COVID-19

Realising the true value of integrated care:

Beyond COVID-19

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IFIC International Foundation for Integrated Care

Acknowledgements

The current COVID-19 pandemic has rapidly impacted every aspect of our lives and, in particular, is creating an unprecedented challenge to our health and care systems worldwide. At IFIC we are not experts in the management of COVID-19. We are, however, an international (not for profit) collective of over 20,000 members spanning health and care services, academia, policy, management and implementation. As such we are able to focus a broad spectrum of views through various lenses. We feel the current crisis represents an opportunity to do things better and speed up integration of our health and care systems so that they are more resilient in the future. This document describes the issues with and opportunities for strengthening the enablers of integration.

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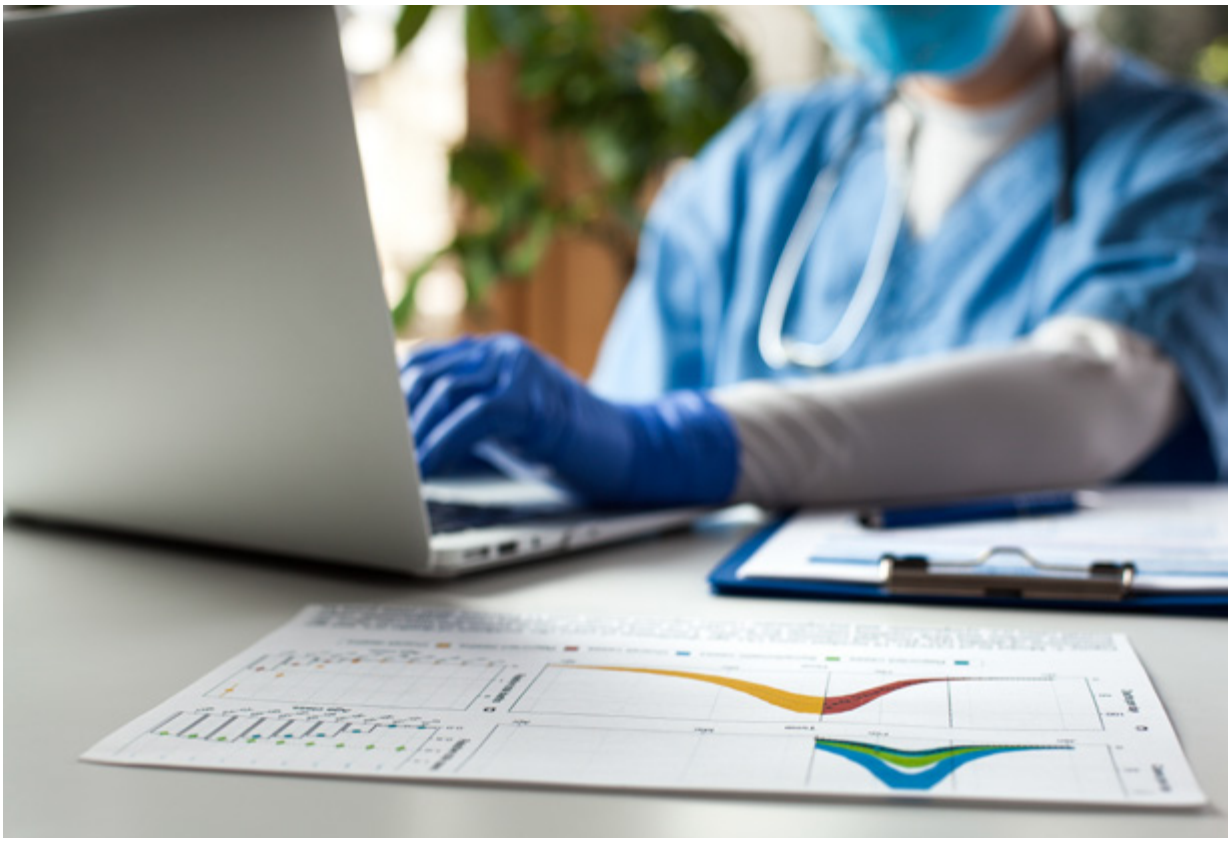

COVID-19

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IFIC's CALL TO ACTION

Realising the true value of integrated care: beyond COVID-19

Stronger and more resilient care systems and communities are better able to cope, respond and adapt to new challenges and crises such as the current COVID-19 pandemic. They are able to quickly come together to 'act as one' and collaborate across disciplines and sectors towards a common goal. This is the essence of integrated care and this is what the International Foundation for Integrated Care (IFIC) stands for - creating a more connected health and care system.

