

News

Integrated care in an international perspective[☆]

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Introduction

The workshop of the EUPHA section Health Services Research took place on Thursday, December 8th, 2001 in Brussels at the annual conference of the EUPHA (European Public Health Association). The theme of the workshop was integrated care in an international perspective. Integrated care can be defined as a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion [1].

The theme was chosen because of its relevance to European health care systems. In several European health systems, a development towards integrated care can be observed. Partly, this takes place under the banner of 'managed care' experiments (e.g. in Switzerland), in which case an American form of integrated care is imported and moulded into the own, national health care system. In other cases, however, the same type of development is named differently throughout European health care systems: e.g. 'shared care' (in Great Britain), or 'Vernetzung' (in Germany), or 'transmurale zorg' (in the Netherlands) [3].

This convergence of trends can be explained by at least two universal developments:

Firstly, despite the differences between countries, especially between Western and Eastern European countries, in morbidity and mortality of their populations, European health systems are confronted with roughly the same problems: namely those of ageing populations that have gradually entered the fourth

stage of epidemiological transition. That stage is characterised by ongoing degenerative or chronic diseases. Chronic diseases ask for a different organisation of health care delivery than do acute conditions. The emphasis is shifting from acute interventions to monitoring, and from cure to care. Apart from that, the optimal management of these types of conditions requires multidisciplinary teamwork.

Secondly, as a result of ongoing technological development (e.g. improved surgical techniques and anaesthesiology) hospitals are changing from "large temples of technology" towards acute care hospitals and ambulatory surgery centres providing short stay care through increasingly specialised professionals [2]. This too asks for more co-operation between hospitals and community services.

In other words, throughout Europe, patient care will have to encompass more and more multidisciplinary care of a 'high tech' character, which is provided over care episodes in which the patient moves in and out of different settings (home care, general practice, hospital, nursing home etc.). This implies that patient care will have to become more integrated at all levels. Based on the work of Shortell et al. [3], a distinction can be made in:

- Functional integration on the macro level of a health care system, i.e. mainstreaming of the financing and regulation of cure, care, prevention, and social services.
- Organisational integration on the meso level of health systems, e.g. in the form of mergers, contracting or strategic alliances between health care institutions.
- Professional integration on the meso level of health care systems, e.g. in the form of mergers (e.g. group practices), contracting or strategic alliances between health care professionals.

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- Clinical integration on the micro level of health care systems, i.e. continuity, co-operation and coherence in the primary process of care delivery to individual patients.

The degree, to which integrated care has developed on the micro level, and the actual forms it takes on the intermediate level of organisations, seems to be affected by characteristics of the health care system on the macro level. For example, Dutch health care providers claim that their efforts in bringing about more integration between ‘cure’ and ‘care’ facilities are frustrated by the fact that there are two different insurance schemes for ‘cure’ and ‘care’, with different administrative procedures and a different incentive structure. The aim of the workshop of the EUPHA section Health Services Research was to provide a starting point for a more systematic mapping of the level of integration in European health care systems and the effect of macro characteristics of health care systems (e.g. financing and insurance systems) on integrative processes. The underlying ‘research question’ was: How do characteristics of the financing and regulatory system (macro level) hamper or promote the development of integrated care on the meso and micro level?

Method

The workshop consisted of an introductory presentation by the organisers based on a study of the literature on integrated care [4]. This study was conducted on request of the Dutch Ministry of Health. Six countries were included in the study: the Netherlands, Germany, Austria, Switzerland, the United Kingdom, and the United States. The first four have a Bismarckian social insurance system in common. However, the governance of the health care system differs substantially across these countries. The United Kingdom was included as an example of a country with a National Health Service. The United States—a system with a variety of financing mechanisms—was chosen mainly because the concept of integrated care was ‘invented’ in the American health maintenance organisations.

