# Integrating Health and Social Care: A global perspective of experience, best practice and the way forward

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Authored by the Institute for Applied Health Services Research (inav)

Foreword

Martin Duggan, Director, IBM Cúram Research Institute

When seeking health and social care services patients are confronted with a fractured system that can lead to many gaps and overlap in their care. Navigating these complex systems can be a major obstacle for an individual trying to reach positive health outcomes. This siloed approach to providing care doesn't only lead to poor patient outcomes but it also increases costs for the health and social care systems.

The solution lies with integrated care, splicing together the health and social systems to focus on single outcomes. This involves taking a holistic view of the patient, factoring in all of their health and social needs and aiming to reach outcomes rather than outputs.

This paper analyzes worldwide experiences of integrated care, bringing together case studies and looking at various different approaches to integrating care. It was written by the inav – Institute for Applied Health Services Research and was commissioned by the IBM Cúram Research Institute as part of the IBM Cúram Thought Leadership Series.

The IBM Cúram Research Institute is IBM's health and social policy research arm. Its mission is to foster the development of innovative service delivery models to raise the social and economic potential for people and society. The Institute is committed to undertaking and commissioning research with a focus on the cross-over from policy to service delivery. In order to analyze contemporary health and social policy issues and foster the development of innovative new ideas and solutions, the IBM Cúram Research Institute launched the Thought Leadership Series which involves running industry thought leadership Executive Roundtable events, commissioning research papers with policy experts and researchers, and holding workshops and interview sessions with health and social organizations in order to learn about and share industry best practices. The hope is to help organizations improve outcomes for all.

The inav – Institute for Applied Health Services Research, is a science, practice and policy-oriented consulting company that focuses on the field of Healthcare and was founded in 2011. Its objective is to develop and implement innovative solutions in the health sector.

I encourage people who work in the domains of health and social care to read this report in order to learn more about good practice in the area of integrated care from around the world.

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*All the information was researched and put together by inav ltd. with great care and to the best of their knowledge. However, no liability can be assumed for the content.

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"[…] We are sick of falling through gaps. We are tired of organisational barriers […] that delay or prevent our access to care. […]We want services to be seamless and care to be continuous.

That means primary and community health services, social care services, and services from voluntary organisations should all mesh together to help us succeed in managing our lives and conditions."

National Voices (2011), UK

Introduction

The World Health Organization describes health as being "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." If the definition alone is multifaceted and three-dimensional, why shouldn't the approach to health care delivery be the same?

The current system of care in most countries is fragmented and complex. The complexity of how care systems are designed leads to an array of problems and widespread inefficiency, along with an urgent need for change. A viable solution is an integration of health and social care into a coordinated system that takes a holistic view of the patient to improve overall outcomes.

Integrated care, the management and delivery of a continuum of services is an approach to healthcare that is characterized by a high degree of collaboration and communication among the professionals who provide services and treatments to an individual. The distinctive characteristics of integrated care are 1) the sharing of patient information among team members related to the care of the individual and 2) the establishment of a comprehensive treatment plan to meet the medical, psychological and social needs of the individual.

As we will see in this paper, the benefits of such an approach are many and extend to patients, caregivers, providers and the broader health care enterprise. These benefits include shorter hospital stays for the patient, lower costs for treatment, reduced recidivism, and improved quality of care. And just as the benefits and beneficiaries are many, so too are the settings in which integrated care may occur. It can occur in primary care as well as specialized medical settings, community based health clinics, mental health clinics, social services programs, and long-term care settings.

The key to making this work, is enabling the patient to navigate two different systems that, by themselves, are extremely complicated and fractured. When seeking health and social care services patients are confronted with systems that have many gaps and redundancies. Navigating these complex systems can be a major obstacle for an individual trying to reach positive health outcomes. The traditional siloed approach to providing care not only leads to poor outcomes but it also increases costs for the health and social care systems.

The solution lies with integrated care, splicing together the health and social systems to focus on single outcomes. This involves taking a holistic view of the patient, factoring in all of their health and social needs and aiming to reach outcomes rather than outputs. This

paper focuses on the benefits of an integrated approach to care, what it takes to provide an integrated approach, examples of where integrated approaches to care are occurring, and some of the key things to consider before attempting to implement an integrated approach to care.

The Value Proposition of Integrated Health and Social Care

Integrated care is a worldwide trend in healthcare reform. It is introduced as a response to the fragmented delivery of health and social services, an acknowledged problem of many health systems today. In this section, we examine the approaches to integrated care, the reasons why social care is important to the health of individuals, and the challenges of integration.

1.1 Integrated care – one idea, various approaches

Integrated care aims at connecting the healthcare system that is focused on acute, primary medical care with other human service systems, such as long-term care, education, or housing services, to improve outcomes such as clinical parameters, satisfaction, and efficiency (Leutz, 1999).

Integrated care is seen as an appropriate tool for reacting to the aging of societies that is accompanied by a rise in chronic disease burden and the rapidly evolving health technologies. As associated costs reach the limits of public financing possibilities, integrated care has the potential to reduce inefficiency and at the same time to guarantee high quality care.

Health is influenced by a complex interplay of physical, social, economic, cultural, and environmental factors. Therefore, health care must be seen in a broader context, with all stakeholders involved (WHO, 2007). To take into account this complex interplay, the term "seamless care" was introduced and refers to care that is delivered so transition from one component of care to another or between different components are seamless without any interruptions or gaps in information or follow-up. Therefore, continuity of care for the patient is maintained. Seamless care can be seen as an ideal characteristic of a fully integrated health care system (Jackson, Oelke, Besner, and Harrison, 2012).

However, integrated care has sparked numerous models that are as diverse and divergent as the health systems in which they are being implemented. Building successful integrated care models potentially can create conflicts that span the fields of economics, medicine, sociology, management theory, and politics, among others. Shared terminology and standards in integrated care are not common, so comparing experiences and results on a national or on an international level is difficult (Stein, Barbazza, Tello, and Kluge, 2013).

From disease-oriented to person-centered care – What needs to be integrated?

Over the last century, the achievements of modern medicine have been impressive. However, health systems have reached an important turning point. Healthcare has become

overly biomedically oriented, technology driven and doctor dominated. Specialization and weak referral systems have led to fragmentation and discontinuity of care (WHO, 2007).

As a consequence, the first generation of integrated care approaches aimed at delivering health care oriented at the demand side – the patient's perspective — rather than the biomedical and technology-driven provider side of healthcare (WHO, 2007). In this view, healthcare professionals focus on a person's condition and provide evidence-based treatment and care. Diagnosis and assessment are the gates to a care pathway (Khalsa, Vocci, Altice, Fiellin, and Miller, 2006).

In this disease-oriented understanding of integrated care, the focus was on improving communication and coordination between the various actors involved in the medical treatment of a patient case: family doctor, specialists, hospitals, and, if needed, rehabilitative institutions. Accordingly, acute medical treatment was of central concern.

This first generation of integrated care was certainly an important step. However, the concept falters at the point where a diagnosis does not lead to a single, definitive sequence of events. A person's condition might fluctuate over time, for example, in cases of long-term conditions such as diabetes mellitus or mental health problems. As a result, the kind and scope of treatment and care needed is not predictable. Thus, diagnosis and assessment do not lead to a single pathway, but to an ongoing process involving regular monitoring (Khalsa, et al., 2006).

A look at such complex care pathways reveals that in most cases acute medical treatment, for example, a hospital stay, only accounts for the shortest part of a patient's lifetime. A considerable amount of time will be spent in other care settings – mainly the individual's own home in the community. However, a person's need for care still exists, even after discharge from hospital. A tremendous amount of care is provided in those alternative care settings. Problems arising in this context cannot be managed in isolation but need to be understood in terms of their effects on the well-being of the patient. The person in need of care is situated in his or her individual social context with all its corresponding conditional factors. For example, an older person who falls might break a hip, but may also become depressed, so it might be important to view the two problems as linked. With this complex context in mind, a more comprehensive approach to integrated care that encompasses all adjacent sectors of service provision (preventive, acute, rehabilitative, long-term and palliative care) and combines acute medical care with social services is needed (Blatt et al., 2013).

That is why the aspect of person-centeredness entered the debate about integrating care. Person-centered care reflects a bio-psychosocial perspective on health. It acknowledges the fact that health problems are not limited to simply biological terms or diagnoses. Rather, health conditions or diseases are simultaneously medical, psychological and social problems

(Valentijn, Schepman, Opheij, and Brujnzeels, 2013). It implies that delivery of care is organized around the health needs and expectations of people and communities (WHO, 2013).

Since care is co-produced, "integration" only qualifies as such if the services integrate at the point of the consumer (Khalsa et al., 2006). Simply bringing systems and structures together, without making the services more responsive to their users, will probably mot meet its goals (National Voices, 2012). When patients can express a preference, they should also be able to influence important features of their care.

Person-centered care aims at enabling people to understand their health status and their care and treatment options in order to involve them in decision-making. It also takes into account the needs of families and caregivers, as they are the principal coordinators of appropriate services. Integrated care services should respond to their needs and acknowledge them as full partners in the delivery process (National Voices, 2012).

Integrating health with social care

To provide integrated care, social and health care should be connected at the point where vulnerable populations – disabled, socially disadvantaged, older, ill, and so on – are in need of medical services. This section explains the importance of social care to an integrated health system.

Social care - a complex service system

Social care can be understood as an even more complex service system than healthcare. Social care – or its frequently used synonyms social welfare or social work - seeks to improve quality of life and subjective well-being of individuals, groups, and communities who are in need or at risk of being in need.

Usually those groups are children, young people and their families or adults, including older people, people with mental or physical disabilities, people suffering from alcohol and substance abuse, and social, ethnic, or racial minorities.
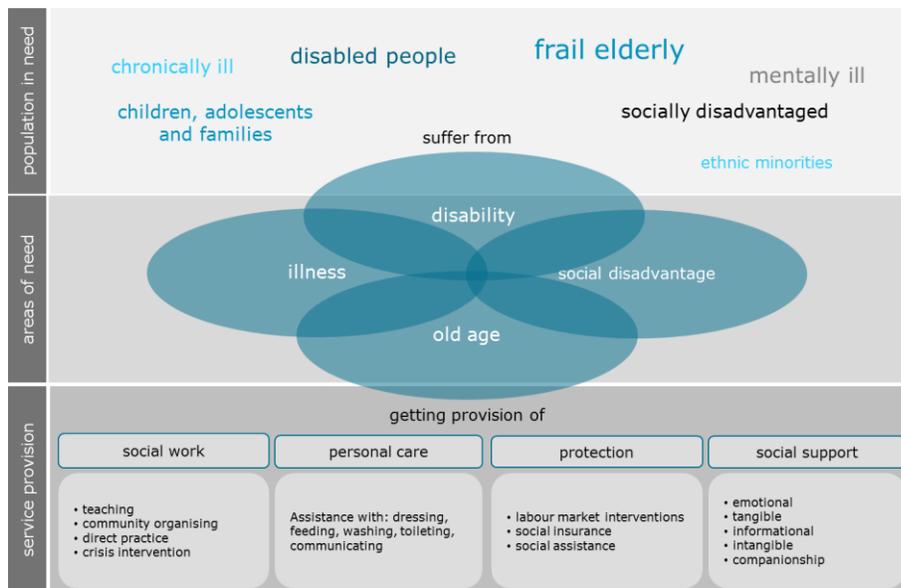
Source: Own illustration.

Social care needs mainly arise from illness, disability, old age, social disadvantages, or injustice (areas of need). Each area of need is to be answered with a different level of specialist services. Therefore, social care delivery encompasses action through research, policy, community organizing, direct practice, crisis intervention, and teaching.

Why does social care in health issues matter?

> *"People don't want health care or social care, they just want the best care."*
> Norman Lamb MP, UK government

Healthcare can be simple and linear. Consider, for example, a 65-year old pensioner who is in need of an artificial hip joint. His family doctor refers him to a specialist who cooperates with a hospital where the intervention – routine elective surgery – will be carried out. The inpatient treatment is followed by a period of rehabilitation, within which the patient already recovers well. When he returns home, his wife cares for him. The family doctor controls the long-term course; the intervention proceeded without any complications. The patient pathway is manageable; only a low level of cooperation between the involved providers is necessary.

Now, imagine a 55-year old man who falls due to a stroke and injures his hip. He is widowed and is living alone in a little one-room flat in the fourth floor of an apartment house. His children live far away. The relationship was broken down a long time ago. After hip-replacement surgery the man remains disabled with limited language capability. As a consequence, he loses his job and retires early. This man is now in need of a new apartment that is accessible. However, the higher rent of a new apartment in addition to

expenses for medication and medical aids amount to a high financial burden, especially in relation to his low rent. Due to the sudden physical disability in combination with social isolation and financial worries, this man becomes severely depressed. His alcohol disorder, which has been under control, re-occurs.

In such cases, linear care delivery pathways must be replaced by a more network-like pattern of service delivery. The integration of social care services into the provision of health care is becoming especially relevant in the case of vulnerable patient groups such as older people with multiple health problems or long-term conditions, persons from socially disadvantaged groups, or people with disabilities.

Complex care journeys can encompass transitions between locations (hospitals and people`s homes), sectors (acute care and social care), and individuals' personal conditions (illness and recovery or acquired disability). Appropriate care could also involve private and voluntary organizations in order to provide a wide range of services, some based in people's own homes and others in non-acute-hospital residential settings.

