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Integration of Health and Social Care: International Comparisons

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Over the past 40 years there has been a trend towards encouraging health and social care agencies to work together to improve care (Cameron, Lart, Bostock and Coomber, 2012). On 12 December 2011, the Cabinet Secretary for Health Wellbeing and Cities Strategy, announced the Scottish Government's plan to integrate adult health and social care. This briefing highlights some of the key enablers and barriers to integration and provides information on integrated approaches to health and social care in the UK, Europe and further afield.

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EXECUTIVE SUMMARY

Many countries in the developed world are facing the same challenges in relation to increasing demands for health and social care due to an aging population alongside declining public expenditure. The integration of health and social care is often seen as a way to reduce costs and make more efficient use of resources and achieve better outcomes for the individual. Much research has been carried out to investigate the factors that help or hinder the process of integration. These include:

- organisational factors such as shared culture;
- factors related to people and relationships such as professional identity;
- financial factors such as shared budgets and
- policy factors such as choice and competition policy.

However, less research has been undertaken looking at the effectiveness of integrated systems in relation to outcomes for service users, and cost-effectiveness. International examples of integration are often based on small scale pilots rather than country wide approaches. There are many definitions of integration and this is an issue when considering examples of integrated health and social care provision. Berchtold and Peytremann-Bridevaux (2011) describe integrated care as a "polymorphous[1] concept viewed and understood very differently between national systems as well as between the various actors within the health systems". It is important to be mindful of this when looking to other countries and assessing the transferability of approaches towards the integration of health and social care.

[1] Polymorphous: occurs in many different forms.

BACKGROUND

In Scotland, like many developed countries, there has been increased policy discussion on integration of health and social care services since the 1970s (Woods, 2001). There are a number of factors that have raised the profile of integration with many countries facing similar challenges. An aging population is projected to have a significant impact on healthcare spending. Jeannet (2010) commented that, in Scotland, current demographic projections would increase primary care spending for those aged 65 and older by 70% by 2033 unless action is taken. In addition Antunes and Moreira (2011) identified a number of challenges to health care systems across Europe which are seen as a stimulus to integrated care. These are: advances in healthcare; multi-system nature of chronic diseases; hospital based care system; insufficient provision of social care services; lack of co-operation between health and social care providers; fragmentation of health and social care systems and rurality. Integration is also seen as a way to make more efficient and effective use of limited resources (Suter, Oelke, Adair and Armitage, 2009) and is believed to be central to the challenge of improving outcomes for patients and service users (Curry and Ham, 2010 as cited in Thustlethwait 2011).

In Scotland there have been a number of initiatives to encourage joint working between health and social care providers. This has included the establishment of the Joint Future Group, the creation of Community Health Partnerships and the Joint Improvement Team[2]. Since 2008, in line with the Scottish Government's Shifting the Balance of Care policy, the Integrated Resource Framework has been developed. These initiatives are discussed in more detail in Payne (2012) and in the SPICe briefing Adult Community Care – Key Issues[3].

The discussion on how best to deliver health and social care services continues and on 12 December 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced the Scottish Government's plan to integrate adult health and social care. In May 2012 the Scottish Government launched its consultation on the integration of adult health and social care. This closes on 11 September 2012 (Scottish Government, 2012).

In advance of legislation in this area being introduced this briefing aims to highlight some of the key enablers and barriers to integration and provide information on integrated approaches to health and social care in the UK, Europe and further afield.

ENABLERS AND BARRIERS TO INTEGRATION

Much research has been carried out investigating the key factors that influence whether the integration of health and social care systems is successful. The following section discusses some of these facilitators and barriers.

A number of common themes are apparent when reviewing the literature. Influencing factors tend to fall into a number of categories: organisational issues; financial issues; factors related to people and relationships; and policy issues. In addition patient focus including involving people and communities in designing services is often seen as an important factor in successful integration, as is ensuring that people have the information they need to make decisions about their own care (NHS Future Forum, 2012).

