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Integrated care

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In many countries of the industrialised world, healthcare systems are faced with a common challenge for the future. An ageing population implies an increase in the number of elderly people with several complex, chronic conditions. An appropriate answer to this new generation of elderly is integrated care that provides a broad spectrum of comprehensive, tailor-made health care and social services in institutions and in the community at large (1).

Definition of Integrated Care and Application at Hospital Level

It is care which appears seamless to the service recipients and which is devoid of overlaps or gaps to service commissioners and providers. Both across and within countries, integrated care appears in a variety of forms: 'shared care', 'continued care', 'disease management', 'transmural care', 'comprehensive care' and so on. These forms have in common that they are aimed at creating a coherent and coordinated set of services which are planned, managed, and delivered to individual service users across a range of organisations and by a range of cooperating professionals and informal carers (1). By engaging in integrated care arrangements, (university) hospitals create synergistic relationships that should secure their (academic) ambitions for the future (2). This may be all the more important for the position of hospitals in healthcare systems which have implemented regulated competition between care providers.

Challenges of Integrated Care

As a consequence, the challenge of integrated care is increasingly recognised. For example, it has been reported that in the Netherlands, general hospitals are involved in six integrated care arrangements on average, with a maximum of twenty initiatives. And of the eight university hospitals, three have been reported to be working on community-based integrated care arrangements. However, securing integrated care is complex as integration requires interorganisational and interprofessional relationships across sectors: public; private; voluntary; service areas (health, social care, housing, transport, education); levels of government and different models of governance.

One also has to take into account legislative frameworks, organisational arrangements, competencies of providers and issues of funding .

At a more aggregate level, three broad categories of factors can impede the creation of integrated care arrangements. These are financial barriers, organisational divides and 'cultural' differences between care providers or institutions (3). The remainder of this article will address financial barriers, and how to overcome them, focusing on the role of hospitals.

Financial Barriers for Integrated Care Arrangements

As recently illustrated in a contribution to this journal (4), financial barriers or problems may arise at one or a combination of stages in the development of integrated care arrangements (5):

1. At the time of the planning and running of a preparatory or pilot project. If a new care arrangement results in new types of provision of care or new types of consultations it is important to include the associated costs in the budget for the project. If such new forms of care cannot be sufficiently covered by e.g. local insurance companies, this may result in budget deficits while the project is ongoing.

2. After completion of the initial project, pertaining to the financing of its permanent continuation as a regular care provision. Already at the time of initiating the (pilot) project, the possibilities for permanent financing need to be addressed in case the project turns out to be successful, otherwise the arrangement may be short-lived. For example, perhaps changes in a DRG (diagnosis-related group) or DTC (diagnosis-treatment combination) are needed, or changes in existing fees or an entirely new fee for a new service is needed. Of course, there is also a possibility that no changes at all need to be made, e.g. in case the project results in cost-savings. Ideally, at the time of decision-making relevant information is

available.

3. After completion of the initial project, pertaining to the budgetary or general financial consequences to particular categories of care providers involved, or of a certain specialty. Integrated care arrangements may often have implications for patient flows in the health care systems. Changes (reductions) in numbers of patients may result in changes in income, which may result in particular groups of professionals opting out. Ideally, the financial consequences of the arrangement for all stakeholders is documented at the time of decision-making.

Expectations and evidence of effectiveness, cost-effectiveness and budget impact of integrated care arrangements It is often assumed that integrated care results in increased effectiveness and quality of care, while being cost-effective or even cost-saving at the same time. Although many authors agree that integrated care holds great promise, they warn against expectations that may be unrealistic, while supporting an evaluative approach. When searching the major electronic databases, such as Medline and Embase, it shows that relatively few studies have been carried out to date. Furthermore, the results of studies can often not be directly extrapolated to other settings. It can therefore be said that there is a need for evaluation in general, and a need for economic evaluation in particular as, as outlined above, and perhaps due to the relative immaturity of the field, many integrated care programmes are short-lived after initial funding by temporary subsidies and grants at either local or national levels runs out. A positive decision on long-term financing or reimbursement of services can be facilitated by a timely and high-quality economic evaluation demonstrating 'value for money' of the programme in question (see ref. 6). Likewise, an economic evaluation combined with a budget impact analysis could support decision-making on permanent reallocation of some share of, for example, existing hospital and/or home care budget on behalf of an integrated care arrangement, thus contributing to its long-term survival.

Conclusion

In summary, it is recommended to start projects aimed at the development of integrated care arrangements on the basis of careful financial planning right from the start. Analytical tools that may prove to be extremely helpful include the techniques of economic evaluation of healthcare programmes and budget impact analysis. If such research is carried out alongside the pilot project the results may contribute to a timely input to arrive at an informed decision on the future of the arrangement when the initial project has finished.

Integrated care is part of the redesign of healthcare systems, aimed at reflecting the needs of an ageing population and a change to the traditional ways of providing care. This is not only communicated by patients but is also high on the agenda of policymakers in the developed world. Healthcare systems of the future are likely to reflect moves away from services geared to acute episodes of care and towards self-care and co-production of health. And healthcare systems of the future are likely to be characterised by a redistribution of work and the creation of new types of healthcare workers (7). If hospitals adopt a pro-active approach to the challenge created by these anticipated changes, e.g. by engaging in integrated care arrangements, the rewards will be many. Perhaps more importantly, hospitals, by taking the lead in reorganising the healthcare system they are part of, will secure their relevance in treatment of future generations of patients.

For references, please contact english@hospital.be

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