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Developing integrated health and social care services for older persons in Europe

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Abstract

Purpose: This paper is to distribute first results of the EU Fifth Framework Project 'Providing integrated health and social care for older persons—issues, problems and solutions' (PROCARE—http://www.euro.centre.org/procare/). The project's first phase was to identify different approaches to integration as well as structural, organisational, economic and social-cultural factors and actors that constitute integrated and sustainable care systems. It also served to retrieve a number of experiences, model ways of working and demonstration projects in the participating countries which are currently being analysed in order to learn from success—or failure—and to develop policy recommendations for the local, national and European level.

Theory: The paper draws on existing definitions of integrated care in various countries and by various scholars. Given the context of an international comparative study it tries to avoid providing a single, ready-made definition but underlines the role of social care as part and parcel of this type of integrated care in the participating countries.

Methods: The paper is based on national reports from researchers representing ten organisations (university institutes, consultancy firms, research institutes, the public and the NGO sector) from 9 European countries: Austria, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, and the UK. Literature reviews made intensive use of grey literature and evaluation studies in the context of at least five model ways of working in each country.

Results: As a result of the cross-national overview an attempt to classify different approaches and definitions is made and indicators of relative importance of the different instruments used in integrating health and social care services are provided.

Conclusions: The cross-national overview shows that issues concerning co-ordination and integration of services are high on the agenda in most countries. Depending on the state of service development, various approaches and instruments can be observed. Different national frameworks, in particular with respect to financing and organisation, systemic development, professionalisation and professional cultures, basic societal values (family ethics), and political approaches have to be taken into account during the second phase of PROCARE during which transversal and transnational analysis will be undertaken based on an in-depth analysis of two model ways of working in each country.

Discussion: Far from a European vision concerning integrated care, national health and social care systems remain—at best—loosely coupled systems that are facing increasing difficulties, given the current challenges, in particular in long-term care for older persons: increasing marketisation, lack of managerial knowledge (co-operation, co-ordination), shortage of care workers and a general trend towards down-sizing of social care services continue to hamper the first tentative pathways towards integrated care systems.

Keywords

health and social care, **integrated service delivery**, **older persons in need of care**, **European overview**

Background and methodological issues

This paper is based on first results of the EU Fifth Framework Project 'Providing integrated health and social care for older persons—issues, problems and solutions' (PROCARE) [1]. The project is to help in defining the new concept of an integrated health and social care for older persons in need of care by comparing and evaluating different modes of care delivery. The first phase of the project was to identify different approaches to integration as well as structural, organisational, economic and social-cultural factors and actors that constitute integrated and sustainable care systems. It also served to retrieve a number of experiences, model ways of working and demonstration projects in the participating countries which are currently being analysed in order to learn from success—or failure—and to develop policy recommendations for the local, national and European level.

Based on a cross-national overview of nine national reports, we would like to show that, though issues concerning co-ordination and integration of services are high on the agenda in most countries, reforms and initiatives are still mainly based on acute health care driven approaches, while the interdependent social care services—not to speak of informal or family carers—remain to be inadequately funded, undervalued, less involved and less trained.

Different national approaches towards integration will be analysed in the context of different discourses on integrated care. Thus, the paper tries to elaborate on a definition of integrated care that is less ''culture-bound'' than mere national approaches by drawing on existing definitions in various countries and by various scholars. This is due to the fact that, for the least in an international comparative perspective, it is difficult to adopt a ''one-fits-all'' definition. In practice, the existing ''tool-box'' of methods and instruments will be used to proceed with different pathways towards co-ordination and integration according to national traditions and professional cultures—a thesis that is underpinned in this article by means of a short inventory of instruments and models used in the selected countries (Austria, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, and the United Kingdom).

Staying with basic definitions, we would like to also adopt a very pragmatic approach as to what we understand by social and health care services. The latter being all services that are provided by medically trained staff with its well-known hierarchy between doctors, nurses and nursing-aides working in institutional settings (hospitals, nursing-homes, day-care) and/or in community care services, e.g. in home nursing. Speaking of hierarchies, usually all social service workers—from social workers to home helpers and visiting services—are often perceived (and perceive themselves) at the bottom-line of service delivery which is already one important feature to explain difficulties to develop integrated care systems. One of our aims is, therefore, to underline the important role of social services in integrated service delivery for also respective discourses are often imprinted by the acute health care model. A starting point in searching for integrated care models was thus that to qualify for an ''integrated care model'' they had to work at (or with) at least one interface between health and social care organisations and/or professions to provide improved services for older persons.

