Integrated Care
A Guide for Policymakers

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Foreword

While health policy researchers, practitioners and policymakers are increasingly referring to the need to introduce 'integrated care' into health policies, the term still remains vague for all too many. What is to be integrated when it comes to care and why? What are the advantages of integrated care and what parts of the population benefit in particular? How can health systems change to accommodate integrated care approaches? What must policymakers and practitioners understand if they to try to change the acute care paradigm to one that offers a veritable integration of health and social care services?

Based on the presentations and outcomes of research and discussions held on the occasion of a dedicated workshop at the European Social Network Conference (Edinburgh, 2005), this publication explores in clear and concise terms the rationale for introducing integrated care and its benefits for different users. It discusses the different levels at which integration must occur as well as the different types of integration. Further, it briefly analyses the various outcomes of integration on different users and providers. Finally, it describes specific challenges that policymakers face when they implement integrated care approaches as well as specific steps to be taken to overcome these challenges. Key recommendations to policymakers who take the integrated care agenda forward complete this brief introduction. The annex provides a selection of examples of integrated care approaches in European countries.

The Ageing and Life Course programme (ALC) of the World Health Organization (WHO) has long been a firm supporter of the integrated care approach, recognising its special value for older populations, regardless of whether they live in developing or developed countries. Through its multi-year and multi-centric project on integrated responses of health care systems to rapid population ageing (INTRA), WHO has sought answers at the community level on how to provide integrated care, with a particular emphasis on developing countries. At the same time, it recognises that many of the systemic obstacles to integrated care are similar across a range of countries even though there may be vast differences in the allocation of resources. With the overall numbers of older people rapidly increasing everywhere, WHO/ALC emphasises the overarching importance of prevention and management of chronic diseases that often afflict the older population. It is precisely in these areas that integrated care, provided within the community, can provide the care needed to maintain autonomy and the highest possible levels of functional capacity and well being of the older person.

"Integrated Care: A Guide for Policymakers" is a useful tool for policymakers interested in gaining an overview of the issues related to integrated care. While the booklet focuses on European countries, it is also useful for a broader global audience of health system managers and innovators. It is hoped that it will stimulate further discussions and action in this growing and important area of concern.

Dr Irene Hoskins
WHO Consultant on Ageing and Life Course

Summary Points

Integrated care has become a core component of health and social care reforms across Europe.

Integrated care seeks to close the traditional division between health and social care. In doing so, it may:

- address the changing demand for care arising from the ageing of the population,

- offer care that is person-centred, recognising that health and social care outcomes are interdependent,

- facilitate the social integration of society's more vulnerable groups through better access to flexible community services,

- lead to better system efficiency through better coordination of care.

Putting models of integrated care into practice poses substantial challenges. These occur at the political, organisational and service delivery level.

Experience of integrated care so far is limited but promising. Further research and evaluation is needed to ensure that implementation of proposed models is feasible, sustainable and results in better health outcomes. Policies need to be adapted to local realities.

We propose eight recommendations for policymakers to take forward the integrated care agenda:

1. Ensure that the development of integrated care is consistent with other health and social care policies.

2. Set realistic objectives for integrated care models. Pay close attention to the possible challenges in implementation.

3. Invest in the training of all professionals to bridge the cultural divide between health and social care. This will facilitate coordination of care and encourage mutual respect.

4. Ask *for whom* care is being integrated – find the appropriate balance between user and provider integration.

5. Harness closer links between policymakers, practitioners and researchers to learn from experience.

6. Share research and best practice within and across countries.

7. Conduct research on cost-effectiveness to determine the effects of different models of integrated care on resource use as well as health outcomes.

8. Explore the scope for technology to facilitate the implementation of integrated care.

Imagine
the following story...

Marie is a 78-year old widow. She lives alone in a small town. Her daughter comes to visit her one day and notices that she is rather forgetful. She takes her to the GP, who dismisses Marie's symptoms as 'part of old age' but gives her some antidepressants. Marie's daughter insists on her mother being referred to a specialist and drives her to the hospital 60km away. The specialist tells Marie that she has early symptoms of Alzheimer's disease but that there is no way of knowing how quickly symptoms might progress. The specialist does not refer Marie to any services in her community but tells her to come again in 6 months time.

Marie's daughter arranges for a social worker from a local private agency to come see Marie 3 times a week. But the social worker finds a better job in another town. Marie does not want to burden her daughter with having to find a replacement, so she does not tell her that the social worker is no longer available.

Meanwhile, Marie's forgetfulness is getting worse. Having not been told otherwise, she is still taking her antidepressants. They make her feel drowsy. She has arthritis in her legs which is getting worse, so that getting down the 3 stairs to the kitchen is too difficult sometimes. She has lost 10kg in 2 months.

