

Towards More Integrated Health Care – The Review of the International Experience

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Most European countries have failed to integrate health care services. This inevitably leads to fragmented health care provision. This fragmentation results in long waiting times and involvement of multiple care providers who offer different forms of care. The lack of integration of health care seems to be one of the biggest challenges in health systems as integration calls for a holistic approach and the implementation of structural changes that are costly. The aim of the paper is to explore the nature and strategic forms of the mechanisms and tools dedicated to health care integration in selected European countries. The literature review was performed using resources of Web of Science and Ebsco. The search criteria focused on the following key words: integrated health care, care coordination, coordinated care programmes, and integration mechanisms. The time span of the analysis covered the last 20 years from 1998 to 2017. Finally, 39 studies were identified that presented the evidence-based experience with care coordination. Several strategic forms of health care integration have been identified, including structural, functional and subject-based mechanisms.

Keywords: health systems, integrated care, care coordination, integration mechanisms, Europe.

W kierunku bardziej zintegrowanej opieki zdrowotnej – przegląd międzynarodowych doświadczeń

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Większość europejskich krajów ma problemy z integracją usług opieki zdrowotnej. To nieuchronnie prowadzi do fragmentaryzacji dostarczania opieki. W konsekwencji mamy do czynienia z długim czasem oczekiwania i zaangażowaniem wielu usługodawców, którzy oferują różne formy opieki. Brak integracji opieki zdrowotnej wydaje się jednym z największych wyzwań systemów zdrowotnych, jako że integracja wymaga holistycznego podejścia i wdrożenia zmian strukturalnych, które kosztują. Celem pracy jest ocena istoty i strategicznych form mechanizmów i narzędzi dedykowanych integracji opieki zdrowotnej w wybranych krajach europejskich. Dokonano przeglądu literatury przy użyciu baz Web of Science i Ebsco. Użyto kryteriów wyszukiwania w postaci następujących słów kluczowych: zintegrowana opieka zdrowotna, koordynacja opieki i programy opieki koordynowanej. Zakres czasowy analizy to ostatnich 20 lat (1998–2017). Ostatecznie zidentyfikowano 39 prac prezentujących, w oparciu o dowody naukowe, doświadczenia z koordynacją opieki. Przegląd dorobku pozwolił na identyfikację różnorodnych form integracji opieki zdrowotnej, w tym opartych na mechanizmach strukturalnych, funkcjonalnych i przedmiotowych.

Słowa kluczowe: systemy zdrowotne, opieka zintegrowana, opieka koordynowana, mechanizmy integracji, Europa.

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1. Why Integrated Health Care? The Key Challenges

An integrated care approach is systematically emphasised as a strategy to address uncoordinated and fragmented health systems (van Rensburg and Fourine, 2016, p. 2). Integrated care is a broadly conceptualised concept that has been mainly understood as a creation of an organizational network providing a coordinated continuum of services to a defined population (Rudawska, 2016, pp. 7–14). The growing interest in this model has several reasons.

Firstly, the progress of both medical science and technologies creates a possibility of shifting the centre of gravity from the treatment of advanced chronic conditions towards early diagnostics and prevention of their further progression. Thereby, it provides a chance of improving patients' quality of life, as well as decreasing the burden placed on health care systems by advanced, highly specialised treatments. What is more, patients' self-discipline and their conscious participation in assuming responsibility for their health through prophylaxis take priority. Incorporating the mechanisms stimulating such conduct and attitudes appears to be a significant element of the target patient-oriented care model.

The second fundamental challenge is shifting the centre of gravity from the model of hospital-based care of senior patients (in international statistics still one of the crucial indicators of health care accessibility is the number of the so-called acute-care beds per 100 thou. population) towards the solutions promoting alternative channels of health services supply, such as community or home care. It refers to both synchronisation and cooperation of the health care sector with other sectors, chiefly welfare care, as well as systemic use of informal care providers, mostly family members. The desirable changes in that respect concern both the organisational scope and the streams of care financing.