PROCARE is (co-)financed by the European Commission's 5th Framework Programme (Quality of Life and Management of Living Resources, Key Action 6, Area 6.5, Contract no. QLK6-CT-2002-00227) and co-ordinated by the European Centre for Social Welfare Policy and Research (Vienna). It involves 10 partners representing university institutes, consultancy firms, research institutes, the public and the NGO sector from 9 European countries: Austria, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, the UK (see also www.euro.centre.org/procare). The literature review carried out during the first phase was to produce national reports, based on a mutually agreed structure, a theoretical and a European overview [1–3]. All national teams were requested to especially gather grey literature, policy reviews and evaluation studies of at least five ''model ways of working'', and to elaborate on the specific approaches to integrated care in their country [4–6, 8, 10–12]. Scholars who wrote these reports encompass a wide range of social sciences and health professionals, mainly social gerontologists, psychologists, political scientists but also nursing professions. Thus, national reports also reflect the views of different professional perspectives and may not only and not in all their content be read as an explicit policy analysis. As always in comparative projects with heterogeneous national teams, much depends on the different authors' subjective approach and competences. It was the task of the European overview [3] to draw on the existing material and to develop it into a common working definition for the second phase of the project during which a selection of two innovative models of integrated care per country and the exploration of the multiple processes and factors impacting on the delivery of care, are being analysed in-depth.

This article is based on all the knowledge produced during the first phase of the project, and thus draws mainly on national frameworks, policies and general approaches in the nine participating countries.

A common agenda in spite of different developmental states

Long-term care systems in Europe have developed in an incremental way over the past 50 years, though in many countries it is difficult to identify clear and co-ordinated strategies towards a coherent design of respective structures and policies. A general developmental pattern could be described as follows: once recognised as a social problem that cannot exclusively be considered as a family affair, most countries followed a model of ''institutionalisation'' that was then complemented by community care services and an emergent differentiation of other services. Obviously, this pattern started to evolve at different moments and in distinct contexts in the different countries. While Nordic countries defined long-term care services

already during the 1950s as part and parcel of the welfare and health system, in Southern Europe such services have become an issue during the 1980s only. This has been explained as a consequence of various factors such as, for instance, different welfare regimes [13], different family ethics and old age policies [14–17] or the nature of the ''social and health care divide''. Furthermore, general social trends such as population ageing, the reduced informal support from families by increased economic migration and women's increased labour market participation—with male breadwinners failing to close the increasing ''care-gap''—have to be considered.

Nevertheless, there is no relevant policy paper at national and European levels that fails to underline that persons in need of long-term care should be supported as long as possible in living at home: residential homes should be reduced, different kinds of providers and services (day-care, short-term care) should be supported, new services are to be developed, social inclusion should be guaranteed, preventative services and person-oriented guidance and assistance are to be extended. Furthermore, family and informal care are to be strengthened, and the whole system of providers should be ''co-ordinated''. All these recommendations and proposals are made, however, in the context of increasingly market-driven regulatory strategies and a general attempt to reduce public spending on health and welfare expenditures.

It is obvious that, given the different developmental states of national and regional long-term care systems, the challenge is to adopt these general objectives to different contexts and frameworks. To give but one example: While in Northern Europe institutional care makes up to 12% of the provision in Southern Europe much lower shares of institutional care are on offer—about 3% of older persons are living in institutions in Italy [9] and less than 1% in Greece [12]. Thus, expansion of institutional care is much more on the agenda in these countries while in Denmark the construction of residential institutions became prohibited by law and thus has come to a halt. While in the Netherlands major reforms of the institutional sector have been put in place (''extra-muralisation'') [6], and in France and other countries ''small units'' and ''assisted living schemes'' are being promoted [7], Southern European policy makers strive, first of all, for a quantitative increase of institutions, in particular with respect to the private residential care sector, and of general health care expenditures.

Given this background, learning from each other would mean to avoid wrong incentives following the ''pre-designed'' developmental pattern and, in particular, a differentiated health care system on the one side and a social care system based on ''poor law'' traditions on the other side. In spite of overarching power structures, political cultures and different approaches, researchers are thus called to develop evidence for the advantages of integrated care systems and to identify useful starting points for their design and implementation [18].

Different theoretic and national discourses

In fact, we can distinguish several ''discourses'' or sets of academic and political perspectives and approaches towards integrated care as a concept of providing care services in which the single units act in a co-ordinated way and which aims at ensuring cost-effectiveness, improving the quality and increasing the level of satisfaction of both users and providers of care. Means to this end include the reduction of inefficiency within the systems, the enhancement of continuity, tailoring services within the process of care provision and the empowerment of service users.

The process of integration can aim at linking parts within a single level of care, e.g. the creation of multi-professional teams (horizontal integration) or relating different levels of care, e.g. primary, secondary and tertiary care (vertical integration).

Integration within and between care services is especially important when it comes to service provision for elderly people. Elderly patients tend to be chronically ill and being subject to multi-morbidity. Hence a broad spectrum of needs has to be met over a long period of time. To fulfil this task there is a number of possibilities to choose from: health and social care, formal and informal care providers, domiciliary service as opposed to residential, hospital or clinic based services and many more [19, 20]. Considering this scenario, both the necessity of integration and the diversity of approaches towards achieving integration become evident and inevitable.

