

## Editorial

# Looking back whilst moving forward: observations on the science and application of integrated care over the past 10 years and predictions for what the next 10 years may hold

*In pursuit of evidence based integrated care* [1] was the title of the first editorial in the International Journal of Integrated Care (IJIC) that was published in November 2000, some 10 years ago. The inaugural issue was actually prepared in 1999 by a small group of enthusiastic scientists from Europe, USA and Canada who decided that integrated care was high on the political agenda but low on the scientific agenda. Between them, the idea for an open-access and electronically-based scientific journal was born. Since then many research papers, case reviews, policy papers, special issues, editorials, book reviews, summaries of doctoral theses and congress proceedings have found their way to the columns of IJIC.

This editorial examines two questions: first, has the pursuit of integrated care become more evidence-based and scientific over the last 10 years?; and second, what should we expect in the coming 10 years in terms of the development of our understanding, evaluation and realization of integrated care?

The first part of this editorial comprises the thoughts and observations of Professor Guus Schrijvers who, after 10 years as Editor-in-Chief, left this role on September 1st this year. Dr. Nick Goodwin, who was one of the original group of scientists that helped established IJIC, has now taken on the role of Editor-in-Chief and so the second part of this editorial examines his interpretation of what the next decade may bring.

### *Looking back*

The first years after 2000 we were in pursuit of a good definition of integrated care. In 2002, Cor Spreeuwenberg and Dennis Kodner provided the Journal with an enduring definition to describe both the meaning and logic of integrated care that has become widely used and cited internationally [2]. Dennis Kodner and Kay Kyriacou [3] also provided the Journal with one of the first taxonomies of integrated care. Drawing on the work of Walter Leutz they described how integrated

care varied in intensity across a continuum: i.e. from 'no integration', to 'linking', to 'coordination' and then to 'full integration'. A variation on the taxonomy used as a model for measurement was developed by Bengt Ahgren and Runo Axelsson [4].

Other important distinctions in the nature of integrated care have since been described, for example between horizontal integration (within, for instance, primary health care) and vertical integration (between, for instance, primary health care and hospitals). More recently, IJIC debated and provided an international definition for disease management [5]. So, from the outset, the conceptual harvest of integrated care was huge territory for IJIC to embrace, as the reader may check for themselves using the new search engine on this Journal [6].

The field of integrated care has also been a subject for continuous debate amongst the editorial board, sharpened by many readers submitting papers and many eager reviewers accepting or refusing them. After 10 years the editorial board now distinguishes its field of integrated care as follows:

1. integration of health services and social services;
2. integration between primary health care and hospital care;
3. integrated care within one sector (e.g. within mental health services); and
4. integration between preventive and curative services.

These generic fields of integrated care have emerged over the last 10 years to follow the key range of topics from the papers that have been submitted to us. Over that time, we have noticed that these same developments towards integrated care show up as recurrent themes across all countries.

At another level, a different taxonomy emerges within these fields in terms of the 'target groups' for integrated care. We have received many papers on integrated

care for the elderly and for persons with an unspecified chronic condition. Sometimes, papers have focused on one type of patient—for instance, to persons with mental health problems [7]. At other times papers have looked at one type of disease, such as diabetes [8]. However, IJIC has not published too many papers on specific patient groups, which seems to be at odds with the focus of attention being made to doing so in the policies and approaches of many countries. It could be that there are enough, disease-related, medical journals prepared to publish accounts of new ways to integrate care for such patients. However, on the general field of integrated care for the elderly and for people with long-term chronic illness we think that the Journal has contributed much to the scientific debate and to the policy agenda.

In recent years, IJIC's attention has switched from definition-making towards research methodology since we were aware that there was a shortage of well-designed evaluation studies but a growing demand to understand outcomes or best-practice in integrated care interventions. Amongst others, we have supported the publication of PhD thesis summaries, published an overview of how integrated care might be measured [9] and, in this edition, published the first in what we hope will be a series of research protocols starting with an important UK-based field study of integrated care pilots [10].

