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Integrated care in Switzerland: Results from the first nationwide survey

Séverine Schusselé Filliettaz[a,b,*], Peter Berchtold[b], Dimitri Kohler[c], Isabelle Peytremann-Bridevaux[a]

[a] Institute of Social and Preventive Medicine (Lausanne University Hospital & University of Lausanne), Route de la Corniche 10, CH-1010 Lausanne, Switzerland
[b] Forum Managed Care (FMC), Zugerstrasse 193, CH-6314 Neuägeri, Switzerland
[c] Swiss Health Observatory (OBSAN) (former employer), Espace de l'Europe 10, CH-2010 Neuchâtel, Switzerland

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ABSTRACT

Introduction: Due to fragmentation of care delivery, health systems are under pressure and integrated care is advocated for. Compared to the numerous existing integrated care initiatives in Europe and elsewhere, Switzerland seems to lag behind.
Methods: The objective of the survey was to produce a comprehensive overview of integrated care initiatives in Switzerland. To be included, initiatives needed to meet four criteria: present some type of formalization, consider >2 different groups of healthcare professionals, integrate >2 healthcare levels, be ongoing. We systematically contacted major health system organizations at federal, cantonal and local level. Between 2015 and 2016, we identified 172 integrated care initiatives and sent them a questionnaire. We performed descriptive analyses.
Results: Integrated care initiatives in Switzerland are frequent and increasing. The implementation of initiatives over time, their distribution between linguistic areas, the number of healthcare levels integrated, and the number of professionals involved vary according to the type of initiatives.
Discussion: Despite Switzerland's federalist structure and organization of healthcare, and only recent incentives to develop integrated care, initiatives are frequent and diverse. Stakeholders should support existing initiatives and facilitate their development. They should also promote innovative avenues, experiment alternative payment models for integrated care, foster people-centeredness and incentivize interprofessional models. This will require systems thinking and contributions from all actors of the healthcare system.

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1. Introduction

Socio-economic and technological advances contribute to increased life-expectancy and population ageing, which impacts on chronic conditions' prevalence and puts health systems under pressure worldwide [1,2]. Numerous challenges have been identified such as misfits between systems designed to deal with acute health problems and increased needs for chronic diseases management, resource's shortages (financial, human), interinstitutional and interprofessional fragmentation, lack of care coordination as well as primary care weaknesses [1,3–5]. To overcome these challenges and to be able to care for an increasing number of people with one (or several) chronic condition(s) and/or complex psycho-social issues, health systems must adapt. They need to master such challenges and improve quality, access, efficiency and equity of care. In that context, a variety of models have been developed [6,7], supporting a shift towards more integrated care [8].

No definite consensus of integrated care has been reached until now, albeit coexistence of numerous definitions [8]. Two of them can be used concomitantly [5], for example:

> "Integrated health services encompasses the management and delivery of quality and safe health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course." [9]

> "[. . .] integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and

* Corresponding author at: Zugerstrasse 193, CH–6314 Neuägeri, Switzerland.
E-mail addresses: severine.schussele@fmc.ch (S. Schusselé Filliettaz), peter.berchtold@fmc.ch (P. Berchtold), dimitri.kohler@gmail.com (D. Kohler), isabelle.peytremann-bridevaux@chuv.ch (I. Peytremann-Bridevaux).

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clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called 'integrated care." [10]

Within this conceptual diversity, it is difficult to elaborate a stable and replicable typology of integrated care initiatives [11,12]: heterogeneous definitions are used to identify, develop and evaluate integrated care programs indeed [3,13–23]. It is also difficult to generalize results and to prioritize implementation efforts [10,24]. Nevertheless, benefits of integrated care are considered to encompass numerous aspects [5,25–30] such as improved quality of healthcare, as well as positive impact on outcomes and efficiency [31,32]. Research has shown that elements from the health system or health policy levels influence the implementation and success of integrated care activities. In short, policy is necessary but not sufficient [33], strengthening health workforce is imperative [34], interacting barriers and facilitators to implementation exist [18,35–38] and finally, individual leadership [39,40] as well as attitude towards change and innovation [41] play important roles.

