Providing integrated health and social care for older persons – A European overview

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Preface

Doing research on long-term care with a focus on the interfaces between health and social care, between institutional and community care and between primary and secondary health care calls for a broad scope of experience and perspectives that often go beyond classic scholarly divisions. This is especially true when it comes to transnational projects with the aim of comparative perspectives. Even though interdisciplinarity has increased it cannot be denied that the social and health divide is still reflected by different approaches, thus duplicating or reflecting the reality of organizational structures, policies and professional cultures.

“Providing integrated health and social care for older persons” (PROCARE) is an international research project co-financed by the European Union’s Fifth Framework Programme (Quality of Life and Management of Living Resources, The Ageing Population and Disabilities). The challenge for PROCARE – and thus also of this first European overview – consists in taking into account the different professional and organizational backgrounds of individual researchers in the different national teams, most of them social gerontologists, some with a special focus on social policies, some more public health oriented, with psychological or social work training; in addition, there are also some economists and nursing professionals. Together we are to explore the realm of integrated care in Europe, to find out about different approaches towards what has been described as one of the most prominent shortcomings in European health and welfare systems – the improvement of service delivery at the interface between the health system on the one hand and the system of social care for older persons on the other. Allegedly independent from national traditions and structural peculiarities of national health and social care systems the last 20 years have brought partial success, some innovation but overall failure to sustain co-operation between organisations and persons involved.

The idea for this project was born as new challenges and changing political and economic contexts in EU member states call for a new effort to define the concept of an integrated health and social care for older persons in need of care and to contribute to the provision of a sustainable model of this type of service by comparing and evaluating different modes of care delivery. From similar attempts that are undertaken contemporarily we feel supported in our aim to look for ways to increase the quality of life of older persons in need of care. Still, PROCARE is one of the first attempts to map a relatively weakly documented area.

The following overview is a first attempt to draw together information from nine national reports that were produced by the teams from Austria, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, and the UK participating in the project. As co-ordinator and author of the European overview I owe all my knowledge and findings to my colleagues who provided both their inputs and their comments to realize this first stage of a project that will go on to carry out detailed case studies on model ways of working in the participating countries.

1 To name but a few examples, we would like to draw the reader’s attention to initiatives in the context of the WHO European Office for Integrated Health Care Services (see http://www.euro.who.int/ihb and http://www.ijic.org; Delnoij et al, 2002) and the Thematic Network in the EU 5th Framework Programme “Managing the integration of services for older people” (CARMEN).
1 Introduction: A common agenda in spite of diverse health and welfare systems in Europe?

Comparative approaches of European health and welfare systems are a most fascinating attempt to compare apples and oranges. Both general comparisons (Flora, 1986) and the ensuing attempt to categorize different systems (Esping-Andersen, 1990), specific areas of social policies (Cichon et al, 1998), health policies (Freeman, 2000), and detailed studies on long-term care systems for older persons (Pacolet et al, 1999) have elaborated on these differences and thus enriched the scientific and political debate. Also the development of the European Union has contributed to an ever increasing interest in comparing social policies and trying to find common traits as a basis of a “European Model”.

Focusing on the interface between health and social care services and potential coordination and integration mechanisms seems to be even more fascinating as we address an area that is influenced by all the above mentioned differences between but in particular within the single countries. As we are dealing with personal social services, the local often becomes more important than the national or the European context. Still, we have to take into account national frameworks and their differences, in particular with respect to financing, systemic development, professionalization and professional cultures, basic societal values (family ethics), and political approaches.

There is no need to underline that health care expenditures are diminishing from Northern to Southern European countries, and even knowing that the level of GDP does not necessarily reflect the level of health care services it still offers a picture of its relative importance in the different countries (Kanavos/Mossialo, 1996). On the other hand, we do not even dispose of such a measure or indicator if it comes to expenditures for long-term care as they usually are dispersed between various budget lines of the social assistance systems or simply subsumed to health expenditures. In any case one can say that social care services are by far less funded and less privileged than health care services which leads to a first question that will be addressed in this overview:

- In how far may an integrated health and social care system give space to social care as part and parcel of this type of care delivery? Could co-ordination be a first step to integration in order to prevent social services from loosing their autonomy?

In all countries, social care services are characterized by a definitely shorter history than health care services. We can observe different traditions and states of systemic development in the context of a general North-South-gap. On the one hand, the Nordic countries started to develop specific social services already during the 1950s, thus undergoing a marked differentiation between different types of services and institutions, and respective professional concepts and approaches. On the other hand, in Southern Europe we experience a general scarcity of social services that present themselves still in a “pioneering phase” with respective difficulties concerning funding and staffing. This is in sharp contrast to the general health care system, which is – despite all differences concerning their extent and quality – characterized by quite well-defined medical professions, differentiated competences and values.

These differences between and within countries may be highlighted by the simple fact that, while medicine and – in many countries – also nursing studies are approved university studies, social service professions are often lacking even national regulations, not to mention international acknowledgments (Badelt/Leichsenring, 1998). Furthermore, the different status of social and health professions may be gathered from the income gaps and deteriorating general working conditions the
more “social” a service is defined. Finally, research expenditures with respect to social care are far behind spending on medical research.

- A main question for this European overview and for PROCARE in general will thus be how joint working and integrated modes of care delivery can be promoted in spite of these differences to improve the quality of life for the users of these services.

Another general feature that has to be considered in relation to long-term care systems is concerning societal values and respective political approaches to face the growing challenge of meeting long-term care needs in an ageing society.

- In how far is long-term care a task of the family and in how far are family carers capable and/or prepared to deliver long-term care? What will be the role of the family in evolving coordinated or integrated service schemes? How can family or informal care be included as a partner in long-term care delivery?

These ambiguities and puzzling issues are, at this moment in time, confronted with additional economic, demographic and societal developments that, at first sight, do not seem to favour innovation and investment in social care issues. However, PROCARE is to elaborate on those aspects and opportunities that could be used to further promote the idea of integrated service delivery.

One of those aspects is the surprisingly similar agenda in terms of health and social reforms, in particular in the area of long-term care. This is why we would like to take up the discourse on coordination and integration in the new context of attempts to increase care at home, to raise the quality of services and the quality of working conditions towards a European model of social well-being.

In the following, firstly, the legal and structural framework, current debates and political perspectives with respect to integrated care will be highlighted with some more details from the participating countries. Secondly, and based on these general observations, the understanding of integrated care in the different countries will need some clarification. Thus, in Section 3 we shall try to reflect on the definitions and approaches described in the national reports and in the general debate on integrated care. This discourse will be taken up in the following article (Alaszewski et al, 2003) to lead to a more common understanding of integrated care. The task of the present overview is then (Section 4) to draw attention to most interesting features from the practice of integrated care and/or co-ordination efforts in the realm of health and social care for older persons. All national reports reflect a wealth of experience from both model projects and mainstream ways of working. These concepts, methods, strengths but also weaknesses should be taken as a basis for further policy developments and for evaluation methods of such ways of working. After some short considerations concerning the different stakeholders (Section 5), the overview will end with some reflections on perspectives and necessary debates for the desired improvement of integrated care delivery.
2 Integrating health and social care services: the national contexts

2.1 The legal and structural framework

The differentiation between health and social care services starts in all countries from the fact that health matters are usually regulated by a specific ministry in the framework of a national health system (UK, Greece, Italy, Nordic countries) or a national social insurance system (Austria, France, Germany, Netherlands), while social care issues are tackled within the social assistance systems that are, depending on respective decentralisation, usually administrated by regional or local entities. In most countries the right to health is thus defined quite differently than the right to social care.

