Integrated Care in Europe: Time to Get it Together?

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1 Introduction

Nowadays integrated care (IC) has become a term adopted across the world underpinning a positive attitude toward defragmentation of service provision inside health and social systems [1].

Since lack of healthcare coordination is often a major problem for chronic and frail patients, integration has certainly commendable aims [2]. Striving for combining parts to form a whole, IC aims at optimizing care and treatments to patients and their caregivers [3]. However, while the principles supporting IC are simple, their implementation is more controversial [4].

As it often happens in the health literature, IC has rapidly become an ‘umbrella concept’ open to various interpretations [5]. After the launch of an international journal in 2000 including IC in its name, a search conducted a decade later had already found more than 175 definitions [6]. Recently, even the European office of the World Health Organization (WHO) issued a working document to provide conceptual clarity on IC models [7].

Here, we summarize the current narrative and the main issues of IC. Then, we draw lessons for Europe and finally put forward a few recommendations in the perspective of a long-term harmonization in the European Union (EU).

2 Definition and Jargon

The growing number of IC definitions is somehow related to the increasing domains of applications. In addition to general IC definitions [8], many IC models have been recently focused on specific groups of patients, often older adults and frail subjects. This reflects the major current challenge

of health systems in highly developed countries, i.e. the increasing demand and proportion of healthcare expenditures induced by ageing chronic patients with both physical and cognitive problems [9]. So, the most recent conceptual essence of IC is the creation of social and health care delivery systems aimed at spanning the borders and improving the communication among services in primary, secondary and tertiary care [10].

Beyond trendy terms like *patient-centered care*, often cited as the key aim for IC compared to the traditional *disease-centered care* provided by single health services [8, 11], some terms are more specific to the IC concept. In addition to the original IC *triple aim* of improving people health, enhancing patient experience and reducing health care costs [8, 9], the *quadruple aim* of improving the work life of health care professionals has been added later on [12].

As in any other supply chain, integration can be either *horizontal* or *vertical* according to microeconomics [4]. The former occurs when IC is applied to various services delivered at the same stage (e.g. hospital wards in tertiary care), the latter when IC brings together services delivered at different stages (e.g. general practices in primary care and hospital wards in secondary care) [13]. Also, IC strategies can target three levels of service provision according to social sciences: *micro-level* for individual patients, *meso-level* for groups of patients (e.g. older multi-morbid adults) and *macro-level* for the whole populations [4, 8].

Because IC interventions usually involve multi-disciplinary teams, *case management* is considered the new role to ensure coordination and communication among different professionals, regularly keep in touch with patients, and finally reduce healthcare and social costs [1, 9, 14].

To conclude, although no single model or definition of IC fits all contexts [12], expectations on IC are still growing and IC initiatives are expected to increase throughout Europe [11].

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3 An Endless Debate

The recent debate on IC is largely influenced by the mismatch between the increasing burden of health and social needs for chronic conditions and patient complexity from the demand side, and the design of healthcare systems still focused on acute care and single diseases from the supply side [9, 10, 15]. This gap might even increase health risks for multi-morbid patients when receiving conflicting recommendations and treatments from different healthcare providers [11].

During this endless period of budgetary pressures the wide debate on IC in the EU has also been affected by the different types of health systems [16]. The ‘Bismarckian’ systems (statutory health insurances) have by default many more players compared to the ‘Beveridgian’ systems (national health services). So, the former are inevitably less favorable to IC [17]. In general, when financial incentives of specific players run against IC interventions, it is hard to involve them, since these players follow their own interests. At micro level, funding is an issue to face in all IC models when trying to involve social services provided outside health systems.

IC initiatives might also reveal ‘unmet needs’ of multi-morbid patients within and beyond health care [4, 12], eventually leading to extra costs rather than savings [3, 11]. At macro level, the ever ageing populations are likely to have put more under strain the social services of southern countries traditionally characterized by a strong family culture like Italy and Spain, where relatives are used to playing the role of informal caregivers when necessary [15].

In general, it is methodologically challenging to prove the effectiveness of IC interventions based on scientific evidence [4]. The outcome measures of organizational studies and their empirical results are hardly comparable with those of ‘usual care’, which in turn can vary widely at local level even within the same health system. Ultimately, this makes the design of studies on IC initiatives open to discretion and their results hardly extendable to other settings, so that any attempt to estimate ‘trade-offs’ between IC additional costs and potential savings seems arbitrary [18].

Healthcare services are quite peculiar from an organizational point of view, since their power structure is somehow reversed compared to the vast majority of other fields [19]. Healthcare professionals at bottom levels have greater influence over daily decision-making than those hierarchically placed at top [1, 20]. Therefore, changes in clinical practice are more likely to be achieved thanks to managerial strategies aimed at building professionals’ trust through bottom-up incremental steps, rather than

through top-down hierarchical directives [21]. This hardly fits common politicians’ attitude, who expect to announce fast results of eye-catching IC initiatives conducted by purposely appointed top managers [22].

Consistently, also the new emerging role of case managers for IC is open to debate [23]. Rather than adding new jobs for spanning boundaries among services, involving the existing staff might be a more effective strategy to push IC [24]. Creating a culture that aligns the existing professionals would also curtail blurring of roles and fears of job losses.

To conclude, IC is another example of a wise concept initially rising enthusiasm, then finding an insurmountable hurdle in scant clinical evidence [25], and finally leading to an endless debate [3].

4 Lessons for Europe

The major reasons of persisting IC weakness in Western European countries stem from arguable choices of health policy taken in the recent past. The political creed in ‘market competition’ is probably the most emblematic [16]. Health is a classical example of ‘market failure’ in economics, from both demand and supply side. So, the myth of competition is fully unjustified and required strong ideological support since the first British attempt [16]. All initiatives encouraging healthcare providers to compete are likely to discourage IC [1, 26]. Furthermore, activity-based funding through arbitrarily fixed tariffs for services can only lead to distortions in allocating financial resources and ultimately undermine IC, discouraging coordination and synergies among providers [27].

The professional status of general practitioners is another historically rooted reason of IC weakness throughout Europe. Differently from their colleagues in hospitals, who are mainly employees, GPs are still self-employed professionals in the English and Italian NHSs too [16, 26]. Since co-location of health professionals favors IC thanks to team-working [1, 23], single large-scale organizations have become a pressing priority for a modern primary care [28]. Therefore, the time has come to radically change the anachronistic status of GPs, in order to strengthen IC in the future [29].

5 Final Proposals

Finally, we offer some recommendations to improve IC in Europe. A national health service should be indicated as the type to be preferred, since public healthcare systems facilitate IC for both funding and provision. Rather than pricing and competing, budgeting and planning should be the right culture for managing them [16]. Ideally, the

future healthcare systems should become NHSSs by adding the second ‘s’ of social, merging health and social budgets to bring all types of services closer together [15, 28]. To improve the supervision of NHSSs activity in a IC perspective, all health and social professionals should become employees, GPs included. This should allow the NHSSs to better cope with the big challenge of constraining political influence and administrative bureaucracy, the most serious motivation-killing threats of public sectors [15]. Striving to enhance patients’ health as the primary interest of healthcare services, the NHSS organization should be inspired by systemic coordination among health and social professionals [27], adding communication and management skills to their traditional education and training [24].

In conclusion, we are convinced that the quadruple aim of IC would not be a mirage in a collaborative rather than competitive context. This should contribute to stop the current European debate around IC.

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