Our call to action is clear: the future of health and care is integrated and the journey to achieve it must be accelerated through our response to this global pandemic. Since IFIC was established in 2011, it has been advocating integrated care as an evidence-based and people-centred approach to enhance the quality, value and experience of care, improve population health and wellbeing, and increase job satisfaction in the workforce.

The speed and scale of the response required by the COVID-19 pandemic has highlighted how the fragmentation in current health and care systems significantly impairs our ability to respond effectively.

For example, the fact that our information and data collection systems are not set up to provide a full picture of the pandemic's impact; or the fact that our uncoordinated supply chain has led to shortages of vital equipment; or that some of those on the frontline, such as home care support workers, were left unprotected because of healthcare workforce, especially those working in hospitals, being seen as a priority.

The virus is affecting every aspect of society, but there is no doubt that the human and economic consequences will be most profound for our most vulnerable citizens, communities and countries.

We hope the current COVID-19 pandemic will prove to be the catalyst for countries and regions across the world to rethink and redesign our health and care systems and networks in a way that works for all, including those most vulnerable, and that makes us all better prepared to cope with emerging systemic shocks.

Indeed, we are faced with a unique opportunity to transform our global health and care system, to better coordinate all partners and resources to address today's global health challenges[1].

We are all interconnected and interdependent. We can no longer work as if we are not. The virus has made it clear that we are vulnerable to actions that happen on the other side of the world. Our response to this pandemic will not be effective unless it is also equitable, and this requires an unprecedented level of international funding and cooperation[2]. The current pandemic risks fragmenting us further, as we saw for example some initial reactions in Europe and in North America included imposing export bans on vital medical equipment. This risk will become greater as the full impact of the pandemic unfolds, and inequalities increase. To overcome this risk, we must pool our scarce resources (from health and other sectors), especially in developing and emerging economies, towards the global common good.

In the past few months, we have all heard extraordinary stories from people involved in the full continuum of health, social care and support services across the world, with people setting aside politics, perceived differences and barriers in order to face the pandemic together. The world-wide responses to COVID-19 have demonstrated that integration really does go so much further than just 'joining the dots'. The 'one team' approach to building alliances of stakeholder organisations, people and communities we have seen must not be allowed to 'wither on the vine'. It offers an opportunity to go beyond a narrow focus on the individual dots, or the patchwork linking of selected dots, to one that truly understands and assesses the changes that have taken place to enable the benefits to be sustained and lead to greater impact.

A note on language

We currently refer to 'health and care' systems as a way to describe health, social care and support services. We recognise that this is due to integrated care's roots being in the health system. Language is (rightly) beginning to change to reflect a wider understanding of 'health' – one that includes wellbeing and one where 'care' is not just 'healthcare' and formal social and support services, but also encompasses informal care, communities and their members are crucial parts of the system.

These are unprecedented times for which there is no clear guidance or best practice to follow. At IFIC, we are not experts in the management of COVID-19. We are, however, an international (not for profit) collective of over 20,000 members spanning health and care services, academia, policy, management and implementation. To help us harness the disruptive innovation now being unleashed, share the rich and varied experiences and insights of our global community and to enable us all to ask questions and identify potential solutions, we propose to use the following 'building blocks' for integrated care as our compass. Over the years IFIC has developed and used a series of building blocks as a conceptual framework that supports the successful delivery of integrated care services. These have been refined through our most recent experiences and we believe they will help steer us towards a radically different reality where we achieve a stronger and more resilient society.

[1] Hoffman S J, Cole C B. Defining the global health system and systematically mapping its network of actors. Global Health. 14, 38 (2018). doi.org/10.1186/s12992-018-0340-2

[2] Gates Foundation. Calls for International Collaboration to Protect People Everywhere from the Virus. www.gatesfoundation.org/Media-Center/Press-Releases/2020/04/Gates-Foundation-Expands-Commitment-to-COVID-19-Response-Calls-for-International-Collaboration [Accessed 30th April 2020]

1.Shared values and vision

Improving population health and wellbeing requires collective action to address the social determinants of health and reduce health inequalities.