A change in the model of the patient-physician relation is becoming yet another challenge moving away from a paternalistic to partnership-based approach. Health care is increasingly perceived as a case of consumer goods, while patients are becoming informed customers. Their growing expectations regarding the quality of provided care lead to the search for new ways of satisfying those requirements. In those circumstances, the role of pro-customer orientation of health care providers increases, as does the conscious formulation of patient-service provider relation, aimed not just at treatment efficiency but also at extra-medical quality attributes.

What is more, treatment outcomes of many diseases depend strongly on patients' will for cooperation, regularity and self-discipline. Hence the emergence of a new role of service providers, who are turning from patient agents into treatment process coordinators, but with an expanded function of information provision.

It is the control of this growing number of information streams in health care that is becoming a challenge to health care systems. Patients suffer-

ing from complex health conditions, navigating various levels of care, will be generating an ever greater demand for medical information and they themselves will come to be a source of medical data (the number of medical procedures and tests that patients undergo has been growing systematically on account of the advances made in medical technologies). Managing a growing set of medical information and its flow will create a demand for new information and communication solutions with a substantial participation of new technologies, including telemedicine.

Finally, a change in health care paradigm to an integrated model will require revising the organisational culture of service providers. The orientation on results inextricably bound with a new paradigm emphasises the role of cooperation and coordination of care levels that previously functioned independently, dividing the process of patient care into fragments.

The lack of integration of health care seems to be one of the biggest challenges in health systems. Therefore, the aim of this paper is to explore the nature and strategic forms of the mechanisms and tools dedicated to health care integration in selected European countries. In order to meet this goal, the desk research was performed using resources of Web of Science and Ebsco. Only studies that presented the evidence-based experience with health care coordination were included. The geographical spectrum of the review was limited to the European countries. Finally, 39 studies were identified.

2. Gaps in Patient Care Coordination

A belief in poor coordination between various health care levels, universally exhibited in public debates, has strong empirical grounds. Numerous studies conducted at various research centres confirm the hypothesis. A review of selected research results dedicated to the problem is presented in Table 1.

| Gaps in care integration and coordination | Consequences of the lack of care integration and coordination – empirical reports |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Between primary care physicians and specialised care physicians | 45% of specialists did not give feedback to referring primary care physicians. 28% of primary care physicians and 43% of specialist physicians claimed that the information flow between them was unsatisfactory; 25% of primary care physicians did not receive results of specialist consultations even 4 weeks after an appointment with a specialist physician. |
| Between primary care physicians and emergency departments | 33% of visits at the emergency department lacked complete medical documentation. Every third primary care physician does not know of an intervention of emergency services that their patients underwent. |

Cont. tab. 1

| Gaps in care integration and coordination | Consequences of the lack of care integration and coordination – empirical reports |
|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Between attending physicians and a diagnostic centre | In 17% of cases, attending physicians did not have the results of diagnostic tests on the date of a scheduled, subsequent appointment of their patient. In 22% of cases of chronic patients treated by one physician and in 43% of cases of patients treated by four and more physicians simultaneously, diagnostic tests were duplicated. |
| Between attending physicians in hospital care and primary care physicians | 1/3 of adult hospitalised patient suffering from chronic conditions (within the two analysed years) did not receive any arrangements regarding further post-hospitalisation therapy. 60% of primary care physicians did not receive any information on subsequent pharmacotherapy and recommended treatment of their patients following completed hospitalisation. 3% of primary care physicians were given a possibility of consulting the attending physician at the level of hospital care with respect to planning their patients' discharge; planning a discharge involves further recommendations concerning medical process: pharmacotherapy, continued treatment and rehabilitation. In 66% of the cases, primary care physicians undertook further treatment of post-hospitalisation patients without a discharge abstract. |
| Between attending physicians of out-patient care and their families | 33% of attending physicians did not notify patients of positive (irregular) results of ordered tests. 18% of patients treated by several physicians simultaneously received contradictory recommendations; 24% of patients did not receive a reply to important questions they posed about their own treatment, and 41% patients did not receive information on the side effects of recommended pharmacotherapy. 50% of patients leaving a doctor's examination room did not understand the attending physician's message. 47% of patients asked to repeat their doctor's orders were not able to do so correctly, thereby demonstrating lack of their physician's clarity. 9% of patients were given an opportunity to participate in making medical decisions. |
| Between attending physicians in hospital care and patients along with their families | 48% of adult hospitalised patients were not informed of the side effects of administered pharmacotherapy, and 67% of the patients who were prescribed a new medication were not informed whether they were supposed to continue taking the medication they had been taking before being hospitalised. |

