Integrated care across Australia: What lessons can be learned

Authors: Nikita Weickhardt, Yael Cass, and Rodger Paul

Over the past two decades, integrated care has become an increasingly common policy aspiration in care systems around the world. There has been considerable work globally – by academics, healthcare providers and governments – to conceptualise, understand, and implement integrated care initiatives, models, and systems. Integrated care seeks to use limited resources more effectively, by promoting collaboration among care professionals, reducing fragmentation in the design and delivery of care systems and enhancing the quality of care and outcomes.

In Australia, the push towards integrated care has come in a range of forms, from the recommendations of the Royal Commission into Aged Care Quality and Safety to the objectives of the National Health Reform Agreement. The Australian Government's planned Wraparound Care for Frequent Hospital Users (FHU) Program was announced in the 2023-24 budget ($98.9 million over four years) as part of a suite of reforms arising from the Strengthening Medicare Taskforce Review. The model of the FHU Program is being developed with a range of stakeholders and is intended to improve access to comprehensive clinical care and support self-management for people with complex and chronic conditions. This model of care will be designed and implemented to support general practices through a blended funding model linked to MyMedicare to work in primary healthcare teams. It is intended to reduce the burden on stressed hospital emergency departments, while improving patient access, experience and health outcomes.

At a jurisdictional level, efforts in New South Wales are guided by a strategic framework that aims to ensure a consistent understanding and approach to integrated care across health and social care systems. South Australia has also recently developed an integrated care strategy. Victoria's approach is more nascent, though its Integrated Care Model represents an effort to move towards a more systematic, risk-adjusted approach.

However, delivering integrated care sustainably and at scale remains a considerable challenge. This article considers the case for integration, the challenges in implementing it, and national and international lessons that policy makers and providers in Australia could consider in their efforts to integrate care more effectively.

Integration can alleviate challenges faced by our health system

At a national level, Australians have among the highest living standards and longest life expectancies in the world. However, our health system is under increasing pressure, particularly emergency departments (EDs) and public hospitals. ED care costs have increased by nearly $1 billion in just four years, to $6.65 billion. This financial pressure mirrors a broader trend: a growing number of Australians living with increasingly complex health needs is rapidly growing.

A key indicator of this strain is the scale of potentially preventable hospitalisations. In 2023–24, there were approximately 778,000 potentially preventable hospitalisations in 2023-24[i] across the country. These are hospital admissions that could have been avoided with timely and effective primary or community-based care. Similarly, the 2023 Report on Government Services (RoGS) recorded over 3 million general practice-type presentations to EDs in Australia in 2021-22[ii]— cases that could have been more appropriately managed outside the hospital setting.

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These figures demonstrate the substantial opportunity: by strengthening primary care and integrating services across the health system, we can reduce avoidable acute care use and improve patient outcomes. Integrated care models—where general practitioners, specialists, allied health professionals, and social services work together—are essential to managing chronic conditions and preventing health deterioration that leads to ED visits or hospital admissions.

This strain is underscored by growing demand for public health services that is greatly outpacing system capacity. In 2023, sixty-nine per cent of patients admitted to Australian hospitals after presenting to the emergency department spent longer than four hours. The 90th percentile length of stay has increased by an average of 6 per cent annually over the past four years.[iii] These delays reflect a system stretched to its limits, where patients are waiting longer for care, and hospitals are struggling to keep up.

There is a growing evidence base that integrating care can help to improve experiences in receiving care and navigating care systems for service users, care givers and families,[iv] more effectively use limited resources;[v] and improve health outcomes.[vi] Integrated care helps reduce hospital readmissions by ensuring patients receive continuous, coordinated support beyond the hospital setting. It enhances chronic disease management through personalised care plans and proactive follow-up, leading to better long-term health outcomes. Moreover, it simplifies the patient journey—reducing the need for multiple appointments and making it easier to access the right care at the right time. In doing so, integrated care not only alleviates pressure on emergency departments and hospitals but also plays a critical role in reducing potentially preventable hospitalisations by addressing health issues early and effectively in community and primary care settings.

