

Projects and Developments

Integrated care at the crossroads—defining the way forward

K. Viktoria Stein, Mag., Institute of Social Medicine, Centre for Public Health, Medical University Vienna, Rooseveltplatz 3, A-1090 Vienna, Austria

Anita Rieder, Prof Dr., Institute of Social Medicine, Centre for Public Health, Medical University Vienna, Rooseveltplatz 3, A-1090 Vienna, Austria

Correspondence to: K. Viktoria Stein, Institute of Social Medicine, Centre for Public Health, Medical University Vienna, Rooseveltplatz 3, A-1090 Vienna, Austria, Phone: +43 1 4277 64680, Fax: +43 1 4277 64681, E-mail: katharina.v.stein@meduniwien.ac.at

Abstract

Introduction and background: The non-existence of a common terminology or standards in Integrated Care makes it difficult to compare experiences and results, whether on a national or international level, while the interdisciplinarity of the concept, both in theory and practice, proves to be a curse when it should be a blessing. Thus, we found it high time to bridge the gap, bring practice to theory and discuss the pressing issues of future Integrated Care research.

Workshop report: During the expert workshop, discussions were held concerning four overarching topics: (1) defining the common base for integrated care, evaluation and quality; (2) discussion on methods and tools, healthy environs; (3) governing and managerial prerequisites for integrated care and the future of integrated care; and (4) research questions arising from the workshop. The results were formulated into actions and research questions for the future.

Discussion: The workshop proved the necessity of consolidation in the area in order to foment the concept. Researchers should improve coordination and cooperation among themselves and draw from the various fields which deal with similar questions.

Conclusion: It remains to be seen whether integrated care manages to grow out of its baby shoes and establish itself as an independent and interdisciplinary field of research.

Keywords

integrated care, quality, evaluation methods, evidence base, research questions

Introduction and background

Integrated Care has become a buzzword among health professionals and the concept has sparked off numerous models aiming to reorganise the ailing European health systems. The experiences made so far with various Disease Management Programmes (DMPs) or regional integrated health systems have been as diverse and divergent as the health systems in which they are being implemented, with economic and scientific evaluation presenting serious challenges. Still, there is some common ground for the introduction and development of Integrated Care projects in European health systems: as has extensively been stated already, the ageing societies in industrialised countries along with a rise in chronic diseases and the rapidly evolving health technologies are causing

the costs associated with the health sector to reach the limits of (public) financing possibilities. Integrated Care is seen as an appropriate tool to react upon the situation by reducing inefficiencies and at the same time guaranteeing high quality care.

Building successful Integrated Care models brings with it many conflicts across the fields of economics, medicine, sociology, management theory and politics, among others. Hence, it presents itself as diverse, vibrant and contradicting as is necessary to meet the demand. The diverse backgrounds of integrated care propagators have also contributed to an extensive application of concepts and theories drawn from different scientific fields. That may be the reason for the non-existence of a common terminology or standards in Integrated Care, making it difficult to compare experiences and results, whether on a

national or international level. Thus, we found it is high time to bridge the gap and bring practice to theory.

The workshop on “Integrated Care—Exploring Concepts and Potentials at the Boundaries of Medicine and Economy”¹ provided the opportunity for established and young researchers from various fields to gather for two days in Vienna and discuss the status of research and the way forward in the field of Integrated Care. Our aim was to foster new ideas, formulate upcoming research questions and promote the topic of Integrated Care on an international level. The results of the vibrant and active discussions and contributions of our participants will be presented in this article and have already proven to be fruitful, initiating international cooperation and working groups.

Creating an agenda for Integrated Care

The programme of the two-day workshop, which took place at the Medical University Vienna from the 24th–25th of April 2008, comprised of four sessions dedicated to the main fields of activity and most pressing topics in Integrated Care:

- Defining the common base for integrated care.
- Evaluation and quality—discussion on methods and tools.
- Healthy environs—governing and managerial prerequisites for integrated care.
- The future of integrated care—research questions arising from the workshop.