Although specific legislation on integrated care is scarce, we can observe an increasing number of policies and respective legislation with respect to long-term care financing and organisation. On the one hand, the number of countries with long-term care schemes has grown remarkably during the last decade (Evers et al, 1994; Pacolet et al, 2000). While for a long time only the Netherlands provided for a comprehensive social assurance based funding mechanism for long-term care, countries like Austria, Germany, France and the UK started to install specific schemes during the 1990s. In addition, a new scheme was recently introduced in the Netherlands to provide for a “personal budget”.

The general trend of these provisions is to allow for cash payments to the person in need of care – not only older persons – and/or their family carers as a way to acknowledge the role of family care and the fact that a complete professionalization of long-term care will not be feasible. Furthermore, such schemes are to offer persons in need of care the possibility to decide more independently on which kinds of services to use. For the integration of services, such schemes are obviously ambiguous as the clients may now choose more independently whether and which kind of service to use. Some of these schemes, in particular the German Long-term Care Insurance and the French “APA”, are – at least partly – based on voucher systems.

These trends have nevertheless called for more defined coordination mechanisms between providers or between national and regional levels. In particular in those systems, where free market mechanisms have been introduced, accreditation systems and quality control were to be developed as public administration was to change its role from a provider to a “purchaser” of services – increasingly, public administration authorities seek to amplify their steering capacities to guarantee and control services, rather than to produce them directly. While in some countries, this approach can build on a long tradition of third sector organizations that have always provided an important part of social services (e.g. Germany, Austria, the Netherlands), for both Nordic and Mediterranean countries this development has gained in importance under the title of extended “privatisation” of hitherto public services. This general trend towards “new public management” is producing very exciting results as it is applied in all types of social and health systems in Europe.

Therefore, we can find remarkable legislative initiatives concerning “out-contracting”, quality control and the promotion of new types of commercial and, in particular, non-profit providers. For instance, in Italy, a national framework law “for an integrated system of interventions and social services” was introduced in the year 2000 in order to regulate, on the one hand, the relationship between public administration and private non-profit providers and, on the other hand, to call for an
integrated planning and the co-ordinated provision of health and social services within so-called “social zones” (districts covering several municipalities within a health district). From 2004/5 onwards regional health and social budgets will be based on respective plans of the social zones so that all actors are given an incentive to participate in round-table discussions and other participative planning procedures.

“Regulating by incentives” can also be observed in other countries. In Germany, where the free market of care services was unleashed with the introduction of the LTCI, providers have to comply with minimum standards and are invited to participate in regional “care conferences” and in ongoing negotiations on quality assurance. In the Netherlands, where the government tries to implement an increasingly demand-driven policy, “care-friendly districts”, i.e. areas in which explicit attention is paid to the improvement of the living surroundings, infrastructure, and facilities, are promoted by means of model projects. Those projects that are aiming at improving the interfaces between housing, care, and service are subsidised, thus enhancing interagency-cooperation.

Also in Finland, the quest for co-ordination mechanisms is more based on incentives than on general legislation. The Finnish Ministry of Social Affairs and Health – one of very few examples in Europe where both competences are combined in one ministry – has addressed quality issues by providing a “National Framework for High Quality Care and Services for Older People” as part of the current national “Target and Action Plan”. In France, local information and co-ordination centres are promoted (“Centres Locaux d’Information et de Coordination”/CLIC) by the Ministry for Employment and Social Solidarity as a means to introduce a more systematic orientation towards joint working (information, assessment, implementation and monitoring) by socio-medical teams.

Legal and structural barriers

All these initiatives by central governments show that there is growing awareness towards the necessity of integrated care provision. However, in general these services are regulated and provided within decentralized structures. Competences thus are not only divided between “ministries” (health on the one side, and social affairs on the other) but in particular between central, regional, district and local levels. The lack of federal legislation is thus only a minor shortcoming, given the enormous regional differences in service provision within the countries. Even in Denmark, a small country with a most developed national care policy for older persons, the responsibilities of implementing health and social policy have been delegated to the counties and municipalities – with resulting inequalities and local differences in budgets and quality.

Some illuminating examples for barriers to co-ordination and integration stemming from decentralized decision-making are provided by the Austrian and the German report. In both countries, decentralization is “doubled” by the fact that social and health insurances are “self-governed” bodies with particular (corporatist) power structures. In Germany, for instance, health insurance companies may now conclude contracts directly with selected cross-sector provider networks (physicians in private practice, hospitals, outpatient care and rehabilitation services, etc.) in order to “integrate” outpatient and inpatient care. The primary interest is, of course, to curb cost expansion but nevertheless the implementation of the regulation is still not settled as there continue to exist different financial regulations and segmented budgets for outpatient and inpatient provisions. In Austria, the division between “cure” and “long-term care” services is particularly strict. For instance, social health insurance is funding only a small segment of out-patient services, i.e. those that are prescribed by the general practitioner and defined as preventing hospital care.
Also in France the national incentives to develop CLICs often clash with the standard organization of social services on the local/regional level, in particular with the regional implementation of the “autonomy allowance” (APA).

The lack of joint budgets and the differences in financing health and long-term care are generally named as the most significant problems towards integration of service provision in all countries. The concurrent problems in financing health care and the various health reforms to curb cost expansion are hardly ever combined with considerations on long-term care, although “bedblocking”, repeated examinations, unnecessary referrals, selective treatment strategies, revolving door effects, technology orientation etc. were identified as most important cost drivers. Still, long-term care budgets, if reflected in national budgets at all, make up a share of five to twenty percent of general health expenditures in the participating countries. The “late comer” in social protection systems, constituted by the long-term care sector, thus remains underdeveloped and in the shadow of problems in health care financing.

2.2 Current debates and new policies

Given the above context, if it comes to debates on integrated provision of health and social care, general discourse is mainly focusing on health care reforms and respective instruments to prevent cost expansion. In a wider context, those kinds of reform discourses have progressively been based on market driven considerations with the aim to reduce supply, e.g. of hospital beds by DRG-financing, and to regulate demand, for instance by the introduction or augmentation of user fees and other mechanisms to prevent accession. However, the introduction of quasi-markets in the health realm did not automatically lead to an “integrated” thinking. It rather directed health managers (and politicians) to keep on thinking in health care terms, and to externalize costs towards the long-term care sector without respective shifts in financing and payments. For instance, some reports (see Austria, UK, Germany) made visible that the reduction of hospital beds and DRG-financing in all countries led to an increasing pressure on long-term care services, in particular community care that was confronted with more clients needing more medical care. Compared to the health care sector, there are only small groups with less political influence that are advocating in favour of social care issues.

What we can observe, therefore, is the development of two separated “quasi-markets”, one in the health sector, and the other in the social care sector. As new public management approaches have now also reached social service sectors, competition, cost-efficiency and quality management have contributed to a more competitive management also in social care, thus perhaps creating a basis for a common language to be adopted in integrated care provision.

Are market mechanisms hampering integrated care provision?