It has been 3 months since her last GP visit so Marie goes to see him again. Her forgetfulness appears to be stable so he is satisfied. He does not weigh her or ask about her arthritis. Marie's neighbour pops in that afternoon and notices that her fridge is half-empty. She fills it up and calls the social care worker who arranges for meals on wheels to be delivered every 2 days. She also registers Marie in a seniors' swimming class at the local community centre.

(Adapted from Nies: 2004)

Introduction

Marie's story is fictitious, but her story can and does occur in any country in Europe. Her case illustrates some of the **failings of current health and social care systems**. These include:

- *Lack of 'ownership'* for the patient and her problems, so that information gets lost as she navigates the system.

- *Lack of involvement* by the user/patient in the management and strategy of care.

- *Poor communication* with the user/patient as well as between health and social care providers.

- Treating patients for one condition without recognising other needs or conditions, thereby *undermining the overall effectiveness of treatment*.

- Decisions made in the *social care setting affect the impact of health care* treatment, and vice versa.

Governments across the EU have recognised these failings and proposed a new model of care to address them: *integrated care.*

> *Integrated care seeks to close* **the traditional division between health and social care. It imposes the patient's perspective as the organising principle of service delivery** *and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless.*

'Integrated care' has become a vital component of health and social care reform across Europe. *Yet there is a gap between policy intent and practical application*. Putting models of integrated care into practice poses substantial challenges. Across Europe, progress toward integrated care remains varied, tentative and sporadic.

This report is based on a workshop on the topic of *integrated care* that was held at the 2005 European Social Network Conference in Edinburgh.[1] The aim of the workshop was to discuss the issues, challenges and opportunities presented by integrated care across Europe. The need for integrated care by vulnerable groups who have difficulty accessing the health care system (persons with disabling chronic conditions, who are socially isolated, dependent, frail or mentally ill) was highlighted.

Building on discussions held during the workshop, this report sets out the key concepts, perspectives and challenges that inform the integrated care policy agenda. It is aimed at European policymakers responding to the integrated care agenda. *It is a policymaker's guide to integrated care*.

What is Integrated Care?

Over the past decade, *integrated care* has become an integral part of health policy reform across Europe. In 2003, the World Health Organisation proposed that it was one of the key pathways to improve primary care (World Health Report: 2003). In 2004, the European Commission declared integrated care as vital for the sustainability of social protection systems in Europe.

Yet there is no standard definition of 'integrated care'. Models that seek to apply the principles of integrated care are continually evolving, and many remain at an experimental stage. Most initiatives are local and new skills and lessons acquired in such experiments often fail to feed up to national policymakers.

As a result, there exist many different definitions and understandings of what *integrated care* implies in practice.

The notion of integrated care has two important components: that of 'care' and that of 'integration'.

Defining integrated *care*

> *"[Integrated care] is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion."*
>
> (Grone & Garcia-Barbero: 2001)

The above definition of integrated care emphasises the merging of all the elements related to care in a unified service. Yet *the concept of 'care' is very heterogeneous among different national traditions and cultures in Europe*. This is particularly true in the newer EU member states, where social care services are sometimes poorly developed.

In fact, there is a long-standing division in the delivery of health and social care across Europe. Healthcare is widely seen as a 'right' and coverage is universal or quasi-universal across the EU. Health care services tend to be centralised and governed by a common set of standards and financial principles.

By contrast, *there is no universal right to social care*. Access to care is often means-tested and individuals may be burdened with a significant share of the costs. Social care services are typically provided within highly decentralised systems, featuring multiple providers, considerable local autonomy and variation in access and quality.

Falling through the net between health and social care: the example of Alzheimer's disease patients in the Czech Republic

Czech law grants all citizens free health care provision. However, they have no legal right to social care, and no funding is guaranteed for providers.
Persons suffering from Alzheimer's disease cannot be treated in hospitals, as their remit is limited to providing acute care. Psychiatric hospitals tend to offer poor quality care and rely heavily on sedation. Access to residential homes is also limited – in fact Alzheimer's disease is one of the factors which excludes individuals from the right to residential care.
The only option left is home care, however home care services are in limited supply. As a result, these individuals are essentially left to their own devices, and the overwhelming burden of care falls on the family.

(Dr Holmerova, European Social Network Conference: Edinburgh 2005)

Defining *integrated* care

A second definition of integrated care emphasises the different organisational levels at which integration may occur.

> *"[Integrated care] is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors."*
>
> (Kodner & Spreeuwenberg: 2002)

The different levels at which integration can occur can be expanded further:

- *Functional* integration occurs at the macro level of the care system, i.e. through the mainstreaming of the financing and regulation of cure, care, prevention, and social services.

- *Organisational* integration acts at the meso level of systems, e.g. in the form of mergers, contracting or strategic alliances between health and social care institutions.

- *Professional* integration is also at the meso level, e.g. in the form of mergers (e.g. group practices), contracting or strategic alliances between health care professionals.

