Literature Review for the Maru Wehi Integrated Whānau Ora Centre Plan WOHIA

Final Report

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For Tui Ora Ltd

Contents

This literature review summarises key New Zealand and overseas evidence about the effectiveness of integration initiatives, and key characterises of successful initiatves. It is hoped that this learning to date may be helpful to guide the planning of the proposed Maru Wehi centre. Relevant key messages coming from the literature review include: the importance of engagement with communities and clinical leaders and building a clear shared understanding of the purpose of the integration initiative; the importance of maintaining a strong focus on improving patient care; the need for a broad, holistic approach to health and wellbeing that includes a focus on whanau and community capacity building; and the need to use models and methods that reflect Maori beliefs, values, aspirations and tikanga. The Māori-specific dimensions of effective health care have been outlined in this report, and attention to these cultural aspects of health is likely to be a key consideration in the successful development of the proposed Maru Wehi centre.

Aim of the Literature Review

Tui Ora Ltd have proposed the development of an integrated whānau ora centre on the Maru Wehi Hauora site (the proposed centre). The aim of this literature review is to summarise the evidence about a) the effectiveness of integrated care initiatives; b) key success factors for integrated care initiatives and c) barriers to success and how these might be overcome. Where possible the review focuses on New Zealand evidence relating to Māori communities, but international evidence and learning is also included.

To set the scene, an overview of the policy context for the development of the Maru Wehi centre is included in the introduction, along with a brief comment about Māori health and the cultural aspects of health care.

Methods

The search strategy was based on:

       i) Search of known websites (listed below)

       ii) Google and Google Scholar searching

       iii) Searching reference lists of relevant articles for further relevant material

       iv) Focused searching of Medline (academic database)

Websites searched:

- Cochrane Database of systematic reviews

- DHBNZ

- Health Services Research Centre, Victoria University

- Health Research Council

- Ministry of Health

- PHO Alliance

- Te Puna Web directory: Māori Health

- Tomaiora Māori Research Centre, University of Auckland

- Whariki, APHRU

Introduction

Definitions and scope for literature review

What is 'integrated care'?

In New Zealand there is no agreed definition of 'Integrated care'. An early discussion paper on Māori integrated care initiatives states: "Integrated care can refer to the co-ordination of primary and secondary services; it can mean placing the responsibility for provision of several services with a single agency; or placing the responsibility for provision of services with many agencies to co-ordinate their decisions. There are certain key features common to all integrated care models. These are: –

- improved communication between providers

- easier access to treatment for consumers

- clearer flows of information

- clearer accountability for service quality and health outcomes

- a key person organising care

- more convenience for consumers

- more co-ordinated clinical and financial management." (Andrews, 1998)

In their review of the evidence base for integration, Ramsey and Fulop (2009) highlight the various dimensions of integration that are possible. These include:

- **Organisational integration**, where organizations are brought together by mergers and/or structural change, or virtually, through contracts between separate organisations

- **Functional integration**, where non-clinical support and back-office functions are integrated

- **Service integration**, where different clinical services provided are integrated at an organizational level

- **Clinical integration,** where patient care in integrated in a single process both within and across professions, e.g. through use of shared guidelines (Ramsey & Fulop, 2008 p 11)

Internationally, the literature on health care integration covers a range of topics including co-location of health services, co-location of health and social services, 'shared care' initiatives, vertical integration, integrated care pathways for patients with chronic conditions, and provision

of specialist services in primary care settings. Ouwens et al (2005) note that integrated care programmes have widely varying definitions and components, and failure to recognize these variations may lead to inappropriate application of research results.

Because details about the proposed integrated whānau ora centre have not yet been developed, it is not yet clear which integration models or dimensions of integration will be relevant. However, Tui Ora has proposed that the centre is likely to bring together a wider range of health services and professionals on one site and therefore the literature on co-location of services is likely to be relevant. It is also proposed that the centre may involve devolution of some secondary services to primary care. If so, evidence on the effectiveness of specialist outreach services and 'closer to home' models of secondary service provision may be useful. The stakeholders involved in the WOHIA scoping hui felt that integration of health and community/social services was important for whānau ora, so evidence about co-location of health and social services is also likely to be relevant.

What does 'effectiveness' mean?

For the purposes of this literature review, 'success' or 'effectiveness' is considered to have four dimensions:

- a) improving health outcomes

- b) improving social factors/determinants of health

- c) reducing inequalities

- d) family/whānau and community self-determination

These are the dimensions of successful integrated care that stakeholders considered to be most important in the development of the Maru Wehi centre.

However the literature on the effectiveness of integrated care does not generally cover all of these dimensions. Much of the research focus is on administrative and organizational impacts (e.g. strengthening of local partnerships and changes in service delivery), and many studies do not cover any of the dimensions above. This paucity of data, particularly in relation to impacts on inequalities, is a significant limitation of the review.

Policy context

National Level

The proposed centre is broadly in line with New Zealand health policies, including the Primary Care Strategy (2001) and He Korowai Oranga, the Māori Health Strategy (2002). Both of these strategies aim to reduce inequalities and improve access to health care services for Māori.

Eight years ago when it was published, He Korowai Oranga stated that whānau ora[1] was the overall aim of the strategy, recognising whānau as the foundation of Māori society. It emphasized the importance of working with people in their social contexts, not just with their physical symptoms.

In 2009, the Government launched the Māori Health Innovation Fund, to support the continued implementation of the vision of He Korowai Oranga and to promote innovation. Over the subsequent four years, the Fund will invest a total of $20 million in the design, development, promotion and delivery of innovative whānau ora driven health services. Tui Ora has been successful in securing funding through this programme to develop a localized whānau ora model over the next three years. The findings from this work will feed into the development of the proposed Maru Wehi centre, which will be developed concurrently.

The *Primary Health Care Strategy* (2001) signalled a transformation towards a population health model, and a focus on community involvement in primary care provision. This transformation is still in progress, and has been supported at the national level by evaluation and research, funding to promote innovation, and development of guidelines and toolkits.

In February 2009 the Minister of Health sent a *Letter of Expectation* to District Health Boards (DHBs), setting out the new Government's expectations for DHBs and their subsidiary entities for 2009/10 and restating a commitment to the *Primary Health Care Strategy* (PHCS). The letter outlined an expectation for the health system to deliver *better, sooner and more convenient* services, and clearly signaled expectations saying "we expect to build on the PHCS by shifting some secondary services to more convenient primary care settings (at no cost to patients), and establishing multi-disciplinary Integrated Family Health Centres" (Ryall, 2009).

In mid-2009 a Ministerial Review concluded that in order to face future challenges, our public health and disability system must operate more efficiently. The final report stated "Bureaucracy, waste, and inefficiencies must be reduced and resources moved to the front-line as spending growth slows. We must focus on quality which will deliver better patient outcomes and on ensuring better access to health services through smarter planning and resource utilisation, at regional and national levels" (Ministerial Review Group, 2009: p4). The proposed Maru Wehi Centre has the potential to be well aligned with the recommendations of this report which include:

- New models of care which see the patient rather than the institution at the centre of service delivery and which aim to promote a more seamless patient journey across community, primary, and hospital sectors, greater use of primary and community care, and the shifting of care 'closer to home'

- Stronger clinical and management partnerships to ensure that doctors, nurses, and other health professionals play a key role in decision-making,

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[1] He Korowai Oranga defines whanau ora as: "Māori families supported to achieve their maximum health and wellbeing"

- Changes in culture and processes to, for example, promote greater clinical leadership and engagement in decision-making, and improve the integration of primary and hospital-based care (Ministerial Review Group, 2009: p4).

