



Integrating health and social care from an international perspective

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The International Longevity Centre - UK (ILC-UK) is an independent, non-partisan think-tank dedicated to addressing issues of longevity, ageing and population change. It develops ideas, undertakes research and creates a forum for debate.

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Summary

This report has been prepared by ILC-UK, drawing on the ideas, issues and challenges of integrating care raised at the Conference on Integrated Care for Frail Older People, 29th September 2011 organised by ILC-Netherlands in cooperation with the Leyden Academy, the Dutch Medical Research Council, Vilans (a Centre of Expertise for Long-term Care) and the International Longevity Centre Global Alliance. It is also informed by evidence from member countries of the ILC Global Alliance and general research into this policy area.

This report links to previous research conducted by ILC-UK on integrating health and social care (Lloyd and Wait, 2006). It highlights that while financial, cultural and logistical barriers exist, countries should continue to work towards integrating health and social care services given its possibilities for cost-efficiency, freeing up acute healthcare facilities and benefits for the patients.

This report covers:

- the need for integrated care;
- the current global context of care;
- the benefits and challenges of integrating health and social care services;
- priorities for action in advancing the issue of integrated care worldwide.

About the ILC Global Alliance

The ILC Global Alliance is an international consortium of member organisations.

The mission of the ILC Global Alliance is to help societies to address longevity and population ageing in positive and productive ways, typically using a life course approach, highlighting older people's contribution to family and society as a whole.

The Alliance member organisations carry out this mission through developing ideas, undertaking research and creating forums for debate and action, in which older people are key stakeholders. The centres work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact on nations around the world.

The priorities of the ILCs are:

- 1) To identify productive ageing as an important topic, not just paid employment, but also the continuing talent and contributions of older people; and
- 2) To promote educational, research and policy initiatives which will advance an active, healthy life throughout the lifecourse.

Current ILCs

- United States of America
- Japan
- United Kingdom
- France
- Dominican Republic
- India
- South Africa
- Argentina
- The Netherlands
- Israel
- Singapore
- Czech Republic
- China (from Sept 2011)
- Brazil (from Sept 2011)

The global care context

By 2050, the number of people aged 60 and over will reach 2 billion; comprising 22% of the world's population (UN Population Division, 2002). All member countries of the ILC Global Alliance are currently experiencing an ageing population, as are many countries across the world. It is a common misunderstanding that ageing populations are restricted to countries with low birth rates, high incomes and effective geriatric health care. Indeed, some of the most rapid increases in numbers of older people are anticipated in countries with developing economies (UN General Assembly, 2010).

For many nations, it is the oldest old group that is growing fastest, a group that is more likely to suffer from a lack of functionality and conditions such as frailty. In many countries, this increase at the older end of the population is coupled with a general decrease in birth rate, meaning a respective drop in dependency ratios. These represent the number of active working people relative to those not working. For example, in Japan in 2010 there were estimated to be 2.63 economically active to inactive people, and by 2050 this is scheduled to fall to just 1.24 people working for every person not working (Andrews, 2011). In light of this change in dependency ratios, supporting frail older people will be a global challenge, increasing the pressure on existing services to work more efficiently with funds as well as resources such as bed spaces.

Frailty

Older people are more likely to have multiple health problems and conditions, leading to a loss of independence and becoming frail. Providing adequate care for those among the ageing population who are frail is a key issue worldwide. Various definitions of frailty have been suggested, with some general features proposed such as simply including a “slow gait speed” (Rockwood, 2005). A clear clinical phenotype (the physical characteristics) of frailty is yet to be agreed upon, as some commentators feel that there is insufficient evidence for a single definition of frailty (ibid). Fried et al (2001) proposed clinically defining frailty in individuals who present three or more of the following characteristics; unintentional weight loss; exhaustion; weakness; slow walking speed and low physical activity. It increases the chances of falls, admission to a hospital or care home as well as mortality risk (ibid). For the purposes of this report we take frailty as:

a biologic syndrome of decreased reserve and resistance to stressors, resulting from cumulative declines across multiple physiologic systems, and causing vulnerability to adverse outcomes.

(Fried et al, 2001)

This definition is one which is commonly agreed by geriatricians (ibid). While becoming frail is not an inevitable part of getting older, the rapid increase in the oldest old will increase the numbers of people suffering from frailty.

