, the emphasis at the State/Territory level is on patient-centred practice. That is, in many regions the focus is on ensuring the patient is in control, is heard and has their needs met (ACT Government, 2008c, ACT Government, 2010, ACT Government, 2011a, Government of Western Australia, 2007b, Government of Western Australia, 2007a, Queensland Government, 2012, Tasmanian Department of Health and Human Services, 2007b, Victorian Government, 2010b). For example, the Victorian policies refer to finding a balance between being patient-centred and improving business and systems to encourage best practice (Victorian Government, 2004). The Tasmanian health system has undergone major reorganisation to allow more emphasis on patients, with a focus on creating better links between the acute hospital and PHC services (Tasmanian Department of Health and Human Services, 2008b). While serving the same main goals, the focus in the NT is on community engagement and a type of bottom-up integration where patients are encouraged to take responsibility for their own health and that of their fellow citizens (NT Government, 2009). Further, there is a consistent concern for vulnerable populations to be considered in health policy. While all jurisdictions refer to policy directions for different groups, the range of vulnerable populations mentioned in documents include mental health patients, prisoners, Aboriginal and Torres Strait Islander peoples, the elderly, low literacy populations, low socioeconomic groups, mothers and children, oral health patients, disease groups, and culturally and linguistically diverse groups (ACT Government, 2009b, ACT Government, 2011b, Commonwealth of Australia, 2009a, Government of South Australia, 2010, Government of Western Australia, 2011d, NSW Department of Health, 1999, NSW Department of Health, 2004a, South Australian Social Inclusion Board, 2007, Victorian Government, 2004). These groups represent the individuals that are most likely to fall through the gaps without integrated health care.

Different approaches to promoting integration in States and Territories
Despite having similar objectives based on integration, in some cases the States and Territories have implemented divergent practical strategies to achieve the shared policy directions.

Western Australia
Some of the practical strategies described in WA policies include improving connections among health services not only through partnerships, but also using a number of other approaches. For example, there is acknowledgement of the value in promoting health literacy and self-management, models of care, improved system design, awareness of context and social determinants of health, and encouraging consultation and engagement with relevant stakeholders (Government of Western Australia, 2007b, Government of Western Australia, 2011c, Government of Western Australia, 2011d). The WA policies consider integration across the whole health system, emphasising all of workforce factors, hospitals, infrastructure, partnerships, community needs and engagement,
availability of resources and leadership from WA Health, with further reference to the importance of partnerships between home, community and hospital settings (Government of Western Australia, 2007b, Government of Western Australia, 2010b, Government of Western Australia, 2011d). Perhaps reflecting the composition of the state, the WA policies also refer specifically to the need for collaboration across rural and metropolitan areas (Government of Western Australia, 2007b). Throughout WA’s objectives there is a focus on chronic condition self-management with a push for improved referral pathways and better health networks in the future (Government of Western Australia, 2007b, Government of Western Australia, 2011b, Government of Western Australia, 2011d). The WA Health Network policies refer to ‘models of care’ which denote agreed guidelines around the flow, responsibilities, and methods required to improve coordination across and within the health care system (Government of Western Australia, 2007b, Government of Western Australia, 2010a).

Queensland
In QLD, there is mention of ‘step-by-step’ integration to allow for the best patient experience (Queensland Government, 2010a). The Transition Alliance Directions papers identify key enablers for integration as a need for clinical leadership and governance, changing infrastructure, further development of organisations and the current workforce to enable new organisations and new relationships, and incentives to encourage desired outcomes (Queensland Government, 2010a). These documents also refer to governance that addresses shared community, corporate and clinical spaces. Further, QLD Health takes a whole-of-government, whole-of-community and local partnerships approach to promote chronic disease management initiatives (Queensland Government, 2005). Additional practical suggestions include identifying existing partnerships and augmenting or developing them to promote improved practice. There are also tools relating to governance options, identification of barriers and success factors and change-management processes, which will support the implementation of new partnerships (Queensland Government, 2005).

South Australia
Due primarily to the ‘thinker in residence’ program which brought Professor Ilona Kickbusch to SA, Health in All Policies (HiAP) has been implemented as a practical strategy to promote integration. Using central governance and applying a health lens analysis, the HiAP group in SA Health has been involved in a range of projects that aim to get non-health government sectors to consider the role of health in their area (WHO, 2010). To date, there have been intersectoral projects around international students’ health and wellbeing, transit-oriented development, improving literacy outcomes for low socioeconomic status schools, Aboriginal and Torres Strait Islander road safety, healthy weight, water security, digital technology and regional migrant settlement. According to evaluations from the South Australian Community Health Research Unit, the use of a health lens analysis has been an effective method for getting non-health sectors to appreciate health in their policy development and decision making (South Australian Community Health Research Unit, 2009).

New South Wales
In NSW, there is an emphasis on the role of GPs in integrating care that involves both the health care community and consumers (NSW Department of Health, 2004a). There is also a move in NSW towards encouraging the use of discharge planners, liaison officers and community discharge workers to improve continuity of care (NSW Department of Health, 2006a), with emphasis around timely and equitable access. NSW policies acknowledge the need to strengthen and train the workforce to improve patient understanding and address patient needs, particularly in relation to Aboriginal and Torres Strait Islander health (NSW Department of Health, 1999). Further, in addition
to the Commonwealth government’s commitment to the establishment of MLs, the NSW government has proffered over $45 million to HealthOne NSW services to support integration across nursing, allied health and other PHC and community health services (NSW Department of Health, 2012a). Capital funds have been invested into four areas that fall into the stewardship and creating resources functions: service and capital planning, information and communication technology, governance and sustainability, and workforce development. HealthOne NSW focuses on multidisciplinary teams of GPs, community and other health professionals and their role at the meso level is discussed further in Report 3 (*Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level?*).

**Tasmania**

Several differences emerge from the Tasmanian policies, one of which is identifying the value of community transport. While community engagement is necessary, some policies suggest that it is not sufficient to provide PHC services unless adequate, affordable transport is available to facilitate patient access (Tasmanian Department of Health and Human Services, 2007d). Given the focus on technology, one Tasmanian document (General Practice Tasmania, 2007) highlighted the challenge and need for a commitment to changing business processes and professional cultures to ensure that e-health is embraced. Other practical strategies discussed in the Tasmanian policies include service agreements between GPs, PHC and community service staff; regular forums between government and industry parties to discuss important issues, facilitate input into policy development and enable communication; and a tiered service delivery model to take into account community needs, location, cost and workforce availability in service provision (Tasmanian Department of Health and Human Services, 2007b, Tasmanian Department of Health and Human Services, 2007a, Tasmanian Department of Health and Human Services, 2008b). Additionally, there is a Memorandum of Understanding and role delineation that has been agreed between the State health department and the GPs (Tasmanian Department of Health and Human Services, 2007d). Several intersectoral ventures are also in place which require collaboration and communication between primary and community health services. This includes not only the development and coordination of integrated care centres (reflecting the Commonwealth’s notion of GP Super clinics) (Tasmanian Department of Health and Human Services, 2007d), but also specific projects around alcohol and drugs action, primary mental health service development, local government and primary health, community transport, and integrating population health approaches (Tasmanian Department of Health and Human Services, 2007d). Further, a Clinical Advisory Council, a multidisciplinary team that provides clinical advice, has been established. This formal group of clinicians works across organisational boundaries and provides recommendations for practice across elements of the health system (Tasmanian Clinical Advisory Council, 2008).

**Australian Capital Territory**

Redeveloping infrastructure through changing funding arrangements and workforce planning is a key approach in the ACT (ACT Government, 2008c, ACT Government, 2011b). Elements of HiAP are also present with reference to collaboration not only between consumers, PHC services and the secondary and tertiary health sectors, but also the departments responsible for housing, justice, employment, education and planning (Commonwealth of Australia, 2009a). ACT policies also address intersectoral action on mental health, particularly around suicide prevention; and the role of nurse practitioners in PHC provision (ACT Government, 2008b, ACT Government, 2009b, Commonwealth of Australia, 2009a).

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vii Transport services and other non-health services are discussed further in Report 3 (*Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level?*).
Evaluating integration policies
The National Primary Health Care Strategy 2010 (Commonwealth of Australia, 2010a) stipulates a number of ‘actions’ that are required to implement regional integration. Specifically, the Commonwealth government has been working with the States and Territories to:

- establish MLs across Australia
- “create linkages and coordination mechanisms” (Commonwealth of Australia, 2010a, p 14) between MLs and other relevant services across the States and Territories
- support the National E-Health Transition Authority (NEHTA) to develop e-health standards
- establish Health Workforce Australia (HWA) to plan future health workforce needs
- establish a National Registration and Accreditation Scheme that replaces the State/Territory systems
- establish GP Super Clinics – one setting for integrated PHC (more details are provided in future report(s) on meso/micro level integration)
- establish system-wide general practice and PHC policies to integrate and coordinate services, including hospital services
- establish a National Partnership on Preventive Health with States and Territories – the Australian National Preventive Health Agency (ANPHA)
- develop a performance and accountability framework for the National Health and Hospitals Network (NHHN). MLs must work within this framework (Commonwealth of Australia, 2011b).
- establish an independent National Performance Authority (NPA) to monitor MLs performance against key indicators.

Reviewing the policies documented by Commonwealth and State/Territory governments revealed consensus on goals across jurisdictions and between the governance levels, but there is less detail about how to operationalise these aims. Typically, the states refer to integration as both an action and an outcome. For example:

Care is achieved through an integrated approach to all the components of our health system (Government of Western Australia, 2010b, p 3).

A critical element of reform is to achieve integration (Government of Western Australia, 2011d, p 6).

Additionally, there is insufficient detail to allow replication in other regions. That is, each state’s annual progress report identifies what has been done in relation to relevant policies but gives limited top-down information regarding the efficacy of these actions. Integration is designed to improve the current health system but at present there is a lack of information as to whether this is being adequately achieved, and what criteria will be used to determine whether the goals have been reached. It must be noted that health reform is ongoing in Australia and many policies are newly implemented, or in the process of implementation; hence it may take some time to identify any improvements. In line with this, much of the documentation and policy currently concerns the relationships between the State/Territory departments of health and the GP divisions in the region. It is expected that once the MLs have had the opportunity to become established in their communities, the policies around their specific practice will emerge and be evaluated. This may help to inform future practice.
Creating resources—what is needed?

A good quality, efficient health system relies on an appropriate mix of resources that involves the creation of new resources, maintenance of existing resources and distribution of resources to areas of need (WHO, 2000). All levels of a health system need a balanced variety of resources to function properly and sustain health services over time and across levels and geographical areas (WHO, 2000). Resources include physical assets (equipment, facilities), consumable supplies, human resources and knowledge/information, including multidisciplinary collaboration and professional development in order to influence integration at the meso and micro levels. It is crucial that the quantity and quality of human resources be adequately matched to the demand for services across the various health care levels and equitably distributed across the country. Naturally, to ensure quality of care, the skills and knowledge of health providers need to be up-to-date and compatible with developments in technology and evidence-based medicine. Policy development for human/physical resource planning for workforce volume, distribution and professional development are usually considered under the resource generation function.

Creating resources: Commonwealth and shared policy perspectives on integration

The Commonwealth and shared policies in Table 6 summarise the macro level strategies towards integration in the context of creating resources. Some policies could fall under both stewardship and the creating resources function as they pertain to policy development for resource planning and regulatory framework for assuring high quality service provision and consumer protection. However, they are included here because they have a specific focus on resource reorganisation as a means to influence integration within the health system.

The policies and approaches represent a snapshot of plans, either already in place and expanding or at implementation, that are designed to influence integration of health care consistent with the population’s health needs. The macro level policies that were identified are all at the State/Territory or Commonwealth level. The lack of shared policies reflects context-dependent resource requirements and resource availability for each of the States and Territories. This differs from the previous section on stewardship policies, which provide overarching nation-wide proposals for improving integration of the health system. This allows the States and Territories greater autonomy and flexibility within the broader context in order to identify and implement resource-creating initiatives based on the needs of the population(s) within different regions of Australia.

Primary Health Care Organisations (PHCOs)

The National Primary Health Care Strategy (Commonwealth of Australia, 2010a) sets out the key priorities and identifies the resources or ‘building blocks’ which need to be in place to provide the foundation for a well-integrated system. PHCOs (such as MLs and former DGP) are identified as the vehicle for this transformation. However, specific details on how integration will be done at regional levels are somewhat vague, possibly to allow for State/Territory/regional autonomy. PHCOs will be the focus of Report 3 in this series (Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level?) which addresses PHC integration at the meso level. Vertical and horizontal integration both play important roles in the creating resources function. For example, in terms of vertical integration, pharmaceuticals and equipment are manufactured in the private sector, yet government regulation across levels and jurisdictions is essential to ensure quality and safety standards are met, reliable information is made available, and a fair and competitive environment exists (WHO, 2000). This role is undertaken by the National
Medicines Policy via initiatives such as the Pharmaceutical Benefits Scheme (Australian Government Department of Health and Ageing, 2000).

Horizontal integration in resource creation means linking services on the same level - for example, strategies to overcome professional and departmental barriers (i.e. multidisciplinary teams). Linking services electronically is another aspect of resource creating policy. MLs are important to both horizontal and vertical integration. The current policies reflect a shift away from the GP-centred Divisions of General Practice towards a much broader PHC focus. While MLs are at the centre of the Commonwealth’s overall strategic vision, they are also integral to creating resources in terms of planning and supporting a range of local activities, including: after hours GP services, facilitating links between health care providers, hospitals, aged care and Indigenous health organisations, maintaining service directories; and supporting PHC providers to meet quality standards (Australian Government Department of Health and Ageing, 2012a).

For nearly 20 years, the DGP were the main instrument at the Commonwealth level to influence integration of PHC. During this time policy developments targeting integration of services were focused largely towards general practices. As a result, the states took on greater responsibility for PHC more broadly. One of the main roles of the DGP has been to create resources. In the past, they have done this in two ways. Firstly, by developing policy to underpin organisational and network growth by establishing positioning platforms to attract grant funding for PHC initiatives. This role enabled the creation or allocation of resources for PHC across areas including the quality of care, provision of skills, and ensuring that the knowledge of health providers is up-to-date and compatible with technology and evidence-based best practice. Secondly, the DGP created resources as part of their core programs. These programs support integration predominantly through access and multidisciplinary care. These programs include After hours GP initiatives, Chronic Disease Prevention and Promotion, Coordinated Veterans Care, e-health and Information management, Effective Resource Management, Indigenous Health, immunisations, Lifescrrips, Mind the Gap, National Primary Mental Health Program, Nursing in General Practice and Rural Palliative Care Projects.

Information technology
At the Commonwealth level, resource-creating policies focused on technologies related to information transfer and access. Policies on e-health have been implemented to enable the resources in the health sector to operate as an interconnected, seamless system. The creation of this resource and pathways between health professionals is posited as an essential way to influence integration. Prior to e-health policies, electronic records across States and Territories were available but not well synchronised. Policies on e-health propose to influence integration by facilitating access to information across sites and health care professionals. Although untested and resting heavily on full implementation, e-health is likely to facilitate health service planning, management and delivery.

Creating resources: State and Territory policy perspectives on integration
Table 7 represents the current initiatives across Australian State and Territory policies targeting integration via a resource creation function. The gaps in the table do not necessarily indicate a lack of policy, but rather that the resource-creating function has not been explicitly identified as central to policies from that particular State or Territory.

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Data on Divisions’ performance related to integration efforts are available on the PHCRIS website (http://www.phcris.org.au/divisions/index.php)
**Common factors promoting integration in States and Territories**

States and Territories with existing strong PHC policy, like the *Primary Care Partnership Scheme 2000* (PCPs) from VIC (Victorian Government, 2010a), benefit from having a framework to reorganise or create resources for the ‘functional integration of systems’. Likewise other States and Territories have frameworks in place that are more targeted towards specific populations’ resource needs (e.g. chronically ill Indigenous in the NT).

Most policies across States and Territories identify that it is crucial to **match the quantity and quality of human resources to the demand** for services across the various health care levels, and also at the regional level. The NT *Primary Care Project 2010* (Race and Nash, 2010) identifies that it is not only the availability of human resources, but also the importance of assisting business relationships between service providers, which will in turn influence collaboration with other programs and initiatives. Likewise, the TAS *Guide to Working with General Practice 2009* (General Practice Tasmania, 2009a) identifies that the **linkages between the resources** are crucial to establishing networks that encourage information sharing as well as establishing and expanding existing community-based health services.

Improving communication and collaboration between service providers and building GP linkages with different health services and systems was mentioned frequently across policies. Exactly how States and Territories establish and maintain these relationships is not specified. The reasons for this may be related to a lack of knowledge about how to go about it, or due to the need for a flexible approach to resource creation and dispersion that represents the unique needs for each region. A scoping paper developed in WA’s PHC strategy entitled *People meeting to work in Partnership for a common Purpose 2012* (Government of Western Australia, 2012d) may provide some insights into how to proceed within a PHCO’s framework to influence integration throughout the state. Nevertheless, MLs are identified as the main resource for fostering coordination and collaboration across service and provider networks.