The Swiss health system ranks very well internationally regarding quality of care, access, efficiency, equity and healthy lives [42]. Patients are offered a large choice of services and access to all healthcare levels is unrestricted, unless specifically chosen [2]. Federal policies and programs address contemporary health issues: i) a global health policy strategy [43] and related strategies targeting non-communicable diseases, mental health and end-of-life care among others [44–47], ii) programs addressing professional roles and interprofessional/interinstitutional collaboration [48–51], and iii) programs to support family medicine [52]. However, healthcare stakeholders face numerous challenges calling for innovation: sub-optimal quality of care, increasing healthcare needs and expectations, high costs, reduced financial and workforce resources [1,2,53–58]. In spite of these challenges, the development and the implementation of integrated care models is considered to be limited in Switzerland. In fact, innovation seems to be restricted to health maintenance organizations and GP's networks implemented since the 1990's [56] and to chronic disease programs [59]. This contrasts with the numerous initiatives identified in Europe and elsewhere [3,15,17–19,21,35,60–64].

Several characteristics of the Swiss health system can explain this situation [65]. Firstly, a tendency to fragmentation: i) a federalist organization of the health system with divided responsibilities between the federal, cantonal and local levels (i.e. Switzerland is often considered to have 26 slightly different healthcare systems, one for each of the 26 cantons); ii) a country divided into two main cultural areas (German-speaking, French/Italian speaking), iii) a mandatory health insurance scheme operationalized by more than 20 insurance companies, iv) complex financing mechanisms including numerous private and public sources, as well as high out-of-pocket contributions from patients, v) fee-for-service payment system, vi) financial and societal valorization of hyper-specialization, vii) absence of interoperable IT communication tools. Secondly, Switzerland has no federal regulatory framework for integrated care.

Despite the above mentioned issues, some cantons consider integrated care policies [66], develop specific integrated care masterplans [67], or promote the implementation of new financing measures [68]. Interprofessionality is supported at several levels in Switzerland: in the new federal law on health professionals [69], in a recent federal program [48] and at various levels in the educational system [70–72,97]. Calls for proposals have been issued to research healthcare services [73] as well as innovative interdisciplinary and integrated care models [74]. Experts recommend innovative models in primary care [75]. Finally, the Swiss population increasingly adopts managed care insurance schemes [76].

In this context, we conducted the first Swiss Survey on Integrated Care (SSIC). It aimed at providing a comprehensive picture of integrated care in Switzerland to i) map existing initiatives and describe their components with special emphasis on the different linguistic areas of Switzerland, and ii) provide healthcare stakeholders with elements for further research, implementation and policy developments.

2. Material and methods

2.1. Study design and period

We conducted an online survey between July 2015 and July 2016.

2.2. Identification of integrated care initiatives and eligibility criteria

We followed a systematic and comprehensive search process to identify Swiss integrated care initiatives: we contacted major organizations of the Swiss health system (providers, regulators, financers, members of educational and research structures, as well as professional and community organizations) at the federal, cantonal and local levels. We also contacted integrated care experts and used the "snow-ball effect" [77] to increase our reach.

In the absence of a consensus on a definition for integrated care, we refrained from using an ex-ante definition to identify integrated care initiatives. Instead, we established a set of operational inclusion and exclusion criteria to methodically select initiatives that we would consider to be integrated care. This was done on the basis of descriptions of existing European or country/regional level projects [9,10,22,24,78] and expert opinions.

2.2.1. Inclusion criteria

Any initiative (i.e. any program, project, model, network, organization) fulfilling the following four criteria was considered an "integrated care initiative":

1. "Formalization" of integrated care principles (such as an agreement between several organizations, a public mandate, a research protocol, a report);
2. Integration of at least two levels of healthcare services (such as physician-led primary care, non-physician-led primary care, specialized medical outpatient services, specialized non-physician-led outpatient services, home care services, community services, public health departments);
3. Integration of at least two different groups of healthcare professionals (such as primary care physicians/specialized physicians, nurses (general, specialized or advanced), dieticians, occupational therapists, pharmacists, physiotherapists, social workers, volunteers, informal carers);
4. Ongoing at the time of the survey (i.e. at least during some period between July 2015 and July 2016).

