International Journal of Integrated Care – Vol. 8, 4 June 2008 – ISSN 1568-4156 – http://www.ijic.org/

Editorial

International comparisons of integrated care as inspiration and tools for research

In 2000 the book ''Integrated care in Europe'' [1] was published. This mile-stone book set the agenda for international comparisons between countries of systems for co-operation between providers. The systems approach included structure, financing, legislation, and research while the providers included were from within both health care and social care.

The basic differences between European countries in terms of health and social care originate from the two financing models, the insurance based and the tax based, respectively. The two models bring with them each a web of cultural appendices concerning distribution of power and incentives as well as legislation and surveillance by the public.

Historically the insurance based models were introduced in most European states during the last decades of the 19th century in order to protect the workers in the rapidly growing industries. In some countries the coverage was not seen as a solid safety net and different financing systems were developed for occupational disorders and other parts of health care in the midst of the 20th century. In some countries the two parts are still integrated.

However, reality, clearly visible as inexorable demographic and epidemiologic development, has moved the two models successively closer in many respects. The compulsory membership in the insurance based financing has made this more and more similar to a tax based model. In addition, in countries with health care financed by taxes where publicly owned facilities used to be the rule, more and more of the care is run by independent providers.

Integrated care by definition tries to bridge gaps between community care, primary care and hospital care. Having the same owner is by no means a guarantee for integration; seamless care may be produced also by individual providers linked by agreements and contracts. The two financing models seem to have lost part of their basic discrepancies concerning achievement of integrated care.

INIC—the International Network for Integrated Care was started based on the knowledge that experiences from different countries may be of great value for development of integrated health and social care when assembled and confronted. This was also the main focus during the planning and carrying through of this year's meeting with the INIC.

At the meeting, the stage was set by key note speakers from North America as well as from Europe, and from academia, from management as well as from the medical professions. In this manner a wide cultural perspective was painted of integrated care, from theories of management, through recruitment and salaries, to the management of individual patients in the seamless chain of care.

Even if the main features are gradually overlapping between countries and cultures, some areas of differences still exist. One of these is mental health care. In some countries the closing of large asylums in the 1960s brought psychiatry into the acute care hospitals as a medical speciality among others. However, in other countries mental health care is still seen as a structure of its own. As a matter of fact, in all countries most of the more frequent minor mental illnesses are handled by GPs in primary care. This theme was the final part of this year's INIC meeting. In addition to the key note speeches, around 30 projects from participants' institutions were presented covering a wide variety of subjects.

This year's meeting also included a study tour through the Swedish landscape with site visits to a couple of local providers with well developed structures for integrated care. It seems as if formal and informal networks and personal involvement are the main ingredients for a successful integration. This may well be the main conclusion of this year's INIC meeting.

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