**Different strategies promoting integration in States and Territories**

In some policies, specific models of care have been identified to influence integration. For example, the *NSW Chronic Care Program* (NSW Department of Health, 2004b) recognises that some Area Health Services have adopted community-based models, whilst others offer a care coordination role located within acute hospitals. Challenges and benefits can be identified for each model. Care coordination has been flagged in both **VIC** and **NSW** as a means of improving service integration for the chronic disease population. However, there is concern about the capacity of services given the current shortage of resources to meet the growing demand for care coordination in a population with increasing prevalence of chronic disease. Community-based models identify strengthening PHC links (i.e. general practice, community-based services and aged care services) as the main way to influence integration of services. The *NSW Chronic Care Program 2000-2003* (NSW Department of Health, 2004b), the first of a three phase program, identifies clinical governance structures as a way to create or reorganise resources in a more strategic way. The focus of these structures varies (generic health through to chronic disease) and from area-wide to locality-based committees. In essence, the community informs policy-makers of the needs for their particular circumstances. To do this, the structures serve as a forum for multidisciplinary groups who have vested interest in planning health (clinicians, community representatives, carers, etc.). These forums are meant to identify core business (needs of population) and best practice care (clinical pathways, research promotion); forge and utilise multidisciplinary arrangements; and plan for future health workforce (resource) requirements. Critically, this type of structure relies on the involvement of a broad range of...
community members, which is both a potential strength and weakness of this model. To further influence and improve integration between community-based services and general practice, policy levers such as the Enhanced Primary Care Medicare Benefit Schedule items, which have been superseded by the Chronic Disease Management (CDM) items, are presented (i.e. Practice Incentive Payments) as well as information management systems (i.e. e-health, telehealth, CHIME \(^8\)).

In VIC, there is a cross-program implementation plan within PCP policy (Victorian Government, 2011a), with a more social model of health that encompasses Integrated Chronic Disease Management and Integrated Health Promotion. This approach proposes to influence integration by focusing on initial needs identification, referral, and care coordination. Strategies range from the development of resources related to communication mechanisms, to the actual development and delivery of shared education and training programs for PHC professionals. ‘Functional integration of systems’ is expected to be achieved by sharing the development of resources, such as the establishment of common protocols, procedures and practices for service coordination supported by information management systems and technology.

The Primary Care Integration Project 2010 in the NT (Race and Nash, 2010) identifies the need to work with resources across the acute care and PHC services in order to improve transitions for patients with chronic diseases. This policy points out barriers to integration. The main barrier is that the level of system change required to change the focus of care from acute to long-term is rarely planned. Furthermore, resistance and interpersonal challenges amongst human resources within organisations is critical to the success of programs.

**Evaluating integration policies**

A health system needs a balanced variety of resources to function properly. However, few policies at the macro level acknowledge how to measure integration of these resources. In VIC, the PCP strategy has an evaluation approach called ‘program logic’ (Department of Human Services, 2004). This iterative evaluation technique is used to revise strategic plans, modify subsequent service delivery, re-evaluate and so on. In PCPs, funding is attached to service delivery of core areas of activity. This in turn informs the next planning phase. Thus, a financial incentive exists for agencies to engage in service coordination specifically to link health planning across agencies and organisations, according to regional/area priorities. The PCP strategy implicitly evaluates integration of health care via system-wide linkages (partnership surveys, agency surveys), as well as impacts on service delivery integration (consumer surveys).

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\(^8\) CHIME is a Community Health Information Management Enterprise system implemented in New South Wales Health, Australia. It is an operational, clinical information system that is designed to improve service delivery, outcome measures and productivity, through improved capture and management of Community Based Health Service Information (Croll and Croll, 2007).
Financing and incentives—who pays for the health care system?

How finances are collected, managed and allocated impacts on the fairness, equity and access to health care services. In general, financing deals with the mobilisation, accumulation and allocation of funds to cover the health needs of the people, individually and collectively, in the health system (WHO, 2000). The financing function is defined by Murray and Frenk (2000) as “the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities” (p 724).

From this definition, three sub-functions can be distinguished: revenue collection, fund pooling, and purchasing. The organisation and execution of these sub-functions impacts on access to, and integration of, health services.

1. **Revenue collection** means the mobilisation of funds from primary sources (households, firms) and secondary sources (governments, donor agencies). There are a number of mechanisms through which funds can be mobilised, e.g. out-of-pocket payments, voluntary insurance rated by income, voluntary insurance rated by risk, compulsory insurance, general taxes, earmarked taxes, donations from NGOs and transfers from donor agencies.

2. **Fund pooling** may be created to share and reduce health risks; funds can be pooled through various forms of health insurance.

3. **Purchasing** refers to the allocation of funds to cover the costs (staff, durables and running costs) of specific health service interventions by providers (institutional or individual) (Murray and Frenk, 2000).

Financing and incentives: Commonwealth and shared policy perspectives on integration

The financing function is used to influence integration of health care in Commonwealth and shared policies (Table 8). The *National Healthcare Agreement 2008* (since superseded, COAG, 2011b) created a more streamlined approach to funding through revised federal financial relations. Successive agreements between the Commonwealth and States and Territories have incorporated further financial reforms to promote outcomes-based approaches to health system management. It is important to note that this is not an exhaustive list. Gaps within the table are not due to a lack of finance-specific policies; throughout this report the financing function is commonly embedded within the stewardship policies described in Table 4 and Table 5 and the service delivery information presented in Tables 10 and 11. However it is worth recognising policies that specifically relate to this function in order to develop a better understanding of the context of PHC.

**Revenue collection**

The 2009 *NHHN Agreement* (COAG, 2011a, FitzGerald and Ashby, 2010) specified several linkages attached to financial arrangements in order to influence integrated care for patients. Revenue collection was flagged - specifically that one-third of GST funds was to be directed toward health and hospitals to allow for the establishment of LHNs and MLs.

LHNs (representing acute care) are required to work with MLs (representing PHC) to improve patient care and the quality of health and hospital services. Governance arrangements (e.g. common membership across boards) between MLs and LHNs require them to work closely together. However, formalised funding arrangements are less clear between the primary and acute sectors. Together
they are responsible for better integrated general practice, PHC and public hospital care, to enable patients to transition smoothly in and out of hospital and continue to receive appropriate and timely care. Delivering this smooth transition includes working with relevant providers to help patients manage their recovery and stay healthy once they have been discharged from hospital. LHNs and MLs are also required to work together to identify and address particular local needs. However incentives and/or sanctions for these actions are not detailed.

**Fundholding**

In contrast to the Commonwealth incentive-style financing arrangements, more recent policies represent a combination of the sub-functions of financing with the specific intention to influence integration in PHC. In 2010, *A National Health and Hospitals Network for Australia’s Future* (FitzGerald and Ashby, 2010) incorporated revenue collection, fundholding and purchasing of health services as a means to influence integration. A key feature is the national introduction of Activity Based Funding (ABF) with a classification system (AR-DRG) being used to define and count hospital ‘activity’ in relation to the treatment of acute inpatients. Providers are funded based on the activity they undertake. This type of funding classifies patients into classes or groups which are both clinically coherent and resource homogenous. Although not specifically designed to influence integration, it allows for meaningful comparison of activity between facilities and is a useful tool for evaluating and allocating funding based on health service requirements. Alignment of funding and activity in this way may have the potential to influence integration across health services.

**Purchasing**

At the shared and Commonwealth levels, funding arrangements predominantly encourage coordination of care via incentive payments to general practice. These are specifically targeted to encourage increased and continuing use of PHC to populations at risk of hospitalisations (i.e. residents in aged care facilities, patients with complex chronic diseases and Indigenous people at risk of chronic disease). There are 13 general practice incentives, including Quality Prescribing, Diabetes, Cervical Screening, Asthma, Indigenous Health, e-health, After hours, GP Aged care Access, Teaching, Rural loading, and a Procedural GP payment (Commonwealth of Australia, 2011c, Department of Human Services, 2012). These play a part in influencing access, continuity, coordination and financing of health services, which are four of the characteristics identified by the WHO as ‘good provision’ (2000). They also allow for funding of services to reflect regional demographic characteristics. For example, general practices in remote areas would have access to Rural Loading incentive payments to reflect the need for these services for people living in regional or remote Australia. Consistent with this incentive funding, the *Practice Nurse Incentive Program* targets patients requiring care coordination to avoid hospitalisations. SA was the first to apply the expanded and enhanced role for nurses working in general practice in 2007, as a means to reduce workforce pressure on GPs in areas of high demand (Government of South Australia, 2009a).

Improving management of chronic diseases is a key priority area for health reform (Commonwealth of Australia, 2010a) and it is expected that this will be achieved through better integration, coordination and continuity of care. A range of CDM Medicare item numbers are available to enable health care providers to develop appropriate multidisciplinary management plans that are tailored to individual patients (Commonwealth of Australia, 2010a) (more information on CDM integration programs is provided in Report 5, *Integrated care: What can be done at the micro level to influence integration in primary health care*?). However, the funding arrangement remains a fee-for-service model which recompenses providers for volume of activity not performance (i.e. disease prevention, management).
Primary Care Infrastructure Grants (Australian Government Department of Health and Ageing, 2013) are available under the GP Super Clinics program to fund enhancements to existing premises. Specifically, the grants are designed to enable providers to upgrade or extend premises to accommodate new services that are aligned with the community needs (Australian Government Department of Health and Ageing, 2012c). Examples include space for additional health care providers (e.g. GPs, nurses, allied health), case conferencing, extended hours of service, and clinical training facilities. These grants support integration initiatives to co-locate different health care providers and services.

Financing and incentives: State and Territory policy perspectives on integration

It is clear from the numerous gaps in Table 9 that financing and incentives policies have largely been the responsibility of the Commonwealth and shared agreements through COAG. Despite this, ABF and Activity Based Management (ABM) were first established and implemented in Victoria (1st July 1993) followed by South Australia (1st July 1994). Other states are just beginning this process. In contrast to block funding, this type of funding is a fee-based service system (Victorian Government, 2012, Eagar, 2010). This is based on hospital activity, not activity that occurs in PHC, although the two are obviously intertwined. There is a great deal of debate over the benefits and pitfalls of this type of funding arrangement for health care (Colier, 2008). For example, establishing appropriate fees for each procedure is a challenge, and if incentives are too low, they have little effect. In addition, measuring the benefits of ABF models is complicated, especially attempting to quantify terms and concepts such as quality of care. Furthermore, the implementation often requires more administrators and data-tracking technologies, with associated costs potentially offsetting any efficiency savings.

WA is one of the few states that have a formalised financial policy plan which takes into account the integration of PHC: Health Activity Purchasing Intentions 2011-2012. This policy proposes to examine the activity of the whole health system over a 5-year period in order to improve integration of services. WA is starting this process by evaluating hospital inpatient and emergency care. However, a key part of this policy is the establishment of a funding arrangement called Quality Incentive Program. Funding for this program is derived from procedures occurring in hospitals, specifically from the ‘gap’ cost of the central episode price to ‘on the line’ payment of a Diagnosis Related Group (DRG) cost signature beyond the high boundary \( x \). DRG is a patient classification system that provides a clinically meaningful way of relating the types of patients treated in a hospital to the resources required by the hospital. Unlike other states where this payment remains in the acute fund pool, the WA approach will redistribute this funding to PHC in Area Health Services to invest in clinical services (Government of Western Australia, 2011a). This funding will also be used to assist in the uptake and spread of ABF and ABM policy across WA.

In the context of integration, funding in Health Activity Purchasing Intentions 2011-2012 is targeted to innovations that are patient-centred and service models that are community-based. This policy also encompasses funding for Journey of Care Projects. These projects are specific to patients that have conditions identified as requiring multiple activities at multiple services across the health system (i.e. stroke and palliative care). Patients with other chronic conditions will also be included.

\( x \) Central episodes in acute inpatient care have a length of stay defined within the low and high boundary points. Boundaries are set at three times the average stay to allow for exceptional episodes. If a patient is discharged before the central episode average night of stay the health service keeps the credit for full episode payment.
These projects aim to: define the disparate activities associated with these conditions into a single activity; focus work on improving collecting, counting, coding and costing data for these activities; develop standardised care models; and be undertaken in collaboration with Health Networks. This policy aims to enable access to all information for the community, clinicians, public servants and the Government in order to promote well-informed decisions about delivery of healthcare across WA.

In VIC, unique funding arrangements have been formalised in policies like the Primary Health Funding Approach (Victorian Government, 2008b). This approach attempts to simplify payments that are derived from different sources for the same services. Examples include alignment of Community Health (state-funded) and Home and Community Care (Commonwealth-funded) unit prices for services, providing unit prices for allied health, counselling and nursing. In addition, this policy outlines block funding for health promotion, development and resourcing costs for organisations and performance targets linked to funding incentives.

The gaps in Table 9 suggest that other States and Territories may not have formalised policies that target funding arrangements solely to influence integration. For example, in this report the Health Services Policy and Funding Guidelines 2010-11 (Victorian Government, 2010d) for Victoria have been included in the Stewardship section Table 5, as they have a more overarching strategic role.

**Delivering services—selecting and delivering the best services**

Health systems across the world are faced with rising costs and growing demand for health care services. Getting the best value from limited resources entails judicious selection of interventions that are known to be effective, can be applied in areas of priority, and can be delivered to the populations that need them. The effectiveness of specific initiatives is not included in this report – see Report 5 on micro level integration for further discussion in this area. At the macro level, the service delivery function deals with the policies that enable good quality services to be provided equitably. Cost-effectiveness is one of several criteria for determining whether and how much public money will be spent on particular initiatives. Social and political factors are also considered.

Service provision involves the mix of inputs (human resources, physical capital, consumables) needed within a specific organisational setting to deliver good quality, effective health interventions (Murray and Frenk, 2000). It relates to preventive, curative and rehabilitative services delivered to individual patients and to services aimed at larger populations (e.g. health education, promotion) through public and private institutions. Providing services refers to what the health system does, not what the health system is.

**Delivering Services: Commonwealth and shared policy perspectives on integration**

While service delivery will be addressed in more detail in integration reports to follow in this series, there are some overarching macro level policies (relating to horizontal integration) that influence this function. Service provision addresses the range of inputs required in an organisational setting which enables the production process that leads to the delivery of health interventions. The initiatives

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81 Integrated care: What can be done at the micro level to influence integration in primary health care?
implemented at the Commonwealth or shared level represent the four main aspects of good service delivery (Table 10) described by the WHO (2000): access, coordination, continuity and financing.

**Access**

In terms of policies at the national level that focus on access, *GP Super clinics* in SA were first introduced and promoted to provide access to a wide variety of health services through co-location of services (e.g. GPs, allied health professionals, nurses, dental, pharmacy, etc.). This approach offers preventive, curative and rehabilitative health aspects with a focus on community engagement whilst attending to local priorities through a population planning approach (Commonwealth of Australia, 2010a). The *GP Super clinics* approach also refers to access in relation to the availability of *GP After-Hours services*. In the area of Indigenous health, the *Indigenous Chronic Disease package* promotes the uptake of health checks and follow-up care in an accessible format. In particular, this policy refers to the importance of access to affordable medications and the availability of follow-up care in Indigenous areas (Commonwealth of Australia, 2009b).

**Coordination**

*GP Super clinics* and the *National Preventative Health Taskforce* play a coordination role at a Commonwealth/shared policy level. *GP Super Clinics*, which require integration between the private and public sectors, aim to align services and organisations in the community, and offer expanded roles for GP specialists, nurse practitioners, lifestyle advisors and care coordinators, with a view to enabling patient care to be coordinated efficiently (Commonwealth of Australia, 2010a). The *National Preventative Health Taskforce* offers a coordinator role with each State and Territory having unique specific plans. The taskforce also addresses the coordination of goals, with objectives around integrating prevention within PHC. This approach emphasises the need to involve Indigenous health services to improve preventive care (Commonwealth of Australia, 2010b). Further examples of coordination are demonstrated in the *Lifescrrips Initiatives* which provide a framework for practice to deliver evidence-based resources to support patients with chronic conditions. The *Lifescrrips Initiatives* aim to empower clients, and provide advice and referrals to connect patients with appropriate support resources (Department of Health and Ageing, 2009). The goals of this initiative are preventive in nature and, despite no explicit reference to integration, the focus on shared effort is evident.

**Continuity**

Continuity was discussed in the stewardship section as an important strategic direction for the states/territories (i.e. improving patient pathways through the health system). One example of the importance of continuity of care is shown in the *GP After-Hours Program* in which continued access to care is a key component (Department of Health and Ageing, 2010b). Although this plan does not specifically mention integration, the principles underlying integration are evident in terms of the need for continued access to appropriate and timely care (WHO, 2008). The policy pertaining to *Aboriginal Comprehensive Primary Health Care* also encourages continuity of care in describing the way clinical care, health promotion and prevention, rehabilitation, public health and advocacy for health are connected. Thus, health needs are integrated as a ‘holistic process’ (Cooperative Research Council for Aboriginal Health, 2005).

