

Integrated Care around the world Examples to help improve (primary) health care in Poland

Report by K. Viktoria Stein



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1. EXECUTIVE SUMMARY

Integrated care has long emerged as a viable approach to overcome deficiencies in the care management for people with chronic diseases and frail elderly, while at the same time improving efficiency, quality and effectiveness of the health services provided. The focus thus has been on better coordination and integration among health sectors to manage specific diseases. However it has become evident that in order to provide truly people-centred services that promote health, the scope of integrated care needs to be expanded to bridge the gaps not only within the health system, but also between the health and social system, among others. These aspirations necessitate the overcoming of many boundaries, most notably between different professions, different organisations and different attitudes.

The many experiences across Europe and around the world have demonstrated that it does not suffice to tackle only one of these barriers, but that sustainable solutions need a multi-faceted approach, which changes the processes and structures of service delivery just as much as the culture and attitudes of professionals involved. Most importantly, patients, families and communities need to be actively involved in this process in order to ensure that their needs are met and their voices heard. And while a lot of efforts are put into the technicalities of integrated care, building the competencies necessary to work in and manage an integrated environment are often neglected.

This report gives a comprehensive overview of the different building blocks of integrated care, and illustrating the concepts with numerous practical examples from around the world. These building blocks include the conceptual understanding and underpinning of integrated care, creating an enabling environment, building common values and shared cultures, developing competencies for integrated care, aligning financing and incentive systems, and supporting people's empowerment and engagement in health and care.

The key messages are:

- Services must be organised around the needs of the people, not the providers or the system.
- This requires a population health management approach, and a look towards the social determinants of health.
- Integrated care can only happen when all levels and all stakeholders are actively involved in the design, management, implementation and evaluation of the initiatives.
- Thus, there needs to be a parallel top-down and bottom-up approach.
- Integrated care needs to be nurtured, lead and managed actively.
- It needs a clear narrative, mission and measurable objectives.
- While there are a lot of examples from which to learn, integrated care needs not only to be adapted to the local context, but actually developed by the local communities to guarantee ownership, buy-in and responsibility.
- Transformational change towards integrated care requires a change in cultures and values from everyone involved.

2. THE BUILDING BLOCKS OF INTEGRATED CARE

In this section key elements of integrated care are described, which all need to be addressed when implementing new models of care. These building blocks have been identified in the literature as vital areas of intervention, which can lead to the failure or stalling of the reform process if ignored. While universally applicable, the elements need to be considered in the Polish context and adequate interventions identified according to the needs of the Polish system and priorities. The different elements are illustrated with good examples from around the world.

2.1. UNDERSTANDING INTEGRATED CARE

Over the past decade many definitions, concepts and theories have emerged trying to explain what integrated care is and what the main building blocks for successful integration of services across sectors and professions may be. This first part presents the concepts of Pim Valentijn's (2015) rainbow model as well as WHO's global strategy (2015), which will guide the analysis, and summarises the lessons learned and key elements of integrated care.

Integrated care is not an end in itself, but a means to improve quality of care. Many authors have also stated, it is a means to achieve the Triple Aim approach (Goodwin, Nolte and McKee, Groene et al.) When thinking about and defining integrated care, it is important to consider, which perspective one takes, as this significantly influences the design and emphasis of the transformation process. As an example, the following, widely used and cited, definitions are given.

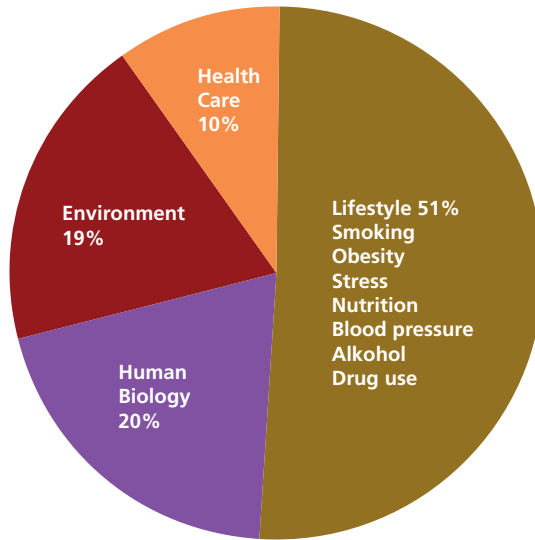
2.1.1. TAKING A SYSTEMS APPROACH

The WHO global strategy for people-centred integrated health services (2015) adapted PAHO's (2011) definition as follows:

"Integrated health services are health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course."

When taking a system's perspective it becomes clear, that health is not by any means only achieved in and influenced by the health system. On the contrary, the health system only accounts for about 10% of a persons' health status (see figure 1). Social determinants of health, transport and infrastructure, lifestyle choices, etc. all have a greater influence than the provision of health services. This underlines the importance of taking a whole-of-systems and whole-of governance approach (WHO Europe) and enforcing the concept of health in all policies, as any decision taken by government, whether on the national, regional or local level, may influence the health and wellbeing of the people.

Figure 1.
What influences health.



Shroeder, Steven A, We Can Improving the Health of the American People, N Engl J Med 2007 357: 12221-1228

2.1.2. A PROCESS-DRIVEN APPROACH

For a long time, integrated care was considered a process improvement strategy, influenced by its roots in managed care, to design a better through-flow of patients along a defined pathway and with well-defined transitional nodes between sectors and systems. Kodner and Spreeuwenberg's definition (2002) reflects this approach:

"Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings. Where the result of such multi-pronged efforts to promote integration lead to benefits for people the outcome can be called ,integrated care."

The merit of this perspective lies in the emphasis on management tools and principles to align the services provided in the cure and care sectors (health and social care). It also highlights the importance of back office functions, such as funding mechanisms and reporting systems, as drivers for fragmentation or collaboration, respectively.

2.1.3. THE PATIENT PERSPECTIVE

While from the very early days integrated care has professed to consider the patient as the centre of every effort to improve service delivery, the patients' perspective, needs and demands have only very recently been added into the discussion on integrated care. And it is still very rarely that patients, their families and caregivers as well as the wider communities are actively and meaningfully engaged in the decision making, design and delivery of services. Active participation, engagement and empowerment of patients and populations, however, is key to successful services delivery along the life course, whether one takes a stewards', managers, or providers' perspective. As illustrated in Figures 1 (above) and 2 (below), it is the individual, who takes care of themselves most of the time, who has the most influence over their own health and wellbeing – not including them in every step of the way is grossly negligent and a main driver for the rise of chronic diseases and the decrease of health life expectancy.

Figure 2.

The importance of self-care.

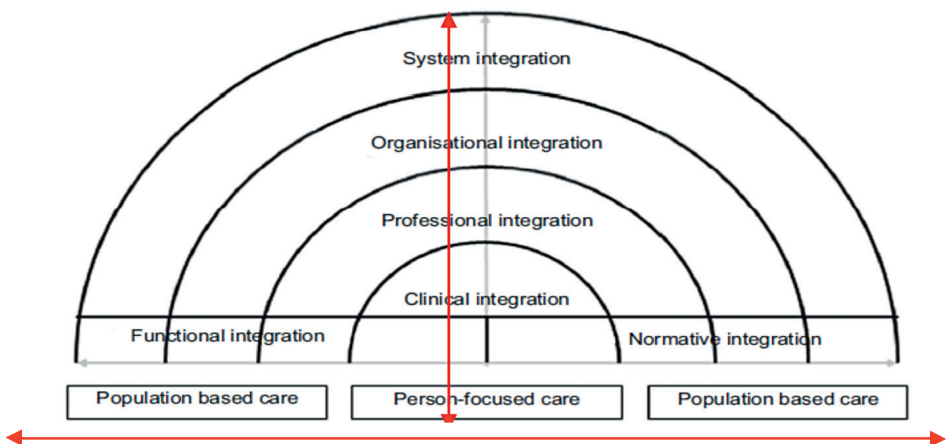


In the English NHS, the average interaction of a person with the system is 3 hours a year – the rest of the year is spent taking care of oneself, so the percentages are even higher than the illustration in Figure 2. While the concrete numbers thus vary from system to country, the main message is clear. It is the patient who is the primary care provider, and the professionals and system administrators need to not only acknowledge that fact, but act upon it, so that the following statement can become true:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.” (National Voices 2013)

In order for integrated care to work, all of the above perspectives need to be taken into account and contextualised as they reflect the different stakeholders’ aims. Elaborating further, integrated care has to happen on all levels of the system in order to be effective and sustainable. While Valentijn (2013) developed his Rainbow model in the Dutch context and taking a primary care perspective, it is still a very useful tool to think through the different levels of a health system and what needs to be changed, integrated or coordinated in order to achieve better outcomes.

Figure 3.
Valentijn’s Rainbow model of integrated primary care.



Source: Valentijn et al (2013) Understanding integrated care: a comprehensive conceptual framework based on the Integrative functions of primary care, IJIC, vol13. Jan-Mar.

Adding further input from the literature to the description of the different levels, they can be described as follows:

System integration:

This dimension of integrated care refers to the ability of the care system in providing an enabling platform for integrated care at an organizational, professional and clinical level (e.g. through the alignment of key systemic factors such as regulation, financing mechanisms, workforce development and training).

Organisational integration.

This dimension of integrated care refers to the ability of different providers to come together to enable joined-up service delivery (that helps to then support professional and clinical integration).

Professional integration.

This dimension of integrated care refers to the existence and promotion of partnerships between care professionals that enable them to work together (e.g., in teams or networks) and so promote better care co-ordination around the needs of the service user.

Clinical integration.

This dimension of integrated care refers to how care services are coordinated and/or organised around the needs of service users.

Functional integration.

This dimension to integrated care refers to the capacity to communicate data and information effectively within an integrated care system.

Normative integration.

This dimension of integrated care relates to the extent to which different partners in care have developed a common frame of reference (i.e., of vision, norms, and values) in support of the aims and objectives of care integration.

While Valentijn (2015) purports that all of the above levels finally lead to person-focused and population-based care, the WHO global strategy (2015), WHO Europe's Framework for Action (2016) and other authors emphasise (Ferrer 2015, Project INTEGRATE (forthcoming)) that the person, their families, caregivers and communities are a dimension and level in their own right:

Person-centred care. This dimension of integrated care refers to the ability to empower and engage people in the improvement of their health and wellbeing. The approach supports a wide range of 'service users' (e.g. patients, people living with frailty or physical disabilities, carers, etc.) to become actively involved as partners in care.

The discussion around the different perspectives and levels of integrated care underlines the significance of considering integrated care horizontally (i.e. across sectors and systems), as well as vertically (i.e. from the systems to the personal level). While it is clear that not all perspectives and levels will need equal attention at all times and in all countries, if any one of them is left out, integrated care will sooner or later stall, as key stakeholders will feel left out or subsystems are not able to coordinate and collaborate effectively.

2.2 CREATING A SUPPORTIVE LEGAL AND POLITICAL ENVIRONMENT FOR INTEGRATED CARE

If change towards integrated systems is not supported by policy makers, who ensure that legal and regulatory frameworks reflect these changes adequately, change will not be long-term. It takes many steps to change the environment in which health and social services are provided and it needs active lobbying towards decision and policy makers, as many of these activities aim at the long-term and are not easily converted into political gains, whether it is the alignment of financial structures, professional regulations or the creation of new legal forms to set up integrated care practices.

Governance functions are multi-faceted but typically include stewardship, the setting of strategic directions and the formulation of policies. Governance enables legal, systems and resource frameworks for integrated care to be formulated and formalized. Policy support is key to scaling up initiatives to the systems level and for creating sustainability (Borgonovi and Compagni 2013, Goodwin 2002, Ling et al. 2012, Mur-Veeman, Van Raak and Paulus 2008, OECD 2012, Williams and Sullivan 2009). Without clear system level policies for integrated care, bottom-up initiatives may have little chance of implementation (Stein 2010, William and Sullivan 2009). Among these, accountability is an essential governance tool by “setting out a framework and making explicit the ways in which actors of the health system are expected to perform and interact” (Barbazzia and Tello 2014, p7).

2.2.1. POLICY SUPPORT INITIATES INTEGRATED CARE

Priority setting by system administrators and policy makers as well as support for integrated care by the regulation subjects is a key issue for the promotion of integrated care and is highly valued across sectors and countries. It is thus safe to assume that policy initiatives towards integrated care will further foster the development and implementation of the concept and that decision makers take this framework into account when planning integrated care. This finding underscores the urgent necessity of coherent strategies and clear priority setting from health policy makers and governing bodies in order to improve overall system performance. (Stein 2010).

2.2.2. TOP-DOWN SUPPLEMENTS BOTTOM-UP APPROACH

Even though many integrated care initiatives start with professionals being unsatisfied with the status quo and looking for alternatives to service delivery, at some point in time clear policies need to be put in place to enable sustainable integration and coordination of services. (Goodwin 2002, Halvorson 2007, Stein 2010, William/Sullivan 2009) These policies need to clarify legal issues, as well as resources availability and co-operation between hitherto separate sectors, such as health and social services, or health and education. (Health 2020, William/Sullivan 2009) Failing to garner support from the policy level has been identified as a key barrier for integration (Nicholson et al. 2013), and in countries like England (Goodwin 2002, Crinson 2009) and Germany (Amelung 2010) active policy setting towards coordination and integration of health services has sparked a wide array of initiatives to improve service delivery and patient experiences through integrated care. Here, it is essential to find the right balance between a bottom-up versus a top-down approach, both of which are necessary to make the solutions context-specific, and implementable on the local level.

2.2.3. WHOLE-OF-GOVERNMENT AND WHOLE-OF-SYSTEMS APPROACH

Health is not the sole responsibility of the health system, and thus alliances need to be sought with all sectors impacting on the health and wellbeing of the population. This entails coalition building within governments promoting a health in all policies approach. (WHR 2000, WHO Europe 2010) The health system is already the biggest employer and fastest growing market in many European countries, necessitating an adequate response on the governmental level. (OECD 2012) In realising some of the activities outlined in other areas for action, it is necessary to align policies and strategies in education, financing, social services, provision of infrastructure and technologies or the labour market, to name but a few.