Integration is difficult to achieve sustainably and at scale

Doing this at scale is no mean feat. Steele *et al.*, write: "health systems globally are still struggling to roll out system-wide models of integrated health and social care [partly due to] a lack of understanding of what elements are important for successfully scaling up integrated health and social care initiatives, and how to overcome associated implemented changes".[vii]

Common barriers associated with integrated care

1. Codifying and replicating complex integrated care interventions is inherently challenging. Integrated care often involves tailored approaches to accommodate a person's unique needs and preferences, differing healthcare settings, and multiple stakeholders. This complexity makes it hard to create uniform guidelines and ensure consistent application across different contexts.

2. Integration requires alignment of various systems across different levels of government to work effectively- regulatory, governance, incentives accountability, informational and funding systems. For example, Siloed funding models (i.e. activity-based funding versus grant-based or shared funding) that incentivise individual and/or activity-based care create impediments to best-practice care pathways.

3. Integrating care across organisations and levels of government can be hindered by different approaches, cultures, incentive structures, data maturity, legal, cultural, and technological factors. For example, integrated care requires building collaborative multidisciplinary teams with clearly defined roles and responsibilities, which can be challenging while working within time and resource constraints.

4. Measuring progress encompasses numerous elements, such as client outcomes, service coordination, and efficiency improvements, making it challenging to develop comprehensive and consistent metrics. Variations in client needs, service settings, data collection and analysis complicate the standardisation of measurement tools.

In this context, there are four fundamental questions for policy makers and providers to ask when developing integrated care initiatives:

1. What outcome/s is integration trying to achieve, for whom? (e.g., improved patient outcomes/experience, system sustainability/efficiency, workforce development)

2. What is the overarching framework and which key aspects of the care system need to be integrated to achieve these outcomes? (e.g., intake, case management, care coordination, system linkages)

3. What are the elements and levers that need to change to improve integration, and who are the actors that need to be involved to change them?

4. How do we develop and implement sustainable integrated models of care?

Figure 1). Each is described below with reference to good practice examples.

Six lessons to help policy makers and providers integrate care

Policy makers and providers seeking to establish or improve integrated care initiatives should consider a range of lessons (see

