Many jurisdictions have been struggling with questions about how their complex health-care systems can effectively identify and implement new ways of delivering care that will result in an improved patient experience, improved clinical outcomes, and better returns on investment.

Late in 2012, the Ontario Ministry of Health and Long-Term Care (MOHLTC) announced Health Links, which represent a new way of delivering health care. The evidence suggests that several key themes are consistently found in high-performing health systems (see Figure 1, p. 15). Health Links builds on many of these themes and will provide a forum for collaboration among different health sectors focused on high-need patients. They are intended to mobilize the delivery of co-ordinated care across the continuum of care, specifically for those Ontarians with complex conditions.

The aging population and a growing prevalence of chronic diseases necessitate a re-orientation of the health system from a historic emphasis on acute care to a focus on prevention, self care, and more integrated care, particularly for those with complex, often co-morbid conditions.

The Ontario Medical Association and Ontario’s physicians are actively contributing to the development process of this integrated care model. As part of the OMA’s contribution to Health Links, a research study was undertaken to better understand the international experience in implementing integrated care programs and how those experiences can be leveraged by the emerging Health Links initiative in Ontario.

The analysis we undertook examined the experiences in Australia, Sweden, New Zealand and the United Kingdom, as well as Canadian experiences in the provinces of British Columbia and Alberta.

We asked the question, “What enabled other health systems to effectively implement programs similar to Health Links, and how could their successes and their challenges be applied in Ontario?” Through a systematic literature review, and interviews with key informants in each of the jurisdictions, our question was answered. We will report the results of this analysis in a series of four articles appearing in the OMR, of which this is the first.

In this article, we focus on the consistently reported success factor across jurisdictions — the notion that providers

“System transformation happens from the bottom-up, even when the concepts are derived at the Ministry of Health and Long-Term Care and Local Health Integration Networks (LHINs). Using an intentional, complexity science approach (especially the use of minimum specification), transformational change concepts can be introduced and nurtured. This requires becoming comfortable with uncertainty, and trusting the process of change to occur without knowing the exact outcome at the outset.”

Dr. Jonathan Kerr, primary care lead, South East LHIN
must own the development of the local processes, mechanisms and solutions for transformative integration of health-care delivery.

Many of the jurisdictions examined have seen clinically relevant and positive results from their efforts to better integrate care of patients, particularly complex ones. These positive results have not appeared overnight but rather are the outcomes of long-term strategic planning, and a willingness to adjust as the initiatives evolved. The international jurisdictions considered have all been fine-tuning their program designs for several decades.

Successful models have a number of things in common, and their success is correlated with the ability of the jurisdiction to create a culture of innovation and the necessary infrastructure and resources to support integration efforts. The evidence from these and other integrated health-care initiatives points to the need for highly organized and appropriately incentivized primary care as a requisite for the transformation of health-care services and the enhancement of patient care.

At the systemic level of health policy, government’s responsibility is to “steer” the course of a reform. While this steering role is fundamentally seen as useful and appropriate, the jurisdictions we explored make it clear that when a government veers from “steering” and takes on the role of “rowing,” or implementing the reform at the programmatic level, there is less success and more scrutiny because, the level at which the government operates often makes doubtful its ability to see reform through by addressing local needs.

The providers interviewed across jurisdictions face similar challenges in this domain in that election cycles can make it difficult for government agencies overseeing the health system to abstain from interventionist management of a reform. While it is understandably challenging at times, success of the reform hinges on the government’s ability to accept uncertainty in the short term in a way that allows providers to “row” and truly take ownership of the objectives and program — not just simply “buy-in.” Every jurisdiction that informed our results highlighted the integral role of provider ownership and engagement that will facilitate iterative policy development and lead to incremental, but sustainable, progress.

Figure 1
Key Themes Underlying High-Performing Health-Care Systems*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent leadership</td>
<td>Embraces common goals and aligns activities throughout the organization.</td>
</tr>
<tr>
<td>Quality and system improvement</td>
<td>As a core strategy.</td>
</tr>
<tr>
<td>Organizational capacities and skills</td>
<td>To support performance improvement.</td>
</tr>
<tr>
<td>Robust primary care teams</td>
<td>At the centre of the delivery system.</td>
</tr>
<tr>
<td>Engaging patients in their care and in the design of care</td>
<td></td>
</tr>
<tr>
<td>Promoting professional cultures</td>
<td>That support teamwork, continuous improvement and patient engagement.</td>
</tr>
<tr>
<td>More effective integration of care</td>
<td>That promotes seamless care transitions.</td>
</tr>
<tr>
<td>Information as a platform for guiding improvement</td>
<td></td>
</tr>
<tr>
<td>Effective learning strategies and methods</td>
<td>To test improvements and scale up.</td>
</tr>
<tr>
<td>Providing an enabling environment</td>
<td>Buffering short-term factors that undermine success.</td>
</tr>
</tbody>
</table>


Alberta’s Tripartite Agreement ensured shared decision-making and shared development of the implementation of the Primary Care Networks (PCN) through meaningful engagement of primary care clinicians. Although the agreement was not renewed in 2012, the Alberta Medical Association and its Primary Care Alliance have a place at the table to provide advice and be part of the decision-making on major issues pertaining to the reform, including new accountability framework for PCN 2.0.

