Report on international forerunners within integrated care

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The pursuit of integrated care for the elderly is a pressing issue, not only for Sweden but for a majority of the Western world. In particular, the design of payment systems for the providers of health and social care plays an important role in affecting the conditions for integration between different areas of care. Depending on whether the payments are prospective or retrospective, the provider is incentivised to either increase or decrease the cost of care. Similarly, whether the payment is fixed or variable provides incentives to increase or decrease the volume of production. Finally, the degree to which multiple components of care are bundled together in one payment scheme determines the incentive to reduce the aggregate cost of multiple interdependent components by, for example, focusing on preventive care.

Based on a review of international research on integrated care for the elderly, this report presents six initiatives that have been described as successful in increasing integration. Each initiative differs in its design and in the characteristics of its payment system. In the US, *Kaiser Permanente* creates regional health care integration through a fixed, prospective capitation system. *Pace*, also in the US, integrates health and social care at day-care centres which receive the same type of fixed, prospective capitation payment. *Torbay Care Trust* in the UK uses a pooled budget consisting of a fixed, prospective capitation payment for its healthcare, which is distributed on a national level, and a variable, retrospective budget for its social care, which is provided by the local municipality. The budget is used to integrate different types of care provided by both the trust and external organisations through the use of care coordinators. In a similar way, *PRISMA* in Canada utilized a combination of a single assessment instrument and case managers funded by a separate fixed, prospective capitation payment to coordinate an assortment of individual health and social care providers. The *personal health budget PGB* in the Netherlands delegates care integration to the individual citizen by assigning a fixed, prospective capitation budget to each care user which is intended to cover his or her variable, retrospective expenses for the purchase of care. Finally, *Singapore* integrates care on a national level through a common patient record system and a specialised coordination agency for the elderly. This is combined with variable, prospective user fees and a mixture of variable, retrospective DRG-related payments and a variable, retrospective budget to reimburse the public care providers.

The common denominator of the six initiatives is the high degree of bundling in their payment systems, where a single commissioning budget is used to pay for multiple components of a person's health and social care. Several of the initiatives also integrate health and social care production in one organization. Though the Swedish public sector bundles individual components of one type of care in single payment schemes, for example in primary care and nursing home care, it does not bundle different types of care; nor are different types of care organisationally integrated to any larger extent.

This divergence points to a potential for development in Sweden, either by increasing the space to transfer the responsibility for health and social care between counties and municipalities, or by integrating different types of care within the same organisation. The studied initiatives suggest that this is possible to combine with care user choice between different providers, as long as sufficient user volume is achieved. A third option is to introduce specialised care coordinators who are responsible for purchasing and integrating both health and social care, on behalf of the individual.