2.2.2. Exclusion criteria

Initiatives with any of the following characteristics were not considered to be eligible for the SSIC:

- inclusion of children or hospitalized patients only, and/or exclusive focus on acute conditions/episodes;

Table 1
Categorization of included initiatives (n = 155, 100%)[a].

Categories	Description & elements used for the categorization of the included initiatives
"Health centers" (n = 20, 16%)	Initiatives including several structures and levels of healthcare under the same governance, such as: primary healthcare (physician or other), specialized outpatient care (physician or other), inpatient acute care, transition care and/or long-term care, etc. This category does not include psychiatry or mental health initiatives (see below).
"Physicians networks" (n = 9, 6%)	Networks of general practitioners and/or family doctors and/or medical specialists, who develop/use guidelines, and organize quality circles.
"Specific target groups" (n = 52, 34%)	Initiatives targeting ≥1 somatic condition or specific patient group. This category does not include psychiatry or mental health initiatives (see below).
"Mental health & psychiatry" (n = 41, 26%)	Initiatives targeting psychiatry (as a whole or a specific pathology) and/or mental health.
"Medicines" (n = 8, 5%)	Initiatives targeting treatment/drug management.
"Transition & coordination" (n = 25, 16%)	Initiatives focusing on transition/coordination activities between several organizations/levels of healthcare (case/care management, interprofessional and interinstitutional care teams, etc.)

[a] Suggested categories are mutually exclusive and reflect all included initiatives.

- implementation exclusively in hospital settings (in- and/or outpatient) without external formal link;
- physicians networks using clinical guidelines and/or quality circles only, without additional integrated care elements;
- provision of "usual care" (such as multidisciplinary diabetic teams, tumor boards, pain, memory or wound centers);
- palliative care (mobile and/or inpatient and/or outpatient) [44,79];
- limited to administrative aspects or to education;
- extremely specialized services/practices (such as initiatives for patients with ventricular assistance devices);
- care management models of health insurance plans, only formalized between patients and health insurance plans, without formal inclusion of external healthcare professionals.

2.3. Online questionnaire

The online self-reported questionnaire was developed on the basis of similar research conducted by the authors in Switzerland [59] as well as by others in Europe [3]. It comprised 24 questions targeting the following aspects: canton(s) of activity, start of the initiative, content (such as target population(s), services provided, healthcare delivery levels targeted, professional groups involved), financing sources, barriers to patient-centered care and to interprofessional collaboration, and evaluation. Ten healthcare stakeholders involved in integrated care in Switzerland tested the French and German versions of the questionnaire and gave feedback on its content and acceptability; the questionnaire could then be finalized.

2.4. Data collection

Organizations and/or individuals first received a personalized email either in German, French or English describing the aims of the survey and requesting permission for a phone interview in any of the above mentioned languages. If accepted, one of the three main authors (SSF, IPB, PB) carried out the interviews. During these interviews, characteristics of potential initiatives were collected to assess eligibility. Representatives of the eligible integrated care initiatives then had one month to complete the questionnaire; non respondents received two successive one month-interval reminders (email or phone).

2.5. Data analyses

Descriptive statistical analyses were performed to describe the identified initiatives: first at a global level, then stratified by linguistic areas (German versus French/Italian) and by category of initiatives. The latter were created a posteriori on the basis of the global results and on the authors' expertise in the field (Table 1).

3. Results

3.1. Data gathering processes

We made a total of 853 initial email contacts, which led to the final identification of 172 initiatives (Fig. 1). Ninety-four percent of the representatives completed the online questionnaire, leaving data for 162 integrated care initiatives, seven of which represented sub-programs of a larger initiative already included. Analyses were performed on the data provided by 155 initiatives.

3.2. Trends in the implementation of integrated care initiatives

In the last 26 years, integrated care initiatives had been steadily implemented in Switzerland, increasing from a dozen in 1990 to 155 in 2016. This increase accentuated during the last six years; more than 50% of the included initiatives started between 2010 and 2016. Analyses by linguistic areas showed that initiatives were more frequent in the German-speaking areas until 2012 only (Fig. 2).