So, after 10 years, this Journal has managed to reach a point in which integrated care has a clear set of definitions, an overview of the major fields of integration and the key target groups for integrated care, as well as the beginnings of a debate on outcome measures and research methodologies that may lead in time to some important standardization in approaches that can facilitate comparison.

### *Moving forward*

When IJIC was founded, the idea of making integrated care a scientific discipline was both novel and mildly eccentric. We recognised in those early discussions that the pursuit of better care co-ordination for patients was an 'age-old' theme, yet pondered on why care systems were so resistant to change.

Today, however, it is clear that integrated care has moved from a backwater activity and into mainstream thinking. There is growing demand to understand 'what works' and 'what value' can be derived from care integration. This is not a passing phase. Care systems around the world are under stress as a result of increasing demand from: ageing societies, greater elderly dependents and fewer carers, the growing burden of long-term chronic and mental illness, new technologies and treatments, the prospects of an obesity pandemic, and so on. The financial crises that have

hit many countries have also added to the problem of sustainability.

There is no alternative under these conditions but to seek fundamental changes in the way care systems operate. Retaining the status quo is not an option since that implies a toxic cocktail of higher taxes and/or insurance premiums; reduced entitlements to care; the rationing of treatments; longer waiting lists; and the cutting back on public health initiatives.

Regardless of the evidence for change, the only option available to maintain quality of care in the long-term is fundamental system redesign and this requires integrated care strategies to be embraced. Changes are often most brought about as a result of necessity, so one would expect in the next 10 years to see a significant growth and acceptance of integrated care as an organising principle.

A scientific journal like IJIC must play its part in supporting the evidence-base for the effective development, organisation and delivery of integrated care. Yet it must also remain critical. Many readers will undoubtedly be converts to the potential power of integrated care, but at present we have only just walked beyond the foothills of integrated care as a scientific discipline and the evidence-base is promising but weak.

There remain a multitude of challenges. The aims of integration are often diverse and the criteria needed to compare and judge outcomes will vary due to differing target populations, the size of the intervention, and nature of the local context in which it is made. Many of the outcomes of integration are also not easily measurable (e.g. in terms of continuity of care) so assessing the impact of integration remains a significant challenge. In the next 10 years, then, IJIC must seek to publish articles that continue to improve the theoretical, methodological and explanatory power of integrated care.

There are also likely to be a new set of themes to enter the integrated care field. In the next 10 years, one might predict a growth in studies looking at:

- E-health strategies that support users to remain independent in their own home and access a range of care services remotely (our conference in London on the 2–3 March 2011 will examine this theme);
- Supported self-management and a new relationship between patients and physicians in personalising care services and embracing shared decision-making;
- Integration between curative and preventative activities;
- Integrated delivery systems that bring together clinicians and managers, funders and deliverers, professionals and patients; and

- System incentives, such as pay-for-performance mechanisms that use quality indicators rewarding integrated care; new forms of collective governance and regulation; and the development and use of best-practice guidance to support care integration in practice.

Over the next 10 years, whilst upholding the traditions it has set for being a high-quality scientific journal, IJIC also needs to continue to spread its wings to embrace studies and new ways of thinking from other parts of the world. In February next year, the Agency for Integrated Care (AIC) in Singapore will be hosting an inaugural integrated care conference in Asia and IJIC is pleased to be associated with that. In addition, in the coming years, we hope to stimulate interest in Australasia and Latin America.

As the depth of research into integrated care develops and expands over the next decade, IJIC also needs to ensure that it does not fall into the trap of ‘medicalising’

the field of study, and so recognise that care integration in its widest sense goes beyond the confines of professionalised health and social care systems. Overall, IJIC must continue to stress that the primary purpose of integrated care should be to improve quality-of-care, user experiences, and cost-effectiveness. As such, integrated care is provided with both a rationale and a common basis for judging its impact.

Our overall hypothesis in this editorial is that care integration is not a passing fad but an organisational principle whose time has come. When we return to examine what has happened in another 10 years from now, we would hope and expect integrated care to have become the norm rather than the exception to the way care is delivered in most countries.

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Dr. Nick Goodwin

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