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## Integrated Care

Physicians supporting better patient outcomes

Discussion paper

March 2018

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## Acknowledgements

The RACP would like to acknowledge the members of the Integrated Care Working Party that led the development of this document:

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The RACP would also like to express their gratitude to Ms Rebecca Edwards, Consumer Advisor, and also to representatives of the Royal Australian College of General Practitioners, Dr Evan Ackermann and Dr Sue Page, for their active engagement, valuable insights and contributions to this discussion paper.

The development of this document has been supported by the RACP Policy and Advocacy Unit, in particular Dr Kathryn Powell, Samuel Dettman, Jason Soon, Andrew McAlister, and Helen Craig.

## Foreword

It is widely accepted that although Australia and New Zealand's health systems generally deliver high quality care and good patient outcomes, there is fragmented service delivery, a lack of coordination across health silos, and an insufficient patient-focus. Low levels of integration and services that do not interface well can lead to gaps in care, conflicting advice or treatments, and duplication and wastage of resources. Patients can experience difficulties in navigating between services or accessing timely and targeted care. There can be instances of suboptimal care and poor patient outcomes, significant patient distress and disruption, as well as unnecessary use of valuable healthcare resources.

Health policy reforms must address the need to improve the integration of care delivery, retain and continually advance the quality and safety of services, and overcome inequities in health. Integrated service delivery structures are needed to better support accessible, more patient centred health services offered closer to home for diverse populations, compared to the hospital-centric and siloed services into which our services have evolved. Reorienting our way of delivering services is a sensible approach to addressing the challenges Australia and New Zealand share along with many countries with an ageing population, increasing numbers of people with chronic and multiple conditions, and uneven service distribution.

Although excellent examples of integrated care can be seen in Australia and New Zealand, these often work despite the system, and are not able to be more widely translated into the broader system as normal and best practice. This paper proposes a set of key principles to underpin effective and sustained integrated care, and includes enabling strategies to drive reforms so that integrated care becomes the norm rather than the exception. As is to be expected, this discussion paper predominantly focuses on better integrating the delivery of specialist care, drawing on core elements from successful trials of integrated care, and principles common to models of integrated care.

Fundamental to effective integrated models of care is a cross-disciplinary, cross-organisational approach; especially for patients who need care for multiple, chronic and often complex health issues. In Australia that will require strong cross-jurisdictional collaboration and cooperation and, most likely, new ways of funding and responsibilities. Regional planning, reporting, commissioning and organising are likely to come to the fore, providing challenges but also opportunities to drive a more patient-centred and connected health system.

There can be no single model or approach to integrated care that will meet the needs of all patients. The RACP is particularly cognisant of this due to the wide and varied range of medical disciplines that the RACP represents.

We need to be future-focused and move to service delivery environments where physicians and other clinicians are more collaborative (multidisciplinary team-based care), and supported to practice more in ambulatory and community settings. As an educational organisation, the RACP ensures our trainee physicians are well-prepared for clinical practice in these contexts, and supports physicians' continuing professional development in skills and knowledge associated with integrated care.

This discussion paper is the result of consultations within the RACP (which represents over 40 different physician specialties), and externally (other health professions and consumers). We look forward to contributing to the development of evidence-based, effective and innovative models of care that will better serve the future health needs of Australia and New Zealand.

**A/Professor Alasdair MacDonald, Chair RACP Integrated Care Working Party**

# 1. Background

Integrated care is about the organisation and delivery of health services to provide seamless, coordinated, efficient and effective care that responds to all a person's health needs. Models of integrated care are based on decisions about what services are needed, who is best to provide those services, and how patient access is facilitated. The practice of integrated care involves collaboration and cooperation between providers and services and occurs across primary, secondary and tertiary care; extending beyond a patient's regular medical home or single provider, and into the 'medical neighbourhood'. The medical neighbourhood for integrated care is inclusive of primary care providers, specialists, hospital services, and allied health providers. It is also closely connected with patient-centred care, and has informed and active shared decision-making between the patient, their support/carer and their clinicians at its heart. Fundamentally, it requires appropriate and effective systems and structures to facilitate, drive and support this collaboration and coordination.

Experience to date shows that while integrated care has significant support, it is not easy to deliver within a context as complex as healthcare. Different ways of integrating health care services have been explored since the 1990s. The potential benefits of integrated care have made it an important policy priority for the RACP. There is potential for integrated and patient centred care to:

- Improve the timely provision of appropriate care
- Reduce unnecessary or inefficient appointments or referrals made for patients
- Improve the patient experience
- Increase patient attendance and lead to fewer patients 'lost to lack of follow-up'
- Reduce the incidence or potential impact of conflicting clinical advice or management (for example, medication interactions)
- Lead to higher levels of professional job satisfaction
- Assist in reducing unnecessary hospitalisations
- Reduce waste of other professional services (unnecessary use of services) within the health system.

