Best-practice integrated health care governance — applying evidence to Australia's health reform agenda

Is Australia ready for evidence into policy?

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> When you run on your own you run fast, when you run together you run far. (*Proverb*)

Internationally, health reform initiatives have identified improved integration between community and acute care delivery as key to sustainability.[1,2] Australian reform initiatives have been no exception. In 2009, Australia's National Health and Hospitals Reform Commission laid the "blueprint" for Australia's health care future.[3] It stressed the importance of "connecting and integrating health and aged care services for people over their lives". However, it also observed that "each level of government formulates policy in relation to its own responsibilities, not necessarily taking account of the health system as a whole", and that "current governance arrangements are contributing directly to weaknesses in the quality, effectiveness and efficiency of the Australian health system".[3]

Three years later, the *National Healthcare Agreement 2012* committed all federal, state and territory governments to support an integrated approach to the promotion of healthy lifestyle, and prevention, diagnosis and treatment of illness across the continuum of care.[4] Despite the critical nature of joint community and acute care cooperation in delivering on the plethora of mutually agreed objectives, there was no mention of any commitment to the integrated governance arrangements pivotal to such success.

Concurrently, Australia's first National Primary Health Care Strategy established a network of 61 primary health care organisations, Medicare Locals (MLs), across Australia.[5] While the Strategy stated that MLs "will be an integral component of the National Health and Hospitals Network" and "have some common governance membership with the Local Hospital Networks [LHNs] in their region", an integrated governance model was never developed.[5]

Given the priority placed on effective governance frameworks to deliver clear roles and responsibilities to both funders and providers of health care, what *is* the governance vehicle best suited to achieving our national reform outcomes, and how is it best crafted in the current Australian health care reality?

In 2013, we conducted a systematic review to explore international peer-reviewed articles and relevant websites for effective and sustainable integrated primary–secondary health governance models. Ten key elements were identified, many interdependent, from 21 articles that met the inclusion criteria.[6] The evidence suggests the following specific governance elements are important to support integrated care across the primary–secondary care continuum:

- *Joint planning* was identified as key in 18 of the 21 articles. Governance arrangements included formal agreements such as memoranda of understanding (MOUs), joint board memberships and multilevel partnerships in the planning process.
- *Integrated information communication technologies* were noted in 17 articles, particularly, a shared electronic health record, and systems that link clinical and financial measures.
- Effective *change management* was noted in 17 articles, requiring a shared vision, leadership, time and committed resources to support implementation.
- Sixteen studies agreed on the importance of *shared clinical priorities*, including the use of multidisciplinary clinician networks, a team-based approach and pathways across the continuum to optimise care.
- Aligning *incentives* to support the clinical integration strategy, noted in 15 studies, includes pooling multiple funding streams and creating equitable incentive structures.
- Providing care across organisations for a *geographical population*, noted in 13 articles, required a form of enrolment, maximised patient accessibility and minimised duplication.
- Use of *data as a measurement tool* across the continuum for quality improvement and redesign, found in 12 studies, requires agreement to share relevant data.
- *Professional development supporting joint working*, supported by 11 articles, allowed alignment of differing cultures and agreement on clinical guidelines.
- An identified need for *consumer/patient engagement*, noted in eight studies, is achieved by encouraging community participation at multiple governance levels.
- One-third of articles acknowledged the need for adequate *resources to support innovation* to allow adaptation of evidence into care delivery.[6]

Governance elements identifiable in Australia's current health care reform environment

We reviewed key statements regarding integrated care delivery from federal, state and regional perspectives to identify evidence of integrated primary–secondary governance support. Although several elements above are noted as goals, formal documents mostly relate to silos of sector activity and not the interface (Box).

The following integrated governance elements are currently well documented:

- Joint planning is documented in agreements at both federal and state level. It is identified as a key role for MLs and LHNs, and there is evidence to support it as

Identification of evidence supporting integrated primary–secondary health care governance in the Australian policy environment

