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INTEGRATED CARE – INTERNATIONAL PERSPECTIVE. IMPLICATIONS FOR POLAND

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Abstract:-
In the course of the almost past 30 years, some health care reforms took place in Poland, which mainly applied to the changes in financing policies among others changes in the sources of health care financing also in the way of particular services financing. Recently, more concerns with integration and continuity of care can be noticed. This is why, the purpose of this article is to recognize the concept and scope of integrated care and implemented models. Also to find out what kind of conceptions should be met in purpose to implement more integration in health care system in Poland? So, to find out what kind of implications can arised for Poland from international perspective.

Keywords: - *Integrated care; health care financing system;*

1. INTRODUCTION

Integrated care, both as a concept and in practice, has received increasing attention from not only researchers but also policy-makers and health professionals during the last decades. It has become so relevant because of demographic, epidemiological and cultural changes, which have caused the pressure to increase efficiency and efficacy of services and organizations within the health care sector, not least in European countries. In fact, the health care systems - not only in Europe - are under pressure from workforce shortages, increasing costs and an aging population with a high prevalence of chronic disease. So, the demand for change and reforms are seemingly similar across nations (Gröne, Barbero 2001). Improving health care services in relation to access, efficiency, quality at a lower cost while maintaining or improving the user health and satisfaction are observed and overarching objectives of most sectoral reforms in many countries.

The driving forces for the reform process are recognized to be similar in many countries. One of the main reform-pressure is the aging of the population due to the changing pattern of morbidity. Aging population who are living longer with long-term conditions cause the rising costs of paying for that care, particularly in the current economic climate (Lewis et al 2010). And chronic diseases such as ischaemic heart disease, cerebrovascular disease, mental illness, diabetes mellitus and cancer are large contributors to the burden of disease (Murray, Lopez 1996)

As a consequence of it, healthcare systems worldwide face the twin challenges of rising demand and raising costs of these healthcare. The burden of aging populations diseases reflect in the growing complexity of healthcare and health needs, what also create the financial challenge (Lewis et al 2010). As the proportion of older people in the population is also growing, it further increasing the number of those with chronic health problems because of accumulated exposure to chronic disease risk factors over their lifetime. It means that people with chronic health problems - especially when they have multiple problems - are more likely to demand and utilize healthcare (Gröne, Barbero 2001).

The increasing burden of chronic diseases has been also recognized by the WHO (2002) as one of the greatest challenges that will face health systems globally in the twenty first century. The World Health Organization (2002) defined chronic conditions as requiring "ongoing management over a period of years or decades". They cover a wide range of health problems that go beyond the conventional definition of chronic illness, such as heart disease, diabetes and asthma, also include some communicable diseases, such as the human immunodeficiency virus and the acquired immunodeficiency syndrome (HIV/AIDS., some mental disorders such as depression and schizophrenia, to defined disabilities and impairments not defined as diseases, such as blindness and musculoskeletal disorders, and to cancer. „Greater longevity, "modernization" of lifestyles, with increasing exposure to many chronic disease risk factors, and the growing ability to intervene to keep people alive who previously would have died have combined to change the burden of diseases confronting health systems" (Nolte, McKee 2008).

Thus the chronic conditions require much more complex forms of treatment than can currently be provided in acute hospitals alone. Moreover, in purpose to achieve also the cost effective treatment of chronic conditions, health care institutions will also need to engage more in providing all types of prevention - primary, secondary and tertiary (Gröne, Barbero 2001).

Generally, demographic transition also influences the demand for change in the healthcare sector. Some underline, that expansion of life expectancy may translate into expansion of morbidity, but others point out that more healthy lifestyles, more effective care, innovative medical technologies and genetic research may allow the compression of morbidity. Even it is difficult to extrapolate the scale of demand, the scope of demand is likely to be characterized by the presentation of multiple disorders with functional, psychological and social dimensions.
And the third major demand-side factor questioning the current organization of care is the individual expectations of patients. It is underline in the literature that patients are demanding better services as they have been becoming better informed through the Internet and other sources, and are more confident and emancipated, acknowledging their rights (WHO 1996).

These factors on the demand-side require a reform of the health system and thus force the integration of services while supply-side factors, such as medical technology and information systems - can facilitate the integration of services (WHO 2016).

