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Integrated care: What policies support and influence integration in health care across New Zealand, England, Canada and the United States?

Report 2

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List of Abbreviations

ABF	Activity based funding	
ACO	Accountable Care Organisation (US)	
AHS	Alberta Health Services	
CHIP	Children's Health Insurance Program (US)	
CIFA	Canadian Initiative on Frailty and Aging	
CLSC	Centre Local de Services Communautaires (Quebec)	[Community Health Centres]
CMS	Centers for Medicare and Medicaid Services (US)	
CSSS	Centre de Santé et de Services Sociaux (Quebec)	[Health and Social Services Centres]
DFP	Divisions of Family Practice (BC)	
DHB	District Health Board (NZ)	
DHHS	Department of Health and Human Services (US)	
EMR	Electronic Medical Record	
FFS	Fee-for-service	
FHT	Family Health Teams (Ontario)	
FMGs	Family Medicine Groups (Quebec)	[Groupes de Médecins de Famille]
GDP	Gross Domestic Product	
GMF	Groupes de Médecins de Famille (Quebec)	[Family Medicine Groups]
GP	General Practitioner	
GPSC	General Practice Services Committee	
HMO	Health Maintenance Organization (US)	
HSSC	Health and Social Services Centre	[Centre de Santé et de Services Sociaux]
IFHC	Integrated Family Health Centres (NZ)	
IPA	Independent Practitioner Association	
LHIN	Local Health Integrated Network (Ontario)	
ML	Medicare Local	
MoHLTC	Ministry of Health and Long Term Care (Canada)	
MSSP	Medicare Shared Savings Program (US)	
NHS	National Health Service (England)	
NSF	National Service Framework (England)	
OECD	Organisation for Economic Cooperation & Development	
P4P	Pay for Performance	
PbR	Pay by Results	
PBC	Practice based Commissioning (England)	
PCI	Primary Care Initiative (Alberta)	
PCT	Primary Care Trust (England)	
PFF	Patient focused funding	
PHC	Primary Health Care	
PHCO	Primary Health Care Organisation	
PHO	Primary Health Organisation (NZ)	
PPACA	Patient Protection and Affordable Care Act (US)	
PROMs	Patient recorded outcomes measure	
RHA	Regional Health Authority	
SCNs	Strategic Clinical Networks	
SHA	Strategic Health Authority (England)	

Executive summary

Context

One of the key challenges for health systems worldwide is the substantial cost of fragmented care, not only financially, but also in terms of patient and population health. In light of this, integrated health care has been a key element of health reforms internationally. Despite substantial diversity in health systems across developed countries, there is consensus that current health care expenditure is unsustainable, particularly in the context of ageing populations with increasing prevalence of chronic disease and multi-morbidities. The universal challenge is to improve the quality and safety of health care and, concomitantly, to curb the rising costs of health care delivery. Evidence indicates that health systems with strong integrated primary health care (PHC) at their core are both effective and efficient at delivering appropriate services where they are needed most. Although Australia is comparable to New Zealand (NZ), England, Canada, and the United States (US) in terms of expenditure and coverage of PHC, recent evidence suggests that there is room for improvement in Australia on indicators of integration including access, cost, coordination, information sharing and chronic disease management, which may reflect the fact that, for the most part, these countries have been working at ways to achieve integrated health services for longer than Australia.

Aim

The aim of this report was to identify PHC policies that influence integrated care in regions of NZ, England, Canada and the US; and to examine mechanisms within these policies that enable health service integration at the macro level, with a view to informing integrated care policies in the Australian health care system.

Scope

For this report, 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 include agreements, policy directives, position statements, submissions, discussion papers, options papers and briefs. The World Health Organization (WHO) framework (WHO, 2000), which outlines four key functions of policy (stewardship, creating resources, financing and incentives, and service delivery) will be used to guide the examination of international policy documents identified in this report.

Findings

There are eight key findings from this policy review, which are relevant to the WHO policy functions:
Stewardship

1 All countries in this review placed strong focus on establishing a model of Primary Health Care Organisation with a shift away from centralised governance towards more tailored regional approaches.
2 There is a trend toward centralisation of regulatory bodies and standardised approaches to monitoring performance and accountability.
3 Whole of system approaches are common, inviting the involvement of other sectors in health care, particularly social services, housing and employment with flexible governance arrangements.

Creating resources

4 Future workforce planning is consistently valued, with a strong focus on training and expanding the scope of providers to work at the top of their licence.

5 Multidisciplinary teams and involvement of a variety of health care providers are the most common initial steps towards integration of services.

Financing and incentives

6 Financing developments have seen funding via pooled budgets and greater financial accountability for expenditure by rewarding high quality, efficient delivery of services and passing costs of overspending back to the providers/organisations.

Service delivery

7 There is emphasis on improving the consumer's experience and satisfaction with health services but also including consumers' voices and choices in decisions about the delivery of services in their local areas.

8 There was little explicit reference to how improvements in well-integrated services would be delivered. The level of evidence on evaluation, definition, and measures of integration, despite common reference, were limited.

Analysis

Policies that combine clear meso and micro level plans have been shown to achieve more integrated care. For example, in an evaluation of NZ policies, poor integration has been attributed to separate responsibilities for financing and delivery of PHC services; and the enduring lack of trust between government and health care providers, which has shaped the kinds of policies that governments are prepared to consider. This was also evident in Quebec, Canada, where providers did not join Community Health Centres, preferring to work autonomously in private practice. Thus, when establishing the new Family Medicine Groups, the government used financial incentives as a policy lever to encourage these providers to work together to provide integrated care. The financing function of policy is frequently the main mechanism used to influence integration by way of budgets, incentives and allocation of resources. Accomplishing precise financing mechanisms is critical for avoiding perverse incentives, engaging relevant stakeholders, and maintaining transparency and accountability.

Results of evaluations suggest that a number of other mechanisms that have previously been successful in different countries (particularly those from Canada and NZ), could be readily adapted to suit the Australian context. Similar challenges arise across countries, such as developing links across jurisdictions as well as between primary and acute care providers; establishing efficient, cost-effective and aligned systems of funding health care services; and creating provider incentives to deliver quality care within constrained budgets.

Conclusions

Although there are considerable differences in the health systems, political environments, historical contexts, financing systems, insurance coverage and format of PHC organisations across the countries examined, each country faces similar challenges in their endeavours to provide good quality, effective and efficient integrated care. This report identified several key elements that may facilitate integration. Some of the enablers are considered more demanding to establish in the current Australian context (e.g. patient enrolment), whereas others could be incorporated more readily (e.g. financial incentives to providers to join networks). Perhaps the most critical elements relate to realistic timeframes for planning and developing, establishing effective collaborations and developing adequate measures to evaluate health outcomes to inform future policy development.

Context

Evidence indicates that health systems with strong integrated primary health care (PHC) at their core are both effective and efficient at delivering appropriate services where they are needed most (Starfield et al., 2005).

This report is the **second** in a series related to integrated health care. Each report addresses different aspects of integration at one of three levels: macro, meso, micro:

- **Macro** (system) level governments and agencies are responsible for national and/or regional level policy, funding strategy and enabling infrastructure.
- **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.
- **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.

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

Report 1 examined integration at the **macro** level and provides a map of Australian policies that are relevant to integration in Australian primary health care (PHC). In particular, Report 1 identified the relevant policies, agreements or other official statements and frameworks that focused on integration and PHC services at both Commonwealth and State/Territory levels, including integration across the private and public sectors. This second report examines a number of international policies that address integrated care, particularly those implemented in across parts of NZ, England, Canada and the US that may be relevant to the Australian context.

Background

Despite differences in the way countries fund and deliver health care, all health and social care systems around the world face the same challenges: to improve the quality and safety of health care; and to reduce costs by improving the efficiency of health care delivery (Blumenthal and Dixon, 2012). Recent data (2010) showed an average of 9.5 per cent of gross domestic product (GDP) in Organisation for Economic Co-operation and Development (OECD) countries is spent on health (OECD, 2012). While Australia's expenditure is approximately 9.1 per cent GDP, other countries range from 6.1 per cent in Mexico to 17.6 per cent in the US. Evidence also shows that the burden of disease is moving away from acute illness towards long-term chronic illness and multiple co-morbidities (Mur-Veeman et al., 2008). Thus, the rising cost of health care and simultaneous increasing prevalence of long-term chronic conditions in ageing populations has spurred governments worldwide to find new ways to address the 'triple aim' of (Berwick et al., 2008):

- Improved patient experience of health care (quality and satisfaction)
- Improved health of populations (better health outcomes for the community)
- Reduced per capita cost of health care (more efficient health systems).

One of the key challenges for health systems is the substantial cost of fragmented care not only financially, but also in terms of patient and population health (Enthoven, 2009, Stange, 2009). Increasingly, evidence indicates that health systems with strong integrated PHC at their core are more effective and cost-effective at delivering appropriate health care services where they are needed most (Kodner, 2009, Starfield et al., 2005).

Integration and integrated care

The terms, 'integration' and 'integrated care' have multiple definitions and meanings. For example, integration may occur 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. Report 1 in this series (*Integrated care: What policies support and influence integration in health care in Australia?*) provides a more detailed explanation of the different definitions, levels and ways these terms have been used. A list of common definitions is provided in Table 11 (Appendix). For the purposes of this report, the WHO definition of integrated care has been used:

> *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 (WHO, 2008).*

Profiles of health systems

The context in which health care is provided and the system that underpins integrated care may impact substantially on the quality, efficiency and effectiveness of health service delivery in different populations. This section summarises health systems from countries reviewed in this report as background to the policy environment. A recent Commonwealth Fund report (Thomson et al., 2012) provides an excellent overview of health care systems in Australia and across 14 other countries. For this review, the characteristics, performance indicators and factors specific to integrated service have been included for Australia, New Zealand (NZ), England, Canada and the United States (US) in Table 12 through to Table 14 (Appendix). NZ, England and Canada have been chosen for this review as they have some similarities to Australia in terms of health system structure and funding. Canada is particularly useful as a comparator as it has the added complexity of provinces, which reflects the challenge that Australia faces to integrate health care across States and Territories. While the US

health system is structurally and economically different to Australia, integration has been a core focus of US health care policies and many elements of US integrated care may be adapted to inform integration policies for the Australian setting. In addition, each country faces similar challenges, including health workforce to population ratios; growing cohorts of older health consumers; increasing rates of chronic disease; indigenous and culturally and linguistically diverse populations; and regional and remote health service delivery.

Table 12 provides a summary of financing and coverage across the health care systems in this review. In short, except for the US, other countries have some form of universal public health insurance or National Health Service. Public health systems are financed primarily through general tax revenue – except in the US, which is mainly financed through payroll tax. The proportion of people with private health insurance varies across countries, from 11 per cent in England to around 67 per cent in Canada, for buying access to private facilities and/or non-covered benefits (Australia ~50%). Out-of-pocket expenses for patients are generally not capped. Most countries have some form of exemptions or protection for low-income, older people, and children; England also has exemptions for some disabled and chronically ill people. Table 12 also provides a summary of health system performance indicators. In short the proportion of GDP spent on health care ranges from 9.1 per cent in Australia to 17.6 per cent in the US. Health care spending per capita is lowest in NZ ($3 022) and highest in the US ($8 233), based on a standardised purchasing power parity adjustment[i] (Australia $3 670). The number of doctors per 1 000 population ranges from 2.4 in the US to 3.1 in Australia. The proportion of PHC providers using electronic medical records is highest in NZ and England (97%), followed by Australia (92%) and lowest in Canada (56%).

Table 13 provides a summary of ownership and payment arrangements for PHC providers. Countries included in this review predominantly have privately owned PHC practices, whilst hospitals are mostly public (with some private), except in the US, which has around 15 per cent public hospitals. PHC providers in most countries are reimbursed largely through a mixture of capitation and fee-for-service (FFS); Australia is mainly FFS. Most PHC patients in NZ and England are registered and some in Canada.

Given the focus of this report, Table 14 is of particular interest as it provides a summary of health system performance indicators pertaining to integrated service delivery including access, care coordination and chronic care management. To summarise, access to same-day or next-day appointments ranges from 45 per cent in Canada to 78 per cent in NZ (Australia, 65%) and after-hours care is difficult for 59 per cent of Australians, compared to 38 per cent of people in NZ and England, and up to 63 per cent in the US. Access due to cost was a barrier for 22 per cent of Australians, compared to England (5%) and the US (33%). Poor coordination related to medical records or tests affects 19 per cent of Australians compared to 13 per cent in England and 27 per cent in the US. Key information was not shared among providers in 12 per cent of Australian cases; the lowest proportion was in England (7%) and the highest among our five countries of interest was the US (17%). Access to chronic care management between regular visits to health care providers is easy for 81 per cent of people in England, but only 59 per cent of Australians.

This review maps international policies which target integration of health service delivery in other countries. This review is important because whilst Australia is comparable to the other four nations described above across financing and coverage, we lag behind on the provision of integrated service

[i] Purchasing Power Parity (PPP) is an economic theory that estimates the amount of adjustment needed on the exchange rate between countries in order for the exchange to be equivalent to each currency's purchasing power.

delivery. This is evident by the lack of access; cost barriers, poor coordination of resources, insufficient information sharing across providers and chronic disease management issues identified in this Commonwealth Fund report.

Aim

This is a review of international policies related to integrated care in PHC. It includes policies specifically targeting delivery of health care services within PHC (between professional organisations) and between PHC and related health areas, for example hospitals.
The overall aim is to identify international integrated care policies to inform Australian policy-makers. Policies included in this review will be derived from regions in the following nations:

- New Zealand (NZ)
- England
- Canada
- United States (US).

Research Questions

The main research questions for this report are:

- What are the relevant policies that focus on integration and PHC services in NZ, England, Canada and the US?
- What policy-related elements are barriers to achieving integration in these countries?
- What policy-related elements enable integration in these countries?

The next (**third)** report in this series will examine meso level integration to identify the organisations, models and mechanisms that enable integrated care.

Scope

Given the limited timeframe for this report, regions/countries were selected on the basis that they were comparable in terms of the organisation, funding and delivery of PHC and the regions selected had similar health system challenges as discussed in the background section above. Although integrated care ultimately aims to link together service providers and organisations to deliver appropriate, comprehensive and coordinated care to individuals and families, this report explores the policy documents (e.g. policy statements, frameworks, directives, etc.) that provide an overarching vision for integrated care. These policies should contain strategies that governments use to enable delivery of integrated health care services.

These policy documents and strategies are underpinned by four functions of health care systems outlined in the WHO framework[ii] (2000):

- **Stewardship**: the overarching function that deals with governance, information dissemination, coordination and regulation of the health system as well as ensuring an equitable health system for purchasers, providers and consumers of health services
- **Creating resources**: this function relates to policies that ensure appropriate planning and distribution of quality resources, including human resources, knowledge/information and professional development to match the demand for services
- **Financing and incentives**: this function deals with the three main areas of revenue collection, fund pooling and purchasing
- **Delivery of services**: this function deals with the policies that enable equitable delivery of good quality services.

This framework is considered useful for identifying strategies for governments to apply to reorganise and/or renew PHC policy. Report 1 in this series (*Integrated care: What policies support and influence integration in health care in Australia?*) provides a detailed explanation of the WHO framework and how the four functions of stewardship, creating resources, financing and incentives, and delivering services were used to organise Australian health care policies that involved integrated care.

This review is limited to several regions across four countries. It is also limited to the most recent policies (i.e. within the past 10 years) that aim to influence integration in PHC. To give context to reforms and where there exists overlap across policy implementation, a brief discussion of the historical background to health reform policies in each region is provided, where relevant. 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 breadth and depth of policy direction towards integrated health care.

[ii] Refer to Report 1 for more details about these functions and how they have been applied in this series of reports.

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 1 lists the types of 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. Where possible, the information was triangulated in order to confirm sources. We also sought advice from international experts for information on policies to promote integration in PHC from international settings.

Table 1 Information sources

Electronic bibliographic databases	e.g. PubMed with the PHC Search Filter, MEDLINE, ISI Web of Science
Government websites	e.g. NHS (England); Ministry of Health (NZ), Provincial Health in Canada (Ontario, Quebec, Alberta, British Columbia); Affordable Care Act (US)
Grey literature	Google, Google Scholar, non-government organisations
Consultations with experts	Communications with international experts in NZ, England and Canada

New Zealand

Summary

In NZ, policies to support integrated care relate primarily to the ways in which health services are financed (e.g. through taxes and/or user fees), planning activities (e.g. needs assessment and priority setting), the way health care providers are funded for their services (e.g. capitation, fee-for-services) and the purchasing arrangements (e.g. allocation of resources via tendering, contracts, commissioning) (Cumming, 2011). Apart from planning activities, which is a sub-function of *stewardship*, the other approaches fall into the *financing and incentives* and *creating resources* functions of the WHO framework, which is described briefly on page 11 (WHO, 2000).

NZ's health reform is moving from the 2001 *Primary Health Care Strategy*, which is characterised by PHOs serving an enrolled population and governed by DHBs, towards a greater focus on integrated care in the *Better, Sooner, More Convenient* approach introduced in 2009. The *Better, Sooner, More Convenient* policy is designed to allow practitioners substantial flexibility to develop health care services and delivery systems that are tailored to local needs. A key aspect of this approach is training and expanding roles of health care professionals to support health workers to work at the top of their practice. That is, health care providers and other health care professionals are trained to undertake tasks traditionally performed by more qualified staff, thus freeing up highly trained practitioners to deal with more complex care provision. For example, GPs learn to do minor surgery within their practice, rather than refer patients to hospital; and nurse practitioners assess patients, manage chronically ill patients and prescribe medication for less complicated cases. This new approach also places much greater emphasis on telehealth, such as virtual appointments and videoconferencing. Alliance contracting has been introduced to bridge the functions of determining goals, financial commitment and service delivery by bringing together government, PHOs and providers to deliver integrated care.

