EUROPÄISCHE FRAUEN-UNION
UNION EUROPEENNE FEMININE
EUROPEAN UNION OF WOMEN

Health Commission

Lena Cronvall Morén, Chairman

Only the British Section has made a contribution to our discussions. Thanks to Sally Elliot, Vice Chairman and Margaret Turner, British Section for their work on this topic. In Sweden there will be a report this autumn at the ordinary meeting; what the subject will be is not yet decided.

March 2013

British Section Report: Could Integrating Care for Older People Improve Health (and Social) Outcomes?

Summary of Findings

The challenge in today's health system is how to offer high-value care in difficult financial and organisational environments. The task is especially daunting because the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. Integration is seen as one solution.

Integrated care means different things to different people. It is most often defined as an approach that seeks to improve the quality of care for patients and carers by ensuring co-ordination of care around their needs.

An 'always good' versus 'always bad' stance on integration is unhelpful. On the ground, integration is about practical questions on how best to deliver services to those that need them.

Integration is best seen as a continuum rather than as two extremes of integrated/not integrated. It involves the organisation of all key tasks which need to be performed in order to provide good quality health services.

No single 'best practice' model of integration exists. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations.

Without integration, all aspects of care can suffer. Patients can get lost in the system, services fail to be delivered when needed, or duplicated, the quality of care declines, and cost-effectiveness diminishes.

Supporting integrated services does not mean that everything has to be integrated into one package. The aim is to provide services which are not disjointed for the user and which the user can easily navigate.

Integration is not a cure for inadequate resources or bad practice but it may provide some savings to reinvest in front line care or better training.

Many professionals are convinced of the benefits of integrated care, whilst others are uncertain about what it entails and/or are threatened by the possible consequences, including the implied organisational changes. However, organisational integration is neither necessary nor sufficient to deliver the benefits of integrated care.

Integrated care is not needed for all service users or all forms of care but should be targeted at those who stand to benefit most, in order to make the best use of valuable resources and gain the most benefit.

Integrated care for people with complex needs (in particular the frail and elderly) can be achieved without further legislative changes. Indeed, a message from clinicians is that any barrier can be overcome if there is sufficient local commitment, leadership and determination.

For integrated care to work there needs to be sufficient capacity in primary and community services and rehabilitation and a subsequent downsizing of activity undertaken in acute hospitals.

Managing change in how services are delivered requires political, technical and administrative action at many levels, including commitment from the top. It does not, however requires legislative changes and should therefore be driven by the health system and not by Governments.

The outcomes of integrating services will not be assured or adequately measured whilst success is measured by numerous separate Outcomes Frameworks e.g. the NHS Outcomes Framework and the Commissioning Framework, the Public Health Framework (or the Adult Social Care Framework).

The Scope of Our Work

Significant international focus is being given to finding ways of delivering better-co-ordinated care to people living with multiple health needs. Our work has been confined initially to healthcare integration, with a view to widening this to encompass health and social care following separate work by the respective Commissions.

A comparison with the health spending per capita across Europe showed little correlation between resources and the degree of care integration or health outcome. For example the examples of best practice were found in Turkey and Greece, both of which are relatively poorly resourced. Therefore we discounted financial shortfall as a significant cause for failings in the NHS system and have not undertaken any financial analysis.

The Case for Integrated Care – who would benefit most?

In the recent integrated care projects across England, additional and improved services outside hospital were required – exposing the lack of current capacity and capability in many community services to deliver care co-ordination and intensive care in the home environment.

If executed well, an integrated model of care should help tackle waste and inefficiency and release resources for investment in new forms of care (particularly outside of the hospitals) needed to make integration work.

Integrated care is most necessary for individuals for whom a lack of co-ordination impacts on care experiences and outcomes. It is best suited to frail older people, adults and children with disabilities and those with multiple chronic and mental health illnesses, for whom care is often poor and who consume the highest proportion of resources.

The benefits of Integrated Care on Outcomes

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham et al 2011b).

