



Discussion Paper on

Integrated Public Health Practice:
Supporting and Strengthening Local Action

National Public Health Partnership
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Introduction

Australia has achieved some well-recognised successes in its organised efforts to improve the health of its population. By many measures of premature mortality and morbidity, and by some measures of risk behaviour, the health of much of Australia's population has improved significantly over the last three decades. This has been achieved to a large extent through a national public health effort that has predominantly been organised around single purpose programs (sometimes referred to as "vertical" or "categorical" programs), as exemplified by the national public health strategies.

Despite these achievements, there have been concerns raised, at the level of service provision, that better coordination needs to be achieved, as most people and communities experience a multiplicity of health issues and risk factors at the same time. At the local level, providers do attempt to deliver programs in an integrated fashion, while endeavouring to meet the accountability requirements of single purpose guidelines.

The National Public Health Partnership's (NPHP) Guidelines for Development and Coordination of National Public Health Strategies suggested ways in which national level coordination can be improved. As a further step in operationalising these concepts, the NPHP's National Strategies Coordination Working Group undertook an examination of existing models of integrated public health practice, at the program delivery level.

The Integrated Public Health Project, undertaken with Queensland as the lead agency, invited nomination of case studies on effective integrated public health program delivery at the local level. A number of case studies were selected for detailed examination to identify the key factors that contributed to the capacity to provide an integrated approach. Concurrently, an international literature review was conducted to appraise the experiences and trends more broadly and to examine the approaches that health authorities have used to facilitate and encourage integrated public health practice.

This discussion paper, reflecting the findings of the Integrated Public Health Practice Project, identifies practical examples of good practice in integrated local service delivery and the key factors required to support integration. The aim of the paper is to invite further input so that policy and other levers for change can be developed and adopted by jurisdictions and national public health strategies to support more integrated approaches to complement current models of practice.

1. What is integrated public health practice?

Integration as a term is commonly used in health and human services, though it has many different meanings. The term may be used to indicate integrated health services, integrated human services, integrated programs, and integrated models of practice. Most 'integration' in the health system has focused on the links between health services, such as linking hospitals, providing a continuum of care, or developing integrated networks of clinical and primary health care services. Links between organisations may also be considered as a continuum from information sharing, coordination, and collaboration through to integration.

For the purpose of this discussion paper, integrated public health practice is seen as encompassing the following elements:

- Recognising and responding to the interrelatedness of health determinants and their multiple health outcomes.
- Combining capacity building with health gain programs.
- Recognising the need for relevance to the individual and community's lived experience.
- Involving coordinated action across programs and across sectors based on an agreed strategy.

2. Why do we need integrated public health practice?

Australia's review of the infrastructure for national health advancement (NHMRC, 1996) found that while there had been substantial successes in public health, Australia continues to face a challenge in reducing inequalities for health, and particularly improving the health status of Aboriginal and Torres Strait Islander communities. Also, insofar as existing vertical programs, such as those represented by national public health strategies, which may operate without reference to each other, there was reduced effectiveness and efficiency in the national public health effort. Thus, there are three key reasons for supporting a more integrated approach to public health program delivery: 1) operational effectiveness, 2) program sustainability, and 3) the complex inter-relationships between risk factors and health outcomes.

2.1 Effective program delivery

Many national programs have the same target groups (such as young people and Aboriginal and Torres Straits Islanders) and work with the same organisations (such as schools, general practice, and community health services). At the delivery end, the result may be uncoordinated activity creating a perception of poor coordination by government and an unnecessary added burden on the local health and community services.

The requirements and expectations of single purpose programs can create significant demands of local services. Common operational problems include:

- Different health service providers provide related services to the same population.
- Different programs address the same risk factor/s without reference to each other.
- Developing specialist staff limits the flexibility and comprehensiveness of services.
- Generalist staff being overburdened by expectations of being 'experts' across many issues.
- Particularly large administrative demand on a small number of providers.
- Duplication of administrative or support systems.
- Increased administrative costs due to separate reporting on each program.

2.2 Program Sustainability

Long-term sustainability of public health programs is necessary to maintain the health benefits achieved through the initial program. The health benefits of a successful program can be sustained if: 1) the program activities can continue within an existing organisational structure and budget, and 2) the recipient community is able to maintain the improvement in health behaviour or environment. Many programs need to be sustained over a long period of time to

demonstrate a health benefit. Similarly, the health benefit may not endure if the program does not continue.