Members of the College have contributed to the development and implementation of more integrated and patient centred ways of service delivery within their practice areas and communities, and their experience is drawn upon in this discussion paper. It was also vital that there was input from the start from the health consumer perspective and from other health professional colleagues, in particular primary care.

## Health system reform in Australia and New Zealand

The Royal Australasian College of Physicians (RACP) is the professional medical College of certain physician specialties in Australia and New Zealand. We are aware of how differently the health systems in Australia and New Zealand are structured. As in any health care system, health reform initiatives must consider the impacts of changes, anticipating possible perverse incentives arising within their respective health system contexts.

A summary of the two different health systems is given here along with a brief potted history of initiatives towards more integrated models of healthcare (so as not to repeat more comprehensive timelines elsewhere).

Australia's health system has the following components:

- Medicare funding for public healthcare and some medical expenses for Australian and New Zealand citizens;
- Subsidised access to clinically-useful and cost-effective medicines under the [Pharmaceutical Benefits Scheme \(PBS\)](#);
- Commonwealth government funding of the primary health sector through general practitioners and the Aboriginal Community Controlled health sector;
- State government funding of public hospitals providing emergency, acute, and specialist care; subsidised by the Commonwealth government which also subsidises private hospitals (largely indirectly through private health insurance);
- Aged care services. Various not-for-profit, private and government organisations provide subsidised aged care services, such as residential aged care. Veterans' health services are funded separately through the Commonwealth Department of Veterans' Affairs.
- Community health facilities that offer a range of free or low-cost public health services, including immunisation and mental health services.

The Australian health care system has seen various reforms in the past. The range of reforms has included introducing divisional structures and clinical streaming in public hospitals, movement towards national activity-based funding of hospitals (2012), and the establishment of Medicare Locals (primary care) that were subsequently replaced by Primary Health Networks (2015). Other payment based reforms that have been implemented include the Medicare funded incentives to support chronic care planning by General Practitioners (GPs). This set of reforms responded to pressures on the health system in providing care for patients with chronic or terminal medical conditions (1).

More recently new models of care and pilot programs are being trialled, for example, the recent Health Care Homes trial. This trial is specifically for people with chronic and complex conditions and introduces important funding reforms in a move away from fee-for-service payments to a tiered capitation funding model.

At the state/territory level, there are many examples of projects that have arisen from a clear need to introduce better integrated ways of providing healthcare to improve patient outcomes and use limited resources more effectively. State funding has supported a number of excellent examples such as those through the Queensland Health's Integrated Care Innovation Fund (ICIF) and NSW Health's Integrated Care Strategy and range of 'Demonstrators', to name only two. There remains however, a lack of sustained and widespread integration between health sectors and in particular, between primary and hospital care (1).

The New Zealand (NZ) health system is structured differently, and has twenty District Health Boards (DHBs) that organize the healthcare of a geographical district. It comprises public and private components which include:

- Subsidised co-payments which apply to primary care and to a large number of medications;
- Public hospitals, managed and funded by District Health Boards;
- Health insurance organisations that provide treatment services for their members privately;
- Private health care system (which includes specialist services, primary care and private hospitals, and private accident, emergency and medical clinics);
- Emergency services provided through mixed public and private funding;

- The Accident Compensation Corporation for accidents (levy based).

Integrated care initiatives have been trialled in New Zealand since the 1990s. At this time general practices formed collaborative independent practice associations (IPAs). In 2000 there was an acute demand programme to reduce the hospitalisation of higher acuity patients in the community which is continuing in 2017. Later 'alliancing' was introduced in 2009 ('Better, Sooner, More Convenient') in which clinicians from across the system collaborate with funding providers and community agencies to redesign services for integrated care (2). Health Care Homes have been operating in New Zealand since 2011, and operate differently to the trial now underway in Australia (for example, there are different funding models for different Primary Health Organisations in NZ).

Integrated care has been facilitated by the incorporation of collaborative IT developments between general practice, secondary care, and local funders, such as HealthPathways and HealthInfo (2). HealthPathways or referral pathways that are adapted to local areas have been developed in most of New Zealand, and also much of Australia. Shared electronic records have also been introduced in both Australia and New Zealand with the aim of giving access of information to different parts of the health care system. Integrated care remains a current national aim as exemplified by the latest national NZ health strategy (New Zealand Health Strategy: Future direction 2016 – 2026) which advocates a one team approach to foster integrated care delivery.