- *Clinical* integration acts at the micro level, i.e. by providing continuity, co-operation and coherence in the primary process of care delivery – integration is thus at the *individual* level of care.

(Delnoj: 2001)

User versus provider perspectives

To understand integrated care, it is essential to understand that integrated care *means different things to different stakeholders.* For example:

- To the *user*, it means a process of care that is seamless, smooth, and easy to navigate.

- To the *frontline provider*, it means working with professionals from different fields and coordinating tasks and services across traditional professional boundaries.

- To the *manager*, it means merging or coordinating organisational targets and performance measures, and managing and directing an enlarged and professionally diverse staff.

- To the *policymaker*, it means merging budgets, and undertaking policy evaluations which recognise that interventions in one domain may have repercussions on those in other domains, and thus should be evaluated as part of a broader care package.

The most important distinction is between the user and the provider perspectives. In some models of care, despite high levels of provider integration, users may experience low levels of integration in their access to care – or vice versa. Take the following example:

> *'Imagine a primary care centre that has organised its professionals in a network, but where communication and exchange of information between professionals is poor. Though this centre may appear integrated from the provider perspective, for the user, navigating the system has not been made any easier. From his perspective, care is still fragmented.'*
>
> (Wait, European Social Network Conference, Edinburgh 2005)

This important distinction can be represented by the Integrated Care Matrix depicted below:

The Integrated Care Matrix
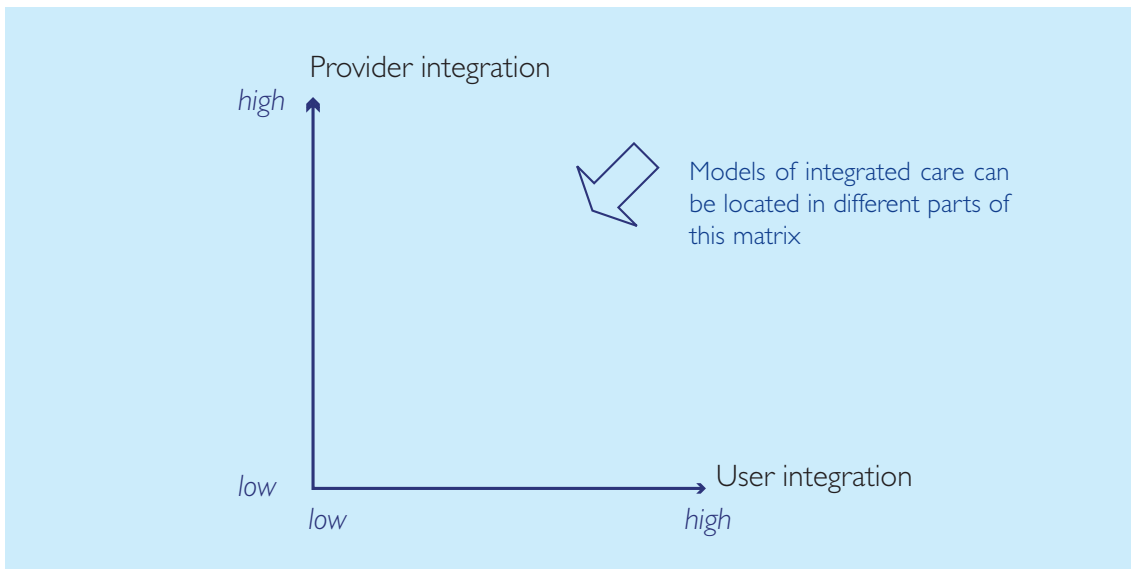
It is therefore important to consider these different notions and understandings of what is meant by integrated care when evaluating integrated care policies in practice.

