Editorial: Integrated care’s missing piece: the US experience

I recently talked to a colleague from the US who is interested in integrated care, and it got me thinking: why do we publish so few integrated care studies in our journal from the US? You may say that this is just a blind spot in this journal, whilst there are plenty of wonderful examples of integrated care initiatives in the country. However, I have been at many integrated care conferences in Europe and outside Europe and have rarely seen a strong representation at these events from the US. I know there is a lot of interest in care integration in the US by scholars and researchers. In fact, some of the foundational texts of the discipline were written by US scholars (Leutz, 1999, 2005). So why is it that we see so few papers by US authors submitted to this journal, and, may I surmise, probably also to any other integrated care journal?

Before embarking on possible explanations, I should probably say why I think this matters. The lack of submissions to our journal from the US is not simply a commercial concern. It is a question whose answer may yield insights into the nature of integrated care as we practice it. By better understanding why US scholars do not write papers on integrated care to the same extent as scholars from Canada, Europe, Australia or South East Asia, we may generate insights into what provides the foundation for the current formation of integrated care research.

If you ask ChatGPT, you may get a succinct response to the question: Why the US is not awash with integrated care initiatives? Here is what it told me:

The US healthcare system’s fragmentation, incentive structures, regulatory environment, cultural preferences, and focus on specialization create significant barriers to the widespread adoption and representation of integrated care practices. While there are movements towards integrated care, such as through ACOs and value-based care initiatives, these are still evolving and not yet reflective of a broader systemic change that is seen in other countries with more centralized healthcare systems.

Two words stood out to me as I was reflecting on this response: “centralised” and “fragmentation”. First of all, using the term “fragmentation” in this context as a barrier to care integration may strike one as odd. Reducing fragmentation is the bread and butter of integrated care initiatives. In fact, some historical narratives identify the time when sectoral fragmentation set in as the birthday of the integrated care movement. In England, such a moment was the creation of distinct health and social care sectors through the Local Government Act (1972). The Act in effect separated social care from health care institutionally by 1974 and advocates of (the structural variety of) integrated care have argued for a recovery of paradise lost ever since. So, it is not fragmentation per se which prevents integrated care solutions. More accurately, it seems to be a specific type of fragmentation which hinders care integration.

This brings me to the second point of note. It is how policy is made and how it achieves an impact. Integrated care organisations such as the International Foundation of Integrated Care (IFIC) carry the promise of policy influence and policy change. Their main thrust (in the domain of policymaking) is to create environments hospitable to positive evidence-based innovation. Such a desire to influence things for the better, be it at the local, regional or
national level, requires a modicum of common purpose amongst all stakeholders. Thus, a key condition for successful integrated care initiatives at scale has been a basic alignment of purpose, incentives, funding and governance structures supportive of collaboration. If you substitute “centralisation” for “common purpose”, you are beginning to see how fragmentation and central policy have been the handmaidens of integrated care initiatives.

In England, central re-alignment of the health sector is frequently done by the Westminster Government, which initiates reorganisations of the NHS ever so often. In turn, every single national reorganisation of the NHS is perceived as “an opportunity”, or “an opportunity missed”, depending on your perspective, by integrated care advocates. The choice of words highlights the hopes pinned on central policy as a driver for change. Where policy and legislation can effect wholesale change across the entire sector, hope is kept alive that one day a truly integrated sector may emerge and fragmentation is swept away. This reveals why, as I argued above, the failure of US scholars to flood our *Journal of Integrated Care* with submissions tells us something about ourselves: It is fragmentation within broader centralisation, which is particularly favourable to integrated care initiatives.

Axel Kaehne

References