The concept of integrated care can be found in various countries and under various names, e.g. seamless care, transmural care, case management, care management and networking [21–24]. In general, we can observe two larger streams within the integrated care discourse. On the one hand, there have been developments starting within the health care realm, in particular the ''managed care discourse'' and the ''public health discourse''. On the other hand there is a broader approach putting increasing emphasis on social services and social integration such as the ''person centred approach'' and the ''whole system

approach''. These approaches are complemented by the ''institutional discourse'' that is mainly focusing on organisational strategies to realize integration and/or co-ordination of services.

The ''managed care discourse''

As health care management is increasingly prone to reconcile the contradictory demands of physician and executive roles, theory and practice have explored ''managed care'' to increase efficiency and quality of health care services, in particular concerning hospital management [25, 26]. Integrated care in this context is thus first of all focusing on organisational interfaces within the health system while applying respective rationales and principles on primary health care and social care services.

Also the WHO has taken up this approach, not least by the implementation of a ''European Office for Integrated Health Care Services'' in Barcelona, suggesting integrated care as ''... a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve the services in relation to access, quality, user satisfaction and efficiency'' [21].

The ''public health discourse''

The ''public health approach'' is particularly focusing on the integration between primary and secondary care but it has been increasingly extended with a view to both the vertical and the horizontal level, and thus to social service delivery. The idea of integration refers to a process aiming at guaranteeing demand-orientation, a continuity of provision and a high standard of quality [27, 28]. At the centre of attention is, in particular, the hospital/community care interface with its well-known problems such as, for instance, the revolving-door effect, bed-blocking and communication problems. This has often resulted in setting-up model projects to introduce change processes [8, 10, 28]. This focus is very close to what has been called ''intermediate care'' in the UK [29, 30], i.e. a range of services to ''facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired'' [31].

Still departing from a focus on health care, also Kodner and Spreeuwenberg [23], who have made an important contribution to the definition exercise, can be located in this stream of thought as they take a ''patient-centric view on integrated care'', though taking into account the ''provision of health care, social services and related supports (e.g. housing) at the right time and place'' [23]. Kodner has recently refined this approach underlining the goals of integrated care that are ''to enhance quality of care and quality of life; and improve system efficiency for clients whose complex problems cut across multiple systems and providers'' [32].

As within most concepts, we still can find a variety of meanings, approaches, theories and practices. In a geographic perspective, the approach might be interpreted as ''Northern European'' as Niskanen [33] put it: ''Integrated care includes the methods and strategies for linking and co-ordinating the various aspects of care delivered by different care levels, of primary and secondary care. In Finland, the concept of integration applies also to the social services, since especially long-term care patients need support, which is a duty of the social sector as well.'' Salonen and Haverinen [11] are using the term ''seamless service chains'' to delineate this kind of integrated care, i.e. ''an operating model, where the social welfare and health care services received by a client are integrated into a flexible entity which will satisfy the client's needs regardless of which operating unit provides or implements the services'' [34].

To sum up, the public health discourse is focusing on ways to deliver better care for the whole population by integrating various providers, starting from a health care perspective.

The ''person centred discourse''

It is certainly difficult to set an unambiguous demarcation line between the ''public health discourse'' and what we would like to call the ''person centred approach''. However, the focus of the latter is clearly on a ''de-medicalisation'' of integrated care perspectives, i.e. to underline the interdependency of social and health services in long-term care. This reflects experiences that the perspective of acute medicine often prevents long-term care delivery from putting the individual at the centre of all interventions: ''The integration of health and social services implies that the services are provided to all elderly—independent of where they live—by integrated teams of home-helpers, home nurses etc. (...) The decision for support is made on request from GPs, hospitals, the elderly or relatives'' [4].

This definition is very close to a notion that can be retrieved both in theory and in policy-making in the Netherlands which is tending towards the construction

of ‘‘demand-driven’’ care systems that, in summary, are promoting integrated care delivery: ‘‘Demand-driven care simultaneously means integrated care for, when the requests and needs which the client may experience in various areas are met, integrated care is provided. From a client perspective, integration is realised when (s)he can expect to receive the right kind of care, and the right amount of care at the right moment in time’’ [6].

This concept draws on the individual as the point of departure and tries to focus on the interface between independent housing and care (‘‘transmural care’’) [35], inter-sectoral joint working and the development of service-networks to guarantee older persons' participation in society. Thus, the approach goes far beyond acute health care models.

A variation of this approach can be found in the UK, where a large number of terms have been used to describe integrated care, including ‘‘joint working’’, ‘‘partnership’’ and ‘‘collaboration’’. Coxon et al. [5] especially underline a recent definition provided by the Audit Commission that has developed a ‘‘systems model’’ of organisational partnership. According to this definition ‘‘whole system working takes place when services are organised around the user, all of the players recognise that they are interdependent and understand that action in one part of the system has an impact elsewhere’’ [20]. Users should thus experience services as ‘‘seamless’’ and providers share ‘‘vision, objectives, action (including redesigning services), resources and risk’’. This concept is surely most remarkable, though its translation into practice will call for major efforts concerning organisational development and communication between players. This definition as such could in any case help create a shared vision between scientists, policy analysts and practitioners.