Surprisingly (and disappointingly), very few studies reported on the impact of integration and tended to focus on perceived benefits rather than empirically derived outcomes.

In some cases, financial performance was better or cost per patient visit was reduced while others found no improvement in clinically related financial performance. Three NHS community trusts reported flatter organizational structures, that is, fewer management tiers and thus savings in administration.

NHS Torbay, a well-established integrated health system, reported a reduction in A&E visits and in the length of stay in hospital. Staff there reported greater job satisfaction, blending of professional cultures into a shared culture, increased teamwork and communication with other sectors, which they believed benefited patients.

With fewer patients presenting at hospital or staying a shorter time, there was greater dependency on community services with the resulting increase in workload (which needs funding from savings elsewhere).

There was universally positive carer and patient feedback on all studies we reviewed.

Recommended Approaches

Different approaches have been taken but integrated care is likely to be more successful when it covers large populations (city or county), a range of groups (e.g. older people, certain medical conditions) and those needing specialist long-term support.

Integration works best where there is good access to extended primary care services (GPs, pharmacists etc.), good health promotion and co-ordinated community-based packages for rehabilitation and independent living.

The evidence shows that it is the cumulative impact of multiple stands of integration that are more likely to be successful in improving the outcomes for patients. This was confirmed by the limited number of carers and patients we have spoken to.

There are many ways to achieve integrated care, but no one best model for doing it, so it follows that any national framework must be permissive and based on 'discovery and not design'. The focus should be on removing the barriers to integrated care and avoiding being prescriptive about how it should be done.

Current Barriers to Integrated Care

We sought to find out why it seems so challenging to develop services that patients and carers feel is well co-ordinated and not reliant on regular prompts and actions by them. There seems to be a number of barriers to integration, including

- The NHS management culture and targets that prioritise certain areas of care with discomfort about investing in developments that challenge the configuration of local hospital care.
- The divide between primary and secondary care in the NHS.
- The lack of time and sustained project management support to prove that integrated care works.
- The absence of sound shared electronic patient records that are accessible to and used by all those involved in providing care to people with complex conditions.
- The persisting weakness of commissioners, who have struggled to use their power as 'paymaster' to exert changes that might avoid fragmentation and duplication.
- The Payment by Results approach to funding hospital activity that has incentivised hospitals to increase admissions, and mitigates against community health, hospital and GPs coming together as a network to develop and deliver integrated care
- NHS regulation that focuses too much on organisational performance and not enough on performance across all organisations and systems in a local health economy.

In talking to those working on the ground, none of the above barriers is seen as so fundamental that they cannot be overcome if there is sufficient local commitment, leadership and the will to succeed.

It was felt that effective integration can be achieved without the need for formal merging of organisations. What matters most is the clinical and service integration that improves care co-ordination around the needs of individual patients. Organisational integration may be a consequence of clinical integration but it should not be the starting point.

Next Steps

It is hoped that we can gain a European perspective by sharing our work and findings with other Section's Health Commissions, but to date we have had no International involvement from our counterparts.

Norman Lamb MP, Minister of State for Care and Support has expressed an interest in our work and has asked to receive the final report to submit as evidence to the Department of Health to support the development of a national strategy for the promotion of integrated care.

Margaret Stockham marg.turner@ntlworld.com

Chairman Health Commission
European Union of Women, British Section

February 14th 2013

APPENDIX A

Average Life Expectancy across Europe

European countries have achieved major gains in population health in recent decades. Life expectancy at birth in European Union (EU) member states has increased by more than six years since 1980, to reach 79 years in 2010, while premature mortality has reduced dramatically. Over three-quarter of these years of life can be expected to be lived free of activity limitation. Gains in life expectancy can be explained by improved living and working conditions and some health-related behaviours, but better access to care and quality of care also deserves much credit, as shown, for instance, by sharply reduced mortality rates following a heart attack or stroke.