[2] The Joint Improvement Team was established in late 2004 to work directly with local health and social care partnerships across Scotland.

[3] The term community care and social care are often used interchangeably with social care becoming more widely used.

Johri, Beland and Bergman (2003) looked at demonstration projects in a number of Organisation for Economic Co-operation and Development (OECD) countries and identified common features of an effective integrated system of care for older people. They noted that successful projects made use of case managers, comprehensive geriatric assessment and a multidisciplinary team. They also identified the advantages of a single entry point.

Organisational

Enablers	Barriers
Developing a shared culture between organisations	Lack of shared culture, language, governance and operating procedures
Information sharing including activity and performance data	Reluctance to share information and data. Lack of a robust patient record. Poor IT connectivity
Alignment of procedures, staff management and training	Lack of attention to staff engagement, behaviour and training
Responsiveness to feedback	Difficulties recruiting staff
Investment in supporting behavioural change including education and training	Lack of organisational alignment
Strong leadership and management	Lack of strong leadership and management
Investment in staff engagement	Insufficient investment in service improvement
Anticipation of side effects	Fragmented services
Co-location	Lack of high quality premises for new services
Regular team building events and team meetings	Lack of time and sustained project management
	Permission based and risk adverse culture

People and relationships

Enablers	Barriers
Vision – a shared vision between partners including GPs	Lack of clear shared vision including agreement about leadership
Sufficient time building relationships	Lack of understanding about roles and responsibilities of agencies and professionals
Existing relationships across organisations and previous history of joint working	Lack of interest from GPs, local authorities and others in new ways of working
Professionals involved in developing services	Professional identity of staff under threat
Effective communication	Communication difficulties
Physician integration	Different professional philosophies
Readiness to change	Negative stereotypes
	Resistance and insecurity among key, middle rank, professionals
	Lack of trust, respect and control
	Complex relationships between agencies

Financial

Enablers	Barriers
Joint commissioning – based on shared budgets	Disparities in funding - particularly between health and local authorities
Flexible funding models	Lack of certainty over future funding and cuts in public spending
	Failure to remove or address conflicting incentives
	Existing payment regimes
	Belief that integration will always reduce costs

Policy

Enablers	Barriers
Effective engagement of the third sector	Repeated structural change and reorganisation
	Choice and competition policy
	Regulation that focuses too much on organisational performance and not enough on performance across organisations and systems
	Large scale and complex integrations

(Sources: NHS Future Forum, 2012; Goodwin et al, 2012; Rand Europe and Ernst and Young, 2012; National Leadership and Innovation Agency for Healthcare, 2011; Cameron et al, 2012; Suter et al 2009).

COMPARISONS

When studying integration in health and social care it is important to be aware of the wide range of definitions used interchangeably to describe different concepts. Armitage, Suter, Oelke and Adair (2009) conducted a literature review and reported that more than 70 terms and phrases related to integration. Woods (2001) commenting on the Scottish context notes that the term integration has been used to describe “joined up services”, “clinical or care pathways” and “care networks”. Robertson (2011, p.6) notes research by Kodner and Spreeuwenberg (2002) that found that “most definitions of integration describe bringing together inputs, delivery, management and the organisation of services in such as way as to improve access, quality, user satisfaction and efficiency”.

Robertson (2011) also describes integrated care as being used to refer to:

- “Health and social services delivered by a single organisation
- Joint delivery of health and social care by more than one organisation
- Links between primary and secondary health care
- Joining care at different levels within a single sector e.g. mental health services
- Joining prevention and treatment services”

Berchtold and Peytremann-Bridevaux (2011) describe integrated care as a “polymorphous concept viewed and understood very differently between national systems as well as between the various actors within the health systems”. A comprehensive discussion about the definition of integration and models of integration is outwith the scope of this paper but is discussed in Robertson (2011) and in Cameron et al (2012).