In the case of the 55-year old disabled and depressed man, he could be informed about adaptations to his current home environment that might be cheaper than changing apartments in the long run. To make sure he gets timely help in the likely case of another stroke, the man is equipped with a domestic emergency call system. This system enables him to quickly get in contact with a service point in case he is in need of help. Additionally, a community nurse monitors his vital parameters to detect early symptoms of

Are home-care schemes divided according to social and health services?

- Yes: 81%
- No: 19%

deterioration of his condition. A social worker supports him regularly, for example, by helping him search for a suitable psychotherapist to treat his depression and alcohol disorder, or helping him organize administrative processes. A volunteer visits the man several times a week to play cards or go for a walk with him.

What the example shows is that the distinction between health care and social care is artificial since needs are inevitably interwoven. Social needs in times of abuse, poverty, and lack of social support are closely linked to poor health outcomes (Blatt et al., 2013). From the perspective of patients, integrating health and social care makes sense as individual needs can affect each other, amplifying disabilities, which results in more complex and profound harms. Immobility breeds isolation, and isolation breeds depression. Or in other words, health and social needs are two halves of a whole person (Boland, 2013).

The challenge: different competencies, different access, different financing

Even though it appears self-evident to combine health care with social services, implementation is bound by, in many cases, the lack of sufficient national legislation and regulation.

Fragmented governance structures of health and social services in most countries is the main challenge. In many countries, the level of integration of governance is low (Royce, 2013). This means that social services are organized in a distinct system that encompasses distinct responsibilities, budgets, and personal qualification and capacity plans. When comparing home care delivery systems in Europe, 25 out of 31 countries (81%) have two distinct systems for health care and social care respectively.[1]

In 17 of the 31 European countries with two distinct systems, responsibility for home care is divided between ministries. But, even where there is one integrated ministry for both social and health home care services, responsibility for financing and regulating home care may still be divided over different levels of governments. Regulation differs among state, regional or municipal responsibility. A rather strong level of integration can be seen in Finland, Norway, and Sweden where, in general, there is only one homecare scheme in place and one governmental unit is responsible for policy-making (Genet, Boerma, Kroneman, Hutchison, and Saltman, 2012).

New policies to promote integrated care are difficult to implement in national health care systems, as legislation is inflexible. Actors are afraid of losing their status, power, and position and therefore often refuse to support change. This strengthens historically based structures and policies that provide an inappropriate environment for integrated care (Mur-Veeman, Hardy, Steenbergen, and Wistow, 2003).

The social care system in many countries, in contrast to most health care systems, is more often organized at the local level, has a lower level of professionalization, and is less generously funded (Genet et al., 2012). Delivering social care often entails informal networks of support and assistance, as well as services funded after assessments by social workers and other professions what makes it even more fragmented and complex.

Financial boundaries like those in the home care sector may hinder the implementation of integrated services. However, countries are working to respond to them:

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[1] yes = Austria, Belgium, Cyprus, Czech Republic, Denmark, England, Estonia, France, Germany, Hungary, Iceland, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Switzerland; no = Bulgaria, Finland, Greece, Estonia, Lithuania, Sweden

Challenges in funding home care services and solutions from European countries[2]
poor funding
o **new financing mechanisms (LV, PL, plans in DE)**
o **childless people make higher contributions to long-term care insurance (DE)**
o **competition among providers (NL, EN, IR)**
o **client co-payments/means testing for middle class and for higher earners (RO)**
o **transparency of costs (FI, NL, HR)**
o **rationing services (most countries)**
o **preventive home visits (FI)**
o **group approaches: supportive communities (CZ)**
o **increasing efficiency (LV, CH)**
No earmarked budget for home care
o **transparency in health and social care budgets (NL)**
Unfair differentiation in payments
o **payment related to case load; case mix; quality (BE, EN)**
Lack of (national) regulation
o **quality control over providers (NO)**
o **centralized decision-making (FR, CY)**
o **more transparency of expenditures on home care (NL)**

Source: Adapted from Genet et al., 2012.

Despite all efforts to integrate healthcare over the past decades, the level of integration at the organizational level is still unsatisfactory with regard to the reorganization of primary care as well as the integration of primary and secondary care. Great numbers of people with complex health needs have no family physician and case management is still very rare in primary care (Vedel, Monette, Beland, Monette, and Bergman, 2011). Many countries face difficulties in providing adequate access to care for patients due to an insufficient number of family physicians and specialists. The heavy workload imposed on these professionals creates an additional barrier to collaboration. Furthermore, poor hospital discharge planning has been identified as a primary factor contributing to poor outcomes for seniors after hospitalization (Khalsa et al., 2006). The performance of care processes is still assessed in silos, resulting in readmissions within a vacuum of responsibility for providers. Gaps in clinical information sharing reinforced by an insufficient use of information technologies are further major barriers to coordination.

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[2] *AU: Austria; BE: Belgium; BG: Bulgaria; CH: Switzerland; CY: Cyprus; CZ: Czech Republic; DE: Germany; DK: Denmark; EE: Estonia; EN: England; ES: Spain; FI: Finland; FR: France; GR: Greece; HR: Croatia; HU: Hungary; IR: Ireland; IT: Italy; LU: Luxembourg; LV: Latvia; NL: the Netherlands; NO: Norway; PL: Poland; PT: Portugal; RO: Romania; SE: Sweden; SI: Slovenia; SK: Slovakia.*

One of the biggest challenges might be that integrated care takes time to be established, developed, and improved, and so does demonstrating its benefits. If integrated care is forced to demonstrate short-term gains, especially in the field of use of resources, it is in danger of being misjudged. Therefore, pioneers of integrated care must be given clear permission to experiment. Stakeholders must commit for the long term – longer than is the norm in politics (National Voices, 2012). Stakeholder buy-in is just part of addressing this challenge, however. Integrating care requires much more.

What it takes to integrate care: People – concepts – contracts

Obviously, health and social care providers, stakeholders and organizations play a pivotal role in the integration of health and social care. But a successful integration also requires the participation of many others outside the realm of care professionals, along with new and revamped concepts and contracts for success.

People supporting the change

The impact and outcomes of care are highly reliant on the people delivering it. The care workforce is therefore a precious resource. Change with a higher degree of integration affects staff, for example, in terms of working hours, new skills, new relationships or even a new work base or profession (Blatt et al., 2013).

Moreover, integrated care is a relationship business. Irrespective of structures and processes, success depends on the trust, mutual commitment and collaborative goodwill of people involved. A study on the introduction of an electronic patient file system in the Netherlands showed that those with high interest in the system lacked the power to implement it, while those with low interest in the proposed system had the power to block it. These negative attitudes were shaped by concerns about the system itself rather than the likely effects on that profession's working routines, power, culture, and financial arrangements (National Voices, 2011). Thus, system implementers should seek to identify and reconcile stakeholder interests (King et al., 2012). For instance, most examples of integrated care from the last few years had been initiated by providers rather than commissioners (National Voices, 2012). However, provider-led initiatives are likely to result in service redesign that meets the interests of the specific providers and not the patient's, service user's or caregiver's needs.

Additionally, a comprehensive part of care work is done by families and other informal caregivers. These caregivers are often the principal drivers when organizing appropriate packages of services. Integrated care services need to be designed in a way that integrates them as partners. That means that services need to respond to the caregivers' interests, and they should be involved in consultations, provided with information and answers to their questions. Caregivers should be seen as part of the team working with the patient.

Managers and professionals in integrated care should therefore recognize that assessing caregivers' needs is crucial to the success of care overall (National Voices, 2012).

Professional cultures in integrated care

Care delivery structures are embedded in various cultures on different levels, such as national (values, traditions, religion, political ideology) and organizational or professional (physicians, nursing personnel, social workers). The influence of culture when integrating care is often underestimated. Nevertheless, it is essential for comprehensive change because such change requires different attitudes, willingness to invest time, and the will to seek consensus and agreements over tasks and autonomy (Mur-Veeman et al., 2003). Integrating care will require reshaping professional cultures since the connection of formerly fragmented systems will lead to the connection of teams or professions that are embedded in different social systems. Its members differentiate their roles, share common goals, interact with each other, and perform tasks affecting others (Taplin, Foster, and Shortell, 2013).

These differences can be perceived as barriers to effectively working together. Research shows that social work values were not respected by health professionals, leading to a lack of appreciation of the contribution made by social workers in multi-professional teams. Also, social workers based in multi-professional teams experienced higher role conflict and more stress compared with their colleagues (Cameron, Lart, Bostock, and Coomber, 2014).

Furthermore, health and social care staff differed in terms of the type and level of decisions they are allowed to make. Social workers are authorized to make decisions about home care and services, household services, safety alarms and special housing. A general knowledge of the welfare system enables social workers to decide to contact other authorities to prompt applications for trustees and to refer to hospital counsellors. In contrast, municipal nurses decide on home nursing and personal devices, and tend to refer to other parts of the healthcare system due to their knowledge on a wide range of health and medical services (Duner, 2013).

Duner (2013) investigated two different care planning teams in Sweden, one that worked in the homes of older individuals and one that worked in hospital wards, that involved social workers, municipal nurses and rehabilitation professionals (Duner, 2013). Integration between the professionals involved was most noticeable during the investigation and assessment phase, while it was lower during the planning phase and almost nonexistent during decision-making. The role of social workers was described as investigating needs for and making decisions about home help or special housing, mapping the social network and everyday life of the older people and determining whether they needed or wanted to be engaged in social activities. Rehabilitative professionals pointed out similarities between their and the social workers' roles in terms of focusing on everyday life and a holistic

approach to the patient's needs. However, they (the rehabilitative professionals) focus on the physical, while social workers stress the social context (Duner, 2013).

The work of care and social professionals is based on knowledge acquired after several years of academic training. Identifying oneself with a body of knowledge is perceived as having intrinsic value and it enables one to undertake complex tasks. As long as health and social care professionals retain a monopoly over their skills and control the supply of labor, they are able to exercise considerable power. To implement integrated care, professionals need to be aware of the importance of the plurality of knowledge, and be sufficiently confident of their own contributions and limitations to allow for adjustment and negotiation. Trust and respect between professionals are key to the success of working together (Cameron et al., 2014).

Working in a team with other professions can lead to more confidence in one's own professional role. Personal specific knowledge can be deepened and expanded when enriched and informed by the knowledge of other professionals (Duner, 2013). In recent studies, team building events and regular team meetings were reported to foster understanding about the various professional roles. They also build trust between different groups as they helped to not only build a common sense of purpose but also provided an opportunity to discuss cases and to share information (Cameron et al., 2014).

Leadership in integrated care

Leadership is the key to making cultural change happen. Leaders create visions and communicate the purpose of integrating care, making change relevant for all parties involved. Leaders are the ones who ensure that all manifested cultural and behavioral patterns will be adapted in line with changing structures and processes.

When fostering integrated care, the role of leadership is often underestimated. Strong management and appropriate professional support, however, are important elements of successful team work, whether in relation to integrated services or the inclusion of social work staff in GP practices, for instance. Strong leadership can contribute to the staff feeling more confident in their new team or role, can help improve the understanding of the aims of the initiative and can contribute to better outcomes for service users (Cameron et al., 2014). Therefore, leaders should work towards creating an organizational culture that values teamwork by:

Encouraging teamwork training to establish important skills

- Providing time for teams to meet and do team tasks such as reviewing the day's plan
- Finding ways to reimburse or recognize all team members for teamwork
- Helping teams map their work flow and clarify roles to improve functioning

- Involving teams in decisions that affect them, which in turn improves team member loyalty, cooperation, and retention
- Creating a culture of safety where medical teams are more likely to reduce medical errors

In practice, several studies reveal the presence of separate management structures as a frequent factor that undermines effective collaborative working. For some professional groups, the absence of effective management is often reflected by a lack of experience in management (Cameron et al., 2014).

Concepts making the difference

Moving care delivery systems toward a higher degree of integration requires the consideration not only of structures but also of processes and patterns. Structural changes make a good starting point by leading to comprehensive process enhancements.

However, all too often organizational changes in healthcare are limited to just changes in structures whereas patterns that drive thinking and behavior are neglected. This leads to reorganization that often fails to achieve fundamental changes in values, trust, or communication between the various groups that are needed.

According to Leutz (1999), integrated care comes in three varieties:

Linkage	Coordination	Full integration
• health and social care providers attempt to work together more closely, but still function within their respective silos • with the constraints of anachronistic operating rules and separate funding streams	• rebalancing of the system through purpose-built structures • mechanisms to bridge gaps between services and users • help to alleviate poor communication and the lack of information-sharing without overhauling the existing system	• combining responsibilities, resources and funding for long-term care from multiple sectors under one roof • creating bundled financing, global management and unified service delivery

Source: Based on Leutz, 1999.

Each model of integration has its advantages as well as downsides. Crucial to a successful delivery of integrated care, however, is a sound governance structure and a strategic framework with the involvement of all relevant stakeholders (Cameron et al., 2014).

Principles of integrating health and social care

So far, there is no single correct way to integrate care. Following the recommendations of the National Voices in UK, generic principles have been derived. These can be used to stimulate change and measure progress. National Voices is a national coalition of health and social care charities in England that calls for integrated care to be developed quickly and at scale (Royce, 2013). This coalition represents the interests of patients, service users and caregivers. However, their discussion mirrors the arguments of most literature.