Finally, current healthcare system have been moving by economic socio-demographic and cultural forces „beyond the largely reactive acute care paradigm to a more holistic paradigm emphasizing optimization of the population's health". The movement away from episodic treatment of acute illness events to the provision of a coordinated continuum of services is the clue of this shift and it would be a chance to support those with chronic conditions and enhance the health status of defined populations (Martin Strandberg-Larsen, 2009).

Thus it is prompting a fundamental rethink of how healthcare should be organized in future especially that current incentives and structures were designed for an era of plenty when increasing activity to reduce waiting times was the priority (Lewis et al 2010). Yet healthcare is still largely built around an acute, episodic model of care that is ill-equipped to meet the requirements of those with chronic health problems. In the face of the specificity of chronic diseases and changing scope of demand because of demographic transformation as well as higher expectations of patients, a need arises

for better coordination between different providers and across the boundaries of care. Moreover, as healthcare becomes ever more complex - with increasing specialization and new options for treatment, diagnosis and care – also the need for more coordination for patients within healthcare and between health and social care has grown (Lewis et al 2010).

Yet although better coordination of care delivery has a logical appeal, still poor coordination is a problem in many developed health systems. The characteristics of poor coordination are easily recognizable as there are many fragmented services which duplicate or, worse, omit important parts of the care process, with poor communication between care teams and patients, and significant avoidable costs to funders and to patient (Lewis et al 2010). Fragmentation means the breakdown in communication and collaboration in providing services to an individual which results in 'deficiencies in timeliness, quality, safety, efficiency and patient-centredness' (Wagner 2009). Fragmentation is often the result of organizations, professionals and services operating independently of each other, with adverse consequences for service users (Curry, Ham 2010).

Thus integrated care is attracting considerable attention as an important framework to develop better and more cost-effective health systems. And as a result of it, integrated care is increasingly present - as the way to these goals achievement - in the agenda of policy-makers, health professionals and researchers (Santana, Szczygiel, and Redondo 2014).

Many advocates of integration see it as a potential solution to fragmentation, which causes that the suboptimal health care is not provided, moreover at higher costs due to duplication, waste and avoidable ill health. Tackling this problem has long been a goal of governments across many countries and recently this has been made more acute by straitened economic circumstances (Lewis et al 2010). Thus integrated care has been also promoted by the World Health Organization, which treats it often as contra posed to fragmented and episodic care, and it is used synonymously to terms like coordinated care and seamless care, among others.

In Poland, in the course of the almost past 30 years, some health care reforms took place, however mainly applied to the changes in financing policies among others changes in the sources of health care financing also in the way of particular services financing. Recently, more concerns with integration and continuity of care as well as some undertaken initiatives aiming at creating conditions for increasing integration of care in Poland can be noticed. This is why, the purpose of this paper is to recognize the concept of integrated care, also possible solutions and models as well as the conditions conductive to introduction of integrated care and thus to define the possible implications for Poland.

2. The concept and scope of integrated care.

Integrated care has become an international health care buzzword, however because of 'the polymorphous nature of integrated care itself', there is no unifying definition or common conceptual understanding of integrated care. There are also many competing definitions of integrated care. In fact, integrated care is a kind of a multifaceted concept (WHO 2016).

According to Øvretveit (1998) integrated care has been defined as the methods and type of organization that will provide the most cost-effective preventative and caring services to those with the greatest health needs and that will ensure continuity of care and coordination between different services. Generally, integration is defined "the act of making a whole out of parts; the co-ordination of different activities to ensure harmonious functioning" (Webster's Revised Unabridged Dictionary 1998), implying a higher level of system-quality that extends the sum of its parts. As Leutz (1999) wrote, integration is the search to connect the healthcare system (acute, primary medical and skilled) with other human service systems (e.g., long-term care, education and vocational and housing services) to improve outcomes (clinical, satisfaction and efficiency). Therefore, integrated care could be defined as „*the concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion…[as] a means to improve the services in relation to access, quality, user satisfaction and efficiency* (Gröne, Barbero 2001).

Whereas, Kodner and Spreeuwenberg (2002) suggest that: „Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors". Usage of these methods and models should enhance quality of care, which in turn improve the quality of life. Moreover, their goal should be also to enhance the consumer satisfaction and system efficiency for the patients with complex, long term problems by cutting across multiple services, providers and settings. All these multipronged efforts, undertaken in purpose to promote integration for the benefit of these special patient groups is called 'integrated care'. Thus integrated care is connected with the processes of bringing organizations and professionals together in purpose to improving outcomes for patients and service users through the delivery of integrated care.