It is clear to see from the previous section there are a number of reoccurring key enablers and barriers to the process of successful integration. Although much is known about the factors determining effective integrated care there is still a gap in the evidence base in relation to the effectiveness of integration on the delivery of services in relation to service users and the wider health and social care economy (Cameron et al, 2012). Therefore, most of the following examples focus on the process rather than the outcomes of integrated working.

When considering the transferability of approaches from one country to another it is important to bear in mind that successful integration is often dependent on the local context. As highlighted above readiness to change and the relationships between individuals and organisations often play a key role in whether integration is successful. Comparisons between countries can also be difficult due to different health and social care structures.

Examples of integration

Goodwin et al (2012) reported that approaches to integrated care are likely to be more successful when they cover large populations such as a country and a range of groups. However, examples of full structural integrations of health and social care are rare (Wetherly, Mason and Goddard, 2010). Cameron et al (2012) note that there is little evidence of the effectiveness of joint and integrated working, and the evidence there is mostly consists of small-scale evaluations of local initiatives.

Many of the examples outlined in the following section focus on small scale examples of integration involving specific groups such as people with a particular illness or in a particular demographic group, such as older people. Although this briefing will primarily focus on the integration of health and social care services for adults, as this is the focus of proposals by the Scottish Government, there is evidence of the benefits of integration to services for children and young people with complex needs, people with long-term mental health problems, homeless people and people receiving palliative care (NHS Future Forum, 2012).

UNITED KINGDOM EXAMPLES

The following section provides information on the integration of health and social care in England, Wales and Northern Ireland and highlights some examples of integrated working.

ENGLAND

Partnership working between health and social care sectors has been a central feature of policy development in England for some time and there are many examples of partnership working at a local level (Glasby, Dickinson and Miller, 2011).

CASE STUDY: *Care for Older People – Torbay*

An often cited example of integration is in Torbay where care for older people is delivered through integrated health and social care teams with pooled budgets. Each team serves between 25,000 and 40,000 people and works closely with GPs in the area. The programme aimed to increase spending on intermediate care services to enable older people to be supported at home and to avoid inappropriate hospital admissions. Results included reduced use of hospital beds, low rates of emergency hospital admission for people aged over 65 and minimal delayed transfer of care. Use of residential and nursing home care fell and there was an increase in home care services. There was also an increase in the uptake of direct payments (Thistlethwaite, 2011; Goodwin, Smith, Davies, Perry, Rosen, Dixon, Dixon and Ham 2012).

One of the key factors in the success in Torbay was the appointment of ward-based health and social care-coordinators. Co-ordinators became the main point of contact for referrals and liaised with other team members to decide who should handle referrals and how. They also worked closely with nurses, allied health professionals and social care staff to put in place appropriate care packages and support. Data sharing was also believed to beneficial. Other factors that have been attributed to the success are continuity amongst senior leaders, organisational stability and the commitment of managers and clinicians (Thistlethwaite, 2011).

There have been a number of recent initiatives to encourage joint working and integration in England.

The Health Act 1999 introduced three options for joint working: pooled budgets between the NHS and health-related local authority services; lead commissioning (where one partner takes the lead in commissioning services on behalf of another body) and integrated management provision (Wetherly et al, 2010).

The Health and Social Care Act 2001 made provision for the creation of care trusts. These are NHS bodies with delegated social care responsibilities. Glasby et al (2011) comments that care trusts are the closest model to a full merger of health and social care in England. However, many of the care trusts focused on mental health services rather than a more comprehensive agenda (Petch, 2011).

Integrated Care Pilots (ICPs) - In April 2009 the UK Government's Department of Health launched a two-year pilot programme to test and evaluate a range of models of integrated care. ICPs were designed to explore different ways in which health and social care could be provided to help improved health and well-being in a local area. They attempted to look beyond traditional boundaries and explore new integrated models (Department of Health, 2010). The pilots were locally driven according to clinical need and were designed to demonstrate innovative relationships (Ernst & Young and RAND Europe, 2010).

