Editorial

TWO ARTICLES ARE FEATURED in this AHR issue's Models of Care section. The first article by May and colleagues entitled "Integrated models or mayhem? Lessons learnt from three integrated primary health care entities in regional New South Wales" reviews integrated general practices and conceptualises a model to explain how integrated service might best function. (*page 595*)

The second article by Coombe and colleagues is "Community-governed health services in Cape York: does the evidence point to a model of service delivery?" (*page 605*) The article reviews the literature on community governance models and community-controlled health service delivery models and their application to service delivery in Cape York.

The content of these articles may look poles apart. However, there is a common element — the challenges of integration. While policy imperatives stipulate "integration", the practicalities of integration are complex. Providers in the health system are, in theory, encouraged to integrate with whomever and whatever is necessary to best manage the care for their patients/clients. Yet, we know that this integration does not always occur. Why is this so?

Integration of care isn't necessary for everyone. The elderly population who find it difficult to navigate the system and those with chronic health conditions can benefit from integrated care.[1] Evaluations of "integrated care" models for these populations have noted that certain elements yield effective results: a single entry point system; case management; geriatric assessment; a multidisciplinary team; and the use of financial incentives to promote downward substitution for the system. Yet, applying this integration in practice is difficult. Other more recent evaluations review the elements which can make integration easier, such as targeted programs, better information transfer through technology, focusing more investment on ambulatory care versus tertiary care, and more seamless integration between health care sectors and providers.[2]

Analysis of effective ways to integrate care is a worthwhile endeavour, but integration is simply a means to an end — in this case, integrating with other providers and organisations for the benefit of attaining adequate care for the patient or client. It certainly isn't the easiest option, nor is our system of care aligned for this to occur. Government silos of funding don't help. Competing stakeholder agendas, workforce shortages, and cultural differences among populations (such as those populations who are not receptive to the care provided) make integration even less appealing.

So, how can integration of care be attained where it makes the most difference to patients/clients? Remuneration for integration is one option, but not the only answer. Most organisations and health care professionals are not directly remunerated to integrate with necessary providers, and even when they are (such as the Federal Government's Enhanced Primary Care items), the uptake is less than you'd imagine. Again, why is this so? Bill Gates, in a recent article on capitalism, articulates, "There are two great forces of human nature — self interest and caring for others".[3] (p. 28) If you accept this summation and apply it to this discussion, the key is finding out how to sustain both forces over time. Motivating providers to integrate for the sake of their patients/clients doesn't seem to be enough.

Most providers will identify patients/clients as their central concern. Yet, the reality is that our systems of care require providers to focus on multiple facets. Along with the identified needs of their patients/clients, at some point the providers have to consider: Who is paying for the care? Will I be paid for the care provided? Who else will be providing that care? Are there cultural issues which impact the receptivity of care? What governance models are in place? Sustainability of any system of care, including one that is developed to encourage integration and attain the best care for patients/clients, requires financial stability over time. This means that integration should be looked at for what it is — an aspiration that needs consultation that builds to a common under-

standing among the relevant parties of where integration is warranted and where it is not.

It is useful to decipher the meaning of integration in particular contexts: the application of such integration, the extent to which integration is likely to occur based on human nature and the reality of practice, and the implications in the broader system. The responsibility rests on policy makers, bureaucrats, providers of care and consumers alike. There should be more targeted forums where shared understanding is sought, evaluations undertaken and results translated into policy and practice. Understandably, this takes time and effort. Yet, if applied, we can better fulfil the aspiration of integration.

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1 Johri M, Beland F, Bergman H. International experiments in integrated care for the elderly: a synthesis of the evidence. *Int J Geriatr Psychiatry* 2003; 18: 222-35.
2 Hofmarcher M, Oxley H, Rusticelli E. Improved health system performance through better care coordination. OECD Health Working Paper No. 30. OECD, Dec 2007.
3 Gates B. How to fix capitalism. *Time Magazine* 2008 Aug 11: 28. □