Workshop sessions and discussions

Defining the common base for Integrated Care

There are many names associated with Integrated Care such as shared care (UK), transmural care (NL), managed care (USA, CH) or comprehensive care and disease management [1–4]. All models work with similar tools and at resembling problems, but differ significantly in scope and point of view. This leads to the problem of defining what Integrated Care actually is. It is often used as an umbrella term under which the aforementioned concepts—and many more—all find their place [5].

¹ Interested readers can get a free PDF of the final report of the workshop by contacting the corresponding author at: katharina.v.stein@meduniwien.ac.at.

Without a congruent definition, though, it is difficult to promote Integrated Care comprehensively in theory and practice. Herein lay the basis for the first tasks of the workshop: to discuss the necessity of a generally accepted definition, to define the core elements of Integrated Care and ultimately, to reach a common understanding on the topic. The questions to be answered were the following [6]:

- Do we need to further consolidate the definitions and frameworks or is it a waste of time?
- Do we need a common definition of Integrated Care?
- Do we need a common framework of core and complementary elements?
- Do we need to treat Integrated Care differently depending on its nature—project or institution?
- Is it viable to formulate a working definition over and over again?
- Do the stakeholders know what the “Integrated Care community” means by Integrated Care?
- Are our concepts ‘marketable’?

During the course of the discussion it became evident, that a clarification and common agreement on the core elements, technical terms and aspects of Integrated Care were a necessary quest for future research. Key to the formulation will be the question of how to underline the difference Integrated Care makes in delivering and organising health and social services and where the improvement lies compared to standard procedure. In other words, we will have to define the Unique Selling Proposition (USP) of Integrated Care.

Emphasis was laid on the development of a common framework by which one is able to assess whether proposed Integrated Care models actually are integrated. As a Canadian literature review has revealed recently, only half of Integrated Care strategies (in Canada and the US) actually are Integrated Care and similar findings probably are true for Europe [5].

Even though it is acknowledged that usually the focus lies on populations with complex problems and needs—where fragmentation becomes more visible or different health system philosophies become more evident—there was a common understanding that the definition of Integrated Care must not be limited. Evidently, the reasoning behind the argument is that by improving services for the most complex and vulnerable patients, eventually the whole system will evolve and adapt itself.

Hence, the conclusion of the session was that the development of a common definition and set of technical terms would be useful. Conceptual clarification is demanded to further pave the grounds for a common body of knowledge in the field of Integrated Care research and practice. Without this base, it is difficult to share insights and advance theory and practice.

However, researchers, policymakers and practitioners will not need a completely new definition. The Integrated Care field is not a nascent field. It has matured over the years, growing on interesting and relevant contributions to the conceptualisation and clarification of the meaning of Integrated Care. We should not set these aside, but use them to develop the common language and framework we need as the heart of our common body of knowledge.

This common language and framework should include the following elements:

- *Description*: a broad, but simple description based on the differential structural, cultural and strategic characteristics of Integrated Care.
- *Typology*: a typology of Integrated Care by typifying the foci, levels, types, forms, system orientations and strategies of Integrated Care.
- *Pluralistic perspective*: attention for the different meanings of Integrated Care for different actors in terms of focal points and goals.
- *Terminology*: the development of a unified set of terms.

Several (interrelated) strategies were discussed to follow-up on the idea to develop this common framework:

- The formation of an international group of researchers to tackle this issue.
- An analysis of literature (definitions, differential characteristics, terms etc.).
- A Delphi-study.
- A paper in the International Journal for Integrated Care (IJIC).

Evaluation and quality: discussion on methods and tools

Economic evaluation forms a key element of the concept, still posing many challenges. For once, scientific evidence is often insufficient due to incomplete data collection, a limited time horizon or diverging evaluation methods. The instruments most commonly used, such as the cost-effectiveness analysis and quality of life questionnaires, vary from country to author and randomised clinical trials (RCTs) are very difficult to achieve. Another obstacle to sound evaluation is represented by the lack of medium- to long-term studies, one reason being that many projects have only been implemented in recent years. The issue additionally touches the delicate subject of valuing human health with economic terms. All in all, the subject of evaluation offers a broad and fruitful range of discussion points to be addressed and thus was addressed in the first part of session 2.

Hindrik Vondeling posed the basic questions of economic evaluations to start with [7]:

- Is the service or programme worth doing compared with other things we could do with the same resources?
- Are we satisfied that the health care resources that are required to make the programme available to those who could benefit from it should be spent this way rather than some other way?