Sixteen ICPs were set up but not all of these focused on the integration of health and social care. A pilot in Norfolk established a fully integrated health and social care team made up of GPs, community health staff and social care staff (Petch 2011). The evaluation of the ICPs found that staff reported improvements in care (most of which were process-related) but this sense of improvement wasn't reported by patients. It found that it is possible to reduce the cost of hospital care but very difficult to reduce emergency admissions. The report noted that improvements were found in healthcare processes rather than in patient experience or in reduced costs (Rand Europe and Ernst and Young, 2012). Darzi and Howitt (2012) believe that

the bottom-up approach, such as that demonstrated in the ICPs, is the most effective way of moving towards integrated care.

The Health and Social Care Act 2012 aimed to create an independent NHS Commissioning Board (to allocate resources and provide commissioning guidance), promote patient choice, and reduce NHS administration costs (UK Parliament, 2012). There were many amendments to the Bill including Government amendments that were introduced in response to the recommendations of the NHS Future Forum[4]. This included amending duties in relation to the role of competition and integration in the health service (Powell, 2011) in particular making clear that the health regulator monitor will have the power to require healthcare providers to promote the integration of NHS Services (Department of Health, 2012). However, some organisations consider that increasing competition will fragment the health service and this will make the integration of health and social care harder (Meldrum, 2012).

WALES

Health and social care services in Wales are devolved. NHS Wales delivers services through seven Local Health Boards (LHBs) and three NHS Trusts (Welsh Government, 2012).

CASE STUDY: *Chronic Conditions Management Demonstrators*

An example of integrated care in Wales is the Chronic Conditions Management Demonstrators (CCMD) which implemented strategies to co-ordinate care for people with multiple chronic illnesses such as diabetes, epilepsy, arthritis, musculoskeletal conditions and non-malignant pain (CCMD, 2009). They employed a shared care model of working between primary, secondary and social care. A reduction in the total number of bed days for emergency admission for chronic illness of 27% was reported in 2007, 26% in 2008 and 16.5% in 2009 (NHS Wales 2010 as cited in Goodwin et al, 2012).

Examples of integrated approaches and working practices across Wales have been investigated in a qualitative study commissioned by the Efficiency and Innovation Board[5]. This found that a range of integrated service models exist across Wales, which: contribute to improved service outcomes and promise efficiency savings over the medium-term; demonstrate characteristics that appear to contribute to positive impact and outcomes and involve primary health and social care agencies but also other sectors such as the voluntary sector. Specific examples that featured in the study include the integration of Powys Social Services and Health Board and an integrated approach to services for frail older people in Gwent (Efficiency and Innovation Board, 2011).

[4] The NHS Future Forum is an independent Forum made up of 55 members chosen for their relevant experience and background.

[5] The Efficiency and Innovation Board was set up by the Welsh Government in 2010 to focus on delivering efficiencies and service improvements in public services in Wales.

CASE STUDY: *Gwent Frailty Programme*

The Gwent Frailty Programme was established in April 2011. It is funded by the Welsh Government and made up of a partnership between the Aneurin Bevan Health Board, five local authorities and the local voluntary sector. The programme aims to:

- Ensure that people have access to the right person at the right time
- Focus on preventative care – and avoiding hospital admissions when possible
- Reduce the length of a hospital stay
- Reduce the need for complex care packages
- Avert crises by providing the right amount of care when needed
- Co-ordinate communication by providing a named person for all contact

Five Integrated Community Response Teams (CRTs) have been established, one in each of the local authority areas. These will provide urgent assessment, rapid response to health issues, emergency social care at home, reablement[6], falls prevention and intervention and care and repair type services. The CRTs will involve medical staff, nurses and specialist staff such as dieticians and podiatrists. Support and Wellbeing Workers will be part of the team and will work as the primary point of contact and will co-ordinate service provision. Longer term support will be provided by Care Co-ordinators who will be responsible for referral (Gwent Frailty Programme, 2011).

