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THE EVOLUTION OF INTEGRATED HEALTH CARE STRATEGIES

Jenna M. Evans, G. Ross Baker,
Whitney Berta and Jan Barnsley

ABSTRACT

Purpose – To examine the evolution of health care integration strategies and associated conceptualization and practice through a review and synthesis of over 25 years of international academic research and literature.

Methods – A search of the health sciences literature was conducted using PubMed and EMBASE. A total of 114 articles were identified for inclusion and thematically analyzed using a strategy content model for systems-level integration.

Findings – Six major, inter-related shifts in integration strategies were identified: (1) from a focus on horizontal integration to an emphasis on vertical integration; (2) from acute care and institution-centered models of integration to a broader focus on community-based health and social services; (3) from economic arguments for integration to an emphasis on improving quality of care and creating value; (4) from evaluations of integration using an organizational perspective to an emerging interest in

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patient-centered measures; (5) from a focus on modifying organizational and environmental structures to an emphasis on changing ways of working and influencing underlying cultural attitudes and norms; and (6) from integration for all patients within defined regions to a strategic focus on integrating care for specific populations. We propose that underlying many of these shifts is a growing recognition of the value of understanding health care delivery and integration as processes situated in Complex-Adaptive Systems (CAS).

Originality/value – This review builds a descriptive framework against which to assess, compare, and track integration strategies over time.

Keywords: Integrated delivery system; integrated care; health system integration; whole systems change; complex adaptive systems

INTRODUCTION

For many years health care systems have focused on improving integration between organizations and levels of care. It is widely believed that the greater alignment and synergy achieved through integration enhances quality of care, efficiency, and patient satisfaction. However, there is a general lack of consensus on what integration is, and how it can be achieved. Literature reviews report the use of numerous definitions, models, and strategies for integration (Armitage, Suter, Oelke, & Adair, 2009; Kodner, 2009; Strandberg-Larsen & Krasnik, 2009; Suter, Oelke, Adair, & Armitage, 2009). This lack of conceptual consistency creates confusion among practitioners when selecting integration strategies, and among the research community when comparing research findings and insights. Increasingly, scholars call for the establishment of a common language and framework of integrated care to provide a base for advancing research and practice (Kodner, 2009; Stein & Rieder, 2009).

There are over two decades of academic research and practical experiences on integrating elements of health care systems, so this is an apt time to explore how integration conceptions and strategies have evolved. The meanings of concepts such as “health,” “health care,” and “integration” lack rigid boundaries and change in relation to context, time, nature of the problem, and evidence of utility (Rodgers, 2000). As well, strategic change represents an evolutionary and iterative process in which managers learn

from their experiences (Lovas & Ghoshal, 2000; Rajagopalan & Spreitzer, 1997). Much of the early thinking on integration is rooted in mechanistic views of care delivery and systems change (Ackerman, 1992; Charns, 1997; Conrad & Dowling, 1990; Fox, 1989; Shortell, Gillies, & Anderson, 1994). It was believed that integrated health systems could be designed from the top-down through a series of steps that brought various elements of health care delivery together under large, centralized structures. Many of these integration efforts failed, prompting scholars and practitioners to recognize the complexity and nonlinear dynamics inherent in the integration process (Baskin, Goldstein, & Lindberg, 2000; Begun, Zimmerman, & Dooley, 2003; Zimmerman & Dooley, 2001). Seminal papers characterizing health care organizations as Complex-Adaptive Systems (CAS) argue that CAS can self-organize without external control as a function of relationships and interactions among diverse agents; in CAS, the future is unpredictable, so learning and sense-making are more important than structure and control (McDaniel & Driebe, 2001; Plsek & Greenhalgh, 2001; Zimmerman, Lindberg, & Plsek, 1998). These ideas are increasingly being applied to integration efforts and other complex change initiatives to better understand the challenges of integrating and to inform the design and management of new or existing integration initiatives (Dattee & Barlow, 2010; Edgren, 2008; Edgren & Barnard, 2012; Nugus et al., 2010; Tsasis, Evans, & Owen, 2012; Tsasis, Evans, Forrest, & Jones, 2013).

In this chapter, we review and synthesize over 25 years of international research to examine the evolution of health care integration concepts and strategies as described in the academic literature. Tracing the development of health care integration strategies can reveal differing viewpoints and applications as well as emerging or outmoded meanings; these insights, in turn, can be used to build a current and common conceptual base for future research and practice (Rodgers, 2000). We identify 14 integration strategies and 6 key shifts in strategy content; we propose that underlying many of these shifts is a growing recognition of the value of understanding health care delivery as a CAS. We conclude with recommendations for researchers, practitioners, and policymakers.

METHODS

We situate our review within the literature on strategy content, which aims to understand the subject of strategic decisions (i.e., “what” is decided) by

identifying and examining different types of strategies in relation to strategic organizational issues such as goals, scope, and competition (Fahey & Christensen, 1986). Much of the literature on strategy content relates to organizations functioning in businesses other than health care referring to categories like “new market development,” “product-service refinement,” and “generic/novel” to organize strategic decisions (Andrews, Boyne, Law, & Walker, 2009; Blair & Boal, 1991; Shortell, Morrison, & Robbins, 1985). Our interests, however, are in the content of strategies used to integrate health care services. To guide our review and analysis of the literature on health care integration, we thus developed four strategy content questions that reflect the key decisions that shape integration strategies: (1) Which organizations and services are targeted for integration? (2) What are the desired outcomes of integration? (3) How will integration be achieved? (4) When, where, or for whom does integration add the most value? We felt that these questions represent the main strategic issues likely to generate discussion and disagreement among health system planners and decision-makers; strategic conflicts typically occur over ends (what), means (how), philosophy (why), location (where), timing (when), and impacts on stakeholders (who) (Bryson, 1988). We hypothesized that a model capturing these potential points of conflict would enable us to identify shifts in health care integration strategies and associated conceptualization and practice. The underlying assumption is that if the four questions represent key strategic issues that generate discussion and disagreement, they may also represent the areas where dominant thought and research have shifted over time.

The review is based on a search of the health sciences literature indexed in PubMed and EMBASE. Although reports on the concept of integration in health care can be traced back several decades, only in the mid-1980s did substantial numbers of academic articles emerge on this topic. As such, only peer-reviewed papers published in English between 1985 and 2013 were included. Commentaries, editorials, and books or book chapters were excluded. We focused the review on papers addressing integration in the United States (US), Canada, Australia, New Zealand, the United Kingdom (UK), and other Western European nations, as these are jurisdictions with the longest history of integration efforts from which we stand the most to learn. Search terms included *integrated/organized delivery system*, *health care/services/systems integration*, and *integrated health care/services/system/delivery*.