2.2.4. CREATING THE LEGAL FRAMEWORK FOR INTEGRATED CARE

In order to scale up integrated care, sooner or later, certain legal issues have to be addressed, for example permitting the collaboration of health and social services, adapting professional laws or creating new organisational structures for integrated care. (Suter et al. 2009, Halvorson 2007, Nicholson et al. 2013)

Illustrative example: Scotland

Scotland has fourteen NHS Health Boards responsible for planning and delivering hospital, primary care and community services for their local populations. The NHS Boards work closely with 32 local authorities that directly provide or commission social care and housing services from the independent and Third sectors. Integrated care features in most healthcare policy documents (3, 4) yet Audit Scotland, the independent public spending watchdog, reported few good local examples (5) and it is widely acknowledged that progress on integrated care was too slow. Service integration was also a priority in the Christie Commission Report on the Future Delivery of Public Services (6). After the elections in 2011 and with support from all political parties, the Scottish government finally embarked on legislating to make integrated care happen. This led to the Public Bodies (Joint Working) (Scotland) Act (2014), which required the local integration of adult health and social care services with the option to include children's health and social care services, criminal justice social work and housing support services in local integrated arrangements (8). The Act required NHS Boards and Local Authorities to establish one of two models by April 2016: delegation of functions and resources between Health Boards and Local Authorities (Lead Agency), or delegation of functions and resources to a Body Corporate (Integrated Joint Board). Each Integration Authority will oversee an integrated budget for agreed functions. The sum of these integrated budgets will be more than £8 billion (more than 60%) of health and social care resources, including all adult social care, adult primary and community health care, and those aspects of adult hospital care that are most amenable to redesign through enhanced primary and community care. A strategic plan and integrated budget, developed with involvement of providers, non-statutory partners, patients, carers and service-user representatives, will commission the required range of integrated services and community support to improve local population health. Progress will be measured against nine health and wellbeing outcomes supported by a suite of 23 indicators that track care experience and data on activity and resources.

2.2.5. CREATING THE CONDITIONS TO GET THERE

Legislation is not a quick fix, even when the conditions are favourable as they were in Scotland. The carefully timed and considered journey took almost three years from announcement of intent to enacting the legislation. Officials reviewed the evidence on successful integrated systems to identify key concepts to include in the legislation: plan for the needs of local populations, pool resources (money and people), involve care professionals in service planning, investment and delivery, and ensure strong local leadership and accountability. Extensive engagement with health and social care leaders, professional organisations, staff and local communities took many months but I believe this was an investment that was critical for success. The approach involved much listening and many conversations across the country. The dialogue was consistently framed around a vision to improve outcomes: people should be supported to live well at home or in the community for as much time as they can and should have a positive experience of health and social care when they need it (9). When Audit Scotland reported widespread support for the principles of integration (10), the Joint Improvement Team, which had been set up to support the process, viewed that as a testament to effective engagement that involved people from all sectors and used both data and personal narratives to secure commitment at all levels.

The path to legislation had strong leadership from a Ministerial Strategic Group for Health and Community Care, chaired by the Cabinet Secretary for Health and Wellbeing. This high level group of local political and NHS leaders was supported by senior policy officers, professional leaders and technical experts on issu-

es such as governance, finance and outcomes. This Ministerial group predated the focus on integration and had established mutual trust and effective cross sector relationships through their previous work to oversee the Reshaping Care for Older People (RCOP) programme [11]. The clear line of sight between policy, delivery and practical support for improvement was another important enabler. The Joint Improvement Team, with cross sector expertise in adaptive improvement, facilitated an improvement network to support local teams to spread good practice, tackle variation and track progress on a core set of improvement measures.

Operating in financial austerity is both a challenge and an opportunity. A £300 million Change Fund (around 1% of the older people health and social care budget) was introduced over four years from April 2011. Funding was ring fenced to test and spread interventions to enhance the wellbeing and independence of older people and their carers, prevent, reduce or delay dependency, improve experience and personal outcomes, and increase the resilience of the system. Early wins were critical to secure buy in and continued investment in new ways of working. The Reshaping Care and Change Fund Building on Progress Report [12] contains over 100 case study examples and evidences the shift in national indicators – e.g. a 10% reduction in rate of emergency admissions of over 75s; over 2 million more days spent at home in 2014/15 than would have been expected.

Learning from what worked for RCOP is now being applied to all adult care groups through an Integrated Care Fund of £300 million over three years from April 2015. Guidance on the use of the Integrated Care Fund [13] encourages investment in preventative supports and acknowledges the crucial role of the voluntary sector in supporting the assets of individuals and communities so that people can have greater control over their own lives and develop capacity and confidence in self-management. Additional investment in social care, telehealth and telecare, primary care, and mental health services will also help to build capacity in community services [14].

2.2.6 SOURCES

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2.3. INVOLVING PATIENTS AND COMMUNITIES

A key principle of integrated care is active patient involvement and empowerment, but in practice, it is often being paid lip service. Until recently, the question of how to involve patients, their families and caregivers as well as their wider communities from the design through to the delivery of health and social services has often been sidelined, even though strong evidence exists for many tools of their positive effect on health outcomes, patient and professional satisfaction and cost effectiveness.

First of all, there needs to be recognition, that the concepts 'empowerment', 'engagement', 'co-production', and 'activation' are complex and contested. These terms have been used interchangeably in different settings to refer to different levels of capacity, interest and activity that people have in relation to their health and care. The target group also shape how the terms get conceptualize and what they mean in practice in different settings. In the following text, 'people' includes everyone, from the individual person or patient, their families, carers, communities, populations and the public in general. The objectives to strengthen patient and community involvement are:

- to support the engagement and empowerment of people for active and healthy living throughout their life course;
- to support people to better manage ill health, ageing processes, disability and to cope with pressure;
- to support people to better care for their dependants;
- to support people to coproduce the health and care services they receive;
- to support people to contribute to service and system change and improvement;
- to support the engagement and empowerment of people to transform their environment and act within their social determinants of health;
- to support the engagement of people who suffer from health inequalities to empower them to become respected players in their own care and care systems.

People engagement represents the fundamental necessity of winning the hearts and the souls of the people, in order to create coordinated/integrated health service delivery, which spans from healthy lifestyle choices and health promotion to rehabilitation and palliative care. (Coulter 2008, WHO Euro 2012) It is essential to put people at the centre of care, using their needs and preferences as a guide to system and services design. In order to do so, goals need to be revised to reflect their interests, and the limitations of the professional sector (e.g. availability, accessibility and resource constraints) need to be supplemented by community and people involvement. (WHO Euro Meeting Report 2014). Given the fact that two of the main principles of integrated care are person-centred care and patient empowerment, the lack of consideration for patient-related aspects in the design and implementation of many integrated care initiatives to date

should raise suspicions. The best-planned and well-intended integrated care initiative makes little sense if the patients are not interested in joining. (Stein 2010) An important aspect here is to ensure an inclusive and holistic approach, identifying ways of involving vulnerable and minority groups, thus making integrated care accessible for all. (WHO Euro Meeting Report 2014)

Without changes in people's lifestyles, their living environments and without their co-development of the services they received, no mayor change can be expected to occur in health outcomes, quality of care, care experience, system efficiency, and reducing health inequalities. People need enhanced skills and capacity to actively support and maintain those changes within an evolving context. The specific tools to achieve these aims can be targeted at individuals, specific sub-groups or the broader community. Ferrer (2015) identified four key strategies for this:

1. Self-managing health and health conditions. This involves support for developing knowledge, skills and confidence to manage one's own health (self-care), caring for a specific health condition and recovering from an episode of ill health.
2. Shared decision making that involves supports patients in taking decisions about their health, in considering options including the choice of taking no action, in pondering risks and benefits and in analysing how the available options suit their values and preferences.
3. Peer-to-peer actions support patients in providing and receiving help from others in similar conditions, based on mutual and shared understanding.
4. Support to families and carers. This seeks to develop knowledge, skills and actions to enabling people to care for themselves and for others.

A full review of the evidence, explanation of the terms and overview of tools available can be found in Ferrer (2015). The following Figure 4 gives an example of the wide array available to support self-management of individuals.

Figure 4.
The continuum to support self-management



Source: The Health Foundation (2015).

The active engagement of people in the design and organisation of the delivery of health care is key to ensuring people-centred services. (Suter et al. 2009, Nicholson et al. 2013) Creating a high involvement culture means also shifting ownership and authority to the health workforce for local innovation and leadership. Ensuring this network of active and connected people, communities and health providers is necessary to build meaningful relationships with the public and health sector that is conducive to the continuous delivery of care. (Suter et al. 2009, Nicholson et al. 2013)

Illustrative example: NorthWestLondon Whole System Integrated Care

The NorthWest London (NWL) journey started as an Integrated Care Pilot in 2011, which was a national strategy to foster innovation in health care. It represents the integration of services in 8 boroughs of London, representing a highly diversified population of 2 million people, from financially very well off, but socially isolated older people to multi-ethnic, vibrant and younger areas with a much broader spectrum of health and care needs. In 2013 it became one of 14 national Pioneers. Only then did the co-production and co-design of the system take shape. This approach was initiated by the organising team of the Pioneer, when they realised that they were still talking about patient-centred care for the patient, but not with the patient. From this sprang an invitation to 150 local community organisations, NGOs, civil society organisations and the third sector to share their needs and ideas with the coordinating team. These discussions, which were organised as focus groups, workshops and open public meetings, were led by the 3 key principles of NorthWestLondon:

- People will be empowered to direct their care and support and receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems will enable and not hinder the provision of integrated care.

The involvement of all of the different representatives finally evolved into a network, which gives regular feedback on the design and co-evaluate and monitor the delivery and implementation of the integrated care services. These are continuously expanded based on the input received from the network. A key player here is the Lay Partners Advisory Board, which is an integral part in all meetings and decision making processes.

The local communities were actively involved in co-designing the local plans, strategies and how to implement them, according to the resources and needs in each of the 8 boroughs. At the same time, involvement of the lay partners in the overall coordination of the NWL Pioneer work assured that transitions across borders of the boroughs were possible and the overall strategy to improve population health was not lost in details. The discussions revolved around the following topics:

- A local vision for integrated care
- Which population groups to focus on first
- The outcomes we want to achieve for that population group
- What the new model of care should look like i.e. how professionals should work together in a single team to deliver joined up care and enable people to stay independent and well

The learning from the change process, the tools employed and the lessons learned are available online as the NorthWestLondon (NWL) Whole System Integrated Care (WSIC) toolkit, <http://integration.healthiorthwestlondon.nhs.uk/chapters>

2.4. FINANCING AND INCENTIVISING INTEGRATED CARE

Apart from organisational and professional barriers, integration of services within and between sectors is often hampered by financial disincentives, budgetary restrictions or incompatible funding structures. Financing systems are determining both providers and users in their behavior to deliver and consume defined services that are to a large extent purchased and funded by third parties (public health system,

social and/or private insurance). Incentives thus influence the type, quality and quantity as well as the modes of care delivery and the extent and modes of use and/or misuse of services. Redefining financial frameworks, e.g. moving away from fee-for-service towards value-based reimbursement, to match the design of services delivery that best serves individuals/populations is then a key priority area. Disincentives for collaboration across professional and sectorial boundaries have actually been discussed at length with respect to health care and long-term care systems. This reaches from strong corporatist or professional groups that are dominating the sector (Ahlgren & Axelsson, 2011) and financial disincentives to legal and privacy regulations that do not allow for information exchange, in particular (Leichsenring 2015, unpublished):

- Fee-for-service arrangements generally do not allow for reimbursement of resources dedicated to coordination or joint training activities. Providers will therefore strive to avoid such activities, unless they are able to retain other tangible advantages from such cooperation.
- Flat-rate or lump-sum cash-benefits or vouchers for users are playing an ambivalent role in creating people-centred integrated health services. On the one hand, they improve independence and purchasing power of users who may choose their preferred type and extent of support. On the other hand, in particular relating to older people with cognitive impairments, such schemes may overburden users and their carers in identifying and coordinating appropriate care provision, in particular if the benefit does not allow for full coverage of care needs.
- Lack of mutual understanding as well as implicit or explicit hierarchies between professional groups may be identified as another disincentive to overcome ‘silo-thinking’.
- Finally, legal regulations with respect to privacy and professional confidentiality may hamper cooperation and coordination in general, but they also contribute to the range of disincentives to engage across professional boundaries. This includes also issues of risk and accountability, in particular with respect to patient safety and compliance with care plans.

2.4.1. INCENTIVES AS ‘CARROTS’ AND ‘STICKS’

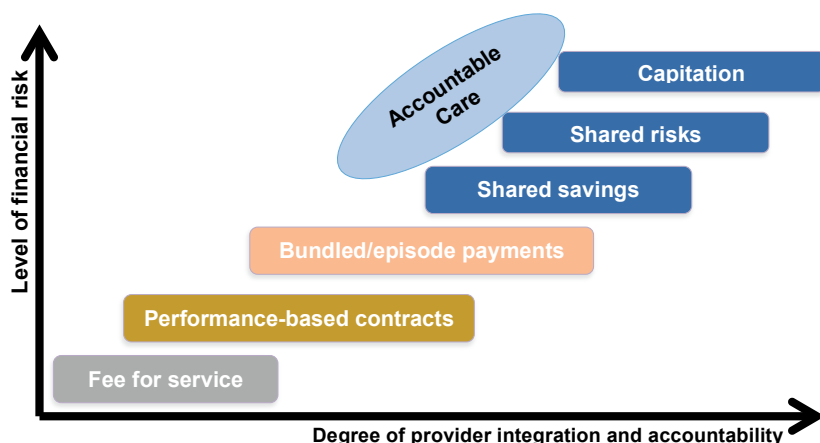
In general, incentives may take the form of rewards or penalizations to inspire and motivate individuals and organizations to work towards defined objectives – usually in a contractual relationship. However, the “underlying goal of incentives is [...] not simply rewarding good performance or punishing bad performance. The goal of using incentives is to support the change in the status quo by stimulating both immediate and long-term improvements in performance through reinforcing positive performance by creating alignment between expectations and rewards (financial/non financial) and removing financial barriers that perversely effect desired performance” (Custers et al., 2007: 382). There is ample debate whether incentives such as bonuses for certain groups of professionals may be well enough targeted or whether they might even undermine intrinsic motivations of staff. Details such as the rules of distribution, e.g. if bonuses are paid to an organization to distribute them among staff, and the definition of performance indicators, their measurement (transaction costs) are of utmost importance in the design of incentive payments, starting from the definition of clear objectives (Elovainio, 2010). Especially in the area of health and social care, where intrinsic motivations are playing a major role both at individual and at organizational level, financial incentives may even result in ‘crowding out’ such intrinsic motivators, e.g. purpose or altruism (Woolhandler & Arieli, 2012; Harrison & Marshall, 2005).