## 2. Physicians and Integrated Care

There are numerous physician specialties that cover a broad spectrum of clinical practice; from the more procedural disciplines, to a range of generalist fields whose clinical services are more cognitive in nature (endocrinology, clinical pharmacology, and child paediatrics are indicative of the diversity). Common to all specialties is an emphasis on delivering high quality, coordinated and patient-centred care; involvement in multidisciplinary teams, although the makeup of those teams will vary. Another common need is for specialties to be able to access the right information at the right time, although the content and detail of that information may be different. Embedding well supported 'connecting mechanisms' that include specialists between and within health care sectors is essential for a more efficient, integrated and population oriented health system.

### 2.1 The role of physicians

For the patient, the physician role is to assist in the determination of diagnoses, advise on or provide treatment and management, undertake interventions and procedures, provide appropriate follow-up, inform and support the patient and their carer/family in their decision-making and ongoing management of their condition, communicate and work as a part of the broader health care team. In a patient-centred approach specialists have a critical role in communicating information to the patient and their carers, and other health professionals. Physicians are especially trained for patients with complex illnesses (including multiple medications), and for whom there may be episodic acute exacerbations, and where diagnosis may be problematic.

In relation to other health professionals, discipline-specific clinical expertise and leadership is often an important part of the physician responsibilities, alongside providing advice, education and support to GPs, nurses and allied health professionals. A better integrated and multidisciplinary approach to care will enhance the relationships and connections between health professionals in a defined area (geographical or population based), creating a working environment in which there are better opportunities for invaluable inter-professional learning and communications to take place. The importance of communication and the need to support professional communications cannot be underestimated in any health care system.

For the broader community, medical specialists play a key role in health prevention and advocacy about health issues.

In all relationships, trust is and reliability must be foundational.

Physicians are intrinsic to health reforms that seek to join up service provision for patients. Data from the 2015-16 ABS Patient Experience Survey [<http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0> Accessed 10/8 /2017] demonstrates how integral specialist services are in terms of population health:

- 36% of people saw a medical specialist in the previous 12 months. Of these 32% went once, 39% went two to three times and the remaining 29% went four or more times. The proportion of people who saw a medical specialist generally increased with age.
- People living in areas of least socio-economic disadvantage were more likely to see a medical specialist than those living in the areas of most disadvantage (39% compared with 36%).



- 16% of people saw three or more health professionals for the same condition. Of those 70% of people reported that a health professional helped coordinate their care. The health professional most likely to coordinate care was a GP (61%), followed by a medical specialist (24%).

Specialists have a key role to in relation to those patient groups that may be sources of pressure on the limited resources in health care systems. Specialist services provide vital services for the increasing number of patients with complex, chronic, co-morbid and acute conditions, and for specific population groups such as children and older people. Physicians specialising in generalist disciplines, such as paediatricians, geriatricians, general medicine physicians and rehabilitation physicians, have particular training and expertise in the longitudinal care of patients with multiple and complex conditions. They especially play a critical role where there are complex health issues, psychosocial problems, and difficulties associated with effectively planning care in cases involving conflicting health priorities.

When an integrated health care system is envisaged, the integration must include inbuilt mechanisms for straightforward timely referral pathways, transitioning patients across vertical and horizontal sectors, and for the communication of care related information and patient status to health professionals. This may also involve support for specialist to specialist integration. In addition to the contribution of their expertise, specialists may also participate in a more integrated health care system by co-designing information systems, communication tools, quality improvements, monitoring and critical evaluation strategies for services.

There is a growing body of evidence demonstrating the positive healthcare outcomes of integrated models of care that incorporate specialist services, and that these often constitute good risk management relating to the quality and safety of care. Integrated models of care involving specialists have targeted:

- Inpatient treatment. For example, recognising, investigating and managing underlying pathologies (such as iron deficiencies) (3).
- Palliative care. There is evidence that integrated palliative care can reduce hospitalisations and maintain functional status. For example, GPs and specialist palliative care teams in New Zealand where there was a commitment to partnership although based primarily on personal liaison, rather than formal systems (4).
- People with end stage heart failure and lung disease. Case conferences between specialists and GP's involving the patient's heart or lung failure team has been linked to significant reductions in service utilization, apparently by improving case coordination, enhancing symptom management and assessing and managing carer needs (5).
- High risk patients in general practice. The Gold Coast Integrated Care Model integrates care between primary care, and acute hospital services to better manage high risk patients with complex and chronic conditions. It is based on a shared care record and aims to reduce presentations to the health service emergency department, improve the capacity of specialist outpatients, and decrease planned and unplanned admission rates (6).

- More integrated care between primary care and specialist care. An example is the HealthPathways project which demonstrated the importance of formal partnerships to encourage system changes in practice (7).