The review aims to identify major shifts in thinking about integration at the systems level. We define “system” as encompassing multiple sectors,

organizations, and professionals involved in the delivery of health care services. This criterion excluded articles focused exclusively on integrating specific programs or services (i.e., cancer care, mental health) and those reporting on integrating care for a specific population group (i.e., children, frail elderly). We also excluded articles focused exclusively on integration enablers (i.e., health informatics, physician integration, governance models) or integration tools (i.e., disease management, joint care plans) as our interests were in pursuing our questions at the strategic level, as opposed to the operational. Because the review is interpretive and emphasizes variations in the conceptualization of integration, criteria for inclusion and exclusion as outlined above are based on relevance not methodological quality; this standard allowed for the inclusion of descriptive or discussion papers and theoretical explorations. To be included, papers had to discuss or examine integration in sufficient depth to clarify or further develop understanding of its perceived meaning and application.

Information pertaining to the four strategy content questions was extracted from each of the articles selected for inclusion, and synthesized through an iterative process into 14 categories of strategic approaches to integrating care (Table 1). This process involved three steps: (1) recording integration strategies (i.e., responses to the four strategy content questions), retaining the authors' own words to the extent possible; (2) grouping similar integration strategies together under preliminary categories; and (3) continuously revising the categories and their definitions to improve clarity and applicability. The categories, thus, *emerged* from an analysis of the characteristics and foci of the articles in relation to the four strategy content questions we posed to frame the review. The 14 categories identified are intended to be flexible and broad to accommodate the heterogeneity of international approaches to integration, while also providing a meaningful set of concepts for high-level comparisons and tracking of integration strategies over time. The categories associated with each question are not mutually exclusive.

Following the development of the strategy content categories, the articles were reviewed a second time and coded based on the extent to which each article: (a) promotes, emphasizes, or reports high prevalence of the strategy, (b) argues that the strategy is insufficient (but is, or may be, necessary or beneficial), (c) discourages or reports a decline in the strategy, or (d) does not address the strategy at all or in any depth. Coding was based on a combination of three factors (in order of increasing importance): number of times the strategy was mentioned, amount of space devoted to discussing the strategy, and the tone and type of language used to describe the strategy

Table 1. Defining the Contents of Health Care Integration Strategies.

Strategy Content	Definition
<i>Which organizations and services are targeted for integration?</i>	
Same level	Organizations that provide similar care services (e.g., hospital–hospital relationships and physician group relationships; also called horizontal integration)
Different level	Organizations that provide different care services (e.g., hospital–physician and hospital–homecare relationships; also called vertical integration)
Institution-centered	Organizations that provide full-time in-house monitoring and care to patients; the focus tends to be on addressing, managing, or preventing acute care needs (e.g., acute care and specialty hospitals as well as long-term care homes) ^a
Community-based	Organizations that provide health and social services to clients within their homes or communities; the focus tends to be on primary care, the management of chronic diseases or special needs, and total wellness (e.g., homecare agencies, community support service agencies, and mental health agencies)
<i>What are the desired outcomes of integration?</i>	
Economic	Minimizing costs or increasing profits through control of resources, efficiencies (economies of scale), marketing, and market share; references to quality are limited or quality is viewed primarily as a means to improve economic performance
Value with a focus on quality	Cost-effectiveness or health outcomes per dollar spent with an emphasis on the quality of patient care; better quality and better patient outcomes are an end in themselves, but are also inherently less costly to the health care system
Organizational level	Evaluation and measurement of integration reflects an organizational focus (e.g., structural and process indicators, financial outcomes, and managers' and clinicians' perceived levels of integration)
Patient level	Evaluation and measurement of integration reflects a patient focus (e.g., patient experiences of coordination and patient-centeredness, health outcomes, functional status, and quality of life)
<i>How will integration be achieved?</i>	
Organizational change	Changes to organizational structures and/or the relationships between organizations/providers; examples include mergers, acquisitions, partnerships, governance, size, location, geographic distribution, hierarchy, centralization, scope of services, specialization, and staffing patterns
Process change	Changes to operational activities, including the way health services are delivered; examples include teamwork, communication, incentives, training, use of technology, use of best practices, standards, and protocols, case management, and patient/caregiver engagement
Policy change	Changes to system-level public policies; examples include laws, regulations, and decisions regarding the funding, management, and organization of the health system

Table 1. (Continued)

Strategy Content	Definition
Cultural change	Changes to the shared norms, values, attitudes, assumptions, and beliefs that guide the behaviors and interactions of professionals and organizations; examples include leadership and change management initiatives
<i>When, where, or for whom does integration add value?</i>	
Defined regions	All patients within a geographic boundary
Targeted populations	Specific groups of patients based on age, gender, socioeconomic status, disability, disease, health needs, or other demographic or lifestyle characteristics

^aMany early vertical integration initiatives were hospital-driven with relationships between hospitals and other providers, such as physicians, fueled by a desire to control and promote hospital referrals. We classify these relationships as examples of institution-centered or institution-driven vertical integration.

(i.e., negative vs. positive). The coding scheme was applied to 25% ($n = 30$) of the papers (random sample) by one of the authors and by a group of five naïve coders, each of whom coded six papers. Disagreements were resolved by consensus, and minor modifications were made to the coding scheme to improve clarity. The revised coding scheme was applied to all of the papers by the main coder. The results were organized in chronological order based on publication date and analyzed to identify any shifts in relative emphasis over time for each of the four strategy content questions.

RESULTS

The search strategy produced over 2,000 bibliographic records after the removal of duplicates. Through a screening process, outlined in Fig. 1, 114 papers were ultimately included in the review; this includes a total of five relevant articles identified through a second search of the databases for the period January–March 2013. The majority of papers excluded based on their title and abstract lacked a focus on system-level integration, while the majority of papers excluded based on a full-text review failed to address any one of the strategy content questions in any depth.