Why Integrate?
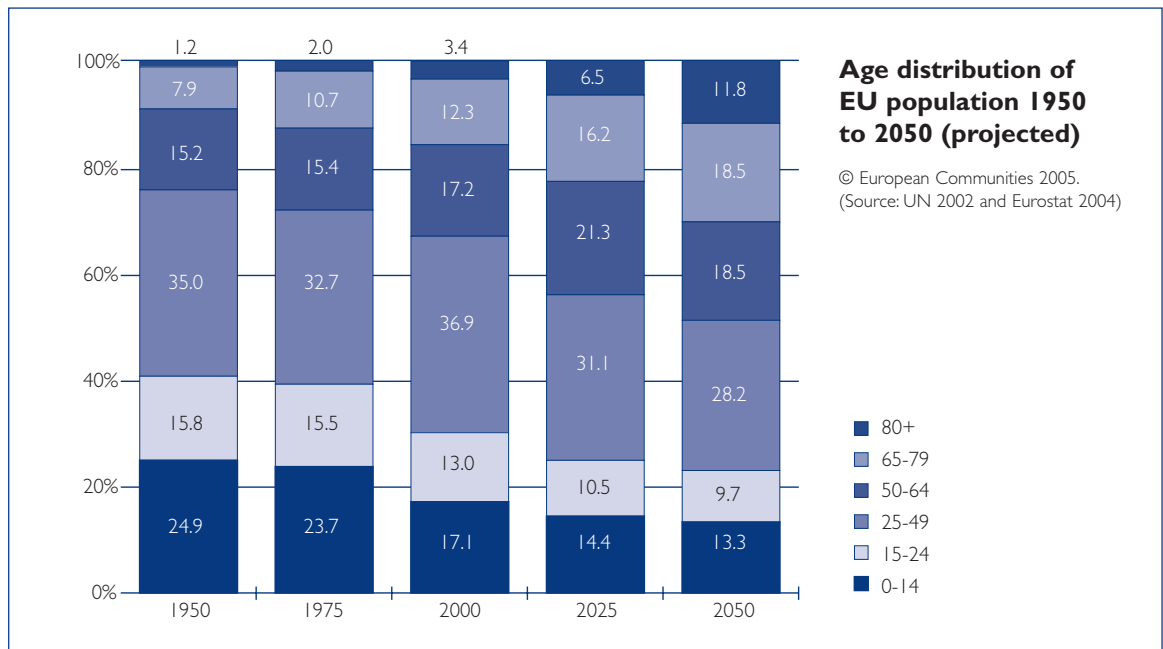# The Case for Integrated Care

**Policymakers may be drawn to integrated care for different
reasons. Five main drivers behind the integrated care agenda are:**
- *Integrated care addresses the changing demand for care*
- *Integrated care recognises that health and social care outcomes are
  interdependent*
- *Integrated care is a vehicle towards social integration of society's more
  vulnerable groups*
- *Integrated care may lead to better system efficiency*
- *Integrated care may improve the quality and continuity of care*

(Wait, European Social Network Conference, Edinburgh 2005)

The changing demand for care

Europe's population is ageing: by 2050, one-third of Europeans will be over the age of 60, as compared to a
mere 13% who will be under the age of 15.

**Age distribution of
EU population 1950
to 2050 (projected)**

© European Communities 2005.
(Source: UN 2002 and Eurostat 2004)

Legend:
- 80+
- 65-79
- 50-64
- 25-49
- 15-24
- 0-14

Age group	1950	1975	2000	2025	2050
80+	1.2	2.0	3.4	6.5	11.8
65-79	7.9	10.7	12.3	16.2	18.5
50-64	15.2	15.4	17.2	21.3	18.5
25-49	35.0	32.7	36.9	31.1	28.2
15-24	15.8	15.5	13.0	10.5	9.7
0-14	24.9	23.7	17.1	14.4	13.3

This will bring a significant shift in the demand for care. Older people are more likely to suffer from several
long-term chronic medical conditions at the same time ('poly-morbidities').
- *Integrated care models can address the growing complexity of patient needs by responding to the
  multiple conditions of users in a coordinated fashion.*

More people are choosing to grow older in their own homes, creating a greater need for social care,
particularly home care. With changing family patterns, there is a greater risk of older people living alone.
- *Integrated care models can provide the appropriate combination of social and home care in the
  community that meet the needs of older users and their families.*

> *In the UK, the number of dependent older people is projected to grow from approximately 3 million in 2000 to around 6.4 million in 2051, an increase of 113%.*
>
> (Source: LSE: 2004)

With the push towards providing care away from hospitals, informal care has become increasingly valuable to society to meet the growing demand for care in the community. In fact, the majority of social care is provided informally by friends and family.

- *Integrated care models may allow for better integration of informal care into the care management process and provide appropriate respite and support for informal carers.*

> *The UK Family Resources Survey (FRS) found that in 1999-2000, 9% of UK citizens had some informal care responsibilities. Of these people most were in the older working age groups, between 45 and 64. Nearly a quarter of male carers and almost a fifth of female carers were aged 65 and over.*
>
> *(Source: UK National Statistics)*

Health and social care outcomes are interdependent

At the level of the individual, the divide between health and social needs is entirely artificial. In fact, it is now increasingly recognised that individuals' *socio-demographic circumstances have significant bearing on their health status – and vice versa*.

The success of health care interventions is often dependent on social care provision as is illustrated in the box below.

> **Social care services are able to provide a better insight as to how patients live. For example, social workers can identify if medical problems result from:**
>
> - *Absence of food in the fridge*
> - *Poor heating in the winter*
> - *Overall status of home*
> - *Family situation, social isolation*
> - *Patients not taking medication because they forget to, or are not sure when to.*
>
> (Elgie, European Social Network Conference, Edinburgh 2005)

This is not only true for older people, it is true for everyone.