2.4.2. PAYMENT SCHEMES AND THEIR CONTRIBUTION TO INTEGRATION

Following a continuum of payment schemes, though in the first place developed for primary care (UHCHRM, 2012; KPMG, 2014), might underpin more value-based and people-centered integration, taking into account both accountability and risk-levels that are linked to such schemes for different stakeholders involved (see Figure 6). This continuum would move away from traditional fee-for-service schemes towards performance-based contracts and eventually to ‘Centers of excellence’ and ‘Accountable care programs’,

understandably with a wide range of variation at provider level and with respect to different framework conditions. Following a continuum of payment schemes, though in the first place developed for primary care (UHCHRM, 2012; KPMG, 2014), might underpin more value-based and people-centered integration, taking into account both accountability and risk-levels that are linked to such schemes for different stakeholders involved (see Figure 6). This continuum would move away from traditional fee-for-service schemes towards performance-based contracts and eventually to 'Centers of excellence' and 'Accountable care programs', understandably with a wide range of variation at provider level and with respect to different framework conditions.

Figure 5.
The value-based payment continuum.



Source: adapted from UHCHRM, quoted by KPMG, 2014.

The general discomfort with fee-for-service payments has triggered new models of financial incentives to overcome fragmentation, to increase efficiency and to reduce transaction costs. Whilst these developments and related assessments have usually been linked to general reforms of reimbursement mechanisms and cost containment, it is difficult to disentangle the degree to which these incentives as such contributed to enhanced provision of integrated care. Yet it is evident that any change in health care delivery is to a large degree induced by financial incentives – or, more often, hampered by disincentives. When it comes to cooperation between health care providers a number of disincentives have been identified in research and policy debates:

- on the individual level: fee-for-service to reimburse GPs or individual specialists are likely to incentivize overtreatment, rather than to search for (potentially cheaper and more appropriate) alternatives; individual contracts might tend to avoid teamwork or multi-professional cooperation (Andersson and Liff, 2012); overburdening with administrative reporting tasks; difficulty to 'personalize' individual contributions to overall performance;

- on the organizational level: hospitals depending on reimbursement by per-diem charges might be interested to prolong patients' length of stay; home care providers being reimbursed by fee-for service based on time-logs might be hesitant to participate in unpaid co-ordination meetings with other stakeholders;
- on the system level: there is ample debate about whether regulated markets and price control are detrimental to efficiency gains (Pope, 2013), but it may also be questioned, whether more user choice and market-oriented governance are able to bolster enhanced cooperation and the delivery of integrated care. At this level, there are also a few examples of incentives for purchasers, i.e. health insurers, by the regulating body (the Government) that might use incentive payments to steer the allocation of funds, rather than imposing such programs by decree. For instance, in Germany, sickness funds have been incentivized to develop disease management programs by an additional flat rate payment (€180) for patients enrolled in such programs (Hernández-Quevedo et al., 2013).

Integration and new types of health provider performance incentive schemes such as 'Pay-for-Performance (P4P)', 'Results Based Financing', 'Performance Based Financing' or 'Performance Based Contracting' (Elovainio, 2010), but also the earlier mentioned trend towards diagnosis related groups (DRG) funding of hospitals may be interpreted as a step towards new incentive structures, although they often fall short with respect to quality improvement (Busse et al., 2011). In fact, DRG-funding principally remains a 'fee-for-service' of individual hospitals with the key objective to move patients out of hospital as quickly as possible, rather than searching for cooperation and collaboration with primary care or other more suitable types of care.

Table 1. Overview of tools, evidence and caveats.

Instrument	Literature	Evidence/Caveats
Diagnosis-related groups funding (hospitals)	Busse i in., 2011	Great diversity of design, transparency improved, comparison of performance, increased administrative efforts, mixed evidence on efficiency gains ('gaming'), potential reduction of hospital costs, but potentially detrimental for ensuing (out-patient, long-term care) services; problems with risk-adjustment
Pay-for-performance	Casalino i Elster, 2007; James, 2012; Mullen i in., 2009; McKalip, 2009; Conrad i Perry, 2009; van Stolk i in., 2010	"P4P and public reporting could induce physicians to focus their time and attention (consciously or unconsciously) on types of care that are being measured, to the detriment of non-measured areas that could be equally or more important" (Casalino & Elster, 2007:406)
Accountable Care Organizations with population-based payment	Chernew i Hong, 2013; Bertko i Effros, 2010; Damberg i in., 2014; Marton i in., 2014	"Accountable Care Organizations (ACOs) [...] can be generally defined as coordinated networks of medical providers that assume the risk for the quality and total cost of care for their patients [...] much like more traditional managed care organizations (MCOs), health maintenance organizations (HMOs), or integrated delivery networks, ACOs may differ both in terms of specific contract characteristics and the populations they serve, with current ACOs providing care through contracts for Medicaid, Medicare, private payers, and different combinations of these groups." (Marton et al., 2014: 47) Savings vs. quality
Multi-level governance: Fines for municipalities unable to supply social care	Emilsson, 2011; Allen i in., 2009; Godfrey i in., 2008	Useful if combined with partnership working (depending on distribution of competencies between government levels/social insurance)

Instrument	Literature	Evidence/Caveats
Managed Care, Disease management	Tummers et al, 2013; Iglehart, 2011; Kodner & Kyriacou, 2003; Werkman & Lensink, 2010	Different models from integrated 'Social Health Maintenance Organisations' to disease management focusing on COPD, cardiovascular diseases, diabetes, stroke etc., but also dementia.
Hospital discharge management	Capitman, 2003	Mixed (qualitative) results; methodological problems; Depending on design and supply in post-acute care (rehabilitation); often ends with discharge (no follow-up)
Pay-for-Coordination; Case Management	2013; Mak, 2011; Czypionka & Röhring, 2009	While 'case management' usually is at the basis of any managed care program, disease management or hospital discharge management, it is often unclear who should pay for the additional costs of case managers who might produce gains that, however, become manifest in another part of the system. One possibility consists in paying for case management by third parties or pooled budgets (AT, NL)
'Bundled budgets' (Care trusts)	Bertko & Effros, 2010; Llano, 2013; Glasby & Peck, 2005	Potential unintended consequences: "providers may try to shift care beyond the post-acute period to increase reimbursement (similar to discharging patients more quickly from hospitals after the implementation of Diagnosis Related Groups [DRGs]). Adjustments for case mix severity could lead to the type of upcoding (i.e., patients coded as having more severe conditions in order to increase the reimbursement amount) seen in the DRG system, which could reduce expected savings. Providers may also try to increase the numbers of discrete bundles to maintain their income. Past bundled payment systems have not included post-acute care facilities in the bundle; including such facilities in the bundle would clearly affect decisions about when the patient was ready for transfer from the acute care hospital to another facility and how payments are distributed among providers" (Bertko & Effros, 2010)
New mix of financial incentives	van Stolk et al., 2010; KPMG, 2014; UHCHRM, 2012	"on the basis of the existing evidence, it is impossible to establish the degree of impact of a specific aspect of P4P on the overall outcome in terms of efficiency and quality of care" (van Stolk et al. 2010)
Bottom-up zero-sum budgeting and alliance contracting	Timmins & Ham, 2013; http://www.cdhb.health.nz/News/Publications/Pages/default.aspx ; see also Cumming, 2011; Addicott, 2014; ACEVO, 2015	Transformation towards more integrated care through better demand management in primary care, significant improvements in hospital efficiency and an important impact on the use of social care (Timmins & Ham, 2013)a

Instrument	Literature	Evidence/Caveats
Incentives for patients/clients (compliance)	Hernández-Quintero et al., 2013; Nolte et al., 2008	e.g. waivers of co-payments, if patients participate in disease management programs and show compliance (FR, DE); discounts for gym or enhanced services (check-ups) for enrolled patients ('Gesundes Kienzigal')
Public reporting on quality	Mor et al., 2014; Rodrigues et al., 2014; Nolte et al., 2011	Usually restricted to individual organizations and clinical indicators, rather than on 'network quality', quality of coordination or quality of life (experienced by clients/patients)

Source: Leichsenring K. (2015), unpublished.

Conrad & Perry (2009) have undertaken a seminal review of studies that illuminate quality-based incentive design in health care with a focus on financial incentives, in particular looking at the following issues:

1. use of rewards versus penalties,
2. nature of the entity and focal quality behavior subject to the incentive,
3. whether the incentive is general or selective,
4. extrinsic versus intrinsic motivation (with reference to unintended consequences),
5. use of relative versus absolute performance measures,
6. size of the incentive,
7. certainty of the incentive,
8. frequency and duration of the incentive.

The article offers some insights concerning financial incentives for individual physicians and health services as well as a number of propositions for incentives design based on empirical evidence:

"a balance of rewards and penalties; a blend of group and individual-level incentives, preferentially weighting group incentives; selective, specific rewards and penalties; comprehensive, evidence-based incentives attuned to norms of medical professionalism; predominance of absolute performance standards; right-sized incentive payments with payoff rules known in advance, a timely payment schedule, and a design to be sustained over the long run" (Conrad & Perry, 2007: 368).

In line with most literature in this area it also concludes "that the effects of selective, quality-based financial incentives akin to those of current P4P programs are likely to be modest" (Conrad and Perry, 2007: 365).

Illustrative example: Bundled payments in the Netherlands

In the Netherlands, there is a long tradition of endeavors to overcome fragmentation of services both within health care and between health and long-term (social) care. For instance, numerous initiatives and disease management programmes were started to enhance the quality and continuity of care for chronic diseases, but although they often showed improvements, the fragmentary funding (fee-for-service for each individual organization) hampered their rollout and the realization of economies of scale. This shortcoming has been addressed since 2007 with the nationwide introduction of bundled payments for diabetes; later also for COPD and vascular risk management. The clear aim of this scheme was to promote disease management programs and adherence to related clinical guidelines, to improve coordination and to increase quality of patient records (Struijs & Baan, 2011).

Under the new payment scheme, chronic care is organized by 'care groups' that are contracted by the health insurers and act as a provider and principal purchaser for the full range of care services for a defined disease during a defined period of time. As care groups in practice are chiefly, often exclusively, consisting of GPs, services are provided both by the care group itself and by sub-contracted other providers such as specialists, dietitians or hospitals (although in-patient care, medication, medical devices and diagnostics are not included in the bundle). However, not all GPs have adhered to 'care groups' and many continue to be paid by fee-for-service as all GPs do for their other services. Health insurers and 'care groups' are free to negotiate on prices for the bundle of services, and 'care groups' are also free to set or negotiate prices for sub-contracted services. This resulted in a wide variety of prices (from €258 to €474 per patient per year), although the general services contained in the bundle had been defined at the national level (Struijs & Baan, 2011).

It seems that task delegation and care coordination concerning the addressed disease groups as well as process indicators, i.e. compliance with clinical guidelines, improved (de Bakker et al., 2012). However, a number of shortcomings still need to be addressed (de Bakker et al., 2012; de Bakker et al., 2013; Struijs & Baan, 2011; Tsiachristas et al., 2013):

- care groups have an incentive to refer costly patients (unnecessarily) to hospitals in order to keep them out of their budget
- cost-pricing of bundles would need more transparency
- mechanisms to avoid 'gaming' between the parallel systems (fee-for-service and bundled payment) need to be further developed (IT support)
- patients with multi-morbidities are obviously not considered appropriately

Furthermore, the following caveats have to be considered (Appleby et al., 2012):

The costs for administration and monitoring might be considerably higher than with fee-for-service payment;

Significant up-front investment of time and resources (negotiations, software, etc.) is needed

Time is also needed to tackle the technical challenges of defining care bundles and to negotiate what should be included in bundles;

The transfer of risk to providers leads to incentives for cherry-picking and under-treatment, unless appropriate risk-sharing (again, based on transparent data) between payers and providers can be achieved; Another risk may develop over time in that dominant lead-providers gain too much purchasing power, which might again result in higher prices; this might also result in a reduction of choice options, both for patients and for sub-contracted parties.

Notwithstanding these risks, many of which may be addressed through appropriate governance mechanisms, bundled payments represent an important first step to move away from fee-for-service systems that are considered as the major disincentive for cooperation and coordination. Further research and policy development is needed to explore the extension of bundles to a broader definition of target groups, services to be included and potentials of cross-sectorial bundles, e.g. to allow for more social care support at home, if this avoids the transfer to hospital or to residential care.

Illustrative example: Accountable care organisations in the USA

Accountable Care Organizations (ACOs) are addressing the shortcomings of disease management that is often reduced to individual diseases (also in combination with 'bundled payments').

"Accountable care organization refers to a health care organization composed of doctors, hospitals, and other health care providers who voluntarily come together to provide coordinated care and agree to be held accountable for the overall costs and quality of care for an assigned population of patients. The payment model ties provider reimbursements to performance on quality measures and reductions in the total cost of care. Under an ACO arrangement, providers in the ACO agree to take financial risk and are eligible for a share of the savings achieved through improved care delivery provided they achieve quality and spending targets negotiated between the ACO and the payer." (Damberg et al., 2014)

ACOs are thus a further development of more traditional managed care organizations (MCOs), health maintenance organizations (HMOs), or integrated delivery networks. They may differ both in terms of specific contract characteristics and the populations they serve, with current ACOs providing care through contracts for Medicaid, Medicare, private payers, and different combinations of these groups (Marten et al., 2014). ACOs are a relatively new tool. First pilot ACOs were introduced in 2012 and sponsored by the Centers for Medicare & Medicaid Services (CMS) Innovation Center, but there are a number of other ACOs that are funded by private payers. CMS offer a variety of options within this program. Apart from the Pioneer ACO Model, there is also the Medicare Shared Savings Program – a program that helps a Medicare fee-for-service program providers become an ACO – and the Advance Payment ACO Model – a supplementary incentive program for selected participants in the Shared Savings Program. Given the short period of implementation, the evidence of the few evaluation studies carried out during the past few years is scarce and restricted to few indicators and measures. Damberg et al. (2014) underline that, at this stage, it is difficult "to discern the effects of ACOs on quality" and "to make conclusions about the impact of ACO payment structures on costs" (Damberg et al., 2014). However, ACOs are expected to implement a variety of quality improvement and care management programs, information technology, and patient registries, which have the potential to improve quality of care more broadly and which could generate positive spillover effects.