The ‘‘institutional discourse’’

The question remains whether the definitions presented hitherto really mean ‘‘integration’’, rather than ‘‘linkage’’, ‘‘co-ordination’’ or ‘‘networking’’ as described by Leutz [36]. As Frossard et al. [7] suggest, ‘‘integrated services are a set of services made available for a specific population group over a given geographical area, or for the population of a given geographical area, by a single company or organisation, grouped together under a single decision-making authority’’. For ‘‘real integration’’ to occur, a stable organisation providing for the complete coverage of health care needs of a given population must be created, and this would probably be within the health system [32]. An attendant concern is that social services would either lose their identity and autonomy or would become further ‘‘medicalised’’. Due to the existing fragmentation of health and social care systems the different units would barely be ready to accept a unique, vertically integrated decision-making authority.

This is why, for instance in France, the concept of integration in the form of a ‘‘Consolidated Direct Service Model’’ [37, 38] is rather undesirable. Instead, we can observe in this country a long history in theory and practice of ‘‘gerontological co-ordination’’ and networking: ‘‘Network or co-ordination means a voluntary organisation of professional people (which may include voluntary workers) who pool their means and resources to develop information, social and health care, and prevention services designed to resolve complex or urgent problems, which have been identified as priorities over a given geographical area, according to criteria decided in advance on a consultation basis (...) a temporary or permanent collaboration between different organisations working towards a specific objective’’ [7].

The three terms *co-ordination, co-operation* and *networking* are commonly used to describe ways of working together, within as well as between different sectors. The difference between the three expressions is the extent of working together, which increases from co-ordination over co-operation up to networking: While co-ordination might still imply the existence of a hierarchy, co-operation hints somewhat more to working together on an equal level, whereas networking additionally requires a certain closeness and continuity [36, 39].

It should be mentioned at this point that neither ‘‘seamless care’’ nor ‘‘person centred’’ approaches are heading towards an ‘‘unfriendly take-over’’ of the social sector by the health system. In fact, also co-ordination aims at a certain level of structural integration, e.g. a one-stop-window or a front office with case management functions (brokerage agency).

Another aspect of institutional (horizontal) integration is concerning the integration or co-ordination of different types of providers, an issue that has been discussed in most countries under the heading of the ‘‘mixed economy of welfare’’ [40, 41]. This is particularly evident in those countries where market mechanisms and choice are part of the equation (e.g. Austria, Germany, increasingly the UK, Italy), and there is a strong argument that the numerous different types of providers are just adding more complexity to a realm that has already been described as being ‘‘among the most complex and interdependent entities known to society’’ [23]. Indeed, steering mechanisms with respect to the Third Sector and other private

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

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

Source: PROCARE [1]; ***most important concept being followed and implemented in mainstream provision; **important concept followed (partly implemented); *concept being discussed and tried out in experimental (model) projects.

providers have been developing during the past few years, in particular where these new providers that have only started to blossom, e.g. in Italy [9].

In Table 1, we undertake the—scientifically—risky experiment of classifying the relative importance of different concepts in the participating countries. Obviously, this classification only builds on the subjective experience of the researchers participating in PROCARE and evidence given in the national reports of this project [1] but it might help to gain some insight into the different concepts at stake.

The single concepts described above have deliberately not been construed in a mutually exclusive way although, for instance, it seems logical that a person-centred approach includes horizontal integration (that is, integration across organisational boundaries and across professions) and ''transmural care'' (that is, integration across residential and domiciliary services). It may be that implementing horizontal integration is the first step in the process of developing a system that supports person centred care. Furthermore, there might be additional and/or alternative pathways towards integrated care, for instance by developing ''gerontological co-ordination''. In brief, the table should be read as an attempt to provide indicators on the level of integration in the individual countries: we are not trying to propose single ''best'' strategies of integration here. In fact, there are variations both within and between countries in methods of service organisation.

As a corollary of this section we may, notwithstanding the existing different approaches, consider the term ''integrated care'' as a helpful concept to describe co-ordination, co-operation and networking between health and social care services with the aim of improving services and quality of life from a user's perspective (for further analysis: [2, 23, 32, 36]). Still, it depends on the specific mix of methods or instruments and on single strategies used to achieve these objectives.

Methods and strategies used in approaches to integrated care

Policies and strategies to reach integration may try to use different forms of leverage and diverse starting points to strive towards the creation of integrated care systems. Kodner and Spreeuwenberg [23] have suggested a continuum of strategies towards integrated care, addressing the well-known problems in five interdependent domains: funding, administrative, organisational, service delivery, and clinical. Kodner [32] has also contributed to a comparison by analysing the categories ''administrative consolidation, co-location of services, care network, case management, chains of care, and service-enriched housing''. However, in the following we shall only partly refer to these categories as we are trying to move further towards a discourse truly focused on the interdependency between social and health services in long-term care. Therefore, we would like to emphasise those methods and strategies that are used to overcome the bottlenecks at the various ''interfaces'' between the health care and the social care realms.