As a basis for selecting the appropriate evaluation method, one has to use the design that fits best to the actual problem and gets the most out of the data considering the time and money constraint. Following this principle, one often has to satisfy oneself with sub-optimal solutions. Still this should not be heralded as an excuse for confining economic evaluation to the simplest available methods.

Following this string of arguments, the question arose of how to advocate RCTs in Integrated Care or whether such trials were actually desirable considering the many obstacles (e.g. concerning randomisation, resources, complexity). The potential of a variety of randomised designs (parallel group design, cluster randomised trials (regions...), preference based trials) has not been exhausted in the field of Integrated Care. In order to overcome some of these issues the following propositions for future investigation were made:

- Learn from Public Health scientists who have already performed numerous successful RCTs under similar restraints.
- Research on why RCTs are so difficult to accomplish and deduce possible solutions.
- Identify and analyse successful RCTs in Integrated Care and apply those experiences to other areas.
- Assess the possible necessity of developing specific levels of evidence for Integrated Care to overcome some of the evaluation and measurement obstacles.

Quality is in itself a challenge, being a very perceptive concept and leaving ample room for dispute. Its definition is by no means static and depends heavily on the background of the persons and institutions applying it. As it is also a prerequisite for “good management”, quality and its measurement have found themselves in the limelight of most institutions—but not necessarily contributing to a qualitative output. As quality is often regarded as self-explanatory and self-evident, this disregard can produce quite unsatisfactory outcomes. Still, it is the key to Integrated Care and therefore, needs further delineation.

The discussion on quality in Integrated Care revolved around three core topics:

- the perspectives of quality
- the informed patient
- the measurement of quality

Undoubtedly, there are many influences on what one labels quality or not, including the cultural and professional background. Also, there can be different levels of quality identified. Notwithstanding, quality itself should be viewed as a neutral concept—the quality itself doesn't change, it's the perception that differs. This fact also explains why service quality does not necessarily equal service satisfaction in the clients [8].

During the discussion it became apparent that we only have incomplete knowledge of the cause and effects of Integrated Care which makes it difficult to pinpoint what actually creates Integrated Care. This leaves us with only a vague concept of quality in Integrated Care and no coherent definition of what good quality is. It has even been suggested that Integrated Care causes a “Hawthorne effect” [9], meaning that an improvement in inputs and outcomes is due to the fact that we are focusing our attention on the situation rather than to Integrated Care itself. We should also not underestimate the “added value created”, blinding ourselves with the conviction that Integrated Care is the philosopher's stone for health systems.

Quality in a health system and henceforth, in Integrated Care, is intertwined with continuity of care and with the patients' view on the system. It is, therefore, imperative to include their views in any future efforts to improve quality in service delivery. Consequently, this would also stipulate an informed patient since the level of information will also be a determinant of quality perception. The patient's perspective additionally opens up a broader picture since it is closely related to the caregiver's and henceforth demands recognition of their needs as well. Quality of Life and Quality of Care aspects are not to be forgotten.

A more concise idea of quality is also needed to improve quality measurement in Integrated Care. Here, the questions and comments centred on how to capture the different levels and perceptions of quality in existing indicators and whether there is a need for Integrated Care-specific indicators.

In conclusion, Integrated Care was agreed to be a long-term engagement which demands for special requirements not necessarily inherent in health professionals. It is a strategy to be managed. To raise awareness and levels of quality the following suggestions were formulated for further inquiry:

- Education plays a key role for quality, not only in patients but especially in health professionals which calls for a formal framework for Integrated Care.
- Quality is still a very lucid topic and further research is needed on the correlation between ‘abstract’ quality and quality perceptions.
- The cause and effects of Integrated Care have to be explored more rigorously in order to be able to define good quality service delivery.

Healthy environs: governing and managerial prerequisites for Integrated Care

The aim of the session was to identify the prerequisites for successful Integrated Care, to pin down the medical and structural frameworks which foster Integrated Care and which precautions have to be taken when implementing business management tools into the health sector. Or, can we manage an Integrated Care project like any other? Cooperation, teamwork and trust evidently play a key role. For this matter, Ingrid Mur-Veeman formulated the following introductory questions [10]:

- How to create a network focused perspective to realise Integrated Care?
- Is chain supervision and chain accountability feasible?
- How to arrive at joint funding arrangements?
- How to consolidate the position of chain management?
- What are the tools for shared service provision?