More specifically, there is potential for the proposed centre to be closely aligned with the Government's new funding initiative to promote *Better, Sooner, More Convenient* Primary Health Care, which was launched early in 2010. The aim of this initiative is to deliver a more personalised primary health care system that provides services closer to home and makes New Zealanders healthier. The Government considers that primary health care has a part to play in helping reduce acute demand pressure on hospitals by better managing chronic conditions and proactively supporting high need populations. A package of services is proposed to make significant improvements. This includes multiple Integrated Family Health Centres, nurses acting as case managers for patients with chronic conditions, providing a wider range of care and support for patients and shifting some secondary care services to primary care. Hauora Taranaki PHO (of which Tui Ora Ltd is a 50% owner) is part of a business case put forward by the Midland Region Network to bid for funding under this initiative.

The Māori Party's Whānau Ora initiative is another national policy of relevance to the current Maru Wehi Centre proposal. It is not yet clear how the policy will be implemented, but in its April 2010 report the Whānau Ora Taskforce clarified outcomes goals, principles, and key foundations of effective whānau-centred service delivery. The report makes six recommendations including the following:

> The Taskforce recommends that Whānau Ora services are integrated and comprehensive, and focused on measurable outcomes that will contribute to whānau empowerment. When whānau access coherent and integrated services, and experience enabling interventions, positive development will follow. […] The Taskforce further recommends that specific outcome indicators reflect whānau ora philosophies and aspirations.

There is clearly potential alignment between the vision proposed in the Taskforce report, and the proposed Maru Wehi Integrated Whānau Ora Centre. However it remains to be seen whether this alignment will remain at the philosophical level only, or might translate into a role for the proposed centre in the roll-out of the Māori Party's Whānau Ora initiative.

Regional and Local Level

At the regional and local levels, DHBs are guided by national directives and localized needs analysis and consultation to produce strategies, policies and initiatives targeted to meet local needs and priorities. There is a range of local and regional strategies, policies and initiatives that the proposed centre is likely to align with, for example:

- Midlands Māori Health Plan

- Taranaki District Strategic Plan 2005-2015
- Te Kawau Maro Taranaki Māori Health Strategy 2009-2029
- Taranaki DHB District Annual Plan
- Taranaki Public Health Strategy
- Project Splice – review of model of care for Chronic / long term health conditions and Older People

Each of these documents has a strong focus on working collaboratively across the health sector and beyond, and improving Māori health. Project Splice is a Taranaki DHB initiative that is particularly relevant to the development of a community-based integrated whānau ora centre. The Project Splice report (Parsons et al, 2010) outlines recommendations to enable improved integration between services, reduction of duplication, and reduced risk of disconnect between multiple services that may be involved in supporting a person's care. The approach recommends that people with complex needs have an identified care manager who has a relationship with their general practice and works to ensure that all the care they are receiving is connected. Each care manager will work with a defined cluster of general practices and will be supported by a locally based team of nursing, allied health and NGO support services. Further support will be provided by a District Support and Development Unit that will provide professional leadership, specialist input, and professional development across the district. It is not currently clear whether the proposed Maru Wehi integrated whānau ora centre would be part of one of the Project Splice clusters/support teams, but if so the Project Splice model is likely to have a significant influence on the care models developed at the proposed centre.

Māori models of health and health care

Māori Models of Health

Whānau Ora Health Impact Asessment (WOHIA) is underpinned by a broad definition of health, and specifically draws on Māori models of health of health and wellbeing. Māori health care initiatives such as the proposed Maru Wehi centre are also typically based on Māori concepts of health and wellbeing. One such model is Mason Durie's Te Pae Mahutonga, which outlines six aspects of wellbeing, each represented by a star in the Southern Cross:

Mauriora - access to te ao Māori, which can lead to a secure cultural identity.

Waiora - acknowledges the importance of environmental protection and the link between people and the natural environment.

Toiora - health lifestyles

Whaiora- participation in the wider community

Nga Manukura- Māori leadership

Te Mana Whakahaere - autonomy, self governance.

This holistic and multi-faceted view of health and health improvement can be contrasted with the biomedical model, which often dominates the health sector in New Zealand and the western world. The biomedical model focuses on the physical processes of disease, such as pathology, biochemistry and physiology, and does not generally take into account the role of social factors, individual subjectivity or culture.

New Zealand and international research has demonstrated the important role that social factors such as income, housing and working conditions play in determining health (e.g. see WHO, 2008). Māori have disproportionately high rates of universal risk factors e.g. poor housing, low educational achievement, unemployment, and inadequate income (Durie, 2001; Durie, 2004), and may have poorer access to universal protective factors e.g. stable family life, school connectedness. There are also Māori specific risk and protective factors that affect wellbeing at the population level e.g. societal prejudice and discrimination, loss of sovereignty, dispossession, alienation from the land and from intellectual and cultural resources (Durie, 2001; Durie, 2004). It is primarily these social factors that produce and maintain health inequalities for Māori. For this reason, as well as for cultural reasons, a broad understanding of health that includes consideration of the social context is vital for improving Māori health and reducing inequalities.

Meeting Māori Needs

Culture, identity and values are important aspects of health and wellbeing (Durie, 2001). Anecdotal and research evidence suggests Māori are more responsive to care provided 'by Māori for Māori ', and that Māori health care workers (e.g. Māori community health workers, Māori case managers) can increase Māori access to and engagement in services (Maniapoto & Gribben, 2003; CBG, 2005). There is evidence that many mainstream services fail to meet Māori health needs because they fail to take account of Māori beliefs and practices and perhaps more importantly treat the patient and the illness individually without consideration of the "whole" person and their wellbeing in the context of the whānau.

For example, Wilson (2008) researched Māori women's perceptions of health and their interactions with mainstream health care. She found Māori women consistently encountered health services and health care providers that were problem-focused, and who compartmentalised their health issues or problems. This resulted in the women's needs not being recognised and planned interventions being inappropriate. Wilson observed that when interventions "went wrong" or outcomes were not achieved it was not unusual for patients to be blamed and labelled "non-compliant". An alternative view presented by Wilson is that it is the service itself which has failed because it is culturally inappropriate and unacceptable to Māori. Wilson concluded: "Positive health experiences stem from meaningful partnerships established between nurses and clients, and influence the efficacy of healthcare providers. In such partnerships nurses bring health and illness expertise while Māori women bring the knowledge about their health beliefs and practices and life circumstances."

Wenn (2007) researched "kaupapa hauora Māori" through qualitative research with kaumatua in the Taranaki region. Wenn identified a core set of values comprising whakapapa, wairua, whenua, whānau, tikanga te reo Māori, tinana and hinengaro that underpin the aronga (worldview) of kaumatua and the concept of hauora (wellbeing). She states that these values along with associated tikanga and ethics influence the perception and understanding individuals have of their world and of hauora.

In her book Malony-Moni (2006) described her practice as a Māori community nurse and gave many examples of how knowing and observing Māori tikanga achieved positive health outcomes for the individuals and whānau she was treating. She put her success down to the fact that she was Māori, cared about her patients, knew what she was talking about, and that her patients understood what she was saying. She explained her success and nursing method as a synergy of clinical nursing skills and intimacy with tikanga Māori. She stressed the principles of He Korowai Oranga and noted the health system should: a) engage with whānau rather than individuals – to focus on the family's potential, rather than individual's problems; b) recognize that health and wellness cannot be separated from each other or from the all the issues that confront whānau; and c) recognise that for Māori it is not possible to separate wellness from whakapapa, reo, tikanga as all these things create and sustain identity.