The final set of papers hailed from several jurisdictions including the US (43%), Europe (excluding the UK) (26%), Canada (18%), the UK (10%),

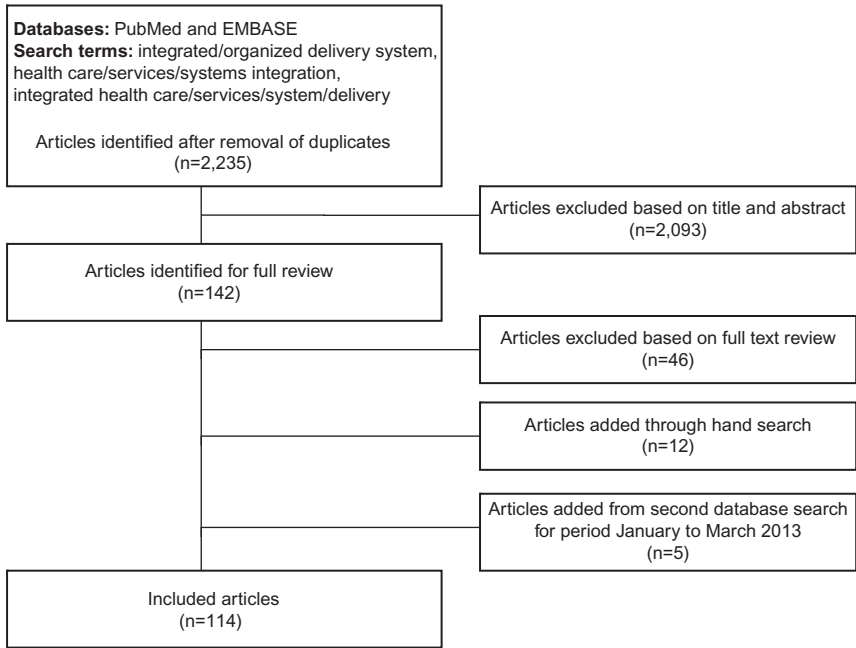


Fig. 1. Article Screening Process.

New Zealand (2%), and Australia (1%). Less than half of the papers were empirical studies (42%). Papers ranged from conceptual or theoretical explorations (15%) and descriptions of integration efforts, characteristics, barriers, and enablers (60%), to evaluation approaches and exercises (25%). The majority of papers were published post-2000 (72%).

A summary of all 114 articles is presented in Table 2 in chronological order. Analysis of the selected literature suggests six important shifts in health care integration strategies, and associated conceptualization and practice. Although the shifts overlap and are interrelated, they are separated here for the purpose of clarity. The six shifts are as follows:

1. From a focus on horizontal integration to an emphasis on vertical integration.
2. From acute care and institution-centered models of integration to a broader focus on community-based health and social services.
3. From economic arguments for integration to an emphasis on improving quality of care and creating value.

Table 2. The Evolution of Health Care Integration Strategies in the Academic Literature, 1985–2013 (*n* = 114).

Reference ^a	Which Organizations and Services are Targeted for Integration? (<i>n</i> =110, 45 Empirical)				What are the Desired Outcomes of Integration? (<i>n</i> =94, 36 Empirical)				How will Integration be Achieved? (<i>n</i> =113, 46 Empirical)				When, Where, Or for Whom does Integration Add Value? (<i>n</i> =80, 26 Empirical)	
	Same level	Diff level	Instit based	Comm based	Econ	Value (qual)	Org level	Pt level	Org	Proc	Poli	Cult	Defined regions	Targeted pop's
Brown et al. (1986)	++	++	++		++				++				++	
Shortell (1988)	++	++	+		~	++			~	++		+	++	
Fox (1989)	+	++	++		++				++				++	
Brown et al. (1990)	++	++	+		+	+			++			+	++	
Conrad et al. (1990)		++	++		++				++	++		+	++	
Ackerman (1992)	~	++	++		++				++				++	
Arndt et al. (1992)		+	++		++				++					
Conrad (1993)		++	~			++			++	++		++	++	+
Gillies et al. (1993)*	~	++	+		+	+	++		++	++		+		
Shortell et al. (1993)*	+	++	~	+					++	++		++		
Devers et al. (1994)*		++				+	++		++	++			+	
Goldsmith (1994)		++	~		~				++	+				
Shortell et al. (1994)*	+	++	++	+	~	++	++	+	++	++	++		+	
Goldstein (1995)	+	++		+		++			~	++		+		
Conrad et al. (1996)	+	++	~	+	++	++			++	++		++		
Griffith (1996)		++	++		++				++	++			++	
Leatt et al. (1996)	+	++				++			++	+	+		++	
Miller (1996)	++	++	+		++	+			~	+				

Table 2. (Continued)

Reference ^a	Which Organizations and Services are Targeted for Integration? (<i>n</i> =110, 45 Empirical)				What are the Desired Outcomes of Integration? (<i>n</i> =94, 36 Empirical)				How will Integration be Achieved? (<i>n</i> =113, 46 Empirical)				When, Where, Or for Whom does Integration Add Value? (<i>n</i> =80, 26 Empirical)	
	Same level	Diff level	Instit based	Comm based	Econ	Value (qual)	Org level	Pt level	Org	Proc	Poli	Cult	Defined regions	Targeted pop's
Robinson et al. (1996)	++	++			++				++					
Walston et al. (1996)	~	++			++				~	+		+		
Charns (1997)	~	++	+	+	++				++	+			++	
Gillies et al. (1997)		++	~	+		++			++	++		++	++	
Leggat et al. (1997)		++		+		++	++	+	++	+			++	
Young (1997)		++	~		+				~	++		++	+	
Barnsley et al. (1998)	+	++							+	++		++		
Fischer et al. (1998)		++	~		~	++			++	++			+	
Goldsmith (1998)		++			~	++			+	+		++		
Hardy et al. (1999)		++	+	+					++	+	++	++		++
Leutz (1999)		++		++	~			+	~	++	++	+	+	++
Lin et al. (1999)*	+	++	+		~		++		~	++			+	
Mur-Veeman et al. (1999)*		++		++					+	+	++	+		+
van Raak et al. (1999)		++	+	++					~	++	~	++		++
Bazzoli et al. (2000)*	~	++	++		++		++		++				+	
Leatt et al. (2000)		++	~	++	+	++	+	+	~	++	++		+	
Paulus et al. (2000)		++		+	+	++	+		+	++	+			++

Table 2. (Continued)

