Integrated Care and Integration

A Literature Review

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1. Introduction

It is now widely accepted that '***one size of integrated care does not fit all'***. It is therefore vital to consider the context (that is different care settings and perspectives) in which a specific integrated care initiative develops.

'Integrated care' is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.

Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination.

Integration is the combined set of methods, processes and models that seek to bring this about. Achieving integrated care requires that those involved with planning, financing and providing services have a shared vision, employ a combination of processes and mechanisms, and ensure that the patient's perspective remains a central organising principle throughout.(Shaw et al)

Across the literature there is a wide call, from researchers in this field, for an urgent need for more robust and high-quality evidence to inform decisions about how to develop integrated care. There is no single model of integrated care that is suited to all contexts, settings and circumstances. There is still a considerable amount of work to be done with researchers and policy-makers needing to work together with practitioners to develop, evaluate and implement effective approaches.

The core ingredients of integrated care are:

- **Defined populations** that enable health care teams to develop a relationship over time with a 'registered' population or local community, and so to target individuals who would most benefit from a more co-ordinated approach to the management of their care
- **Aligned financial incentives** that support providers to work collaboratively by avoiding any perverse effects of activity-based payments; promote joint responsibility for the prudent management of financial resources; and encourage

the management of ill-health in primary care settings in order to prevent admissions to hospitals and nursing homes

- **Shared accountability for performance** through the use of data to improve quality and account to stakeholders through public reporting
- **Information technology** that supports the delivery of integrated care, especially via the electronic medical record and the use of clinical decision support systems, and through the ability to identify and target 'at risk' patients
- **The use of guidelines** to promote best practice, support care co-ordination across care pathways, and reduce unwarranted variations or gaps in care
- A **physician–management partnership** that links the clinical skills of health care professionals with the organisational skills of executives, sometimes bringing together the skills of purchasers and providers 'under one roof'
- **Effective leadership** at all levels with a focus on continuous quality improvement
- A **collaborative culture** that emphasises team working and the delivery of highly co-ordinated and patient-centred care
- **Multi-specialty groups** of health and social care professionals in which, for example, generalists work alongside specialists to deliver integrated care
- **Patient engagement** in taking decisions about their own care and support in enabling them to self-care

(Source: adapted from Curry and Ham 2010)

2. Background

This literature review was initially developed for the New Zealand Institute of Rural Health as context for the Otago and Southland District Health Boards Hospital Capacity Review (OSDHB HCR), the purpose of which was to;

- Develop an analytical planning model (for both rural and tertiary hospitals) using demographic, disease burden/prevalence and epidemiological analysis methods, identifying future health care needs by region/location,
- Develop rural hospital service delivery configuration options that will result in financially and clinically sustainable services, which meet the current and future health care needs of rural communities,

An extensive desk top appraisal of the research and policy literature on Integrated Care and Integrated Models of Care was undertaken, including material from the UK, USA, Canada, Australia as well as New Zealand in late 2009/early 2010.

3. Aims and Objectives of the Literature Review

The aim of the literature review were that it would provide the basis for a proposal for the development of a generic primary, secondary and community, 24 hours, seven days a week service blueprint that could be tailored for each local configuration within the OSDHBs region's rural health/hospital services as well as considering the ongoing implications for its core urban (base) hospitals.

The development of a service blueprint would support the findings, proposals and any recommendations for change, within the current legislative framework of the New Zealand Health and Disability Sector

The main objectives were:

- To identify national and international evidence based practice and models of primary, secondary and community 24 hours, seven days a week, integrated care services centred on clinical and service integration, rather than organisational integration and secondary care dominance, with a focus on improving the patient experience, clinical outcomes and value for money.
- To find resources, from within the last 5-10 years, that would offer examples of integrated care in a similar challenging environment and context of that of the New Zealand Health System; where there is little appetite politically for further large scale policy upheavals. For example, where funding methodologies for isolated populations and health burden, geography and topography that make transfers out when weather conditions become intemperate and workforce shortages are comparable for delivery of an integrated comprehensive 24/7 primary, secondary and community service.
- To clarify and determine the true meanings and conceptual frameworks of the terms 'Integrated Care' and 'Integrated Care Models'
- To identify and appraise the core characteristics of integrated organisations and evidence on integration so that implementation of such systems within rural health/hospital services would be based on sound knowledge, practice outcomes and evaluation methodologies.

The aims of the original literature review still stand in the general legislative environment of the New Zealand Health and Disability Strategy forany DHB with rural hospitals and services. The Literature Review has been updated taking into consideration the substantial amount of research work that is now available, primarily

from the United Kingdom, following trialling of pilots, further clarification of definitions and the recognition of measurement and evaluation tools. Although, it must be stated there is a paucity of financial information and data for any costing comparison analysis.

4. Methodology

The methodology for the literature review has been a desk top electronic database search supported by additional internet searches of international primary and integrated care research websites to obtain suitable published documents and articles of experiences and evidence based practice supported by research and evaluation, both nationally and internationally.

The review used such terms 'Models of Care', 'Integrated Care' and 'Integrated Models of Care' were used initially but it soon became clear that these terms are used separately, synonymously and confusingly, nationally and internationally.

Further use of the terms integrated care organisations, delivery of integrated care, physician groups, multi-specialty groups, family practice models, primary health care, community health services and primary/secondary care organisations was undertaken and literature from the UK, USA, Canada, Australia and New Zealand returned significant results.