Social integration of society's more vulnerable groups

Integrating care can be particularly beneficial for the vulnerable segments of society who have difficulty accessing care due to social isolation or other barriers. This includes all socially disadvantaged groups, ethnic minorities, persons with chronic disabling conditions (of any age) and persons with mental health problems.

Mental health: the urgent need for integrated care solutions

Mental health accounts for almost 20% of the burden of disease in Europe. Mental health problems affect one in four citizens at some time in their lives.
(Source: WHO Regional Office for Europe)

Most psychiatric conditions are chronic requiring long-term support and care. Health professionals, social services and family members are all typically involved in treatment. Social as well as medical care is essential to mental health treatment. Social services can promote healthier life-styles, ensure compliance with medication and treatment, and support family members who provide informal care. By preventing family members from falling ill with stress, anxiety or even depression, integrated care can avoid the premature use of residential care, resulting in significant benefits for families and society as a whole.
(Source: Elgie: 2005: European Social Services Conference)

Better system efficiency

Poor coordination and integration across health and social care can easily result in waste and inefficiency. An example commonly cited is the duplication of assessments, with no coherent approach among different service providers.

Fragmented information systems that result in duplication and extra storage/administration costs, are another example of poorly integrated care models. Indeed, information technology plays a critical role in enabling health and social caresystems to become integrated. For example, 'virtual integration' models, based on web-based user portals, may enable user integration across a complex system of multiple providers. They may also present a cheaper alternative to the high costs associated with organisational and provider integration.

Overall, integrated care may improve efficiency in several ways:
- Appropriately targeting care and resources.
- Preventing duplication of treatment or assessment by different professionals.
- Preventing costly bottlenecks and gaps in care pathways that may arise through poor coordination.
- Ensuring care decisions are taken with due regard to upstream capacity and resources, particularly in external organisations.
- Ensuring that care is undertaken by the right professionals, for example, by preventing health care providers from being used for social care needs.

Integrated care may improve the quality and continuity of care

Possibly the most important benefit of integrated care models is their potential to provide *a more seamless care experience for the user*. Within healthcare, integrated care pathways have long been advocated as a means to improve the continuity, quality and outcomes of care for patients (Bandolier 2003). Specifically:
- The patient and his carers are no longer required to coordinate different treatments and steer themselves across different providers.
- Treatment is no longer 'stop-start' in nature.
- Disruptions in the relationship between patient and care professionals is minimised.

Thus extending integration to encompass both heath and social care may yield even greater benefits for the individual and his carers.

Integration in Practice

There has been considerable experimentation with models of integrated care across Europe. Most applications of integrated care have been exploratory and are local initiatives that are not necessarily replicated at national level. *Innovation remains a core characteristic of integrated care* and no set typology of models of integrated care exists.

Nevertheless, it is possible to identify some of the basic approaches that have been taken in attempts to implement integrated care. These are summarised below, with specific examples presented in **Appendix 1**.

These basic models by no means represent all the models of integrated care that have been implemented or that may be possible.

Basic Models of Integration:

Shared information among professionals from different sectors
This model uses greater sharing of patient information among health and social care professionals to facilitate the treatment of patients in a coordinated fashion, minimise date storage costs, and reduce problems that result from separate information systems.
(eg. Information System for all activities carried out in the territory – Italy)

Standardised communication protocols and formats
Defined communication protocols and formats are used to improve communication between health and social care professionals, and facilitate a more seamless and integrated care process.
(eg. MedCom – Denmark; Wiesbaden Geriatric Rehabilitation Networks – Germany)

Single assessment processes incorporating multi-disciplinary assessment
This involves a single, multi-disciplinary assessment of users' needs for health and social care. Single assessment processes reduce the number of assessments that a patient undergoes, and provide a central point of information from which to coordinate care.
(eg. Single Assessment Process – UK; Multi-dimentional assessment plans – Italy)

Defined pathways of care
This model uses clearly defined multi-disciplinary pathways of care incorporating both health and social care.
(eg. Hospital at Home – UK)

Single access points to care
This model seeks to reduce the number of 'access-points' at which users receive care, ideally to a single access point, so as to reduce the number of professionals and organisations that patients have to deal with.
(eg. One-Window – Netherlands; CARTS – UK)

Challenges to Integration

Experience of integrating care across both health and social care is still fairly recent. Accordingly, we are still learning of the challenges associated with implementing integrated care models. Challenges are present at the
- policy level
- system level
- organisational level

Policy-level Challenges: Competing policy agendas

The agenda for integrating health and social care exists alongside competing policy agendas that are shaping the future and development of health and social care provision.

Patient choice and diversification of provision – An emphasis on giving users greater 'choice' in their care providers can be found in some countries. *Provider competition* is seen by many governments as a stimulus for reform, efficiency and quality improvement. Services are being delivered increasingly by *a mix of public, private and voluntary sector providers.*

This increased diversity of provision may potentially hinder and not facilitate the implementation of integrated care. Why?
- The coordination challenges involved in delivering a complex set of services within a coherent integrated care package may increase.
- It may be more difficult to ensure equitable access for all users in a highly diversified quasi-market.

