Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level?

Executive summary

Fragmentation is at the heart of the ineffectiveness of our increasingly frantic efforts to nurture improvement (Stange, 2009, p 100).

Historically, general practice has been the principal access point for health care delivery in the Australian community. Alongside the growing trend in specialised care, there has been increased fragmentation of health care services, particularly for patients with multiple and/or complex conditions. In Australia and elsewhere, governments recognise that there are multiple health, social and economic implications of fragmented health care; and an integrated health care system is an integral element of health reform. Increasingly, evidence suggests that integrated primary health care (PHC) is an effective way to optimise the efficient delivery of services and improve patients’ outcomes and experiences (Ham and Curry, 2011).

Patients often negotiate many different types of services that impact on their overall health and wellbeing. Therefore, a major challenge is to enable health care to be integrated across different service providers in diverse organisations. A number of organisations and agencies have been established to act at the local/regional level to facilitate linkages and networks between the various health service providers and provider organisations. These organisations operate at the meso level, between policy (macro) and service delivery (micro), to facilitate integration between diverse providers, with the ultimate aim of improving the patient’s journey through the health system.

Aims

This report, which is the third in a series on integrated PHC, examines integration at the meso level. It aims to identify meso level organisations in Australia (and internationally) and discuss their roles in enabling integration in PHC, explore the models and mechanisms for integrating care in Australia and internationally; identify the challenges and enablers of different approaches to facilitating integration

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1 Meso: For the purposes of these reports, meso level integration refers to the activities that organisations and agencies undertake to support integrated care. Meso level organisations generally do not deal directly with patients, but rather interact with other organisations and agencies to facilitate integrated care (Smith, 2007).
across health service provider organisations; highlight promising approaches to integration; and identify potential unintended consequences of integration efforts. Executive summary

Scope
This report examines vertical and horizontal integration at the meso level within the Australian health system with some additional international examples provided. Where possible, this review includes evidence of best practice in Australia and internationally. Other countries are limited to those with comparable health systems and/or those with relevant models of integration that may be applied in the Australian setting (e.g. New Zealand, England, Canada, United States).

Findings from the literature review
A broad range of meso level organisations and peak bodies that play a role in integrated care were identified, including: PHC (e.g. Medicare Locals); allied health; community health (e.g. Aboriginal Community Controlled Health Services); hospitals (e.g. Local Hospital Networks); medical specialties; arms-length bodies; non-health organisations; and research organisations that contribute to knowledge exchange and linkage between relevant organisations and agencies. Governments at all levels also play a role in promoting and enabling integration across sectors.

In Australian PHC, the Commonwealth government’s key strategy to integrate health care has been the establishment of 61 Medicare Locals (MLs). MLs are Primary Health Care Organisations (PHCOs) that have a remit to focus on integration of health care services more broadly in their geographic area, particularly in terms of the needs of the local community.

Australian models of meso level integration
Some of the main models of meso level integration that have been implemented in different Australian states and territories include:

- Primary Care Partnerships (Victoria)
- Connecting Healthcare in Communities (Queensland)
- Primary Care Integration Program (NSW)
- Comprehensive Primary Health Care: a range of different initiatives including Primary Care Amplification Model; Brisbane South Comprehensive Primary Care Network; Uni-Clinic Cessnock
- Aboriginal and Torres Strait Islander-specific organisations and models: Aboriginal Community Controlled Health Services; specialist outreach services and clinics; framework for PHC in the NT; Australian Better Health Initiative (NT).

While the literature base was replete with descriptive articles and reports, evaluations of effectiveness in terms of meso level integration outcomes were very scarce and offered very little details related to integration at the meso level.

International organisations and models of meso level integration
Internationally there are a number of similar organisations that act to improve integrated health care, including:

- Independent Practitioner Associations and Primary Health Organisations (NZ)
- Primary Care Trusts and GP Consortia/Clinical Commissioning Groups (England)

Arms-length bodies is a term coined in the UK to represent executive agencies, independent special health authorities, or non-departmental public bodies (http://www.dh.gov.uk/health/category/arms-length-bodies/).
- Local Health Integration Networks, Primary Care Networks and Divisions of Family Practice (Canada)
- Health Maintenance Organisations and Accountable Care Organisations (US).

The key international models are:
- Integrated Delivery Systems (US)
- Accountable Care Organizations (US)
- Patient-Centered Medical Home (US)

While some evaluations of effectiveness of international models of meso level integration were identified, outcomes were primarily reported at the level of service delivery (micro level integration), which will be presented in Report 5 in this series (Integrated care: What can be done at the micro level to influence integration in primary health care?).

**Mechanisms identified in the models**

The key mechanisms that were contained in the various models, both in Australia and internationally, fell into three main categories based on the WHO framework for functions of a health system:

- **Stewardship**: Governance, regulation, sustainability
- **Creating resources**: Partnerships, engagement and communication, data and evidence, eHealth, Infrastructure
- **Financing**: Funding and financing arrangements, balancing competition and integration.

Few research studies have evaluated the effectiveness of mechanisms at the meso level of integration.