Inclusion of local communities and the voluntary sector

Integrated care must be local. This means service providers need to be socially and culturally competent to provide appropriate access and specialized socio-medical services. Voluntary and community sector organizations play a significant role in the delivery of care, especially on the local level. Therefore, they should be considered on an equal footing with formal health and social care services. They support people through help lines, information provision, care advisers, peer support groups, or specialist nurses so they can better cope with their situation. When designing care processes, an assessment of the possible input of the voluntary and community sector should always be integrated.

Considering long term conditions

The continuing rise in the number and proportion of people with one or more long-term condition challenges current models of care that are mainly based on episodic patterns. Since people with long-term conditions use more services over a longer period, integrated care offers the greatest potential to improve quality of care in this context.

Value-based care delivery

So far, experiments in pooling budgets or joining organizations have been mostly aimed at saving money. The focus of value-based care delivery is on the value generated for patients rather than just on lowering costs. Increasing value for patients means increasing the quality of patient outcomes relative to the money expended. Cost savings should arise from increased efficiency rather than from cost shifting, rationing, or reducing quality. Therefore, the full cycle of care - not limited to single medical conditions and disease episodes – needs to be considered when evaluating the effect of integrated care (Porter and Teisberg, 2006).

User-oriented outcomes evaluation

Assessments of the delivered care should be based on outcomes. The belief is that high-quality care is less costly. Innovation that increases value must be rewarded (Porter and Teisberg, 2006). Considering the aim of person-centeredness, outcome measures should be a mix of clinical parameters and patient-reported measures. Only patients, service users

and caregivers are in a position to report whether the service received was better from their point of view. Evaluations of integrated care must focus on whether the stated outcomes are achieved.

Elements of integrating health and social care

When looking at numerous integrated care models, key elements can be identified that are employed in most of the successful approaches – regardless of country, purpose, target population, or timeframe.

European countries' responses to challenges in integrating home care services	
poor integration of different types of home care	interdisciplinary teamwork (NL, IR, IT) defining roles and boundaries of health/nursing care and social care/domestic aid (EN) financing of coordination time (BE)
poor integration with nursing homes and hospitals	liaison nurses for hospital discharge (NL, ES) case managers for clients with chronic conditions (BE, EN) transmural networks or teams (FI, BE, NL) common electronic client record systems (FI)

Source: Adapted from Genet, et al., 2012.

Inter-professional, multi-agency working and co-location of services

It is uncontroversial that integrating care requires advanced cooperation and coordination between different professions. In literature related to integrating care, "inter-professional working" (IPW) has been established as a useful umbrella term for different ways of working that support health and social care organization integration. It encompasses a wide range of approaches to working that span disciplines and agencies (Goodman et al., 2011). The underlying idea is to achieve a comprehensive assessment of a patient's care needs from different professional perspectives (Duner, 2013).

Goodman et al. (2011) researched how IPW for older people was represented, delivered and evaluated at the organizational and professional levels. Health and social care organizations and their managers recognized the value of IPW. However, the complex mix of allegiances and contexts of care that influences how IPW is achieved at the different levels of service delivery makes it difficult to capture its effectiveness.

Integrating health care and social services often brings together not only different groups of professions but also different agencies from the welfare sector in order to work on one mutual concept of care. Widmark, Sandahl, Piuva, and Bergman (2011) studied the collaboration between professionals in health care (county council), social services (munici-

pality), and schools (municipality) in Sweden. The authors identified several challenges in forcing multi-agency work (see also Cameron et al. 2014).

Challenge 1: Allocation of responsibilities

Organizations face widely varying missions, regulatory frameworks and offer different kinds of services. Some organizations' activities target a wider population (general services, such as schools, child health care for all children), whereas others applied to specific groups (specialist services, such as pediatric medical care, child psychiatry). Services can be mandatory like schools or voluntary. Even some activities in health care and social services also have the authority to make decisions about children without parental consent.

Challenge 2: Confidence

Sometimes professionals feel that their collaboration partner lacks commitment. Mostly this situation is caused by lack of knowledge about the other professionals' skills in assessing client needs, their way of working, and the resources the other organizations could provide.

Challenge 3: The professional encounter

Organizations are different in both culture and structure as they use different models (psychological, medical, social, and educational) to explain how work with their clients should be conducted. This brings with it, that client's needs are viewed from different per-spectives in dependence of the organization's model of work.

Where the allocation of responsibilities and the partner's mission or model of work is unclear, interaction is challenged. Professionals are unsure about what they can expect from the other organizations. Ambivalence about confidentiality rules, which were handled differently by the different organizations, emerges. In these cases, collaboration is often felt as being too extensive and time consuming. Thus, the parties involved tend to be hesitant about or even opposed to communication.

In conclusion, successful multi-agency collaboration requires:

- Joint management of collaborating organizations to foster and maintain collaboration
- A common interest and trust between all stakeholders
- Professionals' motivation for the joint task
- A clear understanding of the factors that impede or promote collaboration

In terms of multi-agency work, the question of collocation of services is also discussed as an element to the success of working together. Collocating services is associated with encouraging informal contact, and in consequence increasing mutual understanding, quicker and easier communication and facilitating learning that spans professional boundaries. However, this view is not universal. Other experiences of multiagency working show that greater informality had the potential to undermine professional practice (Cameron et al., 2014).

Case management and single care plans

Case management comprises a collaborative process of assessment, planning, facilitation, care coordination, evaluation of, and advocacy for options and services to meet an individual's and family's comprehensive needs. It requires communication and availability of resources (Chiatti et al., 2013). In the debate on integrating different health services across the single sectors, the importance of case management has been already recognized. However, when adding social care components to the provision of health care a new dimension of case management is needed (Blatt et al., 2013). The original focus on a "case" must be broadened toward focusing the person and his or her entire socio-economic context. With this, single care planning becomes more important. Single care plans incorporate both health and social care inputs for the person in need of care (Curry et al., 2013).

In a southwest London integrated care pilot, professionals expressed enthusiasm for the idea of care planning, but also reported dissatisfaction (58%) with the extra time required to create a care plan. There lies a danger in increasing the number of plans to be completed, as the process may eventually become a "tick or check box" exercise. Also, patients appreciated having a single care plan. They felt that they were involved in the design of their care plan in the way they wanted and that they were part of the decision-making process regarding their care. Patients reported a better relationship with their general practitioner and an increased understanding of the roles of different health and social care professionals involved in their care (Curry et al., 2013).

Single shared assessment

Single shared assessment describes arrangements whereby others accept an assessment undertaken by one professional, either in their own or another service setting. It is expected to reduce duplication, delay and inefficiency (Abendstern, Hughes, Clarkson, Sutcliffe, and Challis, 2011). In England, for example, the Single Assessment Process (SAP) was introduced in 2004 as a rationale for the planned roll out of the NHS Care Records Service in 2010, a national database that provides information on both health and social care needs and interventions, available to health and social care professionals (Abendstern et al., 2011).

Single shared assessment usually requires deployment of information and communication technology (ICT). ICT has increasingly been seen as an important enabler for integrated care. Nevertheless, its implementation is falling short of expectations in most countries. This is confirmed by a current survey that attests to a limited use of information technology to support the single assessment process in England. The majority of respondents complained that information technology was not sufficiently developed to permit assessment information to be shared between professionals and agencies. The use of information technology was also constrained by lack of hardware or insufficient staff (Abendstern et al., 2011).

Despite these difficulties, cases of successful flow of information between some professionals and agencies were also reported. The professional groups most frequently engaged in single shared assessment are social workers followed by district nurses and occupational therapists (Abendstern et al., 2011).

Single Shared Assessment (SSA) in Scotland
Single Shared Assessment (SSA) is part of a Scottish government strategy to improve community services for users by redesigning the assessment system that people go through at home when they need to access those services. Thus, previously separate systems in finance, management, and the delivery of services are being brought together to provide a more holistic approach to service delivery, with the aim of streamlining and speeding up the process of assessing an individual's need for services. SSA is designed to benefit the people who use the services, the agencies and the professionals who deliver the services. SSA aims to be person-centered and led by a single professional with other specialist involvement as appropriate. Based on King, et al., 2012.

Information and communication technology

ICT enables those who deliver health and social care to exchange patient data without being constrained by time and distance. Access to timely and accurate data about patients and their treatments is associated with better care at less cost (Cameron et al., 2014).

In the "Luxembourg Ministry of Health e health Service Platform Study," the founder and director of the Global E-Health Forum, Ljubisav Matejevic, verified the potential of interconnected systems. In times of limited budgets but increasing demand for high-quality healthcare services, new cost-efficient and reliable technologies are ready to face many of the arising challenges (PWC, 2010). Policymakers also recognize technology's potential to promote information sharing. Unfortunately, many local successes are not extended to a national scale or integrated with other parts of the health or social care system.

Boundaries of ICT-implementation are discussed in all countries. In France, ICT adoption was promoted through a recent incentive scheme for GPs and specialists. So far, Estonia is the only country where a national Electronic Health Record (EHR) system is in place, and STAR - the social care ICT system – is being mainstreamed on a national level. In terms of ICT for Health, Denmark and Scotland show remarkable developments (Cameron et al., 2014).

Catalonia is also engaged in advancing its ICT structure. In order to overcome the historically grown diversification in its healthcare system, the Catalonian government established "The Health Plan of Catalonia 2011-2015" (Departament de Salut, 2012). ICT became a strategic component in the restructuring of the health system as the new health plan encompasses the development of a more interactive and interoperative Health Information System.

The two key elements to develop ICT according to the objectives of "The Health Plan of Catalonia 2011-2015" (Martínez, 2014):

The Electronic Health Record of Catalonia (EHR)

The EHR of Catalonia serves as an information and services network that allows organized access to relevant information of different centers' health records and to some central databases of the health system. Thereby, the EHR is not simply the sum of the electronic records of the healthcare centers as it does not incorporate all the information from medical records.

Personal Health Channel

The EHR is complemented by the deployment of a multichannel network to communicate and interact with the citizen. The Personal Health Channel enables the citizen to be the holder of the health data contained in his or her medical record. He or she gets access to its health information available in its Electronic Health Record.

The following strategic plan for the implementation and deployment of the platform for the management of healthcare and social processes in Catalonia has been developed:

Summary of Processes Governance i-SISS.Cat

Government programs:
- Creation of programs and tracking key performance indicators (KPIs).
- Allocation of KPIs for each program.
- Display of results for program and service provider.

360 ° view of the patient:
- Access to the broad view of the patient and the process (the supplier can decide to use this functionality or not).
- Environments of collaboration between professionals.

Healthcare process integration:
- Social and health-related information sharing of the patient by the definition of integral processes.
- Unique file generation and healthcare.

Integral vision of the citizen:
- Platform that will allow us to expand the coverage to other social benefits and giving coverage to the unique social, labour and health record.

Source: Adapted from Martínez, 2014.

The implementation process is planned to be finished in 2018 (see also section 2.3).

King et al. (2012) explored the way in which structural, professional and geographical boundaries affected e-health implementation in health and social care. Most health care IT systems were poorly integrated into clinical practice. This is caused by several factors, such as failing to change working processes to accommodate the system and using monolithic systems, which were hard to adapt to local conditions. Implementing an inter-organizational system requires significant organizational as well as technical changes that have been mostly underestimated.

Boundaries in implementing ICT

structural boundaries

Shaping respective priorities, IT systems and ability to cooperate

- lacking integration into clinical practice
- underestimation of necessary organisational and technical changes
- different levels of equipment and application knowledge between involved parties
- unclear financial arrangements

geographical boundaries

Affecting the respective understanding and acceptance of the aims of IT

professional boundaries

Affecting the respective understanding and acceptance of the aims of IT

- pertinent structural preconditions in rural/remote areas
- Fundamental boundaries between primary and secondary care settings
- Different local funding support

- Different profession specific information requirements
- Bounded willingness to share information

Source: Based on King, et al., 2012.

Cross-sectorial IT services generally involve multiple stakeholders with different professional cultures and competing interests, which creates or strengthens professional boundaries. Professionals often have different beliefs about the information they need to do their work. Another important aspect in this context is the willingness of members to share information.

From a geographical perspective, ICT systems are seen as a solution to overcome the challenges of working together from a distance. However, in rural and remote areas, issues related to IT infrastructure and connectivity were particularly pertinent. Even the connection of primary and secondary care settings was bounded in fundamental ways. Collocated services have shown to be particularly useful in enforcing information exchange through IT systems. Since future developments in IT depend on the willingness of local Health Boards and councils to provide funding, geographical differences will increase in accordance with local financial constraints.

To sum up, it is crucial that any cross-sector IT innovation meet sufficient interests of all stakeholders in all sectors to ensure their support.

Supported self-management and patient empowerment

Person-centered care aims at enabling people to understand their health status and their care and treatment options in order to involve them in the decision making process and therefore remain independent and in control whenever possible. Supported self-management (SSM) is one of the key features of the chronic care model for recurrent health

conditions. SSM has been embraced by healthcare systems in numerous countries, especially in the context of mental health problems. In Canada and England, it is recommended in the treatment guidelines for depression. Effective self-management support goes beyond telling patients what to do. It means acknowledging the patient's central role in their care in order to foster a sense of responsibility for their own health. Providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way. SSM is the foundation for shared decision-making about care pathways (Bilsker, Goldner, and Anderson, 2012).

The patient is usually provided with a self-management guide (for example, a workbook or interactive website) that teaches knowledge and skills for coping with the health condition. Skills taught for coping with depression typically include behavioral activation, cognitive restructuring, and problem solving. The application of the self-management guide is encouraged and coached not only by a healthcare provider but also by peer support workers, support groups, family, or friends.