This is a system-wide responsibility that is heavily influenced by what our societies and organisations value and the extent to which we are prepared to work together to achieve our shared vision.

COVID-19 is shifting what we value as a society – we are redefining the meaning of 'community', realising that we cannot get through difficult times on our own. We are becoming painfully aware of how the social, economic and health inequities, entrenched in the past decades through austerity measures, exacerbate and are exacerbated by the pandemic. We are discovering the importance of undervalued care work. We are noticing how in many countries we are reliant on migrants propping up systems in order for us all to survive. These realisations are not new. For example, the WHO Global Commission on the Social Determinants of Health (CSDH)[3] concluded that social injustice, and particularly the inequities in the conditions in which people are born, live, work and age, are killing people on a grand scale. We have known this for some time now, but never before has this been more evident than it is now. Disproportionate rates of poverty, insecure and low-paid labour, overcrowded living conditions – are all contributing to putting marginalised communities and ethnic minorities all around the world at an increased risk of COVID-19 infection.

Our goal as a society must be to strengthen and accelerate efforts towards universal access, and crucially to address the determinants of health on a global scale.

This includes taking a 'health in all policies' approach and a holistic cross-government approach to improve health and wellbeing[4]. The vision for more joined up health and care systems need to be centred on citizens, patients, family and the care team experiencing health and care as 'one team' and 'one system'.

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[3] CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on the Social Determinants of Health. Geneva, World Health Organisation; 2008 https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf [Accessed 30th April 2020]

[4] Donkin A, Goldblatt P, Allen J, et al. Global action on the social determinants of health BMJ Global Health. 2018;3:e000603. https://gh.bmj.com/content/3/Suppl_1/e000603 [Accessed 30th April 2020]

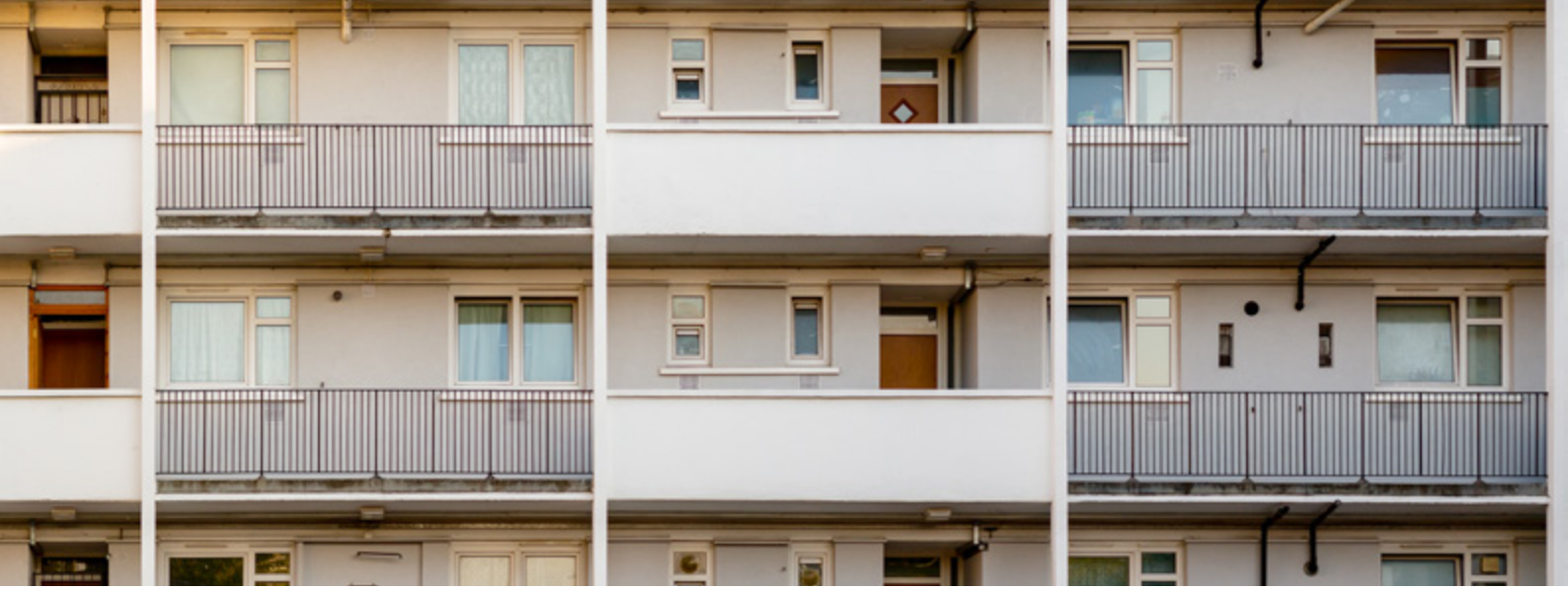
Harnessing the power of multisectoral, interdisciplinary, collective action, begins through co-creating shared values, societal goals and vision amongst all partners.