Sustaining public health activity is more likely when the activities are well integrated into the core services of the host organisations. While vertical programs may fund infrastructure or service development at the local level, experience suggests that these programs must be integrated with other health services to ensure a more coordinated and coherent service. Vertical programming does encourage a focus on continuity of care, a stepping stone in the development of an integrated local health service. This requires local collaboration around particular health priorities and the development of good local linkages and relationship.

The effectiveness of public health programs depends on the capacity of people and communities to maintain health gains achieved. The possibility of sustained health improvement depends, in turn, on the extent to which the health issue is important to, or “owned” by the community, and whether the program has sought to develop the problem-solving capacity of the community to tackle present and future health issues.

Active participation of community members and organisations in the development and implementation of a project may be critical to its success and its sustainability. Public health activity at the local level needs to be flexible enough to use the different modes of local practice and adapt to local circumstances and health needs.

2.3 Multiple determinants – multiple outcomes

The interrelatedness of health determinants and their impact on multiple disease outcomes makes it inevitable that single purpose programs will overlap in targets and strategies. Determinants such as behaviour (smoking, nutrition and exercise), socioeconomic status, psychosocial factors (social support and resilience) and the physical environment contribute to a number of disease outcomes.

Given the long-standing problem of differentials in health status in Australia, and the apparent lack of progress by existing program approaches in public health to address these inequalities, it is imperative that strategies be adopted that address the common underlying risk factors through an integrated approach. More recent work regarding the psychosocial mediators (isolation, self-esteem etc) is providing clearer direction for public health action. The question arises how national strategies in their current form can respond.

2.4 Towards Integrated Practice

Internationally, the World Health Organisation and the World Bank are moving towards sector-wide approaches for health development. Vertical programs are being clustered to enhance their effectiveness and efficiency. Funding support is increasingly being based on local planning for health development.

More holistic approaches to the health needs of disadvantaged groups are demonstrating some potential gains. Taking action against both actual diseases and their underlying causes increases the impact on health and makes effective use of available resources. (WHO, 1996) The combination of activities directed towards individuals at risk, vulnerable populations, and society as a whole holds promise for addressing the vexed problems of health inequalities.

3. What are examples of integrated public health practice?

3.1 Imperatives behind integration

Currently, most public health programs are established to address a particular health issue, as exemplified by the six National Health Priority Areas and the myriad of National Public Health Strategies.

A number of issues, internal to the system, are creating the impetus for development of new approaches to public health. First, there is a need to *ensure* that the public health system is effectively managed – that its services are organised and delivered as efficiently and effectively as possible. Second, there continues to be recognition of the need to engage actively with the community to address health inequities. Specifically, there is a need to *respond* to the underlying determinants of health, including the historical circumstances and cultural context. Public health practice needs to increase its emphasis on a ‘client/community centred perspective’ - one that starts ‘where the community is at’, and seeks to work in partnership with the community to solve problems. Third, the achievements and strengths of single purpose or vertical programs need to be incorporated within all public health programs and services. This involves a strong programming approach that clearly defines a sphere of work, sets clear objectives and targets and includes effective monitoring and evaluation.

3.2 Types of integrated public health program delivery

3.2.1 Combining health priorities

A simple approach to integrated practice is to join up existing or new programs with other related programs. Some examples include:

- Interventions for communicable disease control and those associated with minimising harm from alcohol and other drugs.
- Prevention of chronic diseases, or wellness programs, combining “lifestyle” and psychosocial interventions.
- Incorporating cardiovascular screening with breast and cervical cancer screening.

The Tiwi for Life project provides a good example of a community-owned and delivered education and self-help program based on healthy living practices. It incorporates such issues as: washing people, clothes, and bedding; keeping toilets, bathroom, kitchens, and laundries clean; health care for dogs and pest control; improving access to nutritious food and home cooking; improving physical activity and reducing the incidence of obesity; growing bigger babies and feeding children well; and reducing tobacco and alcohol use.

3.2.2 Integrated delivery systems

Across the specific health issues, public health issues can be joined together at the *provider or delivery system* level. The health service provider may be a single general practitioner, a Division of General Practice, a single health worker or a small rural hospital. Programs may also be delivered through a network of health services. The purpose of this is to improve efficiency by reducing demands on service providers. Integrated health provider programs might include, for example, the bringing together of general practice screening strategies applicable to a particular population group. Contemporary Australian examples include Pharmacy Self-Care and the RACGP guidelines for preventive activity.