At first sight, however, it seems that market mechanisms are preventing integrated care provision. For instance, in the UK the introduction of competitive markets – in the absence of a single health and social care budget – posed a problem to those who were to purchase “continuing care” for patients with long-term support needs. Tensions between acute hospitals and other services, between

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2 This phenomenon is also reported for Sweden (see Andersson/Karlberg, 2000), where the “Ädel”-reform succeeded in reducing the number of persons waiting for discharge from the hospital but triggered increasingly heavy burdens on nursing homes and community care.
different providers and with respect to “the lead role” in assessing and implementing care packages have been reported (Lock, 1996; Hudson/Henwood, 2002; see Alaszewski et al, 2003), thus underlining the social and health care divide, rather than creating incentives for joint working. This experience of market mechanisms without common rules and budgets, for which the UK is the most outstanding example, should prevent other countries from a similar development that, however, might be necessary to trigger the ensuing debate in Britain. With its 1999 Health Act the British government has tried to overcome the existing impediments to joint working by allowing for pooled budgets, lead commissioning and integrated providers.

These developments have nourished our general impression of the beginning of a new phase in the debates on integrated care. What in most countries was for a long time criticized as a mere lip-service on preventing institutional care, has now gained in importance with respect to the development of new policies that, first of all, can be retrieved in policy statements and changes in rhetoric such as, for instance, the discourse on “seamless care” (Burda, 1992) that can now be found in many policy documents (UK, Finland), the focus on “intermediate care” (Vaughan/Lathlean, 1999; Department of Health, 2002; see UK report) and joint working (see the NL report for an extended approach of “extra-muralisation”; see also Jedeloo et al, 2002). Also the multitude of model-projects in the area of co-ordination and integration might be interpreted as a further milestone towards solutions, even if these projects often still lack strategies for follow-up, organisational learning and their translation into mainstream practices.

The role of institutional care

An old feature within the discourse on integration of services is the dichotomy between institutional and community care. Under the general heading “care at home is better than institutional care” integrative processes have often been impeded, rather than facilitated. Indeed, a number of scandals and even homicides in nursing homes have highlighted potential consequences of institutionalisation and hospitalisation. These incidents have, however, also triggered a number of reforms, innovations and improvements in the residential sector. Still, it is not easy to motivate and sustain staff in institutional care if professionals are constantly confronted with the dreadful image of old-age or nursing homes. The discourse on integrated care should help overcoming the “either-or” debate by redefining the role of institutional care in the “chain of care”.

From a European perspective, however, we have to be aware that different realities do exist close to each other. While in the Northern countries institutional care makes up to 12% of the provision – and still faces the problem of waiting lists (see Dutch report: Ex et al, 2003) – in the Southern European countries much lower shares of institutional care are on offer (about 3% of older persons are living in institutions in Italy, respectively less than 1% in Greece; see Italian and Greek report; Nesti, 2003; Sissouras, 2003). Thus, further development of institutional care is much more on the agenda in these countries. While in Denmark the construction of institutions became inhibited by law and thus has come to a halt; while in the Netherlands major reforms of the institutional sector have been put in place (“extra-muralisation”); while in France and other countries “small units” are being promoted, Southern European policy makers strive, first of all, for a quantitative increase, in particular with respect to the private residential care sector.

In this situation it is high time to develop general standards (also on the European level) concerning accreditation criteria, quality assurance and standards concerning the inclusion of residential settings in local service networks. Both qualitative and quantitative improvements are at stake, in par-
ticular with respect to the interface between residential settings and community care, but also be-
tween nursing homes and hospitals.

Long-term care: From “poor law” to citizen’s rights?

It is interesting to draw a direct link from improvements in the residential sector to considerations
on citizen’s rights and integrated service delivery. The strict division between the right to “cure”
and the discretionary provisions of social care services has become more and more cynical, in par-
ticular in countries with a well-established health system – be it in terms of a social insurance (Aus-
tria, Germany, France), be it on the basis of a national health system (Italy). Therefore, it was espe-
cially in these countries that policies started to shift long-term care issues from “poor law” provi-
sions towards legal systems underpinned by rights in terms of quality and financing. In Germany,
the LTCI brought long-term care directly in line with health care services, even though different
mechanisms of guaranteeing services have been implemented. Also France is moving in that direc-
tion, while in Austria the tradition of cash allowances – still based on citizen’s rights – was rein-
forced and financing was guaranteed by the general budget, rather than social insurance. A special
case is Finland, where a “National program for social services to enhance old people’s rights to ser-
vices” is underlining the commitment to improving old age care (Salonen/Haverinen, 2003).

Still, most of these initiatives are approaching long-term care issues in a distinct manner, rather than
trying to integrate funds and funding mechanisms. This might be due to the fact that most policy
makers try to govern the increasing demand by means of supply-driven policies and mechanisms.
Little by little, however, we can observe flourish first trends towards “demand-driven” policies, i.e.
initiatives that start integration from a user’s perspective and from the needs expressed by the users.
Examples can be found in Denmark, where prevention is taken serious by means of “preventative
visits of older persons at their homes”, in the Netherlands, where “hidden care demand” is tried to
be retrieved, and in the UK, where joint budgets (“care trusts”) are on the agenda.

Still, many if not most of the initiatives towards integrated care delivery remain in a phase of model
projects – and many remain there. Indeed, there is already a long tradition of model projects (with
and without evaluation studies) in most of the participating countries. In many cases, these model
projects withered away after two or three years, even if results seemed promising. In other cases,
and not the least, integration projects failed anyway due to one or the other variable that had been
omitted and/or not respected. In both cases, however, experiences faded away with the persons who
had been involved and follow-ups were rare. Real organizational learning strategies could not be
found but it is no coincidence, that many national reports are referring a “new wave” of model pro-
jects to be implemented presently. Before summarizing some of these new developments, however,
it will be necessary to describe and categorize the different approaches to integrated care, influ-
enced by national traditions, the phase of system development, and professional backgrounds of
those promoting and organising new ways of service delivery.
3 Different understandings of integrated care

Integrated Care is a concept of providing care services in which the single units act in a coordinated way and which aims at ensuring cost-effectiveness, improving the quality and increasing the level of satisfaction of both users and providers of care. Means to this aim are the reduction of redundancies, the enhancement of continuity and customizing services within the process of care provision as well as the empowerment of the users of the care services.

In this context the term “unit” can have a multitude of meanings, for example care providers, strategies of care provision or care services. The process of integration can aim at linking parts within a single level of care, e.g. the creation of multiprofessional teams (horizontal integration) or the linking between different levels of care, e.g. primary, secondary and tertiary care (vertical integration). Those links can work in one direction or include a feedback-mechanism. The concept of integrated care can be found in various countries and under various names, e.g. seamless care, transmural care, case management, care management and networking (Gröne/Garcia-Barbero, 2001; Delnoij et al, 2002; Kodner/Spreeuwenberg, 2002).

Integration within and between care services is especially important when it comes to service provision for elderly people. Elderly patients tend to be chronically ill and being subject to multimorbidity. Hence a broad spectrum of needs has to be met over a long period of time. To fulfil this task there is a vast number of possibilities to choose from: health and social care, formal and informal care providers, intra- and extramural services and many more (Ewers/Schaeffer, 2000: 8f.; Steiner-Hummel, 1991: 162; Wendt, 2001: 166f.). Considering this fact the essentiality of integration and the diversity of concepts to realize it become obvious.