After this initial presentation, a discussion took place which was complemented with information gathered in short questionnaires that 13 of the approximately 25–30 participants in the workshop had completed two weeks before the conference. The respondents covered 9 European countries: Sweden, Denmark, the Netherlands, Belgium, Switzerland, Italy, Slovenia, Latvia, and Belarus. Through these questionnaires, participants were asked to provide concise information on the stage of development of integrated care in their own country, and the (perceived) effect of financing and regulatory mechanisms on that development. The

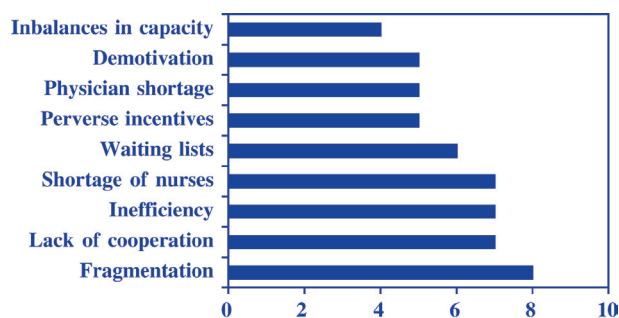


Figure 1. Number of respondents to the workshop questionnaire (n = 13) mentioning the problems listed.

workshop questionnaire was meant to provide input for the discussion and had no ambition whatsoever to serve as a scientifically sound or valid instrument.

Results

Fragmentation and a lack of coherence, and inability or unwillingness to engage in (multidisciplinary) co-operation apparently are serious problems in many European health care systems. When asked about the most important problems in their health systems, these two problems are put in the top-5 by a majority of the respondents to the workshop questionnaire (see Figure 1). Fragmentation and a lack of coherence, and unwillingness to co-operate are among the most frequently mentioned problems, together with inefficiency and a shortage of nurses.

The question is whether this fragmentation is caused by the financing and insurance system. Countries differ with regard to the financing of cure and care, and by the degree to which health care and social services are separated. In Table 1 an overview of the financing systems for curative services (‘cure’: e.g. hospital care, physician services) and long-term care (‘care’: e.g. nursing home care, home nursing) of the Netherlands, Germany, Austria, Switzerland, the United Kingdom, and the United States is presented.

In four of the six countries in Table 1, cure and care are covered by different schemes. There are two exceptions. In Switzerland, home care and nursing home care has been brought under public health insurance in 1994. And the British NHS covers care for the chronically ill and the elderly, though only to a limited extent (a longer stay in the hospital means reduction in the pension). The NHS also finances community nursing (home care). All other types of inpatient and outpatient care (nursing homes, homes for the elderly) are financed by local governments. The limited and means-tested coverage under the NHS has also created a market for private insurance for long-term care [5].

Table 1. The financing of ‘cure’ and ‘care’ in 6 Western health care systems

Country	Financing of ‘cure’ (acute care)	Financing of ‘care’ (long-term care)
Netherlands	Public (61% of the population) or private health insurance (39%)	Catastrophic illness insurance (‘AWBZ’), since 1968
Germany	Public (90% of the population) or private health insurance (10%)	Care insurance (‘Pflegeversicherung’), since 1994
Austria	Public health insurance (99% of the population)	Tax-based social service programme, since 1993
Switzerland	Public health insurance (100%)	Public health insurance, since 1994
United Kingdom	NHS (100% of the population)	NHS, private insurance, and local government
United States	Private or employer-based insurance, Medicaid, Medicare, plus 15.5% of the population uninsured	Private payment, or Medicaid (for the poor, and for those who have spent down their assets)

Based on: Delnoij et al. 2001 [4]

In most of the countries presented in Table 1, problems of co-ordination and continuity of care are experienced along the ‘divides’ in the financing and regulatory systems of cure and care. As in the Netherlands, in the UK and the USA the demarcation between acute curative care and long-term care or social services causes problems and creates perverse incentives [6]. However, there are other problems too that hamper the development of integrated care. Shortell et al. mention e.g. cultural differences between the different organisations and professionals involved in the provision of care, and the small organisational scale of self-employed practitioners (especially physicians) [3].

