International Journal of Integrated Care – Vol. 3, 1 October, 2003 – ISSN 1568-4156 – http://www.ijic.org/

Editorial

Integration of services and the European Union: does EU policy make sense?

What is gradually becoming clear in all countries of the European Union is, that integration of services is more and more urgently needed in order to deal with the changing needs and demands of the ageing European citizens. Everywhere in Europe older people are more and more faced with smaller social networks, growing dependency, less mobility and psycho-geriatric syndromes. Such problems cannot be adequately dealt with by the current functional and fragmented health care services. What has also become clear, however, is, that such an integration faces many problems, ranging from difficulties of inter-professional working to inadequate financial and legislative structures. Every country is seeking its way out of these problems, thus preparing the way to adequately develop, introduce, manage and deliver integrated care services. Whereas all countries obviously face the same problem, the question arises what the European Union could do to help tackling it.

It is apparent that the EU's interest in health and health care of the European citizens is growing. For example, the 1999 Amsterdam Treaty showed the intention to revise and strengthen the EU's public health competency, e.g. by establishing the possibility of adopting measures to ensure and not just to contribute to a high level of human health protection. But this should be done, as the Treaty says, on the condition that EU action will only complement national policies and without aiming at harmonisation of laws. Obviously, the politicians involved were aware of the limitations of European policy, especially that the EU has to recognise the national legislative domains of the member states. This implies that considerable EU involvement in integrated care policy and development in the separate EU countries for the time being is not to be expected, and rightly so. For the EU there are good reasons for being reserved in this respect, whereas the national identity and autonomy of (political) decision making on societal issues are high-ranking values in the member states. In addition, although they share some important health system problems such as fragmentation and complexity, these systems often significantly differ, which impedes the implementation of legislation and measures at European level. Differences not only relate to differences in system (in)-efficiencies or in managerial conditions and capabilities, but also to developing different solutions for these problems. Such a variety of problems and solutions can be explained by the specificity of the different national configurations. This means that every country has its own system—and power structures and its own culture which together are a hank that cannot simply be unravelled, but does shape the nature and amount of problems, solutions and, also, expectations for developing integrated care. For instance, in a country with a more centralised political system, such as England, especially the government is being expected to promote and to develop the integration of services. While in a more decentralised system, like in the Netherlands, it is the care organisations and professionals who are expected to develop integrated care in the first place. Another example is the important role of informal care for the elderly in countries such as Spain and Austria, due to a more familial culture and as such exerting less pressure on professionals, care agencies and policy makers to develop integrated formal care arrangements. This situation is currently changing and these countries make their first steps on the path of integrated care.

Because the variety of problems, solutions and expectations among the countries is inextricably connected with the characteristics of their national configurations, it would be a mistake indeed to develop and implement all encompassing, uniform, compulsory EU policy and legislation that does not allow scope for policymaking to the national governments. Instead of providing a solution, this would aggravate the problems. Does this all mean that integrated care should not be an issue for European Union policy? This would be a far-reaching conclusion, probably too far-reaching. For, provided that the EU holds a reserved attitude and position, it could really take measures to promote integrated care. As a first step, in order to encourage national governments to promote integrated care, it is important that the issue will be placed more emphatically on the European political agenda and that incentives are given, such as subsidies for integrated care development in the member states. If happens in the near future what some recent policy debates indicate, namely that the EU competency in health care will increase, it is even thinkable that certain basic rules could be introduced to promote integration of services. What is most important, however, is that all incentives

or possible rules should be tailored to the national configurations of the member states. For, EU actions can only be successful when they fit the specific national structures, cultures and power relations. So, tailor-made basic rules instead of uniform liability are the key words here. Development of such rules requires more detailed knowledge of the member states' national configurations, e.g. their characteristics and their interplay, promoting and inhibiting factors and opportunities and chances for improvement. In this view, studies and publications on integrated care, such as in this journal, should be continued and deepened as a basis for high quality policy making on the level of the European Union for the promotion of integrated care. For this reason, research on integrated care should be more prominently put on the EU's research agenda.

Ingrid Mur and Arno van Raak