Editorial

Australian Health Review has featured the Models of Care section for its third year. The aim of the section is to highlight the vast issues that impact various "models of care", expose the breadth and depth of the models and their impact and increase the profile of quality-based articles. As interested stakeholders, we are continually exposed to the latest models of care claiming to be a solution for some of the health care system's weaknesses — namely, issues of equity, accessibility, quality and affordability. Individuals and populations across the globe are touched by these matters, and health care systems grapple with ways in which to improve such weaknesses.

In previous Editorials, I have covered a range of issues relating to models of care including:

- Functions (ie, assessment, costing, planning, implementing, client advocacy, monitoring, evaluating);
- Evidence;
- Information management and use of technology;
- Stakeholder interest (ie, government, health fund, provider management, health professionals, clients); and
- Policy impact.

The reality is that the core issues mentioned above (access, equity, etc) are always going to be around, and any models of care claiming to be breakthrough solutions to health care service issues are hoaxes. So, it is no wonder that prescriptive models of care are often ineffective. Taking a broader view of the multitude of issues that impact the care process and eventual outcomes is more sensible.

Although the application of any model of care varies across time and place, they all aim to improve the care process. Three articles are featured in this Models of Care section that deal with issues affecting the care process within (and between) acute and community-based care.

The first article, *Medical model for hospital in the home: effects on patient management* by Tran and Taylor (*page 494*), relays the impact of medical professional contact on the ability to effectively discharge clients through a retrospective pre- and post-intervention study.

The second article, by Basic and Khoo (*page 502*), is entitled *Admission variables predicting short lengths of stay of acutely unwell older patients: relevance to emergency and medical short stay units.* Their prospective study highlights that preserved function and absence of delirium are strong predictors of shorter length of stay, along with no infection, gastrointestinal issues, stroke or anaemia.

The last article, *Discharge delay in acute care: reasons and determinants of delay in general ward patients,* by Ou and colleagues (*page 513*), features a retrospective study that concluded delayed discharges were related to previous medical conditions of patients, delayed consultation (as found in one of the other articles in this issue), delayed diagnostic services and allied health services. As with many other articles, elderly clients living alone and those from a non-English-speaking background were more likely to be delayed. Based on these three articles, better risk assessment and getting adequate clinical care in a timely manner are key issues that models of care aim to improve.

A question that commonly comes into my thinking is whether particular models of care really make a positive difference or whether they complicate an already complex and confusing health care system. The evidence of a positive impact of disease management, case management and other models of care is gaining momentum, yet to date can be argued for or against. There certainly is no unanimous view.

The following may assist stakeholders hoping for a greater impact of models of care — taking in mind the culture, context, circumstances and client-base.

- The culture — whether it be the clients' cultural backgrounds, the organisational culture, the professional culture, the political culture;

- The context — whether it be a model of care that is valued across the organisation, between organisations, within and across professional groups, government, and client groups;
- The circumstances — how the broader political and financial climate affects the potential; and
- The client base — whether a group of clients has particular needs and whether they are involved in the care process and can identify with its goals.

Things do seem to be cyclical, but there is potential for a maturation of views on the same issues. I just came across an editorial on "new integrated care models" in the United Kingdom and pilot projects that are just underway.[1] The process of having pilot projects featuring new models of care has occurred countless times in the past there and elsewhere. I am reminded of the national Coordinated Care Trials in Australia (two rounds of them) which piloted similar projects and so far have not been viewed as "the solution" to the health care system's ills. With, inevitably, new pilot projects that get underway here and abroad, there is opportunity to learn from the past, incorporate a broader view and make a positive impact.

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1 Hawkes N. Integrated care. *BMJ* 2009; 338: b1484.□