Along these lines the recurrent statement was that there already exists a wide range of evidence and literature on relevant subjects concerning management of networks, organisations and systems, if not always specifically for the health system. We should by no means disregard the abundance of research already undertaken and rather evaluate what we can adapt for Integrated Care. From there follows the analysis of those topics genuinely new or unexplored. As to who would be most appropriate for this task, suggestions included the WHO, universities and national reference centres.

The how was also answered, namely in a combination of action and desk research, underlining that learning by doing and learning by listening should play a pivotal role in the process.

Consequently, the role and achievement of innovation within research and the health system was discussed and accentuated. The conviction was expressed that there is a lack of innovation in the system. So,

to counter the persisting attitude that, “[t]he new is quite usually synonymous with the unreasonable, the dangerous, the impossible” [11], an awareness and atmosphere promoting innovation and an education towards achieving it will have to be created among health professionals and administrators. Innovation is not the same as invention; innovation is about newness which can mean taking an idea from one context and applying it within a different context [12]. Innovation in Integrated Care at a local level will, therefore, relate to translating lessons learnt elsewhere into this context.

So, in the future it is imperative that we start to investigate what kinds of outcomes different forms of Integrated Care can produce, for which groups of service users, and importantly what kinds of support mechanisms need to be in place for the staff working within these systems and the types of leadership and management behaviours which will be prioritised in these contexts. This evidence case is crucial and it will involve consolidating the extant literature and searching for mechanisms and the contexts within which these are enabled. At a local level the task will be to translate these mechanisms into specific contexts.

In the second part of session 3 the intention was to define lessons learned by bringing theory to practice and discuss project experience. The discussion didn't so much lead to a summary of lessons learned, but to several statements on factors one has to take into account when developing Integrated Care. These factors are summarised here as the Ten Commandments for Integrated Care [13]:

1. Beware of the “not invented by me”-syndrome. Bring the different actors together when making decisions on the development of Integrated Care.
2. But: don't invite everybody to the party. Only involve those actors that need to be involved.
3. Make sure you combine top-down processes with bottom-up processes.
4. Never lose sight of other diseases than the one you're focusing on.
5. Share your knowledge in order to share care. Knowing what the other does is integration in itself.
6. Don't use generic models. They are not specific enough for your context.
7. Choose your leader wisely. Good leadership is the cornerstone of integration. Find the leader with the right competencies.
8. Make everybody accountable for the quality and costs and pool your budgets. Integrated care is about shared responsibility.
9. Develop a good communication strategy to implement and diffuse your innovation.

10. 'Threaten' and 'intimidate' your people. Make them feel the necessity, the sense of urgency.

The future of Integrated Care: research questions arising from the workshop

Summarising the questions, outcomes and findings of the workshop, this was taken as a basis to formulate the tasks and questions for the future: which are the most pressing research questions? Which projects could arise from these? How will we work together in the future? And which are the trends in Integrated Care?

Conceptual work:

- There is common agreement, that there is an urgent need for a unified and universal definition and typology of Integrated Care. This shall be achieved by synthesising the three to four most commonly cited definitions into one.
- Furthermore, it will be necessary to specify the USP of Integrated Care and to explain what big difference Integrated Care makes. Here, it will also be an issue to clarify on side effects of Integrated Care and what the implementation means for every actor involved.
- For that matter, we will have to make an effort in building a comprehensive and coherent evidence base which is available to all.

Methodology and quality:

- A focus should be laid on study designs and their implications as well as the questions what trials are needed for which kind of Integrated Care.
- The issue of randomised controlled studies, how they are achieved and what alternatives there are is another major issue for the future.
- It is also suggested to create an encyclopaedia for Integrated Care.
- Transparency and quality are a hot topic for further research, suggesting the need of a cross-country study and further research into rankings and quality indicators.
- Quality indicators will subsequently need a weighting system which should be developed for Integrated Care in the process of defining the aspects and quality indicators. Here, the patient perspective and henceforth his involvement must be taken into account.
- Translate evidence to local needs will be another important task for the future.