Indeed, the challenge is to understand, in how far potential economic gains impact on the quality of care. Some disclosed aggregate data from the pilot ACOs serving more than 600,000 Medicare patients seem to be promising (Table 1), and new features are being implemented now, e.g. more organizations are expected to convert fee-for-service reimbursements to population-based payment in order to offer more flexibility for the reallocation of funds (Pham et al., 2014).

Table 2. Early Performance in the Pioneer Accountable Care Organization (ACO) Model, 2012–2013a

Year	2012 ^b	2013 ^b	2012 ^c	2012 ^c
Total program savings, millions \$	87	96	128	96
Mean clinical quality score, %	70.8	84.0	73.0	84.0
Mean patient experience score, %	86.3	88.0	86.7	88.0

Source: Pham et al., 2014. – (a) Data from the Centers for Medicare & Medicaid Services financial reconciliation for the Pioneer ACO model in 2012 and 2013, based on Medicare claims for years 2009–2013, and clinical quality data submitted by Pioneer ACOs in 2013 and 2014; (b) Results for 32 Pioneer ACOs participating in 2012 and 23 Pioneer ACOs participating in 2013; (c) Results for the 23 Pioneer ACOs that participated in both 2012 and 2013; (d) All savings minus all losses generated by the model.

The optimistic stance concerning ACOs reads as follows:

“The Pioneer model continues to mature, fueled by rapid cycles of measurement, reporting, learning, and refinement made possible by the close collaboration CMS has formed with participating ACOs. Performance is on an upward trajectory in a manner aligned with original expectations, as ACOs become more strategic and effective in implementing care strategies and as CMS becomes more effective at facilitating their work. (...) Early success in the Pioneer model suggests that in the long term, accountable care will offer patients the improved outcomes they deserve and ACOs the sustainable business model they need to stay focused on delivering high value care” (Pham et al., 2014: 1636)

However, there are also concerns that the formation of ACOs may lead to greater market concentration and have the adverse effect of raising prices; this could be mitigated by setting a maximum rate of growth in health care spending by providers (Damberg et al., 2014). Currently, experience is gained through trial and error between public or private sponsors on the one hand and providers forming ACOs on the other. The challenge is how to generate information and knowledge from the experimentation and how to transfer this knowledge in a most competitive market.

2.5. BUILDING A COMPETENT WORKFORCE FOR INTEGRATED CARE

While there is a plethora of tools and instruments available to support and foster integration of health and social services (e.g. continuous patient pathways, eRecords, case/care management), little thought is given to the people who need to implement and utilise these tools on a day to day basis. Reflecting on the technical knowledge and skills necessary to work in an integrated system, this part explores the competencies required to implement integrated care and analyses how current education and training approaches fall short of conveying these competencies on all levels.

Education and Training are emphasised by many authors and described as a key element to more people-centred care. (Armitage et al. 2009, Nicholson et al. 2013, Suter et al. 2009, Maslin-Prothero/Bennion 2010, Williams/Sullivan 2009, Goodwin 2002) In order to enable health professionals to fill the new roles assigned to them (Armitage et al. 2009, Hickey 2008, Stewart et al. 2003), to manage health and care rather than disease and cure, to work in teams across professions and sectors, they need to acquire different skills from what they have traditionally been taught. (Maslin-Prothero/Bennion 2010) In supporting and training staff to work in an inter-disciplinary and integrated environment, a gradual change of organisational and professional cultures may also be achieved, thus enabling long-term transformation of service delivery to be conducive to integrated care. (Stewart et al. 2003) Education and training, however, must also create a more conducive environment to continuous learning. (WHO Europe 2008) Education and training efforts have to be viewed from two sides: managers and policy makers need to create learning environments and organisations, in which providers, patients and people may actively seek knowledge. This importantly entails creating trust and having respect for one another to support the learning organisation.

2.5.1. WHAT ARE COMPETENCIES AND HOW DO WE ACQUIRE THEM?

Based on McLelland's (1973) eponymous paper, with which he founded the movement for competency-based education, the “Iceberg model” very aptly visualises the complexity of competencies by distinguishing between technical competencies, what we know and can do (i.e. the iceberg we see above the surface), and behavioural competencies, what we perceive and what motivates us (i.e. the iceberg below the surface). The former comprise knowledge and skills and can be directly influenced by education and training; the latter are our attitudes, which can only be influenced indirectly through education, training and role models. In a paper for the WHO Regional Office for Europe, Langins and Borgermans (2015) describe health workforce competencies as “...essential complex knowledge based acts that combine and mobilize

knowledge, skills, and attitudes with the existing and available resources to ensure safe and quality outcomes for patients and populations. Competencies require a certain level of social and emotional intelligence that are as much flexible as they are habitual and judicious.”

The authors continue by listing key features of competencies, including that they take time to acquire, they must be measurable and flexible, and they are a distinguishing feature for groups – which underlie the emergence of professional and/or organisational cultures.

2.5.2. WORKFORCE COMPETENCIES FOR INTEGRATED CARE

In a literature review, Busetto et al. (2015) summarised the workforce changes taking place during the implementation of integrated care models. These included new leadership and management roles (as in nurse-led care or case management), new professional roles (as in pharmacist involvement), and new working environments (as in inter-disciplinary team meetings or multi-disciplinary pathways). So, not surprisingly, integrated care very often challenges the way professionals have been taught to deliver care as roles and responsibilities are redefined, new tools and processes implemented, and cross-professional and cross-sectoral collaboration formalised. This may lead to resistance, resignation or disregard (Halvorson 2007). In order to enable professionals to fill these new roles, to manage health and care rather than disease and cure, or to work in teams across professions and sectors, they need to acquire a different set of knowledge, skills and attitudes from what they have traditionally been trained to do. Numerous authors have hence highlighted that education and training is a key principle of integrated care (see for example Hickey 2008, Suter et al. 2009, Williams/Sullivan 2009, Maslin-Prothero/Bennion 2010, Nicholson et al. 2013). By supporting and training staff to work in an inter-disciplinary and integrated environment, a gradual change of organisational and professional cultures may also be achieved, thus enabling long-term transformation of service delivery and creating a common understanding and culture conducive to integrated care. (Stewart et al. 2003) The health workforce must be equipped with a skill set that ensures they collectively are capable of meeting and responding to the needs of patients, people and the community. The delivering of services in a more coordinated way may challenge the individualistic approach to care that is traditionally familiar and taught to health providers. (Williams/Sullivan 2009) Redefining roles and responsibilities within an integrated working environment – like that of nurses and midwives, to expand their unique position and encourage a team-based delivery of care – must be accompanied by the relevant skills and tools to do so. (Nicholson et al. 2013, Suter et al. 2009, Maslin-Prothero/Bennion 2010, Williams/Sullivan 2009, Goodwin 2002) An environment for continuous learning is also important for health professionals to create a culture of professional excellence that uses experience constructively rather than to place blame. This will importantly include transparent and open error management. (Ouwens et al. 2005, Ling 2012)

Special attention has to be paid to the fostering of management and leadership skills in providers, as various literature reviews highlight that finding and supporting committed leaders and managers is essential in the design and implementation of integrated care. (Maslin-Prothero/Bennion 2010, Armitage et al. 2009, Nicholson et al. 2013, Suter et al. 2009) However, the evidence also points to the fact that so far it is very often down to luck and coincidence, rather than strategic planning or training, to have such a person in the right place when starting an integrated care initiative. Williams and Sullivan (2009) also emphasise that leaders need to be found on the policy as well as the professional level, since one of the biggest obstacles remains to transfer integrated care policies ‘on the ground’.

2.5.3. BUILDING COMPETENCIES NEEDS A HOLISTIC APPROACH

Developing education and training programmes to build a competent workforce for integrated care needs a multi-faceted approach on all levels. On the system and organisational levels, policy makers and managers need to create a framework for learning environments and organisations, in which providers can work together and engage with patients, caregivers and communities. This importantly entails creating trust and having respect for one another, as well as developing an open error management to support

the learning organisation. But it also means sharing responsibilities and committing oneself to the active involvement in a continuous learning cycle (Langins and Borgermans 2015).

It is also paramount that all professionals on all levels need to participate in this competency-based learning. Currently, if there is any emphasis laid, it is still on the health workforce (Langins and Borgermans 2015, Frenk 2010), but it is clear that everyone involved will need to acquire additional competencies, if transformational change for integrated care is to be achieved. This encompasses decision makers and leaders embracing a common vision for integrated care and providing an adequate regulatory framework, more professional bodies and associations to engage in the development of competency frameworks for education (see for example the work of the Committee of Social Workers Education, CSWE 2014), and people and communities actively taking part in the design and delivery of integrated care (see Ferrer 2015). And so indeed this quote from Frenk (2010) may be adapted to read that "...all (...) professionals in all countries [need] to be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams."

Illustrative examples: NUKA Health System, Alaska

The NUKA Health System was set up in 1997 by the South West Foundation as a response to the very specific and dire needs of the local indigenous population of the Alaska Native Health System (i.e. in the whole state of Alaska). The key idea and driving force behind it is that every native American in Alaska is a 'consumer-owner' of the Alaska Native Health System, which is known as NUKA system. This literally means that everyone has an equal share in the system and thus has a say in how the system is designed, implemented and delivered. The mission is to "work together with the Native Community to achieve wellness through integration of health and other services" and realise the vision of "a Native Community that enjoys physical, mental, emotional and spiritual wellbeing". Importantly, this involves respecting the cultural and spiritual needs of the population.

This approach has shown some impressive results, such as (Gottlieb 2013):

- 95% enrolled in primary care, up from 35%,
- Same day access for routine appointment, down from 4 weeks
- Waiting list for behavioural health consultation eliminated
- 36% reduction in hospital days
- 42% reduction in ER
- 58% reduction in specialist clinics
- High patient satisfaction with respect to culture and traditions
- Staff turnover reduced by 75%

A key element of success is the comprehensive approach to education and training, offering specific courses throughout the professional careers (from the first day to the last), patient education and training sessions, peer2peer support, etc. A special focus is laid on reaching out and training young people, motivating them to teach each other. The RAISE programme for example offers on-the-job experience in the NUKA health system for 14–19 year olds.

The professional training is organised under the key terms: discover (targeting external professionals and researchers interested in learning more about the tools, outcomes and lessons); learn (for people involved in the system, offering workshops on case management, quality improvement or the Family Wellness Warriors Initiative (FWWI) Beauty for Ashes, which teaches people how to address issues related to domestic violence and abuse); transform (change management programme for health organisations).

A whole pillar is dedicated to health education, addressing such areas as maternal and child health, supporting lifestyle changes and prevention programmes.

More information can be found here: <https://www.southcentralfoundation.com>.

2.6. FUNCTIONAL SUPPORT FOR INTEGRATED CARE: ALIGNING ICT SYSTEMS AND COMMUNICATION FLOW

Information and data generation are essential tools for CIHSD design and implementation. The lack of access to data is often cited as a key challenge to health system improvement, and data protection often used as an excuse not to analyse data at all. (WHO Euro Meeting Report 2014, unpublished) Hence, the ways of information generation and information transfer need to be properly defined and managed in order to reach a meaningful understanding within the context of integrated care. (Ling 2012) It is important to note, that this is much more than implementing glossy IT. Rather functional integration encompasses a process from information generation to information (knowledge) transfer, using adequate technological tools, research principles and ethical considerations along this continuum of data utilisation. Special attention needs to be paid to the transformation of information into knowledge and the important role research plays in promoting and validating information in order to improve care. (WHO Euro Meeting Report 2014, unpublished) In a systematic literature review analysing the elements of integrated primary/secondary care (Nicholson et al. 2013), integrated information communication technology was cited in 17 of the 21 included articles as key to enabling CIHSD. Implementing an appropriate ICT infrastructure across health and social services and linking different care levels contributes to improved planning of services and resources, monitoring cost-effectiveness and health outcomes, as well as identifying high risk people for more targeted care. (Nicholson et al. 2013, Brown et al. 2003, Suter et al. 2009)

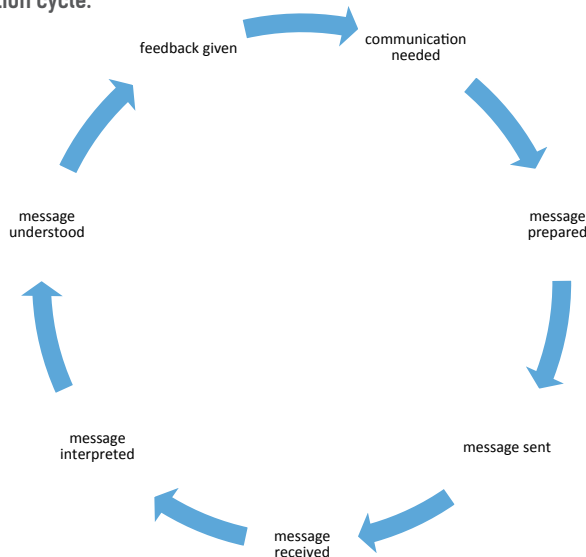
2.6.1. UNDERSTANDING COMMUNICATION FLOWS

The provision of good and effective integrated care involves identifying, acknowledging and nurturing the distinct knowledge, expertise, role and responsibilities of all people involved: patients, their family and friends, health and social care staff including those delivering care and support from third sector organisations, managers, leaders and policy makers. Such an approach will create new forms of collaborative working which sees the patient and their family leading the enablement of seamless interlinking between the different care sectors and settings. The key to successful collaboration is building trust through the use of different communication styles and tools in order to establish a culture of mutual respect which runs through all aspects of the planning, design and delivery of care and support. Communication is a two-way process, and the key elements needed are as follows:

- Sender – the person starting the communication
- Message – what the sender wishes to communicate
- Medium – the method of communication: – verbal, written, signed, electronic, telephone, etc
- Receiver – the person who receives the message and interprets it
- Understanding – the message has to be correctly interpreted by the receiver
- Feedback – the receiver needs to show the sender that he or she has received and understood the message.