SSM is designed to work in existing systems of care and can be provided in the brief visits of primary care. It neither requires extensive training for providers nor costly investments for effective implementation. Thus, SSM is a feasible intervention that is appropriate for widespread dissemination. However, to achieve sustainment, it must be integrated into clinical systems and practice. This will require researchers, policymakers, and healthcare providers to exchange knowledge (Bilsker et al., 2012).

Helping Older People Success (HOPES)
HOPES includes a social rehabilitation and a health management component delivered over a 2-year period. The program included skills classes, community practice trips, and 1:1 meetings with a nurse. HOPES classes were conducted using the principles of social skills training (modelling, role playing, positive and corrective feedback, homework assignments). The curriculum was organized into seven modules: Communicating Effectively, Making and Keeping Friends, Making the Most of Leisure Time, Healthy Living, Using Medications Effectively, and Making the Most of a Health Care Visit. Participants in HOPES showed significantly greater improvement that spanned many of the psychosocial outcomes. Specifically, HOPES participants improved more in social skills, community functioning, negative symptoms, self-efficacy, and leisure and recreation. The findings confirm that psychosocial rehabilitation can benefit older adults with severe mental illness who have long-standing impairments in community functioning. Findings from a randomized trial (Mueser et al. 2010)

Contracts setting the right incentives

Integrated care initiatives need to be adequately resourced in order to be effective. This means that aligned incentives are crucial for the successful implementation of integrated care. Simply relying on the intrinsic motivation of care professionals to cooperate in implementing integrated care might be a naive approach (Cameron et al., 2014). Government, commissioners, regulators and professionals should develop fair frameworks of incentives that will reward people for promoting cooperation between tiers of care (National Voices, 2012)
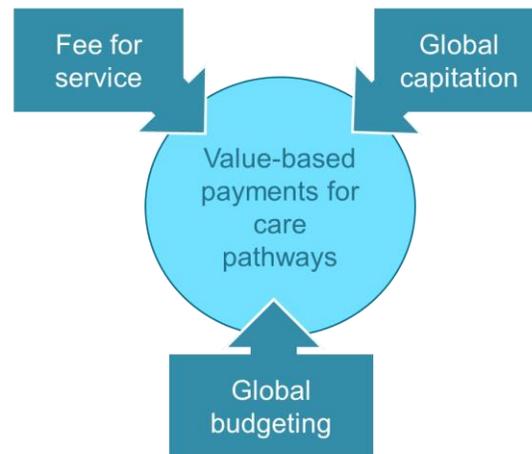
Source: Own illustration.

Payment reform policies have been multifaceted to include experimenting with bundled payments or new capitated funding models that offer providers incentives to work collaboratively in provider networks. Payment reforms influence the occurrence of integrated care, the organizations of integrated care providers, and the service delivery process (Strujs, 2013).

Denmark has developed a cooperation framework for primary and social care, which promotes care delivered in the community. Funding policies were aligned and the way of reimbursing services showed to be strongly influencing cooperation between tiers of care (Cameron et al., 2014). Other countries, however, have had experiences whereby the implementation of integrated care changed considerably after the introduction of new financial incentives. In the UK f1,346 integrated care contracts were concluded between the end of September 2005 and the inception of the Health Reform Act in 2003 (Greb, Focke, Hessel, and Wasem, 2006). Similar experiences were found in Germany, where 1% of the total health sickness fund budget was spent on integrated care projects.

Other payment reforms resulted in the introduction of new provider-led integrated care organizations where payers partly shift economic risks toward those organizations. Examples include the Accountable Care Organizations in the USA or Care Groups in the Netherlands. In terms of the care delivery process, new incentives can foster task reallocation, new care pathways, and the uptake of case management, potentially supported by tele health and tele care (Strujs, 2013).

Research shows that pooled budgets help foster collaborative initiatives. They also make the process of resource allocation more transparent and equitable (Cameron et al., 2014). However, insight into the effects of newly introduced payment models is limited mainly due

to a lack of methodological approaches that are sophisticated enough to disentangle the influence of payment reform (Strujs, 2013). An in-depth case study that provides insight into the role of incentives and reimbursement schemes in the development of integrated care suggests that incentives that align social, primary and hospital care are rare (Lluch, 2013). Hence, the lack of evidence and evaluation of payment reforms remains a major gap in the majority of countries.

That lack notwithstanding, many countries have implemented programs that integrate health and social care. How they work in practice offers insight into the effect a program centered on people, concepts, and contracts can have on improving care.

Integrated Health and Social Care in Practice

Numerous countries have implemented programs with the aim of integrating health and social care. This section describes how they compare with one another and how are they working in practice.

1.1 Care system comparisons – international rankings

In the most recent ranking of care systems, the United Kingdom demonstrates strong performance and ranks first overall. Its dimensions are "coordinated care" and "person-centered care." Switzerland, New Zealand, and the Netherlands are also highly ranked in the latter two dimensions. This international ranking includes data from 11 countries that incorporates patient and physician survey results on care experiences and ratings on various dimensions of care. The ranking is based on the most recent three Commonwealth Fund international surveys of patients and primary care physicians, which focus on medical practices and views of their countries' health systems (2011–2013) (Davis, Stremikis, Squires, and Schoen, 2014).

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWZ	UK	US
overall ranking	4	10	9	5	5	7	7	3	2	1	11
quality	2	9	8	7	5	4	11	10	3	1	5
- coordinated care	4	8	9	10	5	2	7	11	3	1	6
- patient-centered care	5	8	10	7	3	6	11	9	2	1	9
healthy lives	4	8	1	7	5	9	6	2	3	10	11
health expenditures*	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

* Per Capita in $US PPP

Source: Adapted from Davis et al., 2014.

In terms of efficiency, the UK also ranked first, followed by Sweden. In contrast, health outcomes – for example mortality amenable to medical care, infant mortality, and healthy life expectancy – were found to be poor in the UK (Davis et al. 2014). Overall, France, Sweden, and Switzerland rank highest on this dimension, called healthy lives.

Rankings like these are a nice starting point for drawing a global picture of the status quo of the developments of international care systems. At the same time, assessing the relative performance of countries has inherent limitations as rankings summarize evidence on measures of high performance based on national mortality data and the perceptions and

experiences of patients and physicians. Shared patient and physician experiences and expectations depend on country and culture, though. Not captured are important dimensions of effectiveness or efficiency that might be obtained from medical records or administrative data (Davis et al., 2014). This is why the next inevitable step must include a look at international evidence of integrating health and social care.

Integrated care programs in practice

To provide insight into the evidence on integrating health and social care, two types of models of integrated care delivery are distinguished according to Beland and Hollander (2011): community-based models and large scale models.

Community-based models are smaller projects that rely on cooperation that spans care providers, focus on home and community care, and play an active role in health and social care coordination. The second type encompasses models of larger scale that could be applied at a national, provincial, state, or large regional health authority level. Those models have a single administrative authority, a single budget, and included both community and residential services. Based on a targeted review of published literature, international examples and experiences of both types of models are presented in this section. However, this represents a selection of numerous examples.

Community-based models

The smaller, community-based models are characterized by a focus on a specific population in need, such as the frail elderly, the mentally ill, children and their families or persons who suffer from substance abuse. Their care concept is based on inter-professional care teams and inter-organizational care coordination that spans home and community-based services with residential and acute care institutions. Physicians play an active role in the overall management of care of the client in most cases. Usually, the care concepts rely on already existing budgets for home and community care providers. In some cases, an integrated information system exists. Most of the examples noted in the literature are primarily demonstration projects, which might need to be formally adopted by governments or insurers before they become the standard of care for larger geographic areas, or population groups.

Disease-focused care concepts for chronically ill and multi-morbid persons

Without doubt, chronically ill and multi-morbid persons represent the main target group for integrated care activities as they are in need of numerous different services over a long period of time. The increasing number of chronically ill persons reinforces integrated care initiatives to focus on this group of people, which results in a large number of different approaches and projects. However, most efforts have so far only focused on integrating

different sectors within healthcare. The involvement of social care components still falls short of its potential. The exemplary programs that have been retrieved from literature focus either on health conditions that require a high level of patient empowerment (for example, diabetes) or that cause social disadvantages (for example, HIV/AIDS) and their interaction with other social issues like substance abuse. Others reinforce special types of care like intermediate care or end of life care.

Care programs for patients with diabetes (Greaves et al., 2013)

The North West London Integrated Care Pilot (NWL ICP) is a large and complex integrated care intervention in London that aims to improve care for 15,000 people with diabetes and 22,000 people over the age of 75 in northwest London. NWL ICP seeks to improve the quality of care and to reduce emergency admissions as well as overall cost of care.

The program covers more than 100 general practices, five local authorities, two mental health trusts, five primary care trusts, two acute hospital trusts, and two voluntary organizations. Intervention includes risk stratification, care planning that spans care settings, multi-disciplinary group meetings, new financial incentives for participating organizations; and a new information technology (IT) system to facilitate the ability of providers to share of information and patient records. The multi-disciplinary meetings include GPs, hospital specialists, mental health care, community nursing, social care, and other allied health care professionals.

Care programs for patients with stroke (Dewan, Skrypak, Moore, and Wainscoat, 2014)

Interest in intermediate care services that aim to provide choices other than inadequate care at home, inappropriate care in hospital, or expensive care in long-term institutions has grown (Gladman, 2000) Regular follow up for stroke patients has been highlighted as an essential part of care after discharge from the hospital as one factor that reduces the risk of stroke recurrence and hospital readmission for this population. In the UK, the Department of Health recommends that stroke survivors, and their caregivers be offered a review that should encompass their health and social care status and secondary prevention needs. These reviews are to be conducted within six weeks of discharge at home and again six months after discharge. However, it has been noted that health and social care services are not working together as well as they could.

The Camden Stroke Navigation Service started in March 2011 with the aim of offering specialist health and social reviews to all Camden residents diagnosed with a new stroke. Stroke navigation concentrates on education and secondary prevention of strokes, encompassing information and advice on vascular risk factor management, lifestyle modification, stroke rehabilitation, and stroke prevention as well as information about the role and suitability of community–based health and third sector services.

Dewan et al. (2014) showed that the readmission rate for new strokes at 6 weeks and 6 months was 0% for all patients reviewed. On the 6-month follow-up review, none of the patients had been readmitted to hospital for stroke symptoms or a new stroke. Overall, 22% of patients required referral to social service intervention related to care support for patients and caregivers, assistance with personal and domestic packages of care, and support with re-housing. The study also indicates high user satisfaction associated with this method of stroke follow up.

Programs for patients with chronic viral infections and/or substance use disorders (Lindegren et al., 2012)

Patients with chronic viral infections such as HIV/AIDS or hepatitis C represent a special target group when integrating health with social care services. Often these patients have multiple co-existing problems in addition to their original health condition such as psychiatric and addictive disorders, as well as social problems such as lack of housing, transportation, and income that present challenging obstacles to successful management (Willenbring, 2005).

Furthermore, individuals infected with HIV and HCV frequently suffer from substantial disabilities that get worse as the disease progresses. Fragmentation of care is likely to occur when substance abuse disorders are involved. Effects on cognition, mood and motivation limit the patients' ability to navigate through the healthcare system; especially regarding the usually more difficult access to behavioral healthcare compared to general medical care. Care in this context becomes increasingly burdensome for consumers and providers alike. Alcohol and drug disorder treatment can be connected to several forms of medical care such as primary care, emergency care, obstetrics (fetal alcohol syndrome), and mental health care. But, care can also be delivered in the context of various nonmedical social services including welfare, child protective, employment, housing, and criminal justice services. So far, both parts are not sufficiently linked to each other. Screening for medical conditions and medical care is seldom provided as part of substance abuse treatment in the context of social services, while medical conditions like hypertension, coronary artery disease, and chronic liver disease are likely to be treated on medical level without screening for substance use disorders (Hilton et al., 2003).

Lindegren et al. (2012) systematically reviewed literature about the integration of HIV/AIDS services with maternal, neonatal and child health, nutrition, and family planning services. The authors concluded that, despite the fact that integration of services has been identified as a key strategy to optimize HIV care and treatment by the WHO and has been introduced as part of the Global Plan to eliminate new HIV infections in children, there is a paucity of evidence from rigorously conducted research to inform implementation strategies.

Nevertheless, scarce evidence, mainly retrieved from observational studies, shows that the integration of HIV/AIDS and family services was found to be a feasible way to implement and can improve a variety of health and behavioral outcomes. The observed effects have been independent from the integration model, setting, and target population. The main outcome measures were related to changes in health behavior, such as increased contraceptive use. Three studies that measured actual changes in health status stated improved health outcomes for women and children with integrated services (Lindegren et al., 2012).

End of life care for multi-morbid patients (Nuno-Solinis, 2014)

End of life care for multi-morbid patients is particularly complex and, in most health and care systems, fragmented and uncoordinated. In advance, care plans can help prevent the often highly medicalized and hospital-centric overtreatment of those patients. Care plans need be flexible enough to allow for different cultural approaches to dying.