There have been a number of recent developments in Wales. In 2011 the Welsh Government published Together for Health, a five year vision for the NHS (Welsh Government, 2011). This provides information on how NHS structures have been simplified with the establishment of seven Local Health Boards (LHBs). It states that LHBs are organising all their local services including GPs, pharmacists, hospitals and district nurses in order to work with social services as part of a single "integrated" system. It also asserts that LHBs will improve links across primary care, community care, acute care and social care (Welsh Government, 2012).

Setting the Direction (2010) proposed a framework intended to help LHBs develop and deliver improved primary care and community based services. It is designed not to be prescriptive in order to enable local solutions to be developed to address local needs. It contends that services must be designed to enable people to improve their lives and maintain their independence as long as possible, and to support them in their own homes (Welsh Government, 2010). It proposed a system of care where integrated community services act as a bridge between primary care and the acute hospital. These Community Resource Teams may include GPs, nurses, pharmacists, therapists and social workers. These teams are intended to create a multidisciplinary approach, focused on the maintenance of more complex cases in the community (see the case study on the Gwent Frailty Programme above). Integrated Communication Hubs are also being developed to improve communications for patients and staff (Welsh Government, 2012).

The Welsh Government published a white paper Sustainable Social Services: A Framework for Action setting out policy on the integration of health and social services. It focuses on the need to integrate service delivery and prioritises three areas: families with complex needs; transition to adulthood for disabled children; and frail older people (Welsh Government, 2012a). Following this, in March 2012, a consultation on a Social Services (Wales) Bill was launched. This Bill

[6] Reablement refers to helping people regain their independence after admission to hospital.

aims to support the delivery of integrated services for children and adults. It proposes to introduce powers to strengthen partnership working, including the use of pooled budgets and other flexibilities that will require partnerships between local authorities, across local authority functions and between local authorities and LHBs, in order to drive the creation of more integrated models of service provision. The Bill also intends to introduce powers for Welsh Ministers to make regulations and guidance in relation to partnerships (Welsh Government, 2012b).

NORTHERN IRELAND

Unlike the rest of the UK, in Northern Ireland statutory health and personal social services have been integrated since the 1970s. Between 2007 and 2009 there was a review of Public Administration that aimed to further reduce the number of organisations and lead to more integration (Social Care Institute for Excellence). Eighteen trusts were amalgamated into five large, integrated and fully comprehensive social care trusts and the four commissioning boards were replaced by the Regional Health and Social Care Board (Petch, 2011).

Petch (2011) notes research by Hennan and Birrell (2009) that identified a number of achievements in Northern Ireland including: a reduction in delayed discharges; new investment in intermediate care and domiciliary care specialists; the development of integrated teams; and integrated ways of working. They also identified limitations of the approach such as health continuing to dominate the agenda and resources being focused on the acute sector. They commented that the integrated approach had a limited focus and that integration has not been realised to its full potential.

The move towards greater integration in Northern Ireland is continuing. In June 2011 the Minister for Health, Social Services and Public Safety, announced a review of Health and Social Care Services in Northern Ireland - this was published in December 2011. The review aimed to provide: a strategic assessment of all aspects of health and social care services; examine the quality and accessibility of services; and bring forward recommendations for the future shape for services and provide an implementation plan.

The key themes in the recommendations of the review were:

- Quality and outcomes to be the determining factors in shaping services
- Prevention and enabling individual responsibility for health and wellbeing care to be provided as close to home as practical
- Personalisation of care and more direct control, including financial control, over care for patients and carers
- Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector
- New approach to pricing and regulation in the nursing home sector
- Development of a coherent ‘Headstart’ programme for 0-5 year old children, to include early years support for children with a disability
- A major review of inpatient paediatrics
- 5-7 major hospital networks
- Establishment of a clinical forum to ensure professionals are fully engaged in the implementation of the new model
- A changing role for general practice working in 17 Integrated Care Partnerships[7] across Northern Ireland

[7] The Integrated Care Partnerships are intended to join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from

- Recognising the role the workforce will play in delivering the outcomes
- Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups
- Population planning and local commissioning to be the central approach for organising services and delivering change
- Shifting resource from hospitals to enable investment in community health and social care services
- Modernising technological infrastructure and support for the system

It was proposed that these recommendations would be implemented over a 5 year period (Health and Social Care Board, 2011).