Reference ^a	Which Organizations and Services are Targeted for Integration? (<i>n</i> =110, 45 Empirical)				What are the Desired Outcomes of Integration? (<i>n</i> =94, 36 Empirical)				How will Integration be Achieved? (<i>n</i> =113, 46 Empirical)				When, Where, Or for Whom does Integration Add Value? (<i>n</i> =80, 26 Empirical)	
	Same level	Diff level	Instit based	Comm based	Econ	Value (qual)	Org level	Pt level	Org	Proc	Poli	Cult	Defined regions	Targeted pop's
Van Wijngaarden et al. (2006)*		++	++	+					~	++		++	+	++
Ahgren et al. (2007)*		++		+	~	++			+	++	~	++	+	++
Browne et al. (2007)				++			++		++	++				++
Kautz et al. (2007)*		++	+				~	++	~	++				
Lega (2007)		++	~	+		+			++	++	+	++	++	++
Rea et al. (2007)		+	+	+					~	++	~	+		++
Suter et al. (2007)*		+		++			++	+	+	++			+	+
Thaldorf et al. (2007)	+	++		+	~	+		+	~	++	+		+	+
Hollander et al. (2008)*		++	+	++		+			++	++	++			++
Mur-Veeman et al. (2008)*		++		++					+	++	~	++		++
Strandberg-Larsen et al. (2008)*		++	+				++		+	++	++	++		
Armitage et al. (2009)*						+	++			+		+		+
Denis et al. (2009)*		+	+	++					~	+	+	++	++	+
Enthoven (2009)		++		+		++			++	++	~	++	+	+
Kodner (2009)		++		++		+			++	++	+	+		++

Minkman et al. (2009a)*					++	++	++	+	++	++			++
Minkman et al. (2009b)*								+	++				++
Solberg et al. (2009)	—	++	+	+	++			~	++				+
Stein et al. (2009)					++		+	+	++		+		++
Strandberg-Larsen et al. (2009)*		++				++	+	+	++				
Suter et al. (2009)*		++	~	++	+		+	++	++	++	++	++	+
Williams et al. (2009)*		+		++				~	++	+	++	+	++
McCarthy et al. (2010)	+	++	+		~	++		++	++				
Pate et al. (2010)*				+	+		~	~	+		++		
Rumbold et al. (2010)		++		++				+	+	++			
Strandberg-Larsen et al. (2010)*		++		+		++		~	++				
Ahgren et al. (2011)	+	++		++	—	++		+	++	++		++	++
Bevan et al. (2011)		++			~	++		~	++	~	+	+	
Calciolari et al. (2011)		++		++		+		~	++	+	+	+	++
Cumming (2011)	+	++		++	+		+	~	++	~	++	+	+
Glasby et al. (2011)		++		++	+			~	++	++	+	+	+
Ham et al. (2011)		++		++	+			++	++	++	+	++	++
Hudson (2011)		++	+	++	++		+	~	++	~	++	+	+
Jiwani et al. (2011)	+	++		++				++	++	++	++	++	+
Romoren et al. (2011)		++		+	+	+		~	++	~		++	++

Table 2. (Continued)

Reference ^a	Which Organizations and Services are Targeted for Integration? (<i>n</i> =110, 45 Empirical)				What are the Desired Outcomes of Integration? (<i>n</i> =94, 36 Empirical)				How will Integration be Achieved? (<i>n</i> =113, 46 Empirical)				When, Where, Or for Whom does Integration Add Value? (<i>n</i> =80, 26 Empirical)	
	Same level	Diff level	Instit based	Comm based	Econ	Value (qual)	Org level	Pt level	Org	Proc	Poli	Cult	Defined regions	Targeted pop's
Singer et al. (2011)		+		++			+	++	~	+	+			++
Vedel et al. (2011)		++		++		++			++	++	++	+	++	++
Burns et al. (2012)	++	++			~	++			+	++	+	++		++
Edgren et al. (2012)				+		+			–	++		++		+
Evans et al. (2012)		++		+		+	+		~	~		++		+
Lillrank (2012)		+				+		+	~	++				+
Ling et al. (2012)*				++			~	+	+	++	~	++		++
Kreindler et al. (2012)*	+	++			~	++			~	++		++		
Pourat et al. (2012)*		++		++	+	++	++		+	++	++	++	++	++
Rudkjobing et al. (2012)		++		++		++			++	++	++		++	++
Sullivan et al. (2012)		+		+					~	++		++		
Tsasis et al. (2012)*		++		+					+	++	++	++		
Williams (2012)*				++					~	++	+	++	+	+
Ye et al. (2012)*				++		+	++		+	++				++
Demers (2013)		++		++					~	++		++		
Harris et al. (2013)*		++		++			++		~	++		++	+	+

Tsasis et al. (2013)*		++				+	++	+	++	
Valentijn et al. (2013)	+	++	++	++		++	++	++	++	++
Walker et al. (2013)*		++	++		++		++			

^aAll references list first author only. Articles published in the same year are ordered alphabetically.

* Empirical paper.

++ Promotes, emphasizes, or reports high prevalence of the strategy (strong focus).

+ Promotes, emphasizes, or reports high prevalence of the strategy (limited focus).

~ Argues that the strategy is insufficient (but is, or may be, necessary or beneficial).

– Discourages or reports a decline in the strategy.

Blank space Does not address the strategy at all or in any depth.

4. From evaluations of integration using an organizational perspective to an emerging interest in patient-centered measures.
5. From a focus on modifying organizational and environmental structures to an emphasis on changing ways of working and influencing underlying cultural attitudes and norms.
6. From integration for all patients within defined regions to a strategic focus on integrating care for specific populations.

The six themes above represent shifts in *relative* emphasis and do not imply that certain conceptualizations are obsolete or that some strategies are no longer implemented. We describe these shifts in strategy content in further detail below followed by an examination of the contributing factors to change.

Which Organizations and Services are Targeted for Integration?

From Horizontal to Vertical Integration

From the late 1980s to the mid-1990s interest gradually decreased in horizontal integration efforts involving mergers of organizations providing the same level of care, such as among acute-care hospitals or among rehabilitation hospitals (see Table 2). Multihospital systems initially emerged in the US as a means to garner security and protection in a highly uncertain and complex health care environment; achieving economies of scale and increased market power through system participation was a survival mechanism (Conrad & Shortell, 1996; Shortell, 1988). However, multihospital systems largely failed to demonstrate improved profitability, quality, or access compared with independent hospitals (Burns & Pauly, 2002; Shortell, 1988). The lack of improved outcomes has been attributed to a narrow focus on administrative economies with little consideration for the integration of medical care (Shortell et al., 1994).