Caring for frail older people carries a set of distinctive challenges. Many frail older people will suffer from multiple chronic diseases in addition to co-morbidities and as such may require access to multiple strands of health and social care. Communication between these groups of professionals is often poor or non-existent. Increases in the levels of specialisation for medical professionals can mean that care is fragmented and patients are not treated holistically. In addition, with multiple areas of health and social care interacting on one patient, duplication of

care provision or unnecessary repetition, for example in running tests, can also occur. This report argues that while frailty in older age is not unique in that it requires input from a variety of health and social care professions, it is an excellent example of how integrating these services would be beneficial for older frail people.

As people grow older, their risk of developing dementia also increases. Recent reports set global dementia figures at 35.6 million people suffering from different forms of the disease. This number is set to double every 20 years, rising to 65.7million in 2030 and 115.4 million in 2050. (Alzheimer's Disease International, 2009). The impact of these rising numbers of individuals with dementia will be felt worldwide, but particularly in low to middle income countries who will invariably struggle in their response as traditionally their primary focus has been on prevention of communicable diseases and infant and child mortality. In contrast to other chronic diseases associated with age, dementia is among the most disabling, with people suffering from dementia in need of specific care at an extremely high intensity. The role dementia plays in contributing to frailty and increasing need for long term care support must not be overlooked in discussions of integrating health and social care services.

The case for integrated care

What is integrated care?

Integration of care is seen as a potential mechanism for ensuring joined up service responses to the needs and aspirations of older people, and safeguarding the quality of care received by this often vulnerable group. Integrated care takes a comprehensive approach to the issue of older people having 'complex and interacting needs, and they often require treatment and care from a range of professionals and carers, services and agencies at the same time' (Reed et al, 2005). The term 'integrated care' describes a variety of approaches to these issues, for example some schemes have used care coordinators; and others joint meetings with professionals from different aspects of health and social care to manage care pathways for patients.

The potential benefits of integrated care has been advanced at many levels, from small, local organisations to national-level policy promoting a more comprehensive service provision across health and social care. In the UK we have seen the growth of a patient-focused culture at the national level. At a local-level, success has been found in Torbay, in South West England, where keeping service-users at the centre of the development process has been achieved with dedicated health and social care coordinators, shared budgets and records. Integrating services in Torbay has reportedly led to more effective working not only with existing systems but also aided the growth of services available (Thistlewaite, 2011). Elsewhere, multi-level policies have also been successful, for example in Denmark where a national principle of universal (tax-funded) health and welfare services has been coupled with a decentralisation of decision-making and financing of care.

Benefits of integrating health and social care services

There are a number of potential benefits for the recipients of and the wider field of actors involved in integrated care.

Benefits for service users:

- Reduction in the complexity of accessing health and social care
- Enhance the provision of the services that they require

(Reed et al, 2005)

In addition, using a holistic model of care for patients can improve their quality of life in addition to their physiological health. Given the complexity of the various health issues and frequently changing care needs of this group, care pathways should be flexible and responsive. Integrating care can also help to alleviate some of the burden placed on families and communities in filling in the gaps between fragmented services. Communities often have not had a voice in shaping service provision, despite their crucial role in providing support and informal care.

Benefits for service providers:

- Cost-effectiveness
- Reduction in length of hospital stay
- Reduction in inappropriate hospitalisation
- Decrease in admission to long term care

(Reed et al, 2005)

From the perspective of the service provider, and at a policy level, the cost-effectiveness of integrated care is extremely beneficial. Previous research has found that integrated care using a case manager can reduce patient visits to emergency departments; hospital admissions and bed days (Bird et al, 2007). In addition, it can reduce the amount of time spent in residential care and people with case managers have been found to need fewer GP visits (Bernabei et al, 1998). The common alternative to home-based care is a care or nursing home or hospital; expensive options compared to community care provision. In addition to the higher cost of caring for someone in a clinical environment, unnecessary hospital admissions lead to a stress on capacity for acute care beds (for example in the Dominican Republic up to 35% of acute care beds are taken up with older people); patients are at an unnecessary risk of infection while in hospital; and may not receive adequate levels of pastoral care. The potential for integrated care to free space by preventing sustained stays in hospitals and residential care homes in addition to the cost savings implied by reducing unnecessary clinical care is a significant benefit of this approach.

Challenges to be addressed

Despite some successful schemes, in all member countries of the ILC Global Alliance, there is a lack of integration in national health and social care services. There are a variety of causes and issues impeding the success of integrated care models for the respective health and social care systems in place. During the Conference on Integrated Care for Frail Older People debate on this topic it was pointed out that lower income countries may have excellent levels of integration for their care, for example if all care comes from the family. In a global context, it is important to appreciate potential limitations of the different systems of care in varying countries. While each country will have distinctive issues, there are themes in the challenges facing integrated care around the world.

