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Centre for Health Services Studies

Integrating care for older people: Design fundamentals of successful models

Presentation at the *Making Connections: Better Ideas for Better Practice* Conference organised by CRNCC and OCSA at the Sheraton Parkway Hotel, Toronto, October 2008

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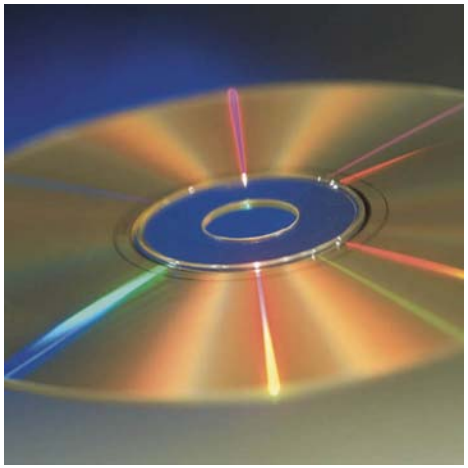
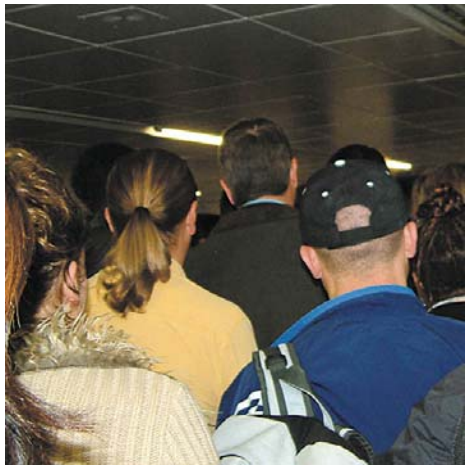


Introduction

- Sources of data and analysis: Procare and other studies
- The organising principle: bureaucracy, markets and trust
- Accessing support and services
- Assessment and referral
- Multiplicity of care
- Audit and outcomes: meeting need, minimizing risk and harm, thriving

Sources of data and analysis: Procare and other studies

- Procare
  - major European study that compared the ways in which a number of European countries attempted to provide integrated care
  - funded by the European Union, Framework V, managed by Austrians, UK had strong input as lingua franca was English
  - combine two main sources of data, overview of development in each country, with two detailed local case studies of services
  http://www.euro.centre.org/procare/body_start_intro.php

- Telehealth and telecare
  - pilot projects in number social care agencies
  -use of assistive technology to provide integrate health and social care
  http://www.kent.ac/chss/researchcentre/docs/telecare_final_report.pdf

- Palliative care
  - challenging area that often associated with ageism in UK
  - working with Hospice to develop rapid response service
  The URL for the report is
  http://www.kent.ac.uk/chss/researchcentre/docs/hospice_at_home_literature_review.pdf

The organising principle

- **Bureaucracy**
  - In most of Europe this has been the dominant principle for organising and providing health and social care for older people
  - state supervises funding, either providing or regulating charges and insurance companies
  - state regulates, mixture internal hierarchy and external bodies
  - organisations employ professionals and other to deliver care

  Strengths clear accountability, clear funding, access to appropriate expertise
  Weakness costs, blame if things go wrong, competitive organisations and no built in mechanisms for collaboration

The organising principle

- **Markets**
  - Development in the 1980s as a response to growth cost and crisis of welfare state
  - UK led the way with internal markets both in health (fund holding) and social care (care management). e.g in 1997 44% of 2.6m hr social care contact time provided by independent sector by 2001 61% of 2.86m hrs

- **Empowering elders: Direct Payment**
  - End user initially excluded, however development of direct Payment system in which elders take control of their budget and buy their own services
  - Personal budgets in the Netherlands, funded by social security (National Insurance) provided through Regional Administrative Care Offices
  - Eligible person receives money or a voucher to pay for services

  Strengths incentive system, money follows the person, Treasury likes it as provides performance measure
  Weakness increase in transaction costs, needs to specify quality, cream skimming disadvantage elders, in direct payment system elders need to have knowledge and take responsibility

The organising principle

- **Trust**

  - the neglected component
  - fundamental to most systems, principal/agent relationship
  - where individual lack knowledge or skills to identify and protect own interests then agent can act on his or her account
  - tends to form basis of client/professional relations
  - trust central, i.e.an act of faith that agent has the required competence/skill and will use this to further his or her client's interest
  - growth of consumerism with emphasis on informed consent conceals issue but it is still there, as consent depends on providers providing trustworthy information
  - most obvious in areas such as dementia where primary client competence in doubt

  - difference between North and South Europe,
  - in North Europe trust relationship between client and service unless there is an issue of competence
  - in Southern Europe relationship tends to be between family and service

  Strengths low transaction cost, in many respects makes it easy for people
  Weakness difficult to see and control, only really visible when things go wrong, governments no longer willing to trust providers

Accessing support and services

- **Multiple points of access**
  - different services tend to have their own access points
  - citizens tend to have poor and dated knowledge of services and what they provide
  - clearest knowledge tends to be of health services, for example in England, universal, non-stigmatised, access via family doctor (GP)
  - social security, such as pensions also tend to be clear however good access to universal benefits, poor to discretionary benefits
  - social care, poorest knowledge, tends to be perceived as stigmatised, means tested and bureaucratic form filling, note that clients often do not directly access social care but are referred on from GP or hospital