The current *Better, Sooner, More Convenient* policy comprises all four functions of sound policy as defined by the WHO (2000):

- Stewardship: alliance contracting as a mechanism to promote amalgamation and develop networks between PHOs
- Creating resources: expanded roles, training, telehealth
- Financing and incentives: flexible funding strategy
- Delivery of services: PHO is an alliance partner, contracted to deliver services; DHBs monitor progress; and details of services are decided together.

While flexible funding is part of the *Better, Sooner, More Convenient* policy, as in most countries, financing and budgetary controls under the new system remain problematic. Moreover, the impact of policy decisions on service users' experience of integrated health services is unknown as it is rarely solicited.

For more than 30 years, NZ has attempted to deliver a more integrated health system through a series of policy reforms. A comparison of policies across 11 countries (Schoen and Osborn, 2011) reported that although a high proportion (69%) of New Zealanders report that their regular doctor coordinates care, approximately 20 per cent of service users have problems related to poor coordination including: conflicting information from different health providers; lack of communication between doctor, specialist and/or hospital care; and test results not communicated, particularly among those with multiple chronic conditions. Health reforms have involved various restructures to governance arrangements, from Area Health Boards, which were established in the

1980s, through Regional Health Authorities (RHAs) and Independent Practitioner Associations (IPAs) in the 1990s, to District Health Boards (DHBs) and Primary Health Organisations (PHOs) in the 2000s and Alliances in the 2010s. Over the past 12 years, two key policy strategies related to integrated care have been implemented in NZ. They are the *Primary Health Care Strategy (2001)* and the more recent *Better, Sooner, More Convenient (2009)* policy discussed below (Cumming, 2011) (see Table 15 for relevant recent policy details, Appendix). The latter approach has a much stronger focus on integration with the use of specific fiscal mechanisms, in particular alliance contracting, which will be defined and discussed in the next section. Nine alliancing projects, covering 60 per cent of New Zealand's population have been implemented; and since most evaluations are in the early stages, the discussion below is drawn from one available pilot evaluation, the Midlands Health Network initiative (Raymont and Jackson, 2012).

Table 2 provides a summary of the policy documents and key characteristics that influence integrated health care in New Zealand. These policy documents are discussed in more detail below.

Table 2 Summary of characteristics of integrated care policies in New Zealand

Policy	Key characteristics
Primary Health Care Strategy (2001)	• PHOs established • Enrolled population • Improve care coordination using multidisciplinary teams • Universal financing and capitation
Better, Sooner, More Convenient (2009)	• Merging of PHOs • More emphasis on integrated care • Less hierarchical approach, more locally responsive • Focus on training and expanding provider roles • Alliance contracting • Colocation of services implemented in IFHCs

Primary Health Care Strategy (2001)

This policy aimed to expand the role of meso level Primary Health Care Organisations (PHCOs) from the GP-focussed IPAs to a much broader role by establishing Primary Health Organisations (PHOs), with emphasis on improving health in an enrolled population, reducing health inequalities and improving care coordination using a multi-disciplinary approach (Cumming, 2011). Cumming reported that evaluations of the strategy had identified some improvements in PHC service integration and performance against target indicators (e.g. screening and vaccination rates). In addition, several precursors to improving opportunities for integration at the macro level were identified, including re-introduction of universal financing and capitation funding, enabling a broader range of providers to deliver services. However, Cumming's (2011) evaluation described integration in New Zealand as "slow and patchy", with efforts ranging across the spectrum[iii] from simple linkages between organisations and agencies, through to cooperation and coordination, but is still some distance from full integration.

[iii] Strandberg-Larsen distinguishes between cooperation, coordination and integration according to the level and intensity of interaction between organisations and/or providers (Strandberg-Larsen, 2011).

Better, Sooner, More Convenient (2009)

This policy was launched in 2009 by the NZ Ministry of Health (Ministry of Health, 2011). With a focus on achieving more integrated care, PHOs have been "encouraged to amalgamate to improve their capacity and capability to manage change" (Cumming, 2011, p 9). As the existing PHCOs primarily represented general practice services, with limited engagement of other PHC and community providers, Cumming suggests that the development of new macro level alliances at the regional level may represent a shift to a less hierarchical arrangement, with responsibility for budgets and service delivery devolved. At the core of this policy lies an integrated health care system that allows health care practitioners the freedom to devise strategies to meet the specific needs of their local community. The key strategies in this approach involve expanding roles via additional training, telehealth and ehealth, colocation of services and arrangements to support multidisciplinary teamwork (Ministry of Health, 2011). Each of these is discussed below.

Expanding roles involves training to expand the roles of health care professionals and devolve certain tasks to other health care professionals so that more highly trained health providers can focus on more complex cases; and training GPs and practice nurses to perform certain treatments traditionally undertaken only in hospitals, so that hospital specialists can focus on complex acute care cases. Examples include minor surgery to remove skin lesions, providing intravenous antibiotics for cellulitis, and giving GPs direct access to diagnostic imaging, rather than referring patients to hospital for imaging. Consistent with the focus on expanding roles is the development of *nurse-led care plans.* For example, instead of waiting until elderly patients (aged 75 years and older) visit the GP when they are ill, patients are invited to visit the practice nurse for a free one-hour consultation; and an individualised care plan is devised. This approach includes training nurse practitioners to assess patients, diagnose and prescribe medication to manage patients with long-term chronic illnesses, in consultation with GPs and training less medically qualified staff to undertake some time-consuming tasks traditionally done by practice nurses. Examples include taking throat swabs in children at school (Ministry of Health, 2011).

Telehealth and e-health includes virtual appointments, whereby calls to the GP clinic are 'triaged' by a nurse, who books appointments for consultations by phone/email (GP time set aside specifically), or face-to-face; and lab tests are booked before GP appointments. This is supported by video links to GPs and specialists in small rural towns staffed with rural nurse specialists who provide most of the care. This strategy addresses some of the challenges to access and integration of services that rural and remote areas face. Patient telehealth monitoring devices for heart and lung disease (e.g. monitor blood pressure, lung function); and electronic tools for medical imaging requests to provide faster access to diagnostics have also been introduced (Ministry of Health, 2011).

Colocation and community-based services are key elements to improve the integration of health services to consumers (Ministry of Health, 2011). *Integrated Family Health Centres (IFHCs)* (Letford and Ashton, 2010) have been implemented which involve several health care services under one roof. In addition, local PHOs can commission community health care organisations to develop individual care plans for patients with chronic illnesses; coach them in self-management; organise health care services; and provide information sharing through electronic patient records (e.g. *Te Whiringa Ora Care Connections*). This approach aims to strengthen the capacity of PHC and improve collaboration with local community groups (Ministry of Health, 2011). For example, Tongan Health Society works with the local IFHC to improve early detection of diabetes in the Tongan community. One of these community-based services is *Primary Options for Acute Care,* which aims to reduce avoidable hospital admissions by providing a range of treatments within the community (Ministry of Health, 2011). Other patient-centred care approaches include both social and health services, such

as *Whānau Ora*, which tailor care to patients' needs, including lifestyle factors, education, housing, income, transport and employment.

Multidisciplinary strategies are a predominant feature of this policy (Ministry of Health, 2011). *Case conferencing* entails regular meetings between health care professionals to discuss patients' care needs. In particular, case conferences are encouraged across acute and PHC settings to influence seamless delivery of care. For example, a hospital geriatrician may collaborate with a GP, psychologist, nurse practitioner and other relevant professionals to discuss older patients with high care needs. Another strategy to connect services includes clinical family navigators, which employs registered nurses and overseas-trained nurses (who are not registered to practice in NZ) to conduct home visits to support health and social needs of high-need patients. *GP and pharmacist collaboration* has also been targeted to synchronise medication dispensing for chronically ill people with multiple medications (Ministry of Health, 2011).

Flexible funding policy is a key mechanism which allows the strategies discussed above to be implemented (Ministry of Health, 2011). Community-based health professionals are able to establish governance arrangements to suit and reflect local needs. For example, clinicians from both private and public sectors work together within a joint clinical governance group. Within the *Better, Sooner, More Convenient* policy context, PHOs were encouraged to amalgamate and/or form networks to improve efficiency and enhance their capacity to deliver services (Ministry of Health, 2011). Alliance contracting is a key mechanism of this policy that underpins a 'whole of system' approach. The alliancing approach draws together the four functions of the WHO framework: stewardship, creating resources, financing and incentives and service delivery.

> *Alliancing is a method of procuring, and sometimes managing, major capital assets. Under an alliance contract, a state agency (the 'owner') works collaboratively with private sector parties ('non-owner participants') to deliver the project (State Government of Victoria, 2013).*

Alliance contracting[iv] is considered a change management tool characterised by several features. Members of the alliance are expected to work together in good faith, with integrity, and make decisions based on what is best for the project; work as an integrated, collaborative team; and jointly manage risks to ensure the project is delivered (State Government of Victoria, 2013). In essence, it is about how the different members of an alliance work together to make decisions jointly, rather than about structures. Through the DHBs, the NZ government determines the overall goals (what to do) and financial commitment (how much to spend); whereas the health care professionals and network organisations determine the detail of how it will be delivered (Ministry of Health, 2011). The alliancing approach bridges these perspectives so that the details of integrating services are decided together. An *Alliance Leadership Team*, which comprises a trusted group of clinical leaders, managers and experts oversees changes, allocates available funds, monitors and reports on progress and makes recommendations for future change. The PHO, an alliance partner, is contracted to deliver services. The DHB, which is both an alliance partner and a funder, monitors progress against agreed objectives.

Barriers to integration in NZ

Within the policy context of the last 12 years (described above), Cumming et al. (2005) identified several barriers to achieving integrated health service delivery within the *Primary Health Care*

[iv] Alliance contracting is currently used in many different areas in Australia where public and private sectors intersect, including the Commonwealth Department of Infrastructure and Transport and State government departments (e.g. Victorian Department of Treasury and Finance).

Strategy. These barriers include: a disparity between funding and infrastructure and innovative models of care; a lack of clarity or roles for PHOs; poor engagement with general practice; lack of awareness of the influence of organisational culture, leadership and management; siloed planning, funding and provision roles that led to duplication and gaps; the partial financing of GP services that have made links between general practice and other services more difficult; and a lack of coherence in some PHC services, such as diagnostic services, midwifery and pharmaceutical services, which were not under the budgetary control of PHOs. A lack of information sharing has led to underservicing, over-servicing and conflicting advice from multiple care providers (Cumming et al., 2005). Arrangements under the *Primary Health Care Strategy* raised two additional issues of concern. First, since DHBs are both service providers and contract services to other providers, better service delivery may not necessarily be their priority. Second, existing PHOs primarily represent general practice services, leaving other health care providers outside the loop (Cumming, 2011). Further, a persistent trouble spot in the delivery of PHC services is the increasing cost to the service user, which is a barrier to access. Cumming also suggests that , while integration has been a key focus in NZ health policy for some time, little is known about service users' experience of integrated health services (2011).

Enablers of integration in NZ

Cumming's (2011) overview of evaluations of the national demonstration integrated care pilot projects identified several factors that were critical to successful integration and addressed some of the aforementioned barriers (Cumming, 2011). Factors that led to success included: a focus on changing culture and attitudes; allowing time to develop cooperation and collaboration between organisations; developing formal relationship agreements with Māori and Pacific island populations at an early stage; fostering enthusiastic leaders and champions; achieving political commitment to change; engaging clinical stakeholders; ensuring privacy for information sharing; closely monitoring progress; establishing realistic time frames; providing adequate funding and support; and protecting against territorialism and competition between providers. Cumming suggests that one aspect of the *Better, Sooner, More Convenient* model that still raises some questions relates to who controls the budgets for secondary care services. In an effort to reduce avoidable hospitalisations and provide better integration of services between primary and secondary care, meso level PHOs may hold budgets for some secondary care services. However, Cumming suggests that this may be problematic for two reasons: New Zealanders may not support the new privately-owned PHOs holding large budgets for delivering services; and hospital transaction costs may increase if a large number of PHOs hold budgets for secondary care services (Cumming, 2011).

England

Summary

Since the first mention of integrated care policies in the UK, the need for more integrated services has grown considerably (Boyle, 2011). The UK has four quite separate health care systems across Scotland, Wales, Northern Ireland and England. Between 2000 and 2010 there has been ongoing increase in health expenditure (from £1 168 per capita in 2000 to £1 852 in 2008) and a large expansion of the NHS workforce. Although the health of the population has improved overall, Boyle (2011) suggests that health inequalities have worsened in spite of policies designed specifically to reduce them. However, some aspects of the health system remain unchanged, including: funding is primarily dependent on taxation; centralised responsibility for ensuring access to health care; the public sector is the main care provider – although there is private sector growth; access to non-emergency hospital care is controlled by GPs (GP fundholding); and purchasing/ commissioning and provision are distinct. The most recent policy implementation of the *Health and Social Care Act 2012* comprises three of the four functions of sound policy as defined by the WHO:

- *Stewardship*
  - Devolution to local decision-making
  - Changes in regulation of workers; governance through newly established bodies
- *Creating resources*
  - Establishment of various bodies (e.g. Monitor, CCGs, Health and Wellbeing Boards) to regulate, support, plan and deliver services
  - PHCOs in some form have been a key element of the English health system
  - Establishment of *Healthwatch* to advocate for patients.
- *Financing and incentives*
  - Commissioning
  - Payment by Results
  - Regulation of prices by Monitor

Policies across the regions of Scotland, Wales, Northern Ireland and England are divergent. England is included in this review as it is sufficiently unique in the UK for its adherence to, and extension of, market-like mechanisms in managing health, which differentiates it most dramatically from the other three services (Timmins, 2013). Over the past six years, three policy strategies have been central to PHC in England. These include *Our Health, Our Care, Our Say* (2006), *Equity and Excellence: Liberating the NHS* (2010) and the *Health and Social Care Act* (2012). While integrated care has not always been specified directly in these policies, elements throughout relate to key integration concepts. The Boyle report provides a comprehensive journey through the various policy initiatives and national targets that had priority at different stages from 1997 to 2010 (Boyle, 2011). Table 16 (Appendix) provides a brief summary of the policy reforms since 2006 that are still relevant to integrated care today. Amongst the raft of reforms was the shift towards more integrated care that is based on partnerships and driven by performance (Boyle, 2011).

A key element of policies has involved establishing PHCOs which operate at the regional level. To influence the integration of health services, policies have largely related to establishing, monitoring, funding and regulating the activities of PHCOs. These PHCOs have been configured in a variety of ways over the past decade. **Primary Care Trusts** (PCTs), which were first established in 2002, have been the main organisations required to engage with local communities, other PCTs, GPs and partners to plan and purchase specialised health care and tailor services to local needs (Boyle, 2011). Initially 151 PCTs were funded from general taxation, which was allocated by the Department of Health according to health needs. The role of PCTs was to commission health care through primary,

community, secondary and tertiary care. PCTs were responsible for commissioning services provided by primary care and general dental services; and holding and managing the contracts for general practice, local pharmaceutical services and optometry (Smith et al., 2010). To facilitate joint planning, most PCTs (70%) covered the same area as social service agencies (Boyle, 2011). However, there is no evidence to indicate to what extent integration has been achieved with this strategy. Recent reform has seen PCTs replaced with **Clinical Commissioning Groups** (CCG) (Department of Health, 2011), which are discussed below in terms of their roles at the macro level.

Table 3 provides a summary of the policy documents and key characteristics that influence integrated health care in England. These policy documents are discussed in more detail below.

Table 3 Summary of characteristics of integrated care policies in England

Policy	Key characteristics
Our Health, Our Care, Our Say (2006)	• PCT's role to establish community care • Health centres with primary and secondary care providers
Equity and excellence: Liberating the NHS (2010)	• PCT numbers reduced • Increased choice for patients • Increased role of GPs • Established CCGs/GP consortia
Health and Social Care Act (2012)	• Patient-centred • Alignment of health outcomes, incentives, regulation • Whole of population approach, addressing local priorities • Increased support for providers • Re-structure, renewal or establishment of new bodies (e.g. NHS Commissioning Board; Monitor; Care Quality Commission; Health and Wellbeing Boards; Clinical Commissioning Groups).

Our Health, Our Care, Our Say (2006)

Introduced in 2006 as a 10-year plan to improve responsiveness to consumer needs and engage in illness prevention and health promotion activities, the *Our health, Our care, Our say* white paper (Department of Health, 2006) aimed to give service users more independence, choice and control. The English government introduced this policy to shift away from the acute care system to more 'joined-up' services in community-based care (Department of Health, 2006). Examples within this strategy include the development of **personal and social care plans** for people with long-term conditions and their carers. The long-term aim of this initiative was to realign the health and social care system and provide more local services that were integrated and built around the needs of individuals and not service providers. One particular strategy was to move care out of hospitals by means of each PCT establishing a health centre that provided both primary and secondary care services, with a particular focus on treatment and management of people with chronic conditions (Boyle, 2011). PCTs held their own budgets and set their own priorities, within the overriding priorities and budgets set by the relevant Strategic Health Authority (SHA), and the Department of Health. However, Boyle (2011) also reported that:

> *Despite these measures a report by the Audit Commission (2009) found no evidence to show that PCTs had been successful in moving care out of hospitals and … use of hospitals continued to rise: between 1996–1997 and 2008–2009 by almost 40% in the case of emergency admissions; and between 1998–1999 and 2008–2009 by almost 30% for elective*

> *admissions. Calls to ambulances and A&E attendances have also increased over a similar period (Boyle, 2011, p 384).*

In 2008, Lord Darzi was commissioned to conduct a review of the NHS and to guide further changes consistent with societal changes, such as the ageing population, the burden of disease, consumer expectations and advances in medicine. With a strong focus on improving access, empowering patients and collaboration between national and local organisations, Darzi's report signalled the importance of integrated care:

> *We will empower clinicians further to provide more integrated services for patients by piloting new integrated care organisations (ICOs) bringing together health and social care professionals from a range of organisations – community services, hospitals, local authorities and others, depending on local needs. The aim of these ICOs will be to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices) (Lord Darzi, 2008, p 65).*

While the objectives did not differ substantially from the first white paper (1997), there was a stronger emphasis on tailoring services to local population needs, integrating services in partnership between PCTs and local authorities, evaluating the quality of care based on clinical outcomes and patients' experiences (PROMs[v]), and publishing the results of evaluations (Boyle, 2011). The National Service Frameworks (NSFs), which are based on the best clinical evidence, cost-effectiveness and patients' experiences, were established as national standards for specific services or programs of care for a specific group (Lord Darzi, 2008). As a result of the Darzi report, pilot integration initiatives were implemented in 16 areas, with adaptations from the Kaiser Permanente integrated care approach (Curry and Ham, 2010). In 2009, while admitting that after 11 years of continuous reform, there was a long list of deficiencies and "considerable room for improvement" (Boyle, 2011, p 367), the government did not propose further major reforms, but rather reiterated those outlined previously in the Darzi report. This policy was archived on the 26th March 2013.