Figure 1 | Six lessons for integrated care
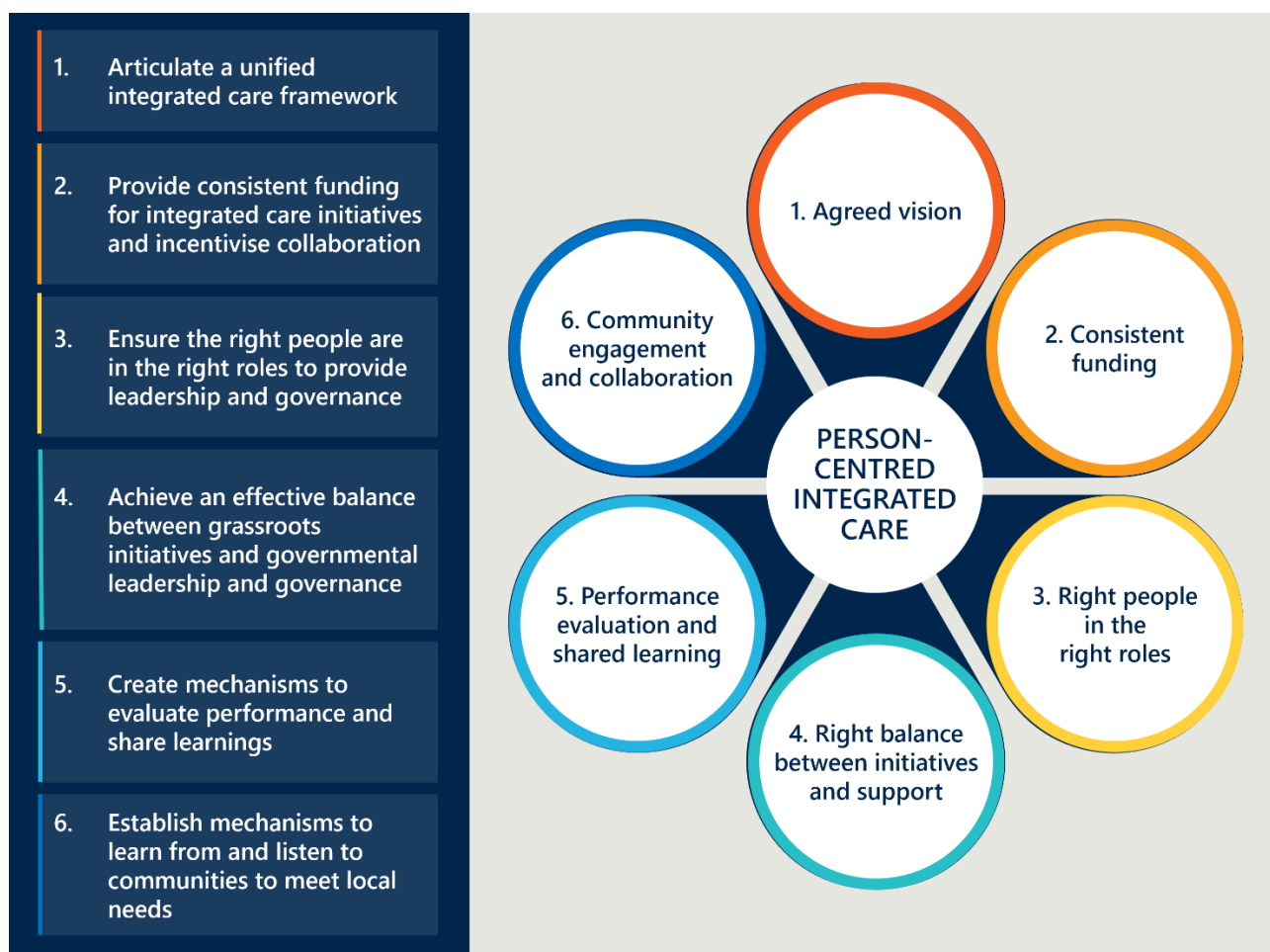
1. Articulate a unified integrated care framework

While it is worth making the simple point that is not possible or desirable to integrate all services for all people at all times, and that, given the effort required, it is important to be clear about the benefits and return of investment, it remains true that delivering integrated care is fundamentally about collective action to achieve more coordinated and connected care systems that better meet the needs of service users. Whether this involves system-wide transformation, or just improving delivery of services, this requires a shared vision for reform underpinned by shared principles for what integration will look like in practice. In short, what you need is a framework. Key to developing this framework is:

- establishing a unified understanding of the problem and a clear articulation of the specific needs and challenges that integrated care aims to address;

- conducting a needs assessment of the target population and service planning to meet those needs; and

- designing an integrated care framework with clear leadership and governance structures, shared processes tools and guidelines, clear roles and responsibilities, person-centred approaches supported by seamless communication and information sharing.

In the words of Nick Goodwin, the former Chair of The International Foundation for Integrated Care (IFIC), "There are no 'short cuts' to implementing integrated care – it takes visionary and stable leadership over the long-term to build the collaborative culture necessary to take integrated care forward."[viii] Agreeing a vision and principles for integration – and making these tangible – is important to set the foundations for reform and ensure that it is not derailed by political and funding cycles.

