INTEGRATED CARE IN A NHS: BETTER HORIZONTAL THAN VERTICAL?

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The concept of integrated care (IC), nowadays commonly adopted across the world, implies a positive attitude to avoid fragmentation of services provided by health systems [1]. Striving for combining parts to form a whole, IC has undoubtedly laudable aims for patients, especially for ageing chronic patients with both physical and cognitive problems, the major current challenge of health systems in highly developed countries [2].Comprehensive IC should encompass the coordination of health and social services to achieve continuous care across organizational boundaries, overcoming the still existing mismatch between the increasing burden for chronic conditions from the demand side and the provision of services centered on acute care from the supply side.

Conceptually, IC can be either horizontal or vertical, like in any else supply chain [3]. The former occurs when IC is applied to various services delivered at the same organisational stage (e.g. hospital services), the latter when IC brings together services delivered at different stages (e.g. hospital and general practice services in health care). In its turn, vertical integration can be either forward (e.g. acute care with post-acute care downstream) or backward (e.g. acute care with community care upstream). Systemically, the Beveridge-type National Health Services (like the English and Italian NHSs) are expected to be more effective in achieving IC than the Bismarck-type statutory health insurances (like the German and French health systems) [4]. In fact, the former have, by default, many fewer stakeholders than the latter, and it is hard to involve all players in IC interventions when some of them have financial interests which may lead to moral hazard.

In the light of this theoretical premise, we find the ongoing debate in the English NHS whether to support or not vertical IC that includes General Practitioners (GPs) in hospital trusts [5] as 'downstream firms' quite confusing. Rather than enhancing patient-centred care, the real thrust for supporting the recent trend of vertical IC in the English NHS was to rescue some groups of GPs that were likely to fail [6]. Furthermore, most of the (questionable) positive evidence on this type of vertical IC comes from the United States [3], which is a very wealthy country with the most dis-integrated health system in the world. Not by chance defined American-type in the literature [7], the US health system is peculiarly characterized by main funding from multiple private insurance, mostly private provision of services, and substantial costs in health care administration.

The crux of the matter of the present weakness of community care in the English NHS is the widespread fragmentation of health and social services delivered [5], with the historical separation of GPs within the system [8] put under additional stress in this era of ageing population by the low funding of social services provided outside the NHS. This is the major issue that faces all European health systems, and the Italian NHS represents an emblematic example of lack of horizontal IC in community

care, highlighted by the recent catastrophic event of Covid-19 pandemic [9]. In addition to most GPs still working as single-handed and isolated practitioners in the Italian NHS, many different facilities provide sparsely and unevenly administrative and health (e.g. infant vaccinations and population screening) services in the local tier during the weekdays [10].

Although the time may have come to change the status of GPs, who are still mostly self-employed professionals in the European NHSs, we think this change will not on its own restore a rational organisation of health community services. Rather, we are firmly convinced that the pressing priority for a modern primary care is to support large-scale organizations open through the day [11], providing all types of community services (administrative and social included) with multidisciplinary professionals (GPs included), thus able to fulfil the increasing expectations of local people. With advantages for planning and supervision, these organizations would dramatically extend daily access to services in the community and should better filter minor ailments away from emergency departments in hospitals [12]. Thanks to broad consolidation in large-scale facilities, the co-location of all types of healthcare professionals should also minimize administrative overlaps, enhance the management of out-of-hours services, and improve the provision of home care for patients unable to move − particularly the older, frail, patients without any formal/informal caregiver. More, co-location will facilitate communication, boost teamwork and better exploit modern information technology tools like telemedicine [10]. The development of hi-tech skills within these organizations should help clinicians recoup time with patients, always their foremost activity. Eventually, leaving the 'running of the business' to administrative colleagues and focusing only on clinical work [6] should (hopefully) limit the burnout symptoms of health professionals, GPs included.

Accordingly, we think that the horizontal IC of community services in the NHSs should be a more suitable option from an organizational point of view than the vertical one with hospitals. Ideally, the future NHSs should add the second 's' of social, merging health and social budgets to bring the two types of services closer together in a perspective of thorough IC. According to this scenario, vertical IC might fit more for hospitals with post-acute care services downstream. In general, striving to enhance patients' health as the primary interest of health and social services, the future organization of NHSs should be inspired by a culture of systemic collaboration and coordination among health and social professionals [12], competing only for quality of services delivered to patients and not for their funding. This should make also more plausible for IC to achieve its quadruple aim [13] of improving the work life of healthcare professionals.

To conclude, the real challenge to face in such a scenario will be to constrain political influence and administrative bureaucracy, the most serious motivation-killing threats of all public sectors, sort of 'elephants in the room' to be removed also for the future NHSs in Europe.

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