INTERNATIONAL EXAMPLES

The following section provides examples of how some countries have approached integration and the success of these approaches. It is not intended to provide a comprehensive guide to all countries.

ITALY

Italy has a comprehensive national health service (Servizio Sanitario Nazionale) financed by general taxation. The state determines essential levels of care and other powers are devolved to 21 regions which control Local Health Units (LHUs) and independent NHS hospitals (Weatherly et al, 2010).

Reforms in 1999 promoted integration between healthcare and social services through institutional integration (between municipalities and LHUs), managerial integration (for the provision of primary and non-hospital care) and professional integration (Weatherly et al, 2010). Studies looking at integration in Vittorio Venteto and in Roverto reported that service integration resulted in better outcomes for patients such as reduced rate of acute hospitalisation, reduced number of acute bed days and reduced length of hospital stay (Johri et al, 2003).

CASE STUDY *– Emilia Romagna Region*

In Emilia Romagna recent reforms have resulted in more powers being granted to local bodies through the establishment of Social and Health Districts which aim to integrate health and social services. Within Emilia Romagna municipal and Local Health Unit planning is integrated and services are planned for groups of people such as older people, cancer patients, young people, drug users and people with mental health problems. This has resulted in municipalities, Local Health Units and the third sector providing integrated services with pooled personnel and resources (Pasini, 2011).

the independent and voluntary sector. The Integrated Care Partnerships will have a role in determining the needs of the local population and planning and delivering integrated services (Health and Social Care Board, 2011).

***CASE STUDY** – San Marino*

San Marino has an "organically" integrated system of health, social care and social-services which is provided by a single body the *Social-Security Institute*. Institutional integration enables easier planning and provision of social and healthcare services. The aim in San Marino is to ensure a continuity of care and rehabilitation services (Pasini, 2011). Pasini (2011) believes that to ensure successful joint working it is important that there is individual and group accountability, that "parochial-outlooks" are overcome and that there is a flexible use of human resources. The *Social-Security Institute* has one budget for health and social care services.

SWEDEN

Sweden has a National Health Service system funded through government grants, user charges and taxation at a national and local level. The Swedish health care system is organised at three levels national, regional (21 county councils) and local (Weatherly et al, 2010; Health Systems in Transition, 2005a).

Over the past 20 years there has been a move towards integrating health and social care in Sweden. The responsibility for care of older people, disabled people and people with long term psychiatric conditions has transferred from the 21 county councils to the 290 municipalities. The aim of this move was to improve the integration between county council health services and social services in the municipalities and to improve collaboration between professionals. There is financial co-ordination in the form of pooled budgets (Ahgren and Axelsson, 2011).
In Sweden, condition-specific care pathways have been developed that include all the services provided for a specific group of patients in a defined geographical area. These are known as "chains of care". They specify the distribution of clinical work between health care providers and professionals and have a clear patient focus (Robertson, 2011 and Ahgren and Axelsson, 2011).

Integration of health and social care in Sweden has also included the restructuring of the healthcare services provided by the county councils and the introduction of a system of local health care which Ahgren and Axelsson (2011) describe as: "an upgraded family - and community – oriented primary health care within a defined local area, supported by flexible hospital services". The aim was to create a service to meet the requirement of the local population and as a result there is no single model. Local healthcare has been important in facilitating collaboration between health professionals and social workers in the care of older people, dementia teams, people with long term mental health issues, addiction prevention, support for vulnerable children and young people and healthcare for refugees.