The District Health Board for Canterbury in New Zealand

The District Health Board for Canterbury in New Zealand has been on a journey to implement a population-wide integrated care system for more than a decade. One of the key lessons has

been the importance of a clear, unifying vision underpinning transformation. In the case of Canterbury, the mantra 'one system, one budget' is firmly held and articulated. A key unifying goal in establishing an integrated system is to deliver 'the right care, in the right place, at the right time, by the right person' and that a key measure of success was to reduce the time service users spent waiting. Reviews of the system have consistently stressed the importance of leadership – both continuity of senior leadership, and that the leadership is collective, shared and distributed.[ix] This model has prioritised investing in workforce development. For example, thousands of staff have participated in different programmes to build managerial, innovation, clinical and change management skills needed to deliver integrated care.

2. Provide consistent funding for integrated care initiatives and incentivise collaboration

Effective funding policies are those that mandate and provide financial and non-financial initiatives to facilitate collaboration and information sharing across healthcare, aged care, disability, housing and social services sectors; support policy experimentation; and align incentives around patient preferences and outcomes. Conversely, fragmented funding streams – such as separate budgets or different arrangements for different types of services – can inhibit integration and create perverse incentives that detract from providing high quality care to patients.

Funding responsibilities for the health sector are currently divided between the Australian government and jurisdictional governments under the Health (Commonwealth State Funding Arrangements) Act 2012.[x] Services may need to duplicate efforts to navigate grant and agreement processes as frequently as every 12 months. Long-term service planning can be disrupted as a result. Many different funding models underpin integrated care initiatives around the world,[xi] and inevitable trade-offs – for example between complexity and the ability to incentivise good quality care – mean that there is no clear best funding model for all care environments.[xii]

Bundled funding for clinical pathways can be effective – for example, pooling multiple funding streams,

creating equitable incentive structures, and moving away from micro-purchasing with a short-term competitive tendering mindset and towards long-term, strategic commissioning. Ensuring consistent funding for integrated care programs – including funding innovative pilot models and providing ongoing funding to those that are effective – can help to ensure sustainability.

This could be achieved through establishing a National Innovation and Reform Agency for the purpose of driving long term system reforms and innovations.[xiii] The Agency would work closely with all jurisdictions and national bodies along clear reporting lines to the Health Chief Executives Forum (HCEF) and Health Ministers, developing and advising on reform initiatives informed by a data-driven evidence base. An Innovation Fund following a clearly delineated funding pathway could support short term implementation activities across jurisdictions and national bodies, from the pilot stage to operation at scale, encompassing services across all care settings. Under such models, federal and jurisdictional funding can be pooled to better coordinate effective service provision.

A national priority innovation fund, as established for other sectors, can support the integration of the health system.[xiv] This arrangement would combine federal and jurisdictional funding streams while providing a clear pathway to distribute funds from the initial stages to full scale implementation of innovation and reform projects.

The Diabetes Connect pilot program

The Diabetes Connect pilot program connects people living with Type 2 Diabetes to providers across the health and social services sectors through primary care referrals, managed by a care coordinator. The program aims to provide integrated access to services across the primary, community and acute care settings. It uses a flexible and risk adjusted funding model to support the coordination of a multidisciplinary workforce to deliver integrated care. The Commonwealth Government is funding the program as part of its Primary Care Pilots initiative.

The Better Care Fund (BCF) programme in the United Kingdom

The Better Care Fund (BCF) programme in the United Kingdom aims to deliver integrated health and social care by requiring integrated care systems and local authorities to enter pooled budget arrangements and agree on an integrated spending plan. Launched in 2015 as a collaboration between the National Health Service (NHS), local government and national government agencies, the BCF programme aims to reduce barriers created by separate funding streams by requiring agreement between different parties about how funds will be spent. The programme includes managers within each of the seven NHS regions to provide support to local areas and ensure flexibility about how funds are used.[xv] A 2018 evaluation found that the BCF programme has helped to improve integration between health and social care.[xvi]

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3. Ensure the right people are in the right roles to provide leadership and governance

Fit-for-purpose governance arrangements are a critical enabler of integrated care initiatives, models, and systems. Clear governance arrangements have defined structures, roles and responsibilities, along with mechanisms for accountability. They help to provide clear roles and responsibilities for driving integration and delivering care and ensure that diverse expertise across the care continuum is represented in decisions about care planning and delivery. For system-wide integrated care models, multi-level governance is needed to address fragmentation and ensure alignment in system design, coordination, funding, and delivery.