Equity and Excellence: Liberating the NHS (July 2010)

Following the 2010 election, another white paper, *Equity and Excellence: Liberating the NHS* (Department of Health, 2010), was published which proposed to dismantle SHAs[vi] and PCTs (Boyle, 2011). The numbers of PCTs was reduced from 303 to 152 in England with an average population per trust of 330 000. The proposed changes represent further devolvement of control away from the centre towards local authorities, which were responsible for promoting and maintaining health in their local population; and supporting integration and partnerships across local NHS and social services (Department of Health, 2010). These changes are expected to give more say to GPs and more choices for patients. PCTs have recently been abolished (March 2013) and GPs are expected to join a CCG (Department of Health, 2010). CCGs are budget-holding, GP-led consortia that take responsibility for commissioning NHS services throughout England (Oliver, 2010, Department of Health, 2010).

Health and Social Care Act (2012)

The *Health and Social Care Act 2012* has been referred to as the most extensive re-organisation of the structure of the NHS in over 60 years (Delamothe and Godlee, 2011). The policy drivers for this

[v] PROMs = Patient Recorded Outcome Measures.

[vi] SHA = Strategic Health Authority is a regional level organisation that monitors the quality and performance of local health services within a specified geographic area (Boyle, 2011).

health reform included fiscal constraints due to rising costs of, and demand for, health services; and need for improvement in quality. Prior to this legislation, PCTs were responsible for spending around 80 per cent of the total NHS budget. Subsequently PCTs were abolished on 31 March 2013 as part of the *Health and Social Care Act 2012*, with their work taken over by CCGs. The responsibility for commissioning services is now a role of CCGs. Concurrently, a report from the NHS Future Forum on integration (Alltimes and Varnam, 2011) provided a number of recommendations to enable a move towards a more integrated health system.

The key recommendations from the Future Forum (Alltimes and Varnam, 2011) were:

- integration should be defined around the patient, not the system – with outcomes, incentives and system rules (i.e. competition and choice) that are aligned accordingly
- integration should be driven through a whole-population, strategic approach that addresses local priorities
- local commissioners and providers should be given freedom and flexibility to 'get on and do' – through flexing payment flows and enabling planning over a longer term.

All recommendations were accepted in full by the government (NHS, 2012a).

Several national bodies have been reformed, renewed or introduced within this legislation. These bodies span the NHS, public health and social care systems that are expected to play a role in improving the experience of integrated care in the England (Department of Health, 2012). Figure 1 (Appendix) provides an outline of the structures related to the Health and Social Care Act. Several of these structures directly or indirectly play a role in improving integration. The main ones are described in more detail below.

Clinical Commissioning Groups

Commissioning is a key mechanism that has been used across various iterations of health reform in the England. Clinical Commissioning Groups (CCGs) have been tasked with integrating care as a priority as part of their commissioning function. CCGs have been given new flexibilities to pool budgets and/or contract integrated care across providers (e.g. year of care tariffs). Commissioning encompasses several functions of the WHO framework, including elements of *stewardship, financing and incentives,* and *service delivery.*

> *Commissioning is a term used most in the UK context and tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or healthcare interventions should be provided, who should provide them and how they should be paid for, and may work closely with the provider in implementing changes. A purchaser buys what is on offer or reimburses the provider on the basis of usage (Smith et al., 2010, p 12)*

Box 1 (Appendix) provides definitions for some of the activities related to commissioning and Box 2 describes some of the different forms of commissioning. The move from PCTs to CCGs has resulted in a change in the way health care is commissioned. This move has seen a shift away from activity based on individual institutions towards pooled/capitated budgets for specific client groups and populations. GPs have a greater presence and have taken over the role of commissioning (Department of Health, 2010). The new approach to fundholding is expected to give patients more choice over which practice they prefer to enrol with (Oliver, 2010).While most patients enrol in the practice closest to their home, in theory they could enrol with any practice. However, Oliver (2010) suggests that practices further from a patient's most local practice may refuse to enrol patients if their lists are full. While the key focus of changes in the Act that are relevant to integration is to enable patients to access a broad range of providers and services that are tailored to their needs

(Department of Health, 2012), there are also several elements within these structures to support providers to reach this objective (e.g. Monitor, Foundation Trusts).

Monitor

In its role as regulator, Monitor's primary aim is to act in the best interests of patients and importantly to promote integrated care where this is in the public interest. To do this, Monitor will liaise with health care professionals for 'best practice' clinical advice, and patient/consumer groups (Department of Health, 2012). Monitor also aims to regulate competition to avoid abuses and restrictions that could potentially lead to poorer care; and to license providers to avoid potential anti-competitive activities. In partnership with the NHS Commissioning Board, Monitor will regulate prices through a national tariff to enable efficiency and integration (e.g. for the whole care pathway) and to avoid 'cherry picking'. Monitor will also support commissioners to enable financial mechanisms to support continuity of care as needed. There has been some concern that competition and choice are incompatible and may lead to greater fragmentation, rather than integration (Ham, 2012). However, Monitor is expected to safeguard against negative effects of competition (Department of Health, 2012).

While current reform policies support competition and choice (e.g. PbR[vii]), Ham and Smith (2010) propose that financial incentives, such as the flexibility to pool budgets and social care resources, are also needed to support collaboration and integration. They also suggest that it may be time to move beyond tariffs that pay for episodes of care to capitated funding that rewards coordinated, integrated care.

Foundation Trusts

Foundation Trusts (FTs) are not-for-profit, public benefit corporations - or more simply configurations of health services which span primary, secondary, tertiary levels (Monitor, 2010). They provide over half of all NHS hospital, mental health and ambulance services and were created to devolve decision making from central government to local organisations and communities. As of March 2013, there were 145 FTs (41 of them mental health trusts and five ambulance trusts). FTs are not directed by government but provide and develop healthcare according to core NHS principles (free care, based on need and not on ability to pay). FTs are able to retain their surpluses and borrow to invest in new and improved service for patients and service users.

FTs are expected to be accountable, transparent and autonomous in their operations in order to support innovative, high quality and locally responsive care. Each of the governing bodies (NHS Commissioning Board, CCGs, Monitor and the Health and Wellbeing Boards) is required to consider the needs of patients, carers and the public (Department of Health, 2012). In addition, the *Healthwatch* organisations are expected to represent the service users' views and report on patients' experiences of health and social services to the local authorities, Care Quality Commission, Commissioning Board and Monitor (Department of Health, 2012). To facilitate the transition to *Healthwatch,* the government has established a *Healthwatch Development Programme Advisory Group*, which will develop partnerships with the NHS, local authorities and the Care Quality Commission; and assist the evolution from the existing Local Involvement Networks (LINks) to *Healthwatch.* The government also plans to establish a *Health Research Authority*, which will report to the Secretary of State on matters related to promoting research that aims to improve integrated and coordinated health service delivery (Department of Health, 2012).

[vii] PbR = Payment by Results.

Barriers to integration in England

Although the policy environment in England has not always been conducive to change, some progress towards integration has been made. Since the first white paper (1997), Boyle (2011) suggests that government policies have tried to improve equitable access by including elements relating to resource allocation formula, national guidelines, frameworks and strategies to deliver uniform quality service. However, Boyle also suggests that while financing resources relative to need is equitable in the NHS, availability of services is highly variable across the country. Ham and Smith (2010) used five case studies to illustrate a number of policy barriers to achieving integration. The authors suggest that policies to change community services were facilitated due to the Department of Health allowing more flexible arrangements. For example, in Cumbria they did not insist on "vertical integration with acute trusts" (p 10); but rather allowed Cumbria to integrate locally with practice-based commissioning. Ham and Smith identified six potential barriers to integration, as shown in Table 4.

Table 4 Barriers to integration from UK integrated care pilot studies

Barriers	
Choice and competition	Separation of commissioning (PCT) and service provision functions (to enable competition) may undermine links between primary, community and secondary care
NHS foundation trusts focus on maximising income	Conflicts with the aims of increasing integration to bring care closer to home and reduce avoidable hospitalisation
Perverse incentives with PbR	Once patients are admitted, particularly if not referred by GP, PbR activity may increase as they are referred across multiple specialists. Activity-based system undermines aim to shift care out of hospitals
World class commissioning	While intended to address some of the weaknesses of commissioning, this approach was time-consuming and resource-intensive, without providing benefit
Impact of regulation	The regulatory system (e.g. Monitor) fosters a culture that focuses on organisational performance rather than health outcomes for the population.
Service reconfiguration	Tensions arise between horizontal integration across multiple providers to improve quality and safety; and vertical integration between primary and specialist care to enable better coordination of care.

Source: (Ham and Smith, 2010, p 13)

Curry and Ham (2010) raise the question of whether integrated care that is provided by a monopoly of providers in a particular area undermines choice and competition. The authors concluded that this should not be problematic if patients get an opportunity to choose between integrated care providers/organisations, allowing competition between them to drive innovation and performance. Curry and Ham (2010) suggest that both integration and competition may play a role in improving performance but that integration will be harder to achieve where commissioning and service provision are completely separate, leading to increased fragmentation and competition between public, private and voluntary sectors (Curry and Ham, 2010).

Enablers of integration in England

Key enablers have been identified in English health policy to influence integrated service delivery: alignment, competition, commissioning and incentives. Alignment is one of the key features of policy in England currently. This has been enacted firstly by integration being formalised into legislation in

the Health and Social Care Act (2012). Specifically this Act has mandated the NHS, as a system requirement, to coordinate care for people. In line with this, the constitution has been amended to include this specific promise. Further alignment has seen public health move from being an NHS function to a local authority function supported by Health and Wellbeing boards that brings together health and social care leaders in local communities to plan and (potentially) joint-purchase care with the central theme of integrating services to people at home.

Competition has also been identified as a key enabler for integrating health services in England. In Curry and Ham's (2010) critique of health care in the UK, it was suggested that effective innovations in care are more likely to occur where there is "**disruptive competition**" between integrated systems rather than competition between non-integrated, fragmented systems. This is because incentives within an integrated system are better aligned and decision-makers take a systems view. Ham and Smith (2010) suggest that competition rules are needed to accommodate the "need for competition in some areas of care and for collaboration in other areas of care" (p 14). That is, competition may contribute to better performance and allow patients the opportunity to choose their provider; however, where patients require care from multiple providers, they have a reasonable expectation that those providers will collaborate to streamline the patient's journey through the health care system. Ham and Smith (2010) also suggest that for emergency care, local integration between PHC providers, hospitals, ambulance services, and after hours services is needed to avoid fragmentation, inefficiencies and confusion for patients.

Commissioning is a central element of integrated care in the English health system (Smith et al., 2010). It is the commissioner that decides on the types of services that are needed, who should provide them, pay for them and implement them. The dilemma of commissioners acting as purchasers and providers has been debated since the inception of commissioning. Smith et al. (2010) argue that the personal medical services organisations "offer the most potential for autonomous commissioning of local services by GPs and their teams" (p 18). The authors also note that few existing approaches have extended beyond PHC into acute or social care sectors; and that patient choice or involvement in the models of care are non-existent. While Smith et al. (2010) acknowledge many of the benefits resulting from various forms of commissioning (e.g. reduced waiting times, extension of PHC, quality and safety standards), they also suggest that there are a number of policy-related issues that need to be addressed. The Care Quality Commission now has set 'Outcomes Frameworks' for health and social care commissioners where aspects of integrated care are explicitly included.

GP **incentives** may also extend beyond PBC. A 'person-based risk-adjusted capitation formula' has been developed (Dixon et al., 2011) to set appropriate budgets for commissioning and reduce the financial risk for practices. Smith et al. (2010) suggest that there is a need for practical management and strategic support for PBC; increased engagement with hospitals involving extension of PBC to incorporate integrated care or multidisciplinary organisations; stronger focus on providing care based on users' or potential users' needs, rather than that of providers or commissioners'; more financial flexibility for commissioners; reform of payment by results; and clarity related to funding priorities and direction (Smith et al., 2010).

Increasingly, GP contracts have developed pay-for-performance measures that imply preventive and co-ordinated activities (NHS, 2012b). In their role as service providers, GPs also act to commission services that are most appropriate for the community. This approach is similar to the integrated medical groups in the US. Some evidence from US studies suggests that specialists and generalists that form 'clinically integrated groups' are more effective at providing integrated care (Ham, 2008).

Ham (2008) suggests that to be effective, GP commissioners should facilitate integrated provider networks and alliances, and eventually develop relationships with local hospitals (similar to Kaiser Permanente in the US).

Canada

Summary

Canada's publicly-funded health system, which provides universal access to hospital and medical care, has sufficient flexibility to allow different models of health care service delivery, including multidisciplinary team care, patient enrolment, capitation and blended payments, based on agreements between the Ministry of Health and local health authorities. Since 2000, several PHC initiatives have been implemented across different jurisdictions to achieve the broad policy objective of better coordination and integration of care (Hutchison et al., 2011). They include recurring themes: improved access to PHC services; better coordination and integration of care; expansion of team-based approaches to clinical care; improved quality and appropriateness of care, with a focus on prevention and the management of chronic and complex illness; greater emphasis on patient engagement/self-management and self-care; and the implementation and use of electronic medical records and information management systems. Less consistently identified objectives include better experiences for patients and providers; delivery of a defined set of services to a specific population; adoption of a population-based approach to planning and delivering care; community/public participation in governance and decision making; building capacity for quality improvement; responsiveness to patients' and communities' needs; greater health equity; and health system accountability, efficiency, and sustainability.

RHAs absorb a bulk of the responsibility of PHC service delivery in each of the provinces and territories throughout Canada. These authorities hold budgetary, regulatory and accountability agreements with provider organisations to support integrated care allocation and delivery of PHC. However, some PHCOs operating within the broader RHA framework also influence integration. For example, Ontario's multidisciplinary teams of providers form Family Health Teams (FHTs) across different sectors and are contracted to deliver services. In Quebec, FMGs are proving to be a promising model of integration. In British Columbia, a Local Collaborative Services Committee oversees the DFP, which are community-based groups of family GPs that focus on integrated care and collaboration within PHC and across different sectors. Interestingly Alberta has seen a shift from away from RHAs back to the formation of a centralised health service (AHS). However, at the same time the establishment of PCNs to improve access and coordination of PHC services has been implemented to influence service delivery at the local level. At different times, the provincial health system in Alberta has shifted from centralised to decentralised control; and more recently shifted back to centralised governance. These cycles of change reflect the ongoing tension between efficiency and cost-effectiveness of a centralised system versus effective coordination and integration of services tailored to the community in a decentralised approach.

PHC in Canada is undergoing transformation. Despite the complexities across different provinces and territories, each jurisdiction is taking steps to facilitate integration of health care by a combination of policy functions which include stewardship by way of governance, regulation and legislation to support integration; contractual agreements with providers and RHAs. Creating resources function is apparent through the establishment and renewal of funding for RHAs and PHCOs and finally PHC policies targeting integrated service delivery have a strong financing and incentives including provider remuneration and funding arrangements.

Since 1957, the development of an integrated health system in Canada has been strongly influenced by a long-term legacy of public insurance, underpinned by the *Medical Care Act* (Jiwani and Fleury, 2011). As in Australia, most health care in Canada is funded publicly through Medicare, but delivered privately (Hutchison et al., 2011). The *Canadian Health Act* (1984) outlined the national health

insurance plan (administered across federal and provincial governments) and stipulated that publicly funded provincial health insurance programs must be universal (coverage for the whole population on uniform terms and conditions); portable (coverage among provinces, public administration and accessibility); and comprehensive (medically necessary health services provided by hospitals and physicians) (Hutchison et al., 2011). The Act places the responsibility for health on the provinces and, although medical necessity covers most services, Hutchison et al. (2011) suggest that, in practice, there is substantial variability across provinces in coverage for pharmaceuticals, home care, long-term care and allied health care services. Similarly, policies related to performance targets (e.g. wait times) and the structure of PHC differ across jurisdictions (Hutchison et al., 2011). However, better coordination and integration of care is a common theme of PHC policies and objectives across all provincial health reform policies.

This section outlines relevant national PHC policy in Canada which aims to improve the integration of health services for consumers. In addition, relevant provincial policies on integrated PHC from four provinces (Ontario, Quebec, Alberta and British Columbia) are discussed. Table 5 provides a summary of the policy documents and key characteristics that influence integrated health care in Canada. These policy documents are discussed in more detail below.