In the literature, it can be found that integrated care may also be treated as „a synonymous of coordination of care across diverse professionals, services, organizations and health sectors intervening in the diagnosis, treatment, care, rehabilitation and promotion of health, it is believed to improve the services in relation to access, quality, user satisfaction and efficiency". There are some evidence that seems to confirm at least in part such expectations (Santana, Szczygiel, Redondo 2014). Also it should be noticed, that integrated care is separate term than economic imperatives, such as mergers and acquisitions.

Generally within the literature, two distinct conceptual subcategories can be identified, which refer to integrated healthcare delivery as being either as an organizational structure (unites with all kind of providers starting from physicians, hospitals, home care through long-term care and pharmacies) that primarily follows economic imperatives or a way of organizing care delivery- by coordinating different activities to ensure harmonious functioning and - beneficial for patients - clinical outcome. In both cases, the provider is not a single facility such as general practice or hospital but a network of providers (StrandbergLarsen, Krasnik, 2009)

According the WHO documents (2016), three principal definitions can be distinguished from the literature. The first definition is used by many national governments in order to understand the different components of integrated care and it is called „process-based definition". It says, that *"Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings. Where the* result of such multi-pronged efforts to promote integration leads to benefits for people, the outcome can be called integrated care" (Kodner 2002).

This definition underlines the complex and intersectional nature of integrated care but also it has the advantage of treating the integration as the process but only bounded within the scope of health care and understood it as the outcome experienced by service users. The weakness is that it does not show integration as something that has a specific meaning or value to the end user.

The second definition supports purpose for integrated care strategies at all levels of the system. Currently it is employed by the Government of England. The definition is determined by people themselves generally by a patient representative group and it underline the importance of individual and population needs not the the importance of process by which it is derived. It states that "My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes" (WHO 2016).

The third definition is proposed by WHO Regional Office for Europe and it is a health system-based definition, which means that it adopts a health system perspective. "Integrated health services delivery is defined as an approach to strengthen people-centered health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectional and multisectoral actions" (WHO 2016a). This definition and uses the term 'integrated health services delivery (IHSD)', confirm that integrated care is achieved not only through the alignment of all health system functions and effective change management.

Based on all three of these definitions it can be concluded that integrated care should be centered on the needs of individuals, their families and communities (Shaw, Rosen, and Rumbold 2011). All of them converge around highlighting the central role of population and individual needs. Thus adopting a health system perspective, the use of the term 'integrated health service delivery' is seen as more reflective of the notion [WHO 2016]. Whatever the degree of integration, it is pointed that „the primary purpose of integrated care should be to improve the quality of patient care and patient experience and increase the cost-effectiveness of care" (Lewis et al, 2010).

3. Types of integrated care models

Given the different definitions of integration set out above but mainly the widest of this concept, it cannot surprise that in practice many different models have been recognized. Integrated care models range from fully integrated organizations as providers or commissioner–provider organizations) to 'virtually integrated' provider or commissioner– provider networks, where close collaboration and coordination of care occurs between participatory teams and organizations (Lewis et al 2010).

One of the main typology of integrated care models was proposed by Flop and others (2005) builds on an existing body of work and identifies the key requirements for effective integration. Further, this typology was also deeply explained by Lewis et al (2010). They distinguish four types of integration. The first one - organizational integration - means the way how the organization is formally structured and it can be described by bringing together several organizations through coordinated provider networks and mergers or virtually through contracts between separate entities. The second is the functional integration expresses how non-clinical support and back-office functions integrated are. For example, shared electronic patient records. The next is the service integration, which refers to integration of different clinical services at an organizational level by, for example, establishing multidisciplinary teams. It means, how the clinical services are offered by the organization integrated with each other. The fourth is the clinical integration, which means integration of care at the clinical team level, whether care for patients integrated in a single process both intra and interprofessionally through, by means of, among others, using shared guidelines and protocols.

Each of these integration types can be further characterized by the mechanism of integration. When integration is based on shared values in co-ordinating work and securing collaboration in the delivery of healthcare that is seen as normative integration, while integration characterized by the coherence of rules and policies at various levels of the organization is called systemic integration (Fulop et al 2005).

Taking into account the functional aspect of integration it can take placed on the clinical, information, financial and administrative levels (Kodner, 2002). Then, based on the structural form, the integration can be either vertical or horizontal (Curry, Ham 2010). Vertical integration occurs when two or more organizations or services delivering care at different levels of the hierarchical structure come together under one management umbrella, as for example tertiary care providers working with secondary care providers. Horizontal integration occurs when two or more organizations or services delivering care at a similar level come together for example mergers of acute hospitals.