## 2.2 Physicians and the “Third Space” model of service delivery

A model of integrated care is needed in response to the changing nature of disease, rising health care costs and the failure to adequately address the whole needs of our patients, including their physical, mental, and spiritual wellbeing. Physicians recognise the need to adapt the way in which they deliver their input into more patient centred care and integrated models of care. This means being less hospital centric and siloed in the way in which they work. Historically, physicians have worked within sections of the health care system designed for hospital based emergency care or procedural services, or short term consultative approaches to answer specific questions.

There are more options for delivering high quality patient care that do not need to be provided in a hospital setting. We may refer here to a ‘third space’ approach in which specialist services can be provided, and this may be a physical space or a virtual space. Out of hospital physical spaces include community-based clinics, residential aged-care, primary-care practices or a patient’s home. Virtual and technology enabled spaces include telehealth and digital platforms to support remote communications.

A more flexible and devolved or ‘third space’ model of service delivery that incorporated the use of a ‘third space’ could be supported within existing local structures such as through Primary Health Networks or through General Practices within a health care home model, and builds upon many existing approaches. This concept of ‘third space’ (more locally accessible care) can be developed at the local health community level to more practically serve patient and integrated health provider needs.

Two key pillars that are fundamental to the RACP vision for integrated care are:

- 1) Supporting specialists to undertake their role in informing, planning and contributing to care for patients with chronic, complex and multiple healthcare needs; and
- 2) Supporting specialists to work in community-based ambulatory settings – whether physically or virtually (the third space).

In advocating for enhanced levels of integration the RACP recognises that this involves exploring new ways of working, working smarter by strategically incorporating technologically enabled activities and being open to non-traditional models of care delivery.

The need for better integration of care has been promoted in many countries with universal health care systems and a single model is not commonly accepted as offering an evidence based solution, although there are good purpose developed approaches within the literature and examples currently in operation. There are however, valuable principles and enablers of integrated care on which ways of working may be based.

### 3. Principles of Integrated Care

To be effective, the RACP has proposed that integrated care systems need to be underpinned by the following core principles:

- 1) **Designed for patient-centred care.** Being patient centred is a core value for many physicians (8). The World Health Organisation (WHO) defines patient centred care or people centred health care services as "... an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways (9)". Achieving integrated care requires those involved with planning and providing services to respect and incorporate the patient's perspective (10). The perspectives of patients, families, and carers, should ideally be at the heart of any reforms (11, 12). Effective partnerships with patients improve clinical outcomes, reduce readmissions rates, lower rates of hospital acquired infections, improve delivery of preventive care services, and contribute to increased adherence to treatment regimens. There is some evidence to suggest that the failure to be patient centred (as perceived by the patient) has been related to higher rates of referral and diagnostic tests (8). This could be explained in terms of the patients' experience of being a participating member in the discussion of the problem and the treatment process can translate into the patients' reduced need for further investigation or referral, which may also serve to reduce the physicians' need as well (8).
- 2) **Focused on quality and safety.** Safety and quality need to be embedded across all health reforms and all integration of services. The evidence based research shows that fragmentation in health systems contributes to patient safety risks. Integrated systems of governance – for example in the context of medication safety—can actively improve quality and safety by managing patient risks, communicating standards, and measuring patient outcomes (13). Sources of patient safety risks include those associated with the processes of care, including administration, investigation, treatment, communication, and missed or delayed diagnoses, inappropriate treatments and errors in task execution (14, 15). The Australian National Safety and Quality Health Service Standards note that whilst integrated care is a potential contributor to improved quality and safety, the unintended consequences of changes to current models of care must be closely monitored to ensure quality and safety are not inadvertently compromised (16).
- 3) **Provides for measurable outcomes and supports regular monitoring, evaluation and continual quality improvement.** A priority for Governments and healthcare providers should be to invest in research to evaluate integrated care. For integrated care to be successful it must be underpinned by best available evidence, and supported over time through the assessment of measurable patient oriented objectives. Quality information and evidence, strong performance measurement, and a culture of improvement assists in better modifying and adapting health care approaches. This should comprise information from across the health care system and through which the participating organisations can be engaged in learning from the impacts.
- 4) **Allows for flexibility and local implementation.** Different local contexts impact the success of integrated care initiatives, and models of care should ideally be monitored and adapted over time (17). Therefore, flexible approaches to implementing models of care help to ensure