**Financing**

Financing, which was discussed in more detail in the previous section, is mentioned in the *Australian Better Health Initiative*, a plan to promote good health and reduce chronic disease burden. This initiative provides a $1.1 billion reform package with funding not only to promote health, but also for
disease prevention, early intervention, integration and coordination of care. This approach has an evaluation component built in to the structure in order to determine whether the priority areas are reached (Government of Western Australia, 2012a). Similarly, the Indigenous Chronic Disease Package promotes partnerships between all levels of government and Aboriginal and Torres Strait Islander communities working towards closing the gap. Funding is provided to encourage coordination of health care, though the policy addresses all of chronic disease risk factors, management and follow-up care, and workforce expansion (Commonwealth of Australia, 2009b). Additionally, the Australian Primary Care Collaboratives Program emphasises prevention and maintenance of health through improved access to general practice. Evaluations of the first phase of these projects found improved patient care, better chronic disease management, increased best practice care, better use of information systems, better methods to meet patient demand, and a cultural shift from individual patient care to population-based care (The Australian Primary Care Collaboratives Program, 2010).

Delivering Services: State and Territory policy perspectives on integration

Table 11 describes the State and Territory policies that refer to the access, continuity, coordination and financing components of good service delivery. There are similarities and differences between the practices across the jurisdictions, as illustrated below. Integration of service provision is discussed at a range of levels. These include horizontal integration by linking different providers within health departments, across health fields (e.g. allied health, mental health), and through different health groups (e.g. clinical practice, research, consumers); and vertical integration between different levels of health system sectors (e.g. primary, secondary, tertiary). Consistently, these documents indicate that there is merit in co-locating services and integrating not only the service providers but also the health needs of patients, enabling patient-centred models and ensuring sustainability of practice.

Common factors promoting integration in States and Territories

There are some similarities in the ways that the different jurisdictions address the four aspects of good service delivery, as presented below.

Access

Access is consistently described as ensuring that the right services are available at the right time (Commonwealth of Australia, 2010a, WHO, 2000). In some areas, the emphasis on access is about providing appropriate services located close to where people live and promoting community engagement (Jackson and Marley, 2007). This is evident in the SA Strategic Plan with development of GP Plus clinics and the Victorian Department of Human Services’ Service Coordination model. Similarly, in Tasmania, the Clinical Services Plan pertains to the development of Integrated Care Centres (ICC). This strategy describes how co-location is appropriate and services are encouraged to relocate if it will facilitate integration. However, the strategy also provides support for a combination of centralised and outreach services. There are specific guidelines around service coordination, transport assistance and other supports that are to be implemented in areas without ICCs (General Practice Tasmania, 2007, General Practice Tasmania, 2009b, Tasmanian Department of Health and Human Services, 2007c). Additionally, the GP Tasmania Network describes how the ICCs complement services in rural areas; and that equity in access is an important issue to address for those areas without an integrated centre (General Practice Tasmania, 2009a).
Operational definitions of integration and access also relate to the importance of multidisciplinary teams which connect the services that patients require to improve patients’ access to support, and encourage referral pathways (Oelke et al., 2009, WHO, 2008). For example, the *WA Model of Care Implementation* describes the importance of these teams spanning the continuum of primary, secondary and tertiary services to ensure that patients receive care by the right person in the right team (Government of Western Australia, 2007b). Furthermore, access has been related to timing with call centres such as *Healthdirect Australia* introduced to improve access to triage, information and advice 24 hours a day, seven days a week. While call centre and after hours initiatives do not explicitly refer to integration, the principles behind such models relate to connecting services and informing patients about the best way to obtain the assistance they require, which has a direct influence on integrated service delivery (Department of Health and Ageing, 2010b).

**Coordination**

Coordination also has a number of components commonly described by the State and Territory policies. In some cases, coordination relates to having a body that directs or organises partnerships and practice among service providers. For example, the *SA Health Strategic Plan* provides directions for how SA Health delivers health in the health system. This is similar to the *NSW Integrated Primary and Community Health Policy*, which provides strategic directions in coordination of primary and community health systems. In TAS, a multidisciplinary policy and planning group coordinates the new ICCs. An additional strategy in TAS was a reorganisation of the health department to increase focus on patients, reflect health priorities and enable integrated care across divisions of the department, including collaboration between acute hospital and PHC settings (Tasmanian Department of Health and Human Services, 2008a). Similarly, the *GP Tasmania Network* developed a model to improve these linkages and coordinate practice by providing a set of guiding principles, while the Tasmanian and Commonwealth governments have a coordinating role regarding a performance monitoring and reporting framework to ensure equitable contributions from community hospitals (Tasmanian Department of Health and Human Services, 2008a).

In terms of coordinating different service providers to encourage best care for patients (VicHealth), the Victorian *Service Coordination* models offer improved experiences for clients with reduced waiting times, early identification of client needs, better client education and patient-centred care provision (Department of Human Services, 2004). South Australian policy documents specifically refer to improving the coordination of mental health services; and the *Health Services Framework for Older People* refers to establishing specialised interdisciplinary older people’s health care services as a means of coordinating care and service use for this specific cohort (Government of South Australia, 2009b). Through the SA *GP Plus Health Networks*, there are also improved linkages between general practice, public health, and NGOs, with a focus on chronic disease management (Government of South Australia, 2008a). Further, specific services have been established in NSW to improve chronic disease management, short-term health condition management and detection and intervention for health issues (NSW Department of Health, 2006a). In Tasmania, the *Clinical Services Plan* describes integration in terms of effective service coordination and partnerships between providers (Tasmanian Department of Health and Human Services, 2007c). The *Ageing Plan for SA* extends this and describes the need to connect all of research, innovative practice and collaboration among service providers (Government of South Australia, 2006).

**Continuity**

Continuity of care in some states refers to the capacity of the health system to respond to disease (Government of South Australia, 2008b). For example, one of SA Health’s roles is to facilitate continuity. The *SA Health Services Framework for Older People* emphasises the need to improve
assessment and address rehabilitation among older adults to promote smooth transitions and improve flow through the system (Government of South Australia, 2009b). Similarly, NSW community health workers and GPs work together to provide ongoing support for prevention, early diagnosis and management through the Integrated Primary and Community Health policy (NSW Department of Health, 2006a). The WA Falls Linkage Independence Program highlights the importance of fostering communication and support to ensure smooth transition through the health system for older adults (Government of Western Australia, 2012b).

**Financing**
Approaches to financing issues of service delivery are presented in the financing policy section (from page 34).

**Different approaches to promoting integration in States and Territories**
While working towards the same objectives, often the states operationalise goals in different ways or apply a variety of strategies to achieve them. Highlighted below are some specific examples of the ways in which the States and Territories differ in addressing access, coordination, continuity and financing aspects of service delivery.

**Access**
The **GP Plus clinics in SA** were specifically developed to improve access. These are designed to increase health promotion and prevention, and improve collaboration between providers (Government of South Australia, 2007a). While services are often co-located in this model, there are connections within the GP Plus and with other community services regardless of location. This is a key component of the **SA Strategic Plan** (Government of South Australia, 2008b). The strategy stipulates that hospital substitution programs should be enhanced to enable patients to access help within their own home environment.

Access is targeted in different ways according to local needs. To ensure equitable access among patients in rural and remote areas (Commonwealth of Australia, 2010a), there are some specific strategies that have been identified to improve health care and integration in these locations. One example is the **NSW Rural Hospital and Health Service Program** which aims to improve access by promoting initiatives in small rural and remote communities. This approach involves establishing multipurpose centres, development of an Isolated Patients’ Travel and Accommodation scheme and improved training and opportunities for the medical workforce including rural nurses and a medical officer cadetship program (NSW Department of Health, 2012b). One of the interesting aspects of the NSW Health-coordinated policy to promote access is the establishment of a telehealth electronic network that is used to deliver specialist services to patients and provide support and training to health care providers. The Victorian **Service Coordination** models also address the challenges of access in rural areas, with focus on health professionals and reference to barriers to establishing connection between service providers. This approach suggests that although there are often small numbers of service providers in rural areas, this may actually serve to make partnerships more efficient (Department of Human Services, 2004).

**Coordination**
As stated previously, coordination can include a coordinating body, combining organisations to strive towards common goals and improving patient pathways (Axelsson and Axelsson, 2006). For example, the **GP Tasmania** Network highlights the manner in which the proposed ICCs should include GPs but not be owned and operated solely by GPs (General Practice Tasmania, 2009b). The initiatives refer to a ‘virtual’ GP presence by embracing the technology that continues to emerge in service delivery.
There is also mention of a model that provides teaching, learning and research opportunities, alluding to the coordination that is required between a wide range of health-related sectors (Axelsson and Axelsson, 2006). Similarly, the Connecting Health in Communities Initiative by General Practice Queensland focuses on coordination and service integration based on the establishment of formal partnerships across providers. These are known as Primary Health Care Partnership Councils (Partnership Councils). This approach proposes to influence integration by shared planning and service delivery, shared assessment tools, common management protocols, agreed roles in patient support and education, and local community health promotion action.

The NSW Multipurpose Service Policy has similar aims to other initiatives but acts in a different manner. While the policy promotes partnerships between a range of government and non-government agencies in local communities, this strategy encourages local services to become a part of the multipurpose service, through co-location or working collaboratively with staff (NSW Department of Health, 2010). The caveat is that if services are not willing to integrate, they are encouraged to collaborate in order to provide patients in the areas with the best care. Service providers involved in partnerships are selected based on the cultural, spiritual and personal needs of the patients, again reinforcing a patient-centred model (NSW Department of Health, 2010). Though findings are yet to be released, there is an evaluation phase built in to the policy, which incorporates a detailed assessment addressing governance, staffing, quality improvement, continuity of care, compliance, risks, complaints and consumer participation.

The Department of Human Services’ Service Coordination models that form part of the Victorian Primary Care Partnerships strategy focus specifically on linking different PHC agencies, with attention to the financial, qualitative and quantitative benefits of such integration (Department of Human Services, 2004). Evaluation of this approach suggests that “for a small investment of funds service coordination acts as a key catalyst for change” (p 2). Coordination is encouraged through the development and use of shared tools and templates, employed in initial sessions with clients to promote continuity of care among the different service providers. These models ensure clear role delineation for administrative staff with a number of different intake and assessment unit structures available to reflect the needs of the service providers involved. There is also emphasis on the importance of change management when coordinating services by ensuring key stakeholders and staff are consulted throughout the process. The evaluation of such Service Coordination models highlighted the value of not only the PCPs in providing resources, advice, and information to the service providers (reflecting stewardship) but also the presence of a ‘change champion’ or an individual in each agency who ‘champions’ the cause.

The WA Cancer and Palliative Care network refers to coordination at a patient level rather than service integration (WA Cancer and Palliative Care Network). This reinforces the importance of patient-centred practice and is implemented by introducing Cancer Nurse Coordinators who promote efficient treatment pathways, and individualised management from multidisciplinary teams. The network coordinates cancer services in WA by distributing resources, providing a service directory, implementing national screening programs, a Tumour Collaborative and the WA psycho-oncology service. Similarly, WA’s Falls Linkage Independence Program refers to coordination in the relationships between patients, GPs, caregivers and service providers (Government of Western Australia, 2012b).

A number of policies address coordination of country health services. In SA, the focus is on coordinating services that enable a complete system of health care to be presented to the patient with links between hospitals in local areas, country and metropolitan regions, in addition to aged care and allied health professionals. Encouraging coordination of care in country health services, the
Strategy for Planning Country Health Services in SA specifies the need to ensure clarity of roles and responsibilities in partnerships between organisations in order to provide the best system for the patient (Government of South Australia, 2008c).

**Continuity**
Rather than continuity of care in terms of the patient’s experience, WA policies discuss continuity in terms of transitioning models of care into clinical practice to ensure evidence-based practice (Government of Western Australia, 2010a). Further, implementing GP Plus services improves continuity of care in SA by offering education on risk factor modification, self-management, chronic disease management and out-of-hospital care (Government of South Australia, 2007a).

**Financing**
Although many of the financing issues were discussed in the previous section, there are some elements related directly to delivery of services. For example, the GP Tasmania Network guidelines describe how integration needs to represent more than a cost-saving agenda (General Practice Tasmania, 2010). Financing refers to ICCs finding sustainability through funding from different sources, ensuring that expensive equipment is not duplicated and highlighting a need to invest in information systems that will support communication.

The Victorian Service Coordination models (Department of Human Services, 2004) identify the importance of considering the fiscal cost and benefits of coordination among service providers. Evaluations indicated high costs to implement service coordination; with staff training and development on planning and change management accounting for the greatest proportion of the costs. However, there were insufficient data to ascertain the overall benefits of the practice. That is, this strategy acknowledges not only the need to assess whether the cost of coordination will impact the cost of an agency providing its services but also the need to weigh up this cost against the quality of services received by clients and the time taken/volume of services provided.

**Integrated service delivery**
The policies presented in Table 11 all have elements of preventive, curative and rehabilitative processes as important aspects of service provision (WHO, 2000). The focus in these initiatives stems from the current National Health Reform priority areas related to better chronic disease management and increasing the focus on prevention. As a result, there are many similarities across jurisdictional processes to address access, continuity, coordination and financing of service delivery.
Summary

The Australian policies related to integrated care were mapped against the four functions of a health system described in the WHO framework (WHO, 2000):

- Stewardship
- Creating resources
- Financing and incentives
- Delivering services.

Across the Commonwealth and State/Territory governments, there were several key policy elements related to those functions, which are summarised in Table 4.

<table>
<thead>
<tr>
<th>Function</th>
<th>Policy elements supporting integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stewardship</strong></td>
<td>Strategic direction:&lt;br&gt;  • Defining roles &amp; responsibilities across jurisdictions&lt;br&gt;  • Focus on health reform priority areas&lt;br&gt;  • Shared goal-setting&lt;br&gt;  • Planning &amp; regulatory frameworks to align resources for the community&lt;br&gt;  • Creating a level playing field&lt;br&gt;  • Whole-of-government, whole-of-community approaches to improve collaborations across a region.&lt;br&gt;Equity &amp; advocacy&lt;br&gt;  • Intersectoral advocacy &amp; consumer protection&lt;br&gt;  • Formal &amp; informal partnerships to support multidisciplinary teamwork&lt;br&gt;  • Alignment with other sectors.&lt;br&gt;Evaluation &amp; performance assessment&lt;br&gt;  • Accountability of governments &amp; organisations regarding equity, effectiveness and efficiency.</td>
</tr>
<tr>
<td><strong>Creating Resources</strong></td>
<td>Equipment and facilities:&lt;br&gt;  • Establishing MLs, the key vehicle to create links across services and address horizontal and vertical integration&lt;br&gt;  • Supporting rollout of information technology tools.&lt;br&gt;Human resources and knowledge:&lt;br&gt;  • Encouraging multidisciplinary collaboration&lt;br&gt;  • Enabling professional development and workforce capacity-building&lt;br&gt;  • Supporting coordination models of care&lt;br&gt;  • Developing shared education and training programs.</td>
</tr>
<tr>
<td><strong>Financing &amp; incentives</strong></td>
<td>Revenue collection:&lt;br&gt;  • One-third of GST funds is directed to health and hospitals for establishing LHNs and MLs.&lt;br&gt;Fundholding:&lt;br&gt;  • Activity based funding and activity based management&lt;br&gt;  • Quality incentive program (WA) re-distributes funding to PHC&lt;br&gt;  • Primary health funding approach (VIC) streamlines payments derived from multiple sources for the same services.&lt;br&gt;Purchasing:</td>
</tr>
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</table>
Integrated care: What policies support and influence integration in health care in Australia?

Delivering services

| Coordination of care via incentive payments to general practice to encourage use of PHC and avoid hospitalisations |
| Expanded roles for nursing |
| Healthy activity purchasing intentions (WA). |

**Access:**

- GP Super clinics – co-location model that provides access to wide variety of services
- GP Plus clinics (SA)
- GP After hours services
- Integrated care centres (TAS)
- Rural hospital and health service program (NSW)
- 24-hour call centres
- E-health and telehealth technology.

**Coordination & continuity of care:**

- National preventive health taskforce plays coordinator role for integrating preventive services into PHC
- NSW integrated primary and community health policy focuses on coordinating primary and community health care systems
- Service coordination models (VIC) coordinate different service providers
- Coordination programs for older people.

While evaluation of integration policies is mentioned in policy documents, there is limited detail about how this will be achieved. However, the ‘program logic’ approach employed by PCPs in Victoria is an iterative technique that may be useful for evaluating integration policies in the future (Department of Human Services, 2004).

Other key points that were considered in integration policy documents were:

- Matching quality and quantity of resources to the demand
- Improving communication and collaboration between service providers (through MLs).

**Conclusions**

This report targeted a selection of Australian health policy documents (over the past 10 years) that referred explicitly to ‘integration’, ‘integrated care’ or related terms. Numerous documents were tabulated spanning national, shared (COAG), and state and territory jurisdictions, indicating that an integrated health care system is an aim across multiple governments.