By the early to mid-1990s, the vertical integration of organizations providing different levels of care became the focus of restructuring efforts with hospitals acquiring physician practices, long-term care homes, and medical equipment companies in addition to other hospitals. This integration strategy, which has persisted to date (see Table 2), was driven by environmental conditions, most notably the introduction of managed care in the US which increased interdependencies among organizations at different levels in health care delivery, as well as desires to control increasing costs, respond to changing patient needs, and acquire legitimacy (Ackerman, 1992; Arndt &

Bigelow, 1992; Burns & Pauly, 2002; Conrad & Dowling, 1990; Walston et al., 1996). Yet, like their multihospital predecessors, hospital-led vertically integrated systems experienced few economies of scale due to higher transaction costs, limited coordination of medical care, and slower decision-making (Burns & Pauly, 2002; Goldsmith, 1994, 1998). Although evidence of sustained financial or clinical value in horizontally and vertically integrated systems – referred to as Integrated Delivery Systems – was scarce, belief in the logic of coordinating functions and services across the continuum of care persisted. Alternative strategies began to emerge seemingly in response to the disappointing performance outcomes of these early integration efforts.

From Institution-Centered to Community-Based Integrated Care

In the last decade there has been an increasing focus on integrating more broadly across various levels of medical care and across public health, social services, and related supports such as education and housing at the community level (Browne et al., 2004; Hollander & Prince, 2008; Kodner & Spreeuwenberg, 2002; Plochg & Klazinga, 2002; Singer et al., 2011). These multi-sectoral approaches recognize the interdependencies between social conditions and health status, and demonstrate deeper consideration for the roles of informal, self-directed, and culturally sensitive care in the delivery of integrated services. This shift may be linked with the emergence of increasing evidence regarding the impact of nonmedical determinants on individual and population health, and associated changes to traditional definitions of what constitutes health and health systems (Arah, Westert, Delnoij, & Klazinga, 2005; Raphael, 2009).

There has been significant movement away from conceptualizations in which acute care hospitals are the nucleus of the system (Burns & Pauly, 2002; Hollander & Prince, 2008). An acute care focus initially dominated because hospitals and hospital chains pursued integration strategies (Brown & McCool, 1990; Conrad & Shortell, 1996; van der Linden et al., 2001). As such, system leaders were encouraged to select integration pursuits based on the “needs of the acute care business” and not necessarily population health needs or health system objectives (Fox, 1989, p. 53). However, Table 2 displays an increasing emphasis on linking various home and community-based facilities and services in addition to improving transitions to and from hospitals, with primary care as the hub (Browne et al., 2004; Burns & Pauly, 2012; Cumming, 2011; Niskanen, 2002; Pourat et al., 2012; Valentijn et al., 2013; Williams & Sullivan, 2009).

Expert opinion and empirical evidence suggest that those systems built around primary care demonstrate superior performance as compared to systems built around hospitals (Burns et al., 2005; Goldsmith, 1994; Robinson & Casalino, 1996). Conrad and Shortell (1996) argue that hospitals must become “peripheral organizations” within the system (p. 36), and Burns and Pauly (2002) state that hospitals will have a role, but “by no means the leading role” in linking services (p. 140). Recent reform efforts like Accountable Care Organizations (ACOs) and the Patient-Centered Medical Home (PCMH) emphasize incentives for quality and efficiency, performance-based accountability, and a strong primary care foundation respectively. Experts suggest combining ACOs and PCMHs to create “medical neighborhoods” that support integration and accountability between clinicians and services within PCMHs, and those that fall outside of those boundaries, including nonmedical providers (Fisher, 2008; McClellan, McKethan, Lewis, Roski, & Fisher, 2010; Pham, 2010; Rittenhouse, Shortell, & Fisher, 2009; Walker et al., 2013).

What are the Desired Outcomes of Integration?

From Economic to Quality Arguments for Integration

Both horizontal and vertical integration strategies emerged in the health care sector for economic reasons, including potential economies of scale, market domination, increased profits, and ultimately better prospects for survival (Thaldorf & Liberman, 2007). The advantages of integration were initially outlined in terms of efficiencies with quality improvement framed as a means to achieve economies of scale or as a potential secondary benefit (Ackerman, 1992; Conrad & Dowling, 1990; Fox, 1989; Goldsmith, 1998; Walston et al., 1996). Some health care views on economic motives may have been rooted in business literature and practices which depicted vertical integration as a rational economic response by organizations to a changing environment (Fox, 1989). Indeed, the dominance of financial performance measures and economic arguments for horizontal and vertical integration is a product of the American policy context in the early to mid-1990s when health service organizations were under growing pressure to perform better financially (Friedman & Goes, 2001). Many health care systems outside of the US also initially adopted integration strategies with the primary aim of minimizing or controlling costs (Ahgren & Axelsson, 2011; Jiwani & Fleury, 2011; Leatt et al., 2000; Niskanen, 2002; Rea et al., 2007). Challenges in identifying and measuring meaningful quality outcomes may

have also contributed to a reliance on financial measures to assess performance (Friedman & Goes, 2001).

However, the focus on potential economic benefits of integration in the literature has expanded to a dual emphasis on both efficiency and quality of care, as Table 2 depicts. This shift in thinking may have occurred for two reasons. First, the increasing “corporatization” of health care management practices in the US fueled fear among some observers that quality was at risk, resulting in demands for greater patient protection and public accountability (Shortell, Gillies, Anderson, Erickson, & Mitchell, 2000). Second, by the mid-1990s evidence began to emerge that successfully integrating policy, staff, funding, and clinical processes requires substantial investments that may result in improved quality of care, but not necessarily efficiencies, particularly in the short term (Burns et al., 2005; Leutz, 1999). While some papers reported, or suggested, improved financial performance as a result of integration (e.g., Wan et al., 2002), others illustrated negative, mixed, or no impacts (Bazzoli et al., 2000; Burns et al., 2005; Fischer & Coddington, 1998; Lee & Wan, 2002). The inconsistency in evidence may be caused by implementation difficulties and methodological challenges, such as conceptual ambiguity, contextual differences, and a lack of long-term studies (Stein & Rieder, 2009).