Case and care management

The most genuine method within the integrated care discourse is probably what has been described as case and care management, a technique deriving from the social care sector, which aims at matching supply and demand for persons in complex situations. The idea is to build up a network of services (resources) over time and across services and to empower the patient and their relatives to use it self-reliantly. The methods used are client- and, therefore, demand-

oriented. It should be noted that in this context the term ‘‘case’’ refers to the situation the person is in, not to the person itself [19, 37]. This approach was also taken up in other domains such as, in particular, the health sector where it is more known under the heading of *care management*. The idea is to maximise the benefits derived from a given amount of money. This aim is reached by means of co-ordination of the care delivery, thus avoiding loss of information and double treatments and—eventually—leading to a cut back of the utilisation of care services. It is currently uncertain whether this strategy even leads to a cut back of the use of necessary but expensive services [42–44]. A further definition problem concerns the term ‘‘care management’’ that, referring to Roth and Reichert [10], denotes the co-ordination of help and networks of service providers at the general level in a care region, while in other contexts it means the management of the individual care process.

In any case, the instrument is used in most countries, though with different interpretations. While in the UK, the Netherlands, and the Nordic countries case managers might be characterised as a mainstream service, in Germany, Austria, Italy and France case management is mainly provided in model projects. Differences concern objectives, funding and the organisational setting. For instance, in the UK case managers also fulfil a gate-keeping function. The GP performs this function with respect to health care, and social services employed ‘‘care managers’’ purchase social care on behalf of clients following an assessment of ‘‘social’’ need. In Austria and Germany, case managers are mainly working in projects at the interface between hospital and community care.

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

As with other instruments of integrated care, a key issue relates to who the ‘‘case and care managers’’ are, which professional background they have (nursing rather than social work?), which kind of training they get and whether they are given the real means and competences to steer the processes and to act as an ‘‘advocate’’ of the client. In the Netherlands, for instance, the ‘‘ouderenadviseur’’ (consultant of the elderly) is a widespread service but it is more focused on information and support, rather than on influencing and co-ordinating different providers. There is one Dutch model project, though, where a so-called ‘‘omtinker’’ is combining advocacy with the means to co-ordinate providers around the needs of the individual client [6]. Other questions with respect to care management concern their role as ‘‘gate-keepers’’ and/or its dedication to individual care planning and the monitoring of outcomes: How should case management be organised? Should case-management remain a public responsibility? Could target setting serve as a mode of steering case managers? How and by involving whom should the role of case managers be developed?

Intermediate care strategies: the hospital/community care-interface

As the need for care often occurs unexpectedly (mostly in relation to a dismissal from hospital), and as frail older people (and their family) habitually do not know where to turn to, rapid intervention and quick, unbureaucratic support are important factors to achieve client-orientation. At this interface, rapid response teams [5] may be an instrument to prevent unnecessary hospital admissions and/or request for a place in a nursing home. This method is part of a whole range of interventions with respect to ‘‘intermediate care’’ that could be complemented by intensive rehabilitation services (situated in hospitals or people’s homes) to help older people regain their health and independence, recuperative facilities (short-term care in a nursing home or other special accommodation to ease the passage), and quick information exchange (transition forms).

While these instruments are part of the UK government’s strategy for improving health and social care services for older people [5], they can also be found in other countries. In Denmark, for instance, preventative visits at the home of all older persons have been introduced that should help both health care staff and social workers to keep in touch with potential users and to organise services already at an early stage. Apart from such early warning systems, contracts between municipalities and hospitals about discharge procedures, meetings between home nurses and hospital staff, and geriatric teams that are following-up the older persons in their own homes are part of the Danish strategy to increase integration between hospitals and community care [4]. Also Wistow et al. [24] underline the necessity ‘‘to conceive of intermediate care in terms of a service system which is built around the needs and aspirations of older people for valued lifestyles (...) in ways which enhance their capacity to meet their social and psychological needs as well as their optimal level of physical functioning’’.

Though it cannot be taken for granted that the different environments (hospital/community) are recognised,

or that working in partnership between health and social care agencies is always successful, care managers situated in hospitals can also contribute to a better preparation of hospital discharge if they are able to create a decent network around the client's needs [8].

The beginning of a complex relationship: needs assessment and joint planning

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

Many countries have introduced interdisciplinary assessment teams and/or agencies responsible to guide the citizen through the ''jungle'' of service providers. The multidimensional ''geriatric assessment units'' within the Italian health system [9] are one example but in reality they often only start their activity when older persons are applying for a place in a residential setting and by referral from other health or social care professionals. In the Netherlands [6], the Regional Assessment Boards (RIOs) are a most important starting point for integrated care strategies: their interdisciplinary members decide to what kind of care, facilities or support the person is entitled. A similar function is given to the Single Assessment Process in the UK, exemplified by an improved version under the heading ''Community Assessment and Rehabilitation Teams (CART)'' [5] and the ''Centres Locaux d'Information et de Co-ordination'' (CLIC) in France [7].