Policy documents were identified through environmental scanning and categorised based on the WHO health system performance framework (i.e. stewardship, creating resources, financing or service delivery). Documents considered to be targeting a stewardship function at the macro level commonly operationalised integration through encouraging, but not mandating, alignment, cross-sector collaboration, consistency, transparency, and effective measurement of results. However, emphasis differed predominantly around Models of Care, which varied according to local context and population demands. The policies categorised as creating resources commonly targeted workforce capacity, composition (i.e. multidisciplinary teams), collaboration and communication across sectors. Again context dictated the resources that policy documents targeted and how they went about coordinating these resources (business models vs. social models). Documents operationalising integration through a financing function commonly concentrated on changes to the composition of funding arrangements across sectors and services (i.e. multidisciplinary teams, co-location) and
predominantly targeted GPs as the lever to enable broader integration across services for patients. However, the evolution and timing of implementation of these policies varied across jurisdictions. Policies to promote integration at the service delivery level identified key mechanisms including co-location, person-centred models and community engagement despite there being substantial differences nation-wide of PHCO composition, strength and stronghold.

The identification of policies across Australia that focus on integrating health services has several benefits. For stakeholders in PHC, intersectoral collaboration creates an opportunity for learning from each other about ways to approach and implement integration policy directives. Emphasis on integration at the policy level may facilitate the development and delivery of care pathways that target both continuity and the overall patient experience. Shared resources (e.g. common protocols, procedures and practices) across sectors (acute, primary, community) and jurisdictions not only assists integration but also has the extra benefit of fostering efficient and sustainable health service provision.

There are challenges around alignment of responsibility for integration. The level of system change required may be underestimated, with subsequent plans and funding underpowered for such activity. Policy documents also contain limited details on practical strategies for integration. In addition, whilst evaluation and/or monitoring are often referred to in documents, there is a lack of evaluation of policies and little detail on how such evaluation will occur. Work is needed to create a common set of useful, operational terms for policy-makers to refer to when discussing integration at the policy level to allow the relevant stakeholders to engage and recognise their role. Currently, different stakeholders have their own specific goals related to integration (i.e. best practice, workforce, continuity of care) and having a common understanding of integration should assist.
Integrated care: What policies support and influence integration in health care in Australia?

References


DAVIES, P. 2012. If networks are the answer, what’s the question? World Health Care Networks conference. Cairns.


GENERAL PRACTICE TASMANIA 2007. Submission to the state government clinical and primary care services planning processes. Hobart: General Practice Tasmania.


GOVERNMENT OF WESTERN AUSTRALIA 2011d. WA primary health care strategy. Perth: Government of Western Australia.


Integrated care: What policies support and influence integration in health care in Australia?


VICHEALTH Partnerships. Melbourne: Victorian Health Promotion Foundation.


Appendix A

Macro level integration: Key considerations SWOT analysis

Strengths (Current performance)
- Enables the priority areas of the National Health Reform to be addressed and carried out.
- Allows collaboration between different sectors, governments, service providers, regions.
- Enables coherence and consistency in integration policies and agreements across jurisdictions.
- Provides clear objectives, performance measures and targets to guide integration policy development and implementation.

Weaknesses (Current performance)
- Each state operationalises instructions in a different fashion.
- There are limited details around practical strategies for integration.
- While evaluation and/or monitoring are often referred to in documents, there is a general lack of evaluation of policies (which may be affected by the rapid changes in policies and organisations that occur in the sector); and little detail on how such evaluation will occur.

Opportunities (Factors in external environment)
- Intersectoral collaboration creates an opportunity for learning from different sectors about the different ways to approach and implement policy directives.
- Integrated care enables care pathways to be developed and delivered, improving both continuity of care and the overall patient experience.
- Macro level integration facilitates the development of shared resources across states and territories e.g. common protocols, procedures and practices.

Threats (Factors in external environment)
- Different operational definitions of integration may lead to dissent in terms of integration at a national level.
- Different parties will have their own specific focus i.e. patient-centred care, best practice, workforce, continuity of care – and some of these may not accord with integration.
- There are challenges around funding, ascertaining who is responsible for funding certain aspects of policy implementation, particularly in partnerships.
- The level of system change required may be underestimated, with subsequent plans and funding underpowered for such activity.
- Implementing integration may not always be an improvement on current practice hence the change in policy direction may alter currently effective programs.
- The varying priorities, culture and language among sectors and service providers may affect the ability and willingness of the different parties to work together.
Table 5  Roles and responsibilities for funding and delivering health care services

<table>
<thead>
<tr>
<th>Roles and responsibilities</th>
<th>Australian Commonwealth Government</th>
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<tbody>
<tr>
<td></td>
<td>• Fund large part of public hospital services (through NHA and NHHN)</td>
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<td></td>
<td>• Provide rebates to patients for medical services provided by GPs and specialists and deliver public health programs</td>
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<td></td>
<td>• Fund PBS</td>
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<td></td>
<td>• Fund high level residential aged care services</td>
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<td></td>
<td>• Fund private health insurance rebates</td>
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<td></td>
<td>• Fund improved access to PHC, specialist services and infrastructure for rural and remote communities</td>
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<td></td>
<td>• Fund Indigenous-specific PHC</td>
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<td></td>
<td>• Promulgate and coordinate health regulations</td>
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<td></td>
<td>• Undertake health policy research and policy coordination across the Australian, State and Territory governments</td>
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<tr>
<td></td>
<td>• Fund hospital services and the provision of other services through the Department of Veteran’s Affairs</td>
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<td></td>
<td>• Fund hearing services for eligible Australians through the Australian Government Hearing Services Program</td>
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<td></td>
<td>• Fund the Medicare Safety net.</td>
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<tr>
<th></th>
<th>State and Territory governments</th>
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<tr>
<td></td>
<td>Contribute funding for and deliver services (including Indigenous-specific services) for:</td>
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<tr>
<td></td>
<td>• Public hospital services</td>
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<tr>
<td></td>
<td>• Public health programs (e.g. health promotion, disease prevention)</td>
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<td></td>
<td>• Community health services</td>
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<td>• Public dental services</td>
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<td>• Mental health programs</td>
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<td></td>
<td>• Patient transport</td>
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<td></td>
<td>• Regulation, inspection, licensing and monitoring of premises, institutions and personnel</td>
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<td></td>
<td>• Health policy research and policy development</td>
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<td></td>
<td>• Specialist palliative care</td>
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<td></td>
<td>• Home and Community Care (HACC) program</td>
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<td>• Aged care.</td>
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<th>Local governments</th>
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<tr>
<td></td>
<td>• Environmental control</td>
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<td></td>
<td>• Range of community-based and home care services.</td>
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<thead>
<tr>
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<th>Non-government sector</th>
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<tbody>
<tr>
<td></td>
<td>• General practice</td>
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<td></td>
<td>• Specialist medical and surgical services</td>
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<td></td>
<td>• Dental services</td>
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<tr>
<td></td>
<td>• Other allied health services (e.g. optometry, physiotherapy)</td>
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<td></td>
<td>• Private hospitals</td>
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<td></td>
<td>• High level residential aged care services.</td>
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### Appendix B

**Table 6**  Commonweath and shared policies that influence integration by means of a stewardship function

<table>
<thead>
<tr>
<th>Document</th>
<th>Vision/Overview</th>
<th>Elements Influencing Integration</th>
<th>Access Document</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commonwealth</strong></td>
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<tr>
<td>Joint statement on Health Promotion, Disease Prevention and Medicare Locals (AMLA and ANPHA, 2012) AML Alliance (formerly AGPN) and ANPHA (Australian National Preventive Health Agency) June 2012</td>
<td>This statement is intended to support the leaders, staff and PHC professionals that are members of a ML to make the case for a significant, innovative and sustained role in health promotion and disease prevention in their region.</td>
<td>This document relates to the four priority areas for building Australia’s PHC system. Includes commitment by ANPHA and AML Alliance to promote health for all Australians and work as partners to support MLs. Outlines the guiding principles as well as actions required for MLs which may influence integration i.e. partnerships, engagement and collaboration with the community, consumers and across sectors.</td>
<td><a href="http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/Jointstatement-medicarelocals">http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/Jointstatement-medicarelocals</a></td>
</tr>
<tr>
<td>Medicare Locals Guidelines for the establishment and initial operation of Medicare Locals 2011 (Australian Government Department of Health and Ageing, 2011)</td>
<td>Development of PHCOs to drive improvements in PHC and ensure that PHC services are better tailored to meet the needs of local communities.</td>
<td>Key areas to influence integration as part of broader Commonwealth plan: • establishing collaborations between MLs and LHNs (coordinated, integrated, locally responsive and flexible health services - right care, in the right place, at the right time) • supporting the development of e-health and health information (shared electronic health records, data provision) to allow for evaluation of health system performance for service planning, monitoring • improving the planning of PHC services to respond to local needs • development of PHC infrastructure i.e. GP Super Clinics • development of PHC workforce • PHC initiatives focused on improving disease prevention, management and access to services.</td>
<td><a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/CD5B5742AD07AFE2CA25783E0077363C/$File/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.pdf">http://www.health.gov.au/internet/main/publishing.nsf/Content/CD5B5742AD07AFE2CA25783E0077363C/$File/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.pdf</a></td>
</tr>
<tr>
<td>Building a 21st Century Primary Health Care System: A Draft of</td>
<td>In response to a discussion paper (Commonwealth of Australia, 2008) this document outlines the first</td>
<td>Five building blocks have been identified as fundamental to integrated PHC systems: 1 Regional integration</td>
<td><a href="http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Co">http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Co</a></td>
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<tr>
<td>Australia’s First National Primary Health Care System 2010 (Commonwealth of Australia, 2010a)</td>
<td>Comprehensive national policy statement for PHC in Australia and provides the platform on which to build a strong and efficient PHC system into the future.</td>
<td>Australia’s First National Primary Health Care System 2010 (Commonwealth of Australia, 2010a)</td>
<td></td>
</tr>
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</table>
### Integrated Care: What Policies Support and Influence Integration in Health Care in Australia?

And integration of primary care service delivery models:
- HealthOne NSW
- GP Plus initiative SA

Identifies gaps between jurisdictions - Commonwealth, State and Territory funded PHC services. This is an area that could aim to reduce fragmentation and improve the patient journey.

| National Chronic Disease Strategy 2005 (National Health Priority Action Council (NHPAC), 2006) | An overarching framework for improving chronic disease prevention and care across Australia. This nationally agreed agenda aims to encourage coordinated action in response to the growing impact of chronic disease on the health of Australians and the health care system. | Integration and continuity of prevention and care is one of the 4 key action areas in the NCDS. This document outlines 3 key directions pertinent to integration:
1. Build an integrated system of care (e.g. nationally agreed data items; risk stratification measures; national electronic patient information systems)
2. Provide policy support of regional and local planning and integration (e.g. funding to support multidisciplinary care and care coordination)
3. Strengthen local partnerships to provide comprehensive care (e.g. integrated PHC networks and services; access to information about local services) |
| National Health Reform: Performance and Accountability Framework, 2012 (National Health Performance Authority, 2012) | Framework is based on the NHR Agreement to support improved local level performance assessment. | This framework outlines specific guidelines for performance monitoring and assessment of MLs, LHNs, clinical units and other health services. |
| National Strategic Framework for Rural and Remote Health, 2012 (Australian Government Department of Health and Ageing, 2012b) | This framework provides a strategic vision for health care for people living in rural and remote areas of Australia – to deliver timely access to quality and safe health care services, irrespective of where Australians live. | Integration is a key element of this framework, which aims to:
- Define an agreed vision and direction for rural health
- Define an agreed set of national rural health priorities, reflecting common issues and challenges across jurisdictions
- Align with the timetable and directions of the national health reform agenda and process
- Align with State and Territory initiatives on rural and remote health. |


# Integrated care: What policies support and influence integration in health care in Australia?

| National Health and Hospitals Network Agreement 2011 (COAG, 2011a) | The shared intention of the Commonwealth, States and Territory governments is to implement a National Health and Hospitals Network for Australia. Specifies the roles and responsibilities of LHNs and PHCOs. | Integration is encapsulated in 3 areas in this document: Policy-making, PHCO creation and funding arrangements. Establish system-wide GP and PHC policy, as a means to influence integration via efficient use of hospitals and other state-funded health care services. Creation of MLs as independent organisations to influence integration by establishing strong links to local communities and health professionals. Drive integration across GP and PHC services by coordinating services and working | http://www.health.nsw.gov.au/resources/Initiatives/healthreform/pdf/NHHN_Agreement.pdf |
| | closely with LHNs to identify and address local needs. Funding arrangements will be put in place as a means to facilitate integration by distinguishing Commonwealth and State funding and policy responsibilities across general practice and PHC. Underpinned by the National Health and Hospitals Network Act 2011. |
Table 7  State and Territory policies that influence integration by means of a stewardship function

<table>
<thead>
<tr>
<th>Title</th>
<th>Vision/Overview</th>
<th>Elements influencing integration</th>
<th>Access Document</th>
</tr>
</thead>
</table>
| Australian Health Care Agreements (AHCA) (Australian Government Department of Health and Ageing, 2010) | Each State/Territory has a bilateral 5-year AHCA with the Commonwealth detailing roles and responsibilities. | Each AHCA specifies:  
- Commonwealth, State and shared responsibilities  
- Financial arrangements  
- Public hospital charges  
- Performance measures.  
| Western Australia | Better health for the people of Western Australia through integrated, accessible, high-quality PHC. | Integration targeted across the framework.  
The purpose of the WA PHC Strategy is to:  
- describe the role of WA Health within PHC in WA  
- provide a policy framework for WA Health to undertake state-wide reform initiatives  
- articulate the importance of PHC partnerships.  
This document is relevant to all stakeholders within PHC including those addressing:  
- Indigenous health  
- healthy ageing  
- mental health and drug and alcohol services  
- maternal and child health  
- oral health  
- chronic conditions.  
A critical element of reform is to achieve integration. This is identified as linking and coordinating between state responsibilities and activities, and those of PHC providers who are independent to WA Health. | [http://www.healthnetworks.health.wa.gov.au/docs/1112_WAPrimaryHealthCareStrategy.pdf](http://www.healthnetworks.health.wa.gov.au/docs/1112_WAPrimaryHealthCareStrategy.pdf) |
This document aims to provide a framework to achieve connection between stakeholders via:
- partnerships (integration highlighted)
- health literacy and self-management
- system design
- awareness of the context of PHC services (regional, cultural, etc.)
- social determinants of health
- implementation through consultation and engagement.

| WA Chronic Health Conditions Framework 2011-2016 (Government of Western Australia, 2011c) | Guide to providing the right care at the right time by the right team in the right place for Western Australians with chronic health conditions. | The Framework is guided by the following principles:
1. Integration and service coordination
2. Interdisciplinary care planning and case management
3. Evidence-based and consumer-centred care
4. Health literacy and self-management for chronic health conditions.

To take the Framework forward, the two recommendations are to:
1. engage with health service providers and key stakeholder groups, especially within primary care and rural areas, through a consultation process to develop an implementation plan for the Framework
2. establish a Chronic Health Conditions Network to complement existing condition-specific networks and drive the implementation plan in partnership with key service providers and planners (e.g. metropolitan and country health services, NGOs, MLs).

| WA Chronic Conditions Self-Management Strategic Framework 2011-2015 (Government of Western Australia, 2011b) | Supporting system and practice changes to incorporate self-management into the core principles of chronic condition management, targeting training for health care professionals, to assist consumers with chronic conditions to actively self-manage their health, developing and implementing chronic conditions | Objectives include engaging and improving consumers, carers and service providers’ culture and attitudes, awareness, services, knowledge and skills, tools and resources specifically around self-management.

A3: “By 2015, referral pathways will be clear and easy to navigate within local communities to ensure that the consumer is linked into the appropriate chronic condition self-management support (e.g. link to recommendations in the models of care and integrate with the role of MLs and WA’s five new Health Services)” (p. 5).
| Clinical Services Framework 2010-2020 (Government of Western Australia, 2009) | Strive to deliver and provide direction to service planning for public health services. | The CSF 2010 focuses on planning, research and consultation, drawing from the following:  
- a review of planning assumptions including the impact of reform measures, the impact of new technology  
- service demand modelling and population projections  
- Area Health Service plans for clinical services  
- Foundations for Country Health Services 2007–2010  
- Models of Care- from prevention and promotion, early detection and intervention, to integration and continuity of care and self-management.  

1. Increasing non-hospital ambulatory care services as outlined in the Ambulatory and Community Care – A framework for non-inpatient care (Health Reform Implementation Taskforce 2007)  
2. Improving clinical and non-clinical administrative processes within health services (e.g. outpatient reform targets)  
3. Improving care coordination with primary care providers. |

| WA Health Networks Models of Care: Overview and guidelines, 2007 (Government of Western Australia) | Ensuring people get the right care, at the right time, by the right team and in the right place. ‘Model of care’ is a multifaceted concept, which broadly defines the way health services are delivered. | Models of care provide a vehicle for achieving the needed reform in WA as set out in the Delivering a Healthy WA Strategic Intent 2005-2010 (2005) and subsequent WA Health Operational Plan 2007-08 (2007).  