Many health improvements have come at considerable financial cost. Until 2009, health spending in European countries grew at a faster rate than the rest of the economy, and the health sector absorbed a growing share of the gross domestic product (GDP). Following the onset of the financial and economic crisis in 2008, many European countries reduced health spending as part of broader efforts to reign in large budgetary deficits and growing debt-to-GDP ratios.

Life expectancy at age 65 has also increased substantially in European countries, averaging16.5 years for men and 20.1 years for women in the European Union in 2008-10. As for life expectancy at birth, France had the highest life expectancy at age 65 for women (23.2 years) but also for men (18.7 years). Life expectancy at age 65 in the European Union was lowest in Bulgaria for women (16.9 years) and Latvia for men (13.2 years)

Large inequalities in life expectancy persist between socioeconomic groups. For both men and women, highly educated persons are likely to live longer; in the Czech Republic for example,

65-year-old men with a high level of education can expect to live seven years longer than men of the same age with a low education level.

It is difficult to estimate the relative contribution of the numerous non-medical and medical factors that might affect variations in life expectancy across countries. Higher national income is generally associated with higher (healthy) life expectancy, although the relationship is less pronounced at the highest income levels, suggesting a “diminishing return”.

Chronic diseases such as diabetes, asthma and dementia are increasingly prevalent, due either to better diagnosis or more underlying disease. More than 6% of people aged 20-79 years in the European Union, or 30 million people, had diabetes in 2011. Better management of chronic diseases has become a health policy priority for many EU member states. (Health at a Glance, Europe 2012, OECD)

Healthcare Funding Across Europe

Public and private funding mix

Most European countries have universal (or near-universal) coverage of health care costs for a core services, but two countries do not yet have universal health coverage. Cyprus has an estimated 83% of the population entitled to public health services. A new National Health Insurance System has been proposed to extend coverage. In Turkey, public coverage has increased rapidly and was estimated to be 98% in 2012.

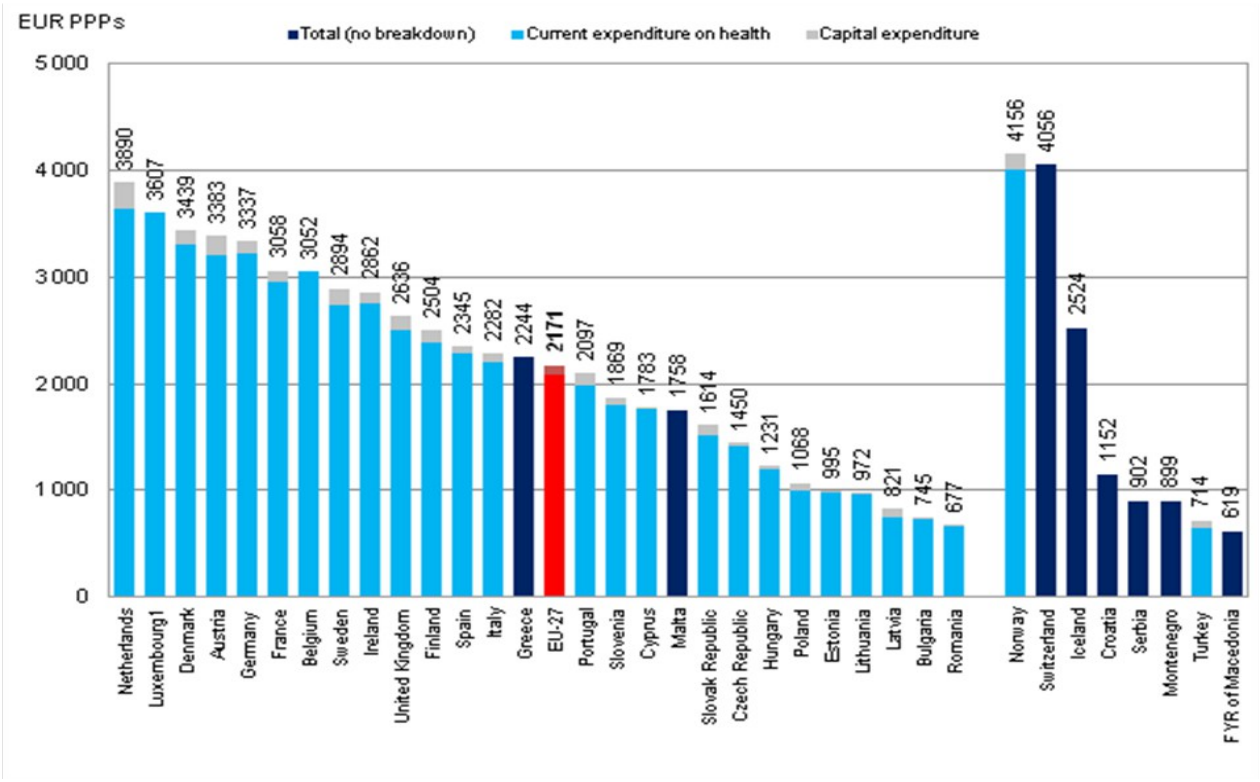
Basic primary health coverage, whether provided through public or private insurance, generally covers a defined “basket” of benefits, in many cases with cost-sharing. In some countries, additional health coverage can be purchased through private insurance to cover any cost-sharing left after basic coverage (complementary insurance), add additional services (supplementary insurance) or provide faster access or larger choice to providers (duplicate insurance).