The Partners in Recovery Program in South-Eastern Sydney

The Partners in Recovery Program in South-Eastern Sydney is an integrated care initiative that supports people who experience severe and persistent mental illness and have complex support needs to access services and supports. An evaluation of the program found that its effectiveness was enabled by its governance structure, which comprised a consortium of local service providers and stakeholders, a Lead

Agency, and Support Facilitation Agencies, helping to ensure wide and diverse expertise. That said, the organisational and cultural differences between agencies presented challenges for the program.[xvii]

The Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)

MARAM is designed to ensure that all parts of the service system share a common understanding of how to identify and address family violence. It is structured around four conceptual pillars that guide organisations in aligning their policies, procedures, practice guidelines, and tools. One of these pillars outlines the 10 responsibilities of practice for professionals and services working in the family violence system.[xviii] To support this alignment, organisational leaders in prescribed organisations are required to understand and enable the role and responsibilities of professionals in their organisations.[xix] The framework's clearly defined responsibilities foster integration and ensure consistent practices across services.

4. Achieve an effective balance between grassroots initiatives and governmental leadership and governance

There are a number of different governance structures for integrated care initiatives, which are highly context-specific and sensitive. A key challenge, widely acknowledged in the academic literature, lies in striking a balance between grassroot initiatives and top-down support. Grassroot initiatives are critical to meeting the needs of specific communities while top-down support is important to ensure the sustainability of these initiatives. Grassroot initiatives actively involve community groups and consumers in the planning, implementation, and evaluation of integrated care services. Too much top-down support risks stifling innovation and creating structures that do not work on the ground. Too little top-down support can undermine strategic alignment and fail to ensure the structures necessary for clear

accountabilities. Governmental leadership and governance should focus on providing structures and mechanisms to cultivate, enable, and evaluate locally led initiatives.

The National Child and Family Hubs Network in Australia

The National Child and Family Hubs Network in Australia is a national multidisciplinary group that is responsible for strengthening connections between Child and Family Hubs across Australia. The Hubs provide families with access to a wide range of supports and services across health, education, and social care. The Network was established to bring interjurisdictional hubs together to support collaboration and shared learning while providing governance structures to ensure sustainable practice.[xx] Members contribute to research, advocacy and collective capacity building while maintaining independence. This model allows community Hubs to integrate what they have learned within a broader evidence base to strengthen the whole system.[xxi] It promotes collaboration and capacity building by establishing a Community of Practice for members to connect to peers and exchange ideas.[xxii] Recognising capability and culture as an important enabler of integrated care, the most recent Network strategy prioritises the development of workforce leadership and capability, and establishes collaborative learning for Hub practitioners and leaders.[xxiii]

5. Create mechanisms to evaluate performance and share learnings

Embedding performance monitoring and evaluation is an important strategy in integrated care initiatives, allowing them to demonstrate value, improve service coordination and delivery, support learning and implementation, ensure accountability, and strengthen the evidence base around integrated care. A key element of this is investing and promoting the adoption of interoperable electronic health records to enable seamless information exchange.

However, measuring the performance of integrated care systems is difficult and remains generally immature. This may be due to unrealistic expectations, insufficient time, limited availability and

reliability of outcome data, and a tendency to focus on limited number of outcomes. Monitoring and evaluation for integrated care models should be part of a comprehensive evaluation strategy that considers outcomes across a range of different dimensions, including patient experience, clinical outcomes, equity, value for money, and provider experience.