In their evaluation of a Māori case management service, Maniapoto and Gribben (2003) commented: 'One strategy to ensure health services for Māori become more effective is to provide services that are more responsive to the needs and expectations of all Māori, and acknowledge traditional Māori models of health. Implicit in these traditional models of healthcare is the traditional practice of 'tikanga' (Māori customs), which are acceptable to many Māori consumers of Māori health services. Whilst Māori and non-Māori live side by side, they do not always share the same environments or the same narratives, nor do they subscribe to identical values or aspirations.' Mason Durie has also argued that Māori-specific health promotion and health care approaches are necessary because Māori and non-Māori do not necessarily share the same values and aspirations (Durie, 2004).

These Māori research findings reinforce the need for culturally appropriate and acceptable interventions and responsive health care providers. Evidence suggests that these are vital to improving access, engagement and ongoing care for Māori. It is recommended that these findings are taken into account in the development of the Maru Wehi integrated whānau ora centre.

Effectiveness of services from a Māori perspective

Health Services are required to provide effective, appropriate and high quality services. Māori scholars have pointed out that for Māori, these requirements must make sense in Māori terms (Wenn, 2007; Durie, 2006). In other words, it is Māori communities who must define what "effectiveness", "appropriateness" and "quality" mean for them.

Durie (2001, 2005, 2009) argues that health must be seen within the context of the broader aims of Maori development. Looking to the future, Durie argues that what is required is both a long term plan, and a holistic approach that overcomes sectoral divisions (Durie, 2009). He points out that failure to take a holistic approach can undermine whanau development:

> Addressing a health problem for example, with little attention to other dilemmas that may be even more pressing, introduces a skew into whānau dynamics that may mask barriers to positive development. Sectoral interventions frequently unbalance whānau priorities and hierarchies by focussing on one aspect of whanau life that in the order of things, may be relatively unimportant to the whānau even if it is of great interest to a health worker (Durie, 2009: 10).

In a recent lecture about the future of Maori health, Durie outlined the following six tasks for health leaders. These are the tasks he believes are required in order for whanau ora to be achieved, and are relevant to the planning for the proposed Maru Wehi centre.

1. Shift from disease focus to a wellness focus
2. Develop programmes that will enable whānau to engage with personalised online health planning
3. Bridge the divide between sectors, between economic and social polices, and between primary and secondary health care
4. Build capability in whānau health promotion
5. Develop quality primary health care arrangements for all whānau
6. Transform health care into health empowerment (Durie, 2009: 13)

In summary, the literature suggests "effectiveness" in a Māori context means setting goals and objectives that reflect Māori values and aspirations, using culturally appropriate models and methods, and addressing Māori-specific as well as generic risk and protective factors. It also means taking a genuinely holistic and intersectoral approach to Maori health, within a wider Maori development context. While important lessons can be learned from overseas research and experience, it is important not to lose sight of these Māori-specific dimensions of effective health care.

Findings

1) Is integration effective?

International research suggests that integration *can* be effective, but there are often costs as well as benefits, and positive outcomes are not guaranteed. Benefits in terms of patient outcomes and cost savings may be modest (if they occur at all) and may take many years to emerge. Reviews of evidence tend to be cautious in their conclusions, for example a recent review of the evidence base for integration completed in the UK for the National Health Service (NHS) concluded:

> There is some international evidence that integration can lead to reductions in patient admissions and length of stay. However, evidence about impacts on costs, health outcomes, and patient experience is weak (Ramsey & Fulop, 2008).

On a more positive note, the authors also stated:

> There is evidence that suggests integration can be an effective way of delivering health care and it can provide opportunities to break down barriers between primary and secondary health care, as well as health and social care" (Ramsey & Fulop, 2008 p1).

A Canadian review of 'shared care' within the health system found that benefits included "improved care coordination, strengthening links between primary and secondary care, increased patient and provider satisfaction, and increased access to health care services" (Chomik, 2005). Another review, completed in the USA, concluded that integrated care programmes designed to improve continuity and coordination of care for patients with chronic conditions "seemed to have positive effects on the quality of patient care" (Ouwens et al, 2005).

Evidence about effectiveness for Māori is limited, but single studies from New Zealand suggest that targeted by-Māori-for-Māori services such as Māori case management (Maniapoto & Gribben, 2003), Māori diabetes nurse educators (Janssen, 2008) and community health workers (CBG, 2005; Ministry of Health, 2008) can improve engagement with Māori, and lead to better coordinated health and social care. There is also New Zealand evidence that intersectoral community action for health (ICAH) can improve access to primary care for Māori, Pacific and low income people. Targeted ICAH pilot projects in four New Zealand sites had some positive outcomes including improved health outcomes, improvements in determinants of health (e.g. nutrition, physical activity levels, housing quality), reduced inequalities, and community empowerment (Ministry of Health, 2008).

2) What are the most effective models of integrated care?

There is limited evidence about the health outcomes and patient experiences associated with the various models of integrated care, and it is not possible to compare the effectiveness of different models. For this reason, no particular model can be put forward as the 'ideal' (Smith & Ovenden, 2007).

Rosen & Ham (2008) agree that there is no single 'best way' to achieve integration, but there are ingredients for success that can form the basis of a local action plan. These are covered in detail in Section 6, and include: a strong focus on improving patient care, inclusion of secondary service providers in strategic development of integration plans, and a strong focus on developing trust and shared values between partner organizations. Clinical leadership, data sharing, robust governance arrangements and alignment of financial and non-financial incentives were also found to be key success factors.

Experience in Counties Manukau DHB points to the importance of engaging with Māori stakeholders from the outset of the integration project, and involving Māori patients in the design of, and feedback from, projects (Clarke et al, 2003). According to Clarke et al (2003), cultural competency must be carefully defined and built into the project from day one.

Evidence from overseas suggests that 'form should follow function'. The initial focus should be on improving the patient experience, and changes in organizational arrangements should follow. Attempts to structurally integrate organizations overseas have proven to be complex and costly, and have not always led to the desired improvements at the front line. For this reason, simpler and easier ways of coordinating care are recommended (Leutz, 2005), for example 'virtual' integration via professional networks or multi-disciplinary teams working across organizations.

Features consistently associated with effectiveness of integrated care programmes for chronically ill patients include: self-management support and patient education; clinical follow-up; case management; multidisciplinary patient care teams; multidisciplinary care pathways; and feedback, reminders and education for professionals (Ouwens et al 2005; Ramsey & Fulop, 2008; Smith & Ovenden, 2007).

3) Integrating Health and Social Care

From a primary health care perspective, integrating health and social care can mean a) providing more holistic primary care that addresses the whole person/whānau in their social context, and provides social support in the primary care setting and linkage to relevant social agencies where necessary; or b) health agencies and social welfare agencies (e.g. WINZ, CYFs, NGO services) working together to plan and deliver joined-up health and social services. In New Zealand, we have several examples of both models, some of which are outlined below. Examples of the latter - intersectoral integration of health and social care agencies -from the UK and the USA are also briefly outlined. The social care sector has often led the way in terms of

client-centred care and integration of services, so the health sector can usefully look to social care models and lessons learned.

Intersectoral Initiatives for Improving Health of Local Communities (NZ)

Four *Intersectoral Action for Health* (ICAH) projects - Porirua, Kapiti, Counties Manukau & Northland -were evaluated from 2001-2004 (Ministry of Health, 2008). The projects differed widely according to identified needs in local settings. They included such elements as community support workers to improve access to and coordination of health and social services (Kapiti); a health and education partnership to improve health and welfare outcomes for teenage parents (Counties Manukau); Healthy Housing pilot jointly delivered by housing and health sectors (Counties Manukau); and a whānau-based gardening and nutrition project (Northland).