4.1 Narrowing the Search

From the plethora of literature available in the original review only 80 documents, papers and articles obtained nationally and internationally were deemed to be noteworthy to achieve the aim and objectives of the literature review. Another 20 have since been obtained.

The articles and documents rejected immediately were a majority of case studies from around the world and New Zealand that demonstrated both models of care and integrated care that are driven by a single service strategy that would leave any collaboration/ integration achieved, isolated by the silo effect of focusing on a single population, service delivery type or disease process.

On the other hand the National Health Service (NHS) in the United Kingdom (UK) has more similarities than differences with the New Zealand Health System certainly with the

form of funding and policy frameworks and for some of its more isolated populations currently managed by Primary Care Trusts (PCTs).

Over the last 5 years, the UK Health System has been undergoing radical health reforms that have seen the implementation of Regional and District Health Trusts, Primary Care Trusts and Hospital Care Trusts. This has resulted in:

- Planned design to combine competition in some areas of care and collaboration in others with more emphasis being placed on the development of competition than collaboration, for example through policies on patient choice, payment by results and increased plurality of provision
- Priority being given to competition because of the emphasis placed on reducing waiting times for planned hospital care such as elective surgery and diagnostic services
- The levers and incentives to promote clinical integration and networks are underdeveloped, despite commitments made in *Our Health, Our Care, Our Say(Department of Health 2006)*,

It could be argued that some of these statements are now relevant to the New Zealand experience with the implementation of District Health Boards and Primary Health Organisations.

The UK health system is now seeking, as a major imperative, the provision of a coherent and credible account of how collaboration, clinical integration and networks will develop in future (Darzi Review 2007)

To support this, the Nuffield Trust has been publishing a comprehensive set of briefing papers on integration and how it can be implemented whilst the UK Department of Health has initiated and is now evaluating Integrated Primary Care Pilot Sites (Carter 2009)

A report for Counties Manukau District Health Board by the Health Services Research Centre in 2007 (Smith & Ovenden) on developing integrated primary and community health services for the Mangere Project has also proved a valuable foundation document.

It is from these sources and seminal papers from the World Health Organisation and articles from the International Journal of Integrated Care that the majority of the literature review has been based.

The updating of this literature review has drawn heavily on briefing papers and research reports work from both the Nuffield Trust as well as the Kings Fund and especially on the work of Professor Chris Ham, Chief Executive of the Kings Fund Trust and his research team.

Significant articles, discussion papers and documents can be found on www.who.int, www.ijic.org, www.nuffieldtrust.org.uk, www.doh.org.uk and www.kingsfund.org.uk Other useful resources can be found at www.anu.edu.au/aphcri/, http://chrsf.ca/home_e.php, www.sdo.Ishtm.ac.uk and www.npcrdc.ac.uk

5. Outcomes of the Literature Review

5.1 Integrated Care in New Zealand

It can be argued that there is a long and chequered history of efforts to integrate health care in New Zealand. Despite the apparent benefits to service users and providers of seamless services tailored to meet individual needs, a combination of professional, organisational, financial, statutory and other factors conspire against integration in many areas.

Organizational fragmentation of health, social care and related services across the New Zealand Health System, local government and other providers, and their respective differences in accountabilities, governance, culture and management are significant obstacles. A variety of government interventions and reforms have sought to overcome these by encouraging a shared agenda, and current devolution is now allowing some divergence in approach between District Health Boards (DHBs) and Primary Health Organisations (PHOs) in New Zealand.

However, the integration challenge remains acute despite repeated and well-intentioned efforts to achieve collaborative outcomes within health, itself let alone between health and other social services. The frustration with getting integration to work in practice has attracted the attention of researchers and policy makers nationally and worldwide, and there is a considerable body of literature that both offers theoretical insights into the complex issues involved and practice guides to assist managers and practitioners in this field as cited by Williams & Sullivan (2009).

The process is not enhanced by the relationships between primary and secondary care which are derived from a market-orientated model of purchaser and provider.

A composite of New Zealand Literature obtained through the internet demonstrates that increasing demand on secondary care services has made funders and providers alike to seek solutions for what has been identified as 'widespread systems failure' (Clarke et al 2003). It would appear from literature obtained that the key players in New Zealand are Counties Manukau, Waitemata, Tairawhiti, Capital and Coast, and Canterbury DHBs.

However, in stating this it would be naïve to classify these DHBS as the only ones working in the field of integrated care, as from the writers experience, there are many 'in- house' DHB documents and projects that have been or are currently being implemented.

At a national level, for example, it could be argued that The New Zealand Cancer Control Strategy (2003) The New Zealand Cancer Control Action Plan Strategy (2005), The Health of Older People Strategy, published in April 2002 ,Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan (2005) and Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015 released in August 2006 are all exemplars of one form or another of integrating services and care.

5.2 International Literature

In broad terms, there are many useful examples in the international literature derived during the search. However, most of the literature stems from Primary Care integration with Community Care. Scarce research results on case studies show varying degrees of success.

Implementation of the Integrated Care Pilots in the UK is mainly focused on individual sites and integration of a specific service such as services for older people, the chronically ill or the mentally unwell (Carter 2009 ibid).

Evidence of the integration of primary, secondary and community care appears to be elusive except in the Kaiser Permante Model.

In presenting the findings of the Literature Review in both theory and practice the document has been structured as follows:

- Defining Integrated Care
- Conceptual Issues
- Core Characteristics of Integrated Systems
- Evidence on Integration
- Ten Principles to support Integrated Care Models
- Next Steps to Implementation
- Evaluation

6. Defining Integrated Care

To implement integrated care and integrated care models it is necessary to understand what the terms really mean.