Since the early 2000s, there is a growing recognition that efficiency and quality are linked and must be addressed simultaneously to create enduring value for patients, providers, and purchasers. For example, eliminating waste resulting from unnecessary and unsafe care can result in both quality and efficiency improvements (Mazzocato, Savage, Brommels, Aronsoon, & Thor, 2010; Porter & Teisberg, 2006); a quality-centered culture also influences multiple dimensions of performance, including financial outcomes (Shortell et al., 2005). As such, the value of integration is increasingly being defined by arguments for enhancing the quality of care delivered to patients with particular attention to patient-centeredness (see Table 2) (Ahgren & Axelsson, 2011; Kautz et al., 2007; Kodner & Spreeuwenberg, 2002; Kreindler et al., 2012; McCarthy & Zuckerman, 2010; Minkman et al., 2009a; Valentijn et al., 2013).

Failure to develop consensus on the purposes of health systems integration among managers, policy-makers, clinicians, and patients can hinder efforts to secure cooperation at all levels (Friedman & Goes, 2001; Stein & Rider, 2009). The shift toward quality arguments for integration may have arisen with the recognition that it is important to align and balance competing motives among various stakeholders in order for integration efforts to succeed.

From Organization-Focused Evaluation of Integration to an Emerging Interest in Patient-Centered Measures

Although, there is a reliance on reporting the *perceived* extent and impacts of integration from the perspectives of managers and clinicians (Strandberg-Larsen & Krasnik, 2009), a growing number of scholars are emphasizing or exploring patient expectations, perceptions, and experiences of integration beyond patient satisfaction (Cumming, 2011; Kautz et al., 2007; Minkman et al., 2009a; Singer et al., 2011; Walker et al., 2013). The definition of integrated care has recently been extended to incorporate the concept of patient-centeredness with measurement focused on the patient experience of integrated care, not underlying organizational structures and processes (Singer et al., 2011; Walker et al., 2013). Table 2 suggests that there is a developing interest in expanding traditional evaluation frameworks to include broader and more complex sets of measures based on the patient perspective. However, 58% of the papers included in the review ($n=66$) do not discuss performance measurement or evaluation at all or in any depth, as the blank cells in Table 2 indicate. The limited attention in the literature to measurement and evaluation highlights a gap in knowledge and practice that may be hindering progress toward integrated systems of care. This gap suggests a need for ongoing attention to the development, implementation, and refinement of multilevel performance evaluation and measurement frameworks which incorporate both organizational-focused and patient-centered measures.

How Will Integration be Achieved?

From Structural to Operational and Cultural Approaches to Change

Initial integration efforts primarily emphasized changes to organizational structures (i.e., mergers, acquisitions, and alliances) with few corresponding modifications to care processes and administrative operations. The reliance on structures to promote integration may stem from the relative ease with which structures can be changed compared with processes embedded in them such as communication, routines, and teamwork. Several studies suggest that structural modifications are inadequate for integrating services and patient care (Burns & Pauly, 2002; Burns et al., 2001; Kautz et al., 2007; Lee & Wan, 2002; Strandberg-Larsen et al., 2010) and many experts attribute integration failures to a narrow focus on bureaucratic mechanisms and a disregard for system functioning (Bevan & Janus, 2011; Demers,

2013; Friedman & Goes, 2001; Hudson, 2011; Shortell, 1988; Tsisis et al., 2012; Williams & Sullivan, 2009; Young, 1997).

Similarly, although the broader context (including public policies, laws, and regulations) can positively or negatively impact integration efforts and outcomes (Mur-Veeman et al., 1999; Mur-Veeman et al., 2008), more micro-contextual factors like local management actions – including stakeholder engagement, participative leadership, and open communication – also play decisive roles in achieving integration goals even if the broader institutional context remains unchanged (Ahgren & Axelsson, 2007; van Raak et al., 1999; Williams & Sullivan, 2009). As shown in Table 2, scholars increasingly suggest that while policy changes to incent and support collaboration may be necessary or beneficial, they are not sufficient for achieving integrated care; in fact, frequent modifications to public policy which result in restructuring or competing incentives can damage existing networks and relationships and focus attention on internal reorganization rather than external relationships (Cumming, 2011; Demers, 2013; Hudson, 2011). In the English National Health Service (NHS), for example, ongoing structural reforms to administrative boundaries and roles paired with policy ambiguity regarding the functions of and relationship between competition and cooperation may have contributed to “increased fragmentation and rivalry across the system” in recent years (Hudson, 2011, p. 4). Similarly, New Zealand implemented a series of reforms over the past decade, including the establishment of District Health Boards and Primary Health Organizations, but reports suggest that these efforts have had limited impact on service delivery (Cumming, 2011).

Within the movement away from an exclusive focus on structural interventions lies a sub-shift: an increasing emphasis on more loosely linked relationships like partnerships and alliances rather than mergers and acquisitions. While there was early acknowledgement of the viability of partnership, or “virtual” approaches to integrating services (Brown & McCool, 1986; Conrad & Dowling, 1990; Fox, 1989), ownership models dominated industry through the mid-1990s. Shared ownership was originally assumed to confer the benefits of reducing conflicts of interest among service providers, increasing strategic control and speed in decision-making, and reducing transaction costs (Conrad, 1993; Conrad & Shortell, 1996). However, there is little and often mixed or only indirect evidence to support these assumptions (Bazzoli et al., 2000; Burns et al., 2005; Kautz et al., 2007). In practice, owned integrated systems exhibited more management layers, slower decision-making, higher costs, and wider gaps between system executives and clinicians thus displaying diseconomies of both scale and

coordination (Demers, 2013; Goldsmith, 1994, 1998; Walston et al., 1996; Yu et al., 2005). The political and logistical challenges of shared ownership contributed to struggles for power that diverted attention, resources, and commitment away from the integration vision. The success of earlier established Integrated Delivery Systems, like Kaiser Permanente and the Mayo Clinic, has been attributed to unique advantages that are difficult to imitate or recreate, such as a favorable socioeconomic and political context and early development, allowing for the accumulation of management experience and the development of a coherent culture (Bevan & Janus, 2011; Burns & Pauly, 2002). Evidence also suggests that integration at a corporate level has no relationship with integration at the patient-care level (Kautz et al., 2007; Leatt et al., 2000; Lee & Wan, 2002).

In response to the challenges of shared ownership and the prevalence of suboptimal outcomes, there was a shift toward managing, not necessarily eliminating, organizational boundaries (Friedman & Goes, 2001; Glasby et al., 2011; Leatt et al., 2000; Miller, 1996; Robinson & Casalino, 1996; Strandberg-Larsen & Krasnik, 2008; Woods, 2001). Shared information, best practice guidelines, and a common culture can facilitate coordination across boundaries through trust, shared objectives, and recognition of interdependence rather than through control using hierarchy or ownership (Burns & Pauly, 2002; Conrad, 1993; Demers, 2013; Suter et al., 2009). In other words, virtual integration may capture the advantages of ownership models without the associated risks and liabilities. ACOs in the US reflect this shift in thinking. ACOs may adopt diverse structural arrangements and relationships, yet the primary focus of reform efforts is clinical transformation at the process level (Burns & Pauly, 2012; Kreindler et al., 2012; McClellan et al., 2010).

