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POLICY OPTIONS

A framework for integrated primary/secondary health care governance in Australia: results of a systematic review

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Policy context

CURRENT SETTING AND POLICY

In 2009 Australia's National Health and Hospitals Reform Commission Report first recommended significant governance change as an important element in increasing the effectiveness and efficiency of health care delivery. In turn, regional service integration was one of the five key building blocks in Australia's First National Primary Health Care Strategy (2010).

Federal government reforms in 2011 created meso-level organisations - Medicare Locals and Local Hospital Networks (LHNs) (in some jurisdictions Local Hospital Districts) For the goals of health reform to be realised it was suggested these organisations must work together to achieve co-ordinated and integrated primary healthcare services. In the 2014-15 budget, the Australian Government announced the establishment of Primary Health Networks (PHNs) to commence 1st July 2015. In the media release on 'Rebuilding Primary Care, 13th May 2014, it was stated, 'PHNs will work to ensure services across the primary, community and specialist sectors work together'.

Given the priority placed on effective governance frameworks to deliver clear roles and responsibilities to both funders and providers of health care, the governance vehicle best suited to achieving our national reform outcomes has not been developed. A governance framework that supports bringing historically-disparate partners together into formal agreements is essential to creating the 'business rules' and sustainable environment required achieving the new care models we seek.

Policy options

Fragmentation of health services, largely caused by the split between federal and state government funding responsibilities in Australia, has created a complex, rapidly changing, and often impersonal health system that is increasingly difficult and frustrating to navigate. To ensure Australia's health system is sustainable, safe, fair, and agile enough to respond to changing health needs recommendations were made to change the governance model. Governments have describe how public hospitals will be brought together with Medicare Locals via LHNs to coordinate and integrate primary health care services, jointly aiming to better coordinate services within sectors, however, the processes to integrate primary with secondary care remains an enigma.

RECOMMENDATIONS

We recommend:

1. It is essential to gain consensus about integration targets which must be put into a strategic framework and agreed between partners to fulfil common integration goals. The focus should be on the ends not the means – what people want and need in terms of care and support and how services are put into place to achieve these outcomes. Macro-level structural reforms alone are insufficient to deliver integrated care as they need to be linked to meso-level and micro-level reforms. In turn, integration agendas must be underpinned by effective governance mechanisms that are appropriate to the undertaking, the stakeholders involved, and the scale of delivery.
2. No one single model of integrated care fits all systems, however the elements described provide a focus for setting out integration initiatives which need to be flexible to be adapted to local conditions and settings. The elements described form a framework for integrated primary/secondary health care governance, applicable to an international community, which allow optimal linkage between meso-level organisations. This information can be used to strengthen the link between evidence, policy development and program implementation. There are examples of successful projects based in primary care organisations, some in partnership between NGOs, local government and primary care, and others led by hospitals working closely with colleges, primary and community services. It is this variety of schemes tailored to meet local need that needs to be supported.
3. Further research is needed to provide empirical evidence that integration at scale across primary/secondary care provides the clinical, financial and system benefits it aspires to and how the elements described can help achieve this. The lack of research in this area is one that needs to be addressed given the drive and expectation of integrated care in the future.
4. We need to document, evaluate and share lessons learnt in trying to effect change. Within the change process how do we link macro, meso and micro reform? We suggest the ten elements as a starting point along with a realistic synthesis evaluation of the process, as we cannot know what we do not measure.
5. Finally, looking forward, what the system needs now is a political mandate articulating desired outcomes for patients and families, leadership at macro, meso and micro level to support system change, and willingness to invest and share risk in determining new models' fit for the future.

Key findings

Examples of successful primary/secondary care integration reported in the literature have focused on a combination of some, if not all, of the ten elements described below, and there appears to be agreement that multiple elements are required to ensure successful and sustained integration efforts. Whilst no one model fits all systems these elements provide a focus for setting up integration initiatives which need to be flexible for adapting to local conditions and settings.

Table 1: Elements of the integrated governance models identified in published papers (n=21)

Element	**Interventions shown to be effective**	n= *
1. Joint planning	Joint strategic needs assessment agreed; formalising relationships between stakeholders; joint boards; promotion of a community focus and organisational autonomy; guide for collective decision making; multi-level partnerships; focus on continuum of care with input from providers and users.	18
2. Integrated information communication technology	Systems designed to support shared clinical exchange i.e. Shared Electronic Health Record; a tool for systems integration linking clinical processes, outcomes and financial measures.	17
3. Change management	Managed locally; committed resources; strategies to manage change and align organisational cultural values; executive and clinical leadership; vision; commitment at meso and micro levels.	17
4. Shared clinical priorities	Agreed target areas for redesign; role of multi-disciplinary clinical networks/clinical panels; pathways across the continuum.	16
5. Incentives	Incentives are provided to strengthen care co-ordination e.g. pooling multiple funding streams and incentive structures, such as equitable funding distribution; incentives for innovative and development of alternative models.	15
6. Population focus	Geographical population health focus.	13
7. Measurement – using data as quality improvement tool	Shared population clinical data to use for planning, measurement of utilisation focusing on quality improvement and redesign; collaborative approach to measuring performance provides transparency across organisational boundaries.	12
8. Continuing professional development supporting the value of joint working	Inter-professional and inter-organisational learning opportunities provide training to support new way and align cultures; clearly identifying roles and responsibilities and guidelines across the continuum.	11
9. Patient/community engagement	Involve patient and community participation by use of patient narratives of experience and wider community engagement.	8
10. Innovation	Resources are available and innovative models of care are supported.	7

* Number of studies reporting the specified element (total n=21)

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