After three years, outcomes included improved access to primary care for Māori, Pacific and low income people; measurably improved health outcomes for teenage parents in Counties Manukau; significantly reduced hospital admissions for intervention households in the Healthy Housing pilot; impacts on the social and economic determinants of health (e.g. access to income); improved health behaviour such as increased physical activity, better nutrition and decreased smoking rates; contribution to the reduction of health inequalities; community skill development and transfer of traditional knowledge in Māori communities in Northland; and enhanced community capacity to find solutions to problems of local concern (Ministry of Health, 2008).

The evaluation confirmed the findings of a related literature review (Ministry of Health, 2005) about critical success factors. These were: (1) clear agreement on the necessity to work together intersectorally to achieve goals; (2) support in the wider community for action; (3) the participating organizations each have capacity to carry through the planned action; (4) relationships enabling action are defined and developed; (5) actions are planned and implemented to the satisfaction of each participating sector and organisation; and (6) outcomes are monitored and evaluated. The evaluation highlighted the importance of drawing on community wisdom in the needs analysis process, and throughout project implementation.

Primary Mental Health Initiatives (NZ)

In 2005 the Ministry of Health provided funding to initiate and evaluate a number of initiatives to enhance provision of mental health care in primary care. A range of models was developed, and integration of health and social care was a feature of several of the pilots. Integration took the form of creation of specific roles (e.g. social workers, non-clinical coordinators) tasked with addressing the complex social needs of service users and linking them to wider social and community services. Overall the Primary Mental Health Initiatives were successful in terms of patient outcomes, with 80% of service users showing clinical improvement over the 2 year evaluation period. There were no significant differences found in clinical outcomes according to the model of care employed, but evaluators noted that improved social care and access to community and social support networks was a key success factor. Evaluators commented "It was important that the service models were able to address the (frequently present) complex

social needs of service users. Appropriate liaison and integration with secondary care services was also an important part of effective intervention." (Dowell et al, 2009)

Community Health Worker Role (NZ)

New Zealand research has highlighted the value of the community health worker role for improving access to health and social services, particularly in Māori, Pacific and low income communities (Ministry of Health, 2008; CBG, 2005). For example an evaluation of 35 'reducing inequalities' initiatives found that community health workers were pivotal in reducing barriers to access to both primary care and wider social services (CBG, 2005). As well as financial and transport barriers, the research found that isolation and extreme discomfort in health care or other 'official' settings were significant barriers to receiving appropriate care for some people. The trusting relationships built by community health workers (CHWs) over time through home visits were effective in breaking down these barriers. The roles of CHWs varied widely but they often provided moral and cultural support, and acted as 'interpreters' explaining medical language in everyday terms. Other key tasks were providing health education and self-management support, transport services, making referrals to other social services and providing advocacy, for example accompanying clients to appointments at WINZ. Community development and organizing events was also often part of the CHW role.

There was high demand for CHW services in the projects evaluated, and there is evidence that CHWs can help increase access to services and reduce inequalities (Ministry of Health, 2008; CBG, 2005). Success factors included professional support and good integration of CHWs with other health care professionals at the same practice; clear scope of practice, rights and responsibilities; clear reporting framework and associated IT skills; and provision of appropriate infrastructure (e.g. provision of a vehicle, desk space and computer terminal) (CBG, 2005).

Strengthening Families (NZ)

Strengthening Families is a cross-sectoral, whole-of-government initiative in which government agencies and community organisations work together in a structured way to achieve better education, housing, health and social outcomes for families. The agencies work together with the family to provide support and develop joint solutions to issues, rather than each agency dealing with one part of the problem and never seeing the bigger picture. A coordinator or agency staff member organises a meeting/s where the family and the agencies discuss the issues and develop a single case plan. At the meeting, an agency is identified as the 'lead agency' and is then responsible for coordinating what is happening.

Strengthening Families was initially piloted in 1996, and by 1999 it had been rolled out across the country including the Taranaki region. It is funded by 10 government agencies, including the Ministry of Health, and administered by Family and Community Services (FACS) within the Ministry of Social Development (MSD). Within each area, the programme is overseen by a Local Management Group (LMG) and is tailored to local needs and circumstances. The groups typically include frontline workers from the health, education, welfare, justice, housing and

employment sectors, as well as non-government agencies and iwi/Māori organisation and whānau support services.

Evaluations show that a significant majority of families who take part in Strengthening Families case management view the process very positively. Between 70-80% of families felt that they had achieved better outcomes through the processes, said they would use the process again, and said they would recommend it to others (MSD, 2005). Key success factors identified in a 2001 review (Young et al, 2001) included: the skills of the regional SF coordinator, particularly facilitation and communication skills; effective promotion of the SF process to agencies in the region and the general public; and local availability of services identified as needed. A key learning identified in the 2005 review was 'the resource demands of collaboration are now widely considered to be greater than was understood when Strengthening Families was first introduced' (MSD, 2005).

Strengthening Families was recently featured in an international study on service integration undertaken by The Accenture Institute for Health & Public Service Value, an international consultancy (Accenture, 2009). The study used fourteen case studies to illustrate how front office shared services deal with four implementation challenges: i) governance , ii) performance management, iii) workforce change , and iv) information sharing and systems. The report notes that higher levels of integration are required when working with complex outcomes, such as responding to the needs of people suffering from multi-dimensional disadvantage.

Strengthening Families is presented as an exemplar of a 'networked delivery' type of shared service because it allows agencies to organise integrated delivery around the needs of specific cases, whilst not restricting their autonomy or affecting their core functions. The Accenture Study identified the following strengths of the Strengthening Families initiative:
- a strong sense of local ownership
- the flexibility for agencies to be involved to different degrees on a case-by-case basis
- governance arrangements that allow for and recognise partner agencies with different service cultures and ways of operating
- a clear mandate for cross-agency working provided by the Strategic Framework
- case-by-case client consent for information sharing, in which clients can specify what information is shared and with whom. (Accenture, 2009)

It also noted the following challenges for Strengthening Families:
- supporting agencies on local management groups to fulfil governance roles
- the need for performance management system that supports collaborative working, meaning that staff involved in the initiative are not accountable for its success and may focus on their own agency work when under pressure
- the difficulty of measuring the impact of Strengthening Families on outcomes for clients. (Accenture, 2009)

Family Start (NZ)

The Family Start programme was established in 1998 and provides intensive, home-based support services for families with high needs, to ensure that their children have the best possible start in life. The aims of Family Start are to: i) improve health, education and social outcomes for

children; ii) improve parents' parenting capability and practice; iii) improve children and parents' personal and family circumstances. Family Start is funded and managed by Family and Community Services and delivered in the community by non-governmental contracted service providers. Currently Family Start is not being delivered in Taranaki.

At the heart of Family Start is a home visit by a family/whānau worker who helps the family identify priorities and supports them to achieve their goals. A family may be involved with many different agencies, and so the family/whānau worker acts as an advocate and coordinator between all agencies to ensure that the family's priorities are met. Designated community agencies refer families to Family Start. Families can be accepted onto the programme from 6 months before the birth of a child up to one year after. Participation by families is voluntary.

Evaluations indicate that many parents were very positive about the programme, and more than half of mothers spoke of positive changes in their own behaviour and/or changes in their children which they related to the help they had received from Family Start (Evaluation Management Group, 2003). Progress had been made towards 79% of the goals identified as part of the intervention (Centre for Child and Family Policy Research, 2005). However a few mothers were very dissatisfied with their whānau worker, and felt the service they received was not of a high standard. Overall, referring agencies had a positive view of Family Start and its kaitiaki, but some sites had a better reputation than others.