Key focus area around integration:  
- Integration & continuity of care  
- Partnerships between government agencies, non-government and private organisations, primary, specialist and multidisciplinary professionals and home, community and hospital settings should be explored and fostered in the development of new models of care.  
- Collaboration and commitment between these partnerships and a desire to place the patient at the centre of all activities ensuring continuity of care. |

Healthy Partnerships

- Models of care provide one of the best methods for improving and strengthening partnerships within and across the health system. Due to the pure nature of Health Networks, partnerships and collaboration are occurring with the non-government and primary care sector and strengthening the relationship between rural and metropolitan health services. This work will need to be fostered and expanded to include the Australian Government and the private sector. Models of care will explicitly describe flows, roles, responsibilities and methods to improve integration and coordination across and within the health care system.

|---|---|---|---|

The major functions of Health Networks are to plan and develop:
- evidence-based policy and practice
- state-wide clinical governance
- transformational leadership and engagement
- strategic partnerships
- evaluation and monitoring systems.

They do this by:
- Planning services based upon community needs
- Developing innovative healthcare policy
- Setting meaningful targets and monitoring patient outcomes
- Promoting efficiency, effectiveness and safety
- Providing opportunities to develop skills and knowledge, and fostering leadership
- Helping to set priorities across WA Health.

Ambulatory and Framework should be used as the Aims to achieve integrated, patient focused health care system, by responding | http://www.health.wa.gov.au |
### Integrated care: What policies support and influence integration in health care in Australia?

**Community-based care: A Framework for non-inpatient care, 2007**

(Government of Western Australia, 2007a)

Strategic direction for the expansion of non-inpatient care and help shape best practice care to provide safe and sustainable, patient-focused health care for WA.

This Framework is aligned with the six strategic directions for WA Health detailed in the Delivering a Healthy WA Strategic Intent 2005-2010.27 and adopts some of the long term reform objectives addressed in the WA Health Clinical Services Framework (CSF) 2005-2015.17. This includes:

- Improved access to services
- Provide safe, high quality health care
- Promote a patient-centred continuum of care
- Optimise public and private services
- Improve the balance of preventative, primary and acute care
- Be financially sustainable as an integrated system
- Support a highly skilled and dedicated workforce.

Guiding principles in the development and delivery of non-inpatient care:

- Care should be provided in a community or ambulatory setting unless considered inappropriate for safety, quality of care and efficiency reasons
- Models of care delivery and management processes should enhance integration across all providers of care
- Services should ensure equity of access, timely and appropriate access to services
- Non-inpatient services should be co-located and/or integrated where there is service or patient synergy
- Services should be planned to meet the population health needs of the area, with a view to responding to and encouraging change in service demand.

**Delivering a healthy WA Strategic Intent 2005-2010**

(Government of Western Australia,)

To improve and protect the health of Western Australians by providing a safe, high quality, accountable and sustainable health care system.

This document recognises that care is achieved through an integrated approach to all the components of our health system. These include workforce, hospitals and infrastructure, partnerships, communities, resources and leadership.

“This will include a significant hospital building and infrastructure redevelopment program during the next 13 years. The result will be better alignment and
### Integrated care: What policies support and influence integration in health care in Australia?

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Supporting Information</th>
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<tr>
<td></td>
<td></td>
<td>The Transition Alliance Directions papers for integrated Health Systems in QLD, 2010 (Queensland Government, 2010a) Health service providers, community and consumer groups, and key partners will work together to: • Jointly identify opportunities for integration, including maximising the opportunities presented by the health reform agenda • Agree on the priorities for integration action • Implement actions step-by-step so that local services are working together to allow patients to access and easily navigate local services. Four key enablers identified to influence integration: 1. Clinical leadership and governance structures to affect change 2. Service re-design (connectivity and information flow to support clinical decision making and performance) 3. Organisational and workforce development to support the new skills needed to operate new organisations and form effective relationships 4. Incentives aligned with desired outcomes. Shared governance as an integration strategy - community, corporate and clinical. Mentions measuring effectiveness: health outcomes &amp; quality of the patient experience, though with little clarification as to how this will be achieved. <a href="http://www.health.qld.gov.au/hcg/publications/directions-paper.pdf">http://www.health.qld.gov.au/hcg/publications/directions-paper.pdf</a></td>
</tr>
</tbody>
</table>
- cardiovascular disease  
- type 2 diabetes  
- renal disease  
- chronic respiratory disease.  
Increased coordination and integration across services and  
| Enhance positive policy environment and community capacity through governance arrangements and partnerships with key stakeholders. Governance to oversee the continuation of the strategy. Partnerships at government to government level, both vertical and horizontal. Testing of different approaches to partnership occurring in three place-based initiatives (North Lakes and surrounds, Logan-Beaudesert, and Innisfail)  
- Whole of government  
- Whole of community  
- Local partnerships  
1.1 Identify the range of local stakeholders and existing partnerships and, where required, augment or develop local partnerships to progress chronic disease | http://www.health.qld.gov.au/publications/corporate/chronic_disease/chronstrat2005.pdf |

2.5 Improve older Queensland assessment services and access to high quality appropriate aged care services evident by:  
- reducing the number of days between assessment referral and approval  
- improving the uptake of transition care program places  
- compliance with residential aged care accreditation standards.  

Strategy 4  
- Investment in IT for electronic medical records available over the internet to assist integration of systems  
- Partnerships to effectively influence health and wellbeing outcomes evident by improving involvement of internal and external partners in the planning and provision of health services  
- Invest in research that promotes evidence-based practice and innovation i.e. increasing the number of clinical trials and active research projects approved and commenced  
- Monitoring - performance and management, governance and accountability to ensure openness and transparency evident by developing and implementing the Governance and Performance Reporting Frameworks  
- Implement national health reform agenda.
Achieving respectful and committed person-centred care and optimal self-care; encompassing prevention and the continuum of care; providing the most effective interventions; addressing the needs of disadvantaged groups; promoting integrated multidisciplinary care; working together in partnership and collaboration; and building on current best practice models. Prevention and management strategies.

| Integrated care: What policies support and influence integration in health care in Australia? |
|---|---|
| **1.2** | Identify the range of federal, state and regional stakeholders and existing partnerships and, where required, augment or develop partnerships at these levels, to progress chronic disease prevention and management strategies. |
| **1.3** | Support mechanisms to enhance linkages between new and existing Federal, state, regional and local partnerships. |
| **1.4** | Develop models and tools to support partnership development, including governance options, identification of barriers, critical success factors and change-management processes. |
| **1.5** | Progress bilateral negotiations between Queensland Health and the Australian Government in relation to funding reform and service delivery models to enhance chronic disease prevention and management strategies. |
| **1.6** | Resource ongoing state-wide implementation mechanisms to manage change, and to coordinate and implement chronic disease prevention and management strategies. |
| **1.7** | Strategies supporting activity across the health continuum. |


... helping people to better health and well-being.

Guide service development and delivery & identifies organisational priorities. Social view of health and embraces a distinctive approach to the organisation and delivery of health services.

**Principles:**
- community-based service delivery
- equitable resource distribution
- population health approaches
- community participation
- responsiveness to local needs,
- cooperation between levels of the health system
- collaboration with relevant external agencies and social justice.

“designed as far as possible to keep people out of the secondary and tertiary levels of health care” and to improve health and well-being.

<table>
<thead>
<tr>
<th>South Australia</th>
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<tbody>
<tr>
<td><strong>SA Health - A Framework for Comprehensive Primary Health Care Services for Aboriginal People</strong> (Government of South Australia, 2011) <strong>Aug 2011</strong></td>
</tr>
<tr>
<td>SA Health has made a commitment to reorient services to improve access to CPHC for Aboriginal South Australians through a collaborative approach to planning and service delivery at state, regional and sub-regional levels.</td>
</tr>
<tr>
<td>Key principles relating to integration: “that services must, as far as possible, be well-integrated, coordinated and address the continuity of care, particularly for those with complex, chronic health conditions” (p. 5)</td>
</tr>
<tr>
<td>Based on The Aboriginal Health Care Plan 2010-2016.</td>
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**The Aboriginal Health Care Plan 2010-2016** **Oct 2010** *(Government of South Australia, 2010)*

| |
| **To make good health a focus and a priority.** |
| CPHC was identified as the key enabler to influence integration and collaboration. |
| Outlines six areas of focus of which 3 are specific to integration: |
| • build stronger PHC |
| • an integrated and collaborative approach to the planning and delivery of services and programs (annual Aboriginal Health Integrated Planning Process) |
| • enablers for action include leadership, workforce, safety and quality, research, evaluation and monitoring, and health information and management systems. |


| Adelaide Statement on Health in All Policies (HIAP) 2010 (WHO, 2010) | To embed health as a central concern for leaders and policy-makers at all levels of government - local, regional, national and international. | The Adelaide Statement outlines how to harness health and well-being. Joined-up governments need institutionalised processes which include providing the leadership, mandate, incentives, budgetary commitment and sustainable mechanisms that support government agencies to work collaboratively on integrated solutions.

HIAP assists leaders and policy-makers to integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services. It involves a joint governance structure and use of a Health Lens analysis to enable agreement on the policy focus and explore links between the policy area and the health of the population. | http://www.sahealth.sa.gov.au/wps/wcm/connect/publiccontent/sa+health+internet/health+reform/health+in+all+policiess

SA Health Strategic Plan 2008-2010 (Government of South Australia, 2008b) | The best health for South Australians. | Overarching framework for all SA Health activities.

SA Health aims to lead and deliver a comprehensive and sustainable health system that focuses on ensuring healthier, longer lives for all South Australians.

Strategic directions related to integration:
- Strengthening PHC (1.3) by facilitating effective coordination and continuity of care
- Promotion of HIAP Approach (see Adelaide Statement below). However there is no performance measure(s) to evaluate integration/coordination, rather the focus is on the medical model measures (i.e. smoking, weight, life expectancy, chronic disease, and birth weight). | http://www.health.sa.gov.au/Default.aspx?tabid=58

South Australia’s Health Care Plan 2007-2016 (Government of South Australia, 2007b) | To improve the wellbeing and health of all South Australians. | This plan proposes to achieve integration through:
- co-location (i.e. GP Plus Health Care Centres) (p. 10)
- investment in new information technology for information transfer across services
- multidisciplinary teams via the establishment of state-wide clinical networks.

Coordination of services for older people is a key area (p. 14) | http://www.sahealth.sa.gov.au/wps/wcm/connect/893b1180428de54db565b7e7eece1070/sahcp-sahealth-20072016.pdf?MOD=AJPERES&CACHEID=893b1180428de54db565b7e7eece1070
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<tr>
<th>Integrated care: What policies support and influence integration in health care in Australia?</th>
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- Reform of the mental health system in South Australia to provide better, more responsive services and an integrated system of care.
- Influence integration of child and adolescent services by promoting multidisciplinary teamwork, strengthening community mental health services, co-location of services and intersectoral collaboration (treatment, vocational and clinical services coordination).
- Community mental health services focus on:
  - leading an integrated model of rehabilitation and recovery
  - facilitating integration across community and bed-based services
  - ensuring continuity of care between the community, hospital and between the stepped levels of care
  - managing appropriate shared care arrangements between primary mental health care and the specialist system.

### Northern Territory

#### Territory 2030 Strategic Plan, 2009 (NT Government, 2009)

- Create a culture where individuals take responsibility for their own health and wellbeing. “We must learn to look after ourselves and our fellow citizens”.

- Target 1.8: By 2030, all Territorians will have a better understanding of their own health issues and the health system and be more engaged in their own healthcare. Develop and implement a framework to increase the level of community engagement in the development, delivery and evaluation of health services.

- Target 1.10: Increase the focus of the Territory health system on prevention. A preventative health agency will focus on healthy lifestyles, preventative health and health literacy. It will have strategic alliances with NGOs, communities, the private industry, and research bodies.

### New South Wales

#### Guidelines for Developing HealthOne NSW Services March 2012 (NSW Department of)

- The purpose of this document is to support the development of HealthOne NSW services.

- Four key features, five key objectives and four key enablers are outlined.

- Specific focus on models to support integrated service delivery acknowledging there is no single model of integrated care that is suited to all settings; Local Health Districts should be guided by their community needs about the configuration that is best suited to each locality.
| Health, 2012a | To date, 3 broad service configurations have been described for HealthOne NSW services: 1. Co-location of services 2. Hub and spoke 3. Virtually integrated services These are not mutually exclusive and some locations may use two configurations, for example hub and spoke and virtual, or co-located and hub and spoke. |
|-----------------------------------------------|
| NSW Chronic Care Program Phase Two 2003-2006 (NSW Department of Health, 2004c) | Identification of key issues in gearing the NSW health system to meet the challenge of improving chronic disease with the vision to enhance the care provided for people with chronic illness. Strategic direction with regard to governance. Development and integration of chronic care policy including: • development of formal agreements between Area Health Services and DGP • joint funding for projects to advance integrated care activities • practicing GPs being employed in liaison roles • co-location of Area Health Service staff in DGP in a liaison position to facilitate. | [http://www0.health.nsw.gov.au/pubs/2005/pdf/chronic_care2.pdf](http://www0.health.nsw.gov.au/pubs/2005/pdf/chronic_care2.pdf) |
### Integrated Care: What Policies Support and Influence Integration in Health Care in Australia

**Integrated Support and Management of Older People in the NSW Health Care System 2004-2006** (NSW Department of Health, 2004a)

- **Purpose:** Older people to remain as independent and healthy as possible and able to participate in community life.

- **Integration:** Integration of health services by guiding and coordinating service delivery for older Australians.

  - The Framework model recognizes GPs involved in the chronic and complex care of patients and that they are central to the integrated care of older people.

- **Key Stakeholders:**
  - The consumer (older people and their families/carers)
  - Government and non-government service providers.

- **Framework:** A Framework Assessment Tool with standards and criteria to meet is provided within this document as a tool for evaluation of system integration.

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**Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System 1999** (NSW Department of Health, 1999)

- **Focus:** Improved health of Indigenous people taking account of the need to restore social, economic and cultural well-being.

- **Principles:** The key principles underpinning the policy and its implementation are:
  - A whole-of-life view of health
  - The practical exercise of self-determination
  - Partnership
  - Cultural understanding
  - Recognition of trauma and loss.

- **Strategic Directions:**
  - Strategic Direction 2.1 (p. 3) - Working partnerships
  - Strategic Direction 3.2 (p. 3) - Improved participation of Aboriginal communities in planning, monitoring, and evaluation.

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**Victoria**


- **Focus:** Creating an equitable, sustainable health system with people at its heart.

- **Planning and Development:** Planning and development priorities for metropolitan health system.

  - Considered they will impact integration via:
    - Development of private sector collaboration, coordination and integration.

- **Policy Initiatives:** This policy includes initiatives to strengthen health promotion and health prevention initiatives that are in partnership with VicHealth.

- **To improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventive health care across all sectors and levels of government.**

- **Acknowledges and sets objectives for integration of the health system.**

- **Identifies Primary Care Partnerships (PCPs) as established mechanisms for collaborative and coordinated planning at the sub-regional level. PCPs function to integrate the efforts of individual organisations and sectors around the needs of local communities, supported by the Plan.**

- **System level integration is outlined across areas including:**
  - Prevention system
  - Governance systems
  - Info systems
  - Financing and resources
  - Partnerships
  - Workforce development.

- Monitoring and management of the plan is also detailed (p. 89).

### Victorian Health Policy and Funding Guidelines 2011-12 Part two: Health operations (Victorian Government, 2010c)

- **Provide Victorian health services with detail on the budget allocation to programs, hospitals and other health services for the coming year.**

  - Integrated cancer services
  - Integrated datasets
  - Integrated service monitoring
  - Integrated health promotion

### Victorian Health Services Policy and Funding Guidelines 2010-11 (Victorian Government, 2010d)

- **Integrated service delivery via funding.**

  - The objective of the health portfolio is to enhance and protect the health and wellbeing of all Victorians through:
    - working with the community to provide better access to health, aged care and mental health and drug services
    - managing the public hospital system
    - developing health infrastructure in rural and metropolitan Victoria
    - pursuing opportunities for partnership with the PHC sector and other
### Integrated care: What policies support and influence integration in health care in Australia?