A good example on a national level is New Zealand's National Wellbeing Budget and Strategy (2019) which shifted New Zealand's economic goal from increasing gross domestic product (GDP) to improving the welfare of New Zealand's citizens.

During the current pandemic, we have seen examples of unlikely partners tearing down largely imagined silos that have characterised our systems in the past to find new and creative ways to work together towards common goals, e.g. funding hotels to act as hospital overspill or as temporary residences for front line staff or for the homeless. How do we ensure new modes of collaboration between the public and private sectors continue past this pandemic? How do we build in the right incentives for cross-cutting, far-sighted, and sustainable efforts?

Our compass needs to be the 'why' (our shared values) and the 'what' (our shared vision).

If this is clear, we will be well placed to find our way there, acknowledging that this often takes time. Otherwise we risk putting system-wide transformation in the 'too hard basket' again.



2. Population health and local context

Improving population health is an urgent matter. Great gains have been made over the last 100 years in terms of life expectancy around the world. And yet health inequalities and inequities have been widening in many countries. In the UK, as in much of Europe, austerity has adversely affected the social determinants that impact on health in the short, medium and long term[5].

In most places, attempts to achieve better population health and wellbeing fall short because efforts tend not to focus on addressing the root causes - the determinants of health and the reduction of health disparities.

It is for this reason that we need to shift our focus from problem solving, disease-specific approaches to assuming accountability towards a territorially defined population. There is ample evidence of successful population health approaches, both in terms of improving outcomes and cost-effectiveness, even though the benefits may take years to materialise.

For population health approaches to work effectively, they must take into account local contexts and have a clear understanding of what the local strengths/assets, pressures and needs are. This requires access to good quality, joined up information to understand the population and the areas of greatest need and vulnerabilities so this can inform policy, service design and delivery. It also requires active involvement and resourcing of local authorities to tailor initiatives according to local strengths and goals. Many regions, for example, divide the land mass into geographical areas as the basis for integrating care for different population distributions and resources. Such a place-based approach facilitates a focus on the social determinants such as housing, education, employment and social connectedness, all of which together have been shown to have a greater impact on health and wellbeing compared to health and care services on their own. It also promotes more proactive approach to care, focusing on strengthened primary and community services designed to enable people to self-manage and seek appropriate and timely support, avoiding a reactive response and hospitalisation or long-term social care wherever possible.

[5] Marmot M, Allen J, et al. Health Equity in England: The Marmot Review 10 years on. London: Institute of Health Equity; 2020 https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf [Accessed 30th April 2020)

The current pandemic has led to governments increasing spending in areas that have suffered cuts in past years in much of Europe. Governments have been exploring with keener interest policy instruments like Universal Basic Income. But Universal Basic Income only goes so far – improving livelihoods through free transport, childcare, internet and housing is increasingly being considered as potentially more efficient and longer-lasting in terms of value for money[6]. Universal Basic Services would help reverse the trend of privatisation in the provision of public goods.

We need to take advantage of the current appetite for more radical options to transform public services. We need to ensure that they are adequately supported by public funds and institutions and that they are shaped by the people who need them.

[6] Coote A. The Case for Universal Basic Services. 2020. New Economics Foundation. London. https://neweconomics.org/2020/02/the-case-for-universal-basic-services [Accessed 30th April 2020]

3. People as partners in care

People are living longer, but not healthier lives. The burden of care is increasing and, with it, complexity, as many people live with multiple chronic conditions. There is a growing imperative to place people and communities, and what matter to them, at the centre of health and care services.