Table 5 Summary of characteristics of integrated care policies in Canada

Policy	Key characteristics
National	
Building on Values: The Future of Health Care in Canada (2001)	• Electronic Health Records • Case managers • Care networks • RHAs to target service integration • Health Council of Canada established
The Health of Canadians: Recommendations for Reform (2002)	• RHA renewal and extension • RHA coordinating service delivery
Health Care in Canada (2003)	• Baskets of services for specific vulnerable populations • Funding incentives • Multidisciplinary teams
A 10 Year Plan to Strengthen Health Care (2004)	• Access to multidisciplinary teams across all jurisdictions • Electronic health records and telehealth
Time for Transformative Change (2012)	• Access to integrated multidisciplinary health care team • Remuneration models including targeted conditional funding arrangements • Governance
Province & Territory	
Ontario	
Local Health System Integration Act (2006)	• Networks of health providers • Devolution of authority to RHAs
Quebec	
An Act respecting local health and social services network development agencies (2003)	• RHAs strengthened • FMGs arranged with remuneration structure based on enrolled pulsation not FFS • Incentives
Alberta	
Tri-lateral Master Agreement (2003)	• PCNs established • Mixture of per patient funding for network , FFS plus targeted payment (i.e. for after-hours services)
Strategic Direction - Defining Our Focus/Measuring our Progress (2012)	• Merger of RHAs • Strategic Clinical Networks established, a collaborative group of stakeholders • Continuity of care by emphasis on health across the continuum - prevention, promotion, multidisciplinary teams, individual and population health • Alignment of resources
British Columbia	
Ensuring Excellence: Renewing BC's Primary Care System (2002)	• GPSC established • GPSC to find strategic ways to optimise funding of PHC • RHAs govern, plan coordinated health care services • RHAs and Divisions of Family Practice partnership
Valuing Quality: Patient-focused Funding in British Columbia (2010)	• Patient-focused funding • Mix of funding to promote delivery of integrated care.

Building on Values: The Future of Health Care in Canada (2001)

In 2001, the Canadian Prime Minister established the Commission on the Future of Health Care in Canada. Its mandate was to

> *…review Medicare, engage Canadians in a national dialogue on its future, and make recommendations to enhance the system's quality and sustainability (Romanow, 2002, p xv).*

The recommendations from this report were to serve as a roadmap for reform and renewal of the Canadian health care system. This document encompassed all levels of integrated service delivery across macro (policy), meso (organisation) and micro (service delivery) levels (Romanow, 2002). Ten critical areas were identified and specifically included five steps towards improving the integration of health services:

1 **Personal Electronic Health Records:** to replace paper records and improve the flow of information between health care providers and organisations.

2 **Case managers:** to guide individual patients through the various aspects of the health care system and coordinate all aspects of their care. The objective is to personalise care for patients and to provide appropriate linkages between different levels and types of care. In many models, family physicians play the role of case manager. Proponents of 'advocacy nursing' see nurses as the patient's key contact point and guide through the health care system. However, a French project from the Health Transition Fund (Durand et al., 2001) demonstrated that the case manager does not necessarily have to be a doctor or a nurse as long as access to required medical and nursing services is assured without untimely delays and unnecessary restrictions. This model has been applied successfully in several locations across Canada and in France (Dubois et al., 2009, Hébert et al., 2003, Hébert et al., 2010, Hébert et al., 2008, Kodner, 2006, MacAdam and MacKenzie, 2008, Somme et al., 2007).

3 **Service integration:** PHCOs within provinces (known as Regional Health Services/Authorities, RHAs) can take on different aspects of diagnosis, treatment, and rehabilitation for patients as well as new responsibilities in prevention and health promotion (Shortell et al., 1994). This concept of service integration is at the heart of initiatives to regionalise services in many provinces.

4 **Care networks or health management programs:** these networks typically focus on providing ongoing care for people with chronic health conditions. In this approach, teams of health care professionals participate in developing and implementing plans for a patient's care, making sure he or she receives all the appropriate services including medications, prevention or education activities, and medical treatments.

5 Creation of a **Health Council of Canada** to facilitate collaborative leadership: this Council was expected to play a key role in development of indicators and measures of progress towards integration and targeted approaches to communities and individuals. The Council was also charged with broadening the work of the Canadian Coordinating Office for Health Technology Assessment to provide a national focus for health technology assessment.

The Health of Canadians: Recommendations for Reform (2002)

In October 2002, the Standing Senate Committee on Social Affairs, Science and Technology (Kirby and LeBreton, 2002) released a final report, the culmination of a widespread two year study of the state of the Canadian health care system and the federal role in that system. The report comprised

five separate reports, and six categories of recommendations. The recommendations on restructuring the current hospital and doctor system to make it more efficient and more effective in providing timely and quality patient care are particularly pertinent to this report on integrated health care in Australia. One of the key mechanisms identified by the committee and recommended for renewal was the extension of RHAs. The Kirby and LeBreton (2002) report recognised the contribution of RHAs to coordinated service delivery and proposed to further devolve responsibility and authority for delivering and/or contracting for the full range of publicly insured health services to the RHAs across Canada. Table 6 details the services administered across Canada by the RHAs.

Table 6 Services administered across Canada by Regional Health Authorities

	Hospitals	Long Term Care	Home Care	Public Health	Mental Health	Rehabilitation	Social Services	Local Ambulance	Laboratories
British Columbia	X	X	X	X	X	X			X
Alberta	X	X	X	X		X			X
Saskatchewan	X	X	X	X	X	X		X	
Manitoba	X	X	X	X		X		X	X
Quebec	X	X	X	X	X	X	X	X	X
New Brunswick	X		X					X	X
Nova Scotia	X			X	X	X			X
Prince Edward Island	X	X	X	X	X	X	X		
Newfoundland and Labrador	X	X	X	X	X	X	X		
Northwest Territories	X	X	X	X		X	X		X

Source: (Kirby and LeBreton, 2002)

Health Care in Canada (2003)

A synthesis of several reports on health policies in Canada showed that the Canadian governments (national and provincial) have had a strong focus on integrated PHC (Table 7) (Canadian Institute for Health Information, 2003). Most integration efforts have been targeted towards specific vulnerable populations that require more coordinated care across health services. One example is a range of home care initiatives, which provide access to a basket of services in the home and community allowing consumers to stay in their home or recover at home. The Canadian Institute for Health Information proposed that these services provided in the home can be more appropriate and less expensive than acute hospital care[viii]. As an incentive, the federal government agreed to provide first dollar coverage for this basket of services for short-term acute home care, including acute community mental health, and end-of-life care. It was also agreed that available services could include nursing/professional services, pharmaceuticals and medical equipment/supplies, support for essential personal care needs, and assessment of client needs and case management.

[viii] Specific data could not be located.

Table 7 Synthesising reports on shaping the future of Canada's health care system

	Commission (Romanow, 2002)	Commission (Kirby and LeBreton, 2002)	New Brunswick Department of Health and Wellness (2002)	Alberta Health (Mazankowski, 2007)	Saskatchewan Health (Fyke, 2001)	Quebec Ministry of Health and Social Services (Maioni, 2001)
	Why reform?					
Expansion of 24/7 access	X	X	X	X	X	X
Prevention and better health promotion	X	X	X	X	X	X
Better continuity of care and chronic disease management	X	X	X	X	X	X
	Recommendations for action					
Interdisciplinary teams	X	X	X	X	X	X
Electronic health record	X	X	X	X	X	X
Integration of health and social services	X	X	X	X	X	X
Alternative payment methods for physicians	X	X	X	X	n/a	X
Family medicine groups/networks	n/a	n/a	n/a	n/a	X	X
Community health centres/ primary health centres	n/a	n/a	X	n/a	X	n/a

Sources compiled by (Canadian Institute for Health Information, 2003)

Within this policy context, one of the key initiatives targeting integrated health service delivery was *The Canadian Initiative on Frailty and Aging (CIFA)* (Bergman et al., 2003). The CIFA was developed as a result of increasing pressure on the healthcare system due to Canada's rapidly ageing population, with an increase not only in the relative and absolute number of 65 year olds, but particularly in the oldest segment of the population (Bergman et al., 2003). The broad goals of the CIFA (Bergman et al., 2003) cover integrated care across policy, organisations and at the service delivery level:

- promote wellness and improve quality of health care and life for older Canadians through prevention, treatment, rehabilitation, environmental adaptation and cost-effective organisation of the delivery of care
- develop a research program on frailty integrating the four *Canadian Institutes of Health Research (CIHR)* themes of research: biology, clinical, population, health services
- propose policy recommendations to decision makers and managers, using a health and social framework that includes but extends beyond the health care system (e.g. education, social activity, housing, nutrition, pension reform); and a focus on health promotion and prevention, public awareness and education, innovative and cost-effective community-based models of organisation and delivery of care
- promote evidence-based guidelines to PHC providers and specialists (physicians, nurses and other health care professionals) on interventions that prevent, delay or slow progression of frailty
- promote healthy ageing to prevent/delay frailty by developing a greater awareness in the population of the role of lifestyle, positive health behaviour and prevention at all ages (Bergman et al., 2003).

A 10 Year Plan to Strengthen Health Care (2004)

Primary care reform is a key part of this policy document. The central elements of this policy document that are relevant to integration of services refer specifically to access to both family and community care through PHC (Health Canada, 2004). The target across all jurisdictions is for 50 per cent of Canadians to get 24/7 access to multidisciplinary teams by 2011 (Health Canada, 2004). Alberta, Quebec, and Ontario have made substantial progress towards this goal (Hutchison et al., 2011). To achieve this, the policy outlined the establishment of a best practice network to share information and find solutions to barriers to progress in PHC reform such as scope of practice. The document also outlines agreement to accelerate the development and implementation of the electronic health record and e-prescribing (Health Canada, 2004). Electronic health records and telehealth were identified as central to health system renewal, particularly for Canadians who live in rural and remote areas. This document outlines a commitment to work with **Canada Health *Infoway*** to guide the development and implementation of health information systems to manage Canadians' health and health care information.

Time for Transformative Change—A Review of the 2004 Health Accord (2012)

This policy document is a review of the *10-year Plan to Strengthen Health Care* (described briefly above) and how the implementation of this policy is progressing (Ogilvie and Eggleton, 2012). It also details the **Communique on Improving Aboriginal Health**. The committee's study revealed that whilst there were many innovations occurring in PHC to ensure that 50 per cent of Canadians had 24/7 access to well-integrated multidisciplinary health care team, many jurisdictions had simply not

been able to meet this goal. The committee heard from witnesses that key challenges relating to achieving systematic PHC reform are: current remuneration models are inadequate; a lack of governance mechanisms to manage and steer reform efforts; and a need for targeted conditional funding arrangements.

PHC delivery is predominantly the responsibility of the provinces, although they work within the broader *Canadian Health Act* (1984). However, in a review of Canadian PHC reform initiatives, Strumpf et al. (2012) reported there is variability across provinces in terms of access, coverage, long-term care and allied health care services. Similarly, policies related to performance targets (e.g. wait times) and the structure of PHC differ across jurisdictions (Hutchison et al., 2011). The following section reviews four provinces: Ontario, Quebec, Alberta and British Columbia which leads the way in PHC in Canada. Table 17 (Appendix) shows the provinces across Canada that have implemented different types of PHC initiatives at the system level.

While Ontario, Quebec and Alberta have common policy legacies, Jiwani and Fleury (2011) suggest that they are on different trajectories to integrating health service delivery. Provincial policies in Ontario, Quebec, Alberta and British Columbia which target integrated service delivery are discussed below as these jurisdictions are considered to have the most advanced PHC transformation in Canada (Hutchison et al., 2011).

Ontario

The Ontario government has undertaken several reforms to facilitate integration and coordination of health services, including implementation of information management and Electronic Medical Records (EMRs) (Jiwani and Fleury, 2011). Table 18 (Appendix) provides a brief summary of the policy changes that have occurred in Ontario since 2000. A form of Regional Health Authority (RHA) that impacts on PHC delivery has been implemented and is described below.

Local Health System Integration Act (2006)

In 2006, Ontario was divided into 14 regions known as **Local Health and Integration Networks** (LHINs) according to the *Local Health System Integration Act* (Ontario, 2006). The role of LHIN model was to bring together a number of health care providers: hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care facilities; and to develop innovative, collaborative solutions to provide more timely access to high quality services (Jiwani and Fleury, 2011). The objective of these networks is to enable better planning, funding and system-wide integration of health services within the local community. Within the LHIN framework multidisciplinary teams of providers have formed Family Health Teams (FHTs) across different sectors and are contracted to deliver services (Jiwani and Fleury, 2011).

Barriers and enablers in Ontario

Results from a KPMG effectiveness review of LHINs (KPMG, 2008) identified three key recommendations including the need for a strong stewardship role for operational and governance mechanisms such as authority, accountability, strategy and direction, process and program devolution, reporting and information management. In addition, the Resource creation function of the Local Health Integration policy identified a need for multidisciplinary collaboration, capacity building, alignment of financing, and alignment of the coordinating LHIN Liaison Branch with LHIN priorities. In terms of the service delivery function, there were considerable implementation challenges which involved allowing necessary time and resources to effectively establish the LHINs.

Overall KPMG's effectiveness review found positive progress (KPMG, 2008). Although the LHIN model is unprecedented, the challenges are similar to those faced by other new systems. LHINs were reported to have managed their authority successfully with few problems, created and executed local decisions, and engaged their local catchments while developing and implementing processes. Many LHINs were involved in integration activities that spanned service providers (horizontal) through to funding and organisational integration (vertical). Overall, KPMG reported that the approach resulted in a successful transition and devolution of authority to the LHINs. Critically this was an evaluation of the implementation process and requires revisiting to evaluate how the LHIN model is working four years on.

Quebec

Quebec's population is ageing and the prevalence of chronic disease is rising faster than the rest of Canada (Vedel et al., 2011). In addition, multimorbidity is more common, with 50 per cent of patients in PHC having five or more chronic disorders, increasing to 70 per cent in those aged 65 years and older (Vedel et al., 2011). Quebec's PHC policy towards integration of health services has seen several reconfigurations of RHAs. Integration in Quebec has been conceptualised as:

> *the process of combining social and health services in order to meet the needs of the frail elderly, through alignment of financial, administrative, and clinical management incentives and modalities with the clinical practices of the multidisciplinary team in charge of their health and social care (Vedel et al., 2011, p 2).*

Policies related to integrated care have predominantly focused on the linking or colocating of services by establishing RHAs, which include both health and social services. Initially known as **Centre Local de Services Communautaires (CLSCs),**[ix] these networks changed between 2003 and 2005, as a result of the passing of two key legislative changes (Bill 25 and 83).

An Act respecting local health and social services network development agencies (2003)

The *Act respecting local health and social services network development agencies (2003)* relates to the establishment of integrated health and social services organisations (focusing on prevention, assessment, diagnostic, treatment, rehabilitation and support services) to facilitate the patient's journey through all aspects of the health and social services network (2003). The Act came into effect on 30 January 2004 and was amended by Bill 83 (2005). The passage of these Bills underpinned substantial structural reforms of Quebec's health care system, primarily relating to the creation of Health and Social Services Centres (HSSCs) (Levine, 2007). HSSCs are Quebec's form of RHA, whereby the CLSCs merged with long-term care centres and nursing homes to form 95 **Centre de Santé et de Services Sociaux (CSSS)**[x], combining social services, community PHC services and home care with the specific aim of coordinating the use of healthcare services for the local population; and developing integrated local care networks (Vedel et al., 2011, Levine, 2007). Seventy-nine of the CSSSs include general hospitals and rehabilitation centres in their geographical areas (Vedel et al., 2011). This is an example of both horizontal and vertical integration of services. CSSSs were charged with developing agreements with other local health service providers, such as pharmacies, youth clinics, volunteer agencies and medical clinics in their areas, to deliver services to the local population (Levine, 2007). Lack of commitment by providers to the previous models of integrated service delivery, paired with continued fragmentation of care for patients, led the Quebec

[ix] CLSCs- Health and Social Services

[x] CSSSs- Health and Social Service Centre.

government to commission a study of health and social services in 2000 (*Clair Commission*), which proposed a new organisational model of care – the **Family Medicine Group** (FMG) and **network clinic** as described below (Pomey et al., 2009).

Family Medicine Groups (FMGs) and network clinics

The provincial ministry for health, ***Ministère de la Santé et des Services sociaux (MSSS)***[xi] stipulates the objectives and requirements of Groupes de Médecins de Famille (FMGs)[xii] (Table 19, Appendix). At the macro level of integration, the provincial government used financial incentives and additional resources as policy levers to change the structure of RHAs and influence PHC services in Quebec (Levine, 2007).[xiii] In this way, FMGs[xiv] were influenced to form multidisciplinary teams of PHC providers linked to the broader CSSSs, working in a defined geographical area to provide services to an enrolled population. FMGs use a different remuneration structure for providers that include Fee For Service (FFS), additional incentives and funding for staffing, premises and information technology (Hutchison et al., 2011, Vedel et al., 2011).

Network clinics are larger than FMGs and were established to improve integration between CSSSs and FMGs. They are responsible for providing access to diagnostic and therapeutic medical services, seven days a week (Beaulieu et al., 2006). "Service corridors" are negotiated with the specialised services sector. A case manager (nurse) joins the medical team to foster exchanges between specialists and attending physicians. These clinics are also responsible for providing access to medical follow-up services for patients with chronic illnesses who do not have family physicians.

In terms of the WHO's four key functions (WHO, 2000) of health care systems, Breton et al. (2011) evaluated the policy related to creating FMGs:

Stewardship: FMGs, which are under the hierarchical responsibility of the MSSS, introduced contractual relationships between providers and MSSS through links with CLSCs. Previously, practices were autonomous entities guided by their own professional logic and with their individual governance structures. FMGs are required to comply with MSSS objectives to become accredited organisations, renewed every three years.

Creating resources as a lever for change: FMGs have opportunities to get additional human and material resources – particularly nurses (roles expanded) to complement physicians' work and free them up for more complex care; and support for IT. Physician recruitment and retention is also facilitated in the FMG model.

Financing and incentives as a lever for transformation: the remuneration of providers involves a blend of FFS, financial subsidies and funding adjustments, based on number of enrolled patients.

Delivery of services: inter-professional collaboration, shared care protocols and joint responsibility for enrolled patients are key elements of the FMG policy.

Barriers and enablers in Quebec

An evaluation was undertaken by way of a non-random sample of the 'first wave' of FMGs implemented (Beaulieu et al., 2006). The evaluation identified several challenges and enablers to implementing the policy. The four main barriers to implementing the FMG policy were:

[xi] MSSS -Ministry of Health and Social Services

[xii] Family Medical Groups

[xiii] Unfortunately the nature of these financial incentives and additional resources are unable to be described in detail as the relevant documents are not available in English.