Success factors identified in evaluations were i) use of individualised plans and goal setting; ii) availability of quality, trained staff with a clear understanding of the role and skills to carry it out effectively; iii) a strengths-based approach that helped mothers gain confidence, skills and problem-solving capacities (Evaluation Management Group, 2003). Issues and challenges included: i) insufficient time allowed for establishment in sites where coalition partnerships had to be built from scratch – setting up governance and partnership structures took more time than anticipated; ii) competitive funding environment and perceptions from agencies that new services presented a threat to existing services; iii) lack of availability of quality, trained staff. The five day induction training for whānau workers was seen as insufficient to prepare staff for the complexities and challenges of the role (Evaluation Management Group, 2003).

According to another review, collaboration with other agencies ranged from excellent to poor (Centre for Child and Family Policy Research, 2005). Facilitators of positive collaboration were existing prior relationships between individuals in Family Start and other agencies, and the perception that Family Start and the other agency provided complementary but distinct services. Relationships with health providers were generally good, whereas relationships with agencies perceived to offer overlapping services from a different philosophical base were often less positive (Centre for Child and Family Policy Research, 2005).

Care Trusts (UK) -

In the UK 'care trusts' were introduced in 2000 to encourage closer working between the NHS and local councils to support better coordinated health and social care[2]. By 2008, 10 care trusts had been formed, and more are anticipated (Ramsey & Fulop, 2008). Care trusts are based on the principles of pooled budgets, lead commissioning (where one partner organization commissions integrated services provided by both partners), and integrated provision (where a single organization provides both health and social care services, though not necessarily in one location). It is possible that the whānau ora policy in New Zealand might follow a similar model.

Leutz (2005) comments that care trust show "some successes, but also tremendous organization challenges". A review in 2005 (Glasby & Peck, in Ramsey & Fulop, 2008) found that care trusts were viewed locally as hard work to establish, but worthwhile. It was perceived that services had become more accessible and flexible, and that a foundation had been built for future improvements. However stakeholders also noted concerns and limitations, for example a limited focus which did not include the voluntary sector, and structural factors (e.g. audit, risk management) that forced individual organizations to remain focused on their own targets to the detriment of genuine collaboration. Clear measures of effectiveness in terms of health or social outcomes or costs have yet to be reported, and some stakeholders have questioned whether the costs of 'wholesale structural integration' are worth the benefits (Glasby 2004, in Leutz, 2005).

Unique Care approach (UK)

The Unique Care approach integrates health and social care by creating a small team with staff from both domains and basing this team in a neighbourhood setting, often a GP surgery. The Unique Care team identifies people who have complex needs or are at high risk of hospital admission and it engages with all local providers e.g. obtaining daily updates on admissions from the local hospital, and visiting patients there to help plan for discharge and aftercare in the community. (In the New Zealand context such a team could equally engage with Corrections, CYF or WINZ to identify local families or individuals with high and complex health and social needs.) The approach was first piloted in 1999 and evaluations report substantial reductions in hospital admissions and length of stay. Some of the pilot sites also reported reduced costs (Ramsey & Fulop, 2008).

Multi-Sector Partnerships to Promote Children's Healthy Development

A US review reports on four interventions that have successfully linked health care with other systems and services to improve the wellbeing of young children and their families, and highlights common characteristics and success factors (Hicks, 2008). These are:

- A broad definition of health and its antecedents - including social, emotional and environmental wellbeing

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[2] In the UK, local councils have primary responsibility for delivering social care services.

- A child-family-community focus – i.e. identification of and response to child, family and community needs simultaneously

- Needs assessment and resource mapping

- Effective community involvement in planning e.g. structured and facilitated community planning

- Paediatricians as program champions. Clinical leadership adds credibility and demonstrates health sector commitment to cross-sector working

- Case management, care coordination and linkages

- Single point access to information, assistance and services – for families, providers and other agencies

- Outcomes tracking –i.e. the ability to effectively demonstrate positive programme outcomes

- Family and community capacity building - a twin focus on meeting immediate needs, and building long term family and community capacity for wellness

Key Learning about integration of health and social care

Because of the complexities of integrating policy, finances, and service delivery, intersectoral integration needs to be enabled at a high level with supportive administrative arrangements and high-powered champions (Leutz, 2005; Hicks, 2008). At the same time high level support must not overpower local and community decision making (Ministry of Health, 2008). National or regional policies should facilitate rather than dictate how integration will occur at the local level. "Each integration effort has to be implemented locally in a way that is consistent with the particulars of local systems and personnel" (Leutz, 2005 p9).

The benefits of integration tend to accrue to small sub-populations, specifically those with complex needs and high risk of hospitalization (Leutz, 2005). Leutz argues that there are simpler and more efficient ways of meeting the needs of these subgroups, along with the needs of the majority, rather than full organisational integration. Coordination and linkage can successfully integrate care (without integrating organizations), and this has been demonstrated both overseas and in New Zealand.

Research highlights the importance of a strengths-based approach that emphasizes the development of family and community problem-solving capacity, skills and confidence (Evaluation Management Group, 2003; Ministry of Health, 2008; Hicks, 2008). This client-centred model of practice may be more familiar to social sector professionals than to health sector professional who have traditionally played the role of expert 'problem-fixers', rather than

facilitators of client-generated solutions and goal-setting. Learning and best practice from the social sector may help to inform development of health sector whānau-ora practice that empowers families and communities.

It has been argued that within primary care settings, attention needs to be given to empowering weaker system actors because medical professionals typically have more power than community health workers, social support agencies, volunteers and family members (Leutz, 2005). Leutz warns that there is potential for integration efforts to be 'captured' by professionals prioritizing their own needs (Leutz, 2005). At the same time, research shows that clinical buy-in and leadership is vital for successful integration. Leutz notes that in the USA "successful sites approached physicians with a solution to a problem in their practice, not a new demand" (Leutz, 2005, p8), and this helped to gain buy-in.

Integration needs to be supported financially. International research found that "integration efforts worked better when three things happened – each of which can increase costs, at least in the short run:

- provide start up support

- add staff and support systems

- add new services or funding for existing services" (Leutz, 2005).

New Zealand evaluations found that the time and funding required for effective establishment of intersectoral partnerships and ongoing coordination was often greater than originally anticipated (Ministry of Health, 2008; Evaluation Management Group, 2003, Ministry of Social Development, 2005). This is also supported by international findings that integration takes time, and costs before it saves (Leutz, 2005).

4) Integrating Health Services

The health system is complex and fragmented, with a wide range of organizations providing different types of care at different stages and levels. With an aging population and increasing rates of chronic illnesses, it has become increasingly recognized in New Zealand and overseas that better coordination and communication between different parts of the health sector is necessary. Integration of health services can take many forms, and some of the models are outlined below. This section concludes with key lessons learned in New Zealand and internationally about successful integration of health care services.

Co-location of health services

Co-location means having a range of health services in one place that are normally delivered by different agencies in separate locations. Such initiatives are sometimes called "one-stop-shops"

or "polyclinics". Polyclinics integrate both hospital and health clinic services at neighbourhood level, offering a comprehensive range of complementary diagnostic and therapeutic services (Imison et al, 2008).