Among the 155 initiatives included, 52% were implemented in the French/Italian-speaking areas and 45% in the German-speaking areas; 3% were implemented across both linguistic areas. Table 1 shows that these 155 initiatives were distributed as follows: 34% in the "Specific target groups" category, 26% as "Mental health & psychiatry" initiatives, 16% as "Health centers", 16% in the "Transition & coordination" category, 6% as "Physician networks", and 5% as "Medicines" initiatives. Analyses both by linguistic areas and by categories revealed that "Health centers" and "Physicians networks" initiatives were more present in the German area, while "Specific target groups", "Transition & coordination" and "Medicines" prevailed in the French/Italian area. Initiatives in "Mental health & psychiatry" were evenly distributed.

Categorization revealed heterogeneous increase in the implementation (Fig. 2). "Health centers" initiatives were the most frequent in 1990 (n = 5) and went through an almost 4-fold increase until 2016 (n = 18). In comparison, the first "Transition & coordination" included initiative was launched in 1994 and 25 were found in 2016 (25-fold increase). There were three "Specific target groups" and three "Mental health & psychiatry" initiatives in 1990; 26 years later, the latter showed a >10-fold increase.

3.3. Healthcare delivery levels integrated by the initiatives

Respondents were asked to indicate which pairs of healthcare delivery levels they targeted for integration (12 different levels,

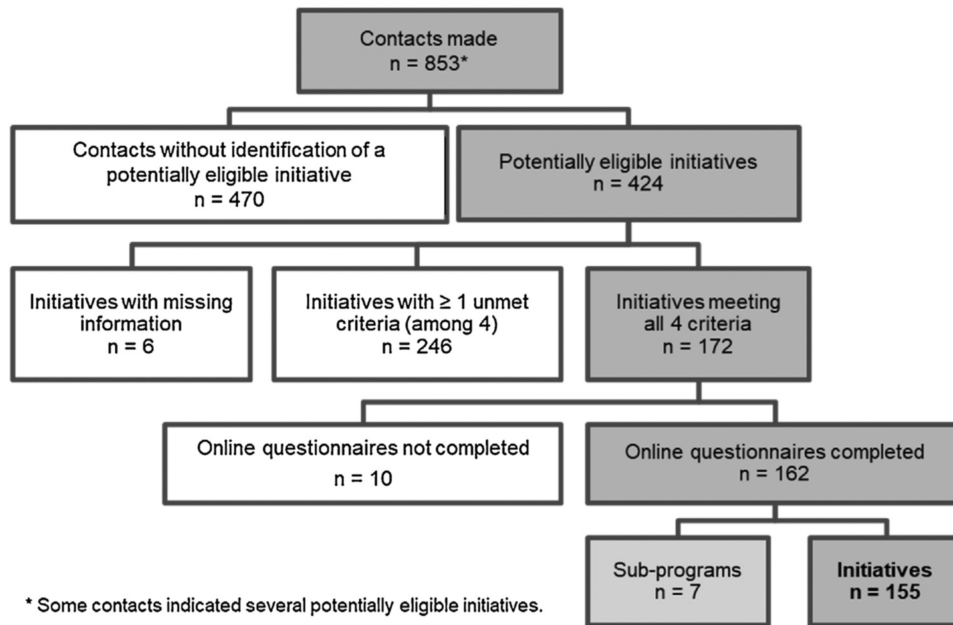

Fig. 1. Swiss survey on integrated care 2015–2016: flow diagram.