Tab. 1. Gaps in patient health care integration and their consequences – research results. Source: own work based on: Bodenheimer, T. (2008). *Coordinating Care – A Perilous Journey through The Health Care System*. *The New England Journal of Medicine*, 358(10), pp. 1064–1071; World Health Organization. (2002). *Innovative Care for Chronic Conditions. Building Blocks for Action. Global Report, (WHO/NMC/CCH/02.01)*. Geneva: World Health Organization, pp. 1–103.

In light of the above empirical reports, the basic objective of the undertaken integration efforts is the improvement of the quality of care provided to patients by reducing its fragmentation. It is an objective that has become a WHO priority (Gröne and Garcia-Barbero, 2002) only to subsequently be presented to the European Commission (Council of the European Union, 2003). The priority is strongly tied to the efficiency objectives, in the form of rational management of available resources and cost control (Desmedt et al., 2016, pp. 892–902; Kodner and Spreeuwenberg 2002, p. 2). The effects of the discontinuity of the service process, its fragmentation, are experienced at three levels: individual patient-physician relation (micro level), service providers and their network (meso level) and the entire system (macro level).

Discontinuity of care is the most frequently mentioned problem encountered by individual health care levels where integration actions have been undertaken (irrespective of the type of the health care system model in force). The consequences of that include:

- documented higher costs incurred by the system, including: duplication of medical procedures, contradictory recommendations leading to complications and unplanned hospitalisations (Gröne and Garcia-Barbero, 2001, p. 4; Yaya and Danhouno, 2015, p. 5);
- patients' dissatisfaction as a result of poor communication between medical professionals of various care levels, limited access to services and lack of smooth patient transfer between individual care levels (Strandberg-Larsen and Krasnik, 2009; Brenner et al., 2017, p. 7); as well as
- worse treatment results as an effect of medical errors ensuing from communication erosion and the interactions between administered medications, and as an effect of patients' disorientation in the system and their lack of subordination (Weinberg et al., 2007, pp. 7–24).

One should be aware that Table 2 has some limitations. It presents the experiences with health care integration only in 6 European countries. Nevertheless, those listed above cover the most outstanding examples, working both in Bismarck model as well as in Beveridge model of health care financing.

3. Integration Mechanisms in Terms of Application Levels

Based on the conducted desk research (Huby and Rees, 2005, pp. 53–8; Fulop, Mowlem and Edwards, 2005; Warner and Gould, 2003; Reed et al., 2005; Berg, Schellekens and Bergen, 2005, pp. 75–82; Rygh and Hjortdahl, 2007, pp. 1–10; Wan and Wang, 2003, pp. 117–124; Wan, Yen-Ju Lin and Ma, 2002, pp. 127–143), it can be stated that integration mechanisms can be considered from two perspectives: a structural and functional perspective and a subject-based perspective (on account of the impact recipient). Both approaches interpenetrate one another, comprising the same mechanisms, but from different perception points. In the structural and functional perspective, one can talk of mechanisms initiated at micro, meso and macro levels of health care.

