Health Policy 97 (2010) 113–121

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

# An integrated health and social care organisation in Sweden: Creation and structure of a unique local public health and social care system

John Øvretveit*, Johan Hansson, Mats Brommels

*The Medical Management Centre, Karolinska Institute, Sweden*

ARTICLE INFO

*Keywords:*
Integration
Health services
Social services
Clinical coordination
Integrated health system

ABSTRACT

Research and citizens have noted failures in coordinating health and social services and professionals, and the need to address this issue to realize benefits from increasing specialisation. Different methods have been proposed and one has been structural integration of separate services within one organisation. This paper reports an empirical longitudinal study of the development of an integrated health and social care organisation in Sweden combining service provision, purchasing and political governance for a defined population.

The study found a combination of influences contributed to the development of this new organisation. The initial structural macro-integration facilitated, but did not of itself result in better clinical care coordination. Other actions were needed to modify the specialised systems and cultures which the organisation inherited. The study design was not able to establish with any degree of certainty whether better patient and cost outcomes resulted, but it did find structural and process changes which make improved outcomes likely. The study concludes that coordinated actions at different levels and of different types were needed to achieve care coordination for patients and that a phased approach was necessary where management capacity and outside expertise are limited.



## 1. Introduction

Increasing specialisation has driven innovation in professions and in health and social services throughout their history, and this is likely to continue. However, there is growing evidence that the benefits of specialisation can be lost if specialist providers and services do not properly communicate or combine their care for a patient or client [1]. Research into communication and transfer errors shows that specialisation without coordination is dangerous, increases risks for patients, causes most types adverse patient events and increases costs [2,3].

There is evidence of an increasing quality problem of "under-coordination", and of the challenges in improving coordination [4]. Explanations suggested have included the costs, time and resistance to reduction in autonomy perceived by individual providers and services, and because of differences in culture and ways of working, as well limitations in clinical information technology (IT) systems [5–9,19]. These challenges in part explain why service organisations have been slow to develop internal coordination and why coordinating different services is difficult, for example for older patients, patients with chronic conditions and with multiple morbidities.

## 2. Previous research

Two fundamental concepts of organisational theory are differentiation and integration [10–12]. The challenge of integration in health services was noted in one study of the UK NHS which described "enormously high degree of

* Corresponding author at: Medical Management Centre, Karolinska Institute, Floor 5, Berzelius väg 3, Stockholm, SE-171 77, Sweden.
Tel.: +46 31 69 39 28; fax: +46 31 69 1777.
*E-mail addresses:* jovret@aol.com (J. Øvretveit), johan.l.hansson@ki.se (J. Hansson), Mats.brommels@ki.se (M. Brommels).

0168-8510/$ – see front matter © 2010 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2010.05.012

differentiation yet rather low levels of integration" and proposed that methods other than managerial control would be needed to increase integration and maintain the differentiation and degree of autonomy required for professional work [13]. Some of the quality and safety improvement literature has also noted the challenge and proposes standardisation and process improvement as the method for better clinical level integration [1,2,4]. Other literature has drawn on network theory from different disciplines to advance the concept and practice of clinical networks [14,15]. As regard empirical studies, the most extensive was of a number of integrated health systems in the USA [16]. The study found three types of integration and proposed that improvements in clinical care required all three,

- functional integration (how well support functions such as management of finance, human resources, IT and planning activities are coordinated across units);
- physician integration (how physicians actively participate in management and are economically linked to their organisation);
- clinical integration (how well services are coordinated between people and sites over time).

Most of the more recent empirical US studies focus on clinical level health service coordination for particular diseases or client groups, especially to reduce avoidable hospital admissions, improve discharge, and better manage chronic conditions, and are summarised in a recent review [17]. From a European perspective, most US studies focus on clinical level coordination, primarily for health care for specific patients, and neglect both social service integration, which are features of European health systems, and integrative structures and processes at higher provider and financing levels.

As regard the concept of integration, there are many definitions, some of which overlap with "clinical coordination" of which there are at least 40 definitions [17]. There are models of dimensions showing increasing integration between previously separate organisations [17,18]. One classification refers to one end of the continuum (a single organisation combining previously separately owned and managed organisations) and differentiates this into two sub-types: structural integration of finance, and structural integration of services. These can be further classified in terms of how previously separate budgets or services are integrated: whether all budgets and all services for a population are combined, or just those for one group such as for people with mental health problems.

In Europe, one model is where there is one organisation for both financing and service provision (one type of "vertical integration"). One example is some Swedish countries which collect public taxation and allocate it to primary and secondary health care services which are run and owned by the same county. Another was UK NHS district authorities before 1990, where public taxation for secondary health care was paid to an NHS district, which ran and owned these services.

The review of research for this study found different types of structural integration, some combing either budgets ("pooling" in one budget), or services, or both in one management structure for one care group (e.g. mental health), or for a number of care groups, or for all care groups in a population [20]:

- Example 1: UK mental health and social care NHS trusts providing these services only for mental health and sometimes learning disability clients.
- Example 2: Torbay or Somerset NHS trusts in the UK, combining for adults both social care services and a selection of health care services in the community (but not GPs or hospital services).
- Example 3: Norrtalje, Sweden (the subject of this study): one organisation administering combined ("pooled") budgets for all health and social care ("TioHundra Forvaltningen") as well as welfare payments (this budget is not combined); as well as one service organisation ("TioHundra AB") combining management for all health and social care for the population.

As regard improved patient outcomes or lower costs, some studies of coordinated clinical care models for specific client groups have reported better clinical and cost outcomes [1]. However, the few studies of comprehensive integration models reported have not been able to establish with any certainty that outcomes and costs are improved. These studies have described the following types of integration:

- UK NHS budget experiments for specific care groups such as mental health, children and families and older people (pooled finance for social services and secondary health) [21].
- UK NHS mergers of social services and secondary health care for specific client groups, such as mental health or children and families [21].
- UK MHS mergers of social services and some health care for adults, such as Torbay or Somerset NHS trusts [22].
- USA integrated hospital or health systems (e.g. Veterans Health Administration, Kaiser Permenante [23,24].
- Netherlands integrated care services [25], and more recently models for funding and organising care for diabetic patients.

The trends in occupational and services specialisation, in demographics and disease patterns, and the evidence of "under-coordination" point to the need for future health and social care better to coordinate clinical care. Better coordination is now a policy of many European countries, but there are different approaches to achieving it [26]. There are different theoretical models and real examples of clinical care coordination [17] and of integrated care organisations [27,28]. Yet there are few empirical studies of organisations which have achieved both, and of how they were created.

## 3. Research aims and methods

The aim of the research was to describe an integrated health and social care system in Sweden and how it was created. One such system was selected in Norrtalje, a local authority area North of Stockholm. It was selected because