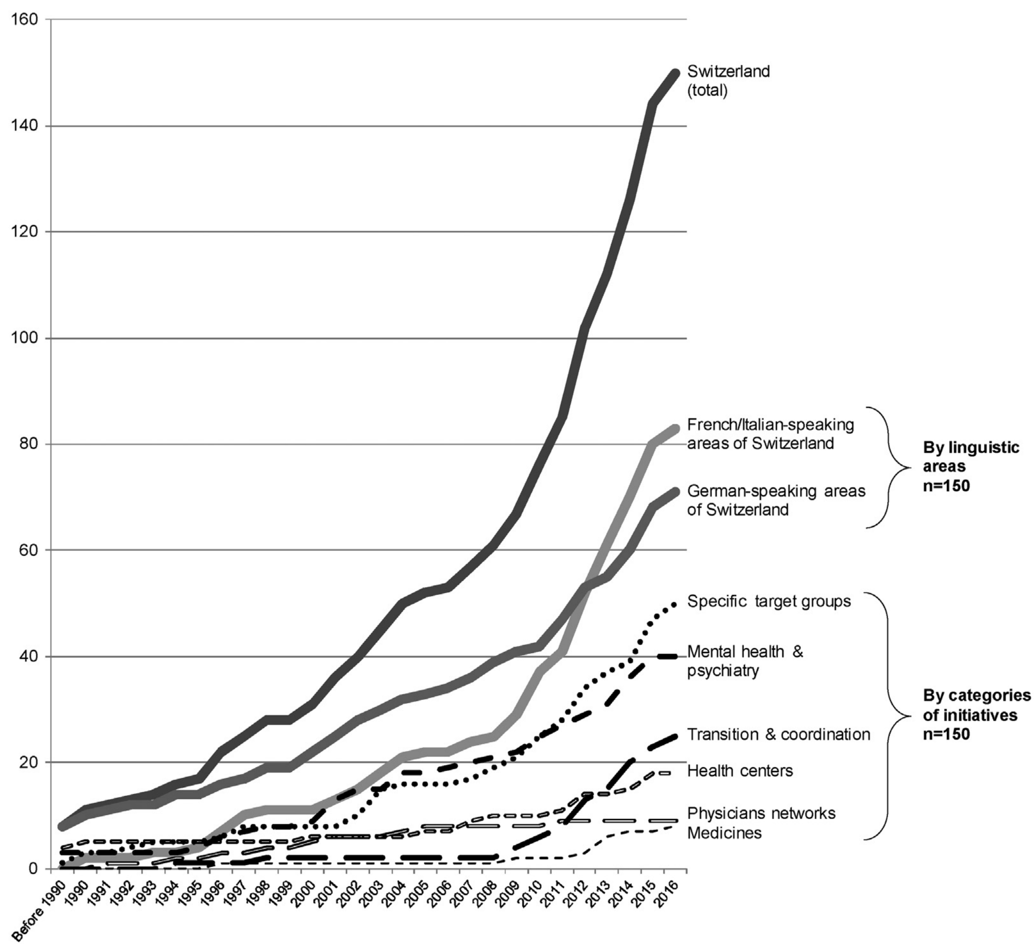

Fig. 2. Cumulative number of initiatives: overall, by linguistic areas and by categories of initiatives (from before 1990 to 2016).

i.e. 66 different pairs). Median number of integrated healthcare delivery pairs was 9 (range 1–66). Results by category showed that “Health centers” initiatives intended to improve integration between the highest number of different pairs (median: 20), followed by “Physicians networks” (median: 10), “Mental health & psychiatry” (median: 10), “Transition & coordination” (median: 8),

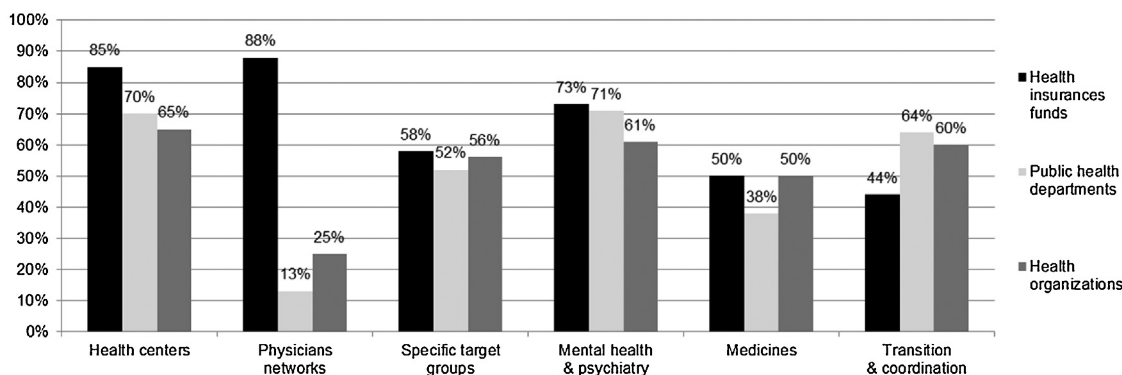

Fig. 3. Frequency of the three main sources of financing, % of initiatives by categories (n = 150).