This process can be described as the communication cycle (Figure 6).

Figure 6.
The communication cycle.



Source: Lewis (2015), unpublished.

The implementation of effective communication and knowledge transfer underpins successful interactions between service users and their care practitioners as well between the care practitioners themselves and this presents a number of challenges including level of health and digital literacy, cultural diversity, an ever-evolving and, sometimes contradictory or confusing evidence-base, and inadequate training for care practitioners on appropriate communication techniques for different recipients and situations.

2.6.2. DEFINING INFORMATION FLOWS

To provide adequate health services and design them according to the needs of the people, data, information and information sharing is needed for many purposes: informing policy and planning efforts for strategic decision-making and planning; monitoring the performance of providers (staff and organizations) and implementation of regulatory measures; and accessing and developing evidence-informed care resources and tools to facilitate the high quality and consistent delivery of services. In addition, a focus on eliciting patient preferences and values coupled with up-to-date service availability will facilitate improvements in targeting services and resources more effectively to meet the needs of patients and their carers. The goal of communication is to bring together and appropriately share all these necessary streams of information with the framing and content of the communication being crucial. This requires the various stakeholders, including the patient and carers themselves, to have personalized appropriate education and training, decision-support, information management and communication tools as today, communication is not restricted to face-to-face but utilizes many different information channels such as hand-held and electronic records, telephone conversations, video conferences and tele-consultations, email, online collaboration, text and instant messages, faxes, snail mail. In order to effectively communicate, the choice or combination of communication mechanisms will be underpinned by the values of team working and being able to actively listen and communicate clearly, without technical jargon and using language which can be understood by the patient and their family.

2.6.3. INFORMATION SHARING

The circle of care implicit within integrated care is often extensive and includes many people (eg patient, family/informal care givers, primary and community care providers, specialists and home care providers) that provide their care services in patients' homes, community settings, GP practices and hospitals. Consequently, the potential for patients to experience gaps in their care is high. Many integrated care programmes include a comprehensive assessment and care plan drawn up by the multi-disciplinary team working collaboratively with the patient and any relevant family/informal care givers. Developing and implementing these aspects of care pathways requires effective information sharing across and between care providers, care settings, patients and other care givers in order to achieve integrated and co-ordinated care. Consequently, mechanisms to optimize communication and information sharing are more likely to ensure patients' and their families' needs are met, improved satisfaction for all people involved, avoidance of repeat tests, investigations and treatments as well as reducing risks and improving patient safety and quality of care.

The use of electronic care information and record systems, preferably with advanced interoperability between the various records and systems used by the care providers is seen as a key ingredient to facilitate information sharing with many projects aspiring to provide an electronic integrated care record including the assessment and care plan which can be accessed by all people including the patient and nominated family members. Furthermore, electronic information systems can enhance patient access to information to help them self-care and self-manage their health and well-being, particularly for people living with chronic conditions and thus provide an environment which connects the patient with the people in their circle of care and change their care experience from episodic to continuous (Beard et al 2012).

Policy-makers and IT specialists will need to understand the range of information systems and care record processes that are in use within local care eco-system and devise a method for bringing together the right information, at the right time, in the right place, for the right person/people and utilizing the capabilities of electronic systems wherever possible and practicable. It is usual for integrated care programmes to develop a roadmap outlining the current and future configuration of information systems and processes.

2.6.4. ELECTRONIC PATIENT RECORD AND TELEMEDICINE

The most important tool within this area has been identified by many authors (Nicholson et al. 2013, Suter et al. 2009) as being the shared electronic health record (SEHR). It not only supports better planning and care coordination, it may also serve as a communication tool with the consumer/patient by offering health information and engaging in shared decision making. (Nicholson et al. 2013, Coulter et al. 2008) The electronic health record is also vital in effectively using telemedicine, eHealth and mHealth tools.

Illustrative examples: Catalunya eHealth Strategy

In parallel to its Regional Health and Wellbeing Strategy (PINSAP 2014), the government of Catalunya has also embarked on using eHealth and health technologies strategically to support their aspirations towards a people-centred and integrated health system. One of the first steps was to map the health information systems currently in use throughout the region, looking at primary care, hospitals, mental health and longterm care. This exercise unveiled that over 60 different systems were in place and a transition towards a shared eHealth record seemed impossible. Instead, TicSalut, the Catalan Institute for Technology, Innovation and Health, created a shared platform, which all of the systems could link into and exchange the necessary information. With this platform, which basically is the eHealth record (EHR), three innovation strategies are supported:

- Integrated Care
- Citizen empowerment and
- Digital health

Supporting integrated care innovations

The first instrument for which the EHR is being used is the management of complex chronic patients. Data regarding their diagnoses, admissions, medication, treatment plans and risk factors are fed into the system and shared among the four sectors. Care pathways help in managing these patients and facilitate the transfer between service providers. 100% of the primary care providers and hospitals are already connected and sharing information, while these percentages lie between 97 and 99% for the mental health and longterm care facilities. 77% of the providers are connected via WIFI and 70% use the web-based services offered in the EHR, which makes real time transfer of data possible and ensures easy access.

Supporting citizen empowerment

Even if EHR are available, patient access to data is often limited or not available. In Catalunya since July 2014, every citizen has their personal health portal, which not only connects them to their EHR but also offers various communication channels with public health services, service providers, access to e-prescriptions (to request, download and print) and general health information. The platform also enables people to book appointments online, request e-consultations and change service providers. Until January 2016, the system had over 60.000 unique users registered. Most of them only access their data, while the uptake on actively engaging with the system is still low (27% use e-booking, 10% e-choice, and 11% e-consultation).

Innovating digital health

Currently, the different government agencies are involved in developing an mHealth strategy for the region, discussing applicability and serviceability of wearables, mobile health apps, and innovative medical devices. The aim is to make Catalunya to one of the most innovative health systems in the world and actively using the many possibilities new technologies have to offer. A first step in this direction has been established with the Marketplace, website offering apps related to health and wellbeing from health promotion (e.g. information on nutrition and lifestyle choices), to monitoring physical activity, and disease-specific apps e.g. to promote cardiovascular health.

While the strategies and tools are largely in place, TicSalut and its partners are now working on promoting the many possibilities to actively get involved in managing the personal EHR, training providers to use the services and information offered in their daily routines while at the same time learning from other areas on how to adapt new technologies to promote health and wellbeing following a population health approach.

More information can be found here: http://www.ticsalut.cat/en_index/

2.7. NORMATIVE INTEGRATION: DEVELOPING CULTURES AND VALUES FOR INTEGRATED CARE

Sustained transformations in the delivery of care, at scale and pace, require a commitment to change the culture of health services in order to challenge the status quo and traditional notions of health and health care. (Glouberman/Mintzberg 2001) For cultural change to be meaningful it needs to take place on all levels, from the individual to the society as a whole. This means a new working culture that fosters forms of cooperation between professionals in public health and health care as well as health and social service professionals and health and other sectors; a shift in values from prioritising acute care with the priority to 'cure' towards a culture of preventive care with emphasis on promoting health; and recognition of patients as key partners in the delivery of health services and the coordinator for their personal health care needs. (Suter et al. 2009, Nicholson et al. 2013)

In order to create sustainable change within a system, organisations and individuals, policy makers, professionals or patients, need to alter their ways of thinking about and acting towards health. (Goodwin 2013, Halvorson 2007, Williams/Sullivan 2009) It is necessary to embrace the principles of Health in All Policies, as well as the people-centredness of the health system: the system exists to serve the people in it, and not itself. But for these principles to permeate health services delivery a cultural change in itself is called for, in health professionals and policymakers alike. Without it, tools like distributive leadership, shared decision making or joint planning boards are not feasible in the long-run, since these require changed attitudes and behaviours. They call for inclusive and inter-disciplinary collaboration and establishment of partnerships rather than siloed and competing approaches. (WHO Euro Meeting Report 2014, unpublished)

The major obstacle to be overcome in implementing any kind of change is 'culture'. Halvorson (2007) attests the culture(s) within a health care system to be uniquely immune to any kind of change. "Health care is an ultimate bastion of the 'not invented here' approach to idea rejection." (Halvorson 2007, p. 87) Likewise, managers and agents in the health institutions have learnt to "sit out" any reform and reorganisation issues, knowing that these efforts will pass and they can continue with business as usual after the storm has passed. (Glouberman/Mintzberg 2001) Unlike other areas of the economy, where the evaluation of good and best practices and the sharing of experiences is inherent in the business models, every unit in every hospital or health care provider has its own set of rules and procedures, cultures to be well aware of. The concepts of systematic process analysis and improvement, of quality management and transparency are whole new sciences for health care systems and their actors, in which none of them are trained. (Halvorson 2007) Thus, Williams/Sullivan (2009) suggest not to ask professionals and providers 'to reject their underlying values and cultures but to work together to create a new form of working directed towards the ultimate goal of satisfying the needs of citizens and users'.

2.7.1. THE PARTNERSHIP PARADIGM

Heaton et al. (2012) suggest that the transformation of health systems towards more coordination and integration of services also brings with it a paradigm shift from the 'professional paradigm', in which continuity of care was delivered 'to' patients, to a 'partnership paradigm' ...that focuses less on the discrete perspectives of different parties...and more on partnerships between patients, carers and professionals... This entails a change in values from all parties involved, and supports the concept of people-centred care.

2.7.2. STRUCTURE AND ORGANISATION INFLUENCE VALUES

It is well established that organisational cultures and local structures are strong predictors of values, and thus may become enablers or barriers for change towards CIHSD. (Williams/Sullivan 2009, Stein 2010, Suter et al. 2009, WHO Euro Meeting Report 2014, unpublished) They also determine the culture of communication and collaboration (Delong/Fahey 2000) within and between health providers and thus need to be considered accordingly, when implementing integrated care, as a failure to recognise their importance in determining professional and organisational values often leads to failed integration of services. (Williams/Sullivan 2009, Halvorson 2007)

Cultural changes have taken place in all successful integrated care initiatives, as it is a key success factor for sustainability. The topic will be further discussed in sections III and IV of this report, and highlighted throughout the case examples.

3. LEADING AND MANAGING CHANGE

Building integrated care systems is a complex and long-term task. Whilst there is knowledge on the core building blocks for integrated care there is a distinct lack of understanding on how to lead and develop such systems. Moreover, it is commonly recognised that there is ‘no one model’ for integrated care, and that integrated care does not appear to emerge naturally in any system of care – rather, it has to be managed and nurtured. Indeed, the barriers to integration are significant at a system-level due to misaligned governance, financial and regulatory practices and the subsequent conflicts of interest in tasks and roles of key organisations. These conflicts mix with a range of professional and cultural barriers and poor systems of information and communication exchange to create significant inertia. As a result, too much emphasis is placed on local innovators and key leaders to drive change forward and the underlying business model for new ways of working is not developed. This fuels the tendency for integrated care to remain localised around small-scale projects with little scope or ambition for scaling-up activities.

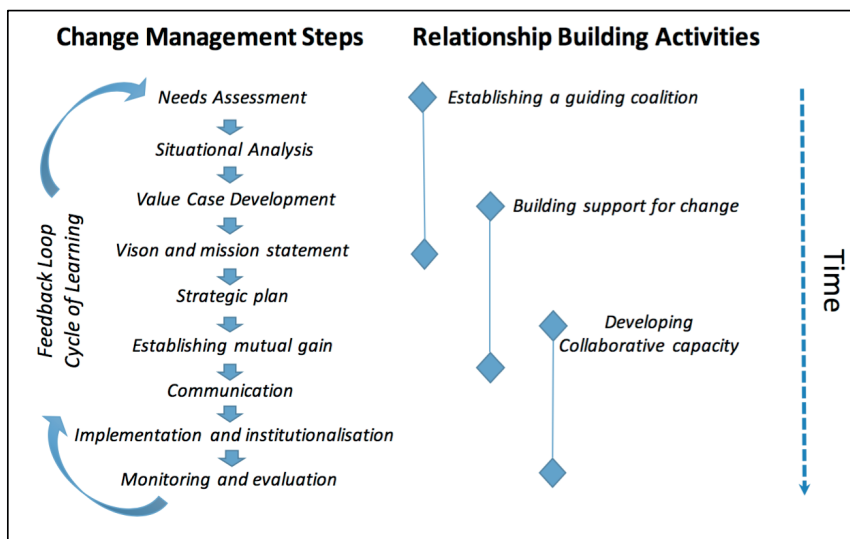
3.1. TRANSFORMATIONAL CHANGE TOWARDS INTEGRATED CARE

Supporting the development of integrated systems of care requires transformational change (for example, as witnessed in the transformation of the Veterans Health Administration (VHA) in the USA from a fragmented and poorly performing system, to a more integrated and successful one). Yet, the implementation science to support the successful adoption, spread and sustainability of integrated health and social care systems is underdeveloped. Nonetheless, there is experiential evidence from many case examples to suggest some of the key components of such a strategy (WHO Europe 2016, King’s Fund 2013, Suter et al. 2010). For example, the complexity of integrated care does not lend itself to business redesign processes that have been used elsewhere in health care reform, so change management strategies need to recognise the key issue of complexity. This is further underlined by the many different technical ‘components’ for change that are observed as core attributes of integrated care systems (as described above). However, several reviews of the literature and experiential evidence provide some guidance on the key success factors and management steps required to make change happen, specifically in the articulation of a common vision that is based on a clear articulation of the needs of people in local communities, which then can develop into a shared strategy for change. (WHO Europe 2016, King’s Fund 2013, Suter et al. 2010) Summarising these findings, Goodwin (2016) illustrates the need for a dual-pronged approach for transformational change: there needs to be a step-by-step change management process, which eventually leads towards a continuous improvement cycle, while at the same time relations and networks need to be established, nurtured and grown to garner the necessary support from stakeholders and overcome the resistance to change (see Figure 8).