> *Policymakers keen to encourage 'patient choice' need to ensure that the substitution of providers does not disrupt service delivery and undermine the equity of access to integrated care.*

Who pays? – Integrated care presents a new challenge to ongoing debates as to who funds the cost of care. It blurs the distinction between health and social care and challenges the way they are currently funded.

> *Integrated care forces a re-evaluation of what is 'essential' care and which components of care should be covered by public funds.*

System-level Challenges: Measurement, quality and regulation

Measuring integrated care – No agreed definitions of measures of integrated care exist. For example, the extent to which health and social care is integrated may be measured in terms of budgets, organisations or levels of user integration.

> *Unified measurement tools and indicators are needed to measure levels of integration across health and social care systems.*

Integrating performance measures – The introduction of integrated care implies the *introduction of integrated care performance indicators or measures.* However, the creation of such measures is complex:

- Professionals from health and social care may have very different notions of what constitutes 'quality'.
- Providers may resent being subject to integrated performance measures when outcomes are dependent on services provided by external organisations.
- The quality systems of social services are typically less comprehensive than health care quality measurement systems. Social care outcomes are comparatively more difficult to measure.
- Performance measures are only useful when agreed upon by all participants. It is unclear whether the different professions involved in providing integrated care would be able to agree on satisfactory performance measures of integrated care.

> *Meaningful and credible performance measures need to be developed to allow for the evaluation of integrated care.*

Regulating quality – Beyond measurement, it is important to monitor and regulate the quality of integrated care. However, this is likely to be complicated given the mixture of providers. In particular, identifying which agent will take responsibility for gathering user feedback and making the necessary changes is a key challenge.

> *Policymakers need to develop tools and systems for regulating the quality of health and social care delivered as part of an integrated care package. Incorporation of the user perspective is particularly important.*

> *Policymakers need to develop the regulatory tools to involve providers from mixed sectors in the process of developing and implementing integrated care models, such as incentives, partnerships, and contracts.*

Organisational Challenges: From policy to implementation

Fragmented bureaucracies – In many countries, health and social care have traditionally been provided by entirely distinct bureaucratic systems at both national and local levels.

- The decision-making and analytical tools used in health and social care budgeting are different and separate.
- 'Co-terminosity' of services may not exist at a local level, i.e., services may be geographically fragmented, and may overlap.

> *Implementing integrated care will mean devising new budgeting formulas, tools and procedures at a national and local level. The fragmentation of social and health care planning, financing and organisation must be overcome.*

Cooperation and coordination between different organisations – Integrated care requires that professionals from different sectors and backgrounds work and cooperate together. *Integrated care implies a movement away from the social care or health care culture towards a new culture and ethos of care.*

Various problems can be anticipated:
- *Across professions:* Different professions may be working in close cooperation for the first time. Some professionals may resent such arrangements as a threat to their status. *Clashes in care cultures and priorities may arise.*
- *Across sectors:* resentment or a clash of ethos and culture may result when professionals from the public, private and voluntary sectors are required to work side-by-side.

> *Training of professionals involved in integrated care models is needed to ensure optimal cooperation, mutual respect and understanding. Creating defined pathways of care in which the role of different professionals is clearly defined may help.*

Capacity building – Lack of resources may limit the capacity of service providers to engage in major organisational changes. Specifically, the severe budget constraints and shortfalls endemic to social care need to be redressed.

> *New integrated care models need to be financially sustainable. Policymakers need to ensure that sufficient investment takes place to enable the provision of integrated care, recognising that in the short-term the costs of implementing integrated care may exceed the economic future benefits.*

Cost-shifting – When integrated care packages require different organisations to work together, it will be important to minimise the practice of cost-shifting among different providers.

It will also be important to ensure that organisations do not cherry-pick the lowest cost or most profitable patients, effectively excluding the more needy users from the system. This has been a recognised pitfall of many managed competition systems.

> *Financial transparency must be ensured within integrated care models to ensure that cost-shifting and adverse selection of users and patients do not occur.*

Conclusions and Recommendations

Experience of integrated care so far is limited but promising. If implemented successfully, new models of integrated care may be able to address the challenges confronting our health and social care systems, not least of which is the ageing of the population.

Key Recommendations to Policymakers

We have identified eight key recommendations for policymakers in taking forward the integrated care agenda.

1. Develop coherent care policies

Policymakers need to ensure that the development of integrated care fits into and is consistent with other health and social care policy agendas.

2. Set realistic objectives for integrated care models

Integrated care policies are sometimes advanced without careful consideration of the practical challenges they face in implementation.