Recent studies examine integrative and developmental processes more closely, including teamwork, communication, decision-making, and knowledge exchange (de Jong & Jackson, 2001; Harris et al., 2013; Minkman et al., 2009b; Tsasis et al., 2013; van Wijngaarden et al., 2006; Williams, 2012; Williams & Sullivan, 2009; Yu et al., 2005). Scholars are also increasingly focused on understanding and managing the cultural, cognitive, and power differences between organizations and professional groups as a means to improving integration efforts and outcomes (see Table 2) (Ahgren & Axelsson, 2007; Denis et al., 2009; Evans & Baker, 2012; Kreindler et al., 2012; Pate et al., 2010; Pourat et al., 2012; Sullivan & Williams, 2012; van Wijngaarden et al., 2006; Williams, 2012). For example, Evans and Baker (2012) develop a framework of “mental models of integrated care” which outlines important knowledge and beliefs whose convergence or divergence

across stakeholder groups may influence interorganizational and interprofessional relations. Others echo the need to build common knowledge and perceptions (Ahgren & Axelsson, 2007; Ling et al., 2012; van Wijngaarden et al., 2006; Williams, 2012), in part through training in teamwork and care coordination (Ling et al., 2012; Pourat et al., 2012) as well as through social strategies that engage and unite people working at different levels and across different settings (Denis et al., 2009; Kreindler et al., 2012; Pate et al., 2010).

The shift in relative emphasis from context and organizational structures to operational activities and cultural issues does not imply that structural modifications are unnecessary. Modifications to governance, funding, and accountability structures are usually necessary, but not sufficient for achieving integration (Cumming, 2011; Hudson, 2011; Ling et al., 2012; Plochg et al., 2006). Structural changes facilitate the meso- and micro-level work needed to integrate care and encourage widespread implementation, adequate evaluation, and sustainability (Fleury, 2006; Lega, 2007; Minkman et al., 2009b; van der Linden et al., 2001; Valentijn et al., 2013), but Table 2 suggests that operational and cultural changes may be more likely than organizational and policy interventions to directly contribute to the delivery of integrated care.

When, Where, or For Whom Does Integration Add Value?

From Integration for All to Integration for Targeted Populations

Although integration in some studies is associated with positive outcomes, research evidence as a whole is limited, and in some cases mixed. This ambiguity is due to differences across studies in the integration models and approaches examined, their context, and the evaluation methods used (Armitage et al., 2009; Burns & Pauly, 2002; Stein & Rieder, 2009). While the intuitive potential value of integrating care remains, integration may not be necessary or beneficial in all circumstances and contexts, and may not be desired by some patient groups (Ahgren & Axelsson, 2005; Burns & Pauly, 2002).

Studies suggest that successful integration is more likely when provider interdependence is high, situation uncertainty is high, and the services to be integrated have clear boundaries, such as in cardiac care or women's health (Fleury, 2006; Leutz, 1999). As depicted in Table 2, the emerging method for achieving integration is to adopt a patient-centric approach by integrating care for certain subpopulations or disease groups (Burns & Pauly,

2002; Fleury, 2006; Hollander & Prince, 2008; Kodner, 2009; Kodner & Spreeuwenberg, 2002; Leutz, 1999; Plochg et al., 2006; Rea et al., 2007; Valentijn et al., 2013). Research focused on integrating care within specific sectors or for particular patient populations has a long history. For example, there is a rich and growing literature on integrating care for mental health patients. Papers like these that focused on such specific populations were excluded from inclusion in this review. However, we note that work with a broader emphasis on integration increasingly recognizes the need to identify and engage targeted patient populations as part of system-level integration strategies. There is a growing belief that more focused integration strategies that involve reorganizing care delivery around medical conditions, interventions, or population groups will yield better quality and efficiency outcomes, and offer competitive advantages, when compared with broader, generic approaches to integration (Burns & Pauly, 2002). These benefits may result in part from a reduction in the implementation of costly large-scale integration initiatives and from increasing attention to patient needs and experiences as the drivers of integration. Improving services for complex and vulnerable patients may eventually contribute to system-wide enhancements in integrated care for all patients (Stein & Rieder, 2009). For example, in Sweden, “chains of care” that link health care providers for targeted groups of patients are viewed as prerequisites for the development of broader clinical networks called “local health care” (Ahgren & Axelsson, 2007).

DISCUSSION

This review identifies and discusses six shifts over time in the conceptualization and practice of health systems integration as described in the academic literature. Other reviews have focused on defining terms, identifying conceptual distinctions, and outlining various views and approaches, but do not track changes in focus and thinking within the integration literature (Armitage et al., 2009; Kodner, 2009; Strandberg-Larsen & Krasnik, 2009; Suter et al., 2009). Using a strategy content model and a coding scheme, we identified evidence in support of our proposition that conceptualizations and applications of integration have shifted over time (Table 2). The six proposed trends are general themes that provide an overview of health systems integration research over the past 27 years. The trends suggest that many previous connotations of integration are less relevant to current

discussions. Horizontal, acute care and cost-focused, one-size-fits-all, structural approaches no longer represent the recommended methods for integrating services. The academic literature increasingly focuses on integration strategies involving community-based partnerships across the continuum of care, operational and cultural change, quality and patient-centered goals, and targeted patient populations. None of these ideas were completely absent in earlier integration research, but they have become a more central focus in recent years.

Three factors are likely contributors to the changes we have observed in integration objectives, desired scope, and proposed methods. First, environmental changes such as aging populations, increasing prevalence of chronic illnesses, and economic pressures have led to increasing demands for integrated care (Grone & Garcia-Barbero, 2001). Although information exchange and interoperability are ongoing challenges, technological advancements in medicine and informatics are providing tools (i.e., video telemonitors and portable patient-friendly biometric devices) for improving the transition to community-based care by making services like telehealth and home care for complex patients more feasible (Darkins et al., 2009), thus reducing the transaction costs of integrated care.