When curative treatment is no longer possible, palliative care services become more important. This type of care aims to prevent and alleviate the symptoms of illness for patients and simultaneously addresses the wider psychological, social, and spiritual needs of people as they approach death. Originally grounded in the end of life care for oncologic patients, palliative care gains importance for people with advanced chronic conditions and at risk of dying. Palliative care can be delivered successfully in different institutional settings, but home-based care models are preferred. Since social support services are important, taking into account resources and networks beyond the health care system has shown to be a key factor in the successful delivery of palliative care. However, many initiatives are still stand-alone programs, neglecting the potential of social support services in this context.

One example of the impressive results the involvement of social support and companionship services in end of life care can achieve can be seen in Spain. The program called SAIATU ("to try" in the Basque language) migrates several hospice values and skills to home care. The main component of the program is 24/7 communication, with a "one face to one family" motto. The simple service approach is based on fast response and family centered care, which takes into account the actual needs of the family and aims at empowering them to provide care. Reductions in health care utilization have been estimated to savings of about 8,000 Euros per case.

Care of the elderly (Johri, Beland, and Bergman, 2003)

A large amount of literature focuses on programs that provide care for the elderly and in particular the frail elderly. Since the frail elderly suffer from a mix of acute and chronic medical problems as well as functional disabilities, this target group poses a central challenge to current healthcare systems. Their social support networks are frequently

overextended or at risk of breaking down. Internationally, there are approaches to establish a single entry point system, with case management provided for continuing care in the community and for admissions to long-term care institutions, all of which can be seen as an important step toward reduced fragmentation and improved use of resources. However, in most cases the sharp division between medical and social care, acute and continuing care, and community and institutional care still remains as each agency continues to function autonomously in its own jurisdiction with its own budget (Johri, Beland, and Bergman, 2003).

The Seniors Collaborative Care Program (SCCP) in Canada (Moore et al., 2012)

The Seniors Collaborative Care Program (SCCP) began as a pilot program at the Stonechurch Family Health Centre (SFHC) in 2008 and continues to operate. The SFHC serves 15,204 patients, including 737 seniors older than 75 years of age. Each SCCP core team consists of 1 nurse practitioner, 1 family practitioner, and 1 registered practical nurse. Additionally, SCCP members include a pharmacist, a social worker, a dietician, and a visiting geriatrician. The aim of the SCCP is to improve the quality, efficiency, and coordination of care for frail elderly patients who live in the community and to enhance geriatric and inter-professional skills for SFHC practitioners and learners. The pilot program emphasized providing care in the homes of housebound seniors.

One of the key features identified was the preventive nature of the program, which in some cases included identification and elimination of home fire and falling hazards, food procurement problems, and caregiver exhaustion. Practitioners reported that identification of problems and potential hazards allowed the team to quickly put plans in place in order to prevent crises.

Three fully integrated programs for the frail elderly in North America: PACE, SIPA, and PRISMA (Kodner, 2006)

The Program of All-inclusive Care of the Elderly (PACE) is a fully integrated system that provides acute and long-term care services that are coordinated by, and largely organized for, an adult day health center in San Francisco, California. The adult day health center setting, in addition to offering social and respite services, functions largely as a geriatric outpatient clinic in which primary medical care, ongoing clinical oversight, and care management play major roles. The program is designed to maintain frail older people in the community for as long as possible, as well as to avoid or postpone institutionalization through effective, community-based geriatric care. PACE operated as a federal demonstration program between 1987 and 1997, and is currently a permanent provider under Medicare and a state option under Medicaid. As of January 2005, there were 36 fully operational programs in 18 states caring for 10,523 enrollees (Kodner, 2006).

The System of Integrated Care for Older Persons (SIPA) - a community-based, primary-care-led, case-managed health system for the frail elderly in Quebec - is the Canadian version of PACE. Two SIPA teams operate with their own management, budget, and staff, and are responsible for the integrated provision of community health and social services and the coordination of hospital and nursing home care for 160 patients per site. Multi-disciplinary teams consist of physicians, nurses, or social workers (acting as case managers), therapists, home care workers, and, sometimes, nutritionists and pharmacists. Evidence-based geriatric techniques including multi-disciplinary clinical protocols, intensive home care, 24 hour on-call availability and rapid team mobilization, are used to minimize functional decline, reduce inappropriate institutionalization and maintain community living for as long as possible. Payment is based on prepaid capitation to ensure responsibility for the full range of health and social services covered by the program. Despite positive findings, due to lacking policy consensus, it was decided that SIPA would not become a permanent program.

Unlike PACE and SIPA, PRISMA, another Canadian program, is a coordinated model of integrated care. The goal is to integrate service delivery to ensure functional autonomy for people who are aged 65 years. A joint governing board on the governance level and a service coordination committee on the managerial level provide the inter- and intra-organizational coordination. A single-point-of-entry mechanism is used to coordinate access to all covered healthcare and social services in the service area. Case management, a common assessment instrument and a care plan are further applied by the program. PRISMA's work is supported by an integrated information system. Services are budgeted.

Integrating mental health care in primary care

Mental health care is typically provided by a team rather than by a single provider. Furthermore, care needs often extend to social issues that include housing and daytime activities. A unique feature of treating mental illnesses is the importance of continuity of contacts over a long treatment period. Care can be confusing and exhausting for clients with mental health problems, which can lead to a lack of agreement or communication with providers. In sum, these factors ask for flexible, personalized and seamless care (Hansson, Ovretveit, and Brommels, 2012).

Table 1 Overview of international practice examples of mental health programs

Program name	Focus	Country
DIAMOND and CALM	On-site nurse care coordinators, supervised by a psychiatrist providing depression education, support and care coordination Coordinated Anxiety Learning and Management (CALM)	USA
UP-TECH	case management for Alzheimer`s disease patients and caregivers	Italy
The Södertälje mental health and social care consortium	Cooperative care model involving a county psychiatric medical and municipal social services and social rehabilitation for people with severe mental disorders	Sweden

Depression Improvement Across Minnesota Offering a New Direction (DIAMOND) in the USA (Vickers et al., 2013)

Depression Improvement Across Minnesota Offering a New Direction (DIAMOND) is a collaborative care model for depression that was initiated in 2008 at the Mayo Family Clinic Northeast in Minnesota. DIAMOND uses on-site-registered nurse care coordinators, supervised by a psychiatrist, to provide depression education and support and to coordinate patients' care with primary care and mental health providers.

In 2011, the Coordinated Anxiety Learning and Management (CALM) model was included in the on-site service. CALM is an evidence-based treatment for anxiety specifically developed for delivery in the primary care setting. Two full-time independent clinical social workers are available on-site to provide psychotherapy, to assist with triaging and referring patients to other on-site mental health treatments, and for general social service needs.

Evaluation results show that DIAMOND care coordination made access easier for patients and providers. Access was improved in terms of greater breadth of on-site services as well as shorter waiting times for patients. Providers appreciated the support provided by the care team. Physicians felt more able to keep track of the care their patients were receiving. However, results only report short-term effects. The sustainability of integrated models of care requires additional study, however.

UP-TECH – Supporting caregivers of patients with Alzheimer`s disease in Italy (Chiatti et al., 2013)

UP-TECH is a multi-component intervention program at the regional level that engages professionals from both social and health care services in a large-scale organizational change to restructure the processes of care provided for Alzheimer`s disease (AD). UP-TECH aims at reducing the care burden for family caregivers of AD patients while enabling AD patients to live at home.

The key components of the intervention are trained and hired case managers. Social workers systematically and comprehensively support each patient-caregiver. They provide individual, face-to-face counseling that focuses on topics such as housing arrangements, disease awareness and problem solving, along with monthly follow-up telephone calls, stress management training, information about services and subsidies offered by the Italian national health service, municipal social services and local volunteer organizations. Furthermore, the case manager coordinates professionals working in different care settings and between hospitals. The UP-TECH project also involves the testing of new technologies to support patients and their caregivers, and the advice of a virtual information counter for technological aids and adaptation to the home environment.

The cost-effectiveness of UP-TECH is currently being evaluated. Recruitment for the trial started in December 2012; results have not been published yet.

The Södertälje mental health and social care consortium in Sweden (Hansson, Ovretveit, Askerstam, Gustafsson, and Brommels, 2010)

The Södertälje mental health and social care consortium is a cooperative model that involves a county psychiatry clinic, municipal social services, sheltered housing and rehabilitation units. Most clients of the consortium are diagnosed with schizophrenia, schizoaffective psychosis, bipolar disorders, and functional disorders.

Since medical and social rehabilitation often overlap in the mental health consortium, staff activities are organized in networks rather than following conventional client pathways. Each client has one coordinator from each service. Additionally, joint coordinators are appointed to facilitate mental health and social services. Their central tasks are helping chronic mental health clients recover, for example, through assessments of needs. Nurses, occupational therapists, and rehabilitation assistants primarily function as coordinators. A standardized assessment and follow up of individual needs and service outcomes using The Camberwell Assessment of Need (CAN) scale has been implemented.

Results show that the number of clients satisfied with the help received has consistently increased during the given case period. The addiction treatment and preventive team has

been found to be a central element in the psychiatric outpatient care. Overall, the experiences emphasize the importance of incorporating special teams in mental health care.

Children, young people and their families

Another vulnerable group in need of health and social care services is that of children, adolescents, and their families. The health of children is closely linked to the health of their mothers. As the newborn grows into a child, a healthy home environment, healthy behavior and care of illnesses are crucial. Lack of care or poor quality care has effects on newborns and children. Activities in this area concentrate on avoiding child maltreatment, improving parent and child health, and enhancing family functioning. Intimate partner violence is another important issue mentioned in the literature.

Table 2 Overview of international practice examples of child and family care programs

Program name	Focus	Country
Building Healthy Children (BHC)	Evidence-based home visiting services integrated into primary care low-income young parents who gave birth to their first child	USA
Integrated Management of Childhood Illnesses (IMNCI)	Integrated management of ill children in facilities and health centers, health system strengthening, and promotion of key family and community practices	India, sub-Sahara Africa, a.o.
One-Stop Crisis Centre (OSCC)	Operational centers offering on-site integrated services to address intimate partner violence, including health, legal, welfare and counselling services	Bangladesh, Malaysia, Namibia and Thailand
International Planned Parenthood Federation (IPPF) project	Integrated violence screening and related support services (counseling, legal advice) into existing sexual and reproductive health services	Latin America

Building Healthy Children (Paradis, Sandler, Manly, and Valentine, 2013)

Building Healthy Children (BHC) - evidence-based home visitation integrated with pediatric medical homes - offers a unique model of evidence-based home visiting services integrated into primary care.

The program is based on the premise that home visitation that provides parenting education and therapy for parent-child trauma and maternal depression, can prevent child maltreatment, improve parent and child health, and enhance family functioning. To achieve these goals, a collaboration of social service and health care agencies provides evidence-based services for families. The main targeted at-risk group are low-income mothers who were younger than 21 when they gave birth to their first child. Most had no previous involvement as a parent in the child welfare system. Assigned outreach workers that reflect the ethnicity and culture of BHC participants provide a consistent, nurturing relationship that helps stabilize families and ensure compliance with medical appointments and recommended care. They support families consistently during their involvement in the program. The BHC pediatric social worker serves as the primary link to primary care practices. A comprehensive family assessment and service plan is placed inside the child's electronic medical record (EMR), and quarterly updates are recorded by the BHC social worker.

In a randomized trial, the BHC model has demonstrated effectiveness in connecting families with preventive care, and it appears to improve family functioning, mental health outcomes, and pediatric health measures for its participants. The program produces high enrollment and retention rates and addresses the multidimensional needs of young, at-risk families.

The Integrated Management of Childhood Illnesses (IMNCI) in India (Prinja et al., 2013)

The Integrated Management of Childhood Illnesses strategy is based on the notion that human rights include a guarantee of healthcare to all children, no matter where they live. The strategy addresses the gaps in knowledge, skill, and community practices regarding children's health, recognition of illness, home management of the sick child, and appropriate care seeking behavior.

The IMCI strategy includes integrated management of ill children in facilities and health centers, health system strengthening, particularly related to drugs and logistics support, and promotion of key family and community practices. All three components should be implemented simultaneously.

IMCI has been implemented in more than 100 countries throughout the world. Nearly half of them are sub-Saharan African countries, of which fourteen countries are carrying out the strategy in more than 50% of their districts. Furthermore, it is implemented in 433 districts of India.

Evaluations of IMCI implementation have shown that IMCI training substantially improves the quality of care in health facilities. Prinja et al. (2013) found an overall increase of per-child cost of health care services when implementing IMNCI. The additional costs are primarily attributable to the additional time spent on child health (54.7%), monitoring and supervision (20.9%) and better availability of drugs (8.8%). Although increased costs have

fiscal implications, full economic evaluation that takes a societal perspective have shown that the reduction of morbidities and the shift in treatment seeking from secondary care to primary care health settings result in reduced treatment costs. This reduction offsets the additional investments needed for the implementation of the program. Multi-country evaluations from Brazil, Tanzania and Uganda also point in this direction.

Intimate partner violence (Colombini, Mayhew, and Watts, 2008)

As research has demonstrated the high prevalence and wide range of health consequences of intimate partner violence (IPV), violence against women has become recognized as a serious public-health issue. The lifetime prevalence of physical or sexual partner violence, or both, varies between 15% and 71%. Abused women are more likely to have poorer health outcomes from which they can suffer long after the abuse has ended. Health is impacted on the physical level, for example, in nutritional status, sexual and reproductive health, and maternal health as well as on the mental level, including risk of depression and suicide. Additionally, IPV has also been shown to affect the health and well-being of children in violent families. For example, it has been correlated with decreased vaccination status and increased risk of behavioral and psychological problems.