The World Health Organisation (WHO) emphasises the need to engage and empower people as partners in creating and maintaining their health and wellbeing. The Astana Declaration (2018)[7] advocates for policies that embed integrated care in strong, community-oriented and community led primary care. This is particularly important for people with multiple health conditions and/or care needs managed by different providers, often through many unconnected episodes of care. Continuity and collaborative care, through planning, monitoring and review are essential if we are to achieve what really matters to the person, their family and carers. This requires the right information, advice and health literacy support to help people to understand their conditions and how to live well. However, the realisation of these aspirations remains elusive. Professional culture and practice are notoriously slow to change, and it is highly probable that the citizen movement will grow to such an extent that the health and care system will be forced to be held accountable for the wellbeing of their populations.

[7] World Health Organisation and the United Nations Children's Fund (UNICEF). Declaration of: Global Conference on Primary Health Care. 2018. www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

The design of our health and care systems needs to be a process that is shared with citizens and patients. It is time for a shift in power - to make the voices and choices of all, not just a few, count.

In tackling COVID-19 we – citizens, patients, carers and professionals together – need to recognise that our actions will only be effective if people are engaged, informed, and supported to look after their own health and wellbeing, reducing demand on services, whilst at the same time ensuring they understand when they should seek help. It appears, for example, that many people are dying during the pandemic, unrelated to COVID-19, because they are avoiding contacting their primary care team or emergency services[8 9].

To protect our most vulnerable citizens, we must have honest conversations about their personal goals, preferences and ceilings of treatment[10]. These steps can move us closer to a future in which integrated care is embedded in strong, community-oriented primary care systems that help individuals, and the people who are important to them, to stay well and make informed decisions about their care and support to achieve the outcomes that matter to them. To leave nobody behind, we must reach out to the underserved and those facing barriers to having their rights and dignity respected.

[8] Health Services Journal. Thousands of extra deaths outside hospital not attributed to COVID-19. 2020 https://www.hsj.co.uk/commissioning/thousands-of-extra-deaths-outside-hospital-not-attributed-to-COVID-19/7027459.article [Accessed 30th April 2020]

[9] British Medical Journal. COVID-19: Cancer mortality could rise at least 20% because of pandemic, study finds. 2020;369:m1735. doi: https://doi.org/10.1136/bmj.m175

[10] NHS Northern Care Alliance and Association for Palliative Medicine. COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care: Role of the speciality and guidance to aid care. 2020. https://apmonline.org/wp-content/uploads/2020/03/COVID-19-and-Palliative-End-of-Life-and-Bereavement-Care-22-March-2020.pdf [Accessed 30th April 2020]

4. Resilient communities and new alliances

There is growing evidence to demonstrate that empowering local communities is essential for citizens' wellbeing and for the care system to function effectively[11]

The capacity of local communities to deal with public health issues and care needs of community members over their life course depends both on the ability of communities to define and organise themselves, and on the extent to which local, regional and national actors are willing to work together to foster community-driven care and invest in place-based initiatives. Social or community capital needs to be built at a local level to ensure that policies are drawn up and owned by those most affected and are shaped by their experiences.

The starting point needs to be what is strong in people's lives and in communities, not what is wrong. Asset-based community development approaches have been found to support silo-ed services to work in a much more integrated and collaborate way with communities and each other[12]. This is what we call Integrated Community Care – a wide range of asset or strength based practices that share the common aim of improving the quality of care and quality of life for individuals, families and communities with an understanding that this can only be achieved through co-productive partnerships and intersectoral and interdisciplinary collaborations. Crucial to success is a shift to genuine 'co-production' with people and communities. There are several examples from around the world of how this works in practice. The TransForm initiative[13] (Transnational Forum for Integrated Community Care) that IFIC has partnered with has collected and described a range of case studies to illustrate this new philosophy and social movement that has been gaining traction in international policy and practice agendas.

[11] Marmot M, Allen J, et al. Health Equity in England: The Marmot Review 10 years on. London: Institute of Health Equity; 2020 https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf [Accessed 30th April 2020]

[12] Russell C. Asset Based Community Development (ABCD): Looking Back to Look Forward: In conversation with John McKnight about the intellectual and practical heritage of ABCD and its place in the world today. Cormac Russell. 2015.

[13] TransForm Project. Case Studies on Integrated Community Care. 2019 https://transform-integratedcommunitycare.com/resources/ [Accessed 30th April 2020]

The current pandemic has heightened our sense of solidarity and illustrated that we cannot overcome a crisis of this scale on our own.