| Item | Health care system model in force | Dominating problem | Introduction of integrated health care | Progress | Dominating area of integration | Target group | Example of integrated health programme |
|---------|-----------------------------------|----------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| Finland | Beveridge model | Lack of care continuity, fragmentation of services | 1970s–1980s | Strategy implementation, continuous updating | Between primary care and specialist out-patient care | Seniors, patients with psychiatric conditions, patients with addictions, pregnant women | “Health Centres” |
| Sweden | Beveridge model | Poor information exchange, fragmentation of services, uncoordinated patient flow | Early 1990s | Strategy implementation, continuous updating | Between primary care and specialist out-patient care in a given region | Seniors | “Chains of Care”, “Local care” |
| Austria | Bismarck model | Lack of cooperation between service providers, system fragmentation | Early 2000s | Formulation of strategy | Between primary care and hospitals | Seniors, disabled patients, chronically ill patients | Disease management programmes, “Medizinische Versorgungszentren” – “Medical Care Centres”, “Community Medicine Nurse” |
| Spain | Beveridge model | System fragmentation, limited resources, lack of coordination | 2008 | First steps in formulation of strategy | Between primary care and specialist out-patient care in individual regions | Chronically ill patients, disabled patients | “Targeted respite schemes” |

Cont. tab. 2

| Item | Health care system model in force | Dominating problem | Introduction of integrated health care | Progress | Dominating area of integration | Target group | Example of integrated health programme |
|-------------|-----------------------------------|---------------------------------------------------------------|----------------------------------------|----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| Netherlands | Bismarck model | Lack of care continuity, fragmentation of services | Early 1990s | Strategy implementation, continuous updating | Between long-term and short-term care (acute care) | Chronically ill patients, disabled patients, psychiatric patients | “Rapid response teams”, “Regional Assessment Boards” |
| UK | Beveridge model | System fragmentation, lack of team work, poor care continuity | Early 1980s–1990s | Strategy implementation, continuous updating | Between health care and welfare | Seniors, palliative patients | “Integrated Care Pathways”, “Protocol-based Care”, “Management Clinical Network”, “Community Matron”, “Community Assessment and Rehabilitation Teams” |

Tab. 2. Review of motives, areas and degree of health care integration progress in selected European countries. Source: own work based on: Mur-veeman, I., van Raak, A., and Paulus, A. (2008). Comparing Integrated Care Policy in Europe: Does Policy Matter? *Health Policy*, 85(2), 172–183; Ahgren, B. (2003). Chain of Care Development in Sweden: Results of a National Study. *International Journal of Integrated Care*, 3(e01); Russell, M., Roe, B., Beech, R., and Russell, W. (2009). Service Developments for Managing People with Long-term Conditions Using Case Management Approaches. An Example from the UK. *International Journal of Integrated Care*, 9; Kokko, S. (2009). Integrated Primary Health Care: Finnish Solutions and Experiences. *International Journal of Integrated Care*, 9(2).

The micro level refers to the relation between employees and the relation between patients and employees usually of various health care levels, less frequently of the same level. Integration mechanisms are mostly of a communicative nature shaping the structure of relations between individual care providers. The most common solutions of the type, applied in all the countries undertaking integration efforts (apart from the ones listed in Table 1, i.e.: Germany, Italy, France, Norway, Switzerland, Ireland, Denmark, Greece and Iceland), include:

- communications systems enabling sharing information resources about patients (electronic patient records made available to individual medical professionals, as well as to patients themselves, shared data bases of the patients registered with a given medical facility, entered into a given primary care physician's list),
- shared or coordinated (through tele-medicine) medical consultations with the use of modern technologies (case conferencing),
- systems of support for medical professionals' development in the form of organisation of joint training for a given specialisation, as well as for different specialisations, but oriented on a given type of a medical case (typically, it concerns chronic conditions, such as diabetes, cerebral vascular disease, neoplastic diseases),
- the protocol for patient transfer between individual professionals of the same care level (usually specialist out-patient care) and various care levels (usually from the in-patient level to the out-patient level) along with the assistance provided in reaching a required specialist,
- creation of multi-disciplinary therapeutic teams evaluating the patient's needs and devising the patient's "pathway" of navigating the health care system along with establishing and arranging priority advice and medical consultations with a required plan of specialists,
- organisation of an educational platform for patients, expanding their health awareness and improving communication with physicians, chiefly through a system of reminders.