"Specific target groups" (median: 7) and "Medicines" (median: 5) initiatives. Initiatives most often intended to improve integration between the "Physician-led primary care" level and the "Physician-led specialized outpatient care" level (39% of the cases). Second came integration between the "Relatives/informal carers" level and the "Non-physician-led specialized outpatient care" level (36%).

Patterns of healthcare delivery levels targeted by initiatives were heterogeneous. For example, "Physicians networks" mostly intended to improve integration between "Physician-led primary care" and the other levels, while "Health centers" initiatives' results showed that integration was much broader and included more levels.

3.4. Healthcare professionals involved in the initiatives

A median of four out of 13 possible groups of healthcare professionals were involved in the initiatives (range 2–12). Grouped results grouped results revealed that physicians (91% of the initiatives) and nurses (87% of the initiatives) were the most frequent professional groups involved.

Categorization revealed that the highest number of professional groups were involved in "Health centers" initiatives (median: 8), followed by "Specific target groups" (median: 5), "Transition & coordination" (median: 4), "Physicians networks" (median: 4), "Mental health & psychiatry" (median: 3) and "Medicines" initiatives (median: 3).

3.5. Financing of integrated care initiatives

Among nine possible financing sources, respondents reported a median of three sources (range 2–4), the three most prevalent of which were health insurance funds (65%), public health departments (59%), and healthcare organizations (57%). Categorization results (Fig. 3) show similar patterns except for "Physicians networks" initiatives, which were funded almost exclusively by health insurance companies, and for "Transition & coordination" initiatives, which reported a higher proportion of public (64%) and organizational funding (60%).

3.6. Patient-centered care measures and support to professionals

Initiatives implemented measures to increase patient involvement in care: while 77% of initiatives gave information material to patients, around 70% promoted the active involvement of patients in decision making and care planning. Initiatives also included specific elements designed to support healthcare professionals. Three out of four initiatives organized regular meetings between health professionals, and almost the same number offered multi/interprofessional training.

3.7. Barriers to patient-centered care and to interprofessional collaboration

More than 60% of the respondents considered inadequate funding and insufficient time to be obstacles to patient involvement. Also, 45% of respondents thought that interprofessional collaboration was hampered by difficulties in information sharing, as well as by different work procedures between organizations.

3.8. Evaluation of initiatives

The majority of respondents (70%) reported that their initiative had been evaluated or was going to be evaluated. These evaluations focused mainly on patients and caregivers' satisfaction as well as care processes (55% and 50% of the initiatives, respectively).

4. Discussion

4.1. Main results

The first Swiss Survey on Integrated Care (SSIC), conducted between 2015 and 2016, included 155 integrated care initiatives throughout the country. Analyses revealed heterogeneity in the chronological implementation of initiatives, in the number of healthcare professionals involved, in the healthcare delivery levels integrated and in the sources of financing. Sub-groups analyses by type of initiatives shed an interesting light on the diversity of integrated care in Switzerland. First, some types of initiatives were more prevalent than others: initiatives for the "Specific target groups" and "Mental health & psychiatry" categories represented 60% of all identified initiatives. Second, the types of initiatives across the two main linguistic areas differed: "Health centers" and "Physicians networks" initiatives were more frequent in the German-speaking part of Switzerland, while "Specific target groups", "Mental health & psychiatry" and "Transition & coordination" initiatives prevailed in the French/Italian-speaking part of the country. Lastly, trends in implementation were on the rise and changed over time: "Physicians networks" initiatives experienced a slow but steady increase since the 1990's, while "Transition & coordination" and "Medicines" initiatives were almost inexistent until 2008, when their number sharply rose.

Revealing this Swiss upward trend in integrated care is promising and reassuring, especially because the Swiss health system presents several characteristics usually considered to be hindering care integration. Facilitators of innovation are probably multifactorial in Switzerland: rising needs for care integration linked to the increasing burden of chronic diseases, multimorbidity and complex needs, rising social and professional acknowledgement of fragmentation, empowerment and leadership of individual healthcare

actors towards innovation, better knowledge and abilities in the field of integrated care implementation, room of maneuver offered by a federalist system, among others.