The experience in Sweden has resulted in some benefits such as a reduction in the number of hospital beds and other improvements in cost effectiveness. However, it has also created a number of problems such as a lack of physicians in nursing homes. Challenges to integration have included some resistance from GPs, the policy shift towards free choice for patients and the competing demands of managing competition alongside collaboration (Ahgren and Axelsson, 2011).

CASE STUDY: *Norrtälje*

An example of a structurally and financially integrated health and social care organisation can be found in Norrtälje. In 2006 one organisation, *TioHundra Forvaltiningen,* was established to administer pooled budgets for all health and social care. Another service organisation, *Tio-Hundra AB,* combines the management of all health and social care for the population (Ovretveit, Hansson and Brommels, 2010). Planning, financing and organisation is based on three groups 0-18 years, 19-64 years and people over 65 (Robertson, 2011).

A longitudinal study looking at the development of this new integrated system found that a number of factors were important, such as readiness to change. Changes in macro-structure were found to facilitate clinical level micro-changes but changes in micro-structure were still difficult. Occupational cultures acted as a barrier to change and there was little incentive for co-ordinated care. The management also underestimated the need for clinical level co-ordination of the project (Ovretveit, Hansson and Brommels, 2010).

CASE STUDY: *Jönköping County Council*

Jönköping County Council established the "Esther project" which represented a hypothetical person. Focusing on Esther's needs over time provided the basis for designing care pathways for older people. A similar approach was taken in Torbay, in England.

The Esther project was a multi-disciplinary project which involved GPs, nurses, social workers and secondary care clinicians. It aimed to improve patient flow thought the system by co-ordinating elements of care and improving communication. Examples of changes included the redesign of the intake and transfer process, the introduction of team-based telephone consultation and self-management education for patients (Robertson, 2011). Baker et al (2008) reported a reduction in hospital admissions, length of stay and waiting times (as cited in Weatherly et al, 2010).

CANADA

Canada has a predominantly publically financed health system with services provided through private and public bodies (Health Systems in Transition, 2005b). In relation to social care there are three levels of governance: the Ministry of Health and Social Services at a regional level (with 18 regional agencies); local level; and nine programmes of care[8] (Vedel, Monette, Beland, Monette and Bergman, 2011 and Weatherly et al, 2010).

Historically the health system in Canada has focused on acute care. Fragmented delivery and deficiencies in patient centeredness are often reported (Tsasis, 2009 as cited in Vedel et al 2011). However, there have been a number of recent reforms and local initiatives to improve the integration of services with the aim of improving co-ordination, reducing resource waste, reducing patient dissatisfaction and increasing cost-effectiveness (Vedel et al, 2011).

[8] The nine programmes of care are public health, general services, people with impairments relating to ageing, physical disability, intellectual disability, pervasive development disorders, youth in difficulty, dependencies, mental and physical health.

***CASE STUDY** – Quebec*

Quebec has been encouraging the integration of health and social services and primary care since the 1970's. Recent reforms have resulted in the integration of local community centres, acute hospitals and long-term hospitals into 95 health and social services centres, *Centres de Santé et de Services Sociaux (CSSS).* These are responsible for planning and co-ordinating health and social services in their local area and for collaborating with partners such as rehabilitation services. Vedel et al (2011) notes that the different institutions are becoming increasingly integrated and a philosophy of collective responsibility and a population-based approach has emerged. There is a greater alignment between organisational structures and the strategic vision of a population-based approach. As part of the reforms large university-affiliated hospitals were merged into four integrated university-based healthcare networks which provide ultra-specialised services and training and research.

Family Medicine Groups (FMGs) and network clinics were established to enhance access and continuity of care. FMGs consist of 6 to 12 family GPs who are collectively responsible for a large group of patients and work in close collaboration with nurse practitioners in their clinic. The establishment of FMGs was intended to provide easier access, extend the hours of access, improve the quality of general medical care and improve patient follow-up and service. FMGs have been found to improve the organisation of primary care (Vedel et al, 2011). Network clinics have been developed to ensure better integration between the CSSS and family GPs. They play a co-ordinating and liaison role and give access to a complete range of primary care services.