3.2.3 Settings based programs

The focus of these programs is to engage particular *settings* in addressing their multiple health issues in an organised, participatory way to create a ‘health promoting environment’. A setting is a place or organisation where people spend their time, and where environmental, organisational and personal factors interact to affect health and well-being. A wide variety of ‘settings’ are available for health promotion action, for example, schools, homes, hospitals, cities, the environment, workplaces and prisons. Other environments or contexts identified include food and nutrition, homes, neighbourhoods, work, transport, social support and care.

Historically, public health programs have been delivered to a ‘captive population’. A more contemporary approach places the emphasis of these programs on organisational development. This approach places the responsibility for management of the program with the setting and ensures that organisational climates are influenced to become more supportive of health improvement. Yet more recent developments suggest that focus be placed on concepts

of social spaces and social development, the impact of information technology and its effects on human development and health, marginalised and excluded populations, 'social toxicity' and 'social capital'.

There have been many approaches used by the health sector in the development of 'healthy communities'. The programs vary on the basis of the level of community involvement, leadership of the program, and the extent to which national or state health priorities set the agenda. Examples considered include Healthy Cities and community capacity building projects.

3.3.4 Population Group Programs

Holistic programs can be developed where the centre of reference for the management, design, implementation and evaluation of the programs is a subgroup within the broader community. The purpose is to engage the population group, build relationships and trust, and empower the population group to address its own health issues in a culturally relevant way to achieve health outcomes. This approach can address the problem of single issue programs delivering services to the same group in an uncoordinated way. The implementation of programs by population group when defined by age (children, young people, etc) allows for the incorporation of a *healthy development* perspective. Examples of programs include:

- Strong Women, Strong Babies, Strong Culture (in NT and WA), focusing on low birth weight, poor nutrition, and infection during pregnancy, within the context of traditional family and cultural ways of caring
- HEATworks program of the Kimberly Aboriginal Medical Service Council that uses story telling in theatre and song to link health promotion with issues in people's daily lives
- Sixty and Better Program in QLD, where local community organisations develop activities based on needs identified by older people in the community
- Unemployment and Health Project in NSW that encompasses training for GPs, cognitive behavioural intervention for the unemployed, improved health service access and provision.

3.2.5 Future directions

Recent research and program development on social and environmental determinants of health is providing some indication of future integrated action. A number of interesting international initiatives seek to implement significant public policy change that links health gain and capacity building. Some international developments to watch include Health Action Zones in the UK, the Verona Initiative of WHO (Euro), and the United States Centres for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health 2010 (Reach 2010). Each of these initiatives is developing within the context of a broad policy framework, for example, *Healthy People 2010 (US)* and the Health21 Agenda (WHO Europe) developed by WHO Europe.

CONSULTATION QUESTIONS

- What do you consider are coordination issues across national or state strategies?
- How could strategies be clustered to help achieve greater conceptual coherence as well as greater practicality for implementation?

4. How can integration be facilitated?

4.1 From ideal to real

Making progress in coordination will require the development of effective working relationships and different organisational arrangements across programs, providers, and services.

Coordination in the public sector requires a pragmatic assessment of difficulties such as the desire of agencies to act independently, the resource costs in developing relationships with others and the perceived 'loss of glory'. Imperatives that affect organisational behaviour include the need to fulfil program requirements, the desire to maintain program exclusiveness, autonomy and dominance, a clear pattern of resource flow and a commitment to the agency's paradigm. A degree of territoriality will exist where professional identity is linked to professional integrity and competency, and program success.

Coordination and integration issues are not unique to public health organisations, or even to the broader health systems. The concept of 'the learning organisation' (Marquardt, 1996) suggests that as organisations realise their key resources are knowledge, information and ideas, then they are able to move from bureaucratic and hierarchical models to partnerships and alliances. Concepts such as permeable boundaries, multi-disciplinary teams, an emphasis on networking and innovation are relevant to integrated public health practice.