Given that IPV is an important risk factor for a range of health problems, there has been growing awareness of this issue. Referral to specialized services in this context is especially important, as many women experiencing violence will not seek help from a legal or stand-alone service, but will most likely visit a health service facility during their adult life. Therefore, it is important that the health sector also facilitate these women's access to non-health services, besides providing efficient delivery of health-related services.

Colombini et al. (2008) identified nine health-sector programs that are related to intimate partner violence in low- and middle-income countries: five programs in central and Latin America, three in Asia, and one in Africa. The One-Stop Crisis Centre (OSCC) model is a provider and facility-level integration model that has been implemented at a national level in Bangladesh, Malaysia, Namibia, and Thailand. These operational centers offer a wide range of integrated services to address IPV, including health, legal, welfare, and counseling services, in one location.

Other types of programs integrated on the system-level offer a comprehensive package of services for abused women, although services are not all provided at the same site. The regional International Planned Parenthood Federation (IPPF) project in Latin America, for example, integrates violence screening and related support services (counseling, legal advice) into existing sexual and reproductive health services. In Bangladesh, the Women's Friendly Hospital Initiative aims to reduce maternal mortality and violence rates and includes treatment as well as referral for abused women in its services. In Armenia, the Prime II project integrates IPV services in a polyclinic's reproductive health services and

used a coordinated approach to strengthen external links to counseling, legal aid, social support, hot-line services and shelter. A similar approach can be observed in a women's hospital in Kenya.

A lack of systematic evaluation for most identified programs limits this review to some extent.

Large scale, population-based approaches

In contrast to the above outlined smaller community-based models, implementation of large-scale systems is more challenging as they can require changes to existing legislation and policy. Characteristics that generally distinguish these large-scale systems from the community-based models are (Beland and Hollander, 2011):

- One single administrative authority mandated by legislation or policy to manage the overall system of care
- One single funding envelope
- Direct control over a wide range of services
- Case management with consultation
- A system-wide client classification system

The global governance structure, including single funding, enforces leverage over care providers to ensure seamless care. Policies and clinical practices can be established at a broader system level to enhance the continuity of care. Case studies of large scale, population-based approaches are presented in the following section.

Case studies by country

This section looks at the implementation of population-based approaches in Sweden, Catalonia, the US, and Japan.

Sweden: The Esther Network, Jonköping

Introduction

Jönköping is a county in Southern Sweden with about 330,000 inhabitants. Its healthcare system has a long history of involving the public in the way healthcare is planned and delivered. The Esther Network started as a small project in 1997, but it now covers health care delivery for a population of 110,000 today. That amounts to a third of the whole population of Jönköping. Caregivers, clinicians, patients, and families work together to continuously promote and improve person-centered health care services (Davies, Fuge, Harris, and Barrett-Lee, 2012).

Service providers in the Esther network focus on patients' values. The key idea is that patients might value services differently than clinicians and managers. Therefore, "Esther" is a symbolic patient with complex care needs who requires the coordination of hospital, primary, home, and community care (The Esther Network, 2014).

The context

Of all Western countries, Sweden features one of the highest percentages of elderly people in its population. This results in significant challenges for health and social care services (Davies et al., 2012). Like most other health systems, the Swedish system is designed in a functional way. That means each actor in the caregiving chain (primary care physician, hospital, homecare provider, pharmacy) acts independently according to the organization`s function (Institute for Healthcare Improvement, 2014).

The Esther Network was initiated as a reaction to the experience of an elderly patient who was living alone and suffering from these fragmented service structures. Breathing difficulties led this patient, identified as "Esther," to seek help. In this process, Esther had to repeat her story to a total of 36 different service providers. After a long journey through the service system she finally got treated in a hospital. Against this background, "Esther" became a generic term that represents the focus of clinical and social care services on the needs, expectations, priorities, and fears of people who are entering the system. An action plan was developed to restructure the system (Vackerberg, 2013):

The Esther Action Plan

1) Develop flexible organisation with focus on patients' values

2) More efficient as well as improved prescription and medication routines

3) Documentation and communication of information adapted to the next link on the care chain

4) Develop an sufficient IT support through the whole care chain

5) Develop and introduce a diagnosis system for Community Care

6) Develop a virtual competence-centre for better transfer and improvement of competence through the care chain

Information technology

Process & Organisation

Competences & Culture

Source: Adapted from Vackerberg, 2013.

The integrated care approach

The Esther approach demonstrates how person-centeredness and patient-oriented values can be transferred into practice successfully. "Esther" symbolizes any service user, especially one who is elderly and has one or more health issues, with all his or her clinical and social care needs, expectations, preferences, and anxieties. Always starting from Esther`s point of view, the Esther Network aims at reshaping the thinking of healthcare providers and planners to integrate what a patient would value from a healthcare system.

The crucial questions to define the patient's values are (Davies et al., 2012):

- What does "Esther" need or want?
- What is important for "Esther" when she gets sick?
- What is important for "Esther" when she comes back home from the hospital?

The patient`s illness is seen as a continuum between treatment and rehabilitation that requires a partnership between several organizations and cooperation that spans multiple departments of health and social services. The underlying key objective of this new approach was to create a network to help patients feel confident, independent, and secure. Therefore, patients need to:

- Receive care in or close to home
- Know where and who to turn to for care
- See the healthcare system as an entity working together to provide their care
- Have access to quality care across the whole region (Vackerberg, 2013)

The Esther Network consists of members from health and social care services. Every participating member is expected to act in line with a shared set of values and working behaviors. Client-centeredness is the key strategy for all involved care providers. Voluntary organizations are embedded in an early stage of the patient`s care pathway to ensure post-clinical support.

The network`s philosophy is that everybody involved in the care chain needs to consider the "next provider." Every health and social care worker shares responsibility for the performance of the entire system. Therefore, a clear vision is crucial for maintaining mutual cooperation. This vision is set and promoted on an annual "mutual strategy day" that includes leaders, patients, Esther coaches, politicians, and staff. The motto is "Your problem is my problem." Challenges are faced and resolved together and always focus on making sure Esther is not getting lost in any gaps in the system.

Care givers meet regularly to promote an understanding of different professional roles and to create a culture of communication. Documentation and communication are also improved

through IT support. A virtual competence center helps transfer knowledge and competency between the different professionals. Esther coaches enable care providers to focus on the patient, and to support the system's perspective on patient-centeredness. They are working beside their normal profession in health and social care, and in different organizations. Esther coaches are trained by an education program of multi-professional learning. Furthermore, the network employs tools of continuous quality improvement and coaching to increase competence of the whole care chain, and mitigate redundancy for Esther (Davies et al., 2012; The Esther Network, 2014).

Governance structure

The Esther Network has more than 7,000 members from health and social care services in the region. Esther's organizing committee consists of directors from primary care, hospitals, social care, and departments of medicine. Additionally, there are smaller networks in each municipality, where Esther coaches are trained. However, the network organization is non-hierarchical, and membership is voluntary. Cooperation arises from a sense of mutual responsibility for the client (Vackerberg, 2013). On the basis of annually made action plans worked out by the contribution of all network members, activities for the next two to three years are defined and reviewed regularly (Davies et al., 2012).

There does not exist any special budget for the Esther organization. Only one person - acting as a coordinator - gets paid. All others involved in Esther accommodate this as part of their normal work. Patients that are involved in the improvement work get compensated by flowers or other gifts. Recently, Esther received some funding but it is not regular. The engagement of care providers in the Esther network still remains an additional part of their daily work.

Nevertheless, the Esther approach has spread out globally to numerous other locations like Singapore or Toronto through a number of meetings.

Evaluation

The Esther Network has been continuously evaluated in terms of patient outcomes and resource usage. Results have shown the approach to be successful. For example, there has been a 20% reduction in hospital admissions (9,300 admissions in 1998 to 7,300 in 2003). Also the number of hospital days in general could be decreased significantly. Unnecessary days in hospital, where patients no longer have a medical need for specialist care could also be reduced as the figure shows. Avoidable stays in hospital might be caused, for example, by a lack of homecare or primary care services to look after the patient after discharge from the hospital (Vackerberg, 2013).

Unnecessary days in hospital – change by Esther
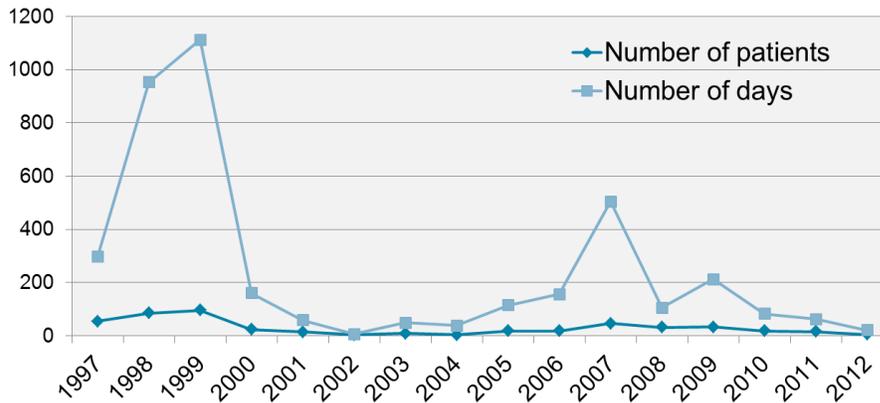
Source: Adapted from Vackerberg, 2013.

Furthermore, waiting times for referral appointments with neurologists declined from 85 days in 2000 to 14 days in 2003. Wait times for gastroenterologists declined from 48 to 14 days in the same period. In 2003, the Esther Network won the "GotaPriset" Swedish national award for quality improvement due to these results.

Catalonia: The Health Plan for Catalonia 2011-2015

Catalonia is an autonomous community of Spain that consist of four provinces - Barcelona, Girona, Lleida, and Tarragona - that established "The Health Plan for Catalonia 2011-2015" as a comprehensive framework to restructure the fragmented Catalan healthcare system. Developed by the Catalonian government, the Health Plan consists of 32 strategic projects that incorporate the objectives developed by the Chronic Care Program (Departament de Salut, 2012).

The context

Like most European countries, Catalonia is facing an increase in its elderly population. Of about 7,612,000 inhabitants, 17% are 65 years and older and 4% are already 80 years old or older. Projections estimate an increase of the elderly to more than 30% by 2050, 12% for people over 80. Consequently, the Catalan health system will face future challenges due to a growing number of people who are suffering from concurrent health and social needs. Especially complex chronic health conditions and multi-morbidity will challenge established structures (Contel Segura, n.s.).

Simultaneously, the Catalan healthcare system is highly fragmented with around 80% of the specialized care and 20% of the primary care providers not belonging to the Department of

Health. This diversification is also reflected in the nonexistent common information system for all the healthcare providers (Martínez, 2014).

The integrated care approach

"The Health Plan for Catalonia 2011-2015" constitutes the road map for the health system until 2015. Overall, the structure consists of three transformation pillars and nine lines of action.

This new health plan encompasses a vision of integrated care in the health sector, including social services, accompanied by a new contractual and financial plan to provide incentives for integrated care. This vision includes developing and implementing master plans for different areas of health and social needs (for example, mental health and addiction, oncology, or rheumatic diseases), in order to systematically conceptualize projects that are aimed at resolving health problems that require intervention in more than one sector. Furthermore, a yearly monitoring and assessment of the health objectives process is planned to verify the progress (line of action 1).

The Catalonien Health Plan 2011-2015

Health Programs: better health and better quality of life for everyone	1. Objectives and health programs		
Transformation of the care models: better quality, accessibility and safety in health procedures	2. System more oriented towards chronic patients	3. A more responsive system from the first levels	4. System with better quality in high-level specialties
Modernisation of the organisational models: a more solid and sustainable health system	5. Greater focus on patients and families		
	6. New model for contracting health care		
	7. Incorportation of professional and clinical knowledge		
	8. Improvement of the government and participation in the system		
	9. Improvements to information, transparency and evaluation		

Source: Adapted from Departament de Salut, 2012.

The second line of action represents the aim to transform the system to one with an intensified focus on chronic patients. This goes in line with the strengthening of the patient's involvement, which already starts at the pre-clinical stage and encourages his or her active role through all stages of health and illness. This comprehensive perspective of care delivery

requires the development of new roles for professionals as well as the use of new technology and communication systems.

The future integrated system is aimed at resolving health problems at initial levels and throughout Catalonia. The goal is higher quality and more equitable delivery for highly specialized care. Therefore, some basic objectives are (Contel Segura, n.s.):

- The construction of integrated care pathways for chronic conditions with the greatest impact. These pathways will involve all different sectors of care delivery, deploy social services, and healthcare facilities that will work on a more integrated care approach.
- A focus on maintaining health and preventing chronic disease by means of health protection, promotion, and prevention strategies and especially promoting the self-care and personal responsibility of citizens for their health, risk factors, and diseases. For example, expert patient programs have been implemented in this regard.
- Increasing efficiency by rationalizing the use of medications, improving adherence in chronic patients, substituting face-to-face visits by contacts through telephone or electronic messaging, and substituting hospitalizations by alternatives like care facilities, or more proactive home care programs.
- Clinical leadership working collaboratively with the commissioner plays a key role in the provision design.

The new healthcare model places the citizens in the center of the health system and aims to be more focused on results while increasing integration of healthcare levels and continuously promoting system efficiency. Professionals and their clinical knowledge are seen to play a key role in the development and execution of the Health Plan.