The mechanisms initiated at the micro level require changes at the inter-organisational (meso) level. A basic solution in that regard is joint planning, implementing, motivating, controlling and/or financing the service process dedicated to a specific patient group (typically chronically ill patients).

The integration mechanisms employed at the micro and meso levels of the health care system are at times accompanied by – depending on the adopted systemic solutions – the mechanisms initiated at the macro level. They are usually linked to the system of financing health plans, undertaking financial liability for the provision of services of a specific quality to a given population, and to the decentralisation of health services financing. A review of integration mechanisms depending on the degree of their initiation is presented by Table 3.

| Level | The main direction of undertaken actions | Example solutions | Countries most advanced in implementing changes |
|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Micro | <p>1. Coordination of clinical activities</p> <p>2. Improvement of communication between employees of individual facilities</p> <p>3. Support of and supervision over physicians</p> <p>4. The use of information systems for the purpose of coordination</p> <p>5. Support for patients</p> | <p>1a. creation of therapeutic teams, joint consultations and evaluation of needs and setting priority medical advice with cooperating service providers (within a network), as well as externally (outside of a network)</p> <p>2a. tele-conferences</p> <p>3a. joint training</p> <p>3b. a system of notification and reminders of scheduled appointments; analysis of critical events (duplicated tests, defective pharmacotherapy, unplanned hospital admissions; lack of post-hospitalisation treatment continuity)</p> <p>4a. development of shared data bases of medical events, patients and service providers; integration of clinical data systems</p> <p>5a. education, a system of notification and reminders; facilitation of access to care</p> | <p>1a. Sweden, the Netherlands, the UK, Finland</p> <p>2a. Sweden</p> <p>3a. Austria, Sweden</p> <p>3b. the UK, Austria</p> <p>4a. Austria, Finland</p> <p>5a. Finland</p> |
| Meso | <p>1. Change of relations between service providers (change in organisational structures)</p> | <p>1a. developing a network of service providers using shared systems of managerial decision support – integration of managerial information systems and a model of a patient’s “single entry” to the network of cooperating service providers – integration of administrative information systems</p> <p>1b. development of joint health care programmes devising a patient’s pathway in the network</p> | <p>1a. the UK, Germany, the Netherlands, Italy, France, Austria, Finland, Norway, Switzerland, Spain</p> <p>1b. Spain, the UK, the Netherlands, Ireland, Sweden</p> |

| | | | |
|-------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Meso | 2. Reconfiguration of human resources | 1c. development of local partnership 2a. delegation of tasks and division of duties among the cooperating service providers 2b. introduction of a case manager – case management | 1c. Spain, the Netherlands, Denmark, the UK 2a. the Netherlands, the UK 2b. Ireland, the UK, the Netherlands, Sweden, Finland, Denmark; Austria, Italy, France, Germany (within the scope of the project) |
| Macro | 1. Change in the system of financing | 1a. Introduction of universal capitalisation 1b. Introduction of joint budgeting 1c. Decentralisation of service financing (to the regional level) | 1a. Spain 1b. Ireland, Spain, the UK 1c. Ireland, the UK, the Netherlands |

Tab. 3. Integration mechanisms in terms of application levels. Source: own work based on: Ling, T., Bardsley, M., Adams, J., and Roland, M. (2010). Evaluation of UK Integrated Care Pilots: Research Protocol. *International Journal of Integrated Care*, 10(3), pp. e1–10; Powell Davies, G., Williams, A., Larsen, K., Perkins, D., Roland, M., and Harris, M. (2008). Coordinating Primary Health Care: An Analysis of the Outcomes of a Systematic Review. *Medical Journal of Australia*, 188(8), pp. 65–68; Antunes, V. and Moreira, J.P. (2011). Approaches to Developing Integrated Care in Europe: A Systematic Literature Review. *Journal of Management & Marketing in Healthcare*, 4(2), pp. 129–135; Mur-Veeman, I., van Raak, A., and Paulus, A. (2008). Comparing Integrated Care Policy in Europe: Does Policy Matter? *Health Policy*, 85(2), 172–183.