- **bureaucratic processes**: these were considered the main barriers to achieving integration between health and social care in Quebec. Whist the establishment of CSSSs, which have responsibility for the population's health, implies decentralisation and more locally relevant services, the increasing bureaucracy and administrative reporting that FMGs are required to complete to maintain their status indicates a more centralised approach (Vedel et al., 2011). The focus on standardising structures and practices is a move away from adaptation to the local context. The initial agreement was described as onerous particularly when compared to the agreement governing network clinics (Beaulieu et al., 2006).
- **complex contractual agreements:** this relates to hiring nurses who were employed by CLSC. The nurses find the lines of authority confusing, while some physicians were frustrated in their negotiations with the union (Beaulieu et al., 2006).
- **lack of support for the change process**: most FMGs felt more or less left to their own devices, lacking the concrete support they needed to manage the changes they had to implement. In CLSCs where administrators did not follow the FMG policy and therefore did not support its leadership, the implementation process was slower and more laborious (Beaulieu et al., 2006); and poorly defined (Jiwani and Fleury, 2011).
- **delayed implementation and unavailable information systems** frustrated FMGs. The actual implementation fell behind schedule, were a source of disappointment to professionals, for whom they represented a significant fault in the FMG implementation. The only improvements they had were email services and computer equipment, while access to diagnostic tests, electronic patient records and prescribing physicians was still not available (Beaulieu et al., 2006).

Jiwani and Fleury (2011) also suggest that the reform process in Quebec has been hampered by ***inadequate funding***, ***unworkable objectives*** and ***constrained timelines***.

Overall, Beaulieu et al.'s evaluation concluded that the protracted design and engineering stage of the FMG policy compared to "its rapid launch" resulted in overlap of the policy's implementation in the field.

> *This situation created significant tension in the first FMGs selected for certification, as they became caught up in a significant change and had to adopt a new model of service delivery without having clear regulatory guidelines, yet at the same time had to continue to provide their usual services (Beaulieu et al., 2006).*

These findings cannot be extrapolated to all FMGs. However, the research used several techniques to strengthen the findings, including: validated instruments; triangulation of data; rigorous theoretical framework and longitudinal follow-up.

The evaluation of the implementation of the FMG policy also identified enabling factors (Beaulieu et al., 2006). These included:

- **flexibility of funding arrangements:** the flexible funding of support staff, which included a secretary and an administrative technician, was seen as an essential benefit during the implementation phase. Resources allocated to this function were used, to differing degrees, in client registration (mostly the secretary) and interactions with the CLSC, agencies and the MSSS (the administrative technician). Once FMGs were well established, the roles played by the administrative technician may have changed, probably towards more information and quality management in the group.
- **Regional project managers:** they played an enabling role in the development of the FMG's service offers. This function made a contribution mostly during the initial phase of

implementation, right up until FMG certification was secured. Stewardship aspects were identified as key enablers.

- **support from professional bodies:** this included the provincial federation of general practitioners (FMOQ[xv])
- **strong leadership and interdisciplinary teamwork** within the FMGs (Jiwani and Fleury, 2011).
- **culture of innovation and collaboration** (Jiwani and Fleury, 2011)

Demers (2013) suggested that whether mergers were **voluntary or by policy directive** influenced the success of the establishment of CSSS efforts to integrate. For example, those mergers that were instigated voluntarily between organisations of similar size, values, systems and intervention approaches were able to transition through the changes and achieve more integrated service delivery. In contrast, the most unstable and ineffective partnerships occurred when mergers were imposed in a top-down manner, which fuelled mistrust and conflict between the different groups.

An analysis of international healthcare reform policies (Contandriopoulos, 2009) summarised the evidence-based desirable characteristics of healthcare systems; examined the recommendations from three separate Government commissions; and then analysed the extent to which recommendations had been implemented in Quebec. The five key desirable characteristics that have been identified in the literature include:

1 Population focus
2 PHC implemented through integrated delivery systems, funded by capitation and responsible for a specific population
3 Physicians work in integrated delivery system
4 Secure integrated information system
5 Accountability mechanisms at both population and individual levels.

Analysis revealed that, while all three commissions were consistent in their recommendations, the implementation of the five elements listed above was limited to modifications of particular areas of the system, such as increasing regional governance[xvi] (but without power over budgets) and investment in information technology. In each case, the unimplemented elements of the recommendations were identified as being 'politically' more difficult as they entailed "significant transformations for powerful interest groups (i.e. doctor's unions, teaching hospitals and faculties of medicine, hospital associations)" (Contandriopoulos, 2009, p 12). Contandriopoulos et al. (2003) concluded that, while evidence-based solutions were identified, the lack of implementation of the critical elements led to constant failure to make improvements where they were most needed. This has been described as a "permanently failing organization".

Alberta

As in other Canadian provinces, health reform policies underpinning integrated care initiatives in Alberta focused on the establishment of networks and PHCOs to deliver integrated services at the regional level.

Tri-lateral Master Agreement (2003)

In 2003, the **Primary Care Initiative** (PCI) was established through a *Trilateral Master Agreement* between Alberta Health and Wellness, the Alberta Medical Association and Alberta's RHAs[xvii]. The

[xv] Fédération des médecins omnipracticiens du Québec.

[xvi] Establishment of CLSCs was part of the shift to a community-level service, but was not supported by physicians.

[xvii] Now known as Alberta Health Services.

purpose of the PCI was to develop **Primary Care Networks** (PCNs)[xviii] to improve access to health care providers (Government of Alberta et al., 2012). The aims of this policy were around access, promotion and prevention, coordination of care and integration of services and providers through multidisciplinary teams and service coordination.

The formation of PCNs occurs through a very formal system of milestones, each of which is associated with a portion of funding (Government of Alberta et al., 2012). The funding arrangements in PCNs involve per-patient supplementary funding for the network (for staffing, administration, premises, equipment) and a combination of FFS and targeted payments for providers for after-hours and other services (Hutchison et al., 2011).

Strategic Direction 2012-2015 Defining Our Focus/Measuring Our Progress

Health service delivery in Alberta was restructured in April 2008 (Collier, 2010) forming the **Alberta Health Services** (AHS). This was the largest merger in the history of Canada's health system (Leipert, 2009). Services previously delivered by the nine regional authorities, the Alberta Cancer Board, the Alberta Mental Health Board, and the Alberta Alcohol and Drug Abuse Commission were combined under one Provincial board, Alberta Health Services (AHS). This is the largest integrated health system in Canada serving 3.5 million people with over 7 000 physicians, 85 000 staff, and over 400 facilities (Alberta Health Services, 2012b). The aim of the AHS was to:

> *increase access to health services and ensure Albertans benefit from one seamless provincial health care system … that provides equitable access to health services* (Tyrrell and Palmer, 2009, p 329).

The purpose was to reverse the siloed and fragmented approach to the delivery of health care that had developed in Alberta. The previous structure of RHAs in Alberta created unhealthy competition, lack of cooperation between RHAs and did not promote patient access. This new centralisation is in contrast to Canadian policy in other jurisdictions which devolves health service responsibilities to the RHAs (Tyrrell and Palmer, 2009).

The AHS *Strategic Direction 2012-2015 Defining Our Focus/Measuring Our Progress* aims to support the advancement of the AHS direction and enable an integrated, patient-centred approach. The AHS is creating **Strategic Clinical Networks** (SCNs). SCNs are collaborative clinical strategy groups that aim to bring the perspectives of all stakeholders (clinicians, policy-makers, researchers, operations and strategy leaders, key community leaders, patients and families) together to develop strategies to achieve improvement in patient outcomes and satisfaction, improved access to health care, and sustainability of our health system.

PHC in this policy includes services such as: health promotion; disease prevention; screening tests and examinations; rehabilitation therapy; and nutritional and psychological counselling. In addition to doctors, a variety of professionals including nurses, pharmacists, psychologists, dietitians, counsellors, rehabilitation therapists and social workers provide PHC. Ideally, this team approach allows the patient to connect with the healthcare provider who can best address his or her needs, while ensuring the continuity of care that provides for the best health outcomes. PHC services are developed to address core health needs of individuals and families, and also reflect the broader health issues of communities. This strategic plan targets PHC as the:

[xviii] A PCN can be one clinic with several doctors, or several clinics; they range in size from 200 urban doctors to five rural doctors; and they are expected to work closely with allied health professionals.

> *comprehensive integrated care a patient receives from a primary health care team which includes doctors and a wide array of professionals working in a collaborative healthcare team to prevent, treat and manage disease and illness* (Alberta Health Services, 2012a, p 12).

Key steps from this strategic direction policy focus on the alignment of resources. The steps include (Alberta Health Services, 2012a):

- development of an integrated team-based approach to PHC: integrate existing AHS community services and PHC services to respond to patients' needs; develop models for PHC that promote a team-based approach for professions to collaborate; align funding, accountability and quality improvement of these integrated PHC teams.
- expand PHC services to improve access: use of technology and other innovations; improve linkages with the acute care system; offer extended hours and integrate broader supports such as HealthLink (a health advice and information telephone service) (Alberta Health Services, 2012b, Letourneau, 2009).
- target interventions to improve outcomes in specific communities: conduct community needs assessment through community engagement; develop community-based supports for vulnerable populations; tailor services to meet individual, family and community needs.
- Improve support for Albertans with addiction and mental health issues: develop coping strategies for people with mental illness and their carers; expand support services in the community; develop partnerships with social care sectors, such as housing and other community supports.

Measuring improvement is a central focus of this policy with specific outcome measures identified as follows (Alberta Health Services, 2012a).

- Patient outcome measures (e.g. quality adjusted life years)
- Avoidable hospital admissions / emergency department visits and readmission rates
- Screening and early intervention on disease
- Patient satisfaction
- Cost per case / other efficiency measures to ensure reduction of duplication between different parts of the system.

Barriers and enablers in Alberta

On the one hand, some critics suggest that centralisation distances the RHAs from the communities in which they deliver services; and which may be arguably better at coordinating and integrating services appropriate to their community. On the other hand, a review of the AHS suggested that a single entity point for health care is more efficient and cost-efficient; able to deliver more effective and efficient patient care, and improve access in a manner that is cost effective (Tyrrell and Palmer, 2009). This restructure to a more centralised model has been identified by health research stakeholders in the Tyrrell and Palmer report as an "opportunity for more intra-provincial cooperation to replace the historical unhealthy competition" (p 7). For example, the report favours the establishment of an Academic Health Centre that is founded on the integration of research, education, and patient care. The United States Academy of Science defines the Academic Health Centre as:

> *… not a single institution, but a constellation of functions and organizations committed to improving the health of patients and populations through the integration of their roles in research, education, and patient care to produce the knowledge and evidence base that becomes the foundation for both treating illness and improving health. The integration involves more than the simultaneous provision of education, research and patient care. It requires the purposeful linkage of these roles so that research develops the evidence base,*

> *patient care applies and refines the evidence base, and education teaches evidence-based and team-based approaches to care and prevention (Tyrrell and Palmer, 2009, p 7)*

While some aspects of centralisation may be seen as barriers, centralisation can also facilitate development of provincial shared databases and access to province-wide, non-identifiable patient databases. Leipert (2009) suggested that centralisation may facilitate coordination with other provinces and countries.

British Columbia

In British Columbia (BC), the RHAs are contracted by the provincial government to build an "integrated system of primary and community care" (Thinkhealth BC). Their main aim is to:

> *…effectively support and manage the health of people with chronic diseases, mental illnesses, problematic substance use, women during pregnancy and childbirth and the frail senior population (Thinkhealth BC).*

The provincial ***Integrated Primary and Community Care Committee*** oversees the integration activities in BC. This group comprises the Ministry of Health Ministers and staff, Vice Presidents of local health authorities and a representative from the BC Medical Association (British Columbia Ministry of Health, 2011).

Ensuring Excellence: Renewing BC's Primary Care System (2002)

The **General Practice Services Committee** (GPSC) was formed under a 2002 Agreement between BC's doctors (BC Medical Association) and the provincial government (Ministry of Health Services) (Cavers et al., 2010). The GPSC, which comprises eight representatives from the BC Medical Association (4) and the BC Ministry of Health (4), was established to develop and implement strategies that optimise the use of funding to support improvements in PHC. The mandate has been renewed and funding for this initiative continues to increase (Thinkhealth BC). Several initiatives, which are determined by consensus, have been supported by the GPSC to transform PHC in BC, including incentive programs for chronic disease management, conferencing fees, practice support program, attraction and retention of family practitioners, shared care and scopes of practice committee, multidisciplinary care between GPs and health care providers, community health and resource directory and establishment of the Divisions of Family Practice.

One of the key policies related to integrated care in BC was the development of three prototype **Divisions of Family Practice** (DFP) in 2008- 2009 (Cavers et al., 2010). These are community-based groups of family physicians. Since their implementation, 31 DFP have been established practising in 120 communities (General Practice Services Committee, 2012). Integrated care is a key focus of the DFP. Funded by the GPSC and managed through the local Collaborative Services Committee, the DFP are expected to work with Ministry of Health Services, their RHA and local agencies to identify and address gaps in service delivery (Hutchison et al., 2011). The structure of the committee is shown in Figure 2 (Appendix) and the process of becoming a Division occurs in stages. Five RHAs govern, plan and coordinate health care services according to the goals, standards and performance agreements specified by the Ministry of Health (Hutchison et al., 2011).

Valuing Quality: Patient-focused funding in British Columbia (2010)

A substantial focus of policy in BC has been finding the right mix of funding to promote delivery of integrated health care. Patient-focused funding (PFF) is defined in this policy paper as any method of "compensating providers (e.g. individual providers, hospitals) and using incentives and supports to

improve the appropriateness, quality, and efficiency of care for patients" (British Colombia Medical Association, 2010, p 8). PFF is not a new concept as financial incentives have been used in various different forms to influence provider behaviour, such as increasing productivity, controlling costs and improving efficiency. Increasingly, funders are turning to financial incentives to achieve multiple goals related to improving delivery of health services. In a forum of stakeholders, participants identified the "benefits, challenges/disadvantages, 'no-go' and 'must-have' policy areas" on PFF (British Colombia Medical Association, 2010, p 35). The forum identified the following benefits of PFF:

- incentivising quality, access, and efficiency improvements
- improving provider morale and work satisfaction through improved efficiencies
- creating opportunities for change and innovation
- increased accountability
- increased knowledge on service costs (p 36).

The challenges/disadvantages of PFF were identified as:

- implementation issues including change management, scaling up the prototype, and receiving buy-in from all stakeholders
- priority setting for PFF funds
- integration of acute/institutional care with community-based care
- alignment of health authority/provider funding with outcomes (p 36).

The 'must-haves' of PFF were identified as:

- using collaborative processes between government, providers and patients at an early stage to ensure buy-in from all stakeholders
- benchmarking best evidence-based practices with measureable, agreed goals. Good data that are appropriate, timely, complete and accurate (p 36).

Most of the identified 'no-goes' of PFF were related to budgeting and funding allocation including:

- unrealistic budgets and uncapped/excessive spending
- inequitable funding to regions
- 'cherry-picking' of services
- PFF as total funding (p 36).

Barriers and enablers in BC

Chan's (2012) review of the inter-organisational relationships in family practice identified a paradox in integration policies: while they aimed to reduce the complexity of care provision by establishing DFP, an **increase in system complexity** resulted from this strategy. Although it is important for integration efforts to include and engage with multiple organisations, and tiers of organisations representing diverse interests, Chan (2012) suggests that streamlining these and coordinating them to avoid duplication of effort, gaps in care and inappropriate use of limited resources are a major challenge. In addition, establishing and maintaining a Division requires considerable **human and financial resources**. Professional boundaries, roles and responsibilities are re-shaped through their involvement in Divisions; and Chan suggests that time and effort is needed for practitioners to develop leadership and management skills outside their clinical commitments.

In a review of policy options in BC, Cohen et al. (2012) suggest that the funding structure, specifically activity-based funding (ABF), is too heavily focused on improving hospital efficiency at the expense of achieving an integrated health system by supporting integration activities outside of hospitals (Cohen et al., 2012). In contrast to global funding, which provided a fixed budget for all hospital

services, ABF was introduced in BC to improve hospital efficiency by remunerating providers (hospital) on the basis of the number and type of "activities" they perform (Cohen et al., 2012). The idea was to increase day surgeries to reduce overnight stays and total length of stay. Cohen et al.'s main criticism of this approach is that it ignores the existing system-wide problems and may hamper integration of services more broadly. That is, the problems are not due to under-activity in hospitals, but rather poor coordination of services outside of hospitals.

Growing evidence also suggests that ABF may lead to (Cohen et al., 2012):

- higher administrative costs; and the potential for "gaming" – a perverse incentive to code services as more complex than needed for greater financial gain
- over-servicing of low-risk patients; and under-servicing of high-risk, complex needs patients that require more time and resources
- 'quasi' market for hospital services that fosters a culture of competition for provision of services.

Barriers to integration in Canada

Canadian jurisdictions add to the complexity of negotiating, implementing and mandating PHC policy to promote integration not just from a national level but across ***multiple jurisdictions.*** It has been argued recently in a policy analysis paper that multiple jurisdictions can make sweeping reforms difficult (Hutchison et al., 2011). At the same time, incremental approaches may result in a lack of coherence across the system resulting in increased inefficiencies due to confusing and contradictory processes and missed savings based on economies of scale. Integrated service delivery at the patient level rely on sufficient alignment of elements both horizontally (providers) and vertically (policy, funding, governance) with the best integrated health systems (e.g. Kaiser Permanente) doing this successfully.

In Canada, the disparate negotiating power of PHC ***stakeholder groups*** has also been identified as a barrier to integration. In particular, after the introduction of Medicare, physician stakeholders successfully negotiated their participation based on the proviso that they retained fee-for-service (FFS) payments, clinical autonomy and control over the location and organisation of their practices. In this way, medical professional associations are able to negotiate remuneration for physicians, which are paid directly by provincial governments; and physicians are at the heart of the decision-making system at all levels. In a policy analysis paper of the last 10 years of health reform in Canada, Hutchison et al. (2011) argued that this proviso leaves little leverage available for the provinces and territories as they need to negotiate rather than impose changes in physician payment and accountability arrangements (Hutchison et al., 2011). The authors suggest that very strong stewardship and physician engagement is required for influencing integrated service delivery efforts as almost half of physicians derive more than 90 per cent of their income from FFS payments. This is considered a barrier to health care reforms as federal and provincial policymakers are reluctant to challenge the professional association for fear of jeopardising the medical profession's allegiance to Medicare (Hutchison et al., 2011). The authors conclude that integrated service delivery at the PHC level requires considerable engagement of physicians and suitable mechanisms to leverage system level change.