International findings indicate that although co-location provides opportunities for better co-ordinated and integrated care, it does not necessarily lead to such improvements in practice. (Imison et al, 2008). A UK review concluded that the potential benefits offered by polyclinics would only be achieved if "considerable investment of time, effort and resources is put into their planning and development" (Imison, 2008). Limitations and risks include lack of overall governance structure; unclear lines of accountability; professional isolation for specialists; and a reduction in accessibility of primary care for many patients if services are centralized. The review notes that the choice of location is crucial, and polyclinics should ideally be sited at natural transport hubs. The review concluded:

> The primary focus should be on developing new pathways, technologies and ways of working rather than new buildings. Co-location alone is not sufficient to generate co-working between different teams and professionals. Investment in change management and strong clinical and managerial leadership will be required. (Imison, 2008, p 3)

It has been suggested that co-location of different professionals could lead to general up skilling via knowledge sharing. An international systematic review found that on-site mental health workers delivering psychological and psycho-social interventions in primary care settings sometimes led to improved professional practice for primary care providers (e.g. fewer and more appropriate referral to off-site mental health specialists, reduced number of drugs prescribed to patients who see the mental health workers). However these changes did not necessarily occur (Harkness & Bower, 2000). This finding tends to support the conclusion of the Imison (2008) review of polyclinics – that co-location presents opportunities but does not in itself lead to better clinical integration or quality of care.

Community Oriented Primary Care

Community Orientated Primary Care (COPC) is presented by Smith and Overnden (2007 p15-16) as a promising way to integrate public health with primary care practice at the local level. COPC does not require co-location of services, but is rather about collaboration between primary care professionals and the community to identify priority community health concerns, and develop an action plan to address both environmental and clinical aspects of the issues. There is some evidence that the COPC approach has been effective in improving health outcomes, for example it has been used successfully in HIV/AIDS prevention efforts in Native American communities (Thurman et al, 2007 in Smith and Ovenden, 2007).

Key learning about integrating within the Health Care System

Rosen & Ham (2008) present ten key principles to support the development and maintenance of integration. These are based on research evidence and discussion amongst expert attending a UK seminar on the topic of integrated care for people with chronic diseases. The principles are:

1. Form should follow function

2. Create a receptive context for change

3 Robust governance and transparent accountability

4. Align incentives

5. Integrate the data

6. Preserve choice

7. Scale is important

8. 'It's the relationships, stupid'

9. It takes time to make integration work

10. Evaluation has to support diverse expectations and provide robust results

Chomik, 2005 also outlines lessons learned:

- The need to engage champions

- Define roles and responsibilities

- Establish sound communication and information systems

- Be patient

- Align payment with care tasks

- Co-locate providers

- Institute sound evaluation methods

5) Shifting Secondary Services to Primary Settings

In New Zealand the Minister of Health has signaled an expectation that some secondary services be 'devolved' to primary care settings as part of a move towards "Better, Sooner and More Convenient" health services (Ryall, 2009). This shifting of secondary services to primary settings can be seen as a particular strand of action in health service integration. This section summarises New Zealand and international evidence about the effectiveness of delivery of secondary services in primary settings, and reports on key learning to date.

International Evidence

A systematic review of specialist outreach clinics in primary care and rural hospital settings found that specialist outreach can improve access, outcomes, and service use, especially when delivered as part of a multi-faceted intervention (Gruen et al, 2003). The review concludes: "Simple 'shifted outpatients' styles of specialist outreach were shown to improve access, but there was no evidence of impact on health outcomes. Specialist outreach as part of more complex interventions involving collaboration with primary care, education or other services was associated with improved outcomes, more efficient care, and less use of inpatient services" (Gruen et al, 2003). This model does not involve 'devolution' of secondary services, but rather re-location of additional selected specialist services to community settings, with or without integration with primary care.

Another model was trialed in the UK in the 'Closer to Home' pilots. This model involved shifting care from consultants to GPs, nurses and other practitioners with special interests. In 2006, 30 demonstration sites were selected in six specialties: dermatology, general surgery, gynecology, orthopedics, urology and ENT (ear, nose and throat). Evaluation showed that providing additional services closer to home was an effective strategy for reducing waiting lists, and patients found it easier to get to Closer to Home services and reported positive evaluations of the care they had received. There was no evidence of adverse impacts on quality of care or patient safety, but clinical outcome measures were unavailable (Leese et al. 2007). Evaluators noted that community based practitioners were able to provide the services at significantly lower cost than the hospital tariff, partly because the cases chosen for Closer to Home services were simple rather than complex cases. The evaluation covered barriers and facilitators of implementation, and noted that prior consultation with stakeholders was critical to success. Other facilitators included prior positive working relationships amongst key stakeholders, local service champions and continuity of leadership (Leese et al, 2007).

The polyclinic model in the UK also includes the provision of specialist services in community settings. A recent review concluded that quality of care for most services shifted out of hospitals is comparable, but shifting of outpatient services was limited to a small number of specialties

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and was more limited than expected (Imison, 2008). Barriers identified included: financial dis-incentives for hospitals (since the funding formula had not changed to reflect that hospitals were left with fewer but more complex cases, with a higher per-unit cost); lack of trust or shared vision between commissioners and providers; lack of clinical engagement. Well integrated polyclinics were found to be those located in a broader context of strong joint working and well developed partnerships supported by strong leadership (Imison, 2008).

New Zealand Evidence

District Health Boards New Zealand (DHBNZ) recently conducted a survey of DHBs experiences with shifting services from hospital to community settings (DHBNZ, 2009). The most commonly shifted services were:

- minor surgery in primary care – primarily skin lesions (9 DHBs)

- services for diabetics (6 DHBs)

- insertion of mirena, a contraceptive IUD (4 DHBs)

- sleep apnoea assessments (4 DHBs); and

- radiology (4 DHBs).

A wide range of other services had been shifted by one or two DHBs, including: community management of cellulitis, multidisciplinary case review sessions in primary settings, needs assessment coordination service for over 65s, and kaupapa Māori clinical mental health and addiction services.

Almost all of the initiatives reported benefits from the shift, most commonly: reduced waiting times and increased access to services for patients, reduced pressure on hospital services and release of specialists for more complex work, improved communication and linkages between primary and secondary care, and upskilling of primary care workforce. Some DHBs reported 'vastly improved' performance against targets. DHBs generally reported lower costs per unit, though this was often offset by higher volumes due to increase in access and demand for services. In some cases (e.g. mental health clinical rehabilitation services; podiatry services) there was no cost saving to the DHB, but other benefits (e.g. quality of life for patients; inequalities benefits) made shifting services worthwhile.

Success factors reported included: good engagement with secondary services about the change; strong governance with primary, secondary and management represented; clinical governance and oversight; good existing relationships between primary and secondary professionals; an ongoing forum to solve system issues and identify opportunities for improvement; good communication;

Challenges and barriers included lack of acceptance of changes from secondary services; administrative complexity and costs higher than expected; challenges in developing protocols that all stakeholders are happy with; culture change issues; data accuracy and recording systems have been an issue in some cases; implications for management of inter-district flow; services take a long time to 'bed in'; workforce capacity; time and resources are required to provide training – often no funding available to support this; requirement for appropriate facilities/space in primary care clinics in order to provide the services.

Key Learning about shifting secondary services to primary care settings

Evidence shows that successfully shifting care from hospital to community settings is about much more than merely relocating services (Singh, 2006 in Smith & Ovenden, 2007). Smith & Ovenden (2007) caution against assuming that relocation of services is necessarily a 'good thing' – the evidence suggests are more complex picture.

Lessons learned in New Zealand include the importance of early consultation with secondary services; clear communication is critical; development and consultation takes time, as does education and training in new procedures – resources need to be allocated accordingly; the importance of a joint primary/secondary clinical oversight group has been highlighted

6) What are the characteristics/features associated with successful integration?

This section brings together the recurring themes from the research outlined above, along with review findings about success factors for integration. The following characteristics and features have consistently been associated with successful integration.