The public health service delivery units may be assisted by considering a model such as Senge's five "disciplines" of a learning organisation (1990):

- *Team learning*: the process of aligning and developing the capacity of a team to be able to think insightfully about complex issues, generate innovative and coordinated action, and inculcating the practices of learning teams throughout the organisation;
- *Shared vision*. A mutually agreed view regarding the goals of the organisation, the sense of communality that permeates the organisation and gives coherence to diverse activities;
- *Mental models*. Deeply held internal images of how the world works that is, beliefs, theories and assumptions used by members of the organisation;
- *Personal mastery*. The discipline of personal growth and learning, and the ability to create results. Organisations learn only through individuals who learn;
- *Systems thinking*. The ability to contemplate 'the whole', or the systems or interrelatedness of actions within organisations, and in the community.

Integration, of course, is a means to achieving public health gain, rather than an end in itself. Therefore, key issues to be considered when introducing integration include:

- Integration depends on dimensions of need and the operational domains of service systems. Those client groups with high need may require more integrated services.
- There needs to be caution about over optimistic claims of efficiency gains made as a justification of integration.
- Integration of services may produce demands on some services.
- It is more difficult to integrate programs with different policy and service frameworks and practices.
- It may be difficult to protect vulnerable and chronically underfunded programs when integrating them with well-resourced programs.
- Whoever leads the integration effort will substantially influence the outcomes with their priorities.
- There needs to be goodwill and a willingness to integrate to achieve better outcomes.

4.2 Some possible measures

While a framework of organisational development is important for diagnosing the possibility of a shift to, or adopting, an integrated approach, there is also the need for practical tools. Some

measures that health and local authorities could adopt appear to be: coordinated local planning; flexible funding; and best practice guidance at national and/or state levels.

4.2.1 Coordinated local planning

Public health planning mechanisms at the local level can facilitate integration as they provide opportunities for communities to articulate their needs and, with public health and other agencies, assess competing priorities determined from national and state policies to set their agenda for public health action. Some specific planning tools and models are:

- PATCH: This model originated from the US CDC and involves the establishment of a local advisory group responsible for data collection and analysis of the local community, problem identification and prioritising, planning and implementation of interventions and evaluation.
- APEX/PH, also from the US, assists local health departments to assess and improve their own organisations, and to work with the local community to assess and address community health issues. It includes an organisational capacity assessment, a community process and a delivery and evaluation framework.
- Municipal Public Health Planning, in place in Victoria, South Australia, and Queensland, is a strategic and collaborative public health planning process led by local authorities. While the policy contexts are different, in general terms, the process involves identifying and assessing public health risks affecting a district, and outlining the programs and strategies that can be adopted to protect and promote the health of the local population.

There is multiplicity of public health planning processes currently being promoted to local government. These include corporate planning by Local Councils, Local Agenda 21, social planning – as required in NSW, local Government planning in environmental health, as part of the National Environmental Health Strategy and Safe Communities. There is a risk of duplication and confusion as many of these local planning processes address similar or related issues. Public health decision makers will need to consider the risk associated with these processes and the desirability of local level planning frameworks.

Planning processes influencing local level decisions also include government planning requirements of their regional health services.

4.2.2 Flexible financing

The mode of the provision of funds to local services and the form for accountability largely determine the direction and shape of local service provision. Integration needs to be supported by more flexible funding but the challenge is to be able to account for improved health gain.

Integration experiences internationally, for example in the US, have raised the debates about the merit of block grants versus categorical funding. These issues emerged in the development of the Public Health Outcomes Funding Agreement (PHOFA) and is also evident in the coordinated care trials. To an extent, the pooling of funds in the Public Health area in Australia has already reduced the problems associated with different funding streams though specific funding of local projects continues from Commonwealth, state and territory governments.

Capitation funding, or regional allocation formulae that take into account local population characteristics and health needs is another long-standing approach adopted internationally by health authorities. This approach largely places the responsibility on the local management for resource allocation decisions and, therefore, depends on local capacity to assess health needs, to understand the evidence-base for effective public health interventions, and to implement them successfully.

Administrative resource allocation tools such as program budgeting marginal analysis (PBMA), purchaser/provider contracts, and the Health Benefit Groups (or disease-based economic modelling) can either facilitate or impede integrative practice depending on their application. There is still limited experience with their application in Australia.

4.2.3 National and state guidance

One of the strengths of the public health field is the level of specialist knowledge on particular health issues. The evidence base for determining effective interventions that have been generated through focussed efforts on particular issues provides an essential resource to local practitioners.