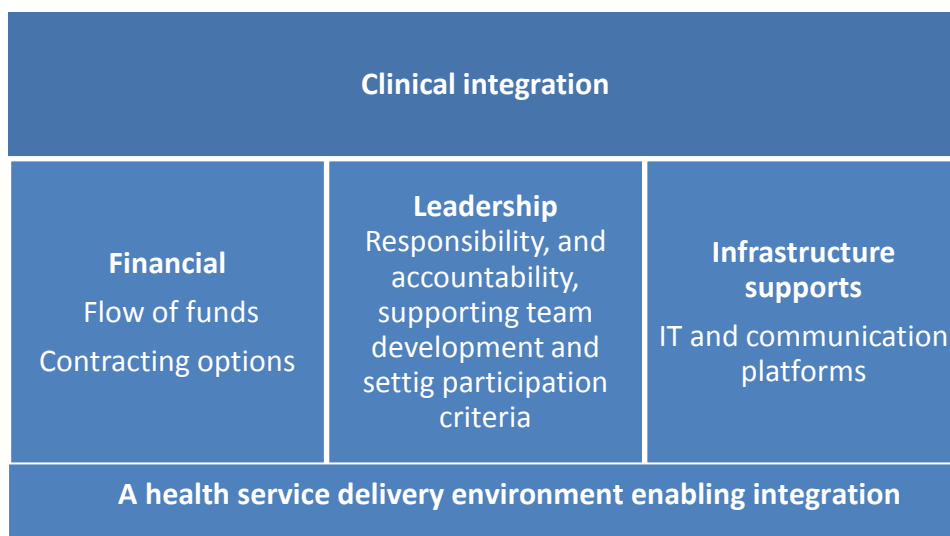
services are relevant to local settings, such as those in primary care, aged care, rural and regional contexts, and Aboriginal and Torres Strait Islander and Māori communities.

- 5) **Promotes a cross-sector, cross-profession approach, respecting the diversity of health care providers.** There are considerable benefits from developing integrated care that involves different sectors of the health care system and a multidisciplinary approach. The benefits impact both the quality of care and can result in more efficient use of limited resources. For example, improved collaboration across health sectors and between healthcare providers – particularly in the coordination of services for people with high and complex needs – has been shown to reduce the incidence of preventable hospital admissions, improve health and wellbeing and transitions of care, improve the interface between hospital and community providers, and provide additional support to caregivers (18-21). Further, there is a statistically significant improvement in the experience of service delivery, comprehensiveness of assessment, level of self-directed care, perceived health support, and education experienced by patients where cross sector, coordinated and multidisciplinary approaches are encouraged (22-25). Multi-institutional settings, co-location of specialist services, care coordinators, and eHealth communications tools are shown to engender greater inter-professional coordination and should be promoted.
  
- 6) **Incorporates systemic supports for clear patient pathways between specialist, primary care, and allied health professionals.** Defined referral pathways have long been used to better integrate health care between sectors and within sectors (26). Referral pathways have been found to improve multidisciplinary communication and care planning, improve clinician-patient communication and patient satisfaction, enable quality standards to be maintained, reduce unwanted practice variation, and support the introduction of guidelines and systematic and ongoing audit into clinical practice (26).
  
- 7) **Supports primary care as the main portal for a community's access to health care.** Primary care focuses on the individual by including not only health-related services, but also community resources to tackle health and social issues. Countries with universal health care need a high quality and accessible primary health care sector as it is the first point of entry for health-care delivery (27). It is from this sector that patients may transition to higher levels of the health system and other services. Focusing on primary health care allows for people-centred care rather than disease-oriented care (27).

Integrated health care cannot be prescriptively established and follow a singular model because there are many conditions that require a different combination of health professionals to be involved, people live in areas with high variations of services and levels of accessibility, and Australia and New Zealand both have a health care system that has both private and government funded sources of health care services, among other reasons. As the simple recognition of the need for better linkages and the capacity to interface in timely ways has been repeated in calls for health reform, it is possible, from the vast body of literature to use emergent common principles to guide the design of integrated models of care. For physicians, the above seven principles are key to future health reform that supports integrated care.

## 4. Enablers of Integrated Care

For integrated care to be more than a concept or ideal, it must be well supported in practice. There are fundamental ways of doing this, using evidence based literature. Figure 1 diagrammatically shows the primary building blocks that support the integration of clinical services. These may be grouped under the headers of a sustainable financial process, leadership responsibilities being clear, key physical systems being in place and a setting that positively reinforces clinicians operating in an integrated way.



**Figure 1 Foundation components for clinical integration**

Adapted from Butts D, Strilsky M, Fadel M. The 7 components of a clinical integration network. (28)

To support the move to a more integrated and effective approach to patient care, the RACP calls for five essential enablers that sit within the different foundation components to be prioritised:

- Supporting multidisciplinary team-based care
- Increasing the value and uptake of digital health (including ehealth and mhealth)
- Introducing funding and payment models that encourage and reward desired health outcomes and best practice care
- Ensuring appropriate governance and management
- Prioritising Health System Research

### 4.1 Supporting multidisciplinary team-based care

Adopting a multidisciplinary approach to health care is a critical enabler to integrated care models, and supports patient centred care approaches. We need to build on and accelerate the work done to date and make a fundamental shift from the status quo of individual services being delivered by discrete providers to a team-based multidisciplinary approach. Such a team-based approach must enable healthcare professionals to work together around good patient care, both when the patient is

directly involved in a consultation, and when clinically important work does not require the patient's presence (including, but not limited to, case conferencing).