Moreover, both horizontal and vertical integration may be real or virtual (Curry, Ham 2010). The first one entails mergers between organizations, whereas virtual integration takes the form of alliances, partnerships and networks created by a number of organizations. Virtual integration is often underpinned by contracts or service agreements between organizations, and this is why it can be seen as a form of contractual integration rather than organizational integration.

Integration can be also reviewed at three levels at which integration can be pursued and which in practice are often used in combination. The first one is the macro level is one at which providers, either together or with commissioners, seek to deliver integrated care to the populations that they serve. (Curry, Ham, 2010). Integration at the macro-level can be described as provision of integrated care to an entire population through stratification of needs and tailoring services according to these needs.

Integration at the meso-level aims to provide integrated care for a particular care group or populations with the same disease or clinical conditions by providers either together or with commissioners. It is made by the care pathways redesignation and other approaches. The third level is micro one, which means that integrated care is delivered for for individual service users and their carers through care co-ordination, care planning, use of technology and other approaches by providers, either together or with commissioners. Integration at the micro-level aims to achieve a seamless care experience for the individual, made possible, for example, through personalized care plans. (Curry, Ham 2010).

Similar to this - depending on the scope of the integration process or breadth of integration, integrated care can range from care integration for particular individuals, care integration for specific diseases or population groups, and care integration for entire population (Nolte, McKee 2008).

The integrated care can be also distinguish as the time-span that integration places focus which depends on the type of orientation. It can be oriented towards a specific episode of care, such as hospitalization and follow-up for acute surgical condition, or it can be provided adopting a life-course approach in case of chronic conditions (WHO 2016).

Moreover as integrated care can take place at various levels and settings within the health sector, thus it can be categorized according to its intensity: full integration involves process of integrating health and social sectors into a new organizational model, while partial integration creates non-binding linkages or ties that support integration between two sectors in order to improve coordination between them (Nolte, McKee, 2008).

As a result of such diversification, a wealth of implemented and evaluated integrated care models can be recoginzed in practice. According to WHO' proposition of classification - they ange from individual and disease-specific models to models that embrace entire populations. And they differ to the scale at which integration happens. This kind of classification of is a kind of attempt made by WHO to capture components and processes involved in model's design and implementation (WHO 2016).

The first group - individual integrated care models - is concerned with individual coordination of care for high-risk patients and/or with multiple conditions and their careers. The medical conditions of these group of patients require more coordinated care, which extends beyond one episode of care and thus the better coordination in providing care by different providers is required. But also embraces the concept of integration across the life course (Bodenheimer, 2008). This group of models include the following models: a) case management, b) individual care planning, c) patient-centered medical home d) and personal health budgets. The principle of case-management model is to ensure coordination of a patient's care through the assignment of a case manager. Then individual care plans are a point of reference for any provider involved in an individual's care. In case of personal health budgets, it is assumed that the coordination of care can be best performed by patients themselves and patients can better coordinate their care according to their needs by purchasing services across providers using given budgets. They have some autonomy. The fourth model is based on the holistic approach to care and was developed and promoted in USA as a model for transforming the organization and delivery of primary care. It offers alternative individual model of primary care where patients are assigned to particular medical homes and physicians (WHO 2016).

The second group of models covers the disease specific models. It is called group- and disease-specific models and they include a) chronic care model, b) integrated care models for elderly and frail c) disease management programmes. These models are designed to meet the needs of patients from specific groups as following with chronic illness, the elderly and frail and people with certain diseases and long-term conditions. And thus the chronic care model is the most well-known and widely applied integrated care models. It was developed as the response to failures of health care system to meet the needs of people with chronic illnesses. It provides a comprehensive framework for the organization of health services in order to improve outcomes for people with chronic conditions. Then integrated care models for elderly and frail and this group is distinguished due to the high specificity of service individual needs that guide the design of care models and the extent to which care requires integration between health and social services. The last one - disease-specific integrated care models developed by some countries in the purpose of provide better integration of care for people with certain diseases and long-term conditions such as diabetes mellitus, cardiovascular diseases, COPD and bronchial asthma. (WHO 2016)

The third main group of model is the population-based models which are wider population models will, as a rule, include elements of more narrowly targeted models. For example, the population-based Kaiser Permanente (KP) model in USA described as an example here includes elements of disease management for all chronic patients and case management for high-risk patients. This model is a virtually integrated system consisting of three interrelated entities: a non-profit health plan that bears insurance risks (Kaiser Foundation Health Plan), self-governed for-profit medical groups of physicians (Permanente Medical Groups), and a non-profit hospital system (Kaiser Foundation Hospitals). And it is is based on stratification of the population and supply of different type of services according to needs among others promotion and prevention services with the aim to control exposure to risk factors. The core components to the KP model put emphasis on prevention, self management support, disease management and case management for members with multiple conditions.

