

Editorial

Integrated care bridges the care gap

In 2011 the US National Health Expenditure is estimated to amount to \$ 9,216 per capita: that is 17.0% of Gross Domestic Product (GDP) [1]. The authors Heffler c.s. give the warning that for 2001 health spending grew faster than expected. In that year and in 2002 the real health spending growth, that is growth without inflation, is expected to average 6.6% per year. Nevertheless they used as a yearly growth rate 3.8% for the period 2001–2011 because of a continued impact of managed care.

Also in Europe there are signs that health care will grow faster than was expected until now. Europe as a whole will increase its expenditure on health care from 8% of GDP to 10.72% in 2005–6 [2]. The Blair Government in the United Kingdom envisages a much higher growth for the National Health Services than in previous years; a financial impulse of 6.5 bn Euro is expected by 2005 [2]. In the Netherlands, the economic institute Nyfer expects that a real health expenditure growth of 11 bn Euro is necessary in the next 4 years [3].

It will be difficult for the populations in the USA, Europe and especially the UK and The Netherlands to accept that faster growth is necessary to stay healthy. Their resistance will be high, whether the expenditures are financed by private insurances, out-of-pocket (USA), taxation (UK) or social insurances (The Netherlands). From this perspective, having better health means less private consumption on for instance housing, travelling and leisure activities. And yet those categories have a higher priority in the short term. Thus, a widening of the care gap can be expected in the period 2001–2011 between the needs of care and the supply of care.

The answers by professionals to bridge the care gap vary from country to country. In the USA, managed care has become popular and has diminished care costs, but the quality of care is doubtful, as has been shown by Robinson and Steiner [4] whose book is discussed in this journal [5]. Nevertheless, the old fashioned Health Maintenance Organization Kaiser Permanente (HMO) has, for the same per capita amount of money, better performances than the NHS

in England [6] although their cost calculations are not the strongest part of their publication [7].

In the UK, a NHS led by primary health care is seen as the best instrument to bridge the care gap, as is shown in this journal by Goodwin [8]. PHC is in his view the best threshold to keep patients in the community away from expensive hospital care. This, and the above-mentioned financial injections, should save the NHS in the coming decade. In the Netherlands, the hope is to bridge the gap oriented towards the market mechanism. Indeed, some publications show a higher productivity for commercial care providers [9], but recently other publications have shown less quality of care for for-profit organisations in comparison to their non-profit colleagues [10,11].

During the conference of the *International Journal of Integrated Care* on the premises of the Council of Europe in Strasbourg, 40 experts discussed research and development in integrated care. I came to the conclusion that the care gap needs a bridge built on three pillars. The first one is an impulse to preventive programmes which are focused on healthier lifestyles: more exercise, better food, less alcohol and tobacco consumption and less stressful jobs and other social roles. Without such an approach all extra money for health services is money thrown into a bottomless pit. The second pillar is a financial injection as is foreseen in the USA, UK and The Netherlands. The third one is the development of integrated care systems in which all patients are treated quickly and in the right place. In these systems, techniques such as working with case managers, protocols, gate keepers and electronic medical records are not a guarantee for effectiveness, efficiency and velocity. More important factors are: the satisfaction of health care personnel, the commitment to health by managers, the trust between professionals and the empowerment of patients. These values are not easy to measure and are more difficult to evaluate than the use of practical techniques. Nevertheless, we hope that this will be one of the topics to be addressed in the coming issues of IJIC.

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