Frequent changes to the health delivery structures in England, which have been largely top-down in design, have left clinicians, executive managers and policy analysts uncertain about the newest model set out in the Health and Social Care Act (2012). The new Act features stronger accountability mechanisms and governance for new commissioning bodies, which means that providers will have to be mindful of the need for full disclosure and conflicts of interest when commissioning care and services. The new regulations have led...
to concerns about the risk of over-regulation because it is feared increased regulatory rigour may stifle local innovation.

There is much to be learned from the experience in the United Kingdom, which has undergone seven major health system reforms in the last 20 years — with increased frequency and breadth of reforms in the past decade. Key informants interviewed about the United Kingdom experience noted that the need to renew provider buy-in after top-down changes such as those experienced in England can lead to a lack of engagement, cynicism, and uncertain or stalled progress.

It has been noted that in the case of England’s National Health System, structures and systems were changed before they had a chance to prove themselves, and primary care groups were abolished at the point when there was at least emerging evidence that they were in fact getting better at the job that had been put before them. Successful integration efforts take innovation, flexibility and time — a long time — so patience is necessary. A long horizon, with a solid strategy to span that time horizon, is required.

New Zealand has been undertaking integrated care improvement for 20 years, with three broad transformations. Similarly, Australia has been working toward system transformation since 1991. Each of these jurisdictions is taking a long-term view, with Sweden, for example, now setting integration plans for 30 years in the future. Alberta has focused on organization of primary care, adding disease-specific networks and integration initiatives over the last 15 years. British Columbia has chosen to adopt a variation of the Australian model of integration through multiple related programs and organized divisions of practice, jointly developed and supported by the province’s Ministry of Health and the British Columbia Medical Association.

Of note, primary care physician engagement has not been episodic, but rather systematic and iterative in areas, including evaluation frameworks, process, setting of clinical objectives, and blended provincial/national and local health-care targets. Program design and delivery articulated by the primary care community is essential.

Infrastructure matters and must fit the purpose. While there is no best model to organize the meso (middle)-level infrastructure, attention must be paid to establishing strong and sustainable management and organizational infrastructure that can support the development of general practice and primary care in a way that enables it to meet the fiscal and health challenges ahead. Primary care organizations are vital to reform, and engagement should be voluntary but irresistible. British Columbia has utilized this approach to help drive a quality improvement agenda in family practice. A strong primary care system with appropriate infrastructure has been shown to be essential if health system transformation initiatives are to be sustained.

The second article in this series will examine the programmatic (meso-level) structures that have been implemented in successful models of integrated care. As Ontario embarks on health system reforms, including Health Links, there is an opportunity to learn from and leverage the lessons learned about the importance of finding and implementing the right infrastructure, and the recognition that transformation is a long process that requires patience.

As the model evolves, with more than 30 Health Links now in place, the Ontario Ministry of Health and Long-Term Care has recognized that reforms such as these require a bottom-up approach, led by providers.

As such, the Ministry has designed Health Links purposefully as local initiatives that are generated at the local level, by local health-care providers, to meet the needs of complex patients in the community.

For more information on Health Links, contact Maggie Keresteci, Senior Director, Health System Programs, OMA Engagement and Program Delivery, at healthlinks@oma.org, or visit www.oma.org/healthlinks.

New Zealand Ministry Of Health: Statement Of Intent 2012/13 to 2014/15

“Clinical integration of services to better meet people’s needs requires effective leadership, including clinical and professional leadership, and effective engagement with the sector. Collaborative cultures, appropriate governance arrangements and good information systems will be key to the success of this work. The shift towards a regional planning approach among District Health Boards and effective engagement of the clinical workforce will lead to better health care at the front line.”

For more information on Health Links, contact Maggie Keresteci, Senior Director, Health System Programs, OMA Engagement and Program Delivery, at healthlinks@oma.org, or visit www.oma.org/healthlinks.
Acknowledgments
The OMA wishes to acknowledge the contributions of two summer interns from the University of Toronto whose research was integral to achieving the objectives of this initiative:
• Kubatka-Willms, Elena (School of Public Policy and Governance, University of Toronto).
• Scarth, Brian (Faculty of Medicine, University of Toronto).

The OMA is very grateful for the reflections and insights offered by the following key informants, without whom this research would not have been possible:
• Booth, Mark (First Assistant Secretary, Primary and Ambulatory Care Division, Australia Department of Health and Ageing, Canberra, ACT, Australia. Interview: 2013 Jul 15.
• Cliffe, Sam (Director of System Integration Group, New Zealand Ministry of Health, Wellington, New Zealand). Interview: 2013 Jul 10.
• Cy, Frank (Professor, Division of Orthopaedics/Department of Surgery, University of Calgary/Alberta Health Services, Calgary, AB). Interview: 2013 Jun 26.
• Jyu, Christopher (Primary Care Lead, Central East LHIN, Ajax, Ontario). Correspondence 2013 Jul 12.
• Kerr, Jonathan (Primary Care Lead, SE LHIN, Belleville, Ontario) Correspondence 2013 Jul 12.
• Lemelin, Jacques (Primary Care Lead, Champlain LHIN, Ottawa, Ontario) Interview 2013 Jul 12.
• Ludwig, Dave (General Manager and CEO, Sherwood Park Primary Care Network, Sherwood Park, AB). Interview: 2013 Jun 24.
• MacCarthy, Dan (Former Executive Director, Practice Support & Quality, British Columbia Medical Association, Vancouver, BC). Interview: 2013 Jul 15.

References

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