In most other countries, assessment processes concerning long-term care needs remain quite fragmented and genuinely based on medical expertise. For instance, in Austria and Germany specially trained medical doctors are carrying out the assessment of needs, i.e. to check entitlement rights for long-term care insurance benefits (Germany) or the Austrian long-term care allowance. Thus, entitled persons who choose services as a support to family care often have to undergo a further, ''duplicating'' assessment concerning service needs and individual planning. An integrated approach, i.e. a ''single assessment process'' could serve to reduce this kind of ''parallel action''.

User's choice: personal budgets and long term care allowances

Needs assessment by (medical) experts is a topic at least as diversely debated as cash benefits for care dependent persons. While the former, however, has always been a fundamental part of the debate on integrated care, ''consumer-directed care appears to be the antithesis of integrated care'' [45]. Giving money to persons in need of care, indeed, is a phenomenon that has been spreading over the past 15 years [17, 46]. It is rooted in claims for independent living—a movement that consists mainly of persons with disabilities at working age but also in traditional cash benefit schemes for disabled persons (invalidity allowances) that have existed in many countries. Furthermore, cash benefits were also to support informal and family carers with some schemes that entitled carers for specific allowances. And, of course, cash benefits are an attractive means for policy-makers to control budgets.

In practice, we can observe quite different approaches, both on the level of financing, and in relation to entitlements that vary between lump sums of €150 up to €1,700 per month depending on assessed needs, kind of services or institutions used. In Germany, entitled persons may choose between cash allowances, services-in-kind or a mix of both; a majority of users are opting for cash allowances. In Austria, it is completely up to the recipients to decide whether to use the allowance to buy services or to ''pay'' informal or family carers. In France, the APA resembles more a voucher system as the allowance has to be used to pay for (informal) carers or to co-finance residential care. Also the different forms of the Dutch ''individual budget'' are more or less earmarked for care—only a small share of this individual budget can be used at the discretion of the recipient, while the main share should be used to buy services, usually with the support of an Insurance Agency. Still, this form of an allowance is intended to increase the user's choice and his/her independence.

With a view on integrated care for older persons, this mechanism might obviously lead to a situation in which the person in need of care (and/or his/her family carer) becomes a kind of case manager, thus shifting the burden. Another consequence might be that the allowance ends up as part of the regular household income so that its specific use for care-related expenditures cannot be retraced and thus generate an alleged ''misuse'' of public funds, perhaps even by encouraging ''black market labour''. At the same time, cash allowances could be a first step towards a more general approach towards demand-orientation and greater differentiation, rather than an orientation to allegedly homogeneous target groups such as ''older persons''. In order to take full advantage of consumer-directed services, a number of preconditions have to be fulfilled [6, 45]:

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

Joint working: shattering the cultural divide

Anybody who has worked with mixed groups consisting of medical, socio-medical and social professionals knows about the cultural cleavages between these groups but also about the fact that structural and hierarchical divisions are often much more significant. Once the various professionals start talking to each other, conflicts and different perspectives often can be resolved. Still, hierarchies remain divisive and may impede development of a common understanding, for instance the definition of ''autonomy'', or a shared care concept. In particular, the medical orientation towards ''healing'' often clashes with the needs of persons who depend on long-term care. Also, wrong incentives presented by, for instance, diagnosis related groups financing (DRG-financing) of hospitals, have contributed to the so-called ''cultural'' divide between health and social care systems. Furthermore, differences in status and hierarchy that are increasingly challenged by the nursing professions complicate the co-operation between medical, nursing and social care professions [10].

A specific group to be addressed in relation to this are medical doctors (general practitioners) who, though having a potentially decisive role in guiding and supporting persons in need of long-term care, also in relation to the LTC insurance, refrain from fulfilling the role as a general reference person (''navigator'') for both clients/patients and other service providers due to time constraints, lack of knowledge and returns for this task.

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

Positive outcomes concerning joint working and improved mutual understanding are also reported by almost all model projects trying to combine social and health care services in one or the other way. The mere fact that the different stakeholders are gathered around one table often helps to create an intensive exchange of ideas, trust in each other's capacities and a new understanding of the other sectors' work [8]. In France, statutory policies have a long-standing history of incentives to support ''co-ordination mechanisms''. Based on the experiences of local implementation projects promoting ''gerontological co-ordination'', Frossard et al. [7] underline that, unfortunately, the process of improving communication is quite time-consuming and calls for very engaged project leaders. In one project it took about 2 years to succeed in getting medical doctors and social workers to work together and to gain a fresh look at given situations.

Another approach towards joint working on the level of promoting the flow of information and co-ordination

between the different organizations and institutions involved is reported from Germany where co-ordinating care conferences, round tables and working groups have been installed in several areas. In a broader sense these also concern the planning and structuring of care provision, and agreements on procedures at a regional or local level [10].

