DESIGNING SUSTAINABLE CARE FOR ELDERLY — A CONTEXTUAL APPROACH

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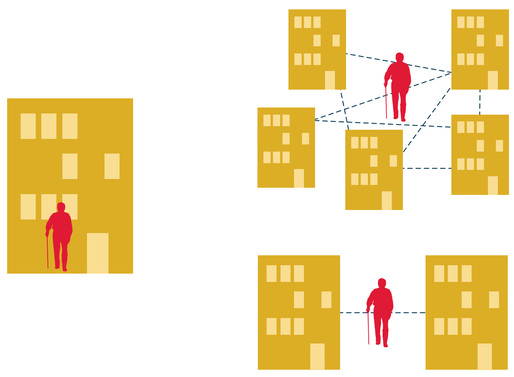

Figure 1: Three causes of failing integration: inadequate prioritization, lack of communication, and absence of coordinating actors.

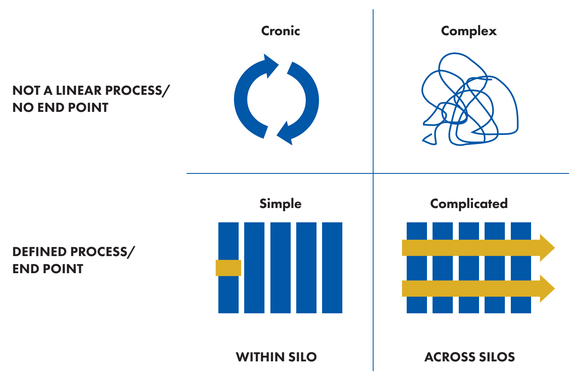

Figure 2: Four categories of patient needs: simple, complicated, complex, and chronic.

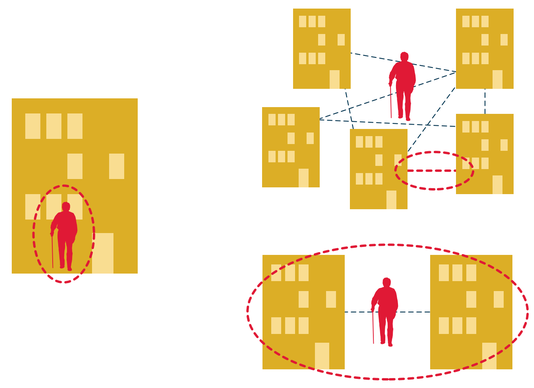

Figure 3: Three reimbursement principles for promoting integrated care: weighting, aggregation, and direct compensation.

Understanding the problem(s)

Lack of integration between different health care providers is a problem that is often addressed by patients, relatives and the media, but also by health care providers and caregivers themselves. In addition to the suffering to which individual patients are exposed, lack of collaboration results in quality deficiencies and waste of resources in the care sector as a whole. Needs for providers of health and social care to cooperate may occur in relation to many medical conditions and many patient groups. A particularly vulnerable group is fragile elderly who are in need of both health and social care.

The elderly patients' pathways through health and social care are many. For the individual, it is important that the care chain, or process, is as effective as possible. Purposeful processes must be supported by appropriate payment systems, which is a main topic of this article.

A general description of the elderly patient's optimal care chain cannot be done, as this is more or less unique to each individual who is in contact with more than one caregiver at the same time. However, focusing on cases where care did not work properly, studies have shown that re-occurring patterns can be identified. Bowin et al. (2012) identify five common problem types in the care of elderly people with complex needs:

- *Repetitions:* The same tasks are performed several times without achieving the desired result.
- *Many parallel processes:* Several simultaneous processes that all involve the same patient, where actions are taken individually and without the patient's overall need in mind.
- *Suboptimal level of care:* A task is performed by a caregiver who is not adequate for the assignment, at a care level that is either too specialized or too general.
- *Pseudo solutions:* Actions are taken to deal with symptoms or single problems, but do not contribute to a long-term sustainable solution for the patient.
- *Unnecessary stops in the process:* Delays and waiting with no purpose, prolonged suffering while waiting for a solution or an answer.

These typical problem episodes are a reality for almost all patients in need of more than one health and caregiver contact. This indicates that there are built-in weaknesses in the health and social care system in terms of integrated care. Integration is a popular concept often raised both as a problem and a solution. However, Fernler et al. (2014) demonstrate that in reality, the difficulties of achieving cooperation consists of many different components. A number of generic problems (see Figure 1 above) are:

- *Inadequate prioritization* within each individual care form of patients with complex needs of health and social care.
- *Lack of communication* and collaboration between different health care providers around individual patients.
- *Absence of actors* with the overall responsibility of coordinating care for individual patients, and/or the tendency of health care providers to avoid taking a coordinator role.

Since lack of collaboration is not one clear-cut problem, it is not one single solution that is needed. For the individual, it depends on the degree of complexity in the needs and number of care contacts needed, as well as the individual's possibilities to take part in the coordination of his/her own care (cf. Vårdanalys 2016). Since the need of coordination differs between different groups of patients and caretakers, the challenges also differ in achieving more effective care paths.

Targeting the needs

Rognes et al. (2016) develop a general analysis framework that can be used to illustrate the different care needs of different patient groups (see Figure 2 above). The framework is to be used as a starting point for discussion and analysis. Not for tagging individual patients, but to see the need for different organizational solutions and governance models for different groups and needs.