3.1.1. IMPLEMENTING CHANGE

A key element in the management of change involves the implementation of the change in practice, both in terms of ‘system’ (e.g. joint financing, governance and accountability) and ‘services’ (e.g. joint delivery through the development of teams). Often, the change process requires the initial piloting of options with the intention of ‘institutionalising’ or rolling-out the lessons learned for wider adoption afterwards. Moving from small-scale programs is important in order to deliver benefits on the scale needed to make a significant and transformational impact on the way care is delivered [47]. There are, however, very few examples of tool-kits which have sought to address the issue of scaling-up of pilots, though one is the DMIC model in which ‘phase 4’ of the model supports strategies for consolidating change [10].

Figure 7.
The dual approach for the transformational change process.



Source: Goodwin N. Change Management, in Amelung et al. Handbook for Integrated Care. (2016, forthcoming).

Two aspects shall be highlighted here: the implementation of change and the development of a continuous improvement strategy:

Table 3: Examples of indicators of maturity to integrated care change management

Examples Dimension	Objective	Maturity Indicator
Readiness for change	Compelling vision, sense of urgency, stakeholder support	Public consultations, clear strategic goals and milestones, stakeholder engagement
Structure and governance	Sustains and delivers new systems of integrated care, presence of effective change management	Funded programmes, effective communication, governance and accountability in place
Capacity building	Investment in training, skills and technologies of the workforce, including systems for continuous quality improvement	Developing of funding and availability of courses to support bottom-up innovation and workforce development

3.1.2. MONITORING AND EVALUATION: DEVELOPING SYSTEMS FOR CONTINUOUS QUALITY IMPROVEMENT

It cannot be emphasised enough that integrated care is a strategy towards better provision of services for patients and populations and is thus a means to an end, not an end in itself. It is a strategy to improve quality, and not to reduce costs. This strategy may be applied on different levels, and needs to permeate all – from the system to the individual level – in order to be sustainable and effective will as mentioned in II.1. When one accepts that, there is a lot to be learnt from classic management literature and practical experiences in other sectors [6 P et al. 2006].

Identifying measurable objectives

A common weakness in approaches to integrated care is that not enough time and effort has been placed to agree the specific objectives for integrated care and how to measure and evaluate outcomes objectively. In particular, it is common that the lack of evidence for cost and impact can lead to significant problems (and programme failures) when seeking to embed programmes within wider health system funding streams [46]. In practice, therefore, managing change requires the ability to measure and monitor outcomes in a number of areas including: user experience, service utilisation, staff experience and the costs of delivering care. Progress towards these goals must be measured frequently to support learning and inform implementation.

Defining suitable measures and indicators

For health care systems it is important to adopt and use a set of measures that align with the main elements of a national, regional or local strategy for integrated care. However, the complexity and the necessary variety in how integrated care strategies need to be developed means that outcomes and measures need to be chosen to suit local and national priorities. Many countries and regions have sought to establish a set of key measures and indicators for people-centred and integrated health services as a means to monitor and manage performance [e.g. 48–49] and a summary of the range of measures that have been used has been usefully summarised through work supporting WHO's Global Framework on People-Centred and Integrated Health Services [6].

Establishing a continuous improvement cycle

An important aspect of developing a monitoring and evaluation framework is that it can be used to bring relevant stakeholders together to define the outcomes through which integrated care strategies should be judged and, as a result, promote joint ownership and collective responsibility to achieving key goals. Including key stakeholders in how care systems will be held to account supports the inclusive process of developing a vision and driving change forwards. A final key element of a change strategy is to utilise data and information from the monitoring and evaluation process to build-in a process for continuous quality improvement. For example, to identify 'high impact' changes that would most benefit patients, or reduce variation in standards between provider teams. In essence, an 'improvement process' is needed to help clarify or re-frame objectives, redesign processes, address capabilities, integrate risks, develop performance measures, learning from performance measures and, crucially, create a feedback loop for improvement over time. Two key aspects for this include: first, the need for managers to properly engage service providers, communities and service users; and, second, the need to build in 'rapid cycles' of build-in and re-building strategies for change following their implementation and assessment of progress.

Summarising the experiences of 85 integrated care initiatives from across the WHO European Region, the authors identified 10 lessons for successful implementation of change towards integrated care (WHO Europe 2016):

1. Put people and their needs first
2. Reorient the model of care
3. Reorganize the delivery of services
4. Engage patients, their families and carers
5. Rearrange accountability mechanisms
6. Align incentives
7. Develop human resources for health
8. Uptake innovations
9. Partner with other sectors and civil society
10. Manage change strategically

Again, these lessons highlight that the change process towards integrated care needs to happen on all levels of a system, include the involvement of people and communities, professionals and other sectors as part of the process, and create the necessary structural, regulatory and financial frameworks to support the transition.

3.2. LEADERSHIP IN INTEGRATED CARE

Leadership in networks differentiates itself fundamentally from that in traditional hierarchies. In the following, five crucial aspects on leading networks are introduced:

1. Network structures resemble new hierarchies that have to be embedded in well-established structures;
2. Networks render it possible that individuals can lead other individuals, likewise organizations can lead other organization (Sydow et al., 2011);
3. Fundamentally, network structures are parallel structures with little power and are predominantly free of hierarchy. Specifically rules and resources create power.
4. Negotiations are more important than 'Command and Control' and are therefore a matter of more complex and invisible structures (Sydow et al., 2011);
5. The leadership complexity is considerably greater than traditional structures, as stakeholders represent various sectors (sectors and work cultures).

Sydow et al. (2011) have developed a regulatory framework that can be transferred in its basic structures to any system, e.g., health care systems along three dimensions:

- Organization: informal – formal
- Nature of leadership: centralized – distributed
- Leadership attribution: individual person – organization

All three dimensions pertain for both, leading a network or leading within a network. The first dimension is identical towards situations in organizations and differentiates between emergent/ad hoc/informal organization and formally-organized structures. Within the network structures one can detect both forms in parallel in different areas. The second dimension differentiates according to the degree of centralization. Here, within the network structures, one can differentiate between very centralized and decentralized/distributed structures. The third dimension considers the question of whether leadership refers to persons or organizations. In practice it becomes evident that innovative care concepts are often initiated and carried out by individual persons or governmental institutions.

Integrated care initiatives can be described as complex adaptive systems which can hardly be managed and organized in detail (Reinertsen et al., 2008). Furthermore, integrated care interventions always take place for persons and communities. Den Hertog, Groen, and Weehuizen (2005) illustrate how different sectors in care (walls; sectors and interdisciplinarity) and system levels (ceilings; policy-makers, managers, and professionals) create a hard to manage and innovation-hampering system. These walls and ceilings

are embedded in a patient-centred and community-based environment in which leadership needs to design and implement change.

Berwick, Nolan, and Whittington (2008) introduced the idea of the Triple Aim: Care, Health, and Cost. Following his idea requires the simultaneous pursuit of three aims in order to improve a health care system:

- Improvement of the individual experience of care
- Improvement of the populations' health
- Reduction of costs of care

These goals need to be treated interdependent as changes towards achieving one of the goals can affect the other two, often negatively. That means the exercise lies in balancing the triple aim (Berwick et al., 2008). To achieve triple aim results high-impact leadership is needed (Swensen et al., 2013). Triple aim results represent a shift from volume to value (Swensen et al., 2013). All too often quality in health care organizations is more seen as an expense or regulatory requirement. But leaders need to develop a fundamental understanding of quality as a business strategy and core work. As quality improvement is rarely part of the health professionals' curriculum, leadership must be conversant with the science and potential of such methods (Swensen et al., 2009).

Illustrative example: The Mayo Clinic Approach to Leadership

Mayo Clinic is a non-profit organization in the USA with establishments in Minnesota, Florida and Arizona. In addition to this, several smaller medical practices and hospitals in Iowa and Wisconsin are part of the Mayo Health System.

Mayo Clinic leadership lives the fundamental understanding of quality as a business strategy and core work. They define quality as a composite of outcomes, safety, and service that is the key to provide highly reliable patient care. The Mayo Clinic Quality Construct contains four fundamental dimensions for high-reliability health care, none stands alone (Swensen et al., 2009):

1. Optimizing culture for safety, outcomes, and service
2. Enhancing supportive infrastructure
3. Streamlining coherent engineering efforts
4. Delivering disciplined effective execution

Mayo Clinic is consequently fostering a culture of safety by defining of a core of standard work based on best practice – knowing that every needless variation in a work environment increases the likelihood of medical errors by the health care personnel involved. A key component of their comprehensive strategy also involves the conscious investment in social capital that moves an organization from a collection of individuals toward an agile, coherent collective mind.

Patient care at Mayo Clinic is organized and coordinated by an integrated multispecialty medical practice with large education and research programs. The organizational structure offers a work environment wherein the interests of medical staff, medical school and hospital leadership are aligned. All physicians are salaried. Departments are accountable to the institutions. The financial performance is shared with the integrated practice and redistributed by physician-led committees in order to achieve the institution's mission and vision. In this system inpatient-outpatient care can be seen as a continuum. The hospital serves as a safety net when chronic and preventive outpatient care is unsuccessful.

To realize this culture of safety Mayo Clinic invests in supportive infrastructure and coherent engineering efforts for example through the establishment of electronic patient records, point-of-care information technology, rapid response systems, or simulation centres.

Mayo Clinic lives a policy of transparency and open communication. At Mayo Clinic asking for help is not considered a sign of weakness – all members of the patient care team must be comfortable speaking up when they have a concern. The aim is to educate staff and employees about quality lapses and to energize them to find solutions.

The Mayo Clinic Value Management System defines its improvement strategy. It is characterized by focus, discipline, and the effective use of data. Each improvement team has a project charter organized in “100-day” segments, and is led by a process owner and a project manager. It has been shown effective to focus on an important problem, measuring improvements, fully implanting proven results, closing the project, and moving on to the next priority.

From different sources of success factors for integrated care (Suter et al. 2009, King’s Fund 2011) it can be derived that “leadership” is a pivotal factor to implement change. When viewing integrated care as strategy to increase quality of care, leadership should be regarded as key. The leader is responsible of putting into place resources and infrastructure. Here, communication technology seems to be a driving force. Leadership in integrated care also entails to transform and reconcile processes, professional cultures, and governance structures with a new vision and narrative for service delivery. Finally, leadership in integrated care needs to invest heavily in the development of relationships with professionals, policy makers and the population.

Amelung (2016) concludes that leadership in integrated care does not fundamentally differentiate itself from leadership roles in other systems, but needs special attention as it is often overlooked as a critical success factor for the transformational change process. He summarises the lessons from the literature and experiences in seven aspects:

1. Integrated care concepts are strategic assets

Integrated care concepts have to be recognized as strategic assets by the relevant institutions. Independent of their actual importance for the business model, integrated care concepts need strategic tailwind. This tailwind can be fostered by leadership.

2. Leadership in integrated care is necessary

Leadership structures should be implemented detached from already well-established structures; meaning, the implementation should not be carried out solely by physicians or other service provider along the way but has to be organized separately and professionally, ideally within a management company.

3. Leadership in integrated care requires investment

The expenditures for leadership need to be priced and not taken as granted. Leadership is an integral field of activity and has to be remunerated separately. The expenditures for management are often looked at as negligible. Through the budget assignment, the appreciation for leadership and management will be documented.

4. Leadership in integrated care must build a culture of shared values

Expert knowledge and professional authority are indispensable for the leadership of integrated care concepts. Leadership should be embedded in existing structures – nearly invisible – and occur indirectly through pointing out direction and growing a culture of shared values. Otherwise resistance will build up.

5. Leadership in integrated care needs time

Leadership needs to motivate all parties concerned to change their beliefs. The longer structures have been in place, the longer it needs to force them open.

6. Leadership in integrated care needs to be focused

Leadership needs to focus on the components and occupational groups that are most difficult to integrate. Generally, this is the medical profession. But leadership should also initiate local activities (e.g. regional conferences, workshops, quality circles, groups of regulars) in order to strengthen and document the solidarity within and between the groups and the involvement of the broader community.

7. Leadership in integrated care needs to be data-based

Medical care is strongly influenced by data. Therefore, in order to lead successfully, a comprehensive Data-Warehouse is inevitable. All data needs to be transparently accessible for all partners.

These conclusions reiterate the messages of change management towards integrated care outlined in the previous section, and thus underline the importance of actively leading and managing change towards integrated care and recognising these aspects as key success factors for the sustainable implementation of integrated care solutions. As such, they need dedicated people, time and resources to be realised.

4. EXAMPLES FOR A COMPREHENSIVE INTEGRATED CARE DELIVERY SYSTEM

This part of the report will give a detailed description of how the different elements came together in selected and well-documented examples. The examples are:

- Gesundes Kinzigtal: remote, high-income rural community, provision of all health services, management organisation in an insurance-based system.
- NorthWest London Whole System Integrated Care: very diverse urban community, provision of all health and social services, merger of health and social services in an NHS system.
- Canterbury, New Zealand: semi-urban district, provision of all health services, tax-based (NHS) financing.

All of the examples follow a population health approach, are primary-care lead and have considerably evolved over time. They have been evaluated from the very beginning, and there is sufficient literature available to prove their value.

4.1. GESUNDES KINZIGTAL, GERMANY

Since 2006 the Gesundes Kinzigtal (GK) model has demonstrated how a people-centred focus on population health management can lead to significant gains in achieving the Triple Aim of better population health, improved experience of care, and reduced per capita costs. Through a strong management organization, a sophisticated data management system, and a trusting relationship between network partners and the communities, the GK model has been able to provide better outcomes for all partners involved. As such, elements of it are being transferred to other regions in Europe, such as the Netherlands and Belgium.

4.1.1. BOUNDARIES AND MARKET STRUCTURE

The German health system is characterised by a pronounced federalisation, leaving the 'Laender' (federal states) in charge of implementing national health regulations. Strong stakeholders in the operationaliza-

The right incentives

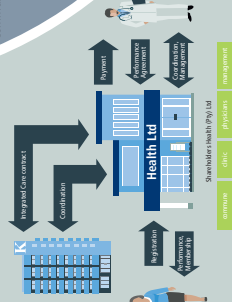
Of vital importance for the remuneration of management companies and physicians are the health benefits: The healthier the regional population, the better the result.