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

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

The Dutch government's approach towards demand-oriented care is trying to face this challenge by promoting the concept of ‘‘care-friendly districts’’, i.e. areas in which explicit attention is paid to the improvement of the habitat, the infrastructure, and existing facilities [6]. Generally, this approach concerns the housing/care-interface that has often been neglected within the medical model. Indeed, if care at home is to be supported, then both housing policies and housing organisations become important factors for providing integrated care. In the Dutch reality, respective policies have led to interesting partnerships, e.g. between the Ministry of Housing, Planning and Environment, and Health, Welfare and Sports. The respective ‘‘sheltered housing stimulation arrangements’’ have triggered several initiatives. For instance, housing corporations are, in co-operation with municipalities and institutions for care and welfare, modernising existent residential and nursing homes into new care centres. They are also developing new sheltered care facilities, preferably in co-operation with private funders [6].

Also the Greek ‘‘Open Care Centres for the Elderly’’ (KAPI) are emphasising the neighbourhood and its social capital to re-build social solidarity as a part of integrated care provision. KAPI aim at preventing isolation of the elderly; they should contribute to increase the ability of older citizens to remain active members of society. As mediating centres KAPI are connecting the elderly to and within their social environment, thus promoting an integrated centre for prevention, health promotion, and social integration [12].

Supporting informal (family) care

The role of families and/or informal carers in creating integrated care networks is crucial to their success. This is equally true for prevention and the actual care process as no care system will ever be able to completely cover all long-term care needs by professionalised services. While informal care was, for a long time, taken for granted by service providers, a number of initiatives now exist to ameliorate this situation. These mechanisms range from cash benefits (UK, some regions in Italy) and pension grants (Germany) to training and information, employment (Nordic countries), and respite services such as day-care or short-term care that can be found in almost all countries although availability of these services tends to be very poor.

It is important to notice that, due to the prevailing ‘‘family ethics’’, in those countries where family care is most important (in particular Mediterranean countries) only minor efforts to integrate family carers in providing systems are being observed [12]. Concepts promoted by the EU such as, for instance social inclusion, subsidiarity and solidarity should help to improve this situation.

The integration of informal care remains a critical area for integrated care delivery, partly due to the fact that family carers often do not even define themselves as carers, and also because professionals in many cases see the family of the person in need of care as an opponent, rather than as a resource. Thus, improvements are difficult to achieve on both levels: on the one hand, by supporting informal or family carers in integrating the various services received by their spouse or older parents (information, specific training); on the other hand, by involving them in formal care systems, even or in particular if these are part of an integrated service system.

With the rising number of non-family informal carers, who are often immigrants from outside the EU—and the related problems of ‘‘black market employment’’, ‘‘illegal immigration’’ and consequent poor continuity of care—it becomes more and more urgent to develop strategies of integration and collaboration with the formal health and social care system [9, 47].

Quality management as an instrument to create mutually agreed outcomes?

The considerable success of industrial quality certification systems (ISO 9000, EFQM, Total Quality Management, Business Re-engineering) has had a significant impact on the delivery of personal social services during the 1990s, with the consequence that the impetus of case management and co-ordination issues—one of the most discussed concepts in social policy research during the 1980s—has moved somewhat into the background. With the ongoing market- and managerial orientation it seemed as if public services and social services in particular could catch-up in their professional and societal image only by taking on board the ''professional approaches'' coming from the business-based concepts [48, 49]. This certainly had a number of positive effects on the changing ''culture of care'' such as, for instance, an increasing user orientation, a clearer focus on objectives and outcomes, re-organisation processes towards more autonomy of teams and working-groups as against hierarchical decision-making and bureaucratic planning and controlling.

Indeed, quality management can also help to improve inter-organisational co-ordination if, for instance, indicators and standards concerning structure, process and outcome of different providers or agencies are defined in commonly agreed proceedings, and if the specificities of social and health service provision are recognised during this exercise.

Examples for such an approach can be found in Finland both in terms of a top-down strategy and in bottom-up models. The Finnish Ministry of Social Affairs and Health has addressed the quality issues since the year 2000 by providing a ''National Framework for High-quality Care and Services for Older People'' and recommendations for quality improvement by involving the municipalities. Single municipalities and projects have used quality management methods in ongoing restructuring and reform processes, e.g. the ''Kuopio'' project [11].

Also the National Service Framework for Older People in the UK is to create quality benchmarks across a wide range of health, social care and other services for older persons, including the extent of their integration [29].

In general, quality management and certification processes have mainly been introduced by single organisations (ISO certification by private non-profit providers in Austria, Germany, Italy and the UK), strategic development processes towards integration by means of quality assurance have been reported to a minor extent [5]. In Germany, quality management tools have been increasingly applied [10, 50, 51] both in the health sector and in connection with the introduction of the long-term care insurance. At the same time, the introduction of a more mixed economy of welfare in Italy triggers the development of regional accreditation systems for social services that are usually based on quality management approaches [9].