Closer attention to potential implementation challenges is needed at the time of policy formulation, in order to ensure success and viability of proposals. Solutions that are adapted to local configurations of care and that are financially sustainable should be prioritised whenever possible.

3. Address the cultural divide between social and health care providers

Developing integrated care is impossible without the cooperation of frontline providers. The cultural and professional divide that exists between health and social care providers should not be underestimated. Investment in training of all professionals to facilitate coordination and encourage mutual respect is thus essential.

4. Find the appropriate balance between user and provider integration

Policymakers and practitioners should ask themselves *for whom* care is integrated – and be clear about which perspectives dominate in the way that care is organised and delivered.

5. Leverage experience and learning from pilot projects

Too often, the experience gained at local levels is not fed back into the policy development process. Yet learning from the experience of frontline providers involved in pilot projects is vital.

The gap between policy intent and implementation can be closed by harnessing closer links between policymakers, researchers and practitioners involved in integrated care development.

6. Share research

The dilemmas posed by the integrated care agenda are similar across Europe, despite differences between national health and social care systems.

The European Union may play a key role in driving a shared research agenda.

7. Conduct research on cost-effectiveness

Very few economic evaluations of integrated care have been reported to date. Developing such tools is indispensable if the potential of integrated models of care is to be exploited.

8. Explore the scope for technology to facilitate integrated care

Information technology is crucial to the future of integrated care. Standardised communication protocols, shared patient information, single assessment procedures and defined care pathways can all be realised via information technology resources, such as 'patient-platforms' and the use of web portals.

Policymakers therefore need to ensure sufficient research takes place on the scope for technology to facilitate integrated care. Information technology experts need to be involved in the development of integrated care models.

Appendix 1: Examples of Integrated Care Models Across Europe

Geriatric Teams – Denmark

Target users: Elderly members of society.

Model of Integration: Some Danish hospitals have deployed multi-disciplinary geriatric teams to visit patients following discharge.

Objective: Geriatric teams guarantee coherent treatment and follow-up, and give patients the opportunity to be treated in their own homes. They also minimize the chance of readmission.

Professionals Involved: Geriatric teams draw staff from across hospital departments, including doctors, nurses, physiotherapists, as well as social workers.

Notes: In some municipalities, the use of such teams has led to increased take up of home-care, day centre, and meals on wheels services, as geriatric teams have identified patient needs which have previously escaped notice.

(Source: Colmorten E et al.: 2004)

'One Window Model' – Netherlands

Target users: Users of health and social care.

Model of Integration: The 'one-window' is a single access point for advice, information and help in utilizing health and social care, usually located in a small community centre. 'Telephone' and 'electronic' windows have also been established.

Objective: To give users a single integrated access-point to information and advice on available care services and facilities.

(Source: Ex C et al.: 2004)

Community Assessment and Rehabilitation Teams (CART) – UK

Target users: All patients identified to be at risk of hospital admission.

Model of Integration: A multi-disciplinary team based in a single location undertakes integrated assessments of patients both before admission to hospital and after discharge, following referrals from both hospitals and community-care organizations.

Objective: CARTs aim to intervene before a crisis point is reached in a patient's condition that requires hospital admission. This reduces the suffering of the patient and the cost of hospital treatment.

Professionals Involved: CARTs comprise nurses, occupational therapists and physiotherapists, among other professionals.

Notes: CARTs are usually funded from both health and social care budgets, and are managed either through the NHS or social services.

(Source: Coxon K et al.: 2004)

The Working Unit for Continuous Care (WUCC) – Italy

Target users: Elderly patients.

Model of Integration: In the Alto Vicentino region, the WUCC is a geriatric assessment unit organised within local hospitals.

Objective: The WUCC aims to guarantee the discharge of older patients from hospital, by organizing and providing continuous and integrated health and social care.

Professionals Involved: The WUCC comprises a professional nurse, physiotherapist, as well as a social worker based at the hospital who provides a link between caregivers and external social workers, in order to plan and prepare a patient's hospital discharge.

(Source: Nesti G at al.: 2004)

The Multidimensional Assessment District Unit – Italy

Target users: Elderly patients.

Model of Integration: In the Veneto region, MADUs assess an elderly patient's needs in a multidimensional way, through the preliminary collection of information by the GP or social worker, using standard assessment forms.

Objective: The MADU defines and implements an integrated care plan, and allocates a case manager who has responsibility for overseeing the plan.

Professionals Involved: The elderly patient's GP, the social worker of the municipality, a geriatrician, physiotherapist, professional nurse, and administrative personnel.

Notes: Some problems with the use of MADUs have been noted, including organisational complexity, the inflexibility of the model that reduces scope for initiative, and difficulties achieving inter-professional cooperation.

(Source: Nesti G at al.: 2004)

Acute Rooms – Denmark

Target users: Elderly patients.