Apart from KP, this group of model include also The Veterans Health Administration (VA) that provides integrated services to older people with chronic conditions in the USA and Basque integrated care strategy which was developed with acknowledgment of the interdependencies between primary care, social services and hospitals to achieve better outcomes among patients with chronic conditions (WHO 2016).
These various classifications of the 'methods and models' that contribute to integrated care have shown that the term has been variously differentiated by type, breadth, degree and process. Although all strategies have in common the aim to improve coordination and integration of services, their scope is quite different. The multidimensional nature of integration points to the complexity in building integrated care models, as well as to the multiplicity of possibilities in their design.

4. Implications for Poland

Based on these presented different integrated model developed in practice and with different level of integrityty, World Health Organization has demonstrated that integrated care models have developed as an imperative to respond to the increasing chronicity and comorbidity in population. The main intention for developing these models was the improvement of care for patients with chronic conditions, multimorbidities, and patients from specific groups such as the elderly and frail. It made them perhaps the most natural entry point for introducing and piloting integrated care models (WHO 2016).

Thus, in developing any integrated care strategy, the identification of population needs should be a starting point. Then, a clear articulation of the population's needs in local communities should be the base for development of a common vision and then shared strategy for change. In practice it is important to recognize and understand the extent to which systems should seek to develop new organizational solutions (Leutz 1999).

The primary purpose of integrated care should be to improve the quality of patient care and patient experience and increase the cost-effectiveness of care, which implies focusing on the clinical needs of patietns. However, as McAdam (2008) found that at least half of integrated health care organizations in the USA and Canada were not providing better coordinated care to clients because were integrated only through acquiring new service lines or merging their operations. It means that a organizational and functional integration did neither guarantee clinical integration at provider level, nor was sufficient to achieve it. This is why, WHO (2016) underlines that in order to sustain transformations over time, integrated care models require actions that span from organizational, functional, professional and service delivery levels up to transformations on system level.

That also implies, that integrated care models should be introduced and implemented by means of a change management strategy. It is clear that even these first steps for integrated care require careful planning and that the process of change needs strong leadership and good management support. integrated care does not apply to business redesign processes that have been used elsewhere in health reform, so change management strategies need to recognize the key issue of its' multifaceted nature.

The multidimensional nature of the integration processes points to the sophistication of building integrated care models, as well as to the multiplicity of possibilities in their design (WHO 2016). Besides, it can be observed in practice, that

integrated care may be achieved through a variety of arrangements, for example, multi-professional integrated care teams working to shared goals but employed by different organizations, networks of provider organizations operating under a single integrated budget, or single organizations consisting of merged providers. Even, driving forces for the reform process are similar in many countries, though strategies to achieve better integration differ. On the other hand, also the diversity of European healthcare systems means that there is unlikely to be a universal solution to the challenges posed by chronic disease. What may be possible in one healthcare system may be impossible, at least in the short term, in another ostensibly similar system if the two differ in critical aspects. Each system must find its own solution, although it can also draw on the lessons learned by others **(**Nolte, McKee 2008).

However, the effectiveness of these different arrangements in delivering truly integrated care for patients depends upon the extent to which: both financial and non-financial incentives and governance arrangements under which they operate are aligned to support shared goals and effective collaboration. Then whether there is effective leadership within the organisation or network and there are linked or integrated information systems allowing the quality, use and costs of care to be identified per patient and by clinicians and their teams (Lewis et al 2010).

Such needs as more integrated care have been recogized in Poland as well. Some pilots have been undetaken. The pilots will serve as an element of wider, primary health care reform. A key objective of the pilots is to create a robust, patient-centric health care system at the local level - one with better prevention programs and effective IT solutions that is integrated with health care solutions (World Bank 2018). As it was in the case of other countires, the needs of chronically ill population became the starting point of all activity and in case of Poland of idea of the first pilot model. From the analysis of the concept as well as models it implies that every country because of health care system specifics should follow its own way.

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