In general, we can observe two larger streams within the integrated care discourse. On the one hand, there have been developments starting within the health care realm, on the other hand there is a broader approach putting increasing emphasis on social services and social integration.

In particular public health scholars and health management literature, exploring into “managed care” and other forms of integrated care, are departing much more from a health care perspective. Also the WHO has taken up this approach, not least by the implementation of a “European Office for Integrated Health Care Services” in Barcelona. This institution suggested the following as a working definition of integrated care:

“… a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve the services in relation to access, quality, user satisfaction and efficiency” (Gröne/Garcia-Barbero, 2001: 10).

Also Kodner/Spreeuwenberg (2002), who contributed an important bit to the definition exercise, can be located in this stream of thought as they take a “patient-centric view on integrated care”, though taking into account the “provision of health care, social services and related supports (e.g., housing) at the right time and place” (Kodner/Spreeuwenberg, 2002: 3).

It is exactly this broader approach that most national reports of PROCARE have looked at, in view of opportunities to create a more equal inclusion of the social services realm in the integration discourse. As within most concepts, we still can find a variety of meanings, approaches, theories and practices in the participating countries of PROCARE. In a geographic perspective, the approach might be interpreted as “Northern European” as Niskanen (2002: 1f.) put it:
“Integrated care includes the methods and strategies for linking and co-ordinating the various aspects of care delivered by different care levels, of primary and secondary care. In Finland the concept of integration applies also to the social services, since especially long term care patients need support, which is a duty of the social sector as well.”

Pragmatically, the Danish report illustrates this approach as follows:

“The integration of health and social services implies that the services are provided to all elderly – independent of where they live – by integrated teams of home-helpers, home nurses etc. Each older person in need of support has a case manager in the municipality, who is the individual counsellor of the older person applying for support. The case manager coordinates the services and calls them off when the client is hospitalised, on vacation or when s/he is visiting relatives. The decision for support is made on request from GP’s, hospitals, the elderly or relatives.” (Colmorton et al, 2003: 6)

The Finnish report (Salonen/Haverinen, 2003) refers to integrated care as seamless service chains, i.e. as “an operating model, where the social welfare and health care services received by a client are integrated into a flexible entity which will satisfy the client’s needs regardless of which operating unit provides or implements the services (Ranta, 2001: 274, 275).

This definition is very close to the Dutch notion that, both in theory and in policy-making, is tending towards the construction of “demand-driven” care systems that, in summary, are promoting integrated care delivery:

“Demand-driven care simultaneously means integrated care for, when the requests and needs which the client may experience in various areas are met, integrated care is provided. From a client perspective, integration is realised when (s)he can dispose of the required care provisions, the adequate types, the accurate quantity, and delivered in the appropriate order and at the right moment in time.” (Ex et al, 2002)

This concept draws on the individual as the point of departure and tries to de-medicalize long-term care, focussing on the interface between independent housing and care (“transmural care”; see also van der Linden et al, 2001), inter-sectoral joint working and the development of service-networks to guarantee older persons’ participation in society.

In Austria, the scientific discourse on integrated care is mainly influenced by the “Public Health” approach (integration between primary and secondary care) but it was extended with a view to both the vertical and the horizontal level, and to social service delivery. The definition of integrated care given in the Austrian report (Grilz-Wolf et al, 2003) is thus clearly in line with those described hitherto. The idea of integration refers to a process aiming at guaranteeing demand-orientation, a continuity of provision and a high standard of quality (Grundböck et al., 1997; Kain, 1994; LBI, 2000).

At the centre of attention is in particular the hospital/community care interface. This focus is comparable with the German one: also in this country transition from hospital to subsequent care is the area where, for instance, a high number of model projects have been carried out, very close to what has been called “intermediate care” in the UK, i.e. a range of services to “facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient’s discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired” (Steiner, 1997: 18).

In the UK, a variety of similar terms have been used to describe integrated care, including ‘joint working’, ‘partnership’ and ‘collaboration’, but the actual meaning of ‘integrated care’ has never been clearly defined within policy documents – there is a sense that understanding of this and other
related terms is taken for granted or assumed. The UK report (Alaszewski et al, 2003) refers to a recent definition provided by the Audit Commission which has developed a ‘systems model’ of organisational partnership. According to this definition “whole system working takes place when services are organised around the user, all of the players recognise that they are interdependent and understand that action in one part of the system has an impact elsewhere” (Audit Commission, 2002: Section 1.2). Users should thus experience services as “seamless” and providers share “vision, objectives, action (including redesigning services), resources and risk” (op. cit.). This concept is surely most remarkable, though its translation into practice will call for major efforts concerning organisational development and communication between players. This definition as such could in any case help to create a shared vision between scientists, policy analysts and practitioners.

The question remains, whether this definition is really meaning “integration”, rather than “coordination” or “networking”. As the French national report recalls, “integrated services are a set of services made available for a specific population group over a given geographical area, or for the population of a given geographical area, by a single company or organisation, grouped together under a single decision-making authority” (Frossard et al, 2003: 14). For “real integration” would thus mean to create a stable organisation providing for the complete coverage of health care needs of a given population – which most probably would be the health system – concern is about social services that would lose their identity and autonomy and/or would become further “medicalized”. Due to the hitherto existing fragmentation of health and social care systems the different units would barely be ready to accept a unique, vertically integrated decision-making authority. This is why, in France, the concept of integration in the form of a “Consolidated Direct Service Model” (Zawadski, 1983; Davies, 1992; 1996) is rather undesirable. Instead, we can observe in this country a long history in theory and practice of “gerontological co-ordination” and networking:

“Network or co-ordination means a voluntary organisation of professional people (which may include voluntary workers) who pool their means and resources to develop information, social and health care, and prevention services designed to resolve complex or urgent problems, which have been identified as priorities over a given geographical area, according to criteria decided in advance on a consultation basis (...) a temporary or permanent collaboration between different organisations working towards a specific objective.” (Frossard et al, 2003: 14)

The trias of coordination, cooperation and networking is commonly used in connection with each other. The three terms refer to ways of working together, within as well as between different sectors. The difference between the three expressions is the extent of working together, which increases from coordination over cooperation up to networking: While co-ordination might still imply the existence of a hierarchy, cooperation hints somewhat more to working together on an equal level, whereas networking additionally requires a certain closeness and continuity (Block/Skrobacz 2002: 21; Mutschler 1998: 49).

Given the above definitions, in particular the Audit Commission’s “systems model” and the “client-centred approach”, it appears, however, that neither “seamless care” nor “client centred” approaches are heading towards an “unfriendly take-over” of the social sector by the health system. It is just the use of different terms that seems to create confusion, while the meaning is more or less compatible. Co-ordination, too, aims at a certain level of structural integration (e.g. a front-office or “one-stop-window” where clients may go and address their questions), a process of joint working and learning to work together, and person-centred, seamless care as a result (see also Alaszewski, 2003).