4. Integration Mechanisms in the Subject-Based Aspect

Integration mechanisms considered in the subject-based perspective can be divided into the ones addressed to service providers and the ones addressed to patients. In the case of mechanisms and instruments addressed to health care service providers, an intervention in clinical decisions constitutes their common denominator. The source of that orientation (sometimes referred to as *utilisation management*) is rooted in its precursors' conviction that since a majority of health care costs is subject to the control of medical professional, the condition necessary for improving the efficiency of use of health care resources (beds, medical equipment, people) chiefly involves influencing the conduct of physicians (Brown, 2009, p. 24).

Therefore, such a system of incentives needs to be created that will motivate medical professionals to make decisions favouring efficient use of resources and at the same time improving the quality of services offered. Therefore, the choices made, which result in the allocation of sparse health care resources, cannot be random, but rather should be a result of a thorough analysis of a given case, based on information gathered. Hence, the canon of procedure, both medical as well as managerial, ought to involve proper standards: medical, organisational and economic.

Integration mechanisms in the form of guidelines on good medical practices and protocols of medical conduct referring to evidence-based medicine constitute an attempt at objectivisation of reasons behind the decision-making and standardisation of the service process. The overriding objective of applying protocols and models of conduct is to eliminate ineffective procedures and to concentrate the resources in those areas through which maximum health benefit can be gained. The central goal of good medical practice also involves limiting wrong therapies. Clinical experimental research demonstrates that only few activities undertaken in medicine have rational, scientific justification, and many of them are simply harmful (Desmedt et al., 2016, p. 893). The consequence of devising the manner of service provision in individual medical cases is a need for treatment standardisation, which stirs a lot of controversy in conservative medical circles. However, it does not seem that evidence-based medicine would pose a threat to professional autonomy. Rather it prevents medical routine and contributes to reducing the distance between science and practice.

The mechanisms and instruments integrating patient care, oriented towards influencing clinical decisions, can in turn be divided into the ones which refer to preventing the need for usually costly hospital treatment and the ones which shorten the time of already existing hospitalisation cases to a minimum. At the same time, the objective of actions undertaken is not to limit access to services, but to reduce health needs which have so far been satisfied by more expensive forms of health care. Therefore, an

indispensable element of managing medical resources is population segmentation according to a criterion of needs, particularly with regard to chronically ill patients.

The so-called patient pathways are used for standardisation and objectivisation of the service process on the grounds of evidence-based medicine. They are an attempt at “navigating patient pathway” in the system, and in particular the patients exhibiting a higher risk factor for a disease, potentially constituting the greatest sources of expenditure, owing to the risk of using an intensive form of care.

Patient pathways therefore belong to a group of prospective integration mechanisms, aimed at preventing the occurrence of a need for hospital treatment. With regard to the patients who are at an early stage of their disease, the pathways are based on secondary prevention. Their fundamental task is continuous patient monitoring and decelerating the speed of disease development. In this patient group, patient activation aimed at disease self-management is an important component. The function of the individual managing a patient pathway (most typically being an experienced nurse or primary care physician) comes down to a permanent evaluation of a patient’s health condition, assistance in determining pharmacotherapy, health promoting education, teaching how to recognise early symptoms of disease exacerbation and how to quickly react to such symptoms.