In most European countries, only a small proportion of the population has an additional private health insurance. But in France, nearly all the population (96%) has a complementary private health insurance to cover cost-sharing in the social security system and in Belgium, Luxembourg and Slovenia a large proportion of the population has complementary health insurance. The Netherlands has the largest supplementary market (89% of the population), whereby private insurance pays for prescribed pharmaceuticals and dental care that are not publicly reimbursed.

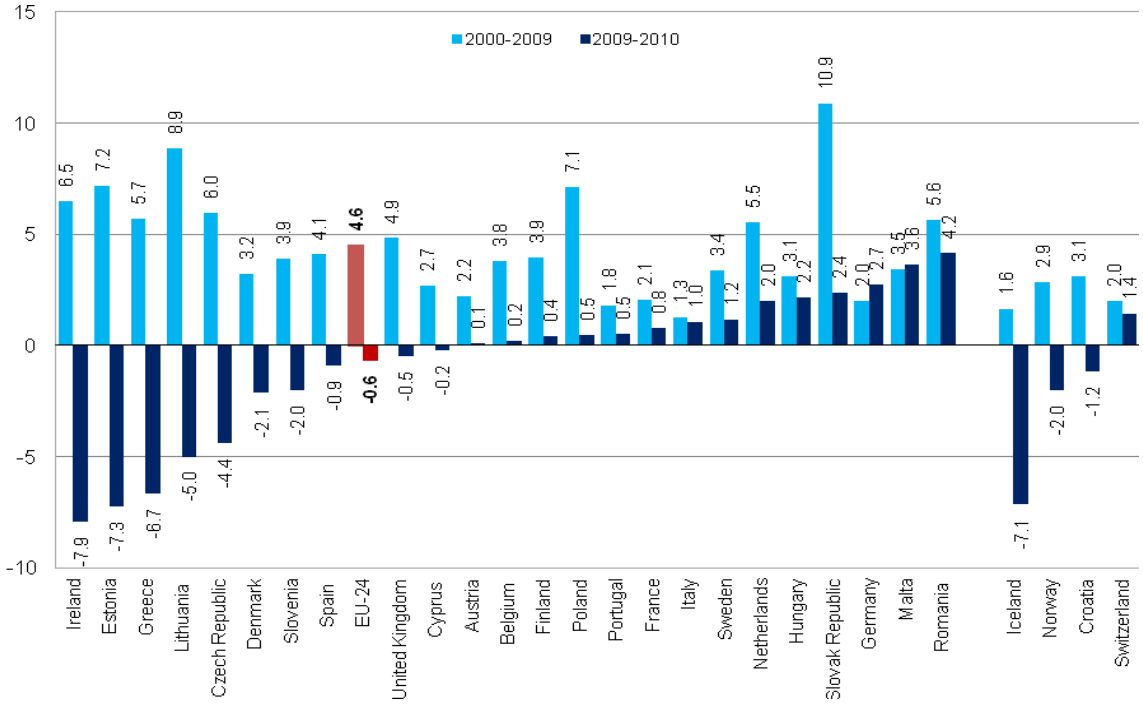
Duplicate markets, providing faster private-sector access to medical services where there are waiting times in public systems, are largest in Ireland (50%). The population covered by private health insurance has been growing over the past decade in some countries including France, Belgium and Germany, but not in Ireland and Luxembourg.