Training and cooperation:

- In order to profit from each other's experiences and knowledge, it will be necessary to strengthen international exchange on all levels and connect via the INIC. In order to achieve this target and foment further development and research, national platforms or networks of Integrated Care could be established.
- Key issue will be to be more open and apprehensive towards useful inputs and research from other sectors, such as coordination, leadership or management.
- Much needed vocational training for professionals and academic training for young researchers should be provided via international training courses, summer schools, mentorship and, ultimately, the creation of a "Training Centre for Integrated Care".
- The future training of health professionals will also have to foster an innovational attitude and improve learning strategies.

Working groups and publications:

- The workshop agreed that one important way forward is to increase publications on the issues afore-mentioned and to initiate international working groups.

Discussion

The interdisciplinarity of Integrated Care forms a vital part of the concept. With a topic at the same time as private and as public as health, it is important to include all partners in order to improve the system, satisfying health personnel, politicians, local authorities and patients alike. Integrated Care has its theoretical foundations in social, economic and medical sciences, drawing input from fields of research as contrary as organisational theory, medical engineering and health economics. The interdisciplinarity is also represented in practice: an Integrated Care network may connect doctors, care professionals, physiotherapists, nutritionists, psychotherapists and pharmacists alike, all working together to improve health service delivery for the patient. Working in a multifaceted environment as this, whether as researcher or practitioner (in Integrated Care one often is both), offers inspiration as well as frustration. Competencies such as flexibility, team spirit and communication skills are key to success in Integrated Care. Admittedly, most research so far has been conducted by scientists and professionals focusing on their respective alleys of specialisation. The challenge now is to foster among Integrated Care proponents to risk a look over the fence and take on the task of

formulating cross-sector research projects—the only way to fathom the complexities and particularities of the field.

Throughout the workshop we heard a lot about how Integrated Care is difficult—difficult to do, difficult to evaluate, difficult to establish an evidence base. To paraphrase and adapt a phrase from mental health reformer and academic Peter Beresford (2007), "this isn't rocket science. It's much more complex and important than that" [14]. Integrated care is not about assembling a number of components and waiting for a specific set of impacts to arise, it is a much more complex set of processes which are influenced and interpreted by a range of different stakeholders. However, for all these difficulties there is a real danger in setting Integrated Care too far apart from other fields of study. Whilst there are a specific set of challenges which Integrated Care faces, much can be learnt not just from other national and international settings, but also from other sectors. Co-ordination is a challenge in all industries to some extent. Health and social care are different in some respects, but we will do the field a disservice if we do not draw on the vast amount of evidence that is already out there. [See for example 15].

Paving the way for a matured Integrated Care

While this workshop was certainly not the first to address these issues and questions, we hope it will be the last, since it is high time for the field of Integrated Care to grow out of its baby shoes and become an established field of research. For this to happen, we will not come around establishing a common body of knowledge including definition, framework and evaluation standards.

Integrated Care needs to be a means to an end and not an end in itself. This consolidation process will strengthen the concept and point the direction to future trends. The workshop has also shown that a tighter and more structured networking and collaboration across research fields and countries will be needed in order to achieve this goal and build a common framework for Integrated Care, flexible and adaptable enough to meet local needs while at the same time allowing for a congruent evidence base and improved evaluation and quality outcomes. With this workshop report we hope to vivify the international discussion and welcome any comments, suggestions or complaints on the subject. The 9th International Conference on Integrated Care, which is being held in Vienna from the 3rd to the 6th of November 2009, gives the perfect opportunity to present solutions and ideas to this discussion. For more

information, please visit the conference homepage at <http://www.integratedcare.eu/inic09vienna/index.html>.

Ingvar Karlberg, Prof., Department of Public Health and Community Medicine, University of Gothenburg, Gothenburg, Sweden

Reviewers

Peter Thistlethwaite, Editor Journal of Integrated Care, Independent R&D consultant, Plymouth, UK

Todorka Kostadinova, PhD., Medical University of Varna, Faculty of Public Health, Department of Health Economics and Management

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