- **One-Window: A Dutch Experiment**
  - use of information and communication technology
  - development by municipalities
  - single point, usually located in a community centre
  - an inquiry desk (Vraagwijzer) that is usually staffed but may also have telephone or electronic interface
  - provide advice on care and well-being, plus help with form filling or referral on to services

Assessment and referral

- **Multiple assessments**
  - crucial in ensuring that clients receive effective services
  - mixture of professional judgement, bureaucratic procedure with an increasing emphasis on clients wants,
  - in health professional judgement tends to predominate, in social security bureaucratic procedure, in social care tends to be a mixture
  - problem is there is no holistic assessment, the purpose of assessment varies and different aspects of client situation is emphasised, i.e. in England health disregards clients financial circumstances whereas it is central to social care.
  - multiple assessments with little visible result?

- **Single assessment**
  - commitment in England to introduce single assessment (health and social care) by 2002
  - agreed information to be collected by first contact using agreed format and to be shared between all providers
  - a number of localities in England have developed,e.g. Cheshire uses MDS and Cambridgeshire has developed CAT (http://www.fujitsu.com/uk/casestudies/fs_cambridgeshire.html)
  - Cambridgeshire approach, handheld pc that can capture and download data, note just starting point as leads on to common referral form
  - serious difficulties in implementation, reduction of professional judgement, fears of surveillance

Multiplicity of care

- **Common feature across Europe**
  - range of agencies, health, social security, social care and housing
  - actual a hierarchical relations, governments tend to give precedence to health, status of providers, cost and high standing with citizens, lowest status to social care, relatively low status of providers, limited impact on budget and low public awareness and esteem
  - policy driven by rising costs of health and elders 'bed-blocking', i.e. delayed discharge because of lack of suitable community placements

- **Joint and innovative working**
  - again a common feature across Europe

  1. New roles, in Netherlands case managers for older people with weak social networks, negotiate home care, transport, leisure activities
  2. Use of new technologies, telecare and telehealth, provide systems by which individuals can access help and monitor health as and when needed
  3. New types of care and teams, intermediate care teams, short focussed multi-disciplinary intervention to enable older people to move from acute hospital care to longer term supported living in the community, rapid response teams for palliative care, short term out of hours crisis support to reduce admission to hospital
  4. Joint working, pooling of resources and skills in partnership. In England joint health and social care trusts as well as units that work on same site developing joint working,

  - a lot of this sounds very good at the level of rhetoric not clear what benefits it creates for elders

Audit and outcome

- Does it make any difference?
  - assessing outcome and taking action
  - development of an Audit Culture
  - in England professional self regulation has increasing be replaced by external regulation
  - funders have increasingly become regulators and their regulation has been subject to inspection and regulation

- So has it improved the quality of care?
  - depends how you measure quality
  - current emphasis on service input, i.e. number of clients, contacts, time
  - need to measure outcome, but there are different ways of doing this
  - utility, benefit that elders gain from services
  - risk, reduction of harm
  - thriving, ability to live a fulfilled life

Audit and outcome

- **Utility**
  - Utilitarian approach, greatest happiness of the greatest number, tends to be translated into adding years to life and life to years, nearest measure is the QALY
  - can develop surrogate to meet specific circumstances, in palliative care extent to which service meets stated preference for place of death, currently most elders prefer to die at home most actually die in hospital
  - Social justice, extent to which those who have higher needs receive greater benefit but there is an inverse care law

- **Risk**
  - focuses on hazards and ability to prevent harm
  - harm reduction or minimisation
  - developed especially in the area of falls prevention and currently accreditation requiring suicide prevention strategies
  - specific interventions to counteract hazards and measurement of effects

Audit and outcome

- Thriving
  - modern development of Aristotle's virtue ethics
  - initially developed context of babies where communication is difficult, i.e. various physical, psychological and social assessment of whether baby is developing normally, i.e. thriving or not.
  - focusses on intrinsic quality of experience

- Palliative care: the good death
  - always a challenging area
  - culturally specific
  - however possible to identify some shared elements, control of process, control of pain, presence of family, in own environment

- Overall care: dignity and respect
  - recent awareness that with emphasis on efficient and effective care basic humanity may be neglected
  - renewed government interest in dignity
  - like a good death, complex culturally specific concept
  - Project in CHSS on dignity and incontinence care emphasised sense of self and perceptions of others (Jenny Billings, Helen Alaszewski and colleagues)
  - in hospital tend to leave at the door, in care homes virtually impossible

Final comment

- Integrated care: a dream?
  - forms a useful piece of policy rhetoric
  - across Europe all government committed to it
  - reality is one of fragmentation, between government departments, levels of government, competing agencies and professions

- Moving to a reality?
  - current emphasis is on getting the system, processes and roles right
  - better starting point would be from the everyday experiences of elders
  - at the core it is all very simple, treat elders with dignity and respect
  - In England despite investment of resources find it difficult to demonstrate we are doing this.

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http://www.kent.ac.uk/chss/docs/toronto.ppt

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