National (and state) groups that take on a 'custodianship' role can be responsible for pooling, analysing and reviewing information for a public health action through the portfolio development processes. The custodian is responsible, amongst other things, for the commissioning of research and analysis, identification and dissemination of effective interventions, and monitoring of overall performance, quality, and outcomes. In that manner, they provide guidance on best practice without dictating the priorities and strategies at the local level.

Concurrently, local staff can take a more holistic perspective, implementing issue-specific interventions within an integrated framework. The activities are derived from the research on specific topics or issues as advised by custodians.

CONSULTATION QUESTIONS

- What are the key barriers for local service providers in balancing the demands of national and state strategies and the local priorities?
- What are the most important barriers and facilitators that need to be addressed in order to support a more integrated approach?

5. What are the key program dimensions necessary for integrated practice?

The Integrated Public Health Practice Project examined a series of case studies in order to consider the common program dimensions that spanned across different program types that contributed to an integrated approach to public health action at the local level. The case studies addressed by the Project were Municipal Public Health Planning (MPHP), Tiwi for Life Project, Health Promoting Schools (HPS), Building 'Social Capital' projects, Regional Women's Health Plans.

Through consideration of these dimensions, as well as the literature review, a number of key program dimensions have been identified. The ten key facilitators for integrated programs are presented below and these are:

- Policy and legal framework.
- Project framework, research and evidence base.
- Community, partners, and stakeholders.
- Planning; financing, resourcing, and contracting.
- Governance and accountability.
- Leadership.
- Information.
- Workforce and infrastructure.
- Demonstrable outcomes.

5.1 Policy and legal framework

Public health programs operate within a certain policy and legislative context at the state/territory and national levels. These may be policies of the health sector or other sectors, such as education and environment. At the local program delivery level, the policy basis and legal requirements are important to defining the shape of programs and their relationships with other services and providers.

The case studies found that the quality of integrated practice could be enhanced by a clear intersectoral policy and planning framework at the state and national level. In a number of jurisdictions there are whole-of-government initiatives to address integration and community participation in the delivery of government services at the local level. These initiatives are providing legitimacy for the community capacity building projects. For other programs, however, they have been initiated in response to need but delivered in a policy vacuum.

The key elements of a planned and coordinated policy approach include:

- Dissemination of best practice.
- Provision of training.
- Provision of information regarding specific health issues of relevance to the program.
- Support for research.
- Policy development.
- Networks or forums of local, statewide or national organisations.

5.2 Project framework, research and evidence base

Most programs are underpinned by particular theoretical frameworks and a body of evidence, although the complexity of public health as an interdisciplinary endeavour is often challenging for the range of professions engaged in public health program delivery. The case studies found that frameworks and evidence for integrated public health practice is well developed in some areas, such as Health Promoting Schools, while those for community capacity building work is still emerging. In these latter programs, action learning features strongly and models are being refined as experiences and evidence accumulate.

Key issues to be considered are appropriate methods for evaluation of the evidence base and the mechanisms for research transfer.

5.3 Community, partners and stakeholders

One of the defining aspects of integration is that activity is joined together around either a population group or a service delivery mechanism. This allows the program to have a greater understanding of the needs, aspirations and culture of the population or partner agency/provider, and thus more effective delivery.

Improving partnerships was a strategic goal of all case studies. This was achieved through mechanisms such as inter-agency committees, joint planning and shared resources. Consultation processes and information sharing forums were key approaches adopted for working with community interests and related organisations.

The case studies also found that planning, per se, does not ensure that the community or partnership involvement occurs. Also, adopting modes of practice that incorporate systems approaches, community participation, intersectoral collaboration require a change in the culture and work practices of local health services. The extent of community involvement, and strong intersectoral partnerships in Municipal Public Health Planning depended on whether it was a public health plan for the council or the municipality, the value placed by the council on community participation, and the skills and perspective of the planner.

5.4 Planning

The case studies found that planning can take a number of forms. They can be focussed on broad strategies or be detailed and specific. Different agencies can take leadership in the planning process. The general lessons are:

- Planning processes that engage the local community, and build local partnerships between stakeholders, enhance the implementation of subsequent projects.
- Local public health planning can assist local services to set priorities in the light of issues raised by community consultations, health data and national and state priorities.

The relative merits of these different organisations in leading such a planning process and in particular, the role of local government, require examination, as local councils vary in the value placed on community participation, the skills of the planner, and the definition of planning parameters (ie for council services vs community as a whole).