The framework is based on two basic dimensions. The first is whether the patient can be treated within a defined period of time, or if it is a chronic condition and needs to be handled continuously, perhaps at lifelong duration. The second dimension is whether the patient can be treated within one medical specialty, or if several units, clinics or functions must be involved.

Based on the location in the framework, four different groups of patients can be identified:

- The first group consists of patients with a condition that can be cured, and that can be handled within a specialty. Systematically looked upon, these are "simple" patients, without a defined care process and without complications. The care can be handled within one clinic, either in primary care or at a specialist. After treatment and follow-up, the patient is "done" and no more care contacts are needed until the next need arises.

  Simple patients benefit from easy and rapid access to primary care and highly specialized care. Here, today's health care system is well suited as clinical organization largely follows diagnosis areas. Aspects such as accessibility and freedom of choice become important, but collaboration is not a big question, because everything can be effectively managed within one care unit.

- The next group consists of patients with a complicated condition but that can be cured. These are more difficult cases, because different care units and specialties need to be involved, but the goal is nevertheless a completed treatment.

  Complicated patients benefit from a focus on waiting times and quality in care processes. Within hospitals, issues such as flow-based care and division of labor between professions become important, as well as cooperation for smooth transition between caregivers in different stages of the process.

- A third patient group is those with a chronic condition. The main difference between this group and the previous two is that the treatment has no defined ending, but is a life-long process. The goal is not to cure, but to avoid a deterioration in quality of life, or a situation that requires hospital care.

  Chronic patients benefit from a focus on preventive health, and on the patient's own role in managing his/her condition. Continuity is a central question, as well as long-term interactions between institutions within both health care, social care and social security, in order to make it easier for the patient to live as well as possible with the disease.

- The last, but most complicated patient group appearing in the framework are patients with several serious conditions at the same time, mostly old and fragile people whose conditions are not always possible to cure, but also people with both physical and psychological needs. The combination of conditions often affects the treatment possibilities, and varying life situations and medical conditions require a great flexibility in offering individual solutions.

  Complex patients benefit from integration, team work and network oriented health care. Continuity in the personal contacts, a balanced view of what shall be treated, and an increased focus on social care can be important. Situation based and flexible collaboration between different care units and between medical and social care becomes a key issue.

The framework brings to light how different types of patient needs can be linked to different types of care pathways, which have different foci and require different degrees of cooperation between health care and social care providers. Both the organization of care and its governance in the form of for example reimbursement systems need to be designed differently for each of the target groups.

Reimbursing for improved coordination

Economic incentive systems are not the only cause for lack of collaboration. Today's design of reimbursement systems, where payment based on clinic division has long been dominating, have a tendency to reinforce the fragmentation between different caregivers and care units and create collaboration problems. The nature of these problems, as well as the solutions needed, depend on the patient's needs, which can differ a lot even within the elderly group.

Based on a thorough analysis of the underlying problems, as well as of current organization structures and governance systems, Fernler et al. (2014) identify various alternatives for how reimbursement systems can be developed in order to increase the incentives for caregivers to collaborate around individual patients. Three different reimbursement principles that in different ways promote integrated care are:

- *Weighting* of a patient group in need of interaction. Weighting means that patients are grouped according to the expected need of resources. The care of high-need patients is reimbursed at a relatively higher rate, for example for elderly people with multiple diagnoses. Weighting prevents caregivers from trying to avoid patients who are costly and time-consuming. Weighting also improves the possibilities to offer these patients care that includes active cooperation and collaboration efforts.
- *Aggregation* of the reimbursement to caregivers who are expected to cooperate around the same patients. Aggregation means that caregivers receive a joint remuneration for single patients, or for a patient group. Aggregation makes providers financially dependent on the quality of each other's activities, which is believed to encourage communication and cooperation. Aggregation also improves the ability to focus on the individual patient's overall needs in the areas covered by the reimbursement.
- *Direct compensation* for collaborative activities. Direct compensation for interaction means that health care providers are payed for activities and processes that connect multiple parties. Unlike weighting and aggregation, which only create indirect cooperation incentives, direct compensation for collaboration focuses on rewarding the interaction itself. One challenge is to ensure that the reimbursement contributes to productive and meaningful interaction in everyday care practice, and not just as funding for administrative meetings or isolated projects.

All reimbursement principles have advantages and disadvantages. Which reimbursement form is most appropriate depends on what kind of collaboration problem is to be addressed, and also on what caregivers are involved. It is important to analyze which interfaces are to be bridged and what values are in focus. Flexibility is also a key issue when it comes to promoting collaboration – too rigid definitions and too detailed reimbursement systems may otherwise counteract the incentives created.

Finally, the interaction between reimbursement systems and other formal and informal governance forms is essential for what kind of cooperation can be expected in practice. Development of reimbursement systems for cooperation requires changes in other governance systems in order for them to interact, or at least not counteract with the principles for reimbursement. An international comparison of Hagbjer (2012) shows that most local health and social care systems that are regarded as fore runners within integrated care, use a mix of reimbursement principles. However, they all emphasize the possibility for buyers to formulate broader assignments; the possibility for caregivers to offer comprehensive solutions (and the possibility for the patients to choose these), as well as follow up of performance that involves both health care and social care.

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