

Editorial

Is it possible to build a bridge between researchers and innovators of integrated care?

A tension exists between research and innovation of integrated care. The first one asks for knowledge independent of persons, location and time. The second one often is driven by individual persons, on a favourable site and during an episode of a sense of urgency that something is un-integrated in health services. Mostly the first one is done within the scientific community. The last one is in the hand of pioneering managers of health service institutes, often supported by consultancy firms who deliver project managers and knowledge on redesigning the core process.

In commercial firms research and development (R&D) is much more integrated. For instance new equipment is mostly based on research as well as on creative inventions. In health services, two approaches for innovations are popular now. The first one is learning by doing (LBD), without any research. With this approach many health care innovations are implemented, as is shown by Van der Linden, whose book is reviewed in this IJIC Issue. We mention also the development of managed care in the United States without too much research and with a lot of trial and error (Robinson, book review in IJIC Issue 3). Disadvantages of this approach are the limited dissemination of the invention. It is as if in a village everybody is trying to renovate his own house in his own way without learning from each other. Eijkelberg showed in Issue 2 an example of two diabetes projects that could hardly be merged because the owners wanted to learn from their own experiences only. Another disadvantage is the amount of frustration when something goes wrong or is not available. Once, a team invented a new geriatric consultation point within a hospital for general practitioners. Everything was well prepared. The only thing that was lacking was GPs referring the older patients. There was a good solution but no problem.

The second approach is RDI: research, development and implementation. Here, the start is a description of public health problems and a search for interesting solutions in neighbouring sectors, in the past and elsewhere in the health world. Once this is done, an innovation is conceptualised and elaborated, and put in a research design with control groups and, if to some degree possible, with randomisation. The RDI approach follows the principle of think first, do later, and it has the support of everybody who loves Evidence Based Medicine.

Disadvantages of RDI are that the real health care world is not organised in this way. Innovators do not read scientific literature to get ideas. They think faster than they read. And researchers have difficulties publishing their articles on innovations because mostly the research design is weak. For instance the patient series is too short. Or the control group is already infected by the new innovation and shows a better outcome as well. Or the innovating pioneer is so mission driven and charismatic that it is unclear what the main influencing factor is: the pioneer, the innovation or the enthusiastic dedicated people within the project.

IJIC has, apart from the policy section, two main sections in its issues: one on research and theory and one on projects and developments. In this way we try to offer different platforms: one for researchers and one for innovators. But, is this the right perspective for the future? Is it possible to build a bridge between researchers and innovators of integrated care? The answer is yes, when a taxonomy of research and innovation is available, like the phases I to IV of research and development of pharmaceutical drugs. The lowest phase of integrated care research shows the public health problem and the direction of the integrated care solutions. This research can be enough for redesigning financial systems and health policy in such a way that they stimulate the indicated solutions. An example is the article of Japanese authors in this IJIC Issue. They show how a change in the financing of long-term care stimulates integrated care management. The second phase in our taxonomy is not the testing of an innovation as is done in the pharmaceutical world. It is the inventory of already existing innovations. A cross sectional, observational study and not one clinical trial is here the indicated research method. By means of multivariate analyses of many observed values or by contrast group analyses with less observed values, best practices can be filtered out. The third phase is a qualitative study of best practices that came up in the second phase. Meiss c.a. gave an example of this type of research using a quality auditing method for a research paper.

In these three phases research follows the developments in integration of care instead of leading them. But the developments are described and published. And that is a scientific profit. The IJIC editorial board

invites their readers to submit these phase 2 and 3 articles. In the beginning of September the members of the editorial board meet each other, not as is usual by phone or by email but in reality. Maybe, we will integrate our two platforms into one big theatre for

papers that discuss research as well as developments in integrated care.

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