Introduction: the challenge of ageing societies in Europe

Over the past two decades an important demographic and epidemiological transition has taken place in Europe which has seen age-related and long-term chronic illness replace communicable disease as the biggest challenge that health systems must now address. Today, more than half of the growing numbers of people aged over 65 in Europe are living with more than three chronic conditions, with about one-fifth having five or more concurrent health problems. This shift means that the economic burden of age-related chronic illness now represents between 75-80 per cent of health care expenditure, a figure that is also expected to rise as European society ages.

This rising demand for care presents a significant problem since it comes at a time of economic uncertainty. Health and welfare budgets across Europe are under pressure yet the cost burden of age-related chronic illness will rise. The ability to find a way to sustain or even improve health outcomes within limited financial resources has become the greatest of challenges, specifically when set against the European Union’s goal to increase by 2 the average number of years that people live in good health by 2020.

Current health and care systems in Europe, however, appear to be ill-equipped to meet the challenge as they have over many years developed systemic and institutional structures that focus on cure rather than care. As a result, most countries have begun the search for structural or technological solutions that embrace new and more integrated care models that place the emphasis on preventing ill health, supporting self-care, delivering care closer to people’s homes, eliminating waste and duplication, and reducing the reliance on hospitals and long-term care institutions.

Of particular concern in this movement for change is the rapid rise of those with complex long-term care needs which tend to be more common among the rapidly growing older populations in Northern and Western Europe. The complexity of needs arising from multiple chronic conditions - combined with the physical, developmental and cognitive disabilities associated with old age – need the development of more integrated delivery systems that bring together professionals and skills from both the cure and care sectors.

There is evidence, too, that people living in the more disadvantaged communities within Europe’s major cities are developing complex long-term health problems (particularly mental health care problems) much earlier in life than was previously recognised. Developing systems of integrated care to manage the burden of the chronic care patient must, then, recognise that the pathology of multi-morbidity starts in childhood and is conditioned by the socio-economic determinants of ill-health such as lower incomes, poorer housing, reduced educational attainment, social isolation, and higher levels of smoking and alcohol consumption. Any integrated care strategy that seeks to co-ordinate care better around people’s needs must also combine with it a focus on primary prevention.

Meeting the challenge: approaches that work
The good news behind the challenges presented above is that there is enough evidence and examples of practical innovation from across Europe that demonstrate it is possible to improve care experiences and outcomes for people without adding to costs. However, what is clear is that the process of change is very complex and that there is no ‘single model’ that can be applied in different contexts. Indeed, multiple strategies are needed, and these need to be applied simultaneously:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Key attributes ...</th>
<th>Problems if overlooked ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-based planning</td>
<td>Community awareness, participation and trust; population health planning; identification of people in need of care – inclusion criteria</td>
<td>Lack of understanding of local priorities and awareness of care needs leads to poorly targeted and/or late/missed opportunities to support interventions</td>
</tr>
<tr>
<td>Health promotion and self-care</td>
<td>Bio-psycho-social and life-course approach, focused on supporting people to live healthier lives</td>
<td>Inability to support and/or engage people to live healthier and more fulfilling lives fails to have any meaningful impact on the rising demand for institutional care</td>
</tr>
<tr>
<td>Care process</td>
<td>Single point of access with holistic care assessment and care planning driven by needs and choices of service user/carer. Active care co-ordination</td>
<td>Failure to plan and co-ordinate services with and around people’s needs leads to fragmentations in care and sub-optimal outcomes</td>
</tr>
<tr>
<td>Wider Network of Providers</td>
<td>Responsive provider network 24/7; key focus on care transitions (e.g. hospital to home); strong communication between care professionals and users.</td>
<td>Inability of wider provider networks to respond to real-time needs of people means co-ordination efforts undermined and under-valued</td>
</tr>
<tr>
<td>Monitoring and Quality Improvement</td>
<td>Access to shared care records; commitment to measuring and responding to people’s experiences and outcomes; continuous quality improvement process</td>
<td>Inability to judge or benchmark impact and lack of evidence leads to loss of funding and professional trust, inability to influence professional behaviour, and limits ability to improve and adapt</td>
</tr>
</tbody>
</table>

Due to the complexity and context-specific nature of integrated care, the transfer of innovation from one community or country to another is problematic. Whilst the change management process for integrated care is not well advanced, key lessons for successful adoption include:

- Focusing on changing behaviours and cultures – integrated care is as much sociological as technical
- Having a common vision and narrative with shared aims is necessary, and this takes strong and respected leadership plus the time and energy to put in place;
- Finances and governance must be aligned to desired outcomes – removing disincentives is often more effective than adding new incentives or freedoms onto existing systems;
- Care delivery systems must be restructured (e.g. less hospital, more primary care);
- Integrated care requires a commitment to continuous quality improvement since there will always be unintended consequences, hence the importance of measuring outcomes and investing in research
- Policy makers can provide the platform to enable and encourage integrated care to happen, but they cannot successfully mandate for change
The policy response: national and regional strategies in Europe

In recent years, many national governments across Europe have accepted the narrative in favour of integrated care and have introduced policies or pledges to support it. These have focused on three main strategies: structural reform, economic incentives (linked to outcomes), and legislative change. Recent examples include:

- Specific agencies in France (ARS) designed to help unite health and social care provision and better support the development of integrated care pathways
- Coordination Reform in Norway and Denmark
- Joint agencies and/or associations to link funding and delivery of care across primary, community, hospital and social care in Sweden (e.g. Jönköping and Nortaljie, Stockholm)
- The National Collaborative for Integrated Care and Support in England
- Versorgungsstrukturgesetz (care structure law) in Germany to support interdisciplinary and cross-sector models of care
- Managed care organizations and bundled payments for disease management in Netherlands
- Health and social care integration in Northern Ireland and Scotland
- Vertically and horizontally integrated care organizations to support better chronic care in many parts of Spain linked to funding reform (e.g. Basque Country, Catalonia, Valencia)
- Physician networks and HMOs in Switzerland

A key tendency of these approaches has been to centralise the administration and funding for integrated care, and/or to create specific pilot or demonstration projects, yet it can be seen through research that such approaches have not had a significant impact in enabling change at the scale and pace required to meet future needs. This is because achieving integrated care cannot be successful if it is only mandated from above since the levers for change are limited. Successful strategies need to be driven from the bottom-up, a process that requires significant effort and investment.

At a pan-European level, through the Health 2020 initiative (a European policy framework supporting action across government and society), the European Innovation Partnership on Active and Healthy Ageing B3 Action Group on Integrate Care has been established to share knowledge and promote action on integrated care adoption from committed organisations and regions across the EU. Within this, there is recognition that a focus on improving health has both a strong social and economic case, and that approaches to integrated care need to more quickly demonstrate such impact.

The Future

Caring for the growing numbers of (older) people living with complex and long-term care needs will be the primary ‘business’ of European health and care systems in the coming decade. Attempting to recalibrate the way care is provided to meet such challenges will take time, but the burning platform created by the economic crisis and combined with the changing demographics of disease has created a compelling case for change. The solution requires the ability to develop both a cultural and operational willingness for collaboration at a clinical and service level (with the investment to match to develop the necessary capacity and capability). More needs to be done to engage patients and carers in becoming ‘fully engaged’ as co-producers of their own care, and the workforce needs to adapt to embrace multi-professional working.

Nick Goodwin, June 2013