5.5 Financing, resourcing and contracting

The types and sources of funding available and their accountability requirements directly impact on local providers' capacity to implement an integrated program model. The case studies found that funding from national strategies has supported integrated practice at the local level where jurisdictions or local services have taken a broad view of the strategic intent of the national strategy. Broadly targeted funds for innovative practice made available at the state level (through health or other departments), or through private sources were used to stimulate projects. In essence, this 'risk capital' made some of the more innovative work possible.

In addition, local collaborative work is able to generate financial and material support from agencies outside of health where processes have generated trust between the agencies.

Amongst the case studies, the Municipal Public Health Program is found to be sufficiently mature to have been integrated into the ongoing work programs though special funding is required to support research. All other programs continue to require funds to continue the work, and the projects require more time to demonstrate outcomes.

5.6 Governance and accountability

The management and accountability requirements of programs may differ for highly targeted health programs and for integrated programs. Projects with a number of partners may require

new organisational structures, with appropriate compliance requirements to demonstrate accountability, as well as flexibility to respond to community or target group issues.

The case studies found that 'Settings-based' programs, local public health planning and community capacity building projects do not have to be managed by the health sector. The Health Promoting Schools example illustrated how governance changed between sectors for different elements of the program. At the school level, governance and program accountability rests with the school. The support function may be located in either the health or education sector, but the policy framework requires a joint approach. Given the interest in community capacity building across government in a number of states, the health sector's current leadership in a number of the capacity building projects may change as the program is taken up more widely.

5.7 Leadership

Reforms to work practices, including the development of integrated models of service delivery that have a strong client and community focus, are dependent on the skill, vision and capacity of local managers.

In each of the case studies there were examples where local leaders were the key to either generating innovative practice, or successfully reorienting the health service towards more integrated practice.

5.8 Information

Data and information are needed to inform the development of local programs, to assess their progress, and monitor their impacts on health knowledge, attitude and behaviour. The case studies found that health data, as it is currently available, is not sufficient to support local level planning and monitoring of integrated strategies. A number of projects are developing indicators and evaluation methods to monitor community capacity. Project reports can provide a useful source of data for planning purposes.

Effective systems for the documentation, storage and retrieval of local project reports need to be developed by the health system.

5.9 Workforce and infrastructure

Different models of integrated practice may require different spreads of skills in the workforce. The introduction of new programs may also affect the service delivery unit by changing systems or work practices. The case studies found that training programs and management of organisational change are important factors requiring consideration in developing integrated programs.

A number of projects were based on community or organisational development principles, and required a good understanding of community participation methods. Settings based programs require a good understanding of the culture and practices of the setting. Currently these skills are not readily available within the health sector, particularly in rural areas.

A number of the case studies illustrated how effective involvement of the community and partners in health programs requires some accommodation or change in the health sector. Good organisational change management processes need to be implemented to support these changes.

5.10 Demonstrable outcomes

The strength of single-issues programs has been the establishment of clear and demonstrable objectives and targets. A more integrated approach to public health practice also needs to be able to demonstrate valid and sustainable outcomes.

The case studies found that the outcomes of these projects were more often not defined in terms of changes to health status. Rather, they were defined in terms of changes in capacity, participation or collaboration – which, it has been argued, are underlying health determinants and precursors to conventionally measured health status outcomes. Such outcomes have been achieved by a number of the projects presented. Trust building and community engagement processes are slow, as demonstrated in the Tiwi for Life project, and the building community capacity projects. The challenge is to link the nature of demonstrable outcomes with appropriate measures at an appropriate time frame for the interventions.

CONSULTATION QUESTIONS

- Of the specific program dimensions discussed - policy and legal framework; project framework; research and evidence base; community, partners and stakeholders; planning; financing, resourcing, and contracting; governance and accountability; leadership; information; workforce and infrastructure; and demonstrated outcomes - which are most important?
- Are there other dimensions that could be considered?
- What are the key dimensions and strategies that can be implemented at the national level that will support integrated public health practice at the local level?
- What are the key dimensions that states and territories can address that will support integrated public health practice at the local level?
- What are the dimensions that must be secured and supported at the local level?

6. Where to from here?

6.1 Possible Future Directions

The intention of the National Strategies Coordination Working Group of the NPHP is to develop strategies and tools that can be used by jurisdictions to facilitate integrated public health practice. Where relevant, changes to the management of national public health strategies may be considered as well.