Many countries are currently focused on the loss of life, but other impacts will be far reaching. There are many people who currently feel isolated and mental health problems are on the rise. Given our increased awareness and knowledge on the psychosocial dimensions to health and wellbeing, we need to prepare creatively and swiftly to support people in these times, both through helping build virtual communities and support, but also through maximising local community and neighbourhood resources.

We are all in this together. New and creative alliances are developing in our communities.

One example is the spread of compassionate communities, a vibrant global movement that recognises that caring for one another is everyone's business.

Some focus on palliative and end of life care or on older people while others embrace an assets-based approach to participation, wellbeing and healthy neighbourhoods. Let's be bold and strive to sustain these alliances between communities, businesses, local government and health and care services after the pandemic - with adequate support and funding from central governments. This is the right time to build bridges over the traditional fault lines between professions and sectors and to shift power towards community-led health and place-based approaches to integrated care.

5. Workforce capacity and capability

Health and care workers are our greatest asset, working alongside family carers, community partners and local networks of support. However, without reforms, sustaining the workforce is also one of our greatest challenges.

A global shortage of health and care workers coupled with an ageing workforce results in high levels of workforce stress. The Quadruple Aim[14] highlights the critical importance of workforce well-being for high quality care.

Core competencies for integrated care are highly relational: patient advocacy, communication, interdisciplinary working, people-centred care, and continuous learning.[15] These skills are critical for strong, trusting relationships between care practitioners, across sectors, and with volunteers and community partners. Our future multidisciplinary workforce must be creative, flexible and resilient, able to manage complexity and make better use of their different skills and strengths as well as accepting of new roles and responsibilities. Leading and managing transformational change is a collective responsibility and sustainable improvements will only take place if a flexible approach to driving the change is embedded. Enabling individuals and the system to be their own change agents will create an environment that can effectively respond to the continuous evolution of communities and populations alongside being able to harness the potential of innovations and new ways of working.

The current pandemic has stretched our workforce beyond what we could have imagined. They have stepped up by extending scope of practice, blurring roles to support each other, and rapidly acquiring new caring and remote consultation skills to offer the best possible care and support in extremely difficult circumstance. Rapid workforce redesign and training is supported by local, regional and international networks for mutual aid and a more pragmatic approach to clinical and information governance. These changes are amplified by shifting some tasks from practitioners to unpaid carers, volunteers and communities.

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[14] Bodenheimer, T and Sinsky, C. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine, 2014; 12(6): 537–76. Available from: doi: https://doi.org/10.1370/afm.1713

[15] Langins M, Borgermans L. Competent health workforce for the provision of coordinated/ integrated health services. Working Document. Copenhagen: WHO Regional Office for Europe; 2015. http://www.euro.who.int/__data/assets/pdf_file/0010/288253/HWF-Competencies-Paper-160915-final.pdf

The current innovative and risk enabled inter-professional ethos augurs well for workforce reform. We have a unique opportunity to test integrated workforce solutions that will strengthen our systems and lead to better health, better care and better value.

6. System wide governance and leadership

For integration to work, governance models need to take into account the complexity and interdependencies of ever complicated and evolving organisation of health and care systems (including new standards, protocols and regulations). Governance models should help break down barriers between services, enable collaboration, and facilitate the move towards a model of co-operation over competition.

Network governance models can be used to rethink the way cross-organisational services and joint actions are contracted and funded, coordinated, inspected and regulated, and on how outcomes and benefits are assessed for the care recipient, care teams and the system.

The pandemic has forced us to reflect on the nature and effectiveness of our governance systems and go beyond just health and care to look more broadly at the governance of our societies and their globalised nature. The spread of the virus and our disjointed efforts to contain it has evidenced on the one hand the lack of systems thinking (reflecting the complex and interconnected characteristics of our world) and as a consequence, the lack of foresight. At the same time, it has illustrated that central governance has managed things that were inconceivable pre COVID-19 in very short periods of time – for example, governments have rallied people to sacrifice their normal routines in the name of public health goals. Different governance models are being put to the test by leaders around the world as they confront this crisis. There may be a case for a public health authority that can ensure cooperative policy solutions across member states, for instance. The pandemic will hopefully lead to more global, collective and coordinated governance mechanisms, including for example global health security.

Far from command and control leadership, the current crisis is teaching us that successful leaders are those leading in a compassionate, inclusive and dynamic manner.