The disparity between stakeholder groups described above also influences ***teamwork versus autonomy*** and the acceptability of multidisciplinary team arrangement (Hutchison et al., 2011). Hutchison et al. suggest that while policies like, *A 10 year plan to strengthen health care (2004),* mandate provision of inter-professional team-based care, there is a direct contradiction between physician autonomy versus teamwork required, and expanded roles involve overlap in the scope of

practice. Tension is often greatest between nurse practitioners and physicians and effective implementation of inter-professional PHC models will require that change management support is available to providers as they make the transition (Hutchison et al., 2011).

Lack of ongoing ***investment in infrastructure and information technology*** was also identified as a barrier for integrating health service delivery (Schoen et al., 2009). Only 37 per cent of Canadian respondents to the 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians reported using a computer to generate lists of patients according to diagnosis (the second lowest of the eleven countries in the survey), and 22 per cent said they used a computer to generate lists of patients overdue for tests or preventive care (the lowest among the countries studied) (Schoen et al., 2009). Although many provincial and territorial governments have made sizable investments in PHC information technology, the implementation of electronic medical records remains limited, and most currently approved systems have frustratingly inadequate performance measurement, disease management support, and registry capability. Schoen et al. (2009) conclude that the federal and provincial governments must maintain infrastructure and IT investments, despite the recent economic recession and the deficits incurred to combat it. Successful investment has entailed increases in physicians' incomes and significant investments in PHC infrastructure and this has been associated with more successful integration activities aligned with health care reform (Schoen et al., 2009).

Inadequate collection of baseline data to inform policy has also been identified as a barrier to achieving integrated care. Hutchison et al. (2011) suggest that effective improvements in the quality of a health system, especially improvements enabling integrated health services, require solid ***evidence-informed policy***; and this relies on rigorous, ongoing ***performance measurement*** and ***timely evaluation*** of health care policy, management, and delivery innovations. Most provinces and territories in Canada are moving in this direction, with commissioned evaluations of major initiatives becoming increasingly common. However, Hutchison et al.'s policy evaluation criticised these evaluations as beginning too late to allow for the collection of baseline data or to provide useful feedback on the implementation process; and evaluation results are also not consistently made public. Evidence-informed decision making relies on routinely collected, good quality data on appropriate performance measures for appropriate evaluation of policies and initiatives.

Enablers of integration in Canada

The decentralisation of funding responsibility and accountability to the provinces and territories should allow for ***alignment of resources*** required for integrated service delivery that is targeted towards local needs. A recent report on the Canadian health workforce indicated that there is a substantial PHC ***workforce*** available to influence integrated service delivery (Canadian Institute for Health Information, 2011). Despite a low physician to population ratio, the GP to population ratio is above average for member countries of the OECD. Family physicians comprise 51 per cent of the physician workforce and continue to grow at a faster rate than population growth (Canadian Institute for Health Information, 2011). Provincial governments have increased the number of PHC providers (physicians, nurse practitioners, and midwives), increased training and employment opportunities; changed licensing laws and regulations; and financially motivated physicians to integrate services with other providers.

Funding mechanisms have most recently been targeted toward creating and renewing provincial health care systems, with the federal and most provincial governments making substantial, multiyear funding commitments towards strengthening PHC. This provincial focus is due to three main challenges: Canada's long history of physician-autonomy; provincial governments mostly

adopting a voluntary approach to physician engagement; and major initiatives having to be negotiated with provincial medical associations (Jiwani and Fleury, 2011, IHI, 2012). Integration-focused policies have also moved towards blended payment system (FFS, capitations, and incentive payments); and enabling factors include patient enrolment, electronic medical records and provincial medical association support. However, Jiwani and Fleury (2011) suggest that lack of coherence across policies may impede the integration efforts.

A ***strong stewardship and regulatory role*** stipulated from the *Canadian Health Act* facilitates integration. National policy allows significant flexibility for development of a variety of models across jurisdictions; in addition, health ministries have explicit agreements with local health authorities to improve accessibility of services. Engagement of stakeholders is experienced widely across federal, provincial and professional organisations. Given the collective bargaining rights of Canada's medical associations, Hutchison et al. (2011) suggest that broad-based PHC transformation is possible only with the support of organised medicine (Hutchison et al., 2011). To guide PHC system planning and management, relevant health system performance indicators need to be identified and utilised at the local, regional, provincial, and national levels. Various provincial health quality councils (Ontario Health Quality Council, Health Quality Council of Alberta, and Quebec's Commissaire à la santé et au bien-être) have begun to assess the performance of PHC and its contribution to the overall performance of their health care systems. Other policy levers across jurisdictions include contractual agreements with providers; funding and resources for training; governance, regulations and legislation (Hutchison et al., 2011).

Across jurisdictions there is evidence of ***innovative initiatives*** in PHC that can be transformed in a pluralistic system of private health care delivery through a process that is voluntary and incremental and has strong government and professional leaders working together. Examples include the DFP (British Columbia) and the Regional Departments of Family Medicine (Quebec). Strumpf et al. (2012) suggest that the benefit of an incremental approach across jurisdictions is that it enables a relatively quick, system-wide implementation of relevant reform elements with broad public and stakeholder support. The variety, flexibility and configuration of PHC mechanisms may influence integrated health care opportunities to those ready to embrace innovation without imposing changes on other regions where it is not relevant. Multidisciplinary team care, patient rostering, capitation and blended payments, and introduction of PHC nurse practitioners have been implemented in Quebec and Ontario (Jiwani and Fleury, 2011). Likewise, RHAs have been established across Canadian provinces to deliver geographically-based coordinated and integrated services. However, while progress has been made in establishing multidisciplinary PHC practices, there is little evidence that the RHAs have achieved effective coordination or integration of services (Jiwani and Fleury, 2011).

United States

Summary

The US health system has a mixture of private health insurance (primarily employer-funded) and public health insurance (funded by both federal and state governments). It is characterised by complex divisions of responsibility and accountability, both between the federal government and the States and between the private and public sectors. Coverage is far from universal: 16 per cent of people have no health insurance, many others are under-insured, and patients are often required to pay substantial costs. Medicaid, Medicare, and the Children's Health Insurance Program provide health insurance for some of the neediest people, but many others are not eligible. Health Insurance Exchange is an alternative that has not yet been evaluated. The US has the highest healthcare expenditure in the OECD, but life expectancy and some other key outcome indicators are below average, and the system is recognised as being inequitable, inefficient, and fiscally unsustainable.

The landmark 2010 *Patient Protection and Affordable Care Act* primarily aims to improve access to appropriate health care by removing cost as a barrier, but it also focuses on coordination and integration of services. All ACOs are expected to have a strong base of PHC. The legislation has established a range of mechanisms, models, and entities to help achieve its aims, including ACOs, the Medicare Shared Savings Program, the Center for Medicare and Medicaid Innovation, the Independent Payment Advisory Board, and the Pioneer Accountable Care Organizations program. The PPACA also provides States with new funding and tools to promote integration of healthcare service delivery. However, the future of the PPACA is uncertain, because it does not have bipartisan support or strong public support. It remains controversial and potentially vulnerable to cutbacks.

While the health system in the US differs substantially from Australia, US integrated care policies have been included here as there was a large body of integrated care literature that was based in US settings. The US faces some of the same dilemmas as Australia, thus learnings from the US literature may be useful to inform policy decisions pertaining to integrated care in Australia. The US health care system is largely competitive, funded by a mixture of private and public insurance (Blumenthal and Dixon, 2012). It is characterised by complex divisions of responsibility and accountability, both between the federal government and the states and between the private and public sectors.

The US currently has the highest total health expenditure (17.6% GDP) compared with other OECD countries, yet it lags on some key outcomes (Blumenthal and Dixon, 2012). Life expectancy is below the OECD average, and obesity rates are the highest in the OECD, auguring escalating demands on the health system (OECD, 2012). While there are fewer physicians and hospital beds per capita, there are more nurses and much higher numbers of computed tomography scanners and magnetic resonance imaging units (OECD, 2012) raising questions about the appropriateness of the mix of services provided. A recent comprehensive report showed that even when multiple individual factors are controlled (e.g. racial/ethnic diversity, low income, smoking, alcohol use), Americans are in poorer health compared to those in similar wealthy countries; and their health disadvantage may partially be attributed to deficiencies in the health system that give them less access to the types of health care that may protect them from the effects of economic and social disadvantage (Woolf and Aron, 2013).

The US aimed to achieve integration primarily through the introduction of private managed care models (Leutz, 1999). Managed care models fall into three main categories:

1 Integrated acute care: Medicare and Medicaid Health Management Organisations (HMOs)

2 Integrated long-term care: Gatekeeping systems and managed long-term care HMOs
3 Integrated care, both short and long-term: Social HMOs and Senior Health Options.

Although managed care organisations have existed in various forms since 1930s, they were specifically endorsed by the federal government in the 1970s, with associated legislation underpinning certification and funding; and they were re-badged as Health Maintenance Organisations (HMOs) (Petchey, 1987). To address the challenges and achieve the 'triple aim' the US government has introduced a series of incremental reforms, including (Carey et al., 2009):

- Shift to managed care organisations (HMOs)
- Introduction of health savings accounts
- Reforms to Medicare.

Table 8 provides a summary of the policy documents and key characteristics that influence integrated health care in the US. These policy documents are discussed in more detail below.

Table 8 Summary of characteristics of integrated care policies in the United States

Policy	Key characteristics
The Expanded and Improved Medicare for All Act (2009)	• Medicare program expanded • Health insurance (Medicaid, Medicare, Children's Health Insurance Program, Health insurance Exchange)
Patient Protection and Affordable Care Act (2010)	• Pioneer Accountable Care Organisations established • Medicare Shared Savings Program • Centre for Medicare and Medicaid Innovation • Independent Payment Advisory Board

The expanded and improved Medicare for all Act (2009)

Health care insurance in the US is built on a principle of pluralism, whereby numerous types of insurance programs co-exist; yet particular sectors of the population 'fall between the cracks' and have no coverage or are underinsured with respect to their needs. Even for people with insurance, the health system imposes substantial co-payments and other out-of-pocket expenses for many services (Blumenthal and Dixon, 2012). Indeed, medical costs are one of the main causes of personal bankruptcy (2010).

The 2009 Act (The Library of Congress, 2013) expands the Medicare program to provide all individuals residing in the US and US territories with free (i.e. tax-funded) health care that includes all medically necessary care. This includes PHC and prevention, prescription drugs, emergency care, long-term care, mental health services, dental services, and vision care. Medicare is a federal program that provides health insurance for people aged 65 and over and younger people with disabilities or end-stage renal disease (HealthCare.gov, 2012). It is administered by the *Centers for Medicare and Medicaid Services* (CMS) (previously the Health Care Financing Administration), a federal agency within the Department of Health and Human Services. In contrast, Medicaid is a means-tested program jointly funded by state and federal governments, administered by state governments, and monitored by the CMS. Eligibility criteria and benefits vary significantly between states. Poverty is a necessary but not sufficient eligibility criterion; other criteria include age, pregnancy, disability, and blindness. However, many disadvantaged people are not eligible. The Children's Health Insurance Program (CHIP) partially addresses the gap, providing coverage to nearly eight million children in families with incomes too high to qualify for Medicaid, but unable to afford

private health cover (Medicaid.gov, 2012). Health insurance exchange is an alternative insurance option for people who are not eligible for Medicaid (Sommers and Rosenbaum, 2011). Health insurance exchanges are regulated and have standardised health plans so they are comparable and transparent, so that patients can make an informed choice.

Patient Protection and Affordable Care Act (2010)

The most significant recent health reform in the US was the passing of the Patient Protection and Affordable Care Act (PPACA) in 2010, often referred to as the Affordable Care Act (Oberlander, 2012). Although the primary aim of the PPACA is to improve access to appropriate health care by removing cost as a barrier, the Act also recognises the importance of coordinating and integrating services to improve efficiency and patient experience (Koh and Sebelius, 2010).

To address the growing problem of unaffordability and fragmentation of health care, the PPACA established a range of mechanisms, models, and entities. Section 3022 of the PPACA established the *Medicare Shared Savings Program* (MSSP), a permanent program to encourage the development of *Accountable Care Organisations* (ACOs) (Boyarsky and Parke, 2012, Berwick, 2011). As ACOs have "evolved into an amorphous cluster of possible collaborative models" (Goldsmith, 2011), a clear definition has been difficult to identify. See Figure 3 for examples of different ACO models.

In simple terms, an ACO is a model of configuring healthcare organisation by a payment and service delivery that links provider reimbursements to measures of quality service delivery and reductions in the total cost of care for an assigned population of patients. However, ACOs have substantial flexibility in terms of their organisational requirements, performance measures and payment models (McClellan et al., 2010).

> *ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients. ACOs may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations* (McClellan et al., 2010, p 982-983).

The establishment of ACOs is the first step towards achieving the 'triple aim' better care for individuals, better health for populations, and better value health care (Berwick et al., 2008). This approach aims to reward more efficient and higher quality care provision by enabling providers who deliver services to Medicare patients to share in savings, as well as losses.

The PPACA established the *Independent Payment Advisory Board*, which aims to develop strategies to reduce the per capita rate of growth of Medicare expenditure (Newman and Davis, 2010). The PPACA also established the *Center for Medicare and Medicaid Innovation* within the Centers for Medicare and Medicaid Services. The CMS Innovation Center aims to identify, test and implement new effective models of care for Medicare, Medicaid, and CHIP. Another model developed by the *Center for Medicare and Medicaid Innovation* is the *Pioneer Accountable Care Organizations* program, which develops and evaluates alternative payment models for ACOs, entailing greater risk but potentially greater profits (Boyarsky and Parke, 2012). The PPACA also provides States with new funding and tools to promote integration of healthcare service delivery (VanLandeghem and Schor, 2012). Opportunities include the *Medicaid Health Home State Plan Option*, which provides funding to establish health homes (designated providers or teams of healthcare professionals who provide

comprehensive and timely high-quality healthcare services) for individuals with chronic conditions (PPACA section 2703), *Community Transformation Grants*, and *Community-Based Collaborative Care Networks*. Related to the health home is the 'patient-centered medical home', which employs an enhanced primary care model.

The ACO model builds on similar initiatives that Medicare had previously implemented over the past several years. For example, the Physician Group Practice Demonstration (Department of Health and Human Services: Centers for Medicare & Medicaid Services, 2009) engaged ten provider organisations and physician networks, of varying configurations ranging from freestanding physician group practices to integrated delivery systems, in a “shared savings” reform. The providers in the demonstration continue to receive all of their usual FFS payments. However, they also receive bonus payments if their efforts to improve care through better care coordination and other delivery reforms translate into slower risk-adjusted health spending growth and improved performance on quality measures for the patients they serve. Participating providers were also held accountable for a portion of any excessive spending through reductions in future bonus payments. Evaluation indicated that all ten participating sites achieved success on most quality measures. In the third year of the demonstration, five had achieved sufficient reductions in spending growth to allow them to obtain more than $25 million in shared-savings bonuses as their share of a total of more than $32 million in Medicare savings (Department of Health and Human Services: Centers for Medicare & Medicaid Services, 2009).

Barriers to integration in the US

The future of the PPACA is uncertain, because it does not have bipartisan support. Furthermore, it has been described as complicated and unwieldy, “not so much a program as a series of programs, regulations, subsidies, and mandates that fill gaps in the current patchwork insurance system” (Oberlander, 2012, p 2167). Oberlander (2012) suggests that it has been poorly understood by, and unpopular with, the public. Despite having survived a Supreme Court challenge in June 2012, and despite the four years for consolidation provided by President Obama's re-election, the PPACA remains controversial and potentially ***vulnerable to cutbacks*** (Oberlander, 2012).

The PPACA proposes to extend health insurance coverage by expanding Medicaid eligibility and regulating health insurance exchanges. Using national survey data, it is estimated that a change in eligibility could disrupt the continuity of care for ***patients transitioning*** between Medicaid and a health insurance exchange, potentially affecting up to 28 million people (Sommers and Rosenbaum, 2011). Sommers and Rosenbaum suggest that strategies are needed to mitigate disruptions in care caused by these transitions. This is a particular challenge for integration and continuity of care.

Unhealthy ***competition between acute and primary health care services*** is a threat to integrated delivery of healthcare across countries (Ham, 2012). For example, in the US, although many potential participants in ACO models are PHC providers, hospitals are still central to the health system and may dominate contracting processes (Goldsmith, 2011). Moreover, the relationship between hospitals and physicians has been highly competitive, vying for control of the lucrative ambulatory care services market. Originally envisioned as an alternative payment method to reward provider organisations that reduce Medicare spending, a potential share in savings is insignificant compared to the real incentive of FFS payments gained by providing more services (Goldsmith, 2011).

Enablers of integration in the US

The ACO policy is ***patient-centred***. The model itself is rooted in existing relationships between PHC physicians and their patients. The ACO policy identifies PHC as a central tenet to its success. As such any reforms that support PHC can leverage accountable care, and vice versa. Flexible ***funding arrangements and configurations of providers*** comprising ACO allows maximum participation ranging from integrated delivery systems and PHC medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations. ACOs and medical homes both contain structures that support new and unproven payment mechanisms. Many other types of payment reforms of interest to policy makers also have not yet been widely implemented or evaluated, including bundled payments for episodes of care and payments to reduce readmissions. Some evidence suggests that these reforms may be more likely to slow cost growth if they are tied to overall accountability for producing better results (McClellan and Fisher, 2009) Similarly, episode-based payment reforms may work more effectively if they are coupled with initiatives and incentives that pay more when reductions in the rates of some types of episodes (such as surgeries for chronic diseases or hospitalisations for heart disease).