There has been a common trend in recent health care reforms in many European countries and worldwide a focus on a more coordinated and integrated forms of provision to overcome the flaws associated with fragmentation (WHO 1996 & Stocker et al (1999).

Though various countries in the WHO European Region have introduced a range of mechanisms to link levels of care more closely, a lack of common terminology and plurality of definitions complicates communication and application.

The WHO European Office for Integrated Health Care Services suggested the following working definition of integrated care:

"Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency." (Grone et al 2001, WHO)

Rosen and Ham (2008) state that in its most complete form, integration is a single system of needs assessment, analysing and understanding demand for service provision that aims to promote alignment and collaboration between the cure and care sectors.

A recent review of the literature on integrated care revealed some 175 definitions and concepts (Armitage and others, 2009). Such diversity reflects what one commentator refers to as 'the imprecise hodgepodge of integrated care' (Kodner, 2009).

When considering integrated care, it is important at the outset to distinguish between integration and integrated care. Integrated care is an organising principle for care delivery with the aim of achieving improved patient care through better coordination of services provided. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care.
Accordingly, where the result of efforts to improve integration is beneficial for patient groups, so the outcome could be called integrated care (Kodner and Spreeuwenberg, 2002).

6.1. What is Integrated Care?

The patient's perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to 'impose the patient perspective as the organising principle of service delivery' (Lloyd and Wait, 2005: p7).

6.2 What is Integration?

It is the processes, methods and tools of integration that facilitate integrated care. Integration involves connecting the health care system (acute, community and primary medical) with other service systems (such as long-term care, education or housing services) (Leutz, 1999: p77–78).

Although often used synonymously it is also necessary to distinguish *coordination* (the relation of parts) from *integration* (the combination of parts into a working whole) (See Table 1 over page).

Table 1: Concepts of Autonomy, Coordination and Integration - A Comparison

	Autonomy	Coordination	Integration
Health Information	Circulates mainly within a group of the same partners	Circulates actively among groups of different partners	Orients different partners' work to agreed upon needs
Vision of System	Influenced by each partners' perception and possibly self interest	Based on a shared commitment to improve the overall performance of the system	A common reference value, making every partner feel more socially accountable
Use of Resources	Essentially to meet self-determined objectives	Often to ensure complementary and mutual reinforcement	Used according to a common framework for planning, organisation and assessment activities
Decision Making	Independent coexistence of decision-making modes	Consultative process in decision making	Partners delegate some authority to a unique decision mode
Nature of Partnership	Each group has its rules and may occasionally see partnership	Cooperative ventures exist for time limited projects	Institutionalised partnership is supported by mission statements and/or legislation

Source: Grone 2001 ibid

Strategies of health service and system configuration hence can be understood as distributed along a continuum, with *autonomy* being its one end and *integration* being the other, while *coordination* refers to an in-between point.

It can be argued that the goals of integration are to enhance quality of care, quality of life, patient outcomes and efficiency in the use of resources.

Nevertheless prior to implementing integrated care Shaw et al (2011) have developed the following key prompts to assist in decision-making as to whether this is the best form of service change that is required.

Table 2 - Key questions to ask when pursuing and developing integrated care

Key questions to ask when pursuing and developing integrated care	
Feature	Key Questions to ask
Goal	a) What are you seeking to achieve by pursuing integrated care? What is the problem that you are addressing? Is integrated care the 'best' solution? b) What is the initial target service user group? How will you ensure that service users remain the organising principle for integrated care throughout? How will integrated care address inequalities for service user groups, as well as the wider community? c) How will you ensure organisational support for the goals of the project (for example, a senior officer responsible for delivery, a dedicated budget)?
Context	d) Is the proposed integration project associated with any other improvement programmes? How will this impact on local integration? What competing national or local agendas do you need to consider? e) Which sectors are involved and what is their role in relation to integration (for example, patients/public, primary care, acute care, third sector, private sector)? What are the potential consequences of integration on other parts of the health/social care economy? f) How will you bring in strong, visible leaders from each integrating organisation or group to champion the change? How will you ensure dialogue and consensus across stakeholders and/or organisations about the shared objectives of integration and about the need to spend resources differently?
Type	g) What are the most important integrative processes for your project (for example, joint administrative processes, aligning financial incentives, coordination of clinical services, developing shared values)? What existing structures, partnerships and processes can you build on? What will you need to start from scratch? h) How will commissioning arrangements support and enhance integration rather than perversely incentivise it? i) How will you ensure effective data sharing and management of information, both of which are crucial to the success of integration?
Breadth	j) How will vertical or horizontal integration (i.e. integration across different levels and/or aspects of the care system) contribute to the success of your project? How might you avoid a possible disconnect (for example, between horizontally integrated primary/community services and vertically integrated care pathways)? k) How will you address issues of choice, competition and contestability? How will you keep momentum and ensure a sustained focus on integrated care? l) How will you identify and align the incentives needed to

Key questions to ask when pursuing and developing integrated care	
	support integration across professional groups, teams or organisations?
Intensity	m) How does the degree of integration (full integration, coordination or linkage) relate to your goals and the local context in which you are working? n) How will you ensure that integration within one part of a health economy does not result in inappropriate and/or increased fragmentation elsewhere?

A focus on integrated care can help policy-makers, managers and practitioners decide on the model of care they mechanisms that enable integrated care to develop. The term 'integrative processes' provides a link between the concept of integrated care (in terms of the ambition to deliver services across providers with minimal duplication and disruption, and with high-quality outcomes and patient).

In the literature, five main types of integration are typically described (See Figure 1 below and Table 3 over page).

Each type of integration is enabled through a range of integrative processes, some of which focus on systems and structures; others on less tangible aspects such as professional behaviour and teamwork. However, analysts tend to use diverse and confusing terms and, in some cases; focus on areas and processes of specific relevance to the integration project under consideration only.

In the UK, recent government policy has encouraged health and care providers to consider integration in terms of aligned organisational structures and shared governance arrangements.

Source: Lewis et al (Where next for integrated care organisations in the English NHS The Kings Fund and Nuffield Trust)

Figure 1 - Typologies of Integrated Care

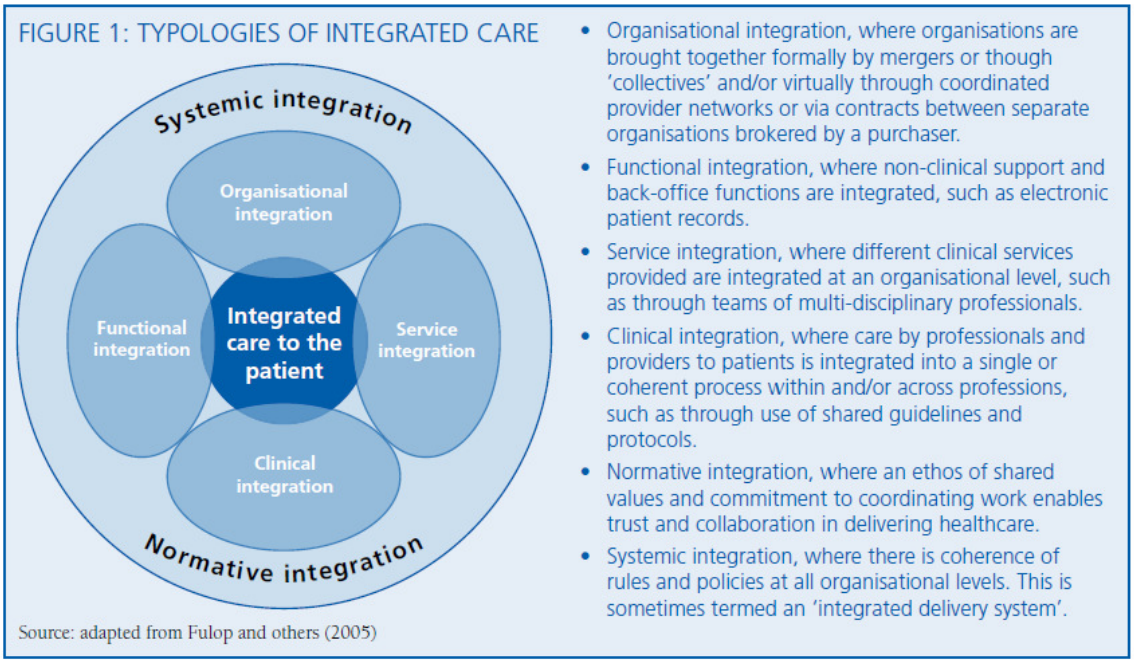

Table 3: Description of the Five Main Types of Integration and Allied Integrative Processes

Description of The Five Main Types of Integration and Allied Integrative Processes	
1. Systemic	Coordinating and aligning policies, rules and regulatory frameworks for example, policy levers emphasising better coordinated care outside of hospitals, central impetus for diversity of providers, development of national incentive schemes or financial incentives to promote downward substitution.
2. Normative	Developing shared values, culture and vision across organisations, professional groups and individuals for example, developing common integration goals, identifying and addressing communication gaps, building clinical relationships and trust through local events, or involving service users and the wider community.
3. Organisational	Coordinating structures, governance systems and relationships across organisations for example, developing formal and informal contractual or cooperative arrangements such as pooled budgets or practice-based commissioning; or developing umbrella organisational structures such as primary care federations or local clinical partnerships.
4. Administrative	Aligning back-office functions, budgets and financial systems across integrating units for example, developing shared accountability mechanisms, funding processes or information systems.
5. Clinical	Coordinating information and services and integrating patient care within a single process for example, developing extended clinical roles, guidelines and inter-professional education, or facilitating the role of patients in shared decision-making.

There is no hierarchy of integrative processes. Rather, the goals of any integrated care initiative must guide decisions about the processes that can best facilitate integrated care within any particular setting. It is unlikely that all types of integration will be relevant to every project. Decisions about which are most relevant will be guided by, for instance, the goals of the project, the stakeholders involved, existing local arrangements

for health (and social) care and the available resources. However, Shaw et al cite there are additional points to bear in mind when thinking about how to integrate:

- Some types of integrative processes will be more important than others. For instance, where the goal of integration is to develop joint working across health and social care, an important focus will be on establishing work groups as a way of engaging care professionals in the operation of integrated care (Simoens and Scott, 2005); developing structures and processes to enable teams and/or organisations to work collaboratively towards common goals (Rosen and Ham, 2008); and/ or building leadership and management capacity to facilitate partnership(s) (Feachem and Sekhri, 2005).
- The interplay between different types of integration can influence the value that can be secured. For instance, integrating administrative processes can significantly aid integration of clinical services into a single process (Shortell, 2000). Similarly, simply focusing on organisational integration in an attempt to integrate providers is unlikely to create improvements in care for patients (Ramsey and Fulop, 2008) and can fail to alter the way in which doctors practise medicine and collaborate with other health care professionals (Burns and Pauly, 2002), which also requires underpinning clinical and normative changes in teamwork and care delivery.
- Integrative processes can have unintended effects. For instance, whilst targeted financial incentives can provide a valuable means of changing clinician behaviour, they can also increase bureaucracy, motivate unintended behaviours such as gaming or cherry-picking (Oxman and others, 2008), and potentially counteract the development of shared values and working practices (Rosen and others, 2011).

7. Conceptual Frameworks of Integration

A distinction often made is the one between horizontal and vertical integration, where ***horizontal integration*** focuses on competing or collaborating organisations, networks or groups in the health economy and might involve, for instance, grouping outpatient clinics within a geographic network of providers.

Vertical integration focuses on networks and groups at different stages of care within the health economy (what some analysts refer to as the supply chain or care pathway) and might involve, for instance, the drawing together of a hospital with local community services.

In addition, it may be 'real' or 'formalised' through organisational mergers or 'virtual' in the form of networks between different organisations underpinned by contracts or informal agreements.

Integrated care can be experienced at three levels:

7.1. Individual Patient Level Experience

Here the term integration may be used interchangeably with coordination to describe the close collaboration between different professionals and teams required to deliver timely, efficient and high quality interventions.

7.2. Local/Regional Level Experience (Service Level)

Organisational or clinical structures and processes designed to enable teams and/or organisations to work collaboratively towards common goals. Examples include clinical pathways that cross primary and secondary care, integrated health and social care teams and may include shared IT, administration and data systems that support timely and efficient sharing of processes (such as booking appointments) or information.

7.3. National Level Experience (Whole of Systems Level)

Here integration will typically describe structures and processes that link organisations and support shared strategic planning and development. Examples

include merged provider organisations that span health and social care services (such as care trusts); integrated funder and providers organisations (such as Kaiser Permanente, California USA); or the virtual integration achieved through joint strategic planning processes linking health and social care.

The terms continuity of care and integrated care are often used synonymously, however, they contain different connotations. While continuity of care is frequently understood to imply a patient perspective integrated care is here understood as a broader conceptual framework.

Continuity of care emphasizes the patients' experience and journey through the system of health and social services and hence provides valuable lessons for the integration of systems. Three main definitions of continuity of care refer to:

- *longitudinal or provider continuity* (seeing the same professional each time, with added value if there is a therapeutic, trusting relationship);
- *continuity across the secondary/primary care interface* (discharge planning from specialist to generalist care); and
- *continuity of information* (through shared records) (Freeman 2001)

Traditionally the focus in the New Zealand has been on 'vertical integration' (between health and other care professionals working together and between bringing different providers together in mergers

Ham *et al* (2008) identify four types of integration that are relevant for discussion

- integration of GPs and other primary care professionals into a primary health care team
- the integration of the primary health care team with other community-based health professionals
- the integration of the community-based team with social care
- the integration of the health and social care team with hospital specialists.

8. Core Characteristics of Integrated Organisations

Integration is more likely when several of the following are evident (Glendenning 2002):

- Joint goals
- Very close-knit and highly connected networks of professionals
- Little concern about reciprocation, underpinned by a mutual and diffuse sense of long-term obligation
- High degrees of mutual trust
- Joint arrangements which are 'core business' rather than marginal
- Joint arrangements covering operational and strategic issues
- Shared or single management arrangements
- Joint commissioning at macro and micro levels.

Porter and Teisburg (2006) say that the original idea of managed care was that "a primary care physician close to the patient would ensure that the care delivered was neither too much nor too little, involved appropriate specialists and reflected individual patients' needs and values"

9. Evidence on Integration

Ramsay and Fulop's (2008) summary of published research on integrated care shows that most research has focused on process measures rather than outcome measures with the majority of reports on American experience. Methodology for economic evaluation has been weak, supporting only limited inference about the cost-effectiveness of integrated services. Presenting her findings around different structural forms of integration in health care, Fulop (2009) summarised the evidence to date in three main groups:

- **Integration of payer and provider** has been found to result in improved partnerships between participating organisations and greater focus on case management and information technology (IT) use. Impact on admissions and cost of care is under-evaluated, with only weak evidence available.

- **Integration of providers** shows some evidence of improved partnerships and increased capacity but limited evidence on cost and improved health outcomes. Progress was found to be limited by poorly coordinated national policy initiatives.

- **Virtual integration through networks** was also explored, with mixed results in relation to impact on communications and limited evidence on cost and clinical outcomes. There was also some evidence of staff resistance to changing roles.

10. Ten Principles to support Integrated Models of Care

Ten principles for supporting the development and mainstreaming of integrated models of care have been identified from the literature (Adapted from Rosen and Ham 2008)

Form Should Follow Function

The starting point for integrated services should evolve from primary care to secondary and community care thus improving the patient experience, clinical outcomes and value for money. This is important as primary health care links communities to first contact heath care, facilitates access to other health and related services and coordinates care for those with complex and chronic care needs (Starfield et al 2005)

Alongside improving patient experience, there is a need to pursue population and health promotion goals. With this starting point, many possible services and organisational forms could emerge to address defined goals, and the central challenge will be to build that characteristics identified by Glendenning (ibid) across whatever organisational form emerges.

Create a Receptive Context for Change

Several factors are important in creating a context in which integrated organisations can thrive. Some maybe national - such as the need for tolerance or 'waivers' (such as a 'holiday' from national policy) in relation to selected financial, data governance and employment regulations - and others are local, such as ensuring there is high-level 'buy-in' to integration efforts across all participating organisations, with a clearly focused and understood vision for care or set of objectives.

Robust Governance and Transparent Accountability

Governance encompasses high-level or system-wide ways to 'Integrated Care Systems' and local mechanisms to support transparency and assure quality. The former includes the extent to which choice, contestability, regulation and contractual mechanisms are

the best means to ensure high-quality care in integrated care organisations. The latter focuses more on public reporting of performance and outcomes; patient feedback; and overall planning to ensure good practice and maintain quality.

Align Incentives

For District Health Board primary/secondary care-led integration to deliver care in community settings presents both threats and opportunities. The immediate financial disincentives are obvious, but these can be mitigated over time. Integration could help to manage problem areas for DHB's such as pressures associated with growing accident and emergency attendance or appropriately reducing avoidable hospital observations and admissions for treatment for which the national price is below the local cost of delivering care in hospital. Alternatively, integration may allow growth in an area of clinical strength to replace services that transfer to the community.

For GP's and primary care colleagues, the financial incentives associated with integration are likely to be an important determinant of progress. There is an argument that without a designated (probably risk-adjusted and capitated) budget for a defined population, linked to real transfer of financial risk and real opportunities for profits, there would be not enough 'grit' in the system to drive change. Testing out the impact of allocating a full capitation budget to an integrated group involving GP's, specialists and community clinicians serving the population in a locality should be an explicit aim of integrated care

Integrate the Data

The effective development of financial incentives will depend partly on a step change in the ability of all parties involved to integrate and analyse data for different purposes. Peer review of clinical performance, assessment of need to target people for case management and other support, risk-adjusted budget allocation, performance monitoring of new services and management of at-risk budgets are interrelated activities that are all dependent on accurate, integrated and well analysed data.

Preserve Choice

At a patient level, choice through support for self-management and shared treatment decisions are crucial elements of high quality integrated services. The baby-boom children of now-aging parents with multiple long-term conditions were seen as key advocates of choice, who will drive improvements in current services.

Scale is Important

There is no clear answer in terms of population size required and to a large extent this will be determined empirically by the population size required to manage an acceptable level of financial risk on a risk-adjusted capitated budget.

However, Rosen and Ham suggested in 2008 at least a population of 50,000 people would probably be in a reasonable position to manage these issues. Yet, research shows and has been tested (Shaw et al) that more rapid progress can be made by smaller groups (Boutique Pilot Sites) that do not have to spend time building high-trust relationships across multiple organisations.

'It's the Relationships, Stupid'

Glendenning's list of common characteristics of integrated organisations includes shared goals, high trust, close networks and shared processes - each of which takes time to develop issues lacking in the current development of clinical service plans and models of care.

For integrated care systems, these characteristics must develop horizontally across clinical teams, vertically across primary and secondary care organisations and in many cases across the organisational and cultural divides of health and social care, assuming that they do not exist at the outset.

It Takes Time to Make Integration Work

The need for high-trust relationships and shared goals and values will inevitably shape the nature and duration of the start-up phase of any Integrated Care System. However, the formation and development of these relationships cannot be rushed.

Other essential elements of the start-up phase include:

- Strategic discussions with local trusts
- Inclusive planning of all stakeholders across the primary, secondary and community health services
- Establishing robust governance arrangements
- Integrating data sources and compliance within the data protection regulations

- Agreeing outcome and value for money metrics
- Developing together robust reporting systems
- Developing together local financial incentives
- Exploring options for local budgetary 'innovations' such as integrated packages of care to begin with

Each will take time and effort to achieve and a combination of practical and technical support in these areas along with waivers of selected regulatory requirements could speed the journey to effective integrated service delivery.

It may take several years before integration results in significant improvements in clinical outcomes.

11. The Steps to Implementation

The Primary Health Care Strategy and current government and Ministry thinking strongly supports the development of Integrated Family Health Centre's (IFHC).

Whatever the focus, integrated care initiatives rarely move smoothly along a continuum in a linear fashion from linkage, through coordination to full integration.

As with any structural, organisational or behavioural change, the process of integrating care may involve complete transformation, for example creating new organisations and shared governance arrangements, or more limited shifts, such as building on a strong history of communication across health professionals to establish a clinical network supported by shared clinical information. The former is rare and, as a result, a small number of 'boutique pilots' tend to be frequently cited in the literature (Shaw et al).

So what are the next steps?

There is no single 'best way' to achieve integration, but there are some common ingredients for success that can form the basis of a local action plan by using lessons from international experiences and targeting the achievement of the components identified for the future generic integrated rural health/hospital services .

- Ensure that improved patient care remains the main objective of every proposal and that overall the goals for an IFHC are clearly articulated and shared. Use this

as the starting point for deciding the structures and processes needed for integration and the rationale for clinical engagement.

- Develop integrated packages of care that involve the rural trusts .primary care and rural hospital clinicians with the DHB Funding and Planning Arm and Provider Arm Clinical Directors in the strategic development of integration plans. They need time to adjust to changes in patient flows that might result and develop alternative service lines if their departments are to become involved in integrated services.
- Invest in creating integrated teams and/or organisations with shared goals and values. It takes time and effort to build the relationships, trust and clinical leadership required for effective management and successful integration.
- Ensure that pooling clinical, and where possible, social care data is a condition of approval for IFHC to support needs assessment, risk stratification, outcomes monitoring and performance management.
- Undertake work to unbundle national prices, and identify risk-adjusted budgets and resources that can be allocated to an integrated team or service.
- Start early to develop robust governance and clinical governance arrangements. These must clearly identify the roles and responsibility of each participating group in relation to performance, quality and risk and be linked to transparent accountability arrangements.
- Map the existing financial and non-financial incentives that affect all potential members of an integrated care service. Consider local micro-incentives that will influence the professional practice of all involved.

Nationally, there maybe a need for waivers of selected rules and regulations governing PHO & DHB activity and an emphasis on experimentation and willingness to support some risk taking. Of particular importance will be:

- Support for IT innovation
- National leadership on outcome measurement to support outcome evaluation of integrated services.
- National guidance on governance and accountability arrangements for different forms of integrated organisation; rapid learning and efficient dissemination of early experiences will be particularly important here.

It is important to recognise that integration is not a panacea for all or it will result in being a 'band aid'.

Policy-makers need to avoid rushing to make judgements about the progress and to ensure that the policy context facilitates closer integration of services, and supports clinical and managerial leaders within the New Zealand Health System to demonstrate proof of the concept.

Are financial incentives the answer? The United Kingdom has set up hospitals as profit centres seeking to generate surpluses for investment under the regulatory regime established by Monitor, recent health reforms have put significant barriers in the way of necessary changes in clinical practice.

Anecdotal evidence of specialists being instructed not to undertake work that reduces hospital activity and income, or that is not remunerated under the Payment by Results tariff, such as telephone consultations with GPs, offer powerful evidence of this. In effect, financial incentives serve to lock in an outmoded model of care and provide no reward for the integrated models that should be at the centre of the health care system of the future.

In theory, world class commissioning and practice-based commissioning were intended to act as a countervailing force to Payment by Results and the establishment of foundation trusts, with the aim of moving to the new model of integrated care. In practice, neither primary care trusts nor practice-based commissioners in most parts of the NHS found it easy to challenge the power of acute hospitals, with the result that activity levels in hospitals have continued to increase and progress in developing care in alternative settings has been slow and uneven. The reasons for this can be found in the inherent difficulties involved in commissioning health care services, not just in the NHS but in other health care systems (Ham 2008), and the relatively weak incentives available to commissioners(Ham 2011).

It has to be asked is this an approach New Zealand wishes to follow already knowing these failings ?

12. Evaluation of Integrated Care

Evaluation has to support diverse expectations and provide robust results

There are five desired outcomes from integrated care:

1. Rapid improvements in quality of care and in health and equity.
2. Improved patient and user satisfaction and quality of life.
3. Improved partnerships in care provision.
4. More efficient use of resources.
5. Improved relationships, governance and risk management between participating organisations.

Overall, although many case studies can be found in the literature on integrated care, studies based on sound evidence related to the effectiveness of integrated care strategies are still rare (Freeman 2001 [2]). In selected areas related to continuity of care evidence is available on improved patient and staff satisfaction, reduced costs and hospital admissions and tests, better follow up attendance and screening uptake rates.

The major shortcoming in the literature is that *integration* or *continuity* is frequently not defined or conceptualized. Consequently, it is difficult to review systematically the findings in this area. Furthermore, not many studies provide quantitative outcome measures and experimental study designs, which, however, are requested by policy makers, managers and clinicians.

Further work is needed to identify:

- the specific problems of fragmentation that integrated care initiatives seek to resolve
- the impact of integrated care on patient experience and improved processes of care
- how integration changes patterns in the use of services (especially inpatient care)
- the impact on costs and outcomes (Ramsey and Fulop, 2008).

It is therefore vital that those pursuing integrated care consider how development and impact will be evaluated and measured. Evaluations of integrated care initiatives tend to focus on the processes and outcomes involved. Any such examination also needs to account for the context in which integrated care develops, and the diverse perspectives

(service user, provider and so on) and levels of health care provision involved. Traditional research methods (such as randomised controlled trials) are often not feasible as they fail to capture the context and evolutionary processes allied to integration (Vrijhoef, 2010)

Novel measurement approaches are being used in the UK to evaluate the integrated care pilots established by the Department of Health for England (Ling and others, 2010). The plan is to track the hospital use of a set of individuals receiving integrated care – both before and after the individual started to receive the care – using linked, administrative datasets.

Since a robust comparator is essential, but randomisation is not possible, controls are selected retrospectively from within the large datasets. There has been a tendency for evaluation of integrated care to focus on 'boutique pilots' which is making it difficult to generalise findings to other health and care settings (Ouwens and others, 2005). The challenge for managers, clinicians and service users is to propose and support an evaluative component at the outset of any integrated care initiative.

The aim should be to make a robust contribution to the emerging evidence base for integrated care, encouraging users, planners and decision-makers to become more directly involved in shaping evaluation, and appreciating where the big gains are to be made in developing better integrated care.

Those evaluating integrated care must be clear about the comparator used within any study. Appropriate choice of comparator is vital in reaching a view on the effectiveness of integrated care. For instance, the association between the features of integrated systems and high-performance systems may not imply causation. Evaluators therefore need to ensure clarity about whether they are comparing integrated against fragmented care; more against less integrated care; or a newly integrated model against a previous less integrated model.

A key challenge for policy-makers and planners pursuing evaluation is to develop more suitable approaches to measuring and assessing integrated care. Such work requires sound theoretical underpinnings in order to guide evaluation and measurement, and the use of both quantitative and qualitative methods. Such an approach might help measure integration, for instance, not only in relation to the impact on health outcomes, but also improved quality of care, service user satisfaction, and effective relationships and systems.

While the evaluation of (multiple) outcomes in integrated care systems is hampered by the complexity of such programmes and the timescale necessary to establish results many instruments have been developed in the evaluation sciences that take into account the nature of the intervention, i.e. the application of *quasi-experimental* designs (ex ante and ex post designs) where longitudinal, experimental designs are not applicable for the evaluation of integrated care programmes. In addition to quantitative evaluations of integrated care programmes triangulation techniques and qualitative evaluations should be used in parallel in order to identify the critical components of a programme and to increase the understanding of the generality of integrated care strategies.

Shaw et al drawing on the work of Leutz, 1999; Kodner and Spreeuwenberg, 2002; Ahgren and Axelsson, 2005; Lloyd and Wait, 2005; Armitage and others, 2009; Strandberg-Larsen and Krasnik, 2009; Vrijhoef, 2010), include:

- Approaches to evaluating integrated care that:
    - situate it within wider health and care systems
    - acknowledge the level and combination of strategies used based on the challenges faced in obtaining appropriate quality care for local communities and user groups
    - consider the contextual factors that affect development and delivery.
- Standardised, validated tools and indicators that measure integration across different settings relative to a set of models, structures and processes.
- Focused, 'off-the-shelf measures' that suit a specific purpose or aspect of integrated care which can be applied by decision-makers and planners across diverse health and care systems and settings.
- Qualitative and mixed methods approaches (such as comparative case study research and/or realistic evaluation) that facilitate understanding of which integrative processes work, for whom, and in what circumstances.
- Longitudinal methods that move beyond simple snapshots of integrated care and follow integrative processes through time, allowing evaluators to assess not only the long-term implications for integrated delivery, organisation and outcomes, but also the way in which planned change is actually experienced for those with long-term conditions.

Table 4 - Examples of existing methods for evaluating the extent of integrated care and its impact

Examples of existing methods for evaluating the extent of integrated care and its impact (Source: Adapted from Strandberg-Larsen and Krasnik, 2009)		
Method	**Measuring**	**Example**
Audit of medical records	Clinical integration	To explore the coordination of care for patients visiting a setting involving multiple providers
Analysis of administrative datasets on hospitalisation rates compared to individually matched controls	Organisational, administrative and clinical integration	To assess the extent to which changes affect the hospital use of patients compared to matched controls
Self-assessment form for managers	Administrative processes supporting service coordination	To evaluate the degree of integration across local health care settings
Annual surveys and disclosure reports, and financial data	Administrative integration and intensity	To examine the relationships between a hospital's structural clinical integration and average total discharge cost per patient
Questionnaire survey for managers and clinical leaders	Clinical and administrative integration	To measure perceived levels of clinical and administrative integration, along with perceived effectiveness of these activities
Qualitative interviews with hospital executives	Organisational and normative integration	To examine the degree to which the processes of integrating doctors and hospitals are closely linked to the structure and content of integrated delivery systems
Interviews, web forms and workshops with service coordinators	Organisational and clinical integration	To produce a new measure of integration quantifying the extent, scope and depth of integration within and across organisations, sectors and services
Questionnaires, interviews and focus groups with staff and managers	Normative and organisational integration	To investigate the experiences of front-line staff working in integrated health and social care organisations

12. Conclusion

In conclusion, the terms Integrated Care or Integration require further understanding prior to implementation. These terms have become part of 'health jargon' and are often used inappropriately in conversation or as an invalid methodology for solving problems in delivering health services.

Integrated Care is not a "One Stop Shop". It is not a "single entry point" or a "24 hour/ seven day a week service unless it is designed to resolve those particular issues e.g., fragmented services.

To focus upon Integrated Care Models suitable for establishment that fufill the current policy context ten principles to support the development and mainstreaming of integrated care models and next steps for implementation have been offered for discussion and debate along with models of evaluation.

This literature review has examined what is meant by 'integrated care', clarifying the underpinning concepts and identifying the features relevant to integration across care settings.

Shaw et al(2011) recomend four key points for those pursuing integrated care:

1. Integrated care is best understood as a strategy for improving patient care. Integrated care is concerned with improving patient care through better coordination. A decision about the intensity of integration is essential, starting with links across services, coordinating teams or pooling resources. Where there is a strong history of partnership working, further steps to amalgamate into a single integrated organisation may be more feasible (although integration that is focused largely on bringing organisations together is unlikely to create improvements in care for patients).

2. The service user is the organising principle of integrated care. Careful analysis of the goals of integration is critical in order to establish what might help or hinder progress. There is a need for a shared vision in which the service user perspective and patient experience is central. This will then shape how, when and where to integrate services in order to improve patient care. Policy-makers and

practitioners should use the prompts provided in Table 2 to inform discussion and decision making about when to integrate, how and why.

3. One form of integrated care does not fit all. There is no one model of integrated care that is suited to all contexts, settings and circumstances. Careful analysis is needed about the different integrative processes that can support integration within a particular care setting. Decisions about which approaches are most relevant to a particular setting will be guided by the goals of the project, the needs of service users and other stakeholders involved, existing provision and available resources.

4. It is only possible to improve what you measure. There is a shortfall in evidence of the impact of integrated care. What evidence there is tends to be drawn from a limited range of settings and initiatives, which focus on structures and processes, and involve limited assessment of outcomes or costs. Further work is urgently needed to identify what integrated care initiatives work best for whom, and in what circumstances.

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