New models of care and large system transformation require more collaborative, distributed forms of leadership and approaches to change management and a move away from operating within institutions and defined boundaries to leading change between services, professional groups and organisations. Another crucial attribute is adaptability and an ability to work with a large and varied number of stakeholders. We need to rethink how we recruit, educate and support our leaders and staff to be successful in a complex and adaptive system.

7. Digital solutions

As each integrated care building block is reliant on information, digital solutions could be seen as the cement that holds the blocks together.

Albeit, the arguments for greater use and investment have become increasingly compelling, the rate of adoption remains below expectations. Furthermore, most health and care organisations still lack a comprehensive Information and Communication Technology (ICT) infrastructure and electronic care record systems to effectively enable data and information to be collected, stored and shared. The absence of a common language, terminology and coding standards is another impediment to semantic interoperability between digital solutions.

Increasingly, digital solutions – such as telemonitoring, teleconsultations, decision support, mHealth, machine learning and AI – are emerging to support the assessment, diagnosis, treatment and monitoring of patients, especially those living with long term conditions and multimorbidity. The interest from big tech companies like Google and Amazon to disrupt the traditional care delivery models by using their digital capabilities and assets speaks about such potential. However, despite all the attention and compelling arguments, the care sector has largely continued to discuss and debate rather than invest and take action; that is until COVID-19.

Since the outbreak of COVID-19, countries have seen a rapid citizen-led proliferation of digital solutions being used for remote working, socialisation between family, friends and communities, and education, to name but a few. This rapid pace of change has been mirrored by national and local government and public health through the use of social media to effectively reach individuals to provide guidance, support, collect well-being and COVID infection data, and undertake tracing through Apps. Furthermore, many countries have created fully functioning field hospitals with IT departments working around the clock to ensure these new care facilities can be up and running to provide safe care in a matter of days. This is a huge logistical undertaking. Shortages in PPE are being met utilising 3D printing technologies, video conferencing is being widely adopted for many health and care consultations to avoid exposure to crowded and potentially infectious clinical areas, and multi-national clinical trials happening and on an unprecedented scale and timetable.

However, the response to COVID-19 has also highlighted weaknesses in our data collection processes as it appears that there is little consistency between the way countries are recording infection rates, deaths, who is being infected and dying, when and where. We can see that this has impacted on the effectiveness of countries' 'lockdown' strategies, deployment of PPE, workforce demands, and COVID-19 testing, and countries' economies are likely to take a greater hit because the lack of data will result in governments being overly-cautious in releasing the 'lockdown' measures.

Due to the unprecedented drive to keep people out of hospital on a global scale, there is a new sense of urgency to find the right balance between keeping people at home and in the community as much as possible, without adversely deferring necessary health services for those who need it. Digital solutions can support alternative options for delivery and can help harness the best of community and hospital services.

We need to ensure our leaders understand the strategic place of digital solutions in the post COVID-19 world, whilst ensuring appropriate privacy measures are put in place.

The evidence of how digital solutions can help deliver care with greater scale, flexibility and sustainability is there for everyone to see and we have a responsibility to act now to ensure we all continue to benefit.

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8. Aligned payment systems

Fragmented financial systems include those with separate funding streams and governance structures for different types of services, or provider payment mechanisms that do not adequately reward and encourage care coordination. Payment mechanisms to providers also tend to reward volume and provide little incentive for providers to collaborate whilst separate budgets also create incentives to shift people and costs. Many countries continue to finance health and social care substantially through direct and indirect fee-for-service systems.

Many countries and systems are moving to value-based rather than volume-based care. This also recognises the need for integration of health and social services to ensure the overall wellbeing of the population. However, evidence suggests that successful integrated care arrangements can be achieved without integration of financial flows if the necessary structures to sustain and institutionalise collaborative arrangements are in place.

Integrated care has often emerged, or been accelerated, in times of crisis. The impact of COVID-19 again tells us that "where there's a will, there's a way" to solving problems, including to long-established policies and fragmentations in financing.

In Australia, a very clear example of this is in enabling financial support to be provided to GPs by enabling payments for services otherwise required to be provided by other practitioners (e.g. mental health treatment or chronic disease assessments). Payment for telehealth consultations has also been enabled to support a variety of remote consultations. Similar financial flexibilities worldwide have supported telecare services into care homes; repeat prescriptions and home-based delivery led by pharmacists; the waiving of co-payments and other out-of-pocket expenses; and so on. Less attention has been paid on attempting to use financial flexibilities to integrate care and support in residential aged care, despite residents and their carers being at highest risk. The same may also be said of rural and remote communities and other disadvantaged groups.