The competences of the individual managing a patient pathway also include evaluating the risk of the patient’s transfer from out-patient care to hospital care, thus the probability that if no steps are taken, the patient will require hospitalisation within the next six months. The risk is evaluated on the basis of a special questionnaire. Patients found to be at higher risk are incorporated into a case management programme and are provided with care by a multidisciplinary therapeutic team. In order to assess the efficiency of such programmes in retrospect, indicators reflecting changes in the use of resources are applied. The most popular indicator of the type is an indicator of hospital admissions due to a sudden illness.

Another mechanism integrating chronic patient care is devising criteria for referrals to hospital treatment, typically concerning individuals suffering from multimorbidity. The tools employed in that regard involve pre-confirmations, diagnostic standards and consultations given by a multi-disciplinary team of physicians. In the case of pre-confirmations, the payer’s consent needs to be acquired for the performance of a given medical procedure, the basis of which is usually provided by the so-called second opinion. It is an evaluation made by another physician of whether the performance of a given service is justified on the basis of previous medical documentation. It is worth emphasising that the other professional’s remuneration does not depend on the contents of their opinion, therefore in the systems applying this tool no regulatory financial incentives are employed.

If it occurs necessary for a patient to be hospitalised, it is important to shorten the time during which hospital resources are used to a minimum and to decrease the intensity of using such forms of care. To that end, many countries (the USA, the UK, Italy, the Netherlands, France) have founded “quick diagnosis” centres, enabling the requisite diagnostic tests to be performed before a patient is admitted to a hospital (Leichsenring, 2004, p. 4). If such specialised centres are lacking, pre-operation diagnostic tests are conducted as out-patient procedures. In turn, consultations by a team of physicians within the scope of case management are meant to evaluate the results of previous treatment and to confirm the need to undertake or to continue hospitalisation.

If the patient covered by the programme needs to be hospitalised, the individual managing their care is responsible for selecting such forms of care that are the most patient friendly and at the same time most cost efficient. Thus, the objective is to substitute more costly forms of stay, typically short-term (“acute-care”) hospitals, with cheaper ones – such as care and therapeutic hospitals, care and nursing hospitals, or the so-called day care departments and one-day surgery centres. Research results demonstrate that the course of treatment is more successful if – as far as it is possible – it is conducted outside of hospital walls, in patient friendly surroundings (Cochrane, 2001).

5. Conclusions

Health care is becoming a more and more complex process, facing several, presented key challenges related to the transformation of a model based on care fragmentation to a model based on its integration. The above-discussed mechanisms and tools employed in integrated health care are chiefly of prospective nature. The tools of retrospective supervision would require a separate examination, including the ones concerning an analysis of the course of a contract and an evaluation of the service process (justification of administered medical procedures, implemented pharmacotherapy). What is more, financial incentives addressed to patients as final service beneficiaries occupy a significant place in the analysis of health care integration mechanisms.

Although strategies for reaching an integrated health care model differ from state to state – neither the European Union nor the Regional Office for Europe of the World Health Organisation provides any guidelines of the kind, leaving it to the member states to independently shape their health care systems – and the process of reform is similar. Its determinants are of universal nature. On the side of demand, the main driving force behind those reforms are the demographic and epidemiological changes of contemporary societies and growing patient empowerment, expressed through bolder articulation of needs and preferences as well as an organised con-

sumer movement. On the side of supply, the key significance is assumed by: the advancement of medical technologies and information systems as well as the economic pressure to improve the efficiency of managing limited resources being at the disposal of health care systems. These variables define the directions of building integrated ways of health care service provision.

It is worth stressing that Poland is at the beginning with experimenting with care integration. Some interesting programmes have been recently initiated (<http://nfz.gov.pl/dla-swiadczeniodawcy/koordynowana-opiekana-kobieta-w-ciazy-koc/aktualnosci>, accessed on: 10.08.2017; <http://www.mz.gov.pl/aktualnosci/kompleksowa-opieka-dla-pacjentow-po-zawale-sercaw-konsultacjach-publicznych>, accessed on: 10.08.2017). Their social as well as economic impact should be carefully examined and reported.

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