Different national strategies followed to achieve integrated care in selected EU Member states

Table 2 tries to sketch the situation of key innovations or strategies that are underpinning and/or signalling the implementation of integrated care approaches in the participating countries. This assessment is based on the PROCARE national reports [1] and should thus be read as work in progress. However, the overview helps to explain differences and similarities that often run counter to the usual division of welfare state regimes. For instance, the fact that in a ''late-comer'' country such as Italy quality management and accreditation systems are on the agenda as clearly as in Germany or the UK, is at least as surprising as the fact that Greece, apart from Denmark, is the only country where an explicit approach towards prevention has been developed.

Again, this overview is intended to show that different combinations of ''instruments'' or methods can be used as a starting point to achieve integrated care, depending on national traditions and local conditions. It could nevertheless be suggested that in countries where more methods of integration are being adopted, the political will to achieve an integrated service delivery is likely to be stronger.

Conclusions: pathways to integration instead of a single definition?

With the given diversity between and within countries concerning structures, procedures and outputs of health and social care systems it seems difficult to imagine a reform process in which shared visions, strategies and policies lead to the development of a shared culture between health and social care. Yet, the emerging challenges in ageing societies increasingly call for joint structures, training, and funding mechanisms. Integrated care ''by law'' will certainly not suffice, and market mechanisms are less likely to improve joint working and the development of shared visions. Some more promising pathways could nevertheless be identified:

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

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

Source: PROCARE [1]; ***broadly perceived and applied as a main stream method; national standard; **partly implemented on a local or regional level; *applied in an experimental stage (model projects).

- Reforms that intend to integrate health and welfare services should be founded on the integration of financing systems and the overcoming of institutional barriers, especially between outpatient and inpatient care, between health and welfare services, and between professional and informal care.
- Geriatric screening and multidimensional assessment are part of modernising the system in many countries (e.g. Germany, Italy, France, Finland, the Netherlands, the UK and Denmark)—it can be incorporated into practice without too much difficulty, it meets with a high level of acceptance, and it helps to involve different kinds of professions and to improve communication between them.
- Demand-driven, integrated care has to strive to increase clients' control over the care process, e.g. by way of "individual budgets" or other means that increase their purchasing and negotiation power.
- Innovation programmes promoted by central government can trigger a number of private and local initiatives—a vision of support that goes beyond the traditional notion of care, and integrates care and nursing, adapted housing, local resources, and welfare services.
- A central service point for advice, information and help is useful to support clients in clarifying their care needs and to improve co-operation between different organizations that operate according to different logics and have different types of personnel. It is of utmost importance to help staff in developing a new understanding of the other sectors' work.

The generally observed marketisation track will surely increase with more voucher systems, payments for care and steering mechanisms that try to make use of demand and supply mechanisms. We know, however, that health and care are no more than quasi-markets with their own characteristics and criteria. It will, therefore, be important to increase regulation (accreditation mechanisms, quality assurance) with respect to providers and, in particular, in relation to employment and human resource development to reduce "black market work" and to enhance clients' control over the care process.

The integration process will certainly boost the importance of management and related tasks. On the one hand, both social and health staff will have to perform more managerial work in addition to direct care which might also lead to new specialisations and new job profiles, e.g. with respect to case and care management. On the other hand, the necessity of developing steering mechanisms on the national, regional and local level will call for more managerial decision-making with respect to commissioning, contracting, purchasing, planning, evaluating and quality assurance mechanisms.

These developments might be accompanied by a more fervent introduction of information technology, also in the area of social care. Indeed, the "techno

track'' has already begun with respect to tele-care devices, with the introduction of information technology in the organisation of care processes and the construction of ''smart homes''.

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

I would like to conclude with a brief consideration concerning the common practice of model projects as one of the most frequently applied strategy to develop integrated care networks. Such projects are often accompanied and evaluated by scientific research. Still, many of these projects remain without any documentation or evaluation, and in most cases there is not enough funding for a real evaluation of outcomes and lessons to learn. Compared to medical research, scientific research concerning community care or integrated service delivery is weakly funded and almost not at all published. Denmark, Finland and the UK are countries where targeted R&D programmes can be identified, and have some influence on the practice of organising services. In most other countries, research remains somewhat distinct from practice, and development projects in the area of integrated care organisation depend heavily on single decision-makers and selective project funding. In order to develop evidence-based solutions it will, therefore, be necessary to improve research and development, in particular with respect to evaluation methods and in relation to the fact that complex change processes need special skills and respective accompanying measures [52].

It is in this context that PROCARE will carry out further investigations, in particular by looking at model ways of working that have shown to overcome existing barriers and to resolve everyday problems in the co-operation between health and social services. In the end, it will be such examples that will shape the future development of integrated service provision together with public policies that are aware of their responsibility in providing a decent framework for modernisation and reform.

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Vitae

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