The use of information and communication technology (ICT) has become a strategic component in the Catalonian health system. The aim is to manage information throughout its lifecycle in order to create shared information, transparency and assessment. The two key elements in the implementation of the ICT-strategy are:

1) The Electronic Health Record of Catalonia (EHR) serves as an information and services network that allows for organized access to relevant information of different centers' health records and to some central databases of the health system.
2) The Personal Health Channel works as an interactive tool in a multichannel network that allows citizens to communicate, interact, and access personalized services online.

TicSalut Foundation was established in 2006 as an agency of the Ministry of Health to promote the development and use of ICT in the health and social care domain. The

foundation observes trends, innovations, and emerging initiatives, and provides services for the standardization and accreditation of products (Martínez, 2014).

Evaluation

Monitoring, assessment, and evaluation play a crucial part in the Health Plan. Therefore, relevant indicators have been identified and first assessments between January 2012 and August 2013 showed the following results (Contel Segura, n.s.):

- Decreasing avoidable emergency admission of ambulatory care sensitive conditions: a decrease of 9.43% in the number of avoidable potential emergency admissions related to chronic conditions, 18.4% related to COPD, 7% related to heart failure and 20.6% related to diabetes complications have been achieved.
- Decreasing 30-day readmission rates: a 1.1% decrease in the case of 30-day readmissions in COPD and 4.5% in the case of heart failure could be reached.
- Almost 50,000 patients with either a complex chronic condition or an advanced chronic disease had an attached intervention plan published in the shared clinical record that is accessible to all providers including secondary care and emergency and out-of-hours services.
- More than 3,000 patients have participated in the Catalonian Expert Patient Program.
- All geographical areas have designed integrated care pathways related to relevant chronic conditions diabetes, COPD, heart failure, and depression and are implementing them.

Despite these first positive evaluation results, some barriers still remain due to some fragmentation that is still present. There are still different contractual and financial programs for different sectors of care delivery (primary care, hospital care, mental health, long-term care) as well as different electronic clinical record systems related to different providers. These challenges will be tackled in the upcoming years.

USA: Montefiore – Inspired Medicine

The Montefiore Medical Center is an academic, non-profit medical center located in New York, and was founded in 1884. The Montefiore Home for Chronic Invalids, as it was called, focused on chronically ill patients, with the average stay being longer than 350 days. The first steps by the Medical Center toward integrated care were as early as in 1920 with the development of outpatient clinics and in 1947 with the introduction of home healthcare. Elements of integrated care expanded during the 1980s with the development of primary care networks (Amelung, 2013).

Today, the Montefiore Health System is one of the largest healthcare systems in the United States, providing services to approximately two million people in the Bronx borough of New York City and Westchester County, New York State. The integrated delivery network encompasses hospitals, an extended care facility, primary and specialty care at more than 150 locations and a school of nursing. It also includes a school health program and a home health program (Chase, 2010; Montefiore Medical Center, 2014).

The context

To understand the work and success of Montefiore, it is crucial to take into account the context in which Montefiore operates. The Bronx is one of the largest American metropolises and at the same time one of the poorest city districts in the United States. Of the approximately 1.4 million residents in the Bronx, around 30% are entitled to Medicare or Medicaid. About one-third of the population has a yearly income of less than $10,000 and the child mortality rate is as high as 13.3%. About half of the population is Latino or Hispanic and more than one-third is African American (Amelung, 2013; Consalvo, 2013).

Bronx Community Demographics
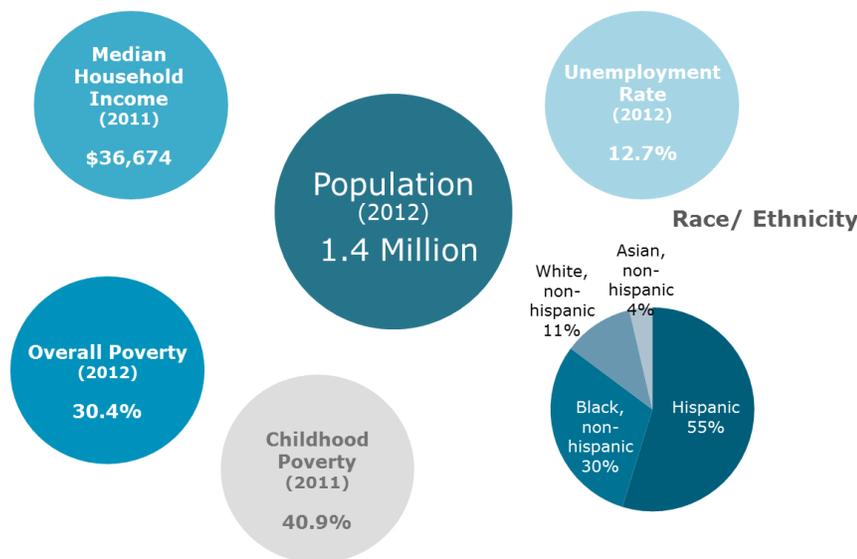
Source: Adapted from Montefiore Medical Center, 2013.

Montefiore thus serves a large share of low-income, vulnerable and disadvantaged persons with complex medical needs. These include medical conditions that are typical of deprived populations such as Hepatitis C, HIV/AIDS, obesity, and hypertension. Hospital and emergency service usage rates are high, as is disease prevalence (Chase, 2010; Rosenthal, Meara, and Hollingsworth).

The integrated care approach

To successfully target and serve the previously outlined population, Montefiore follows an integrated patient and community-centered approach, which recognizes the social needs of the population as well as the importance of social determinants of health.

Montefiore integrates structures and providers, processes, academia, healthcare provision, and the community. The focus on patients and the community as well as on successful transition between the various parts of the value chain is an important characteristic of Montefiore.

The three main focuses of Montefiore are:

1) Improving the management of chronic illnesses by expanding access in the community through outpatient and general primary care strategies
2) Opening up access to high quality care and hospital services, and
3) Providing a stronger integration of the provision of specific services and stable e-health technologies (Amelung, 2013; Chase, 2010).

Montefiore is not simply a hospital or a network that focuses on healthcare provision. It is a system that works in the community, the health system and academic institutions. On the academic side, it includes research and teaching, whereas the health system integration of Montefiore encompasses hospitals, primary and specialty outpatient care, mobile, satellite, and school clinics as well as home care (Home Health Agency and House Call Program). Lastly, Montefiore strongly emphasizes the health of the community. Programs are focused on obesity prevention, nutrition, wellness, disease management, teen pregnancy, and lead poisoning prevention. Montefiore also recognizes the difficulties of accessing care for parts of this population and actively addresses these by bringing care to where it is needed. With its mobile care centers Montefiore provides services at schools and homeless shelters. Besides mobile care centers, Montefiore strongly focusses on primary care centers, which also encompass specialty care provision. With a nursing home on campus, integration of acute and rehabilitation care is easier. Also, positive effects on cost-effectiveness and quality of transition and care are evident (Consalvo, 2013).

The Montefiore system targets specific groups of the population with tailored programs that have been implemented since 2007, including school children (for example, focusing on obesity prevention) and seniors (e.g., emphasizing fall prevention) while also focusing on indication-specific care. Montefiore's Care Management Organization specifically targets chronically ill patients via disease management programs. These programs currently are centered on coronary heart disease (CHD), diabetes, depression, high blood pressure, and liver failure. They are characterized primary care, interdisciplinary approaches, and tele-medical support. Some programs are privately sponsored and others are government-

sponsored, with the majority of the population served being either insured through Medicaid or Medicare (Amelung and Berchtold, 2008).

The strong focus on integration is evident in the medical training provided at Montefiore clinics which stresses social determinants of health and how to address them adequately. The belief in the importance of social determinants is mirrored for example in the screening for factors such as housing conditions, which is done upon arrival at the emergency departments (as it has been shown that unstable housing for example, is one important risk factor of repetitive emergency department use) (Chase, 2010).

An important factor that supports integration of care in all disciplines and levels of care is the implementation of information technology. Telehealth is successfully used for health management and prevention. The lifetime electronic health record enables communication across providers and the integration of former medical history into current treatment processes (Chase, 2010).

Governance structure

Montefiore is an active classic service provider. It also takes the complete risk of over 0.5 million residents in the Bronx by receiving yearly negotiated capitations from Medicaid for all patients formally served by Medicaid.

Evaluation

The strengths of Montefiore lie in the experience of managing care for a defined population. With its broad community based network, which includes both primary and specialty care, Montefiore can deliver care successfully. Montefiore has invested $950 million between 1995 and 2005, with as much as $200 million dedicated to IT and these investments have paid off. The main drivers for the success of Montefiore are not only the focus on community-based primary care delivery, the disease management programs, and the implementation of one consistent IT system and patient records, but also the development of a consistent corporate culture and value system (Amelung and Berchtold, 2008).

Japan: A community-based integrated care vision

Japan's healthcare has drastically changed due to the fact that the older population will rise to one in three by 2025. By then, the baby boomers will have turned 75 and thus Japan will reach its peak in the number of old people. To face this problem, Japan has been creating a long-term vision more than ten years. It started in 2003, when a study group called "Caring for older people in 2015" was set up from the government to prepare for this situation. This group was the first to suggest creating a community-based integrated care system and as a result, it led to the first reform of the Long-Term Care Insurance System in 2006. Additionally, a research committee with a focus on community-based integrated care was

formed by the government in 2008. Its aim was to examine and solve issues related to the creation of such a system, in which medical, long-term, and social care are combined. The integrated care takes place in various facilities and centers, which play a significant role in policies that integrate health and social care (Tsutsui, 2014).

The Japanese government aims to deliver healthcare and social care for the aging population with its "2025 vision." To do so, a localized and comprehensive total care provision needs to be established. This includes healthcare, long term support, preventative initiatives, housing and supported living programs, as well as other welfare services such as safeguarding, outreach, and dementia care. The older population will be able to remain in their communities thanks to this vision.

The context

This vision deals with the demographic issues that will arise in the future. Projections indicate that the proportion of the elderly in the overall population will increase by 2025 from one in four to one in three. Furthermore, the elderly, which are over 75, are estimated to make up 20% of the population by 2025. This cohort will represent 87% of eligible users of the planned total care provision (Hayashi, 2014). The proportion of older people in the population has changed dramatically over the last decades. The percentage has risen from 5% in 1950 to 14% in 1994 and is projected to reach 40.5% by 2055. This prognosis is based on the decrease in the total population and the increase in older people (Kaneko et al., 2008).

The integrated care approach

In the Japanese vision, a community-based integrated care system is limited to one community and aims to guarantee health and safety for its users by offering living arrangements and social care that supplements long-term and medical care. Each community ideally covers around 2,000 habitants. Community-based integrated care centers are of great importance in community care. Health nurses, social workers, and care managers work as a team. Since 2006, these centers have increasingly been established by municipalities and are planned for every district. These centers offer various preventive care services, counseling for elderly in the need of care, and continuous and comprehensive care management support. The centers are financed from funds from the Long-Term Care Insurance System and from taxes (Tsutsui, 2014).

The Research Committee stated that there are three main topics concerning the community-based integrated care that need to be dealt with. These can be seen in the figure below:

Providing medical care at home

Supporting the system by providing long-term care services and more residential care homes

Implementing preventive care and daily life support services
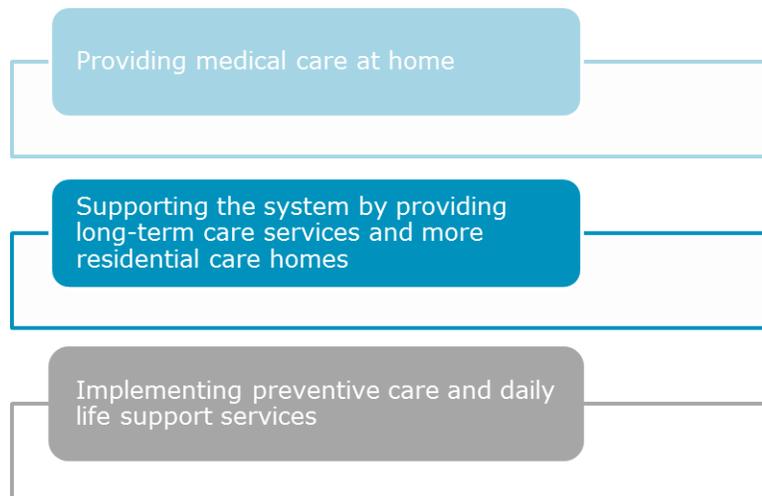
Source: Own illustration.

According to Hayashi (2014), the following four key components are essential for the implementation of the "2025 vision" and therefore must be included:

- Exploiting the integration of healthcare and social care
- Stimulating policies for prevention and outreach in addition to safeguarding
- Inserting supported living programs and dementia-friendly community initiatives
- Addressing specific housing needs for the elderly

These four key components were implemented by means of various concepts.

To maximize integration, the government introduced a micro-multifunctional facility in 2006, which is a model provided by a number of organizations. A maximum of 25 older people are cared for in each facility. They receive an inclusive and comprehensive care package, which includes on-demand healthcare, personal care, and domestic support. In exchange for this service, they pay a monthly fixed fee. The care coordinator in each facility is responsible for implementing and monitoring individual care plans and supporting family caregivers. Currently, about 4,000 facilities support 76,000 users. However, the model only supports about 2% of those eligible, despite its success and popularity. This may be due to the small financial gains for the providers of the facility. Through local events, they are trying to open up to the wider community. Larger, independent non-profit healthcare providers in Japan shifted their resources to the community-based model while establishing multiplatform care business models.