A core principle and design feature for all ACOs is the implementation of a ***robust quality measurement*** strategy (McClellan and Fisher, 2009). Such a strategy should help ensure, and make the public confident, that any cost savings are attributable to actual improvements in care.

Conclusion

Integrated care is a means to an end, the end being to improve patient experience, health outcomes and efficiency of care. Policies implemented within the timeframe of this review generally flux between devolution and centralisation of roles, responsibilities and funding for integrating health service delivery, with varying degrees of success from both approaches depending on the context. All countries in this review placed strong focus on establishing a model of PHCO with a shift away from centralised governance towards more tailored regional approaches (except Alberta, Canada, which has more recently shifted back). However, there is a trend toward centralisation of regulatory bodies and standardised approaches to monitoring performance and accountability. Emphasis seems to be on a whole of system approach, including the involvement of other sectors in health care, particularly social services, housing and employment with flexible governance arrangements and tailoring services to local needs. A brief summary of the relevant international policies and their key characteristics is provided in Table 9; and a summary of the common challenges and enablers of integration is provided in Table 10.

Health workforce requirements are highlighted as a vital resource for delivery of integrated health services. Policies consistently identify the need for sufficiently skilled health professionals to deliver care. Future workforce planning frequently appears in policy documents, with a strong focus on training and expanding the scope of health professionals to work at the top of their licence. In addition, training towards models of collaborative and multidisciplinary team work has been identified. The establishment of effective collaborations has been highlighted as a vital hurdle to overcome. For example, there have been and remain instances of professional bodies with sufficient power to negotiate and influence alignment with policy (i.e. NZ and Canada GP professional associations).

Patient-centred care is another trend common across international policy documents. The patient-physician interaction is central to the experience of integrated care and more recently there has been greater focus on incorporating the consumer voice. Ways of improving the consumer experience and measuring satisfaction with health services also appear on the policy agenda. In addition, consumers' choices in decisions about the delivery of services in their local area have been flagged as an outcome to evaluate.

Overall, PHCOs are responsible for integrated care as they are considered to be more locally responsive. However, some have greater leverage than others. This leverage usually comes in the form of fiscal arrangements. These financial mechanisms include budget holding, incentives and allocation of resources. As such, developments in financing policies have seen funding via pooled budgets; and greater financial accountability for expenditure by rewarding high quality, efficient delivery of services and passing costs of overspending back to the providers/organisations.

The policy documents reviewed in this report illustrate that the achievement of integrated care still requires significant barriers to be overcome. These barriers include getting the right mix of funding arrangements; facilitating cross-sectoral practice with primary and secondary care, health and social care; and in some nations, negotiating national policy in line with multiple jurisdictions. One of the main barriers reflects the lack of evaluation of policies and the challenges of differing definitions and measures of integration across sites, leading to a limited evidence base to inform policy decisions. Nevertheless, this report has also identified several promising elements to facilitate integration. Patient enrolment, financial incentives, realistic timeframes for planning and developing, effective

partnerships and implementing evaluations are elements for policy makers addressing integration to consider, and reflect key lessons from international experiences.

Table 9 Summary of international policies and key characteristics

Country	Policy	Key characteristics
New Zealand	Primary Health Care Strategy	Primary Health Organisations (PHOs) were established and required to: • improve health in an enrolled population • reduce health inequalities • improve care coordination using multidisciplinary teams
	Better, Sooner, More Convenient	• More emphasis on integrated care • Less hierarchical, more locally responsive • Focus on training and expanding provider roles • Alliance contracting
England	Our health, our care, our say	• Better integration between health and social care • Shift from hospital to community-based care
	Equity and excellence: liberating the NHS	• Increased choice for patients • Established clinical commissioning groups/GP consortia
	Health and Social Care Act	• Increased voice for patients • Increased support for providers • Re-structured system and established new bodies (e.g. NHS Commissioning Board; Monitor; Care Quality Commission; Health and Wellbeing Boards; Clinical Commissioning Groups)
Canada	Canada Health Act	• National health insurance plan (universal, portable, comprehensive) • Established PHCOs – differences across jurisdictions
Ontario		• Local Health Integration Networks (LHIN) • integrated health service plan • accountability agreements
		• Family Health Teams (FHT) • multidisciplinary health care team • flexible governance • blended remuneration system
Quebec	Castonguay-Nepveu Commission	• Health and Social Service Centres (CSSSs)
	Clair Commission	• Family Medicine Groups and Network Clinics
Alberta	Tri-lateral Master agreement (Alberta health services; Alberta medical association; Alberta health and wellness)	• Primary Care Networks (PCNs)
British Columbia		• Divisions of Family Practice
United States	Patient Protection and Affordable Care Act (PPACA)	• Health care insurance (Medicaid, Medicare, Children's Health Insurance Program, Health insurance exchange) • Accountable Care Organisations (ACOs) established

Table 10 Summary of common challenges and enablers for integration

Challenges	Enablers

• Lack of:
  ○ clarity regarding roles and responsibilities; and implementation strategies
  ○ engagement between government and provider organisations
  ○ leadership, management
  ○ coherence across policies; competing policies
  ○ information sharing
  ○ transparency and accountability leads to mistrust and conflict
• Increasing cost to service user reduces accessibility to services
• Ongoing structural reorganisation is disruptive and a burden on the system
• Top-down mergers result in unstable and ineffective partnerships; and inhibit integration of services
• System complexity inhibits coherence in policies and discourages effective implementation of reform policies
• Unrealistic objectives and constrained timelines
• Separation between planning, funding and service roles leads to gaps and duplication
• Split financing of services inhibits links between service organisations
• Perverse incentives lead to over-servicing, under-servicing, or inequitable services
• Some forms of commissioning (e.g. world class commissioning) are time-consuming and resource-intensive
• Increase in regulation, bureaucracy and administrative reporting may inadvertently lead to a focus on organisational performance, rather than population outcomes (e.g. Monitor, England; CSSS, Canada)
• Horizontal vs. vertical integration; centralisation vs. regionalisation (e.g. standardisation of care quality vs. local tailored approach to care)
• Tension between physician autonomy (developed in training) and policy mandates to work in a team
• Pre-existing competitive or conflicting relationships across sectors.
	• Foster organisational commitment to change
	• Recognise organisational cultural differences; and foster culture of innovation and consultation
	• Allow time for cooperation and collaboration to develop
	• Establish realistic timeframes and goals
	• Provide adequate funding and resources to support and maintain change (e.g. training; recruitment)
	• Develop formal/explicit agreements at early stage
	• Foster strong leaders and champions
	• Political commitment to change
	• Engage clinical stakeholders
	• Monitor progress
	• Maintain flexibility in the system to allow tailoring to local needs
	• Establish transparent budgetary control mechanisms
	• Engage with hospitals to incorporate integrated care with multidisciplinary organisations
	• Blended payment systems to deter perverse incentives
	• Patient enrolment
	• Investment in information and communication systems (e.g. Electronic medical records)
	• Quality data collection to inform policy (and clinical) decision-making.

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Appendix

Table 11 Definitions of integration and integrated care

Original term/Author	Definition
Integrated care (Øvretveit, 1998)	The methods and type of organisation 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.
Integration (Leutz, 1999)	The search to connect the health care 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).
Integrated care (Gröne and Garcia Barbero, 2001)	A concept bringing together inputs, delivery, management and organisation 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.
Integrated care (Kodner and Spreeuwenberg, 2002)	A coherent set of methods and models on the funding, administrative, organisational, 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

Source: (Kodner, 2009, p 7)

Table 12 Summary of health care system financing and coverage in five countries

Country	Government role	Public system financing	Private insurance role (core benefits, cost-sharing, non-covered benefits, private facilities or amenities, substitute for public insurance	Caps on out-of-pocket (OOP) spending	Exemptions & low-income protection
Australia	Regionally administered universal public insurance program (Medicare), joint (national & State) public hospital funding	General tax revenue; earmarked income tax	~50% buy coverage for private hospital costs and non-covered benefits	No. Safety nets include 80% OOP rebate if physician costs exceed AUS$1 198 [US$1 247]	Low-income and older people: lower cost-sharing; lower OOP maximum before 80% subsidy
New Zealand	National health service	General tax revenue	~33% buy for cost-sharing, access to specialists, and elective surgery in private hospitals	No. Subsidies after 12 doctor visits/20 prescriptions in past year	Lower cost-sharing for low-income, some chronic conditions, Maori and Pacific islanders; young children mostly exempt
England	National health service	General tax revenue (includes employment-related insurance contributions)	~11% buy for private facilities	No general cap for OOP. Prepayment certificate with £2 [US$3.20]per week ceiling for those needing a large number of prescription drugs	Drug cost-sharing exemption for low-income, older people, children, pregnant women and new mothers, and some disabled/chronically ill, transport costs for low-income
Canada	Regionally administered universal public insurance program (Medicare)	Provincial/federal tax revenue	~67% buy coverage for non-covered benefits	No	No cost-sharing for Medicare services. Some cost-sharing exemptions for non-Medicare services, e.g. drugs outside hospital,varies by province
United States	Medicare: age 65+, some disabled; Medicaid: some low-	Medicare: payroll tax, premiums, federal tax revenue;	Primary private insurance covers 56% of population (employer-based and individual),supplementary for Medicare	No	Low-income: Medicaid; older people and some disabled on Medicare

	income (most under age 65 covered by private insurance; 16% of population uninsured)	Medicaid: federal, state tax revenue			

Source: (Thomson et al., 2012)

Table 13 Provider organisation and payment in five countries

Country	Provider ownership		Provider payment		PHC role	
	PHC	Hospitals	PHC payment	Hospital payment	Registration with GP required	Gatekeeping
Australia	Private	Public (~67% of beds), private (~33%)	FFS	Global budgets + case-based payment in public hospital (includes physician costs); FFS in private hospitals	No	Yes
New Zealand	Private	Mostly public, some private	Mix capitation/FFS	Global budgets + case-based payment (includes physician costs)	Yes (for 96% of population)	Yes
England	Mainly private (most GPs are self-employed or partners in privately owned practices)	Mostly public, some private	Mix capitation/FFS/P4P; salary payments for a minority (salaried GPs are employees of private group practices, not the NHS)	Mainly case-based payments plus service contracts (includes physician costs)	Yes	Yes
Canada	Private	Mix of public and private, non-profit	Mostly FFS, but some alternatives (e.g. capitation)	Global budgets + case-based payment in some provinces (does not include physician costs)	Not general, but yes for some capitation models	Incentives in some regions/programs
United States	Private	Mix of non-profit (~70% of beds), public (~15%), and for-profit (~15%)	Most FFS, some capitation with private plans	Per diem and case-based payment (usually does not include physician costs)	No	In some insurance programs

Source: (Thomson et al., 2012)

Table 14 Selected health system indicators for five countries

		Australia	New Zealand	England	Canada	United States
Population, 2010	Total pop (millions)	22.2	4.4	62.2	34.1	309.1
	% pop aged over 65 years	13.0	13.0	16.5	14.1	13.1
Spending, 2010	% GDP spent on health care	9.1[a]	10.1	9.6	11.4	17.6
	Health care spending per capita[d]	$3 670[a]	$3 022	$3 433	$4 445	$8 233
	Out-of-pocket health care spending per capita[d]	$682[a]	$317	$306	$631	$970
	Hospital spending per capita[d]	$1 482[a]	$1 155	n/a	$1 271	$2 634
	Spending on pharmaceuticals per capita[d]	$541[a]	$285	$369[b]	$741	$938
Physicians, 2010	Number of practicing physicians per 1 000 pop	3.1[a]	2.6	2.7	n/a	2.4
	Average annual number of physician visits per capita	6.5	2.9	5.0[a]	5.5[a]	3.9[b]
Hospital spending, utilisation, and capacity, 2010	Number of acute care hospital beds per 1 000 pop	3.4[b]	n/a	2.4	1.7[a]	2.6[a]
	Average length of stay for acute care (days)	5.1	5.5	6.6	7.7	5.4
IT, 2012	Physicians' use of EMRs (% of PHC physicians)	92.0	97.0	97.0	56.0	69.0
Health risk factors, 2010	% adults daily smokers	15.1	18.1[c]	21.5[a]	16.3	15.0
	% obesity (BMI>30) prevalence	24.6	27.8[a]	26.1	24.2[b]	35.9
Adults' access to care, 2010	Same- or next-day appointment when sick	65%	78%	70%	45%	57%
	Very/somewhat difficult getting care after hours	59%	38%	38%	65%	63%
	≥ 2 months wait for specialist appointment[d]	28%	22%	19%	41%	9%
	Access barrier due to cost (in past year)[e]	22%	14%	5%	15%	33%
Care coordination and transitions among sicker adults, 2011	Coordination problems with medical tests/records (in past 2 years)[f]	19%	15%	13%	25%	27%
	Key information not shared among providers (in past 2 years)	12%	12%	7%	14%	17%
Chronic care management, 2011	Health care professional developed treatment plan for routine daily life	61%	58%	80%	63%	71%

	Health care professional easy to access between visits	59%	71%	81%	62%	77%

[a] 2009; [b] 2008; [c] 2007; [d] adjusted for differences in the cost of living (purchasing power parity adjustment); [e] self-reported as opposed to measured data; [d] Base: needed to see a specialist in past 2 years; [e] Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care; [f] Test results/medical records not available at time of appointment and/or doctors ordered medical test that had already been done.
Source: (Thomson et al., 2012)

Table 15 Macro level integration in New Zealand 1980s – 2010s

Period	Macro level integration	Description	Key focus
2000s	*Primary Health Care Strategy* (2001)	80 Primary Health Organisations responsible for health of enrolled population; funded by capitation; IPAs and other providers (e.g. community, Māori and Pacific Island-led providers) play a key role in PHOs. Evaluation reported increased services and consultation rates, reduced user fees; and improvements against targets (e.g. cancer screening rates, vaccination rates).	Focus on improving population health, reducing health inequalities, improving care coordination Collaborative, multi-disciplinary approach across and between different health and social welfare sectors
	District Health Boards *most services*	20 District Health Boards responsible for funding, hospital services, planning and contracting community services and primary care. Re-integration of funding and service provision. Some services centralised to one national provider (e.g. well-child, telephone helpline, sexual health, public health and disability services).	High users of hospital services Improving links with primary care services Increasing role of primary care provider Information systems aimed to reduce duplication and address service gaps Improve discharge planning Increase use of treatment and referral guidelines Develop care coordination tools -improved diabetes care, reduced BP and cholesterol etc.
2010s	2009 *Better, Sooner, More Convenient* (Ministry of Health, 2011)	The key principles of this policy are: • Putting patients first • Bringing care closer to home • Integrated care • Developing trust in health professionals • Working together for better care • Promoting healthier lifestyles	Reduce waiting times: GPs with special interest may provide minor surgery in clinics Judicious use of public-private partnerships Innovative management and improved discharge planning Co-location of GPs in emergency departments Quality use of medicines Co-location of multidisciplinary teams Coordinated care Chronic care and social support Devolution of treatment and diagnostic

			services to primary care Universal subsidies for GP visits
	Regional Alliances some services; providers included District Health Boards *most services*	Nine Alliances formed to develop collaborations with other organisations to plan and deliver services; comprise regional macro-level networks, meso-level networks of PHOs, and amalgamated PHOs. Alliances have a single governance and integrated management structure, with transparent financial information, shared objectives and outcomes-based funding. Funding and services devolved from DHBs to the community.	Focus is on patient-centred care; improving the patient journey across sectors; shifting care 'closer to home' Increased coordination of services between primary care providers and hospitals Nurse-led services and multi-disciplinary teams Devolution of services to Māori communities and fostering family wellbeing models (whānauora) to improve Māori health
	Integrated Family Health Centres (IFHCs)	IFHCs may comprise many different professionals including: GPs, pharmacists, midwives, oral health professionals, physiotherapists, podiatrist, primary care nurses and visiting specialists. Additional services may also include: extended hours walk-in access, radiology, laboratory specimen collection/processing, day-stay surgical procedures and observation beds. Co-location is expected to reduce the number of episodes of care for patients. A range of social care services may also be available including: counselling, social and family support.	Multi-practitioner clinics, IFHCs, co-located clinics, and clusters of providers aim to deliver more integrated services
	Whānauora contracts high needs populations	Whānauora policies and initiatives introduced to enhance coordination between health and social services for high needs people (e.g. community and social development, education, justice, housing).	Focus is on development of whānauora contracts to enable Māori providers across different sectors to work together to form a coherent approach to whānau.