It is hoped that this paper will generate discussion at many levels within the public health workforce, health departments and non-government organisations. It is envisaged that through this process, recommendations will be developed to inform decision-makers at various levels throughout the system. The National Public Health Partnership Group, that provides advice to the Australian Health Ministers' Advisory Council, will consider these recommendations. It will also assist the NPHP to pursue its agenda of improving coordination of strategies at the national level, and more generally, the development of public health in Australia.

6.1.1 Local Level

Possible future directions listed below are targeted at decision-makers at the local level within the health sector, non-government organisations, and local councils. In the health sector this may include managers of area/district/or regional health services, community health, public or population health or health promotion programs.

1. Ensure coordination across interrelated health determinants, by organising and delivering a greater proportion of public health programs at the local level, on the basis of the setting or population group ('a client focus').
2. Ensure appropriate training and support of local health services managers, to facilitate and encourage local leadership required for work practice changes associated with integrated practice.
3. Institute regular meetings of government and non- government health services, providing programs to the same organisations or client groups, to ensure planned and coordinated programs.
4. Ensure that public health programs are developed and delivered within the context of local public health plans that are based on:
 - Effective community participation.
 - Developed in partnership with service providers from health and other sectors.
 - Involve or are led by local councils.

6.1.2 State/Territory Level

Possible future directions listed below are targeted at decision-makers in the state and territory health departments, and within the health sector in areas such as public health, health service development policy, and purchasing and organisational development.

5. Ensure that programs are required to support the delivery of integrated practice such as settings programs. These programs need to:
 - Develop the policy context.
 - Coordinate dissemination of best practice.
 - Coordinate training or skill development.
 - Undertake intersectoral negotiations.
 - Facilitate discussion across health programs and statewide service providers within health, and with other sectors.

- Develop a monitoring and evaluation framework.
 - Support research on innovative practice.
6. Encourage effective cooperation and collaboration across programs at the State/Territory level to enhance integration at the local level. Institute organisational change programs that foster 'system thinking' and organisational learning into the jurisdiction's Quality Management System.
 7. Institute more flexible funding arrangements that provide drivers for local programs to adopt integrated service delivery and encourage settings or population based interventions.
 8. Encourage and support participation of other sectors in public health programs, through funding and other mechanisms.
 9. Public health policy makers actively engage with whole of government initiatives to foster integrated service delivery, and social and economic development at the local level.

6.1.3 National Level

Possible future directions listed below are focussed on policies and strategies that can be implemented at the national level. This may include national level bodies such as the NPHP Group, national advisory groups, peak bodies, Australian Health Ministers' Advisory Council, Australian Institute of Health and Welfare and the National Health and Medical Research Council.

10. The National Public Health Partnership develops a clear policy framework regarding local public health planning.
11. Support local level practice and promote integrated public practice by providing national leadership in broadening the concept of national strategies to incorporate a settings approach.
12. Institute a review process for national strategies to ensure their activities in other sectors, for example, schools, are consistent with best practice as defined by health and by the other sectors.
13. Resource and support recommendations in the National Public Health Information Development Plan which promote the scope and coverage of public health information.

6.2 Questions for Consideration

The key consultation outcome is to identify the levers that can be used to support collaboration and to move to a more clustered approach to implementing national public health strategies.

The following questions are posed in this document and are summarised to assist in your consideration of the levers.

QUESTIONS FOR CONSIDERATION

Specific Consultation Questions

- Of the specific program dimensions discussed - policy and legal framework; project framework; research and evidence base; community, partners and stakeholders; planning; financing, resourcing, and contracting; governance and accountability; leadership; information; workforce and infrastructure; and demonstrated outcomes - which dimensions are most important?
- Are there other dimensions that could be considered?
- What are the key dimensions and strategies that can be implemented at the national level that will support integrated public health practice at the state and local level?
- What are the dimensions that must be secured and supported at the state and local level?

General Questions For Consideration

- What do you consider are coordination issues across national or state strategies?
- What can you suggest by the way of clustering strategies that would help achieve greater conceptual coherence as well as greater practicality for implementation?
- What are the key barriers for local service providers in balancing the demands of national and state strategies and the local priorities?
- What are the most important barriers and facilitators that need to be addressed in order to support a more integrated approach at the state and local level?