The formation and make-up of multidisciplinary teams is likely to be varied. Multidisciplinary care planning has increased in recent years, but many incentives, such as the Team Care Arrangements as provided under Medicare, remain focused on General Practice. Teams may be initiated in the secondary sector or by primary care practitioners. They may be professionals from within one sector, for example, a hospital team focused on the patient's in-hospital stay, or a primary care-based team. Alternatively, they may come from across sectors, for example a rehabilitation team encompassing hospital-based specialists, community-based specialists, community-based nurses, a GP and private-practice allied health practitioners.

Physicians work at all levels of the health care system. For example, in primary care settings there are paediatricians and geriatricians) and in secondary care there are a range of specialities that are essential to chronic conditions not always able to be managed in primary care such as endocrinology, cardiology, gastroenterology. They are important parts of the chain of service delivery across the health care system and in many cases, for those patient groups who are resource intensive.

Effective integrated team based care should support health professionals to work at the top of their scope of practice. This requires building and supporting capacity and capabilities across the team, and this can include allowing for more mobile and less restrictive ways of providing services (for example, through teleconferencing, providing services that do not require the patient to be present such as treatment and feedback advice to other health professionals). In particular, for physicians this can mean working in more hospital-devolved settings ('third spaces').

#### **4.2 Increasing the value and uptake of digital health**

Digital technologies have been key drivers for more integrated ways of working across health sectors and within organisations. Integrated care can be supported by physically positioning services out of highly centralised hospitals into more community settings and also virtually via technological platforms. Importantly, through digital platforms, patients and consumers can be supported and empowered in managing their own health, which is central to patient centred care approaches. Australia has introduced the digital MyHealthRecord, and NZ has introduced HealthOne which is a shared electronic record view of many parts of the health system (primary care, secondary care — inpatient and outpatient — pharmacy, radiology, laboratory, community nursing, and others) (2).

Digital health is essential to an interconnected healthcare system and can be used to promote more effective, personalized and precise medicine and more efficient healthcare delivery. Examples of digital health developments are telemedicine, telephone and web based triage, remote monitoring, physician web messaging, electronic patient records (longitudinal electronic patient records), decision support capabilities for healthcare providers, e-referrals and discharges, and use of e-ordering for pathology tests and diagnostics. Broadly speaking, information and communication technologies use both hardware and software solutions and services to address health care issues. Importantly, digital platforms can help resolve medical staff shortages. New technologies and terms are emerging fast. For example, along with ehealth, there is now mhealth which refers to mobile health technology and applications.

To clarify, 'eHealth' refers here to the use of information and communication technologies (ICT) for health. EHealth examples include, electronic health records, electronic medical records, ePrescribing options, clinicals (providing information electronically about guidelines, protocols and standards) [8]; telehealth and telemedicine, consumer health informatics (use of electronic resources on health topics by healthy individuals or patients), virtual healthcare teams (healthcare professionals collaborating and sharing information on patients using digital mechanisms); health informatics / healthcare information systems: software solutions for administration such as appointment scheduling, patient data management, and work schedule management.

Mhealth or m-Health is the use of mobile devices to collect health data, provide information to practitioners, researchers, and patients, allow real-time monitoring of patient vitals, and direct provision of care, via mobile telemedicine.

RACP members work in every hospital around Australia and New Zealand, and their participation and uptake will be vital to the success of digital health, which in turn must support them and their patients for it to be successful.

The uptake of digital health is being driven by the wider availability of the technologies, the increasing efficacy and guarantee of security of the technologies and increasing uptake by practices and professionals. For health professionals working in different places and regions, and the increasing range of services able to be provided in nonhospital settings, there is a high demand for interoperability.

Australia and New Zealand both have digital health strategies to support the effective application of these technologies to their respective health care systems. New Zealand has established its Digital Health 2020 (steering strategic digital investments between 2016–2020) as part of the New Zealand Health Strategy. The core components are an electronic health record; a health and wellness dataset; a preventative health IT capability (information and enabling ICT capability to support and improve the targeting of screening, immunisation and other public health initiatives); digital hospitals (to lift the digital capability within hospitals and the integration with the wider sector); and regional IT foundations (eHealth foundations that support regional access to health information, delivery of the single electronic health record and lifting digital capability within hospitals).

The Australian Digital Health Agency's National Digital Health Strategy (2017) signals a move away from dealing separately with the individual sectors and is a chance to focus instead on the necessarily broad and whole-of-health perspective needed to drive eHealth forwards. It reinforces that there needs to be a recognition of the importance of digital health interfacing with clinical workflow and tapping into clinical leadership and role-modelling.