Clarity of Purpose

- "Be very clear about the reasons for which integration is pursued and reflect carefully on whether integration is the best way to achieve stated goals". (Rosen and Ham, 2008)

- The objectives of integration need to be made explicit. It is important to determine the desired outcome of integration, because no model can deliver on all dimensions. The integration model chosen should reflect the desired outcomes (Smith & Ovenden, 2007; Ramsey & Fulop, 2008)

Strong focus on improving patient care

- Successful integration grows organically from a desire to improve services. Top-down approaches driven by administrative needs (e.g. reduction in use of hospital beds) have tended to be less successful. (Ramsey & Fulop, 2008)

- An existing culture of quality improvement is a factor associated with success (Chomik, 2005; Leutz, 2005; Imison et al, 2008; Ramsey & Fulop, 2008).

- Integration focused mainly on merging or co-locating organizations is costly and may not create improvements in care for patients. An alternative approach is to begin integration at the front line, based on patients' needs. Through this work, the most suitable organizational supports for integration may be identified (Leutz, 2005; Ramsey & Fulop, 2008)

- "The starting point should be clinical and service integration rather than organizational integration, with a focus on improving patient experience, clinical outcomes and value for money. " A focus on population health and health promotion goals is also seen as important (Rosen & Ham, 2008)

Broad definition of health

- Success is associated with services that address environmental as well as clinical aspects of health issues (Smith & Ovenden, 2007)

- Consideration of the whole person & the context in which they live is important (Durie, 2004; Hicks, 2008; Maloney-Moni, 2006).

- A focus on family and community capacity building has been associated with long-term positive health and wellbeing outcomes, and improved equity (Hicks, 2008; Ministry of Health, 2008).

Cultural appropriateness and responsiveness

- Objectives, models and methods that reflect Māori beliefs, values, aspirations and tikanga can lead to better engagement and better outcomes for Māori (Durie, 2004; Durie, 2006; Malony-Moni, 2006; Maniapoto & Gribben, 2003; Wenn, 2007)

- Services that focus on the family/whānau and their potential, rather than the individual and his/her problems have been shown to be successful (Maloney-Moni, 2006; Hicks, 2008)

Strong partnerships built on shared values and trust

- Successful integration is associated with the pre-existence of positive relationships, mutual trust between professionals and partner agencies, and a willingness to work together (Centre for Child and Family Policy Research, 2005; DHBNZ, 2009; Imison, 2008; Ministry of Health, 2005 & 2008; Ramsey & Fulop, 2008; Rosen & Ham, 2008)

- Joint goals and shared values in coordinating work is important to successful integration (Ramsey & Fulop, 2008; Rosen & Ham, 2008)

- The development of an agreed set of principles to guide the planning process is recommended (Smith & Ovenden, 2007)

- Joint arrangements that are 'core business' rather than marginal, and joint arrangements covering operational and strategic issues are core characteristics of successfully integrated organizations (Ramsey & Fulop, 2008)

Supportive Management and Clinical Leadership

- Success requires strong leaderships and leaders with a clear vision of integrated care (Ramsey & Fulop, 2008)

- Integration depends heavily on management commitment and support for change (Ramsey & Fulop, 2008)

- Clinical leadership has been found to be a vital success factor across a wide range of integration models. (Chomik, 2005; Hicks, 2008; Imison, 2008; Leutz, 2005)

- High powered champions for integration (often clinicians) help to engage stakeholders and gain endorsement for the proposal (Chomik, 2005; Hicks, 2008)

- Better integration between clinical and community services is one of the most valuable potential outcomes of integration. However there may be significant power imbalances between clinical and community services, which makes such integration a challenge. Strong leadership is required to ensure community services do not miss out (Leutz, 2005; Ramsey & Fulop, 2008)

Financial support for integration

- Integration costs before it saves (Leutz, 2005) and additional funding is necessary for the successful implementation and maintenance of new approaches and systems (Ramsey & Fulop, 2008; Imison, 2008)

Appropriate IT infrastructure

- Supportive clinical information systems have been identified as an enabling factor for integration in a UK review (Ramsey & Fulop, 2008), along with mechanisms for sharing information (Rosen & Ham, 2008)

- Investment in primary care infrastructure including IT is crucial as a route for improving access, equity, quality and efficiency in primary health care. (Smith & Ovenden, 2007; Chomik, 2005)

- The prime IT focus must be on systems to improve the co-ordination of care for patients. There should be a focus on member/patient access to information through an interactive web portal**.** The IT systems should also support the information flows required for effective performance management and peer review. (Rosen & Ham, 2008)

Skilled workforce

- A highly skilled workforce has been identified as a key success factor. Communication and facilitation skills, as well as clinical skills, are important for making integration work (Malony-Moni, 2006; Young et al, 2001).

- Workers with a clear understanding of their role, and a clear scope of practice (CBG, 2005, Evaluation Management Group, 2003)

- Provision of professional education, training and support in integration and associated skills is associated with successful outcomes (CBG, 2005; Chomik, 2005)

- Professional behaviour change and education are key to the effectiveness of multidisciplinary team working (Smith & Ovenden, 2007)

Engagement of clinical and community stakeholders in planning

- Strong clinical engagement and community engagement from early stages of planning is key (Smith & Ovenden, 2007; Hicks, 2008)

- Inclusion of secondary care providers in planning has been identified as an important success factor in health care integration models (DHBNZ, 2009; Leese et al, 2007)

- Local ownership, and responsiveness to community-identified issues and needs is associated with success (Accenture, 2009; Hicks, 2008; Ministry of Health, 2008)

- In the New Zealand context, early engagement with Māori stakeholders has been shown to be vital (Clarke et al, 2003)

Alignment of policies and incentives

- Incentives that support rather than hinder integration are important (Rosen & Ham, 2008)

- Alignment of shared care tasks with provider payment (Chomik, 2005)

- Buy in from front line staff may require financial incentives. Certainly structural disincentives to integration can be a significant barrier.(Ramsey & Fulop, 2008)

- The different funding streams and payment mechanisms need to be aligned so that all parties are incentivized to work together and rewarded for providing integrated care (Rosen & Ham, 2008)

- "to incentivize the delivery of integrated care, the balance between 'risk minimisation' (usually associated with vertical integration) and 'risk transfer/sharing' (as in vertical integration) needs to be addressed" (Rosen & Ham, 2008)

- Coherence of rules and policies at all organizational levels is important for successful integration. (Ransey & Fulop, 2008)

- Greater freedoms to pool budgets, transfer data between organizations and to encourage individuals to work for more than one organization were identified at important tolerances (Rosen & Ham, 2008)

Funding and Planning arrangements that support integration

- "Organisational structures are more effective in changing service delivery in primary and community care where they control funds through some form of contracting or planning" (Smith & Ovenden, 2007)

- Joint commissioning at macro- and micro- levels is a characteristic of successfully intergrated organizations (Rosen & Ham, 2008)

Robust governance and accountabilty

- Community involvement and ownership of new initiatives in primary and community services can increase the likelihood of success, and assessing community readiness for change is a key component of this (Smith & Ovenden, 2007)

- "Any devolution of responsibility for primary and community health service delivery needs to be matched by increased accountability and appropriate governance arrangements. These governance arrangements need to carefully balance community governance, clinical leadership, the nature of integration with secondary care, and economies of scale " (Smith & Ovenden, 2007)

- "Successful governance is always built on strong clinical leadership and robust management processes" (Rosen & Ham, 2008)

- When there is a network of partner organizations working together, there needs to be clarity about who is responsible for ensuring delivery of integrated care (Rosen & Ham, 2008; Imison, 2008)

Evaluation

- Success can only be proven if appropriate monitoring and evaluation is in place. It follows that evaluation has been found to be a key characteristic of successful integration efforts (Chomik, 2005; Hicks, 2008; Ministry of Health, 2005 & 2008; Rosen & Ham, 2008).