Apart from the Nordic countries, there is only one country where we can find clearly defined legal guidelines towards integrated care. Indeed, Italy as a “late-comer” in the development of European
welfare states, offers a range of interesting experiences concerning the integration of health and social services. Indeed, when the National Health System was finally installed in 1978, the “Local Health Units” were designed as “Local Health and Social Service Units”, with the organization of social services being delegated by most municipalities. Thus a kind of consolidated direct service model was founded by law – with the result that, apart from various implementation problems, municipalities were mostly dissatisfied with the quantitative and qualitative level of services that they had delegated to the “Local Health Companies” (ASL) as they were renamed during the 1990s. Opposite to a compulsory standardisation in the health sector, also in the Italian reality today, the social sector is still characterized by a vast regional and local variety of operative models, professionals, approaches and methods of intervention. It took until the year 2000 when a reform was to give an answer to these cultural, financial, dimensional and organisational distortions. The “Framework law for an integrated system of interventions and social services” defined the process of integration between health and social care stemming from the cooperation and coordination among different territorial levels of governance and among public and private actors. Particular attention is put on older persons with care needs for whom the realization of a local integrated network of services is foreseen. Furthermore, the process of provision (geriatric assessment, personalized individual care plans, coordination of different government levels and governance of public and private actors), and fundamental principles (indivdual right to welfare, anti-discrimination, universality) are defined (see Nesti et al, 2003).

Greece is known as another “late-comer” in social welfare development, with care for the elderly being “a family affair” (Sissouras et al, 2003). Two distinct mechanisms – the National Health System (NHS) and the National Social Care System (NSCS) – have contributed to a soundly segregated service delivery. Two developments have improved the situation during the past few years, also contributing to a definition of integrated service provision. On the one hand, the “Open Care Centres” (KAPI) for older persons have introduced preventive health services and psycho-social support to older persons under one roof and close to the citizens (Sissouras et al, 1998; Emke-Poulopoulou, 1999). The Open Care Centres are staffed by a team comprising social workers, medical staff, visiting nurses, occupational and physical therapists and family assistants. On the other hand, the Greek report (Sissouras et al, 2003) underlines another aspect of integration, that is the integration of different types of providers, an issue that has been discussed in most countries with respect to different “welfare mixes” (Evers/Wintersberger, 1990; Evers/Olk, 1996). In particular in those countries, where subsidiarity has been one of the guiding principles of welfare state development (e.g. Austria, Germany, increasingly Italy and all other countries, where market mechanisms and choice are being implemented), the argument should not be underestimated as the different types of providers are just adding some more complexity to a realm that has already been described as being “among the most complex and interdependent entities known to society” (Kodner/Spreeuwenberg, 2002: 2). Indeed, steering mechanisms with respect to the Third sector and other private providers, have been developing during the past few years, in particular where these new providers have only started to blossom (e.g. Italy; see Nesti et al, 2003).

As a corollary of this section we may consider the term “integrated care” as a helpful concept to describe coordination, cooperation and networking between health and social care services with the aim to improve services and quality of life from a user’s perspective (for a further analysis, see Alaszewski, 2003; see also Kodner/Spreeuwenberg, 2002: 4).
4 Different approaches towards integration: strategies, methods and instruments

As Delnoij (2001) suggested, it makes sense to distinguish different levels of integration. His typology includes clinical integration as a first level, i.e. the micro-level of the primary process, ‘chains of care’ and transmural care. Secondly, professional integration between different kinds of professionals (and between them and the institutions they work for) has to be taken into consideration. Another level is concerning organisational integration, which can take place with respect to the specific welfare mix of a country, by creating networks or even by mergers of different organisations. And finally, functional integration can be described as a continuum of cure, care, and prevention.

Policies and strategies to reach integration may thus try to use different forms of leverage and diverse starting points to strive towards the creation of integrated care systems. Kodner and Spreeuwenberg (2002) have suggested a continuum of strategies towards integrated care, addressing the problems that we have mentioned above, in five interdependent domains: funding, administrative, organisational, service delivery, and clinical.

Again, in trying to further “de-medicalize” the discourse, we would like to emphasize those methods and strategies that concern the various “interfaces” between the health care and the social care realms, and the structures and processes that are to overcome these bottlenecks.

4.1 Case and care management

The most genuine method within the integrated care discourse is probably what has been described as case and care management, a technique deriving from the social care sector, which aims at matching supply and demand for persons in complex situations. The idea is to build up a network of services (resources) over time and across services and to empower the patient and its relatives to use it self-reliantly. The methods used are client- and therefore demand-oriented. It should be remarked that in this context the term case refers to the situation the person is in, not to the person itself (Davies, 1992; 1996; Wendt 1991; 2001; Ewers/Schaeffer, 2000). This approach was also taken up in other domains such as, in particular, the health sector where it is more known under the heading of care management or “managed care” which is mainly to introduce steering mechanisms and economic thinking in medical care (Haubrock et al, 2000). The idea is to maximize the benefits derived from a given amount of money. This aim shall be reached by means of coordination of the care delivery, thus avoiding loss of information and double treatments and – eventually – a cut back of the utilization of care services. It is being disputed whether this strategy even leads to a cut back of the use of necessary but expensive services (Barr, 1996; Huntington, 1997; Seng, 1997). A further definition problem concerns the term “care management” that, referring to German sources (Roth/Reichert, 2003), denotes the coordination of help and networks of service providers at the general level in a care region, while in other contexts it means the management of the individual care process.

In any case, most national reports make reference to case and care management. The instrument is used in most countries, though with different interpretations. While in the UK, the Netherlands, and the Nordic countries case managers might be characterized as a mainstream service, in Germany, Austria, Italy and France case management is mainly provided in model projects. Differences concern objectives, funding and the organizational setting. For instance, in the UK case managers (key workers, link workers) are also to fulfil a gate-keeping function and thus are often located close to
the General Practitioner. In Austria and Germany, case managers are mainly working in projects at the interface between hospital and community care.

In theory, case managers should follow the client’s situation from the initial moment the person in need of care is asking for support. Thus, “one-stop-windows” and information centres have been developed in some countries, mostly on a project basis in different organisational settings (municipality, health care centre, old-age home).

As with other instruments of integrated care, it has to be analysed who the “case and care managers” are, which professional background they have (nursing rather than social work?), which kind of training they get and whether they are given the real means and competences to “steer” the processes and to act as an “advocate” of the client (see, for instance, the “omtinker” mentioned in the Dutch report; see Ex et al., 2003). Other questions with respect to care management concern their role as “gate-keepers” and/or its dedication to individual care planning and the monitoring of outcomes: How should case management be organized? Should case-management remain a public responsibility? Could target setting serve as a mode of steering case managers? How and by involving whom should the mission of case managers be developed?

4.2 Intermediate care strategies: the hospital/community care-interface

As the need for care often turns up from one moment to the other (mostly in relation to a dismissal from hospital), and as frail older people (and their family) often do not know where to turn to, rapid intervention and quick, unbureaucratic support is an important factor to obtain client-orientation and thus an indicator for quality assurance. At this interface, rapid response teams (see UK report: Alaszewski et al, 2003) may be an instrument to prevent unnecessary hospital admissions and/or request for a place in a nursing home. This method is part of a whole range of interventions with respect to “intermediate care” that could be complemented by intensive rehabilitation services (situated in hospitals) to help older people regain their health and independence, recuperative facilities (short-term care in a nursing home or other special accommodation to ease the passage), and quick information exchange (transition forms).

While these instruments are part of the UK government’s strategy for improving health and social care services for older people (Alaszewski et al, 2003), they can also be found in other countries. In Denmark, preventative visits at the home of all older persons have been introduced. Furthermore, early warning systems, contracts between municipalities and hospitals about discharge procedures, meetings between home nurses and hospital staff, and geriatric teams that are following-up the older persons in their own homes are part of the Danish strategy to increase integration between hospitals and community care (Colmorten et al, 2003: 13f).