**Challenges and enablers of integration**

The challenges and enablers for meso level integration fell into five main categories. To facilitate integration both between PHC organisations and across different sectors and levels of the health system, meso level organisations need to consider these factors:

- **Communication**: strong communication, networking and exchange of information amongst stakeholders; clarity of aims, objectives, goals, roles and outcomes; and transparency in use of funds and accountability are necessary conditions for successful integration initiatives
- **Organisational culture**: Strong leadership – managerial and clinical; flexibility and adaptability to changing needs; an appropriate pace of change; and working with existing collaborations
- **System and structural arrangements**: Inclusive, shared board membership and joint governance; alignment of boundaries to facilitate coordination of planning and service delivery; formal contracts/informal partnerships agreements; favourable political climate; adequate accountability and evaluation structures; realistic timeframes to allow change to occur; registered/enrolled patient population
- **Information technology and resources**: Adequate resources (human, administrative, financial) to support integration efforts; development of skills/experience in planning, commissioning, purchasing; investment in IT for data collection, sharing, privacy and security; technical support for IT and training
- **Funding arrangements**: capitation or blended payment systems; adequate funding for establishment and maintenance of integration efforts.

For some populations, particularly those living in rural and remote areas, there are few services available to integrate. These populations rely on additional strategies to bring them to the services
(e.g. partnerships with public transport services) or vice versa (e.g. Outreach services). A framework for PHC has been developed in the NT to address the challenges of health service delivery, particularly for Indigenous Australians living in remote areas.

Similarly, for culturally and linguistically diverse (CALD) populations, there are many challenges to navigating an unfamiliar health system; and engaging appropriately with CALD communities is essential to facilitate their interactions with integrated health services.

The research also identified a number of potential risks/unintended consequences of integration, including:

- Perverse incentives: under-serving, over-serving, selective servicing and ‘gaming’ depending on the type of incentive offered
- Health insurance: risk selection, adverse selection of patients that influences costs and cover
- Integration vs. competition: tension may hinder integration
- Change fatigue: may lead to conflict, resistance to change and high staff turnover.

**Summary**

It is clear from the literature that there is an ongoing tension between central and regional control of health service planning and delivery. The advantage of central control is greater consistency across organisations, alignment with national priorities etc. However, the trade-off is potential loss of local context, reduced engagement of providers etc (McDonald et al., 2007). Over time, the focus has shifted back and forth both in Australia and elsewhere.

In Australia, meso level organisational integration has largely relied on good will, memoranda of understanding (MOUs) and formal or informal agreements related to partnerships. This has led to local innovation but it has been patchy across regions and success is dependent on strong leadership, common objectives, and clarity of roles, responsibilities and accountabilities.

It is unlikely that a one-size-fits-all approach to integration will be an advantage. Planners and policy makers may need to consider using sets of complementary mechanisms, structures and processes to create an integrated system that fits the needs of the population across the continuum of care. Careful management of change is essential, focussing on a limited number of stakeholder-approved specifications required to induce a shift towards integration. Evidence suggests that large scale, imposed, realignment of complex systems is often destabilising, resisted, unmanageable and unproductive. Any major initiative should be flexible enough to accommodate contextual factors to shape aspects of a new model at the local level.

Importantly, in order to have reliable evidence for decision-makers, evaluation needs to be included, for the purpose of accountability and to develop a better understanding of the effectiveness and impact of health systems integration (Armitage et al., 2009). There is little empirical evidence of the impact of meso level integration on the subsequent delivery of integrated health care. This is due largely to the lack of consensus on how to define it, measure it and implement it; and the lack of a suitable conceptual framework to guide integration at the organisation or systems level (Hogg et al., 2008, Martin and Sturmberg, 2005). Selecting appropriate indicators to measure performance will also be a key challenge.

From the available literature evidence, the main strategies and other arrangements that are more likely to support and influence integration at the meso level are:
Five key findings

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<td>Integration of organisations at the meso-level does not guarantee integrated health service delivery; however, some of the leading models (i.e. Integrated Delivery Systems) show significantly improved health outcomes, cost reductions and evidence of integrated health service delivery across the health system (both vertically and horizontally).</td>
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<td>The mission to integrate health service delivery involves engagement of numerous health and non-health organisations and providers, across multiple levels (horizontal and vertical) involved in the delivery of health services.</td>
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<td>In Australia the overlapping roles of the commonwealth and states for the delivery of health services makes identifying who is responsible and accountable difficult. The system is complex which influences its efficiency with regard to integrated service delivery.</td>
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<td>Strategic and targeted financial incentives are required to deliver both long-term and short-term outcomes for integrated service delivery. Voluntary participation and goodwill facilitate health service integration.</td>
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<td>Infrastructure is necessary to support coordination (e.g. shared records), needs assessments and longitudinal measurement of both population and individual health outcomes.</td>
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Conclusions

Health system integration is not a final destination for PHC, but rather a means of achieving improved performance, whilst at the same time adding value to the system, program, community, patients and providers (Armitage et al., 2009). The siloed structures of the past, built in part to preserve professional autonomy, are difficult to align with the inter-professional approaches demanded by systems thinking. Creating agile, responsive, intelligent systems that learn from feedback, reduce unnecessary duplication and harness the creativity of those within and beyond the traditional borders of health systems demands new ways of working. These new modes of working should seek to integrate across disciplines, hierarchies, departments and specialties. The literature suggests identification of appropriate partners in order to grow relationships and build local capacity; and learnings may be generated from feedback in order to adjust, adapt, dissolve and regenerate to meet the changing needs of health systems.

Historically, given the disruptions caused by major re-structures of health systems, changes that rely on inter-organisational relationships are often difficult to implement and appear overwhelming. However, with good planning, leadership, adequate resources, flexibility and realistic objectives, well-chosen meso level initiatives are capable of achieving improved integration of health care.