The NSW Health Lumos Program

The NSW Health Lumos Program seeks to provide insights on the patient journey across the NSW health system. By linking de-identified data from general practices with other health service data, it builds a comprehensive picture of patient pathways. At its core, Lumos drives integration with its vision to 'integrate health data to enable better care.'[xxiv] This system-wide focus actively works to improve patient outcomes, enhance experiences, and strengthen the efficiency and strategic direction of the health system. Lumos data collection prioritises patient privacy as a core principle. The program safeguards privacy by using Privacy-Preserving Record Linkage (PPRL) technology and securely storing data in a centralised, regulated cloud solution.[xxv] These measures actively protect sensitive information and ensure privacy remains central to delivering integrated care. The Lumos data set is integral to modelling for Collaborative Commissioning and development of Integrated Care initiatives in NSW.

6. Establish mechanisms to learn from and listen to communities to meet local needs

Integrated care initiatives must be underpinned by an understanding of the health care needs of the communities and population groups for which they provide. Ensuring that the voices of patients, their families, and local communities are heard throughout the design and delivery phases of integrated models of care can avoid a tendency for these groups to be, in the words of one researcher, "passive recipients of professional efforts." A 2022 study on the previous decade of integrated care found that "the biggest challenge … remains the lack of person and community involvement, which sadly pervades all areas of integrated care."[xxvi]

Community participation should be seen as a dynamic, ongoing process, rather than one of mere

service design. This can help to ensure that care delivery meets the needs of local populations and is attentive to how these needs can change over time. Effective integrated care systems use a range of mechanisms to ensure that interventions are informed by a deep understanding of local contexts, including community participation forums, formalised patient advisory groups within the governance structure, and the inclusion of performance measures that matter to patients.

The South Australian Aboriginal Mental Health and Wellbeing Centre

The South Australian Aboriginal Mental Health and Wellbeing Centre is an example of collaborative commissioning between the South Australian and Commonwealth governments to address gaps in mental health care for First Nations people. The centre aims to improve access to interdisciplinary mental health and wellbeing services that are culturally sensitive by increasing the visibility of existing initiatives and driving reform. This will be achieved through close consultations with the Aboriginal Community Controlled Health Service sector, other Indigenous health organisations, and members of First Nations communities, providing a greater understanding of how services can best be integrated to meet the needs of First Nations people.[xxvii]

Integrated Care Systems in the UK

Integrated Care Systems in the UK have developed a range of approaches and models that listen to and learn from people and communities in the delivery of integrated care.[xxviii] For example:

- The **West Yorkshire and Harrogate Health and Care Partnership** has adopted a grassroots approach to engagement activities, underpinned by the principle of subsidiarity. This holds that decisions should be made as close to local communities and staff as possible, and that activities should only be led at scale where there is good reason to do so.

- The **Health and Care Partnership Executive Group** in Leeds has adopted a 'balanced scorecard' to identify different sources of existing patient and user intel used to improve system improvement. This includes real-time stories from health care journeys and analysis of compliments and complaints through a city-wide complaints group.

Healthwatch Network is a system-level partnership that oversaw a nationwide open conversation with communities asking them how they want the NHS to improve, which emphasised the importance of reducing travel, promoting choice, and improving links between health and care services.

The Australian health system is at a critical juncture in service provision

Integrated care presents an opportunity to optimise the health system. Its emphasis on delivering care that is appropriate and equitable in the community, and help to counter the tendency of activity-based funding to prioritise acute care, maximising the efficiency of resource distribution. While the Australian Government and jurisdictional governments are already making progress towards integrated care, there are key learnings for all actors across the sector. By strengthening the position of community-based and primary care services as the first line of defence for healthcare, an integrated system helps mitigate acute presentations or reduce clinical complexity through robust early intervention.

Integrated care can decrease potentially preventable hospitalisations resulting in fewer patients needing to present to emergency departments, increasing the availability of beds across the state and reducing the burden of disease by creating critical treatment and management opportunities at earlier stages of disease.

By embracing integrated care, Australia can continue to shift healthcare delivery out of tertiary settings and into the community, delivering the right care, in the right place, at the right time.

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