Model of Integration: Acute-rooms are established in nursing homes or centres for the elderly.

Objective: Acute rooms aim to provide an alternative to hospital admission for patients who do not need specialist treatment, but are suffering acute illnesses such as fevers, or pneumonia. They also allow patients to remain in their local community close to friends and relatives. Patients also typically prefer to be treated by staff familiar to them.

Professionals Involved: GPs take responsibility for acute-rooms, but referral and treatment is coordinated with specialists from hospital and emergency services, and social care units.

Notes: A crucial challenge for acute rooms is ensuring that quality of care is equivalent to that available at a hospital.

(Source: Colmorten E et al.: 2004)

MedCom – Denmark

Target users: Health and social care professionals.

Model of Integration: MedCom sought to develop national procedures and standards for essential communication between providers of health and social care. It developed standardised referrals and discharge letters, laboratory requests, results and prescriptions.

The first phase of MedCom focused on hospital communication with local municipalities, and the second phase concerned communication between local health and social care units and hospitals.

Objective: MedCom aims to overcome communication problems between social care units, hospitals, GPs, and other health providers, that can be a barrier to delivering integrated services for admission and discharge to hospital.

Professionals Involved: Health and social care professionals.

(Source: Colmorten E et al.: 2004)

Wiesbaden Geriatric Rehabilitation Network – Germany

Target users: Public and private health and social care professionals.

Model of Integration: The Network uses a standardised survey tool to ascertain the personal and domestic situation of elderly citizens over 70 years of age who meet certain criteria, such as suffering multiple diseases.

Objective: By improving communication between different health and social care providers, the Network aimed to enable elderly patients to remain independent and in their own home, reducing their need for care.

Professionals Involved: Private medical practitioners, hospital therapists, geriatric rehabilitation centres and mobile services for the elderly.

Notes: The Network provides an example of standardised communication tools being used to facilitate communication across public and private sector providers.

(Source: Roth G et al.: 2004)

Preventive visits – Denmark

Target users: Patients over 75.

Model of Integration: All Danish local authorities are obliged to conduct at least two home visits per year by health and social care workers to citizens aged over 75.

Objective: The purpose of the visits is entirely preventive: to minimize the risks from falls, social isolation, suicide, traffic accidents and to improve physical activities.

Professionals Involved: Health and social care workers.

(Source: Colmorten E et al.: 2004)

Information System for all activities carried out in the territory – Italy

Target users: Health and social care professionals.

Model of Integration: In the Valdelsa and Valdarno regions, this project enables access to shared information about patients collected during different phases of the care process, by all the different services involved in care. Information about patients receiving social and health care services, whether from general practitioners, hospitals or nursing homes, is collated in a single continuously updated database.

Objective: The database enables joint working and reduces the time required for information exchange between different agencies and organisations. The system ensures patient details only need be recorded once, and enables collaboration between staff that are geographically separate.

Professionals Involved: Health and social care professionals.

(Source: Nesti G at al.: 2004)

Rapid Response Teams – UK

Target users: Elderly patients.

Model of Integration: Referral to a rapid response team will typically occur from A&E staff, GPs or other community sources, and is followed by a fast-track assessment, and the delivery of health or social care in the patient's home.

Objective: Rapid response teams aim to prevent admission of the elderly to hospitals or nursing homes.

Professionals Involved: Rapid response teams comprise nurses and social workers that work together, but nevertheless retain separate line managers, and are based in separate locations.

Notes: After the intervention of a rapid response team, which typically lasts 2 to 6 weeks, responsibility for financing and providing care returns to community social or health services. However, this necessitates another round of assessment and intervention, which has caused some to question whether the strategy adds more complexity to the system, and ultimately undermines joint working.

(Source: Coxon K et al.: 2004)

'Hospital at Home' – UK

Target users: Hospital patients who have recovered from their 'acute' phase.

Model of Integration: Hospital care managers initiate social care packages which are funded by NHS money, so as to enable the patient's discharge, ahead of assessments by social services. Care packages may provide social support, therapeutic interventions such as physiotherapy, or community nursing services. Schemes are generally limited to 2-6 weeks.

Objective: To enable earlier discharge for patients.

Professionals Involved: Care packages are agreed with health professionals, patients and carers after joint assessments.

(Source: Coxon K et al.: 2004)

Single Assessment Process – UK

Target users: Health and social care professionals.

Model of Integration: The use of a single multidisciplinary assessment process.

Objective: To prevent the unnecessary information storage costs and repeated assessments that are associated with multiple care assessment procedures.

Professionals Involved: Health and social care professionals.

Notes: Barriers to such a plan are poor IT resources, the problem of developing a universal database, and cultural issues among the professions involved. Patient confidentiality is another consideration as the scheme requires the widespread sharing of patient information.

(Source: Coxon K et al.: 2004)

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