4.2. Strengths and limitations of the survey

The main strength of this project was the systematic and comprehensive search of initiatives across a whole country, approaching all major healthcare stakeholders in Switzerland. The 94% response rate reinforced the results.

While interpreting results, the following three main limitations need to be considered. Firstly, the absence of a consensual definition for integrated care led us to set up an operational set of criteria for integrated care. While it did help us circumscribe the scope (internally and when exchanging with respondents) of what we would consider to be integrated care, and while it did help us capture a wide spectrum of integrated care initiatives, this set of criteria may not be comprehensive enough. This means that initiatives not meeting the eligibility criteria were excluded from the survey: for example, initiatives targeting care integration within the same organizations, or initiatives considered to be "usual care", or initiatives in the field of palliative care, which had already been thoroughly identified [44,79]. Based on our deep knowledge of the Swiss situation, we are nevertheless confident that this set of criteria allowed us to capture the vast majority of initiatives existing in Switzerland. Secondly, the fact that the data gathering processes entirely relied on information reported by the contact persons. Therefore, we cannot exclude that eligible initiatives might have been missed. We cannot exclude either that the reported information might not be fully accurate, thus limiting the quality and conformity of the collected data. Finally, we defined the six categories a posteriori: the criteria used for this exploratory categorization and the subsequent analyses may be discussed.

4.3. Parallels between SSIC and other surveys

Direct comparison of the SSIC results with those of similar research conducted in Switzerland and elsewhere is difficult because authors used different definitions of integrated care and data collection processes. Nevertheless, parallels can be drawn which seem to match trends identified in our survey.

In Switzerland, two previous surveys support the upward trends in integrated care initiatives revealed in the SSIC. Firstly, in 2010, a survey focusing on physicians networks [56] showed that they predominated in the German-speaking part of Switzerland. Six years later, the physicians' networks fulfilling the criteria of the SSIC were found in the German-speaking areas exclusively. This may be due to cultural differences or diverse prioritization and organization of healthcare at the cantonal level. Secondly, in 2013, a survey focusing on chronic conditions programs detected 44 of them [59]. In 2016, the SSIC identified 76 integrated care initiatives targeting at least two chronic conditions.

At the European level, several projects targeting various aspects of integrated care produced findings similar to ours: "Developing and validating disease management evaluation methods for European healthcare systems" (DISMEVAL) [20] and "Innovating care for people with multiple chronic conditions in Europe" (ICARE4EU) [17]. DISMEVAL revealed that the majority of the initiatives identified focused on defined conditions. On the second hand, its results showed the emerging implementation of models focusing on elements of coordination. DISMEVAL also highlighted that funding came from numerous sources [18]. ICARE4EU published results from 101 programs targeting multimorbid patients across 25 countries, including Switzerland [3].

More recently, further European projects were launched: "Benchmarking integrated care for better management of chronic and age-related conditions in Europe" (Project INTEGRATE) [19], "Scaling integrated care in context" (SCIROCCO) [16] and "Sustainable integrated care models for multi-morbidity delivery, financing and performance" (Selfie2020) [15]. INTEGRATE is building up on 50 evidence-based policies [13]. SCIROCCO is learning from 34 good practices to catch systemic facilitators for integrated care. SELFIE elaborates on 17 projects to propose appropriate financing/payment schemes that support the implementation of these models [21]. Their preliminary results are congruent with the heterogeneity of integrated care showed in the SSIC and the need to support it with targeted facilitators, among them a probable blend of financing patterns.

Finally, Belgium launched INTEGREO [64,80] in 2015 to develop integrated care at the country level, with around 20 pilot-projects starting to include patients in fall 2017. Results from this project will help understand the impact of contextual elements on integrated care development, and clarify issues regarding transferability of initiatives [81,82]. Since the Belgian federal organization presents similarities to Switzerland's, their results may help Swiss stakeholders to further consider, develop, implement and evaluate integrated care on a larger scale.

4.4. Suggestions for stakeholders

Results from the SSIC can suggest directions for Switzerland or for countries with similar decentralized health systems.