Second, there has been growing interest in providing patient-centered care. Researchers, system leaders, and clinicians have been moved to ask “who needs integrated care” and to visualize the patient experience receiving care over time and across providers. The movement from an organizational focus to a patient focus may be influenced in part by increasing use of wellness as opposed to illness models of health (Larson, 1999), a greater emphasis on customer service as a result of the application of business frameworks and tools (Ford & Fottler, 2000), and the growing interest in patient experience as a dimension of quality of care (Berwick, 2009).

Finally, research on health systems integration over the past two decades has provided new information regarding the costs, benefits, and challenges of integration. We have a better sense of what integration entails and what works for whom and under what circumstances. Contrary to traditional assumptions, the integration of organizations and their activities to form systems does not necessarily result in the integration of direct patient care (Singer et al., 2011). As such, integration has become less defined by Integrated Delivery Systems, which are one means for promoting integration, and more by the desired output, integrated care.

The failure of many early attempts at integration also may have fueled growing recognition of the value of seeing integration through the lens of CAS theory (Baskin et al., 2000; Begun et al., 2003; Dattee & Barlow,

2010; Edgren, 2008; Edgren & Barnard, 2012; Nugus et al., 2010; Tsasis et al., 2012; Zimmerman & Dooley, 2001). Scholars and practitioners are gradually moving away from linear, command-and-control views of system transformation in which change is implemented from the top-down and attention is focused on organizational structures. A CAS lens emphasizes instead the role of relationships and interactions in shaping change efforts; as such, cultural similarities and differences, learning and sense-making processes, and the voices of patients and their caregivers take on more central importance (Edgren & Barnard, 2012; McDaniel & Driebe, 2001). Our findings suggest that there is a growing belief that integration strategies involving community-based partnerships, operational and cultural change, quality and patient-centered goals, and targeted patient populations may be more effective than, or may increase the effectiveness of, more traditional integration methods. CAS theory offers an explanation for why this might be so; replacing top-down control with mechanisms that support dialogue, experimentation, and collaboration from the bottom-up maximize the potential for the system to coevolve and self-organize in ways that positively impact performance (McDaniel & Driebe, 2001; Tsasis et al., 2012). Formal rules, procedures, and structures are typically too rigid and static to effectively address and manage the complex and dynamic nature of change in CAS (Lanham et al., 2013). Agents not only need sufficient structure to allow for information exchange, but also sufficient flexibility to allow for local trial-and-error and mutual adaptation to changing needs and capacities and changing demands and opportunities from the environment (Comfort, 1994). These insights from CAS theory are supported by recent research on whole-systems change in health care, which links success and sustainability to “engaged human agents” and sociocultural and interpersonal factors, rather than hard structures (Best et al., 2012; Greenhalgh, MacFarlane, Barton-Sweeney, & Woodard, 2012, p. 543).

Policy-makers, managers, and care providers involved in integrating care may use the four strategy content questions outlined in Tables 1 and 2 to reflect on their current practice and to guide discussions and interactions. Comparing responses to the questions across stakeholder groups may reveal areas of potential conflict that need to be addressed or potential opportunities for securing buy-in or leveraging efforts. This type of dialogue may be particularly important given the increased focus in the literature on the cultural challenges of integration. Given that experiences with integration fail to align with mechanistic views of health care delivery, practitioners may consider applying managerial strategies (Edgren & Barnard, 2012; Lanham et al., 2013; McDaniel & Driebe, 2001; Tsasis et al., 2012)

and scholars may consider developing research designs (McDaniel, Lanham, & Anderson, 2009) rooted in a CAS perspective. Finally, the 14 integration strategies in Table 1 can be used as a descriptive framework of strategy content against which to assess, compare, and track new concepts and approaches emerging in the field.

The six proposed shifts are intended to describe and characterize the literature, not prescribe or predict; the evidence base is modest and the shifts are general; therefore, judgments regarding which strategies are best are premature. These trends may also be broken down to examine more specific changes and issues that have emerged over time and within specific contexts. Future studies on integration would benefit from specifying the contextual factors and strategy content of integration initiatives under study, permitting more detailed analyses of how these two factors interact to shape performance outcomes. Describing these details in published reports will enable more objective and accurate comparisons to be made across studies and will help clarify which integration strategies produce the desired outcomes and under what conditions.

LIMITATIONS

Changing terms and the interdisciplinary nature of the field suggest that relevant papers may have been missed. Grey literature reports and papers on integration at the program or provider levels were not included, but these may provide further insights for future research. Furthermore, the extent to which the peer-reviewed academic literature accurately captures integration practices as they have unfolded over the years in real world contexts is debatable. For example, although there has been a shift in emphasis in the literature from horizontal, institution-centered, and cost-driven integration strategies to vertical, community-based, and quality-driven integration strategies, in practice horizontal integration schemes, acute care paradigms, and cost-driven policy interventions persist in some contexts (Ahgren & Axelsson, 2011; Hudson, 2011; Jiwani & Fleury, 2011). Professional publications, trade and business magazines, and documents from organizations and systems offer further information on if, how, and to what extent integration strategies and practices have evolved.

Trends and changes over time were assessed based on publication year. Considering the lag in published articles and the differences in time to publication from one journal to another, this is an imperfect method. Finally,

many early papers on integrated health systems emerged from the US as a response to the development of managed care; as a result a substantial number of papers in this review are based on the American experience (43%). Nevertheless, the changes in health care integration strategies have transpired along similar trajectories in other national contexts (Delnoij et al., 2002; Grone & Garcia-Barbero, 2001; Hardy et al., 1999; Leatt et al., 2000; Leutz, 1999; Woods, 2001).

CONCLUSION

The meanings and focus of health systems integration have shifted over time with the evolution of health care needs and the broader social environment, and with growing experience of the challenges and impact of integration strategies. The six broad shifts that we have described above reflect a broader paradigm shift in health care away from acute inpatient care, the treatment of illness, and responsibility for the individual patient to a focus on integrating services, improving quality of care, and accountability for population health (Shortell & Kaluzny, 2005). Our findings suggest a growing movement away from mechanistic conceptions of health care management and delivery, and an increasing recognition of the value of understanding integration as an agent-based, nonlinear, emergent, self-organizing and coevolving phenomenon (Tsasis et al., 2012). The evolution of integration strategies raises the question, “What new trends will emerge in our quest for integrated care?” In this chapter, we suggest that improving health systems integration requires periodically looking back to understand the development of current strategies and to learn from past experiences and ways of thinking.

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