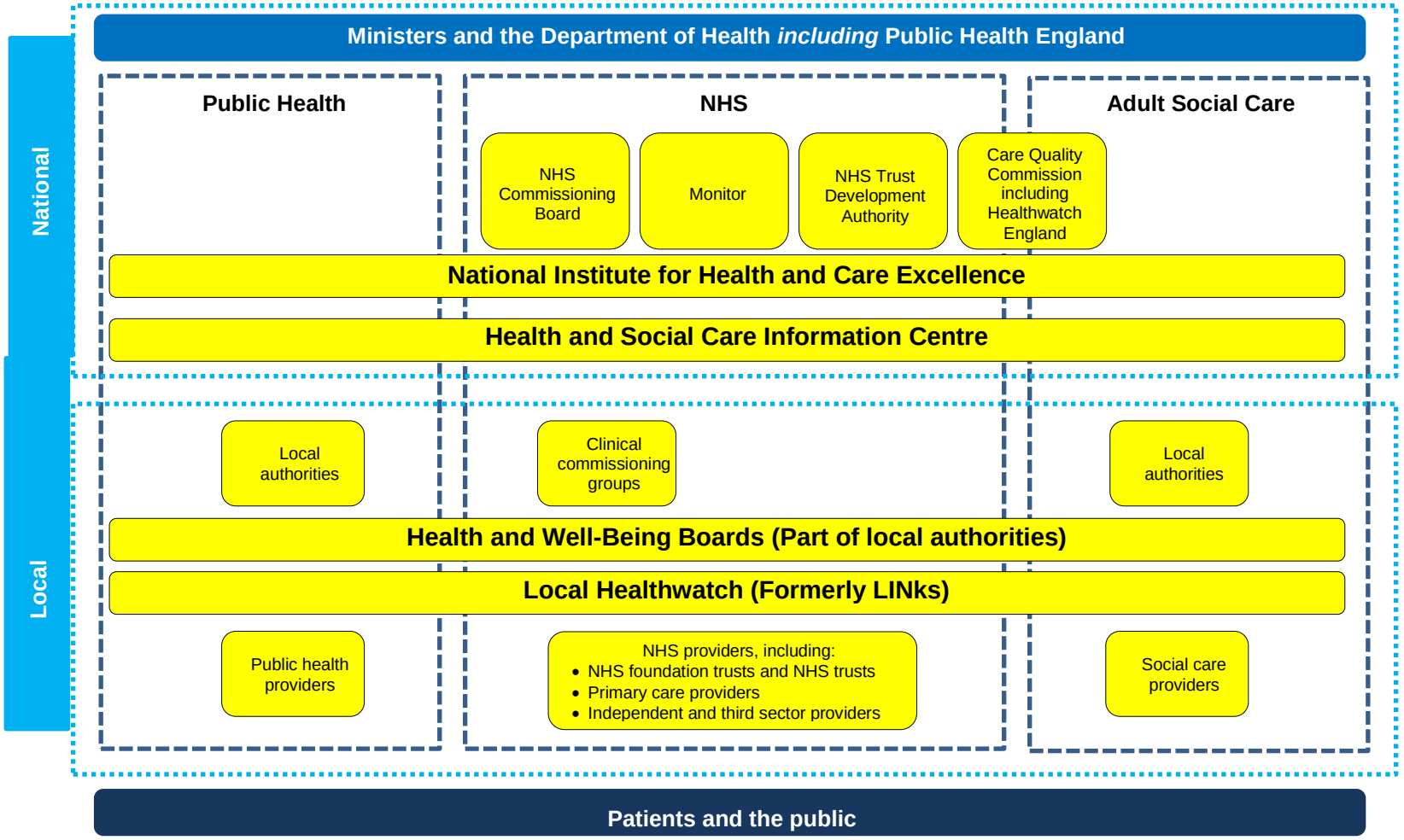
Sources:(Cumming, 2011, Ryall, 2007).

Table 16 Major policy statements and reform measures in England, 1997-2010

	Reform/Policy Statement
2006	As the market in health care delivery develops, the Department of Health issues guidance on how services should be commissioned and how providers should behave. An updated set of guidance was issued in 2010. The White Paper *Our Health, Our Care, Our Say* and its implementation strategy are published, with a view to switching some hospital services to community settings.
2007	The Local Government and Public Involvement in Health Act 2007 creates a requirement for a joint needs assessment between health and local authorities. The World Class Commissioning framework is established, along with a Commissioning Framework for Health and Well-Being, which outline effective joint commissioning of services by health and local authorities. NHS Choices is launched as part of the NHS website. The new Mental Health Act is passed, aimed at safeguarding the rights of individuals with mental health problems. The White Paper Trust, Assurance and Safety: Regulation of Health Professionals is published.
2008	The Darzi report, *High Quality Care for All,* is published, indicating, among other things, that NICE would be asked to develop a comprehensive set of guidelines for all services, complementing the coverage provided by NSFs. The Government announces that each PCT must establish at least one health centre in which both primary and secondary care services are available.
2009	The NHS Constitution is published and the accompanying Handbook sets out a number of pledges regarding waiting times. The Government's commitment to greater use of the private sector appears to wane as an intention to give NHS facilities "preferred provider" status is announced. In addition to its performance monitoring role, the CQC is given a new power to license all providers, both public and private, and including primary care providers as well as hospitals.
2010	The new Conservative Liberal Democrat Coalition Government publishes a White Paper that signals major reforms ahead, as well as an intention to reduce the number of arm's-length bodies in the health sector.
2012	The Health and Social Care Act was enacted in March 2012 (Department of Health, 2012). The key elements of the Act are to: • establish an independent NHS Board to allocate resources and provide commissioning guidance • increase GPs' powers to commission services on behalf of their patients • strengthen the role of the Care Quality Commission • develop Monitor; which currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS • cut the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing PCTs and SHAs.

Modified from: (Boyle, 2011).

Figure 1 **Overview of health and social care structures in the Health and Social Care Act 2012**



Source: (Department of Health, 2012)

Box 1 Definitions of activities associated with the commissioning function

Commissioning is the set of linked activities required to assess the health care needs of a population, specify the services required to meet those needs within a strategic framework, secure those services, monitor and evaluate the outcomes.
Purchasing is the process of buying or funding services in response to demand or usage.
Contracting is the technical process of selecting a provider, negotiating and agreeing the terms of a contract for services, and ongoing management of the contract including payment, monitoring, variations.
Procurement is the process of identifying a supplier, and may involve for example competitive tendering, competitive quotation, single sourcing. It may also involve stimulating the market through awareness raising and education.

Source: (Wade et al., 2006, p 3).

Box 2 Different types of commissioning

GP Fundholding: The roles of purchasing and providing services in the NHS were separated in 1991, allowing GPs, alone or in a practice, to commission services through various fundholding mechanisms (Smith et al., 2010).While there was some evidence of reductions in emergency admissions, prescription drug costs and shorter waiting times related to GP commissioning via fundholding, Smith et al. (2010) also described a number of problems, mainly related to the scale of GP businesses; and the potential for inequitable access to care services (i.e. fundholders getting priority).

Practice-based Commissioning (PBC): In 2004, an alternative version of commissioning was introduced – practice-based commissioning, which provided a framework for local practitioners to expand integrated services in the community, based on needs; invest in preventive care and wellbeing; and focus on continuous quality improvement across the continuum of care (Boyle, 2011). PCTs allocate a notional budget to practices to commission community health and secondary care services according to the needs of an enrolled population. PBC occurs in various forms, including: individual practices; consortia of local practices; groups of practices in a PCT; and personal medical services provider groups.[xix] (Smith et al., 2010)

Joint commissioning – healthcare and social care: Under the *Health and Social Care Act* (2001), NHS organisations and local authorities also set up commissioner integration arrangements, whereby resources from one authority are transferred to the other, which undertakes lead commissioning of health and social care (Curry and Ham, 2010).The lead commissioner manages the pooled budget on behalf of both authorities (e.g. see Torbay Care Trust) (Thistlethwaite, 2011).The English government's green paper, Shaping the future of care together (2009), encouraged more joint commissioning through pooled budgets.

World class commissioning: launched in December 2007, the key objectives were: competencies to develop knowledge, skills and behaviours consistent with a world class organisation; an assurance process to assess performance against competencies; and access to support and development tools to enable achievement of world class commissioning. In June 2010, the World Class commissioning program ceased (NHS Leeds, 2010).

[xix] See Smith et al. for comprehensive details on the complex PBC arrangements (Smith et al., 2010)

Table 17 System-level PHC initiatives in Canada

Province	Infrastructure	Payment	Workforce	Quality/safety	EMR (%)*
British Columbia		●	●	●	55
Alberta	●	●	●	●	66
Saskatchewan				●	41
Manitoba		●	●		41
Ontario	●	●	●	●	57
Quebec	●	●	●		32
New Brunswick			●		43
Prince Edward Island.			●		54
Nova Scotia			●		58
Newfoundland/Labrador			●		57
Northwest Territories		●			ND
Yukon			●		ND
Nunavut			●		ND

*EMR = electronic medical record. Implementation reflects the per cent of family physicians in each province that report using only EMR of a combination of EMR and paper charts in their main patient care setting. ND = no data available.
Source: (Strumpf et al., 2012)

Table 18 Key policy shifts towards integrated care in Quebec and Ontario from 2000

Time points	Quebec	Ontario
2000-current	• Launch of the current reforms (Bills 83, 90, 21, 30) • Creation of health and social service networks (95 CSSSs) • Formation of the university-based health-care networks (4 RUIS-ultra-specialised care networks) • Implementation of family medicine groups or network clinics • Launch of mental health reforms (primary mental health care and shared care, 2005-2010) • Development of increased initiatives toward chronic care prevention and treatment (e.g. provincial public health program in 2001, and framework for preventing and managing chronic disease in 2007)	• Formation of Family Health Networks, Family Health Groups (FHGs), Comprehensive Care Models (CCM), Family Health Teams and Family Health Organisations (FHOs) • Restructuring of integrated Cancer Care Ontario (CCO) • Increased investment in mental health, specifically community-based care • Development of chronic disease prevention and management framework; implementation of diabetes strategy • Increased investment in electronic health records • Establishment of Local Health Integration Networks (14 LHINs) • Increase in Nurse Practitioner-led clinics

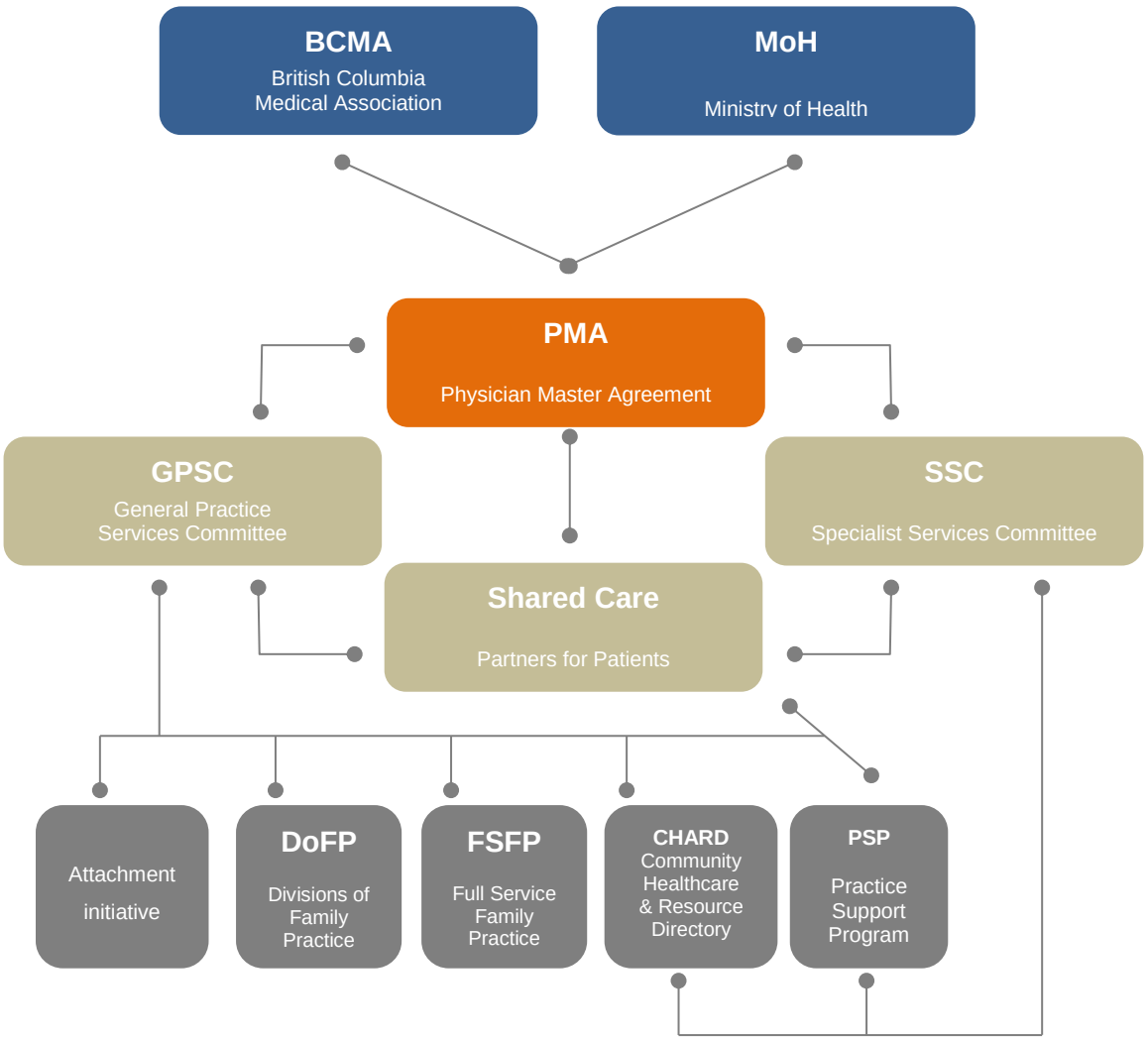
Source: modified from (Jiwani and Fleury, 2011, p 6)

Table 19 Family Medicine Groups' objectives and requirements

FMG Objectives (as set by the Ministry of Health and Social Services – 2002) ✓ Provide all Quebeckers with access to a family physician. ✓ Ensure greater accessibility to services as well as comprehensive clinical responsibility for patients (continuity of services) and follow-up of patients. ✓ Improve the delivery and quality of medical care as well as the organisation of primary care services. ✓ Develop services that complement services offered in CLSCs. ✓ Acknowledge and make the most of the role played by the family physician.
According to the Ministry of Health and Social Services (2002), an FMG must have: ✓ 8 to 10 physicians to form the group; ✓ 2 nurses having an employment relationship with a CLSC; ✓ A registered clientele (1,200 to 1,500 patients per full-time physician); ✓ An offer of service defined in agreements with the regional authority and the CLSC that covers less desirable hours (access 365 days per year); ✓ Administrative support: a secretary and an administrative technician; ✓ Compensation for the additional leasing expense resulting from the extra staff (800 sq. ft.); ✓ A compensation premium: a registration package ($7 per patient; $14 if "vulnerable"), up to 3 billable hours per week for non-clinical work (calls, team meetings, work for the FMG), a package for on-call availability (24/7); ✓ Computerization (fixed assets remain the property of the regional technical centre); ✓ Service corridors for access to technical support centres and certain specialized services.

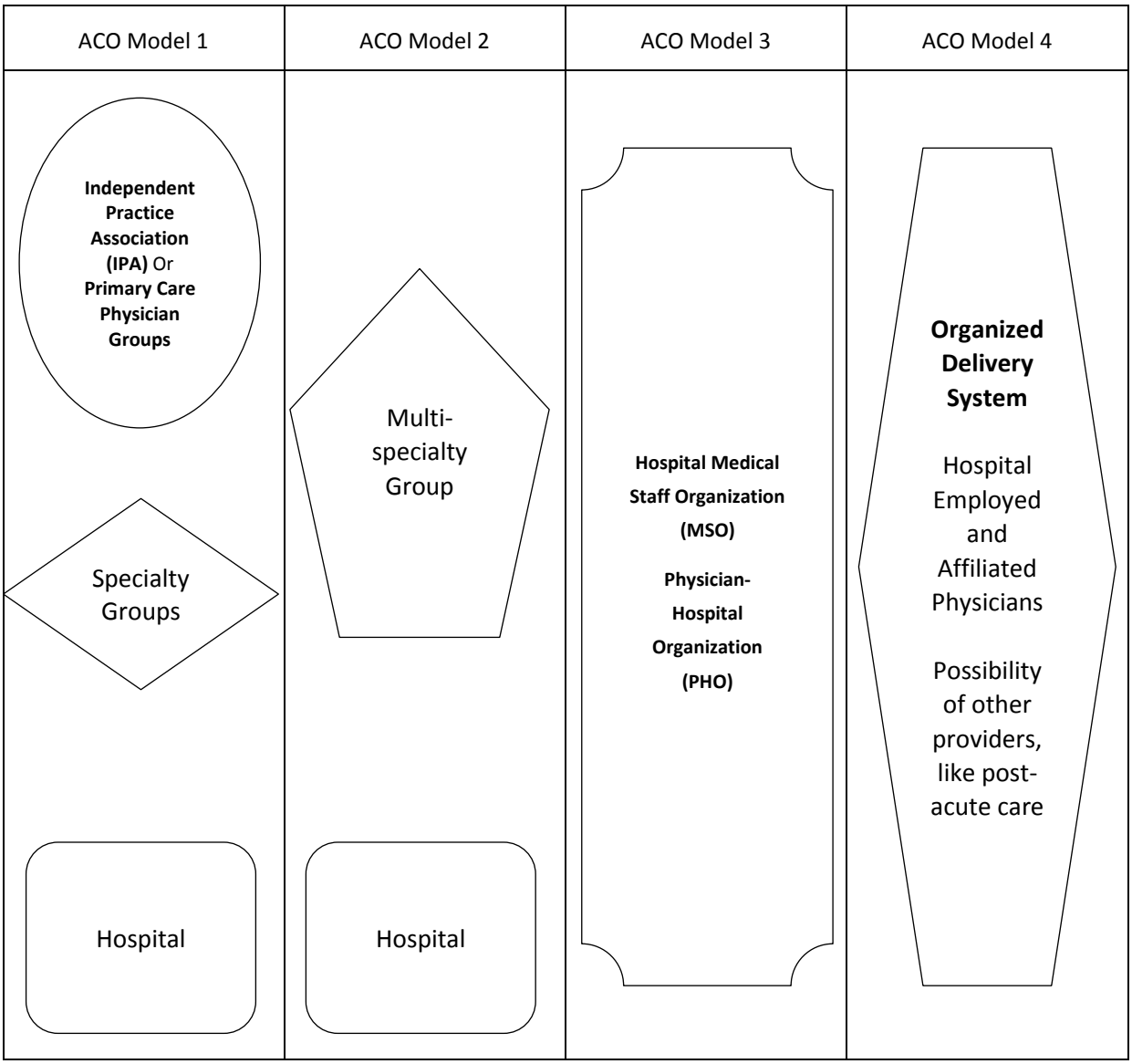
Source:(Beaulieu et al., 2006)

Figure 2 **British Columbia general practice services committee structure**



Source:(General Practice Services Committee, 2012)

Figure 3 Potential configurations of Accountable Care Organizations



Source:(Shinto, 2010)