Apart from that, health care systems carry burdens of the past. Health care systems are complicated constellations that—like oil tankers—can hardly make sharp turns. In Austria and Switzerland health care had always been very hospital-oriented. As a result, there is an overcapacity of the hospital sector and a lack of capacity in community services and long-term care. This makes it difficult in those countries to re-focus the health care system towards care in nursing homes or home nursing, even though the needs of the population demand such a reorientation [7, 8].

The fact that there are more factors inhibiting further integration in the health care system than financial barriers only is corroborated by the results of the workshop questionnaire (see Figure 2). The majority of respondents state that for their countries it is ‘true’ or ‘partially true’ that financial barriers, but also differences in the training and background of professionals and lack of trust (often referred to as ‘cultural’ differences) are blocking the integration in their system.

The workshop was concluded with a discussion on care arrangements for chronically ill patients. This discussion was based on an imaginative case of a 74-year-old widow with severe rheumatic arthritis. This widow lives in an apartment building in a small rural town in which there is only one community hospital. She has only one daughter who lives in the capital (two hours travelling), and an elder sister with a heart condition. The widow needs medical attention, but because of her impairments she also needs help with bathing/showering, cleaning the house, doing groceries and cooking. According to the respondents of the workshop questionnaire, in most countries this widow would receive medical attention from her GP (n=11). Help with showering would in most countries be offered by trained home helpers (n=9). Cleaning would be provided either by neighbours and friends (n=10), or trained home helpers (n=9). Meals would be provided most often by a special dinner service (n=8). Medical and nursing care are often covered by public insurance or a national health service. However, cleaning is either not covered or financed by local government as a part of social services. The Netherlands and Sweden are the only two countries in the workshop sample where cleaning services are covered by public insurance, respectively the National Health Service.

Discussion

The aim of this year’s workshop of the EUPHA section Health Services Research was to discuss the effect of macro characteristics of health care systems (e.g. financing and insurance systems) on the development

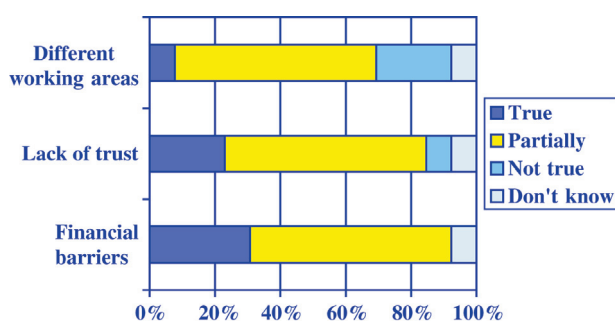


Figure 2. Factors hampering integrated care according to respondents of the workshop questionnaire (n = 13).

of integrated care. Judging from both the signals that are caught up in the literature on integrated care, as well as from the results of the workshop questionnaire and the related discussion during the workshop, financial barriers or important organisational divides (e.g. between generalists and specialists, or between ambulatory and clinical care) can indeed play a role in frustrating integrative processes. But the so-called 'cultural' differences between professionals or institutions may well be equally important blockades. Professionals and institutions defend the domains they acquired in the past and are not necessarily enthusiastic about sharing this domain with other providers.

The general conclusion in the workshop's discussion was that the development of integrated care under different conditions of financing and organising health care are a very relevant topic for health services researchers. A topic also that needs further study. There is a pressing need to develop measures of the degree of integration in health care systems (both on the meso and the micro level) that are valid across

different systems. Only then will it be possible to relate differences in the degree of integration to differences in financing or organising care in a more analytic way. However, it may take some more workshops of the EUPHA section Health Services Research before such an 'integration index' has been developed ...

About the EUPHA section Health Services Research

The European Public Health Association (EUPHA) consists of the national public health associations of 22 European countries. Public health researchers and practitioners are EUPHA-members through membership of their national associations. EUPHA organises an annual meeting and publishes the *European Journal of Public Health*. Within EUPHA there are sections covering different public health themes. Sections organise workshops on the annual conferences and can initiate activities in between conferences. The sections serve as a forum for discussion and a meeting place for researchers and practitioners that are active in the same field.

If you are a EUPHA-member and are interested to become a member of the section Health Services Research, please contact the president of the section:

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