4.4.1. Should the heterogeneity of integrated care initiatives revealed in the SSIC be considered to be positive?

Shaw et al. stated that "one form of integrated care does not fit all [83]". If the heterogeneity showed in the SSIC reflects the adaptation of initiatives to specific settings, users' needs and stakeholders involved, then this diversity must be considered to be positive and be supported. Swiss stakeholders should adopt "systems thinking [84]" to integrated care and develop policies for all three levels of the health system: the macro (system) level, the meso (organizational) level and the micro (clinical) level [85]. In a federal system, this might require a framework with a shared vision and clear distribution of roles explicitly in favor of care integration. This framework should foster facilitators and remove obstacles. However, concomitantly, local innovations should be supported and leadership encouraged [84].

4.4.2. Which financing schemes are suitable to integrated care?

Kodner & Spreeuwenberg [10] reported that care integration is "designed to create connectivity, alignment and collaboration within and between the cure and care sectors". Although the fee-for-services schemes used in Switzerland include some compensation for coordination activities, these schemes do not support care integration: this is highlighted by our results showing the multiple financing sources as well as the barriers reported by the respondents. Swiss authorities acknowledge that healthcare innovations must be encouraged, supported and durably paid for, and that new financing schemes have to be developed [46]. Indeed, for further integrated care developments, there is a crucial need for alternative payment models such as pay-for-coordination/-performance, bundled payment, capitation or populational-based global payment [86–88]. Within the Swiss context, such new models should first be experimented, then implemented consensually with all stakeholders, among them federal and cantonal authorities, health insurance companies, integrated care providers and patients' organizations.

4.4.3. How to focus integrated care on people?

Among authors highlighting the patients' call for integrated care [8,78,89], Walker et al. wrote that "patients may not under-

stand the term integrated care but are relatively clear on what the concept of integrated care entails and support its successful implementation" [90]. More specifically, Borgermans et al. stated that "excellent care is essentially integrated, people-centered and values a bio-psycho-social approach to care [...] [13]". In the SSIC, whereas the majority of initiatives focused on a specific disease, it remains unclear how these initiatives managed to combine a disease-centered perspective with this recommended wider bio-psycho-social approach. Additionally, only around 70% of the initiatives implemented measures to actively involve patients in their care plans and decisions. We hope that programs such as the Swiss National Science Foundation research program on health systems [91] will further identify barriers and difficulties hindering people-centered approaches [65,92]. Further surveying patients' satisfaction and experiences [93] will also help. User's perspectives should be systematically integrated to quality improvement approaches at all levels of the healthcare system, indeed (see examples in the UK, USA and Germany [94,95]).

4.4.4. Where are the interprofessional teams?

Among other authors, Suter et al. claimed involvement of "interprofessional teams [96]" to be a key element of integrated care. Electronic patient records will probably facilitate communication, but "aspects of personal relationships between clients and professionals/among professionals are central" [21]. Even if elements of the Swiss context do promote interprofessionality (see Introduction), the SSIC results showed that teamwork and implementation of interprofessional teams in practice could still be improved at the micro level, especially when professionals belong to various organizations. Academic research (for examples [97,98]) will contribute to increase knowledge on this topic. However, field implementation, not only through education [99], is needed: interprofessional collaboration should be facilitated, mostly through organizational and systemic change management [92,100,101], with support of institutional and political stakeholders.

5. Conclusion

Up to now and in the absence of comprehensive data on integrated care in Switzerland, the Swiss health system seemed to lag behind other countries. This first Swiss Survey on Integrated Care revealed an important and increasing number of initiatives. It also showed the heterogeneity of existing initiatives. While supporting existing initiatives and facilitating their development at the national and cantonal levels, policy makers and healthcare stakeholders should take the existing diversity into account. In addition, policy makers and healthcare stakeholders should further provide incentive for care integration and remove obstacles to their implementation and durability. This will require systemic thinking and change management approaches from actors at the macro, meso and micro levels of the health care system. The steps recently taken in Switzerland will definitely help move into the right direction [102].

Conflict of interest statement

The authors have no conflict of interest to declare.

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Supplementary data

Supplementary material linked to data described in this article is available upon request and/or online [102].

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