Appropriate remuneration and cooperation in the networks improves the satisfaction levels of physicians and other partners such as physiotherapists, medical assistants or nurses.

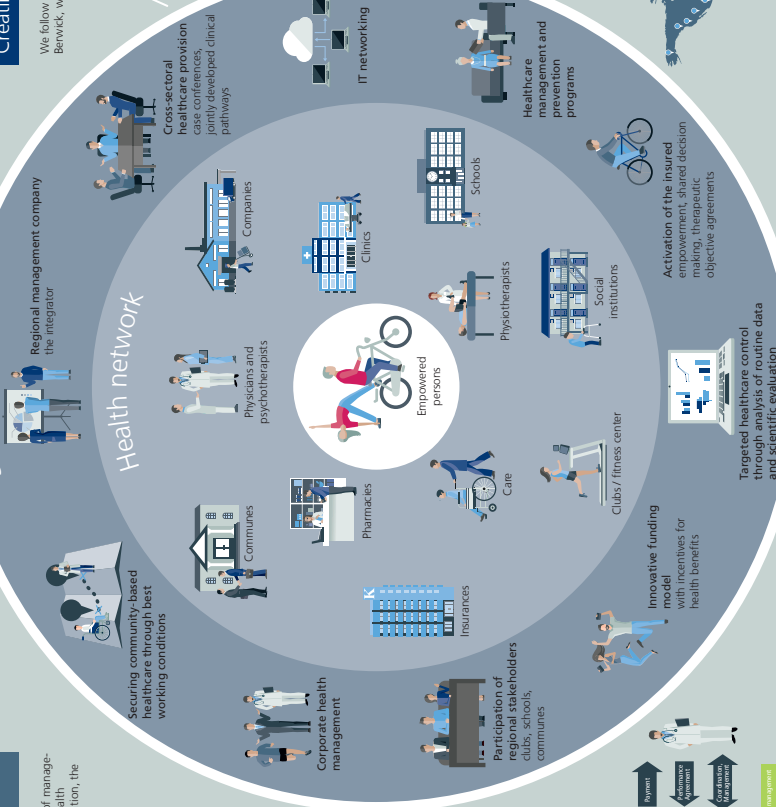


The regional management company organizes networking and memberships, develops measures for prevention and health promotion, trains practice staff, and more.



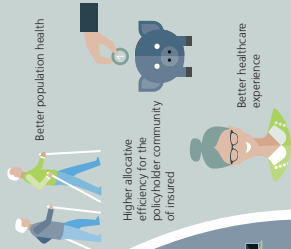
Sources: www.optimedis.de

Success factors



Creating value

We follow the Triple Aim approach, proposed by Donald M. Berwick, with three goals:



A Look at the Future

We support the international move towards regional, population-oriented healthcare through our work in the International Foundation for Integrated care and through cooperation in diverse projects. Our model is equally applicable to a wide range of settings (urban and rural), in Germany and abroad.



www.optimedis.de/informatik

tion, delivery and design of the health services on the regional and local level are the health insurance companies and sickness funds, of which there are non-for profit and private ones, all competing for potential insurees. German citizens have (in principle) free choice between the public, non-profit and private insurances, but they are compelled by law to be insured (i.e. one cannot opt-out of the system). While being the originator of the Bismarck system, the modern German health (insurance) system is thus a highly competitive and at the same time highly regulated system. It is also characterised by frequent national health reforms, creating an environment of seeming constant change while maintaining the key features of a publicly funded health system, strong stakeholder organisations and fragmented governance, accountability and funding structures.

Population and organisation structure

The *Gesundes Kinzigtal* (GK) model is designed around the Triple Aim approach (Berwick et al. 2008) and based on promoting a strong governance compromise among all stakeholders towards population health. An independent private management organisation, Optimedis, acts as the regional integrator, brings together the stakeholders involved in service provision and systematically monitors the implementation of the GK model. Based on a powerful data management system, the GK model features a continuous learning environment, which also drives the further development of the services and programmes offered.

Despite its success, it is still a very small and local initiative, which services 33.000 of a total population of 71.000 in that area (post code). As freedom of choice of provider is a fundamental principle of the German health system, participation is voluntary from the patient's as well as the providers side. Access is granted by signing a contract with the regional integrator (provider) or a signed consent form with your chosen 'health guide' (patient). Optimedis has shared savings contracts with the AOK (the biggest sick fund in Germany and in the region) and another smaller public sick fund, so people insured with other health insurers or sick funds may not be able to access the services offered. Based on the positive outcomes of the model according to all Triple Aims, the contract with the AOK has recently been extended indefinitely.

Scale and scope of services

At the moment, services are still limited to health, but there they include everything along the continuum of care. As mentioned above public health and population health management tools are an integral part of the portfolio. That is why also fitness centres, health clubs and local community activities are part of the network and have contracts with the regional integrator.

GK is a full integration model, which in addition created a wider network of collaboration for active and healthy living in the area. For this, they partner with local city councils and other service providers, which subscribe to their ideas. Some of these partnerships are formalised in contracts, others are more informal and for specific events.

4.1.2. GOVERNANCE, ACCOUNTABILITY AND MANAGEMENT

As mentioned above, GK is organized following Berwick's (2008) principles. A private management company, Optimedis, works as the regional integrator and is the inventor and developer of the model. Together with a physician network and the *Gesundes Kinzigtal* company limited, they manage the service provision for their clients. A board of directors representing these three partners has the overall responsibility for the strategy, while the management is in the hands of GK Ltd. Human resource management is limited to the employees of the company limited as all service providers are contractual partners.

By signing a contract with GK, service providers commit to the principles of GK and become part of an extensive evaluation and performance measurement system. This technology-based tool has been developed from the very beginning and has now reached a stage where regular and detailed feedback is provided to each service provider using dashboards and comparing their outcomes and that of their patients

to other providers in the model, but also the regional and national average. These evaluations are the basis for the review and feedback meetings between the regional integrator and the service providers. Moreover, GK is ISO-certified.

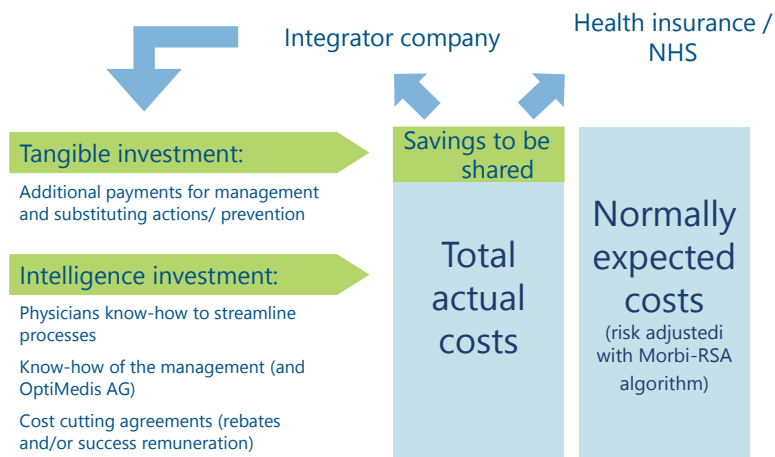
GK is accountable to its contractual partners, as well as to the payers: at the moment, these are the regional AOK and a smaller local sickness fund for farmers. As part of the shared savings account described below, GK has to proof its viability against the triple aim objectives, specifically that it could save the sickness fund money, while increasing quality and improving outcomes.

4.1.3. FINANCING MODEL

In 'Shared Health Savings Contracts' the management organisation generates an economical benefit for purchasers (sickness funds or in another context the NHS) for a defined population through investments, prevention and optimized care. The surplus is shared between the management organization and sickness funds. Within GK, the surplus is used to pay the management structure, as well as financial incentives for the service providers, and reinvested into the further development of the system (e.g. the performance measurement system, the patients academy, or external research).

Figure 9.
Health gain sharing: the risk adjusted contribution margins of the partnering health insurances

The integrator company (re)invest and benefits from its success



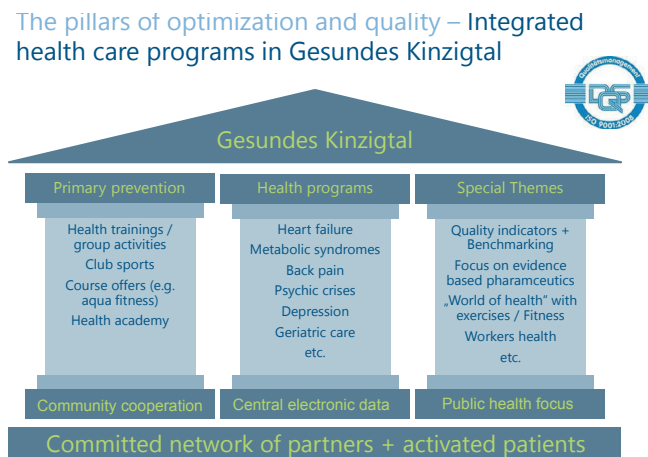
The contract is negotiated between OptiMedis and the sickness fund, and has recently been extended indefinitely. For the service providers, a standard contract is available for download on the OptiMedis website.

4.1.4. SERVICE DELIVERY MODEL

The GK Ltd. recently moved to a new purpose-built building, which houses the operational management, the Health Academy and an education and training centre (still in development). The actual services are provided in the localities of the partners, e.g. practices, pharmacies, at home.

Figure 10.

The pillars of optimization and quality – Integrated health care programs in Gesundes Kinzigtal



There are regular case conferences and partner meetings, where both service delivery as well as management and development topics are discussed. An annual minimum attendance is mandatory for the service providers and partners. The agendas are set by the partners and highly interactive.

Every patient selects a 'health guide', who functions as a voluntary gatekeeper (binding gatekeeping is legally not possible in the German system), but especially as a case and care manager. Together they develop a health and care plan with measurable objectives. Added value and benefits for the patients are the varied programmes, which are available for free as part of the GK, such as fitness classes, community activities, and the services of the Health Academy (health information and patient education). GK also organizes annual festivals, sports and health events and similar to raise awareness of the services and engage with the local communities.

As outlined above, GK has an intricate performance and quality improvement system in place, which is based on evidence. Moreover, it has been scientifically evaluated from the start. It has not only proven its success in the triple aim, but also in three other dimensions: quality of life and professional satisfaction of providers, community building and securing health care for the region, and supporting a healthy workforce in the region.

4.1.5. STRENGTHS AND WEAKNESSES OF THE MODEL

GK ticks most of the boxes for success as outlined in the previous sections. It has strong management and leadership, a compelling narrative, shared values and shared gains, an inclusive population health management approach and a comprehensive evaluation system and continuous improvement cycle in place. It relies on a wide variety of tools and instruments, is open to innovation and invests heavily in adding value to the community it works in. However, the number of inscribed patients is only about a third of the patients eligible (i.e. all insured of the two sickness funds in the area), and the services are limited to the health sector. Within the health sector, they provide most of the services from health promotion to palliative care, and those which are not or cannot be offered locally are arranged for. Another weakness is the lack of patient and community engagement: while the offers are extensive for them, they do not have a say in the design or management of the services. Until recently, the uncertainty of the contractual arrangements with the sickness fund was another weakness, as it had to be extended several times. As of 2016, GK is officially a standard of care in the region.

Optimedis invests heavily in the dispersion of its model and is continuously looking for opportunities to transfer its model and lessons to other contexts. So far, this has only worked with limited success and only with very specific tools, not as a fully integrated model. It remains to be seen, how transferable the model really is.

4.1.6. SOURCES

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<http://www.gesundes-kinzigtal.de/en/>

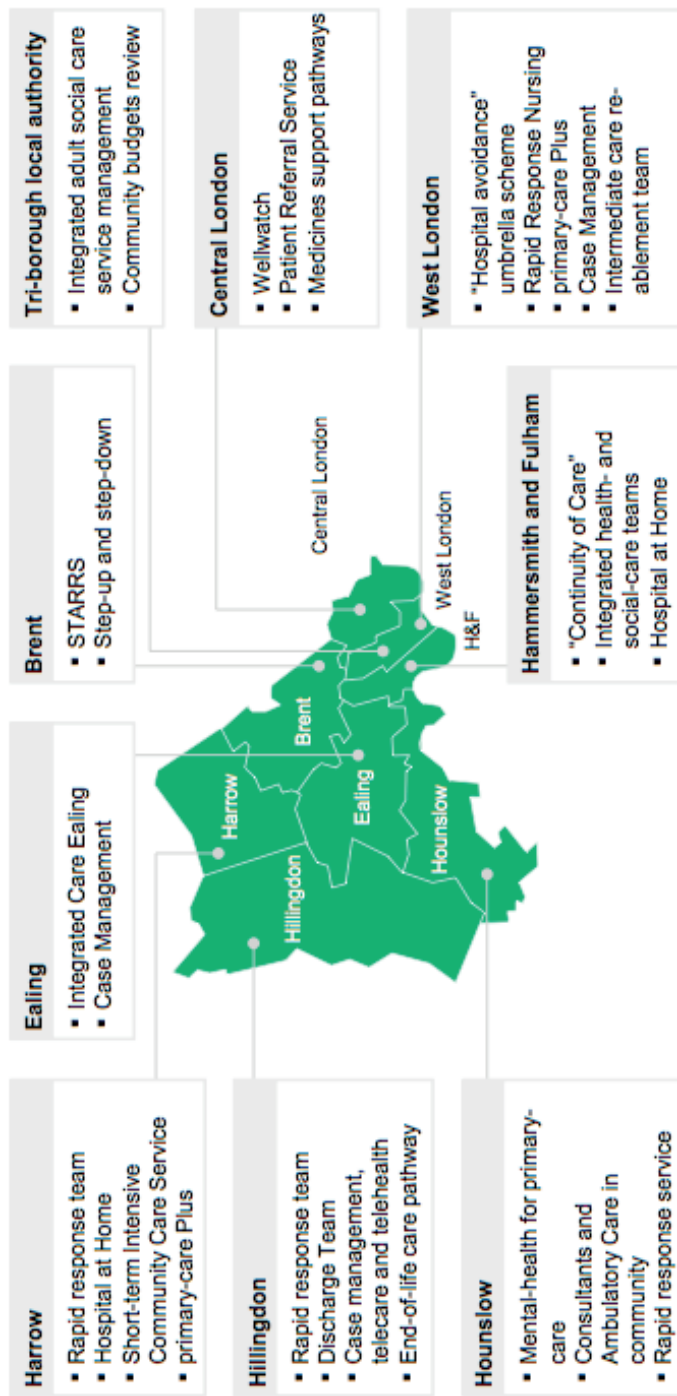
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4.2. NORTHWESTLONDON WHOLE SYSTEM INTEGRATED CARE

As described previously, North West London started its integrated care journey in 2006, when it became one of 14 Integrated Care Pilot sites in the NHS England. Since then it has rapidly evolved into the North-WestLondon Whole System Integrated Care (NWL WSIC), and is currently a part of the Pioneer programme. It services a population of 2 million inhabitants in the 8 boroughs of Northwest London.