By and large these changes in financial flows appear to be developed as temporary fixes with time-limited authority based upon enabling payments for additional (rather than joint or coordinated) activities. In some countries, such as the UK, the crisis has accelerated existing ideas to create joint commissioning / provider authorities and it may be that moves towards managed care / population health-based systems are boosted as a result of those systems experimenting with them. However, most financial reforms resulting from the COVID-19 are not seeking to 'integrate' across the system but are providing new capacity to manage the current crisis. Commentators have picked up on how the use of funding to support remote patient management through telehealth may be a long-term game changer in our future care systems.

What has not yet been discussed much is that for the first time in modern history there is an international drive to keep people out of hospital. Unfortunately, this seems to also be leading to the deferral of necessary health services to people who need it. The right balance lies somewhere in between and to find it, funding needs to reflect the shared responsibility for the health and wellbeing of the population.

Perhaps the most significant legacy of COVID-19 might be the recognition that financial flows need to be significantly streamlined and changed to support effective supply chains of equipment and drugs.

Whilst not integrated care from a person's viewpoint, COVID-19 has picked up on significant technical and operational inefficiencies in procurement. Beyond COVID-19, countries will need to include the private for-profit and not-for-profit sectors, whether national or transnational in planning of any strategy.

9. Transparency of progress, results and impact

Just as there is no 'one size fits all' model of integrated care that suits all ambitions, situations and contexts, there is no one single tool or approach that can be used to measure the progress, results and impact of an integrated care initiative which consists of a number of interrelated interventions, rather than a single one.

Measuring all the different dimensions is complex and it is further complicated because integration is ongoing and part of the journey to delivering innovative and transformed health and care services rather than the destination. Furthermore, each integrated care initiative needs to define and understand what success will look like and when for the many different stakeholders involved as many outcomes and benefits will only be realised in the medium to long term.

In recent years, the Quadruple Aim and Value-based Health and Care have both emerged as a more rounded way of ensuring that the cross-organisational nature of integrated care is also reflected when measuring and reporting on progress, results and impact. This means that data and information from health, social care and support organisations' care delivery, care outcomes, workforce wellbeing and satisfaction, together with patient and citizen outcomes and experiences is required for inclusion in such a comprehensive approach. Data from activity undertaken in primary and secondary care is now widely available, but the same cannot be said of community health and social care services, with the role and activity of the voluntary sector and communities usually completely absent, and thus there is a lack of transparency as only a partial picture is given. New and exciting approaches to evaluation of complex and adaptive systems such as Developmental Evaluation, are also being increasingly employed.[16]

We need to be open and honest about the scale of the challenges that lie ahead post COVID-19 because continuing to base our integrated care evaluations and assessments primarily on available health data and information will go nowhere near capturing the unprecedented responses and scenarios that are emerging around the world.

[16] Gamble J. A Developmental Evaluation Primer. The J W McConnell Family Foundation. Canada. 2006. https://mcconnellfoundation.ca/wp-content/uploads/2017/07/A-Developmental-Evaluation-Primer-EN.pdf [Accessed 30th April 2020]

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Our conferences bring together researchers, clinicians and managers from around the world who are engaged in the design and delivery of integrated health and social care. Our European conference has been taking place annually since 2000 and attracts up to 1,500 delegates from all over the world. Our online events and live streams are viewed by 5,000 people representing more than 60 countries.

integratedcarefoundation.org/conferences-events

Integrated Care Knowledge

IFIC is an international centre of knowledge, expertise and ideas on integrated care. The Knowledge Centre is an open-access and authoritative resource on integrated care for use by policy makers, managers, care professionals and researchers. IFIC Research and Development team participate in a number of European funded projects which generate the most up to date learning on Integrated Care.

integratedcarefoundation.org/our-work

IJIC

The International Journal of Integrated Care (IJIC) is supported and administrated by IFIC and is an online, open-access, peer-reviewed scientific journal that publishes original articles in the field of integrated care on a continuous basis since the year 2000. IJIC's official Impact Factor is 2.489, with 17,500 full text views per month.

ijic.org

International Foundation for Integrated Care

The International Foundation for Integrated Care (IFIC) is a not-for-profit educational network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice. The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.

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