- Whatever the model of care and whatever the criteria used for its evaluation, it is crucial that there is long term assessment of the impact of change, led by senior managers and overseen by the main governance bodies. Development of an agreed set of desired outcome measures is recommended (Smith & Ovenden, 2007)

7) What are the barriers to success and how might these barriers be overcome or avoided or minimized?

A number of evaluation studies and reviews identify barriers to successful integration. Key themes are summarized here, along with suggestions from the literature on how the barriers can be overcome.

Structural change alone does not necessarily lead to more integrated care

The health system has historically been focused on episodic rather than chronic care (Chomik, 2005), and structural changes alone may not be sufficient to redirect this focus. Evidence from the UK indicates that organizational integration does not necessarily result in the delivery of more integrated care (Ramsey & Fulop, 2008). Similarly co-location of services does not necessarily lead to more co-ordinated or convenient care (Imison et al, 2008).

As outlined in the section above, the best way to overcome this challenge may be to focus on improving continuity of care for patients, rather than starting with organizational integration.

Research has shown that effective forms of both formal and informal clinical integration can develop regardless of the organizational configuration or location of services (Ramsey & Fulop, 2008).

> There is some evidence to show that virtual integration using networks can provide a valid alternative form of healthcare delivery to the structural reorganization involved in horizontal or vertical integration. Studies on the former have found that the process of change itself can constrain service improvement (Ramsey & Fulop, 2008, p6)

Financial and other disincentives

At both the organizational level, and the level of individual practioners, there may be disincentives to partnership working and integration. This is one of the most commonly reported barriers to integration. For example:

- UK and US research has highlighted that national policies, regulations and accountability arrangements can sometimes create perverse incentives and barriers to integration of services. (Rosen & Ham, 2008; Ramsey & Fulop, 2008; Leutz, 2005). For example, privacy regulation may create barriers to data sharing.

- Structural factors (audit, risk management) force individual agencies to remain focused on their own targets to the detriment of genuine collaboration (Ramsey & Fulop, 2008)

- A UK review found that financial disincentives for hospitals were the primary barrier to shifting outpatient care into the community, since the cost of treating a smaller number of more complex cases in hospital would not be covered by the existing funding formula (Imison, 2008)

- Current performance management systems mean that staff involved in a cross-agency initiative are not accountable for its success and may focus on their own agency work when under pressure (Accenture, 2009)

- Leutz (2005) notes "your integration is my fragmentation". GPs, specialists and other professionals may perceive tasks associated with integrated care as taking them away from their core work

As noted in the previous section, alignment of incentives and policies is important to ensure that integration is not hindered by structural barriers and disincentives. National level support - e.g. 'waivers' from selected national policies or financial and employment regulations – can help to create an environment conducive to integration of services (Rosen & Ham, 2008).

Integration takes time and costs money

One of the key lessons identified by a number of reviewers is "be patient" (Chomik, 2005; Ramsey & Fulop, 2008). Patience is required because it takes time (several years) to effect demonstrable changes in organizational structures and processes, and to have these filter down

to outcomes (Ramsey & Fulop, 2008; Rosen & Ham, 2008). In a New Zealand review, Smith & Ovenden (2007) conclude "New organisational arrangements for primary and community care (including integration with secondary care) need time and stability in order to develop community readiness, sustainable capacity, trust, culture and systems".

Both overseas and New Zealand research shows that successful integration requires high-trust relationships and shared goals and values between potential partner organizations. The formation and development of these relationships takes time and cannot be rushed (Rosen & Ham, 2008; Evaluation Management Group, 2003; Chomik, 2005).

As noted in the previous section, new clinical and administrative systems and protocols are more likely to succeed if they are developed collaboratively, through community and clinical engagement, and such engagement is resource intensive. New Zealand experience is that cost of establishing integrated care initiatives and the time taken to bed in was often greater than expected (DHBNZ, 2009; Ministry of Health, 2008; Evaluation Management Group, 2003; MSD, 2005).

Although one would expect better coordination of previously fragmented services would lead to efficiencies, findings from the US and UK suggest that integration has seldom led to overall cost savings (Ramsey & Fulop, 2008). The cost and time involved in integration means that any potential economies of scale and scope will take a long time to achieve.

Change management challenges

Major organizational change is not always welcomed within the workforce, and if not handled well this can divert energy away from core business and lead to low morale and workforce dissatisfaction. Patients may also find it difficult to adapt to changes in how their care is delivered. Therefore the case for change needs to be clear and communicated to all stakeholders (Smith & Ovenden, 2007).

Because of complex interrelationships between autonomous agents within the healthcare system, linear 'top-down' approaches to change management may not work, since over-prescription of new approaches may stifle innovation and lead to resistance (Smith & Ovenden, 2007). A focus on an agreed set of outcome measures and a simple set of guiding principles is suggested as a more effective approach than micro-management.

New Zealand and overseas research has found that lack of clinical engagement early in the change process can lead to resistance (Imison, 2008; DHBNZ, 2009). Professional territorialism has been noted as a barrier to change (Chomik, 2005).

Organisational and community readiness needs to be assessed prior to implementing innovative approaches to service delivery and organization (Smith & Ovenden, 2007). A careful assessment of people's concerns about change paves the way for managers, clinicians and

community leaders to plan effectively for the design, implementation and review of any transition. (Smith & Ovenden, 2007)

Community versus clinical leadership

Clinical leadership has been found to be an important success factor for integration, and clinical 'buy in' is essential. On the other hand, community governance is also seen as an important principle, particularly where Māori health and whānau ora is concerned. Smith and Ovenden (2007) point out the inherent tension involved in seeking to bring together clinical professionals and community members within a model of primary health care that aims to deliver population based care at a local level.

Partnership development challenges

Collaborative work between organizations with very different organizational cultures is a significant challenge to integration, and this obstacle must be considered when planning future integration (Ramsey & Fulop, 2008). Evidence suggests there are significant challenges in bringing together organizational cultures that have, in many cases, evolved separately over decades. This may be a particular issue for the current Maru Wehi proposal which may require Māori-led and mainstream organizations to work closely together.

Evaluations have identified specific barriers to partnership working including:

- A competitive funding environment and a perception that new agencies or approaches represent a threat to existing agencies (Evaluation Management Group, 2003)

- Lack of trust or shared vision between organisations (Imison, 2008)

- Lack of overall governance structure and unclear accountability was identified as a barrier to the success of polyclinics in the UK (Imison, 2009)

Lack of supportive context for integration

Success depends heavily on an existing culture of quality improvement, a history of trust between partner organizations, existent multidisciplinary teams, local leaders who support integration, personnel who are open to collaboration and innovation, and effective communications and IT systems. Attention may need to be given to building a supportive environment as a first step towards future integration (Ramsy and Fulop, 2008).

Conclusion

This literature review summarises key New Zealand and overseas evidence about the effectiveness of integration initiatives, and key characterises of successful initiatives. It is hoped that this learning to date may be helpful to guide the planning of the proposed Maru Wehi centre. Relevant key messages coming from the literature review include: the importance of engagement with communities and clinical leaders and building a clear shared understanding of the purpose of the integration initiative; the importance of maintaining a strong focus on improving patient care; the need for a broad, holistic approach to health and wellbeing that includes a focus on whanau and community capacity building; and the need to use models and methods that reflect Maori beliefs, values, aspirations and tikanga. The Māori-specific dimensions of effective health care have been outlined in this report, and attention to these cultural aspects of health is likely to be a key consideration in the successful development of the proposed Maru Wehi centre.

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