Finance

A lack of financial provision for individuals in need of care in later life is a prime stumbling block for many discussions related to care around the world. There is often an intersection between different sectors in health and social care funding, and there are different systems to be navigated in every country. Where public funding exists for elements of health and social care, some countries may not have made allowance for the care of frail older people as they have for other, more pressing priorities. In countries with rapidly ageing populations the sheer demand for funds and resources for frail older people may leave provision scarce. Families and communities are often vital in providing financial support, although many may not see caring for frail older people as a financial priority. Whether financial responsibility lies with the individual, their family or the state, there may be a reluctance for limited funds to be spent on what may be perceived as additional elements of caring, particularly if the current standard of care is seen as inadequate.

Practical issues

The intrinsic complexity of achieving partnership between a wide variety of parties has been a major challenge to successful care integration. There are administrative, financial and historical barriers to be navigated when different organisations need to work together. Policy on integration should be aligned at both a national and a local level. The majority of models of integrated care use modifications to existing systems rather than brand new approaches, meaning that while cost savings are protected by minimising change, previous barriers will remain. A modified care integration process necessitates that professionals actively work across the boundaries of their own profession to reduce both the fragmentation and duplication of care (Wu et al, 2010). An alternative to a team of professionals and relevant parties brought together is that of the 'case manager' role. At the Conference on Integrated Care for Frail Older People the limitations of this approach were discussed, both in the cost of providing the personnel as well as the autonomy and independence case managers have in dealing with other representatives within health and social care services.

Cultural barriers

Even with financial and practical structures in place, a culture of support for the care of frail older people is vital for the success of improving provision through integration. Even within the member countries of the ILC Global Alliance there are contrasts in the priority respective

communities attach to caring for the older generation. Even where adequate funding exists, this must be prioritised and allocated appropriately; some conference delegates suggested that sometimes older people's voices are not heard, and the younger generation is prioritised.

An issue raised at the Conference on Integrated Care for Frail Older people was a lack of responsibility felt by societies and individuals in regard to care provision for older people. In some higher income countries with state provision for some health and social care services there is a perceived culture of dependency on the delivery of this support. This has led to a situation where service users may take provision for granted and do not actively seek to improve the standard of care they receive. This is coupled with the view with some healthcare professions that a patient should be compliant rather than proactive (Kodner and Spreeuwenberg, 2002). A consumer culture in health and care may go some way to promoting the benefits of integration from the patients' perspective. There is a need for increased responsibility to be taken at all levels to improve the quality of care that older people receive, and to be responsive to the needs and desires of the patients.

Conclusions

The International Longevity Centre –UK has developed specific focuses for action based on the conclusions and suggested priorities during the final part of the conference on Integrated Care for Older Frail People. The following are drawn from participants' contributions and points arising from the presentations.

We hope all the ILCs will help to advance the integration of health and social care through increased advocacy at the regional, national and international level on this issue.

Integration should take place on all levels

Integration should occur on multiple levels through primary and secondary healthcare and all facets of social care, to ensure success and also avoid barriers between systems; initiatives should take place at a national and local level.

Integration should include all players, but be patient-focussed

There are many different informal and formal actors in health and social care, all of whom have a role to play in promoting integration. Discussions should include participants from all health and social care pathways from professionals to families, but should remain fundamentally rooted in the needs and desires of the patient.

Cost-effectiveness should be communicated clearly

Finance will always be a key issue in discussions of care for an ageing population, and critically models of integrated care have been found to be more cost-effective than alternative systems. These savings include reduced demand for resources such as hospital beds as well as lower costs of care through integrating services. These savings need to be articulated to policy makers and commissioners of services to encourage further integration of health and social care.

Worldwide culture of caring

Moving towards integration should be fortified by the promotion of a worldwide culture of caring for older people. High quality of care should be expected by patients and families, and seen as standard by service providers.

Dignity and respect for older people must be protected

Crucially, we need to see older people as simply adults, some of whom are frail and some of whom are not frail. Education to improve perceptions and understanding of the rights of older people, particularly those suffering from frailty, should be targeted at all levels; medical professionals, families, carers and the patients.

Care as a starting point

Well-integrated care is one part of a larger picture, where integration of transport, housing and product design can all contribute to easier and better quality standards of living for older frail people. Integration and the general principle of holistic care should be spread across many other areas of service provision.

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Please also see the collection of reports on integrated care from a selection of the ILC Global Alliance members, as well as documents from the Conference on Integrated Care for Frail Older People available from the website www.ilc-alliance.org



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