Part of the digital health development that is needed is the increased uptake and implementation of supported and complementary infrastructure. This is critical enabler of the transformation of a health system from one that has traditionally been largely divided between two main siloes: health care obtained at a general practice or health care in a hospital. Digital health technologies are creating opportunities to envision new ways of interconnected working that do not need to be anchored to a single place nor funded around economies of scale. These developments support more patient centred care, health literacy and non-hospital health monitoring, and mean clinicians can adopt a more rapid response to health care.

### 4.3 Funding and payment models that drive and support integrated best practice care

Appropriate funding and payment models must be used to support models of integrated care. New approaches to funding and payment emphasise managing patient populations and overall health, compared with methods of the past that have been based more on transactions for distinct episodes of care and focused solely on the direct interaction between the patient and clinician.

Whilst the fee-for-service (FFS) payment model is very effective to support patient access to an important range of health care services, this is primarily best suited to care that is acute, clearly defined and time-limited. However where the health need is ongoing, complex, multi-faceted and changing, then a pay-for-performance or value-based funding approach can offer advantages; whether in addition to or replacing the FFS model. To enable more healthcare services to be provided in community-based settings and to support multidisciplinary teams and enable effective shared patient care, there is a need for Australia to move away from the current dominance of fee-for-service in funding healthcare. The College has previously raised limitations with fee for service payment systems that restrict more integrated care, for example, health care can be deficient in cases where patients have complex or long-term chronic issues. For instance, there is scope to better incentivise responses to changing patient needs by reorienting the MBS to better support ongoing, coordinated care provided by a multidisciplinary health care team (29).

It is important that funding and payment structures enable individual practitioners and organisations to adopt and drive new integrated models of care. These funding structures also need to facilitate those activities necessary for good care that do not require the patient being present; for example, supporting the conversation between two clinicians to coordinate patient services or treatment, conducting preconsultation exchanges, or recording and sending patient information to another clinician to support their clinical decision making. In summary, fit for purpose reimbursement models for physician services in integrated care systems need to be explored and introduced.

There is literature on numerous ways that health care systems can use payment systems to incentivise integrated care. For example, global, partial or blended capitation and within that, 'carve-out' capitation (paying for certain care areas on a capitation basis). One of the implications of funding methods is how a payment method impacts patients and physicians when they make treatment decisions and the goal of aligning the patient's best interests with those treatment decisions. An example is that with a per case payment, providers have incentives to improve efficiency within cases but this is offset by the lack of incentive to reduce volumes of care because the more cases a care delivery group handles, the higher the income. Other models like patient-centred medical homes and accountable care organizations (ACOs) for US Medicare patients still use fee for service and per case payments but offer grouped care delivery arrangements a potentially larger share of the savings, subject to their charges not overstepping agreed spending limits (30). Fundamentally, all payment system approaches have their own strengths and weaknesses, no one payment system is perfect. Bundled payment systems can risk giving incentives to patients to seek specialised condition based treatment groups (30). Intended overall outcomes must be overtly considered in the decisions to change funding methods. A system which blends different payment options – recognising that different care models and levels of care are needed, and that supports varying operational settings and contexts – is likely to be most effective. Within such a blended funding system, it should be expected that fee-for-service payments would remain the most effective option for a certain range of services—perhaps a significant number and type of services, but not the default mechanism.



The Health Care Home (HCH) trial which commenced in October 2017 provides a test case for innovative bundled monthly payment at the primary care level, but in its current iteration it does not incentivise changes to the way specialists work or incentivise the integration of specialist care with that of primary care and allied health.

#### **4.4 Ensuring well planned Governance and Management**

Improving governance arrangements between health care providers has been identified as a key enabler of integrated care (31-34). Clear connections and accountability structures between organisations that commission and deliver care are fundamental to effective integrated care models. At a regional level, for example, establishing integrated care should proceed from a strong and shared vision between the stakeholders, a clear plan on how the goals will be achieved, and a commitment to change management principles. In Australia, health care governance arrangements must accommodate the complexity that arises from both the federated structure (national and state governance of health sectors), and from the mix of public and private providers. The New Zealand Alliance model is a specific governance approach that has been internationally recognised. Governance factors identified in the New Zealand experience include input from recognised clinical leaders, partners that bring resources to the table, and very importantly all parties being able to cast aside sectorial interests and commit to and work towards a whole of systems approach (35).

High quality and effective health care is when patients get the right care, at the right time, from the right health care professional, in the right location. For this to happen the facilitating organisations must have relationships and processes in place that enable effective integrated care strategies. For example, one such process might be joint planning across the Australian Primary Health Networks and Local Hospital Networks to enable integrated care.