To promote policies, the government invited 1,700 councils in Japan to create localized and comprehensive centers for the entire older population. This aim was to achieve the desired outcomes of the vision. Local resources and assets were combined to 7,000 centers, which

were staffed with multidisciplinary teams and delivered information and guidance to the elderly at no charge. The government encouraged the centers to coordinate and monitor the delivery of preventive measures due to the known benefits of preventive interventions. The centers also offered training and support for care coordinators because of their important role.

Various initiatives were embedded through these centers, which play an important role for securing the "2025 vision." They should differentiate the core users from the people with low-level care needs, which represent the majority. This allows the programs to be more flexible and cost-effective and their development more innovative. A volunteer supporter scheme was developed, which is already used by 88 local authorities. A volunteer can earn points while volunteering, which will go toward the payment of his public social care insurance premiums. Another initiative was the dementia-friendly community initiative, for which almost four million people volunteered.

To address specific housing needs for the elderly, the government also introduced "care added supported living" facilities in 2011, which will attract potential developers through financial incentives. These facilities offer affordable renting opportunities in a barrier-free environment, where the users are constantly monitored and guided. Furthermore, required medical and personal care is provided for the users, which can live here independently. It was originally expected to accommodate about one million older people by 2025 because of the financial benefits compared to the institutional model. However, there are currently only 150,000 users due to some challenges in efficiency and performance, such as the dependence on private capital. Signs are given that the model might be predisposed to "warehousing", standardization and monopolization by private sector monopoles. This shows that these facilities cannot replace the institutions.

Governance structure

Through the coordination of non-profit organizations, volunteer organizations and private businesses in the community a community-based integrated care system can be built, which supports the delivery of both family and community care. The already existing social resources in each community will be mobilized so the implementation of the system can be adapted to each municipality. The government of Japan has decided to offer upfront and continuous financial means to be able to achieve the 2025 vision. Justification, monitoring and evaluation outcomes will not be taken into regard too much. This will allow a fast delivery with flexibility, innovation and experimentation (Hayashi, 2014).

Evaluation

The implementation of the community-based integrated systems needs to be validated. Currently, there is not much evidence of the success of these centers. This is because only

30% of them undergo any evaluation measures. Therefore, it is difficult to assess the impact of these services. However, the government still funds the provision sufficiently. The focus of further research should be on developing a management strategy to create a system in the community and finding a way to evaluate it (Hayashi, 2014).

Effectiveness of Integrated Health and Social Care

The examples of large-scale programs that integrate health and social care demonstrate the differences in implementation and how some are more successful than others. But, overall, how effective is integrated health and social care and its components? This section takes a look.

1.1 Effectiveness of Interprofessional Working

Inter-professional and multi-agency working is one key element and basis of almost every integrated care model (see 1.2.2.2). Therefore, inter-professional working has been a separate subject of investigation in the literature. Cameron et al. (2014) conducted a comprehensive review on this topic.

The research evidence on the effects of integrated working on clinical outcomes is divergent. Whereas a number of studies report improvements in quality of life, health, well-being, and coping with everyday life, evaluations that are based on a comparative design did not find any significant or marginal effects. Observed differences might reflect service user characteristics, insufficient time for services to have been fully implemented, or might simply be an artifact of the study design itself (Cameron et al., 2014).

Intermediate care services, for example, have found to be effective in terms of avoiding inappropriate admission to acute care or residential care. Also, rapid response teams that provide health and social care services in the community can play an important role in enabling people to remain in their own home (Cameron et al., 2014).

From the late 1970s to the early 1990s, the majority of studies focused on the processes rather than on the outcomes of integrated working. By contrast, today's studies purport to address such questions and offer more evidence that focuses on outcomes. Special emphasis has been placed on identifying and measuring the outcomes for service users and organizations of joint services. However, the lack of economic evaluations hampers the assessment of costs and cost-effectiveness of integrated working (Cameron et al., 2014).

To sum up, the evidence based on the effectiveness of integrated working remains inconclusive. Nevertheless, recent developments indicate that integration might have benefits for organizations and for service users and caregivers. Integrated working can lead to improvements in health and well-being, reduce inappropriate admissions to acute care or residential care and intermediate care can save costs. Results suggest that more work is required if the full potential of the concept is to be fully realized. Important in this regard is a reinforced appreciation of the aims and objectives of integration (Cameron et al., 2014).

Effectiveness of integrated care models

Admissions to hospital, service utilization and physical functioning

Beland and Hollander (2011) and Kodner (2006) reviewed integrated care models for the frail elderly. Clients who participated in integrated care models were shown to be admitted to hospital later, to have reduced hospital length of stay and a lower number of visits to the emergency room. In addition, the cumulative number of days spent in a long-term care facility or in an acute care hospital was significantly lower for the intervention group.

The PACE model, for example, showed to be very effective as an integrating mechanism in terms of decrease in hospital use (both admissions and days), reduced institutionalization (both admissions and days), and substantial increases in the utilization of outpatient medical care and therapies, as well as home and community-based services. Physical functioning results were inconsistent. In the SIPA model, utilization of all hospital-based services (emergency, outpatient, and in-patient services), but mainly of acute care hospital beds for alternate level of care patients ("bed blockers"), also decreased. In the 3-year, quasi-experimental study to evaluate the PRISMA model in the Bois-Francs region, a declining trend in institutionalization was observed. Furthermore, the model was shown to impact functional autonomy, though more frail clients have been in the study group. However, the effect disappeared in the long-term. A positive effect on caregiver burden, but not on mortality (survival) was also observed (Kodner, 2006).

In the High Intensity Case Management Model, however, no significant difference between the intervention and control groups with regard to hospital admissions or the mean number of days in the hospital was found (Kodner, 2006).

Reviewing evidence on the effectiveness of emergency department–based case management models designed to improve the health, social service utilization outcomes for non-institutionalized older patients, Sinha, Bessman, Flomenbaum, and Leff (2011) found that 8 out of 13 studies reported reductions in the re-visitation rates to the emergency departments. Obviating immediate inpatient admissions was successfully shown in five of the six studies that examined this issue. Six of the seven studies that examined the ability to reduce subsequent non-elective hospital admissions demonstrated this as well. In three of five interventions, decreases in lengths of inpatient stays were achieved. The ability to reduce subsequent nursing home admissions was demonstrated in only one of the four studies examining this outcome.

Costs and cost-effectiveness

A saving of $170,448 (US dollars) over 6 months, including the cost of case managers, was achieved by the Hong Kong Model of care, driven mainly by a significant reduction in hospital days of the intervention group compared with the control group in a randomized

trial. The Roverto Model produced an average saving of $1,806 (US) per client over a 1-year period, even after additional costs of case management were included. A cost-minimization analysis of the British Columbia model shows that for each level of care and home care, services were less costly than residential care services. This is true for costs from governmental perspective and from broader, societal perspective, including out-of-pocket expenses and the time spent by informal caregivers (Beland and Hollander, 2011).

In the High Intensity Case Management Model, no meaningful differences between the two comparison groups on the measure of total costs was observed. Also, findings of a randomized clinical trial showed the SIPA program to be cost-neutral. However, although SIPA costs for community-based care were 44% higher than those of the services provided to the control group, SIPA costs were 22% lower for institutional care (Beland and Hollander, 2011).

A negative cost balance has been shown in the Illawarra Coordinated Care Trial. The trial was established as part of a series of nine coordinated care trials in Australia that aim to coordinate care for people 65 years of age and older with complex medical needs. A deficit of $1.7 million or 12.7% of the allocated budget was reported at the end of the trial. The main cost drivers in the coordinated care group were the newly introduced care coordinators. Almost all of the coverage on budget expenditures was attributable to these added costs (Beland and Hollander, 2011).

The way forward: What still needs to be done?

To bring integrated care into practice, efforts must be made to demonstrate their effectiveness. As the examples cited have shown, a lot has been achieved already. However, some challenges remain.

Negative context factors still hindering successful implementation of integrated care

Financial savings, role ambiguity and unclear guidelines were frequently mentioned as hindering circumstances present in the current situation and extraordinarily persistent (Cameron et al., 2014; Hansson et al., 2010). The combination of multiple programs under one umbrella still remains a challenge in most of the practice examples. Providers struggle with having a solid understanding of and respect for others' methods and skills. Continuously working through confusion or conflict about service plans, team member expectations, methods, and staff performance problems requires effort. Time is devoted to team building and to resolving tensions or miscommunication between participating agencies (Paradis et al., 2013). Inflexible authorities and unclear roles were addressed as a barrier to coordination.

Additionally, a lack of organizational structure reinforced problems. For instance, staff contracts were not unified, creating differences between terms and conditions, staff appraisal systems, and tensions between managerial and professional accountability. Furthermore, IT systems were not unified, resulting in separate arrangements continuing to operate simultaneously with different access for certain members of staff. Implementation of shared medical records would often help to strengthen trust in inter-organizational collaboration and care coordination (Williams, 2012).

In all integrated models in low- and middle-income countries, financial components appeared to be a severe constraint. Health services typically faced poor infrastructure, nonexistent or poor documentation systems, and a lack of private examination and counseling rooms. Issues of confidentiality, privacy, and policies safeguarding medical records have shown to be especially challenging in those countries (Colombini et al., 2008). Funding the substantial capital and start-up costs without assistance of the federal and state governments was also difficult (Kodner, 2006).

Integrated care is complex and so is the measurement of its effectiveness

Integrated care is local. That is, programs operate in a local healthcare and social service context. The existing organizational differences in healthcare between countries will influence and set limitations for what can be achievable and even legal. Involving the social care sector makes the context even more divergent and complex. Results of most studies came from experiences in a single regional setting. Thus, a conclusion of how models generally work can hardly be drawn (Johri et al., 2003). Any generalization of findings should be made with caution.

With the diversity of programs, the range of possible methods to evaluate their effectiveness increases. The wide variation of measures that were used even for similar indicators and outcomes leads to a ubiquitous heterogeneity in evaluation methodology (Kodner, 2006; Sinha et al., 2011). Whereas some studies are descriptive, providing no information on effectiveness, others lack defining outcome measures or used outcomes that were unrelated to the intervention. Only a few studies applied a comparative design comparing treatment and control group or offering before and after comparisons (Cameron et al., 2014).

Outcome measures for assessing integrated care programs need to be further developed. The application of patient related outcomes in particular is still rare. Most studies focus on organizational and procedural measures. Frequently measured variables are emergency department re-visitations (72%), patient satisfaction (67%), subsequent hospital admissions (39%), and functional decline (33%) (Sinha et al., 2011). Where surveys and interviews with program participants have been included, most studies reported only experiences and assessments of providers or even managers of integrated care. Although

some patient experience measures are available, there is an urgent need to develop ways to measure and monitor patient experience over time, care pathways and different services (Paradis et al., 2013).

There seems to be progress towards using evaluation methods that involve both quantitative for example, service utilization, costs and effectiveness) and qualitative strategies (for example, users' experiences and service re-organization). Nevertheless, evidence of cost-effectiveness is still lacking all too often. Most governments aim at reducing public funding and improving the effectiveness of services while also delivering cost savings through integrating services this lack of research is problematic (Cameron et al., 2014).

Take away messages

Integrated care delivery can be achieved in various ways. Irrespective of which model is adopted, some key factors regarding how to coordinate different types of services effectively should be considered. These key factors arise mainly from the different interests of all stakeholders, which should be incorporated in the integrated care delivery model.

1.1 Take away messages for managers and leaders on strategic level

- Integrated care requires strong leadership and target-orientated management. Any project needs a strong and clear vision that is shared at all levels. Engagement particularly of middle managers (clinicians), who will be delivering the change understood as an ongoing process is essential.

- Integrated care needs sufficient upfront resources and carefully designed governance and financial structures that are agreed upon at the onset of the project. Umbrella organizational structures guide integration, encourage effective work, and maintain overall accountability for service, quality, and cost outcomes.

- Integrated care takes time to be developed and embedded. Sufficient time must be allowed for structures to be put in place. Expectations of professionals must be carefully managed accordingly since delays in rolling out key elements, such as IT, risk frustration and disengagement.

Take away messages for professionals on operational level

- Collaborative ways of working need to be part of "business as usual" rather than seen as additional responsibilities.

- Case-managed, multidisciplinary teamwork allows for the effective evaluation and planning of client needs, and provides a single access point into the healthcare and social service systems. It also coordinates services and allocates care responsibility.

- Standardized referral procedures, service agreements, joint training, and shared information systems, or even common ownership of resources enhance inter-professional and multi-agency collaboration in order to realize seamless care.

- Financial incentives promote prevention, rehabilitation, and the downward substitution of services, as well as enable service integration and efficiency.

Take away messages for researchers

- Evaluating the effectiveness of integrated care should be considered in advance and simultaneously with the planning of the project. Study design and required study size as well as time frame must be synchronized with the program design. Therefore, researchers need to be involved in the initial project planning

- Any evaluation needs to be designed according to the time frame it takes to develop the integrated care. The detection of changes in service utilization or clinical outcomes usually requires sufficient time.

In the future, barriers could be turned into drivers if addressed and managed properly. This reversibility allows for hope that the reorientation of care services required to meet the challenges of our ageing societies is possible (Cameron et al., 2014).

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