Of course, care managers situated in hospitals can also contribute to a better preparation of hospital discharge if they are able to create a decent network around the client’s needs (see, for instance, the Austrian report: Grilz-Wolf et al, 2003).

4.3 The beginning of a complex relation: needs assessment and joint planning

If it is important to provide a single point of reference for persons who have become chronically ill and/or care dependent, it is at least equally important to cater for an assessment of needs that con-
siders both social and medical aspects, both psychological, mental and physical factors, i.e. an interdisciplinary and multidimensional team. In order to provide integrated care it seems only logical that from the very moment a person is taken in charge by a service providing agency, his/her general needs should be assessed and matched with the existing resources. If needs are assessed only in relation to medical requirements, it is most probable that only medical remedies will be prescribed (home nursing, medicines etc), and vice versa, if only social needs are assessed, devices from the social assistant’s kit will be proposed. Furthermore, if needs are not assessed rightfully, clients/patients could tend to make use of the most expensive but perhaps less efficient and less satisfying service.

Many countries have thus introduced interdisciplinary assessment teams and/or agencies responsible to guide the citizen through the “jungle” of service providers. The multidimensional “geriatric assessment units” within the Italian health system (Nesti et al, 2003) are one example but in reality they often only start their activity when older persons are applying for a place in a residential setting. In the Netherlands (Ex et al, 2003), the Regional Assessment Boards (RIOs) are a most important starting point for integrated care strategies: their interdisciplinary members decide to what kind of care, facilities or support the person is entitled. A similar function is given to the Community Assessment and Rehabilitation Teams (CART) in the UK and the “Centres Locaux d’Information et de Coordination” (CLICs) in France. In most other countries, the assessment process remains quite medicalized and fragmented. For instance, in Austria and Germany specially trained medical doctors are carrying out the assessment of needs, i.e. to check entitlement rights for the LTCI (Germany) and the Austrian long-term care allowance. Thus, entitled persons who choose services as a support to family care often have to undergo a further assessment concerning service needs and individual planning. An integrated approach could serve to reduce this kind of “parallel actions”.

4.4 User’s choice: Personal budgets and long term care allowances

Needs assessment by (medical) experts is a topic at least as diversely debated as cash benefits for care dependent persons. While the former, however, has always been a fundamental part of the debate on integrated care, “consumer-directed care appears to be the antithesis of integrated care” (Kodner, 2003: 1). Giving money to persons in need of care, indeed, is a phenomenon that has been spreading over the past 15 years (Evers et al, 1994). It is rooted in claims for independent living – a movement that consists mainly of persons with disabilities at working age but also in traditional cash benefit schemes for disabled persons (invalidity allowances) that have existed in many countries. Furthermore, cash benefits were also to support informal and family carers with some schemes that entitled carers for specific allowances. And, of course, cash benefits are an attractive means for policy-makers to control budgets.

In practice, we can retrieve quite different approaches, be it on the level of financing, be it in relation to entitlements that vary between lump sums of 150 Euro up to 1,700 Euro per month depending on assessed needs, kind of services or institutions used. In Germany, entitled persons may choose between cash allowances or vouchers for services-in-kind; a majority of users is opting for cash allowances. In Austria, it is completely up to the recipients to decide whether to use the allowance to buy services or to “pay” informal or family carers. In France, the APA resembles more a voucher system as the allowance has to be used to pay for (informal) care or to co-finance residen-

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3 Not to speak of the additional assessment procedures concerning invalidity pensions/benefits.
tial care. Also the different forms of the Dutch “individual budget” are more or less earmarked for care – only a small share of this individual budget can be used at the discretion of the recipient, while the main share should be used to buy services, usually with the support of an Insurance Agency. Still, also this form of an allowance is to increase the user’s choice and his/her independence.

With a view on integrated care for older persons, this mechanism might obviously lead to a situation in which the person in need of care (and/or his/her family carer) becomes a kind of case manager, thus shifting the burden. Another consequence might be that the allowance ends up as part of the regular household income so that its specific use for care-related expenditures cannot be retraced and thus generate an alleged “misuse” of public funds, perhaps even by encouraging “black labour”. At the same time, cash allowances could be a first step towards a more general approach towards demand-orientation and greater differentiation, rather than an orientation to allegedly homogeneous target groups such as “older persons”. In order to take full advantage of consumer-directed services, a number of preconditions have to be fulfilled (see also Kodner, 2003; Ex et al, 2003: 15f):

- Consumers’ choice can only be guaranteed if the consumers achieve a considerable overview on supply – knowing that the perfect transparency does not exist, this could be realized by means of “peer consulting”, an independent counselling, initial-contact and brokerage centres (see Germany) or an “omtinker” (see The Netherlands).
- Sufficient competition between providers is another important aspect, in particular guaranteed a sufficient differentiation of services should be fostered.
- Staff has to be trained towards empowering users and service providers will have to develop more user-oriented services.
- Consumer-directed services should be designed by involving the target groups as much as possible, and
- cash allowances should be combined with other tools of integrated care provision (case and care management, joint budgets, joint working etc.).

4.5 Joint working: shattering the cultural divide

Who ever has worked with mixed groups consisting of medical, socio-medical and social professionals, knows about the cultural cleavages between these groups but also about the fact that structural and hierarchical divisions are often much more significant. Once the various professionals start talking to each other, conflicts and different perspectives often can be resolved. Still, hierarchies remain do be decisive if it comes to develop a common understanding, for instance the definition of “autonomy”, or a shared care concept. In particular, the medical orientation towards “healing” often clashes with the needs of persons who depend on long-term care. Also, wrong incentives presented by, for instance, DRG-financing of hospitals, have contributed to the so-called “cultural” divide between health and social care systems. Furthermore, differences in status and hierarchy that are increasingly challenged by the nursing professions complicate the cooperation between physicians and nursing professions (Roth/Reichert, 2003: 19).

A specific group to be addressed in this connection are medical doctors (general practitioners) who, though having a potentially decisive role in retrieving, guiding and supporting persons in need of
long-term care, refrain from fulfilling the role as a general reference person (“navigator”) for both clients/patients and other service providers.

The Danish system of care for older persons offers some potential solutions for these aspects. First, the municipalities have to pay for patients at hospitals who have finished their treatment and are waiting for a place in a nursing home. Secondly, some municipalities have concluded cooperation contracts with hospitals stipulating that community care services have to be informed at least 3 days before a patient’s discharge, if s/he needs health or social care at home. Thirdly, experiences with “geriatric teams”, “mixed meetings before hospital discharge”, 24-hours integrated community care and joint training present some first steps towards joint working on an equal footing. In relation to GPs, however, the Danish model rarely has them participating in formalised cooperation with either the hospital or the municipality, unless specific illnesses have to be cured.