Jiwani and Fleury (2011) state that networks characterised by strong leadership and a culture of consultation and innovation have flourished and positive outcomes for Family Medicine Groups and networks have been seen. They report that the reforms have encouraged a culture of collaboration and teamwork and a greater focus on clinical care and physician interaction.
In Quebec structural integration has been achieved but clinical integration has been slower. Regional health authorities and provincial government have been criticised for inadequate support in the reorganisation. Reforms have been hampered by vague implementation schemes, inadequate funding, challenging objectives and constricted timescales. Vedel et al (2011) notes that primary care and secondary care at a clinical level are still provided in parallel. They identify gaps in clinical information sharing and a significant lag in the use of information technologies and problems using some of the electronic medical records as some of the major barriers to co-ordination.

NEW ZEALAND

New Zealand has a health system mostly funded through general taxation. Reforms have focused on integrating key functions around financing, planning and providing more integrated care for service users (Cummings, 2011). Twenty one district health boards are responsible for hospital, community and primary health services as well as residential care and home care for older people (Robertson, 2011).

Many of the reforms in New Zealand have occurred at the macro-level with an emphasis on integrating planning and funding, this included the establishment of Primary Health Organisations (PHOs) in the 2000's. Cummings (2011) commented that, on their own, macro-level reforms are insufficient to deliver more integrated care and that this is in part due to distrust between the government and primary care providers.

These reforms are considered to have increased the opportunity for integrating care but there are also concerns that there have been insufficient changes in actual service provision. Cummings (2011) identified that there was:

- insufficient attention paid to identifying new models of service delivery during the delivery of the primary health care strategy;
- a lack of clarity around the roles of PHOs;
- a lack of positive engagement between government and general practice;
- little attention paid to leadership, management and organisational development; and
- an issue that budgets remained outside the control of the PHOs.

The focus has now moved towards "alliances" and to reducing the number of PHOs. The alliances are developing new collaborations to plan and deliver services. This includes:

- the devolution of funding from district health boards;
- increased co-ordination of services between primary care providers and hospitals;
- the development of integrated family health care centres;
- co-located clinics;
- more nurse-led services; and
- the creation of multi-disciplinary teams.

The policy focus has shifted onto integrating service delivery within primary care, between primary and secondary care, and between sectors (Cummings, 2011).

The New Zealand Government's (2012) Statement of Intent 2012/13 to 2014/15 outlines that the Ministry of Health will, over the next few years, implement a work programme to improve the clinical integration of health services. It states that this requires effective leadership, including clinical and professional leadership, and effective engagement with the sector. Collaborative cultures, appropriate governance arrangements and good information systems will be key to the success of this work. It is hoped that the shift towards a regional planning approach among district health boards and effective engagement of the clinical workforce will lead to better health care at the front line.

CASE STUDY: Canterbury Clinical Network (CCN)

The CCN focuses on establishing collaborative relationships as a platform for integrated service delivery. It comprises urban and rural GPs, practice nurses, pharmacists, allied health professionals, community nurses, the Canterbury District Health Board, Primary Health Organisations and GP groups. Baird and Smith (2011) note that the CCN is a "highly functional alliance with extensive clinical engagement across a broad spectrum", which incorporates a range of integrated care initiatives some of which have been established for over 10 years.

Part of the CCN is the Aged Care workstream which aims to keep older people at home as long as possible, including a reduction in care home admissions and the extension of independent living. Initiatives in relation to this workstream include the development of integrated health and social services clusters to:

- "Align Older Persons Health Specialist Services (OPHSS) community team members, community nurses, pharmacists, physiotherapists and other clinicians as appropriate for the benefit of the individual patient and their carers;
- Identify relevant social services and link to each cluster;
- Align care workers with each cluster, based on requirements identified through a model of care analysis."

(Canterbury Clinical Network, 2009)

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