	Federal–state		Federal		State		Local
Integrated governance elements[6]	Council of Australian Governments *National Healthcare Agreement 2012*[4]	*National Primary Health Care Strategic Framework* 2013[7]	Medicare Local Operational Guidelines 2013[8]	Medicare Local strategic plan[9]	State health department agreement with Local Hospital Network[10]	Local Hospital Network strategic plan[11]	Medicare Local/ Local Hospital Network local agreements[12]
Joint planning	Nil	Demonstrated	Demonstrated	Demonstrated	Demonstrated	Demonstrated	Demonstrated
Integrated information communication technologies	Demonstrated	Limited	Nil	Demonstrated	Nil	Nil	Limited
Change management	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Shared clinical priorities	Demonstrated	Demonstrated	Demonstrated	Demonstrated	Nil	Demonstrated	Demonstrated
Incentives	Limited	Nil	Nil	Nil	Nil	Nil	Nil
Geographical population focus	Nil	Demonstrated	Demonstrated	Demonstrated	Nil	Demonstrated	Demonstrated
Measurement of data as a quality improvement tool for clinical care	Nil	Limited	Limited	Nil	Nil	Nil	Limited
Continuing professional development supporting joint working	Nil	Nil	Nil	Nil	Nil	Demonstrated	Nil
Patient/community engagement	Nil	Demonstrated	Demonstrated	Demonstrated	Limited	Demonstrated	Demonstrated
Innovation	Demonstrated	Demonstrated	Nil	Demonstrated	Demonstrated	Nil	Nil

a key objective in both strategic plans.[9,11] Some MLs and LHNs have created joint board positions and local MOUs, demonstrating a commitment to managing deliverables, risk and processes through a collaborative approach.[12,13]

- A key objective of MLs[7,8] and federal–state agreements[4] is to work in partnership to document and together address shared clinical priorities for action. ML–LHN MOUs identify agreed shared clinical priority areas,[12,13] some based on local need (eg, mental health),[13] others on national benchmarks set by the National Health Performance Authority (NHPA), Close the Gap and national priority areas.[12]
- At local level, ML–LHN MOUs have documented evidence of commitment to patient, consumer and community engagement.[12,13] This includes joint planning fora and input into informed patient choice regarding options for care. A joint consumer engagement approach including co-hosting of events is supported in one ML–LHN MOU.[13]
- Federal and state health departments and authorities produce documentation on the health of their populations, and MLs and LHNs must focus on population health service planning as part of their reporting. MLs and LHNs have collaborated to provide population health reports for regions. Lack of enrolment is currently a limitation to accurate geographical population health data in Australia.

Areas still to operationalise:

- Policy direction requires "e-health tools to link providers and improve quality of care".[4] However, as an integrated information communication technologies tool, the personally controlled electronic health record (PCEHR) has some way to go before it becomes a shared electronic health record capable of providing "access to more health information, creating a more efficient system, making continuity of care easier and improving treatment decisions".[14] This remains a significant barrier to integrated health care going forward. Federal support for the rollout of the PCEHR is articulated,[7,9] although this is not reflected in state plans.[10,11] The PCEHR review was completed on 20 December 2013, but the findings have yet to be released.[15]
- Federal and state governments "will … look to improve quality and accessibility of data to inform planning and service delivery with a 'whole of system' view".[7] One ML and LHN have agreed to use shared data as a measurement tool to meet performance requirements articulated by NHPA.[12]

> What *is* the governance vehicle best suited to achieving our national reform outcomes?

Areas still to evolve:

- There is little in current policy documents to incentivise integrated care. Primary care functions on a largely fee-for-service model, moving patients to emergency departments or hospitals when more comprehensive care is required. State-funded acute care has few current funding or governance levers to link with private or federal-funded care. New models in New Zealand employ governance frameworks that create the funding and business rules to better incentivise care models across the interface. Instead of input-defined, competitive, fee-for-service contracts with penalties for underperformance, it has moved to "alliance" contracting to create joint incentives to manage cost.[16,17] Preliminary evaluation shows wins in patient acceptability, quality of care and hospital avoidance.[16]
- There is no documented evidence that LHNs or MLs have currently committed resources to jointly manage the change required to working collectively across the interface. This can be complex, challenging and resource intensive.[18]

- There is no documented evidence of organisational commitment and resourcing to deliver interprofessional training across the continuum or to develop training programs that align differing cultures and integrated ways of working.[19]
- The Council of Australian Governments supports the need to "invest in research that promotes evidence based practice and innovation".[4] Although one ML noted the importance of building a culture of innovation and the need to invest in and demonstrate leadership in innovation, evidence of this occurring is lacking.

The Australian reform environment has made steady progress in building integrated governance arrangements around joint planning, shared clinical priorities, consumer involvement and population health service planning. However, other areas, such as integrated information communication technologies, using shared data as a measurement tool, shared resources to support change, and interprofessional or interorganisational training and innovation remain ad hoc or non-existent. Despite their importance, incentives for integrated care still fall predominantly into short-term programs, rather than robust governance arrangements at federal, state or local level.

If we are to apply important evidence to health care policy, and maximise reform success, we must review current governance frameworks to address the gaps identified in this paper. While it is challenging to bring historically disparate partners together into formal agreements, they are essential to creating the "business rules" and sustainable environment required to achieve the new care models we seek.

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