There are different governance structures that have been used in integrated care approaches such as single joint boards, formal or informal overarching governance bodies, or legislation based governance. Whichever is adopted, it is important that leadership is defined along with clear the roles and responsibilities, areas and levels of accountability, decision making processes, funding mechanisms and outcome measures. All the stakeholders must understand and support how their responsibilities will be defined and their performance measured, as well as how the success of the overall effort will be gauged and reported (36). One of the difficulties when integrating care across different organisations and sectors of all kinds is to not build in inadvertent counter incentives at different points. There must be new platforms of engagement that allow appropriate input and shared vision alongside 'the governance arrangements that acknowledge, and positively leverage, inevitable reform tension' (37).

How clinical services with as diverse a range of funding as the MBS/PBS, state-funded hospitals, private hospitals, and private health insurers, are integrated with appropriate physician input is a project requiring significant strategy, design, and evaluation.

At the service delivery level, good team care relies on clarity of roles and identifiably discrete responsibilities; good multidisciplinary care relies on precision about scopes of practice, boundaries of capacity, and administrative and other support for clinical processes. In an integrated health care system and new ways of working, health professionals may require learning incorporated into their professional training through education and training providers, including postgraduate medical colleges, as well as accreditation authorities.

A final consideration for governance and integrated care is that of organisational and professional cultures. Integrating specialist care with hospital care may be less of a cultural challenge for the sector, given that many physicians work in and out of hospitals (and all are hospital-trained). Integrating specialist care with primary care may prove somewhat more challenging, especially when new payment models, lines of responsibility and accountability, and new and untested funder-imposed rules (in the case of HCHs) are under development simultaneously.

#### **4.5 Prioritising Health System Research**

Establishing better models of care and service delivery across Australia and New Zealand is enabled by useful and meaningful assessment of their effectiveness, efficiency and ultimately, impact on health outcomes. Health system research has a crucial role to play in investigating and evaluating integrated models of care and inform quality and appropriateness of care to support governance and management decisions.

Transformation of health care processes need to have time and monitoring invested in order to nurture the concept into a normative practice. Research literature features trials of models of integrated care and provide evidence of positive outcomes. It is important health reforms have agreed frameworks for evaluation and monitoring in place to enable healthcare system problems to be addressed at a systemic level rather than at a symptom level. Regular and long term monitoring and response through careful research can help to avoid a cycle of pilot programs that are not developed and adapted to the operating context. The best performing health systems are those that embed research in health delivery, leading to better health outcomes (38).

Translational research will be an essential driver of integrated care which serves to utilise the results of research, as current trials and pilots are being extended in Australia. A further step might be to establish integrated health research centers and quarantine funding as was recommended in the McKeon report (38). Should the evaluation of integrated care models demonstrate benefit, strong and committed policy will be needed to ensure the initiatives can be scaled up and extended for widespread implementation(39).

## 5. Conclusion

The World Health Organization (WHO) has stated there is an urgent need for health systems to move to people-centred and integrated health, and that this may mean a major change in the way health services are funded, managed and delivered (9). Indeed, the low levels of health service integration and coordination have been described as the most pressing current issue facing health systems (40). Historically, integrating care that relies on inter-organisational relationships is often difficult to implement, and international experience has highlighted the challenges of integrated care.

Models of integrated care are continually being developed around the world, and Australia and New Zealand have some excellent examples such as the Transalpine Health Service Model and Eastern Health Integrated Diabetes Education and Assessment Service to name only two. Whilst much focus has understandably been on the importance of integrated care to primary care, the evidence base for models of care involving specialists based integrated health care models is expanding (5) and highlights that a cross-sector and broader team-based approach is crucial for a better functioning health care system.

The siloed structures of the past are becoming increasingly difficult to align with the inter-professional approaches required to treat chronic and complex illnesses. With an ageing population and increased prevalence of chronic disease, Australia and New Zealand face similar challenges in their endeavours to provide good quality, effective and efficient integrated care. As our healthcare systems continue to adapt to meet these challenges, the input of specialists on how integrated care may be achieved is vital.

In response to growing concerns regarding poor access to care and the need to improve the quality and efficiency of health care delivery, this discussion paper identifies several key principles intended to facilitate better integration of care. These include principles of patient-centred, flexible, locally implemented and multidisciplinary healthcare that provide for measurable outcomes, and that focus on quality of care and patient safety. The discussion paper also suggests several enablers which the RACP support, and if implemented will provide effective strategies for greater integration of care.

Active engagement and leadership by physicians, as well as support for clinician-led models of integrated care will be critical to achieving practicable reforms. This discussion paper provides the foundation for the RACP's position on and future advocacy for better integrated care.

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