<table>
<thead>
<tr>
<th>Governments’ public health interventions</th>
<th>Putting Patients First 2010 (Victorian Government, 2010b)</th>
<th>Support for PHCOs: “they will facilitate integrated, innovative and locally responsive approach to PHC and to better manage chronic and complex illness at the local level” (p. 21)</th>
</tr>
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<tr>
<td>- implementing major health initiatives, such as the Victorian Cancer Action Plan</td>
<td>Proposes a series of practical reforms related to the Commonwealth and Victorian Governments’ shared policy goals, while avoiding unnecessary rearrangements of existing funds or bureaucracies.</td>
<td>Technology is identified as a tool to assist in integration of services (i.e. e-health).</td>
</tr>
<tr>
<td>- encouraging Victorians to improve their health through preventative health initiatives and education programs.</td>
<td>Support for PHCOs: “they will facilitate integrated, innovative and locally responsive approach to PHC and to better manage chronic and complex illness at the local level” (p. 21)</td>
<td>This document criticises the NHR process: ‘Properly integrated local hospital services with local PHC services will provide the best opportunity to tailor services to patient needs. The reform proposals to date do not address how to better integrate these systems’ (p. 26).</td>
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<tr>
<td></td>
<td></td>
<td>The Victorian Government program, the Hospital Admission Risk Program initiatives are presented as already trialled and tested to integrate hospital services and PHC.</td>
</tr>
<tr>
<td></td>
<td>Optimal PHC systems, with a focus on: wellness, person-centred care, access to a health professional when and where needed through an appropriate mix of public and privately funded services, enabling people with chronic and complex conditions to have well-planned, integrated care in a community setting that supports their capacity to self-manage, thus reducing hospitalisations.</td>
<td>Section 2 (p. 3)</td>
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<tr>
<td></td>
<td></td>
<td>- Focusing on streamlining funding and financing arrangements, incorporating regional level organisations- Health Living Partnerships, super-clinics, and regional level primary health organisations.</td>
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<tr>
<td></td>
<td></td>
<td>- Embracing and broadening the use of e-health systems. Proposed as a means of enhancing service integration across health service providers. PHC partnerships assist with this via e-referral. Includes internet, mobile phones, telehealth etc.</td>
</tr>
<tr>
<td></td>
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<td>Section 3 (p. 7)</td>
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<tr>
<td></td>
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<td>- Outlines a population-focused response to improve access and integration,</td>
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### Integrated care: What policies support and influence integration in health care in Australia?

<table>
<thead>
<tr>
<th>Section 3.3 (p. 12)</th>
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<tbody>
<tr>
<td>• Chronic disease populations in particular are targeted for improving integration – structured care models like Wagner Chronic Care Model plus e-health for referral, clinical decision-support and shared health records.</td>
</tr>
<tr>
<td>• The Expanded Chronic Care Model, registration at the regional level of clients with chronic diseases, multidisciplinary care models and incentives to promote partnerships are all important.</td>
</tr>
<tr>
<td>• Action plans specific to access, service delivery, workforce and sustainability.</td>
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<table>
<thead>
<tr>
<th>Towards a Demand Management Framework for Community Health Services DHS, 2008 (Victorian Government, 2008a)</th>
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<tbody>
<tr>
<td>Preparing Community Health Services (CHS) for their evolving role in delivering health care services, this document aims to improve and consolidate current practices in managing demand.</td>
</tr>
<tr>
<td>This framework is designed to manage demand and supply of health services. It applies to all services provided from CHS, where practicable, in order to provide an integrated and consistent approach to managing demand for the CHS and clients. The framework overviews relevant state and federal policies. Specific to integration of health services this document identifies the systems and strategies to manage clients from initial contact to exit from a service. Enablers of integration of service delivery are outlined including 10 models of service delivery (p. 17), practical tools and case studies. Barriers and management strategies are also identified.</td>
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<table>
<thead>
<tr>
<th>Care in your community: A planning framework for integrated ambulatory health care 2006 (Victorian)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To deliver person- and family-centred health care in community-based settings, reducing the need for inpatient care and improving the health outcomes of Victorians.</td>
</tr>
<tr>
<td>This outlines a detailed plan which covers a broad range of Department of Human Services-funded health care services in relation to planning, implementation, and responding to local needs. It includes refocusing and investing in a mix of inpatient and community-based integrated care services to meet health needs. There are five overarching principles all pertaining to integration. (The best place to treat, Together we do it better, Technology to benefit people, A better health care experience, A better place to work).</td>
</tr>
<tr>
<td>Country/Region</td>
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<td>---------------</td>
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<tr>
<td>Australia</td>
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</table>
| Victoria      | Community Health Policy: Community Health Services—creating a healthier Victoria 2004 (Victorian Government, 2004) | Community Health Services—creating a healthier Victoria identifies 5 strategic directions:  
- community health services as a platform for delivery of PHC  
- coordinated community-based disease management and ambulatory care  
- expanded primary medical care  
- focus on child and family health  
- leadership in health promotion. | Key enablers to achieve the strategic directions include a focus on ‘business systems and quality’. This includes the development and improvement of systems, including demand management, to enhance their quality and efficiency across Community Health Services. | http://www.health.vic.gov.au/pch/downloads/chs_policy.pdf |
<p>| Tasmania      | Strengthening Clinical Support Discussion Paper, June 2008 (Tasmanian Clinical Advisory Council, 2008) | Formal groups of clinicians who work together across organisational boundaries to improve the performance of the health care system. They have been shown to provide a valuable platform for service planning, communication, system-wide | This paper aims to define the role and draft terms of reference of the Clinical Advisory Council (governance, membership, etc.). New multidisciplinary Tasmanian Clinical Advisory Council as the principal vehicle for clinical advice. Key function: Recommend strategies that promote an integrated and cohesive approach | <a href="http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0015/31641/Strengthening_Clinical_Support_Discussion_Paper_1_0.pdf">http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0015/31641/Strengthening_Clinical_Support_Discussion_Paper_1_0.pdf</a> |</p>
<table>
<thead>
<tr>
<th><strong>Tasmania’s Health Plan Clinical Services Plan: Update</strong></th>
<th><strong>Endorses the key principles established for Tasmania’s health services in the 2007 Clinical Services Plan</strong></th>
<th><strong>Department will finalise its policy and planning framework for Integrated Care Centres (ICCs) by July 2008, enabling progression to a detailed model of care and facility planning.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporating changes to ownership of the Mersey Community Hospital, May 2008 (Tasmanian Department of Health and Human Services, 2008b)</td>
<td></td>
<td>Implementation commitment: 23. The Tasmanian Government will seek to agree on a robust performance monitoring and reporting framework with the Australian Government to ensure that both the Northwest Regional Hospital (NWRH, Burnie) and the Mersey Community Hospital contribute equitably to the provision of an integrated health service for the region by December 2008. In endorsing Tasmania’s Health Plan, the State Government adopted key principles for Tasmania’s health services including: • integrated through effective service coordination and partnerships between providers. During consultation for the development of the 2007 Clinical Services Plan, many stakeholders suggested that the allocation of responsibility for acute and PHC to separate divisions of the Department was a major barrier to integrating care at an operational level. In March 2008 the Minister and the Secretary of the Department announced a reorganisation of the Department to increase its focus on patients and clients and better reflect priorities under Tasmania’s Health Plan. Key integration feature of the reorganisation includes bringing together acute hospital and primary health functions. Effective planning and management of Tasmania’s ICCs will enable many</td>
</tr>
</tbody>
</table>
### Tasmania’s Health Plan Primary Health Services Plan (PHSP) Program Implementation Plan 2007-2010 (Tasmanian Department of Health and Human Services, 2007d)

| **Introduce a range of initiatives to improve the integration of primary health and acute care services including the development of Primary Health Partnerships, Integrated Care Centres and Clinical Networks.** |
| **Themes and target outcomes:** General Practice Integration - a new relationship between general practice and the department will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease. |
| **2. PHSP Initiatives: Primary Acute Integration** |
| **2.1 Role Delineation and Memorandum of Understanding Development** |
| **2.2 Developing Integrated Care Centres** |
| **2.3 Rural Emergency Response** |
| **2.4 Integrating Primary and Acute Care** |
| **2.5 Strengthening Clinical Support** |
| **4. PHSP Initiatives: Primary Health Partners** Five projects will promote improved communication and collaboration between primary and community health services: |
| **4.1 Alcohol and Drugs Action** |
| **4.2 Primary Mental Health Service Development** |
| **4.3 Local Government, Primary Health** |
| **4.4 Community Transport** |
| **4.5 Integrating Population Health Approaches.** |

### Tasmania’s Health Plan Summary, 2007 (Tasmanian Department of Health and Human Services, 2007b)

| **Comprises Primary Health Service Plan & a Clinical Services Plan.** |
| **Five key strategic objectives from 2007-2012:** |
| **1. Supporting individuals, families and communities to have more control over what matters to them** |
| **2. Promoting health and wellbeing and intervening early when needed** |
| **3. Developing responsive, accessible and sustainable services** |
| **4. Creating collaborative partnerships to support the development of healthier communities** |
| **5. Shaping our workforce to be capable of meeting changing needs and future** |


## Integrated care: What policies support and influence integration in health care in Australia?

**Objective 4 focuses on integration of GPs, PHC and community services, specifically working in partnership across national, state and local governments.**

### Key priority areas:

1. **Primary health approach** will be promoted throughout the network of primary health services to guide day-to-day practice and to better meet the needs of Tasmania.
2. **Designing a primary health system** that can better meet the changing needs of the Tasmanian community.
3. **A tiered service delivery model** establishing an integrated network of primary health services across Tasmania has been applied to all services delivered by the Department of Health and Human Services. Tiers 1-3 represent primary health service sites and have been developed considering current and future needs, specifically population trends and levels of community need; distance from other services; and sustainability considerations such as cost and workforce availability.
4. **Community-based health services** will be changed and expanded. A new relationship between general practice and the Department of Health and Human Services will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease. Changed and expanded role for rural health centres will be implemented to ensure these services better meet these needs.
5. **Improved communication and collaboration** between service providers will be a priority.

### Recommendations relating to integration:
- The interface between primary and acute care services
- Access to services and alternate models of care
- Community engagement and partnerships.

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<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
<th>Recommendations</th>
<th>Policy or Report Address</th>
</tr>
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<tbody>
<tr>
<td>Tasmania’s Health Plan</td>
<td>Strengthening the PHC system to better respond to chronic disease epidemic.</td>
<td>Key priority areas:</td>
<td><a href="http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/24796/PrimaryHealthServicesPlan_nav.pdf">http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/24796/PrimaryHealthServicesPlan_nav.pdf</a></td>
</tr>
<tr>
<td>Primary Health Services Plan, 2007 (Tasmanian Department of Health and Human Services, 2007a)</td>
<td>Working with our acute health services, specifically the major hospitals, to assist them to better respond to clinical demands. Reforms must be balanced and timed to ensure they are affordable.</td>
<td>1. Primary health approach will be promoted throughout the network of primary health services to guide day-to-day practice and to better meet the needs of Tasmania. 2. Designing a primary health system that can better meet the changing needs of the Tasmanian community. 3. A tiered service delivery model establishing an integrated network of primary health services across Tasmania has been applied to all services delivered by the Department of Health and Human Services. Tiers 1-3 represent primary health service sites and have been developed considering current and future needs, specifically population trends and levels of community need; distance from other services; and sustainability considerations such as cost and workforce availability. 4. Community-based health services will be changed and expanded. A new relationship between general practice and the Department of Health and Human Services will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease. Changed and expanded role for rural health centres will be implemented to ensure these services better meet these needs. 5. Improved communication and collaboration between service providers will be a priority.</td>
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</table>
### Integrated care: What policies support and influence integration in health care in Australia?

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<tr>
<th>(General Practice Tasmania, 2007)</th>
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**Australian Capital Territory**

ACT Primary Health Care strategy, Dec 2011 (ACT Government, 2011a)  
A strong responsive and cost-effective PHC system is central to equipping the ACT to meet future challenges.

Three of the 6 principles pertinent to influencing integration for the ACT Primary Health Care Strategy 2011–2014 are:

**Principle 1 – Empowered person-centred care**
- Individuals will be enabled to make informed decisions about their health and wellbeing with support from a PHC system which focuses on the needs of the individual and which works in partnership with individuals, families and carers to support their needs.

**Principle 5 – Collaborative model of team-based coordinated care**
- PHC services provide collaborative team-based services in consultation with consumers to deliver an effective, appropriate and coordinated service appropriate to the needs of the consumer.

**Principle 6 – Integration and collaboration to support the patient journey**
- Collaborative, strong partnerships are developed between consumers, carers, public and private PHC services, secondary and tertiary sectors and the wider sector responsible for housing, justice, employment, education and planning.

ACT Clinical Services Plan Discussion paper December 2011 (ACT Government, 2011b)  
Provides the strategic framework for the delivery of health services.

As a broad planning document, the plan identifies the challenges in the health system, the number and types of services to be delivered in the future, and the infrastructure requirements. Specific clinical service plans, developed as related documents to the Clinical Services Plan and to assist the Capital Asset Development Plan include:

- Adult Corrections Health Services Plan 2008-2012
- Children and Young Peoples Justice Health Services Plan 2008-2012
- Critical Care Services Plan 2007-2011
- Diabetes Service Strategic Plan 2008-2012
- Mental Health Services Plan 2009-2014
- Renal Health Services Plan 2010-2015.


<table>
<thead>
<tr>
<th>ACT Health Corporate Plan 2010-2012 (ACT Government, 2010)</th>
<th>&quot;Your health, Our priority&quot;. Strategic direction of ACT Health business units to support the achievement of ACT Health’s overarching organisational vision and corporate values. This document is a plan overview. The Plan has 7 key performance areas: • Consumer experience • Sustainability • Hospital and related care • Prevention • Social inclusion and Indigenous health • Community based health • Aged care. Priorities specific to integration include: • Community based health • Consumers with complex care needs can access comprehensive, integrated and coordinated services. • Better connect hospitals, primary and community-based health care to meet patient needs, improve continuity of care, and reduce demand on hospitals. • Use e-health to link providers and consumers to support self-management and improve the quality of care.</th>
<th><a href="http://health.act.gov.au/c/health?o=dlpubpoldoc&amp;documnt=2144">http://health.act.gov.au/c/health?o=dlpubpoldoc&amp;documnt=2144</a></th>
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<tr>
<td>Mental Health - Fourth National Mental Health Plan 2009-2014 (Commonwealth of Australia, 2009a)</td>
<td>An agenda for collaborative, whole of government approach in mental health. The plan will provide a basis for governments to advance mental health activities within the various portfolio areas in a more integrated way, recognising that many sections can contribute to better outcomes for people living with mental illness. • Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community. • Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage. • Coordinate the health, education and employment sectors to expand</td>
<td><a href="http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-f-plan09-toc">http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-f-plan09-toc</a></td>
</tr>
<tr>
<td>Policy Area</td>
<td>Description and Objectives</td>
<td>Source</td>
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<td>------------------------------------------------</td>
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<tr>
<td>ACT Chronic Disease Strategy 2008-2011 (ACT Government, 2008a)</td>
<td>Provides a framework to pursue work that involves better coordination of existing chronic disease services and to develop new and innovative projects and programs that aim to reduce the incidence or complications of chronic disease.</td>
<td><a href="http://www.health.act.gov.au/c/health?adlpubpoldoc&amp;document=917">http://www.health.act.gov.au/c/health?adlpubpoldoc&amp;document=917</a></td>
</tr>
</tbody>
</table>
To enable this new service delivery model, the program is investing in:

- New models of care
- Improvements to the physical infrastructure of the Health Directorate
- Workforce planning and change management
- Technology to support the transformation program (referred to as the Digital Health Enterprise or DHE).

Specific service delivery initiatives of this policy focus on integration via co-location and planning for service distribution:

- New Community Health Centre/Walk-in centre at Gungahlin and the redevelopment of Community Health Centres
- Provision for Phase 1 - Clinical Services redevelopment
- Provision for Project Definition Planning.

The establishment of a solid framework which supported and effectively integrated necessary policies, practices and documentation for the establishment of new positions.
Table 8  Commonwealth and shared policies that influence integration by means of a creating resources function

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<thead>
<tr>
<th>Document</th>
<th>Vision/Overview</th>
<th>Elements Influencing Integration</th>
<th>Access Document</th>
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<tbody>
<tr>
<td><strong>Commonwealth</strong></td>
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<tr>
<td>Medicare Locals (Australian Government Department of Health and Ageing, 2012a, Australian Government Department of Health and Ageing, 2010)</td>
<td>Coupled with Local Hospital Networks, MLs are the key elements of the health reform. The goal is to develop “more locally responsive and flexible services” and improve integration and accountability across the health system.</td>
<td>MLs are expected to improve patients’ access to services by working within the PHC sector and across other sectors in the health system to improve care coordination and integration. The five key objectives of MLs are: 1 Identify health needs of local areas and develop locally focused and responsive services 2 Improve the patient journey through integrated and coordinated services 3 Provide support to health care providers to improve patient care 4 Facilitate implementation and performance of PHC initiatives 5 Engage with the community, be efficient, accountable, and manage effectively.</td>
<td><a href="http://www.anpha.gov.au/internet/anpha/publishing.nsf/content/Jointstatement-medicarelocals">http://www.anpha.gov.au/internet/anpha/publishing.nsf/content/Jointstatement-medicarelocals</a> <a href="http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/MedicareLocalsDiscussionPaper">http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/MedicareLocalsDiscussionPaper</a></td>
</tr>
<tr>
<td><strong>National E-Health Strategy, 2008 (Victorian Department of Human Services, 2008)</strong></td>
<td>To enable a safer, higher quality, more equitable and sustainable health system for all.</td>
<td>e-health aims to facilitate integration by: 1 Ensuring the right consumer health information is made available electronically to the right person at the right place and time 2 Operating as an inter-connected system overcoming the current fragmentation and duplication of service delivery 3 Allowing multidisciplinary teams to electronically communicate and exchange information to provide better coordinated health care across the continuum of care. The expectation is that this will transform the way information is used to plan, manage and deliver health care services.</td>
<td><a href="http://www.ahmac.gov.au/cms_documents/National%20E-Health%20Strategy.pdf">http://www.ahmac.gov.au/cms_documents/National%20E-Health%20Strategy.pdf</a></td>
</tr>
<tr>
<td><strong>Divisions of General Practice Program, 1993-2011 (Department of Health and Ageing, 2012)</strong></td>
<td>To provide services and support to general practice at the local level, through DGP, to achieve health outcomes for the community that would not otherwise be achieved on an individual GP basis.</td>
<td>All DGP have provided core programs to support integration and multidisciplinary care. Specific initiatives delivered through the DGP include: 1 Rural Primary Health Services Program (RPHS) 2 Aged Care Access Initiative (ACAI) 3 Workforce Support for Rural General Practitioners Program (WSRGP) 4 Closing the Gap - Improving Indigenous Access to Mainstream Primary Care</td>
<td><a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-divisions-index.htm">http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-divisions-index.htm</a></td>
</tr>
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</table>
**General Practice Immunisation Incentive Scheme (GPII).**

The DGP infrastructure provides a mechanism for informing and educating GPs and practice staff about changes to programs, services and new initiatives for continuous quality improvement. DGP allow GPs a representative voice with local health services planning and other health agencies.