Positive outcomes concerning joint working and improved mutual understanding are also reported by almost all model projects trying to combine social and health care services in one or the other way. The mere fact to gather the different stakeholders around one table often helps to create an intensive exchange of ideas, trust in each other’s capacities and “a new understanding of the other sectors’ work (...) both groups of personnel learn from each other and can improve their performance” (Grilz-Wolf el al, 2003: 25). In France, statutory policies have a long-standing history of incentives to support “coordination mechanisms”. Based on the experiences of local implementation projects promoting “gerontological coordination” projects the French report underlines in this connection that, unfortunately, the process to improve communication is quite time-consuming and calls for very engaged project leaders. In one project it took about two years to succeed in getting medical doctors and social workers to work together and to gain a fresh look at given situations (Frossard et al, 2003: 16).

Another approach towards joint working on the level of promoting the flow of information and coordination between the different organizations and institutions involved is reported from Germany where coordinating care conferences, round tables and working groups have been installed in several areas. In a broader sense these also concern the planning and structuring of care provision, and agreements on procedures at a regional or local level (Roth/Reichert, 2003: 21).

4.6 Opening the institutions: towards an integration of housing, welfare and care

Future trends in social and health policy have to take into account that the traditional emphasis on target groups and respective solutions will be increasingly confronted with a focus on the solution of social and health problems that regard different target groups with the same type of needs. Furthermore, the increasing mobility of family members will trigger the need for new types of support systems within the neighbourhood and the community. Traditional nursing or old-age homes (“total institutions”) will hardly survive in this scenario, unless they become pro-active, open and innovative neighbourhood-centres providing all kinds of services and facilities to the public.

The Dutch government’s approach towards demand-oriented care is trying to face this challenge by promoting the concept of ‘care-friendly districts’, i.e. areas in which explicit attention is paid to the improvement of the habitat, the infrastructure, and existing facilities (Ex et al, 2003). Generally, this approach concerns the housing/care-interface which, in medicalized concepts, is often being neglected. Indeed, if care at home is to be supported, then both housing policies and housing organiza-
tions become important factors for providing integrated care. In the Dutch reality, respective policies have led to interesting partnerships, e.g. between the Ministry of Housing, Planning and Environment, and Health, Welfare and Sports. The respective “sheltered housing stimulation arrangements” have resulted Care providers have triggered several initiatives. For instance, housing corporations are, in co-operation with municipalities and institutions for care and welfare, modernising existent residential and nursing homes into new care centres. They are also developing new sheltered care facilities, preferably in co-operation with private funders (op.cit.).

Also the Greek “Open Care Centres for the Elderly” (KAPI) are emphasizing the neighbourhood and its social capital to re-build social solidarity as a part of integrated care provision. KAPI aim at preventing isolation of the elderly; they should contribute to increase the ability of older citizens to remain active members of society. As mediating centres KAPI are connecting the elderly to and within their social environment, thus promoting an integrated centre for prevention, health promotion, and social integration (Sissouras et al, 2003: 17).

4.7 Supporting informal (family) care

The role of families and/or informal carers in creating integrated care networks is crucial to their success. This regards both prevention and the actual care process as no care system will ever be able to completely cover all long-term care needs by professionalized services. While informal care were, for a long time, taken for granted by service providers, a number of initiatives can now be reported that are to improve the situation. Also in this case, support mechanisms may vary from cash benefits (UK, some regions in Italy) and pension grants (Germany) to training and information, employment (Nordic countries), and respite services such as day-care or short-term care that can be found in almost all countries but at very poor levels only.

The integration of informal care is thus remaining a critical area for integrated care delivery, partly due to the fact that family carers often do not even define themselves as carers, partly because professionals often see the family of the person in need of care as opponent, rather than as a resource. With the rising number of non-family informal carers, often immigrants from outside the EU – and related problems of “black work”, “illegal immigration” and lacking continuity – it becomes more and more urgent to develop strategies of integration and collaboration with the formal health and social care system (see also Motel-Klingebiel et al, 2002). To date, no convincing integration strategy has yet been developed, apart from some ambiguous experiences with health professionals (nurses) being “imported” from the Philippines, China, Tunisia or other countries from outside the EU.

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4 A relatively wide-spread practice seems to become that persons from third countries are accomplishing full-time care of older persons in EU countries travelling with tourist visa (valid for 3-months). Specialized agencies then cater for a replacement every 3 months (see for instance, Nesti et al, 2003).
5 The role of different stakeholders

In order to understand the complexity in developing integrated care networks it is essential to analyse the different stakeholders and their vested interests, concerns, worries and expectations. Many aspects of the complicated relationship between the different stakeholders have already been mentioned above. Therefore, we would like to underline only a few features that were mentioned in the national reports concerning stakeholders.

Given the huge number of interfaces where the different stakeholders cooperate in funding, contracting, providing and controlling, a difficulty is to gather them around one table and to agree upon mutually agreed visions, procedures, and objectives. Steering these players by means of market mechanisms – a strategy followed in many countries – does not necessarily lead to positive results for all parties. Obviously, it is more difficult to reach common grounds the more actors are present. In Germany, for example, a long tradition of third sector organizations has resulted in a further fragmentation of the already shattered responsibilities between social insurance, regions and the state. The augmentation of providers by introducing a free market of care should therefore be approached with caution – in any case, it is indispensable to develop steering mechanisms (accreditation, quality assurance) that are able to direct the providers towards mutually agreed objectives. Competition is an unhealthy feature if it comes to create integrated service provision, in particular if common guidelines and rules of working are missing.

Anyhow, it should be considered that no stakeholder deliberately creates unsatisfying results. A common phenomenon concerning funding is to try shifting financial burdens from one funder to the other. The specific mix of private and public funding, the different types of user-contributions both in health and social care would be an interesting policy issue. However, given systems are lacking in transparency, rather than providing crisp data to open a fruitful public dialogue. Also recently introduced long-term care insurances or benefits (Germany, Austria) were not able to start such a debate, although both systems have underlined that the provisions from these schemes will only be able to cover a part of the incurring costs in case of dependence.

The question “who does what” thus remains unsolved both on the structural (political) level and on the shopfloor-level. On the one hand, for instance, providers or even single professional groups are often forced to get contracted and reimbursed by different agencies for one and the same activity. On the other hand, in most countries, old-age and nursing homes have to “combat” for financing from the same budget line as community services. Instead of using this kind of contracting for a coordinated or integrated policy in cooperation with the providers, public administrations seem to like the “divide et impera” doctrine. In particular, this doctrine is followed to divide the different professional groups, with health care professionals who traditionally have a better regulated educational and job profile, higher pay and higher status than staff in the area of long-term care for the elderly. The respective consequences for the ability and willingness of professional groups in health and long-term care to cooperate and work together can easily be deducted.

Still, the actual and/or imminent shortage of labour in caring professions might help to reduce the worries of staff to lose their jobs, to increase the quality of working conditions and to improve the image of careers in the social and health sectors. An open question in this respect remains how to integrate informal (and illegal) care-giving into the network.
Moving towards user-oriented integrated care delivery it should be a main concern to include citizens, clients and users of services in policy-making, local debates and regional care conferences. It is extremely difficult to organize carers and/or care-dependent persons but to gather information, to ask users for their needs, to consult carers as advocates and to support existing links within the community is the only way to create a functional equivalent to traditional intra-family solidarity. Examples from the Netherlands (one-stop-window and neighborhood centres), Greece (KAPI) and France (small housing units) show some interesting approaches towards the involvement of the civil society and older persons themselves in developing services and participating in decision-making. Future generations of older persons will certainly be even better informed and they will be prepared to express their needs and expectations as critical and well-informed patients or clients.