Cross-borough

- Inner and Outer Integrated Care Pilots
- 111 immediate clinical advice or referral
- Mental-health IC programme

Source: North West London Out Of Hospital Strategies, Shaping A Healthier Future

It is organised along 3 key principles:

- People will be empowered to direct their care and support and receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems will enable and not hinder the provision of integrated care.

4.2.1. BOUNDARIES AND MARKET STRUCTURE

NorthWest London developed out of different policies and initiatives on the national level to promote integrated care. It incorporates the transition instigated on the national level from primary care trusts (PCTs) via clinical commissioning groups (CCGs) to primary health networks (PHNs), as well as the merger of local health and social services into local health and wellbeing boards. As in the *Gesundes Kinzigtal* model, not all the primary health networks active in the 8 boroughs are part of NWL WSIC, but their intention is to service everyone.

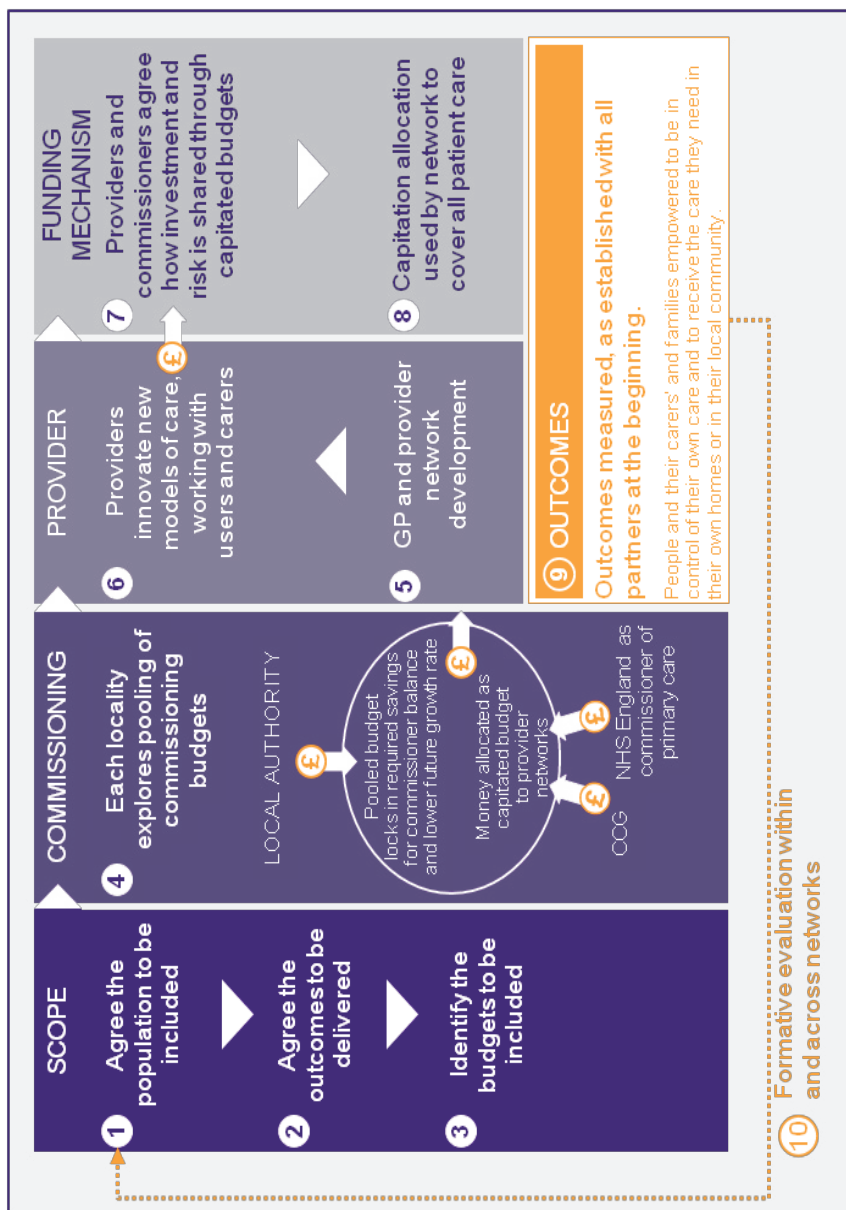
While it started to target populations with diabetes and (frail) elderly (and these programmes are still running) it has since evolved into a fully integrated system, which offers a wide range of services, including mental health and public health, and from primary to tertiary care. Importantly, it also offers all the social services the English system provides. All of the programmes are developed based on population risk stratification, targeting specific groups and addressing their individual needs. As the populations vary considerably between the 8 boroughs, representing all socio-economic strata and all age groups, the portfolio of services offered also varies to the local needs in each of the boroughs.

The integrated care management board did that by creating a shared patient registry that covered the whole population and used associated data from all settings of care to analyse the subgroups with the highest risks and costs for the system. This led to the initial focus on diabetic and elderly patients, developing targeted care pathways. Later on COPD, and cardiac pathways were developed. Currently the NWL WSIC focuses on segmenting individual patients by risk, enabling the planning of proactive care. The aim is to provide every person in the locality with a care plan, which may be as simple as helping them to stay healthy, pointing them to educational events or wellbeing activities, or as complex as managing a social isolated frail elderly person with multiple conditions and complex needs.

Competition is relevant as every patient can choose their GP. These have a gatekeeping function throughout the system, not only in the NWL WSIC. While competitive elements have been introduced into the NHS England, these are not specific for the Pioneer and within NorthWest London there obviously is only one provider of integrated care.

4.2.2. GOVERNANCE, ACCOUNTABILITY AND MANAGEMENT

The NorthWest London Whole System Integrated Care is managed by a provider-led, integrated management board, of which the Lay Advisory Group is a vital part. It has evolved its structure based on the lessons learned from the Integrated Care Pilot (see figures above and below).



Source: NorthWest London Integrated Care Pilot.

NWL WSIC is accountable to NHS England for their outcomes, and within the system, GPs and provider networks (PHNs) are accountable to the integrated management board, as well as to their patients. Based on shared records and a pooling of the data from all settings, a comprehensive performance improvement framework monitors and evaluates the outcomes. These form the basis for commissioning and distribution of incentives. NWL has developed its own measures and indicators to monitor success. They align incentives through case conferences, enhanced care plans and innovation funding. NWL WSIC also tracks and evaluates the performance of GP's surgeries and MDTs to drive competition and share best practice. As such, each MDT is reviewed based on patient experience, clinical outcomes, financial performance and team effectiveness. Clinical protocols and care packages (including activity and resource requirements) were developed for each group, ensuring standardisation of best practice.

A key success factor throughout the development of the WSIC was the active involvement of patients and the local community. From the very beginning, 150 third sector organisations, NGOs, and civil society organisations were included in the design, implementation and evaluation of the integrated care initiative. This led to the foundation of the Lay Partners Advisory Group, which is part of every meeting, gives feedback and monitors implementation as well as being actively involved in the further development of the system.

4.2.3. FINANCING MODEL

As shown in the above figure, NWL WSIC uses a pooled budget for health and social services to commission the services needed in the locality. The service providers are paid on a mix of capitation and fee for services. The global budget received a huge cut last year, as government obliged the NHS and the social services to reduce costs significantly until 2020. This means that also for NWL WSIC less money is available to commission services. There was no seed money for the integration pilot, but as part of the Pioneer programme, NHS England promised to pay some extra money in 2018, if the Pioneer can prove cost savings and quality improvement.

It is important to note here, that while there is a pooled budget for health and social services, the payment systems and prices still vary greatly between the two sub-systems.

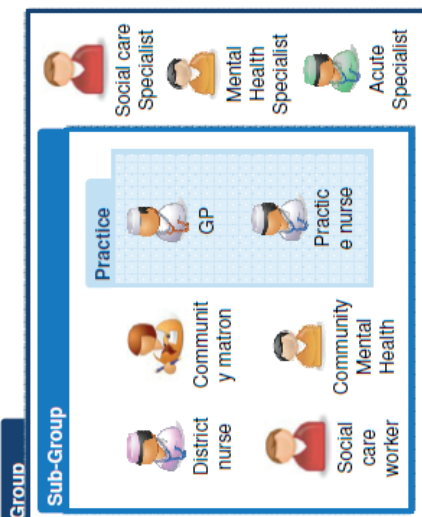
4.2.4. SERVICE DELIVERY MODEL

At the heart of the organization are the multi-disciplinary teams (MDTs), which work together to manage the care of the patients. They include include a GP, nurse, social worker, acute physician, mental health team, district nurse co-ordinated by an MDG manager. More specialized professionals are available for consultation and services on a case-by-case basis. Care plans are developed in one-to-one meetings between clinicians and patients allowing for better doctor-patient relationship, and greater patient involvement in decision making. These care plans are delivered by the multi-professional teams through an integrated approach. The patient has one contact point in the delivery of their care plan.

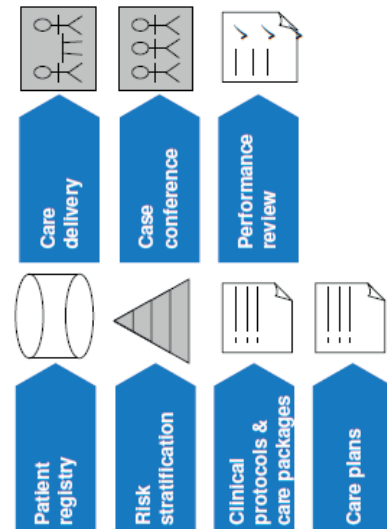
Information sharing across multiple organisations is made possible by a single platform. This is an IT tool which links and shares provider information, allowing health and social care professionals to see key integrated data sets for patients that had consented to share their personal information. The most complex cases are discussed at a case conference in an MDT session. At these conferences, root cause analysis of non-emergency avoidable admissions is presented for shared learning and solutions for future avoidance of such cases are discussed.

Improve the quality of patient care for patients with diabetes and the elderly

Local Multi-Disciplinary Groups...



...working in a Multi-Disciplinary System



Patient, user and carer engagement and involvement

Joint Governance through IMB with shared performance and evaluation framework

Aligned Incentives through an innovative financial model

Information sharing to timely access and analyse data

Organisational development and culture

Source: NorthWest London Integrated Care Pilot.

4.2.5. STRENGTHS AND WEAKNESSES OF THE MODEL

NorthWest London WSIC has seen tremendous development on all levels of integration driven by a strong change management process, which included all relevant stakeholders in regular planning and design meetings. As mentioned above, a key milestone was the creation and institutionalization of the Lay Partners Advisory Group. The manifold experience and lessons learned were also documented in the WSIC toolkit, which is available online and a living resource, as the integration process is far from being completed. The very inclusive and bottom-up approach to the service design also helped garnering the support of GPs and primary health networks, using early adopters as mediators to draw more professionals in. At the moment, the integrated management board is looking to redesign the different disease-focused care pathways into more holistic service delivery packages and ensuring that they fit into the other programmes and modules developed. Only recently, the first integrated care clinic opened in St. Charles's hospital to give a physical presence to the integrated care initiative. It is conceptualized to be a one-stop-shop for integrated primary care, offering information, consultation, triageing and transfer services. NorthWest London also boasts three world-famous hospitals, one of them being Imperial College. They are actively involved in designing intermediate care and specialist consulting services in primary care to help them achieve their DRG-led outcomes.

According to their own information however, they have not been able to achieve many of the set objectives, especially around cost-effectiveness and hospital admissions. Also, health outcomes have not generally improved, giving a mixed picture of their disease management programmes and care plans. Some of these are down to too ambitious goals, policy changes and complexity of services. They admit that they did too much too fast. So, for the next years, the aim is to consolidate the MDIs, improve coordination between health and social services and try to shift more services into the home setting.

4.2.6. SOURCES

North West London WSIC website:

<http://integration.healthiorthwestlondon.nhs.uk/about-us/our-journey>

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5. CONCLUDING REMARKS

As has been mentioned throughout the report, designing and implementing integrated care needs considerable investment of human resources, knowledge and time to make it happen. It also needs a burning platform, whether that is a lack of money, new legislation or bad health outcomes, and in most of the illustrated cases, it was a combination of these and more factors. The numerous examples from around the world also highlight that integrated care is a strategy for continuous improvement, which takes a long-term perspective and is never at an end. In order to garner support and buy-in from people, professionals and policy makers, the integrator needs to identify mutual gains and build a coalition for change. Having clear and measurable objectives and an evaluation framework in place from the very beginning is another must, and in relation to that establishing external (scientific) evaluation and publication of results. Furthermore, education and training for professionals, patients and communities supports the cultural changes necessary as well as building the skills to deliver and actively participate in these new approaches to care. Clinical and administrative leadership, strong management structures and aligned incentives are needed to make the transformation sustainable and withstand external changes, such as changes in policies or budget cuts. Finally, integrated care is about building trust and realising that the status quo of service delivery is detrimental for everyone involved. Focussing on the holistic needs of the people has to be the guiding principle on all levels of the system, where supportive regulatory, legal and financial structures foster local innovations according to the needs of and developed with the local people and communities.