<table>
<thead>
<tr>
<th>Shared Policy</th>
<th>Description</th>
<th>Related Website</th>
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Table 9  State and Territory policies that influence integration by means of a creating resources function

<table>
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<tr>
<th>Document</th>
<th>Vision/Overview</th>
<th>Elements Influencing Integration</th>
<th>Access Document</th>
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<tbody>
<tr>
<td><strong>Western Australia</strong></td>
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<td><strong>Queensland</strong></td>
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<tr>
<td><strong>South Australia</strong></td>
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<tr>
<td>Nil</td>
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<tr>
<td><strong>Northern Territory</strong></td>
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</table>
| Primary Care Integration Project 2010 | To improve the management of chronic conditions through informing policy and practice. | Aboriginal and Torres Strait Islander people with conditions such as end-stage renal disease need to be relocated in regional centres to undertake appropriate treatment; this primary care integration project provides support to patients in their new locations. Project not yet evaluated. Identified next steps related to integration:  
  - Working with acute care services and primary health providers to improve the transition of patients with chronic conditions from hospital to community settings  
  - Supporting business relationships between health providers and other sectors who contribute to the social and economic wellbeing of renal dialysis clients  
| Northern Territory Australian Better Health Initiative (ABHI) (Race and Nash, 2010) | | | |

Integrated care: What policies support and influence integration in health care in Australia?
### NSW Chronic Care Program, 2000-2003 (NSW Department of Health, 2004b)

Seeks to improve the quality of life of people with chronic and complex conditions, their carers and families, and prevent unplanned and avoidable hospital admissions.

Key initiatives that support integration and best practice care:
- 4.2 Care coordination and clinical pathways
- 4.6 General practice linkages
- 4.8 Information management systems
- 4.9 Achieving sustainable organisational change.


### Victoria

**Evaluation of the Primary Care Partnership Strategy 2005** (Australian Institute for Primary Care, 2005)

Evaluation process to provide information to maximise learning from the initiative

To allow for refinement of policy and service development and whether PCPs have achieved objectives:
- Partnership development
- Integrated health promotion
- Service coordination
- Integrated chronic disease management.

Integration is central to the areas of evaluation.


Move towards more person-centred care of older people. It contains practical tips on getting started and examples of ‘policy in action’.

Integration is embedded within principles:
- Principle 7: Treatment and care provided for older people is coordinated to achieve integrated care across all settings.
- Principle 9: Health Services integrate their community-based programs to provide the appropriate treatment, therapy and supportive care to meet the needs of older people.
- Principle 10: Robust protocols and agreements developed between Health Services and ongoing community support providers ensure that older people continue to receive the care they require in a coordinated and integrated manner.

| Primary Care Partnerships: Achievements 2000 to 2010 (Victorian Government, 2010a) | Key policy initiative of the Government of Victoria. Aims to facilitate relationships between agencies across a catchment area so they are able to implement system change, coordinated service delivery and joint programs, thereby improving outcomes for consumers and promoting community health and wellbeing. | Service Coordination - “focussing on improved initial needs identification, referral and care coordination. A coordinated approach with key programs will drive the implementation of this aspect of the reform. A cross program implementation plan has been developed…” |

Integrated Health Promotion programs - “There is good evidence that the coordinated approach being taken by PCPs is leading to better health promotion programs and planning. We will continue to build on this approach and implement integrated health promotion initiatives through the PCP alliances wherever possible.”

Integrated Chronic Disease Management (ICDM) - “improve the health status and quality of life of the community, encourage independence and reduce the burden of disease, ill-health and disability, by creating a robust, integrated, consumer responsive primary health and community support service system”.

### Tasmania

| A Guide to Working with General Practice, Sept 2009 (General Practice Tasmania, 2009a) | A guide containing practical advice to support improved collaboration with general practice. | Identifies Divisions as responsible for actively promoting integration and linkages between different health services and systems. |

### Australian Capital Territory

| Nil |  |  |

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Integrated care: What policies support and influence integration in health care in Australia? 90
Table 10  Commonwalth and shared policies that influence integration by means of a financing and incentives function

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<thead>
<tr>
<th>Document</th>
<th>Vision/Overview</th>
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<tbody>
<tr>
<td><strong>Commonwealth</strong></td>
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<tr>
<td>Practice Nurse Incentive Program, Jan 2012 (Department of Human Services, 2012)</td>
<td>Supporting nurses to move into &quot;advanced roles&quot; in General Practice.</td>
<td>Supporting practices with a &quot;whole of practice&quot; approach to collaborate and create comprehensive systems to improve patient care. Targeting patients &quot;at risk of hospitalisation&quot;. Incentive payments to support expanded and enhanced roles for nurses working in general practice. Promotes integration - i.e. Practice Nurse acts as a key worker who coordinates, communicates, navigates and advocates for the patients at risk of hospitalisation. Coordinating comprehensive general practice care of patients &quot;at risk of hospitalisation&quot;. Nurses will case find patients for initial needs assessment, comprehensive assessment and care planning.</td>
<td><a href="http://www.medicareaustralia.gov.au/provider/incentives/pnip.jsp">http://www.medicareaustralia.gov.au/provider/incentives/pnip.jsp</a></td>
</tr>
<tr>
<td>Practice Incentives Program Aged Care Access Initiative, 2011 (Commonwealth of Australia, 2011c)</td>
<td>To encourage continuing improvements in general practice through financial incentives to support quality care, and improve access and health outcomes for patients.</td>
<td>• Incentive payments to GPs to encourage them to provide increased and continuing services in Commonwealth-funded residential aged care facilities and multipurpose services • Funding for the provision of allied health services to those residents.</td>
<td><a href="http://www.medicareaustralia.gov.au/provider/incentives/pip/files/gp-aged-care-access-incentive-guidelines.pdf">http://www.medicareaustralia.gov.au/provider/incentives/pip/files/gp-aged-care-access-incentive-guidelines.pdf</a></td>
</tr>
<tr>
<td>Chronic Disease Management (CDM) Medicare Items, August 2011 (Commonwealth of Australia, 2011a)</td>
<td>Clients receive care from a multidisciplinary team including a GP and have a GP Management Plan and Team Care Arrangement.</td>
<td>Enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. The items are designed for patients who require a structured approach to their care: 721- preparation of a GP Management Plan 732- review of GP Management Plan</td>
<td><a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement">http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement</a></td>
</tr>
</tbody>
</table>
| **Primary Care Infrastructure grants** (Australian Government Department of Health and Ageing, 2012c) | **Fund enhancements to existing premises to accommodate a broad range of PHC services** | Three streams of funding with grants ranging from $150,000 to $500,000 each. Funding is available to:
- Upgrade/extend existing premises to accommodate additional providers (e.g. GPs, nurses, allied health professionals, students)
- Provide access to new services according to local community health needs (e.g. preventive care, chronic disease management)
- Strengthen team-based approaches (e.g. case conferences)
- Provide extended hours for services
- Develop or enhance clinical training facilities. |
|---|---|---|
| **A National Health and Hospitals Network Agreement, 2011 (COAG, 2011a)** | **Deliver better health services and better hospitals by establishing National Health and Hospital Network.** | Funded nationally and run locally. Commonwealth responsibilities:
- Funding responsibility for public hospitals (60%)
- Investing 1/3 of GST revenue directly in health and hospitals
- Take over responsibilities for all GP and PHC services
- Establish LHNs
- Pay hospitals directly for each service they deliver, rather than block funding
- Bringing fragmented health and hospital services together under this framework. |
| **Australian Healthcare Agreements, 2011 (COAG, 2008)** | **Funding to assist the states and territories to provide free public hospital services to the Australian community.** | Hospital focus. Australian Health Care Agreements are negotiated bilaterally with each State and provide Commonwealth monies to the States in exchange for ensuring the States continue to provide free hospital care. |
| The Indigenous Chronic Disease Package, 2008 (Department of Health and Ageing, 2008) | A partnership between all levels of government to work with Aboriginal and Torres Strait Islander communities to achieve the target of closing the gap on Indigenous disadvantage. | Three main elements: chronic disease risk factors, management and follow-up care, and workforce expansion. Improve chronic disease management and follow-up care: The Medicare Benefits Schedule currently provides for routine health checks and chronic disease management items. However, the use of these by health service providers and the uptake by Indigenous Australians is limited. This measure will deliver a comprehensive approach to chronic disease management that seeks to encourage greater uptake of health checks and the provision of follow-up care in a coordinated, accessible and systematic manner. Incentives will be provided through the Practice Incentives Program to encourage general practices to improve the coordination of health care for Aboriginal and Torres Strait Islander people, including best practice management of patients with chronic disease. Greater support will also be provided for Aboriginal and Torres Strait Islander people to actively participate in their own health care, in addition to improved access to affordable medicines and multidisciplinary and specialist follow-up care for Indigenous Australians with a chronic disease. | http://www.health.gov.au/internet/ctg/publishing.nsf/Content/Indigenous-chronic-Disease-Package-factsheet/$file/6411%20COAG%20Indigenous%20Chronic%20Disease%20Overarching%20Fact%20Sheet%20SCREEN.pdf |
### Table 11  State and Territory policies that influence integration by means of a financing and incentives function

<table>
<thead>
<tr>
<th>Document</th>
<th>Vision/Overview</th>
<th>Elements Influencing Integration</th>
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<tbody>
<tr>
<td><strong>Western Australia</strong></td>
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<tr>
<td>Health Activity Purchasing Intentions, 2011-2012 (Government of Western Australia, 2011a)</td>
<td>Development and implementation of a state-wide health reform program such as Activity Based Funding and Management (ABF/ABM).</td>
<td>Integrating funding for integrated health services.</td>
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<tr>
<td><strong>Queensland</strong></td>
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<td>Nil</td>
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<td><strong>South Australia</strong></td>
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<tr>
<td>GP Plus Practice Nurse Initiative, 2007 (Government of South Australia, 2007a)</td>
<td>To increase the capacity of general practice by increasing the number of Practice Nurse roles. Enhancing the role of Practice Nurses.</td>
<td>Improve integrated care arrangements for people with chronic complex conditions and include the use of patient information systems to track and follow up patients, the use of multidisciplinary care teams in the provision of care, and support for patient self-management programs. Previously funded by Regional health services, nurses recruited and placed by DGP. Reduce workforce pressure on GPs in areas of high demand or areas with significantly high rates of chronic disease in metropolitan Adelaide.</td>
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<td><strong>Northern Territory</strong></td>
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<td><strong>New South Wales</strong></td>
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<tr>
<td><strong>Victoria</strong></td>
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</table>
| Integrated Care-Primary Health Programs Primary | Stipulates the funding arrangements for Primary Health through the Primary Health | Three elements:  
  - Unit-priced funding for direct care services  
  - Funding for health promotion activities |
| Health Funding Approach (PHFA) 2002-2009 (Victorian Government, 2008a) | Program. | Block funding for organisation infrastructure costs (development & resourcing). 
Aim: 
- Funding allocation process more transparent and equitable 
- Simplify administration (especially where organisations receive separate funding for similar services e.g. from HACC & PHC Programs) 
- More robust and meaningful indicators of performance 
- Allows benchmarking to identify good models for service delivery. |
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<tbody>
<tr>
<td>Tasmania</td>
<td>Nil</td>
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<tr>
<td>Australian Capital Territory</td>
<td>Nil</td>
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Integrated care: What policies support and influence integration in health care in Australia?

Table 12  Commonwealh and shared policies that influence integration by means of a service delivery function

<table>
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<tr>
<th>Document</th>
<th>Vision/Overview</th>
<th>Elements influencing integration</th>
<th>Access Document</th>
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<tbody>
<tr>
<td>More Comprehensive and Convenient GP and Primary Care, 2010-2011</td>
<td>Aims to ensure that as many people as possible have access to quality after hours GP services when they need them.</td>
<td>As part of its NHR, the Australian Government is committed to improving access to after-hours care, particularly in those areas where people currently struggle to get the care they need, when they need it. Healthdirect Australia: A health call centre was established enabling anyone, anywhere, to obtain health triage, information and advice. The service is accessible 24 hours a day, 7 days a week. Advice is provided by trained nurses and based on guidelines developed in collaboration with health professionals. This will include advice on where health and medical assistance might be obtained thus may influence service delivery.</td>
<td><a href="http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2010-hmedia03.htm">http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2010-hmedia03.htm</a></td>
</tr>
<tr>
<td>(Department of Health and Ageing, 2010b)</td>
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<tr>
<td>Taking Preventative Action: A Response to Australia: the Healthiest Country by 2020</td>
<td>Refocusing the health system towards prevention.</td>
<td>Seeks the better integration of prevention within primary care. Each state and territory has developed an individual plan for integration and dissemination of the resources within existing networks. Aim is to improve integration between local service providers, including with Indigenous health services as well as provide access to high quality, affordable and integrated after hours GP services.</td>
<td><a href="http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/6B7B17659424FBE5CA25772000095458/$File/tpa.pdf">http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/6B7B17659424FBE5CA25772000095458/$File/tpa.pdf</a></td>
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<tr>
<td>The Report of the National Preventative Health Taskforce, 2010</td>
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<td>(Commonwealth of Australia, 2010b)</td>
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<tr>
<td>Initiative</td>
<td>Description</td>
<td>Framework/Impact</td>
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<tr>
<td>Lifescripts Initiatives, 2009 (Department of Health and Ageing, 2009)</td>
<td>Provides general practice with evidence-based tools and skills to help patients address the main lifestyle risk factors for chronic disease.</td>
<td>Mentions referral to other providers. Framework for: • raising and discussing lifestyle risk factors with patients • advice (written script and associated patient education) • referral to other providers to support healthy lifestyle.</td>
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<tr>
<td>GP Super clinics, 2007-ongoing (Department of Health and Ageing, 2010a)</td>
<td>Proposes a model of service delivery that will support a flexible and responsive approach to local priorities as well as enabling the development of new or expanded roles such as GP specialists, nurse practitioners, lifestyle advisors and care coordinators.</td>
<td>This model of service delivery takes a population planning approach that includes: • Epidemiological evidence of the local community’s burden of disease. • Community consultation and engagement processes, especially to determine the health needs of vulnerable populations. • The alignment of services and strategic partnerships and links with existing diagnostic and PHC services (such as general practice, NGO, local government and private sector) in the community. Underpinning the service profile will be strong links to the local general practice, which will help determine the services required. This model proposes infrastructure that will impact on service delivery.</td>
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<tr>
<td>National Health Reform Agreement 2011 (Commonwealth of Australia, 2012)</td>
<td>To improve health outcomes for all Australians and the sustainability of the Australian health system.</td>
<td>Schedule E1 to S: GP and PHC. Commonwealth will take responsibility of system management, funding and policy development. Commonwealth will be in charge of the development of national strategic framework for PHC (due Dec 2012) on agreed future policy directions and priority areas with bilateral input from the states and territories. Influence integration of service delivery via initiatives including MLs, GP Super Clinics, infrastructure grants, practice nurse incentive, after-hours programs, additional training for health care professionals.</td>
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<td>Aboriginal Comprehensive Primary Health Care 2010 (South)</td>
<td>Comprehensive Primary Health Care (CPHC) prioritises dealing with health as a holistic process, which includes a strong emphasis</td>
<td>Refers to collaborative research programs with NHMRC funding. A systematic study of what makes CPHC, with all its complexity, work. Stage 1: Development of a program logic and evaluation framework for CPHC.</td>
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### Australian Community Health Research Unit, 2012

- **Program:** On working with families and the communities we live in.
- **Stage 1:** (2009 - mid-2010). The program logic will articulate how and why CPHC services are likely to lead to improved individual and population health outcomes. The model will be informed by interviews and workshops with funders, practitioners, and the community, and will be based on CPHC theory and values.

  Stage 2: Case studies of PHC services (2010 - 2013). The program logic model developed in Stage 1 will be used to investigate how services are delivered and their effectiveness at the six case study sites. The project will focus on two key health conditions: diabetes and depression. These conditions were chosen after consultation with stakeholders, including case study site managers. The project will examine where the services are contributing to individual and population health outcomes, and what barriers and challenges are faced by the services.

  Stage 3: Analysis. The analysis will tie the various aspects of the results into a coherent story about success factors in CPHC in the case study sites.

### Australian Primary Care Collaborative Program

- **Phase 1:** Flinders university, 2004 - 2007
- **Phase 2:** Improvement Foundation, 2008 – 2012 (The Australian Primary Care Collaboratives Program, 2010)

- **Program:** To improve clinical health outcomes, reduce lifestyle risk factors, maintain health for chronic and complex conditions and improve access to Australian general practice.

  **Phase 1 - Funding to 500 practices in 42 DGPs. Led to:**
  - Improved patient care through better management of chronic disease
  - Increased best practice care through better use of information systems (both medical and business systems)
  - Evolving roles among practice staff to better meet patient demand
  - A cultural shift from individual patient care to population-based care.

  **Phase 2 - Involved about 500 practices. Improvement Foundation (IF) has delivered more than 18 large-scale, state-based and national workshops, each bringing together up to 300 PHC staff from across Australia. IF also delivers virtual workshops and supports the facilitation of locally-based workshops across Australia.**

### Australian Better Health Initiative

- **Aims:** To refocus the health system to promote good health and

  **A joint Australian, State and Territory government initiative. This $500 million reform package aims to promote good health, disease prevention and early**

| (ABHI), 2006-2010 (Government of Western Australia, 2012a) | reduce the burden of chronic disease. | intervention, and improve integration and coordination of care for people in the community. The five priority areas for action are:  
- Promoting healthy lifestyles  
- Supporting early detection of risk factors and chronic disease  
- Supporting lifestyle and risk modification  
- Encouraging active patient self-management of chronic conditions  
- Improving the communication and coordination between care services. Evaluation by the National ABHI Evaluation Technical Reference Group. |
### Table 13  State and Territory policies that influence integration by means of a service delivery function

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<thead>
<tr>
<th>Document</th>
<th>Vision/Overview</th>
<th>Elements Influencing Integration</th>
<th>Access Document</th>
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<tr>
<td><strong>Western Australia</strong></td>
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| Improving the patient experience WA Cancer and Palliative Care Network, 2011 (WA Cancer and Palliative Care Network) | Focused on coordination at the patient level rather than integration of services. | Initiatives include:  
- Cancer Nurse Coordinators to facilitate a coordinated approach to cancer services so that the patient experiences an efficient and effective treatment pathway that is individualised and embraces multidisciplinary care. | [http://www.healthnetworks.health.wa.gov.au/cancer/home/index.cfm](http://www.healthnetworks.health.wa.gov.au/cancer/home/index.cfm) |
| Model of Care Implementation, 2009-2010 (Government of Western Australia, 2010a) | Shift from facilitating development of models of care to facilitating their transition into clinical practice. | Goal 3: ...receive care by the right person or team  
3.2 A multidisciplinary team will provide coordinated integrated care across the continuum of primary, secondary and tertiary services.  
| Falls Linkage Independence Program, 2007–2010 (Government of Western Australia, 2012b) | Pilot of a community-based falls prevention project to reduce the incidence of falls in older people (aged 65 years+). North Metropolitan Area Health Service Ambulatory Care Program in collaboration with the Perth Primary Care Network, Community Physiotherapy Services and the Falls Prevention Health Network. | The objectives of the project were to:  
- Engage and strengthen primary care partnerships across the continuum of care  
- Enhance the role of the community and non-health sector through education and training  
- Provide evidence-based falls prevention at every opportunity across the continuum of care  
- Foster communication and support between sectors to ensure the transition of older people is better managed.  
### Queensland

| Connecting Health in Communities Initiative (CHIC) General Practice Queensland (Queensland Government, 2002) | ...joint approach to establishing partnerships in the PHC sector to improve the health of Queenslanders and increase the capacity of the health system. Establishement of formal partnerships: Primary Health Care Partnership Councils (Partnership Councils). Geographical boundaries of the Queensland Health, Health Service Districts. Aims to enhance service coordination and share service delivery, target the reduction of risk factors and provide better primary clinical care. Each Partnership Council jointly identifies a priority and delivers shared PHC services from within the scope of the Government health priorities of chronic and complex care, integrated health promotion and illness prevention, early childhood health (including ante- and post- natal care), community mental health and drug and alcohol services. |

### South Australia

| Health Service Framework for Older people 2010-2016 (Government of South Australia, 2009b) | Deliver services that are integrated across the continuum of care; promote smooth transitions between the care settings that exists along that continuum; position at the ‘right places’ along the continuum of care, the right types of services that specialise in care of older people in ways that ensure the sustainability and efficacy of those services. Integrated interdisciplinary approach: Establishment of specialised interdisciplinary older people’s health care services that work across all care settings within a defined service catchment. This includes homes, residential care facilities, GP Plus Health Care Clinics, and the outpatient and inpatient areas (including rehabilitation services) of hospitals. 2.5 Greater integration between regional older people’s health services and transitional care programs including new governance and support arrangements. Key directions: 3.1 Better management of the interface between in hospital, in centre and in community health care services. 3.2 Integrate and coordinate mental health services for older people across the primary health, aged/community care, and specialist mental health services. 3.3 Improved access to rehabilitation and restorative services. 3.4 Streamline assessment processes. 3.5 Improved opportunities for involvement in decision making on end of life care |
| **Strategy for Planning Country Health Services in SA, 2009** (Government of South Australia, 2008c) | To achieve an integrated country health care system. | Improving the coordination and integration of services so as to present a complete system of health care to the patient (SA Strategic Plan Objective 2).

Enabling integration and coordination of services to support links between Country General Hospitals, Country Community and Local Area Hospitals and Health Services, metropolitan hospitals, aged care facilities, medical, nursing and midwifery and allied health practitioners, state-wide clinical networks and other community-based services.

Enabling integration and coordination between local Health Advisory Councils.

Exploring opportunities with health organisations in both public and private sectors, NGOs and the Commonwealth to further develop and enhance health services.

Ensuring clarity of roles and responsibilities of health care providers to enable a partnership approach between all stakeholders, providing the patient with a state-wide integrated system to service their needs. |
| **SA Health Strategic Plan, 2008-2010** (Government of South Australia, 2008b) | The four strategic directions to assist SA Health lead and deliver a comprehensive and sustainable health system aim to ensure healthier, longer and better lives for all South Australians. | 1. Strengthen PHC.
1.3 Facilitate effective coordination and continuity of care.
1.5 Provide appropriate services closer to where people live.

GP Plus is a strategy to provide better integrated health care closer to home for all South Australians through integration and collaboration between local GPs, allied health, mental health, drug and alcohol, nurse practitioner, counselling and other support services (from Glossary). |


### 3. Reform mental health care

3.4 Improve inter-agency coordination of service delivery to people with a mental illness who have high needs.

**Target 2.6 Chronic diseases:**
- Increase the capacity of the PHC system to respond to chronic disease.
- Provide integrated chronic disease care planning and care coordination based on a self-management model.

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<tr>
<td><strong>GP Plus Health Care Centre Model:</strong></td>
<td>Irrespective of their actual physical location there will be service integration between Community Mental Health Centres and GP Plus Health Care Centres.</td>
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<td>GP Plus Health Care Centres will help to advance and support the reconfiguration of the health system as outlined in the SA Health Care Plan.</td>
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<td></td>
<td>GP Plus is a strategy to provide better integrated health care closer to home for all South Australians through integration and collaboration between local GPs, allied health, mental health, drug and alcohol, nurse practitioner, counselling and other support services.</td>
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<td>Development of GP Plus Health Care Centres within metropolitan and country areas, beginning in localities that have been identified as having the highest need.</td>
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<td>Further enhancement of GP Plus Health Networks (previously known as Primary Health Care Networks) in metropolitan and country areas.</td>
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<td>Continuing the development of population-based health promotion activities that enable individuals, families and communities to take</td>
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<td>Initiative</td>
<td>Description</td>
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Improving with Age- Our Ageing Plan for South Australia, 2006

- Enabling choice and independence - in where we live, in getting around, connecting to our community and staying healthy.
- Delivering the right services and the right information - timely, responsive and tailored to the needs of individuals.
- Staying in front - through research, innovative practices and collaboration with others.
- Work with service providers to improve coordination and integration of consumer focused community services, residential options and hospital care.

New South Wales

Integrated Primary and Community Health (IPaCH) Policy (2007-2012) Implementation Plan (NSW Department of Health)

- An integrated and coordinated primary and community health care system working in partnership to promote the health and wellbeing of our community.
- Sets out the actions to be taken in achieving the aims of the Integrated Primary and Community Health Policy 2007-2012. For each priority stated, a strategy, or in most instances, a number of strategies have been identified to help achieve that priority.

Jan 2009. The Primary Health and Community Partnerships Branch of the NSW Department of Health, in consultation with stakeholders, will undertake a mapping...
| **Integrated Primary and Community Health (IPaCH) Policy, 2006-2011** (NSW Department of Health, 2006a) | An integrated and coordinated primary and community health care system working in partnership to promote the health and wellbeing of our community. | A number of IPaCH services are being established across NSW over the next three years. These services will aim to:  
- Improve assessment and treatment of short term common health problems  
- Improve early detection and intervention for health problems and risks  
- Improve management of chronic and complex conditions in collaboration with more specialised services.  

In these services, GPs and community health workers work together in multidisciplinary teams to deliver ongoing and coordinated care to communities, focusing on prevention, early diagnosis and the better management of people with chronic and complex conditions.  

The NSW IPaCH Policy provides the platform for the development and implementation of these crucial services. (Planned evaluation of the outcomes of this policy). |

- Telehealth electronic networking delivering specialist services from larger centres, and providing peer support and training to rural and remote health care providers.  
- Development of 18 new multi-purpose centres in small country towns. The Rural Hospital and Health Service Program is also ongoing with a further 18 centres to be developed over the next four to five years.  
- Nursing initiatives such as nurse practitioner services, education and training opportunities for rural nurses.  
- Medical workforce initiatives such as the Rural Medical- Undergraduate Program and the NSW Resident.  
- Medical Officer Cadetship Scheme (in conjunction with the Australian Department of Health and Ageing).  
- Improvements to the existing Isolated Patients’ Travel and Accommodation |
### NSW Multipurpose Service policy and operational guidelines ongoing from 1998-2010

(NSW Department of Health, 2010)

**MPS model calls for integration of health services.**

Integration may involve services becoming part of the MPS, services co-locating with the MPS or working with staff to provide care and service to the community.

Partnerships and coordinated efforts between a range of government and non-government agencies within local communities are promoted with the MPS model.

Where services do not integrate with the MPS, collaboration is required to ensure an effective range of services for the community. Partnerships need to be established and maintained with relevant service providers to meet the needs of the community. This includes partnerships that meet the cultural, spiritual and personal needs of residents and patients served by the facility.

As a minimum, MPS will evaluate their performance using an assessment approach that incorporates:

- Corporate governance
- Management, leadership & staffing policies (including staff participation)
- Clinical governance
- Continuous quality improvement
- Integration and continuity of care
- Statutory compliance and administration
- Risk management/safety
- Complaints management
- Consumer participation
- Specific standards covering the provision of a range of key health and aged care services appropriate to the service mix.

The evaluation framework chosen for MPSs in NSW is known as a Logic Model.

### Victoria

**Analysis of the Impacts of Service**

The PCP strategy aims to improve wellbeing for Victorians accessing Service coordination is a model through which agencies can come together to develop localised systems and processes. Agencies refer to members of the 32

<table>
<thead>
<tr>
<th>Primary Health Care Research &amp; Information Service</th>
<th>Integrated Care: What policies support and influence integration in health care in Australia</th>
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<tr>
<td><strong>Coordination on Service Capacity in the Primary Health Care Sector, 2004 (Department of Human Services, 2004)</strong></td>
<td>PHC through the creation of better networks, a coordinated approach to service provision and health care promotion. A significant component of the PCP strategy is Service Coordination, which aims to place consumers at the centre of service delivery. Local partnerships set up through the PCP strategy. Part of service coordination is service providers developing and using common tools and templates for initial contact with clients, initial needs identification, care planning and referral. Reported benefits of service coordination are improved efficiency of service provision, reduction in waiting times, more informed clients receiving tailored care, improved cross-program coordination, improved documentation and staff understanding of the system. Service coordination is affected by services’ location, IT infrastructure, PCP input, position in local network, change management and availability of change champions.</td>
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<tr>
<td><strong>Tasmania</strong></td>
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<tr>
<td>General Practice Tasmania Policy Statement</td>
<td>Delivering local health solutions through general practice. Divisions actively promote integration and linkages of different services and systems to enable local communities to have better and more coordinated access to necessary health services. Divisions also provide direct patient care through the employment of allied health professionals such as physiotherapists, dieticians and psychologists and by developing partnerships with other local primary care service providers. Identified “a significant lack of integration between the components of the State health system. The General Practice Tasmania Network strongly supports the need for greater integration in patient care and the development of a model that provides better linkages between care currently provided separately in the primary and acute care settings.” ...“Despite efforts to address this problem through initiatives such as the establishment of Integrated Care Centres (ICCs), the proposed model for ICCs remains unclear and concerns remain as to whether sufficient recurrent funding has been allocated to support new service models.” ... “Also believe that all public hospitals, both regional and rural, should be part of one integrated system with seamless entry, exit and transfer of patients with essential and appropriate systems and communication to facilitate a multidisciplinary and continuity of care approach.”</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>General Practice Tasmania</td>
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| Centres in Tasmania, May 2009: Position Statement from General Practice Tasmania (General Practice Tasmania, 2009b) | Network strongly supports the need for greater integration in patient care and the development of a model that provides better linkages between care currently provided separately in the primary and acute care settings. | 1. Integration cannot be successfully achieved merely with the co-location of services.  
2. The ICC model must exemplify innovation of ICC sites unless relocation yields greater opportunities for effective integration.  
10. ICCs should focus on step-up primary care delivering services for patients with chronic and complex care needs including those not well serviced by the current system, via referral only.  
11. ICCs must not detract from or reduce services available to patients in rural areas. Equity in access to services for those patients in areas not covered by an ICC must be assured.  
12. The service model must meet the expectations of GPs particularly in relation to referrals in and out of the centre and their participation in case management.  
13. Adequate investment in information systems to support clinical communication between service providers will be essential.  
14. The service model must provide quality teaching, learning and research opportunities including the potential for clinical attachments. |
|---|---|---|
| Tasmania’s Health Plan Clinical Services Plan: Update | Endorses the key principles established for Tasmania’s health services in the 2007 Clinical Services Plan. | Department will finalise its policy and planning framework for ICCs by July 2008, enabling progression to a detailed model of care and facility planning. Implementation commitment:  
23. The Tasmanian Government will seek to agree on a robust performance monitoring and reporting framework with the Australian Government to ensure that both the NWRH (Burnie) and the Mersey Community Hospital contribute equitably to the provision of an integrated health service for the region by December 2008.  
In endorsing Tasmania’s Health Plan, the State Government adopted (among others) the following key principle for Tasmania’s health services:  
• integrated through effective service coordination and partnerships between providers.  
During consultation for the development of the 2007 Clinical Services Plan, many... |
<table>
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<tr>
<th>Services, 2008b)</th>
<th>Stakeholders suggested that the allocation of responsibility for acute and PHC to separate divisions of the Department was a major barrier to integrating care at an operational level. In March 2008 the Minister and the Secretary of the Department announced a reorganisation of the Department to increase its focus on patients and clients and better reflect priorities under Tasmania’s Health Plan. Key integration feature of the reorganisation includes bringing together acute hospital and primary health functions. Decisions about these and other relevant issues will need to be reached as planning for Tasmania’s ICCs proceeds. Effective planning and management of these facilities will enable many patients, particularly those with chronic and complex conditions, to receive multidisciplinary care that will reduce their need for inpatient care and enable better management of their health and wellbeing.</th>
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<tr>
<td>Tasmania’s Health Plan Clinical Services Plan, 2007 (Tasmanian Department of Health and Human Services, 2007c)</td>
<td>Tasmania’s health services will be: • accessible - as close as possible to where people live, if services can be delivered safely, effectively and at acceptable cost • appropriate to community needs • client and family-focused • integrated through effective service coordination and partnerships between providers • designed for sustainability. Integrated Care Centres (ICC): The Department will convene a multidisciplinary ICC policy and planning group immediately to develop, consult on and finalise a policy and planning framework for ICCs by July 2008, which will support a subsequent detailed model of care and facility planning. Where services cannot be delivered safely, effectively and at acceptable cost locally, access will be facilitated through service coordination, transport assistance and other appropriate support.</td>
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