Health Spending across Europe

The following tables show the total expenditure and the increase in expenditure by country:



Annual average growth rate in health expenditure per capita, in real terms, 2000 to 2010 (nearest year)



Source: OECD Health Data 2012; Eurostat Statistics Database; WHO Global Health Expenditure Database 1 2

APPENDIX B

Integration – A European Perspective

An unequivocal message from the literature is that, as with the UK there is no single, agreed definition of integrated care. Integration can take place at a number of levels: team, service or organisation. It can apply to a small number of specialist services or to the full range of health and social care services.

The following two tables show some of the varieties of approaches

Table 1 Main concepts of integrated care in selected EU Member states

Key concepts integrated	**A**	**D**	**DK**	**EL**	**F**	**FIN**	**I**	**NL**	**UK**
Public health discourse	**	**	**			*	***		**
Managed care (health system)	**	**	*		*	*	**	*	***
Horizontal integration (provider mix)	**	**		**	*	*	*	*	*
Vertical integration integration						**	**		**
Seamless care/transmural care	*					***		**	*
Gerontological co-ordination/networking	*	*			***		*		
Whole system approach									*
Person-centred approach			***			**		***	**

Source: PROCARE EU Fifth Framework Programme

** most important concept being followed and implemented in mainstream provision
*

** important concept followed (partly implemented)
* concept being discussed and tried out in experimental (model) projects.

Table 2
The status of different strategies and instruments to achieve integrated care in selected EU Member states

	A	D	DK	EL	F	FIN	I	NL	UK
Case and care management	*	*	***			**	*	**	***
Intermediate care	*	*	**			**	*	**	**
Multiprofessional needs assessment and joint planning			**		**	**	**	**	***
Consumer directed services: personal budget/long-term care insurance	***	***	*		**			***	*
Joint working	*	*	***		*	**	*	**	**
Admission prevention and guidance		*	***	**				**	**
Integrating housing, welfare and care	*	*	***	*	*	**	*	**	*
Integration of family carers (incl. targeted respite schemes, employment)	*	**		*	**	**	*		*
Independent counselling	*	**			*			**	*
Co-ordinating care conferences		*	**		*				**
Quality management/assurance	*	**	*		**	**	**	*	**

Source: PROCARE EU Fifth Framework Programme

** broadly perceived and applied as a main stream method; national standard

*

** partly implemented on a local or regional level

* Applied in an experimental stage (model projects)

However, there is much continuing research and many calls for change in the provision in health and social care across Europe as all countries struggle with the issue of increased longevity.
For example: A new position paper, *Developing a New Understanding of Enabling Health and Wellbeing in Europe*, published by the European Science Foundation, highlights this need for change and suggests a number of priorities for important advances to be made toward the harmonisation of healthcare delivery and informatics support:

- Integrated delivery of health care and social care support of individual's health
- Personalised care delivery including reasonable accommodation of individual choice
- Ensure effective use of ICT applications based on user acceptability
- Bring processes of consent, delegation, representation, coordination and privacy into the electronic era
- Ensure respect for and teamwork with formal carers and the informal care team
- Ensure equity in an electronic era regardless of digital literacy, assets and connectivity
- Examine stable , sustainable models of trusted infrastructure provision
- Establish governance, authentication, management, and sustainability principles.

Although technology has a great part to play in the efficient organisation of care we should not forget the vital role of human contact for the elderly and vulnerable.