The role of research and development

It was already mentioned that conducting model projects is one of the most applied strategies to develop integrated care networks. Such projects are often incited, accompanied and evaluated by scientific research. Still, many of these projects remain without any documentation or evaluation, and in most cases there is not enough funding for a real evaluation of outcomes and lessons to learn. Compared to medical research, scientific research concerning community care or integrated service delivery is weakly funded and almost not at all published. Denmark, Finland and the UK are countries, where targeted R&D programmes can be retrieved, with some influence on the practice of organising services. In most other countries, research remains somewhat distinct from practice, and development projects in the area of integrated care organisation depend heavily on single decision-makers and selective project funding. In order to develop evidence-based solutions it will thus be necessary to improve research and development, in particular with respect to evaluation methods and in relation to the fact that complex change processes need special skills and respective accompanying measures (see, for instance, Broome, 1998).
6 Conclusions: ambiguities, necessary debates and future perspectives

What theoretically reads quite logical and convincing does not necessarily mean that practice is following the allegedly “logical” path. The hypothetic gains of integrated care networks and delivery not only are difficult to evaluate in terms of scientific research designs. To produce comprehensive evidence of the relative cost-efficiency and cost-effectiveness of services across the countries studied, modelling and evaluating the production functions of social care services would be complex, expensive, and it would require longitudinal studies of large national samples (Davies et al, 2000). On the other hand, even with smaller samples and a fine control-group design it often turns out that (not always) better outcomes cannot be clearly connected to the delivery system (see, for instance, Hultberg et al., 2002). Nevertheless, policy documents underline in most countries the necessity for integrated services, as they do stress that “care at home is better than institutional care”. However, long-term strategies and solutions building on gained experience and evidence from single model-projects are scarce. As an exception, in Denmark, the “Skaevinge Project” served as a valid inspiration for the organisation of health and social care in other municipalities with the Ministry of Social Affairs as a promoter and disseminator of good practice. In most other countries, model projects are badly documented, not always evaluated and often stopped without any follow-up activities.

It seems logical, though, to increase endeavours in linking the development of integrated health and social care policies (joint structures, training, funding) to integrated delivery of services. Until to date, the allegedly unanimous policies in Europe with respect to long-term care are lacking coherent strategies. Indeed, there is no relevant policy paper that misses to underline that persons in need of care should be supported as long as possible in living at home: residential homes should be reduced, different kinds of providers and services (day-care, short-term care) should be supported, new services are to be developed, social inclusion should be guaranteed, preventative services and person-oriented guidance and assistance are to be extended. Furthermore, family and informal care are to be strengthened, and the whole system of providers should be “co-ordinated”.

However, concrete implementation programmes with priority lists and clear objectives are often missing. In the context of general restrictions to public spending, innovation funds and/or targeted investments remain scarce. Usually, strategies remain restricted to model projects (or even programmes) with a limited time-frame, restricted finances and hardly ever any follow-up activities. As a corollary, projects are often under pressure to “produce” results and do not have time for dialogue between persons/organisations involved to develop common grounds and a shared vision.

Dialogues at the front-line, eg. involving staff, users and civil society, have not yet been used efficiently to discuss priorities and local needs. However, the almost 50 model ways of working gathered in the nine country reports, also allow for some general lessons to be learned:

- Reforms to integrate health and welfare services must be founded on the integration of financing systems and the overcoming of institutional barriers, especially between outpatient and inpatient care, between health and welfare services, and between professional and informal care.
- Geriatric screening and multidimensional assessment is part of modernising the system in many countries (eg. Germany, Italy, France, the Netherlands, the UK and Denmark) – it can be incorporated into practice without too much difficulty, it meets with a high level of acceptance, and it helps to involve different kinds of professions and to improve communication between them.
- Demand-driven, integrated care has to strive to increase clients’ control over the care process, eg. by means of “individual budgets” or other means that increase their purchasing and negotiation power.

- Innovation programmes promoted by central government can trigger a number of private and local initiatives – crucial is a vision of support that goes beyond the traditional notion of care, and integrates care and nursing, adapted housing, local resources, and welfare services. Top-down initiatives should only be to support bottom-up change processes.

- A central service point for advise, information and help is useful to support clients in clarifying their care needs and to improve cooperation between different organizations that operate according to different logics and have different types of personnel. It is of utmost importance to help staff in developing a new understanding of the other sectors’ work.

- The success of model projects often depends on the engagement of staff involved and in the structural framework of the projects – clear objectives, competencies and guidelines are needed to function successfully. The institutional structure may ease the process of integration, eg. if institutional care, home help and home nursing are managed by the same agency such as the municipality (Denmark). Also in Greece, it is local authorities that are responsible for the development and implementation of integrated projects (KAPI) as they have first hand knowledge of the needs and particularities of the elderly living in their area.

- Change processes are very time-consuming as it might take years to have a project started and to construct common grounds of working.

- Evaluation has become a common practice. In France, for instance, the evaluation of private and public projects in social and health care has become compulsory. Investment must be accompanied by a programme of reform and modernisation involving the development of greater cooperation and collaboration within and between sectors and joint working practices.

- Collaboration between hospitals and municipalities can be organised in many ways, depending on motivation and existing cooperation. It is not possible though to emphasise the best practice or the best model for cooperation or to expect that a general model can be implemented in all countries.

**Perspectives: More market, management and IT – or more civil society?**

It is impossible to predict future developments but some trends and their potential impacts should nevertheless be outlined. The marketization track will surely increase with more voucher systems, payments for care and steering mechanisms that try to make use of demand and supply mechanisms. We know, however, that health and care are no more than quasi-markets with their own characteristics and criteria. It will thus be important to increase regulation (accreditation mechanisms, quality assurance) with respect to providers and, in particular, in relation to employment and human resource development to reduce “black work” and to increase clients’ control over the care process.

In this respect, the importance of management and related tasks will also spread. On the one hand, both social and health staff will have to perform more managerial work in addition to direct care which might also lead to new specialisations and new job profiles, eg. with respect to case and care management. On the other hand, the necessity of developing steering mechanisms on the national, regional and local level will call for more managerial decision-making with respect to commissioning, contracting, purchasing, planning, evaluating and quality assurance mechanisms.
These developments might be accompanied by a more fervent introduction of information technology, also in the area of social care. Indeed, the “techno track” starts taking grounds with respect to tele-care devices, the informatisation of processes and the construction of “smart homes”.

Even the most advanced technology though will not be able to replace human resources and local social inclusion. Therefore, two other evolutionary tracks might be of interest to the development of integrated care. On the one hand, new types of volunteering and new kinds of solidarities (intra- and inter-generational) might be interesting resources to build up respectively. On the other hand, shortage of labour in the care professions, illegal immigration and black work in care will call for new forms of integration and an even extended notion of integrated care networks.

Much will depend on the general development of labour markets and the behaviour of women with respect to family care: Will the Mediterranean countries follow the pattern of the Nordic countries? And if yes, in how far will integrated policies be developed to compensate for the loss of unpaid female labour?

It is in this context that PROCARE will carry out further investigations, in particular by looking at model ways of working that have shown to overcome existing barriers and to resolve everyday problems in the cooperation between health and social services. In the end, it will be such examples that will shape the future development of integrated service provision.
7 Literature


Southworth, 1992


Vaughan/Lathlean, 1999


PROCARE National reports:


