

In-flight integration: learning from Australasia

This special edition of the *Journal of Integrated Care* comes at a time of rapid change in the delivery of health and social care services across Australasia. Population and patient/client demands are changing rapidly in ways which could not be envisaged even a decade ago. Structural reforms in, and societal expectations of, the health, aged care and disability sectors are re-shaping the way services are funding, staffed and delivered. The converging agendas of client controlled care, co-design, and the broader neo-liberal agenda have resulted in a period which has been described by some critics as an attempt to build an airplane while still in flight (Whalan *et al.*, 2014).

Internationally there are two areas which are highlighted as key elements of integrated care policy. These are patient-centred care, where there is recognition that patient experience and choice along with a focus on the consumer voice are essential to effective care provision, and the requirement for a skilled workforce of healthcare professionals in which to deliver this care (Oliver-Baxter, Brown and Bywood, 2013; Oliver-Baxter, Bywood and Brown, 2013). Planning for future needs is a key element of this. Concurrent calls for integrated, safe and high-quality care across all sectors have emerged from the recognition that services have, and continue to, fall short on these principle measures. In order to meet these requirements, new approaches need to be developed. The argument made is that these reforms will result in greater control of care by clients, but whether they will produce either better or more integrated care, or indeed if these will necessarily result in better patient/client outcomes is still under debate (Billot *et al.*, 2016).

In the Australasian region, there is also a growing awareness of the need for the integration of healthcare and other services to ensure that care is organised and delivered in ways that are meaningful to the person receiving the care. As with other nations, countries in the Australasian region have focussed efforts to support better integration, responding to what the World Health Organisation (2015) says is the need “for a fundamental paradigm shift in the way health services are funded, managed and delivered” (p. 7).

Integrated care must be provided contextually, to reflect the needs of individuals and communities. From the policy context, efforts in Australia and New Zealand to improve care integration are underway, with a view to creating the macro-levels of support across jurisdictions (Oliver-Baxter, Brown and Bywood, 2013; Oliver-Baxter, Bywood and Brown, 2013).

In New Zealand, policies have moved from the Primary Health Care Strategy (2001) to the Better, Sooner, More Convenient (2009) which has a greater emphasis on integration through mechanisms such as alliance contracting (Ministry of Health, 2001, 2011). Much of New Zealand now has a shared governance model, where there is a formal alliance between each of New Zealand’s 20 District Health Boards and the 30 corresponding primary health organisations. It is said that these alliances have the potential to enhance collaboration by bringing different health professions together with a focus on care from the perspective of the patients (Gauld, 2014).

National Health Reform in Australia has also recognised the need for integrated health care where there is partnerships across Commonwealth, State and Territory governments, as illustrated in the 2011 National Health Reform Agreement (Council of Australian Government (COAG), 2011; Oliver-Baxter, Brown and Bywood, 2013; Oliver-Baxter, Bywood and Brown, 2013). In more recent times, the Commonwealth has engaged with state and territory jurisdictions to develop a National Primary Health Care Strategic Framework (Department of Health, 2013), with further work anticipated as part of Healthier Medicare – trial of health care



homes initiatives which will fund stage 1 of the Health Care Homes Primary Health Care Model (Department of Health, 2016).

In this edition of the journal, the authors grapple with exactly these “in flight” questions of integrated care. In a way they, and this edition of the *JIC*, are looking not so much “integration”, as at “integrating” in the same way that Amy Edmondson talks about the difference between “teams” and “teaming” as the dynamic form of collaboration, particularly in environments characterised by uncertainty and ambiguity (Edmondson, 2012). We can similarly interpret integrating care as a never ending process of negotiated or coordinated relationships (Gittel and Douglass, 2012) intended to produce better outcomes for patients and clients.

The authors in this volume span various elements of the integrating assembly process. These include broad perspectives on the impact of population changes (Robertson, 2017) and governance (Gauld, 2017) and the sector (Dickinson and Carey, 2017) and service responses to such changes (Stewart *et al.*, 2017). Phillips *et al.* (2017) and Patterson (2017) critically examine the purpose and the limits of an integrated approach, exploring one of the fundamental principles of integrated care: “why what matters to the patient [and to staff], matters”.

Robertson (2017) starts the issue making a case for a new perspective, based on one of the oldest disciplines – geography, as a way of understanding both the demand for, and ways to organise, care at a population level. For Robertson, health and social care services integration, particularly for the elderly, is not just about establishing organisational partnerships (although it is about that also) but about examining the historical roots as well as future demands for the location and integration of services. As he argues “[...] each new policy development has geographic implications that interact with existing spatial dimensions of demography, epidemiology and health and social care infrastructure. It is these dynamic spatial and temporal interactions that will produce shifting challenges for the degree of integration achieved in Australian health and social care as population ageing unfolds” (Robertson, 2017, p. 9).

For the Australian disability sector, the introduction of the National Disability Insurance Scheme (NDIS) marks the end of at least a century of organisational directed care. Dickinson and Carey (2017) describe the rationale of, what on the surface seems an entirely appropriate process of re-distribution of control from service providers to clients. What they find is a lack of clarity in terms of the boundaries of the NDIS, and “how it will work with a range of different services in the provision of seamless and consumer-direct care” (Robertson, 2017, p. 9). This lack of clarity, three years into the introduction of the scheme means that there is marked uncertainty about what the NDIS should look like, and most importantly how it will operate across the life of individuals whose needs and concerns do not fit neatly into a single category, which change – as most human needs do – over time.

Gauld (2017) provides a case study of an experimental form of integrated care governance in New Zealand, the alliance approach. Emerging in New Zealand in 2008, Gauld contrasts the alliance approach with more traditional alternatives of corporate, democratic or even the relatively recent clinical governance approach. Alliance South is said to present a multiprofessional, multiorganisational approach which has built relationships across primary care, public hospitals and allied health providers, and inclusive of a wide range of stakeholders ranging from “ambulance services, aged care residential homes, Maori representatives, and other contracted providers of public services such as rural hospitals” (2016, pp. 6-7). While still being evaluated, Alliance South has already commissioned professional networks, developed health pathways and is in the process of creating a Community Health Council to more actively involve the community in both the work of the Alliance and in its leadership.

These broad sector changes need to be understood within the context of localised attempts to improve not only the coordination of care, but also its value and efficacy in

specific contexts and for vulnerable groups. The final two papers provide overlapping as well as contrasting case studies of approaches to integrated care. Stewart *et al.* (2017) describe the “House of Care” approach used by one of the largest health districts in Australia (SESLHD) in their attempt to develop a whole of system, primary care; focussed, and integrated care model. Their approach speaks to the primacy of partnerships, ongoing consultation with patients and communities, and the value of multifaceted approaches in any attempt to redesign the delivery of care in accordance with Triple Aim principles (Berwick). The model builds on an organisational commitment to micro (e.g. patient self-management), meso (e.g. localised needs and risk assessments, staff training) and macro (e.g. single points of access and clinical pathways, shared goals) integration strategies.

Phillips *et al.* (2017) continue the organisational metaphor of homes and houses, this time the clients and staff of a refugee service, Companion House in Canberra, ACT. Here, however, integration is not directed by structural responses, but through the use of an organic combination of both formal and informal processes the “fostering of an emergent self-organising form of integration through a complex adaptive systems approach” (Phillips *et al.*, 2016, p. 15). This, the authors argue, has led to a people focussed, needs-based integration which speaks to the values underpinning the need for integrated care, particularly for vulnerable groups.

This edition is brought to a close by Patterson (2017), who examined the value of integrated care from the perspective of both population (Berwick’s Triple Aim) and person-centred approaches. Key to their paper is a challenge to all of those involved in integrated care: are health (and social) care providers able, they ask, to “[...] meaningfully capture the elusive and dynamic elements of the individual’s perception of their integrated care experience”? (Patterson, 2016, p. 10). Unwilling just to leave us with a question, the answer they propose is to develop a shared narrative that defines integrated care from the perspective of patients, carers and communities.

The use of integrating rather than integrated care is, of course, meant as a prompt to think about both the process and the purpose of integration in Australasia. As Robertson (2017) argues, the current demand for integrated care is the result of historical patterns, and historical thinking. What the other authors provide is evidence of how critical, organic and emergent responses provide is not only new ways of thinking about the delivery of services, but new ways of thinking about how care is defined, enacted and evaluated. Not only then must integration be built in flight, but without a pre-determined blueprint to follow.

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