Department of Healthcare Management & Health Economics

ASSIGNMENT REPORT

NEW SUPPLY MODELS: OPTION 1 - INTEGRATED CARE SYSTEMS AND COMMUNITY-BASED CARE

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Programme:	Healthcare Management & Health Economics
Module:	New Supply Models (M11)
Submission Date:	19 / 10 / 2026
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1. Abstract

This report examines how modern health systems are shifting their service delivery models away from traditional hospital-centred care toward integrated, community-based care structures. Driven by aging populations and a sharp increase in chronic illnesses, healthcare organizations face severe pressures on hospital bed capacity and operating budgets.

The paper defines key integrated care structures, such as Accountable Care Organisations (ACOs), Integrated Care Systems (ICS), and population health management models, contrasting them with fragmented hospital-centric care. Through comparative case studies of England's Integrated Care Systems and New Zealand's Canterbury health system, the report evaluates results achieved for patient access, continuity, and clinical outcomes, alongside structural challenges faced. Finally, a comprehensive integrated care model is proposed specifically for elderly patients with multimorbidity, detailing its organisational framework, care process workflows, and evaluation metrics.

2. Introduction

For decades, acute hospitals have been the central pillar of healthcare delivery in most developed nations. However, medical advancements, rising life expectancies, and a high prevalence of chronic conditions mean that acute hospitals alone can no longer meet population health needs efficiently (Nolte & McKee, 2008). Patients with long-term conditions frequently bounce between emergency departments and hospital wards, receiving fragmented care that is costly and stressful.

To address this challenge, health authorities are redesigning service supply models to follow the patient rather than the institution. Integrated care aims to connect hospitals, general practice, social care, and community nursing into a single coordinated network (Valentijn et al., 2013). This report explores the conceptual foundation of integrated care, evaluates global case experiences, and develops a practical framework for managing multimorbid elderly patients in regional health systems.

3. Literature Review

The health services literature emphasizes that traditional hospital-centric models were designed for acute, episodic illnesses rather than ongoing chronic disease management. When care is fragmented, general practitioners, specialists, and social workers operate in silos, leading to duplicated tests, conflicting treatments, and avoidable hospital admissions (Shortell et al., 1996).

Integrated care models attempt to resolve these inefficiencies by aligning financial incentives and clinical pathways across different organizations (Kodner & Spreeuwenberg, 2002):
1. *Accountable Care Organisations (ACOs):* Networks of doctors, hospitals, and providers that share responsibility for the cost and quality of care for a defined patient population.
2. *Integrated Care Systems (ICS):* Regional partnerships uniting health and social care commissioners and providers to plan and deliver joined-up services.
3. *Population Health Management:* Using data analytics to identify health risks in specific community groups and deliver proactive interventions before acute crises occur.

According to Ham (2010), successful integration requires breaking down professional barriers between hospital clinicians and community social workers, ensuring that patients experience seamless transitions across care settings.

Dimension	Traditional Hospital-Centred Model	Integrated Community-Based Model
Primary Focus	Acute episodic treatment & specialized intervention	Continuous prevention, chronic care, & wellness
Service Location	Centralized acute hospitals & emergency rooms	Primary care clinics, patient homes, & community hubs
Provider Alignment	Fragmented departments acting independently	Multidisciplinary teams sharing clinical goals
Financing Incentives	Volume-based reimbursement (Fee-for-service)	Value-based payment, capitation, & shared savings

4. Methodology

This study adopts a qualitative, secondary research design utilizing health policy documents, peer-reviewed literature, and empirical case evaluations from international health systems.

The research investigates demographic and epidemiological drivers of integrated care, analyses two national case studies (England and New Zealand) in terms of access, continuity, and outcomes, and synthesizes these insights into an operational model for elderly multimorbid patients. Data sources include publications from the World Health Organization, The King's Fund, and academic databases.

5. Findings: Integrated Care vs Traditional Hospital Delivery

The research findings indicate that traditional hospital-centric models are increasingly unsustainable due to demographic shifts. With populations aging rapidly, the prevalence of chronic illnesses such as diabetes, heart failure, and dementia has surged, generating high demands for continuous rather than episodic care.

Key Findings on Demographic & Structural Pressures:

1. *Bed Occupancy Strain:* Elderly patients occupying acute hospital beds while waiting for social care placement create severe bed blockages and ambulance handover delays.
2. *Care Continuity Gaps:* Lack of electronic health record sharing between primary care and hospitals results in medication errors upon discharge.
3. *Proactive Prevention:* Community-based multidisciplinary teams successfully prevent emergency admissions by monitoring chronic patients in their homes.



THE LOGIC OF POPULATION HEALTH MANAGEMENT

By stratifying patients based on clinical risk, health systems can target intensive case management to the top 5% of high-utilization patients, significantly improving clinical outcomes while relieving hospital congestion.

6. Discussion: International Case Studies (England & New Zealand)

To understand how integrated care operates in practice, this section examines two international health systems that pursued structural integration: England and New Zealand.

Case Study 1: England - Integrated Care Systems (ICS)
England formalized Integrated Care Systems nationwide to bridge the historic split between NHS commissioners and hospital providers, alongside local authority social care. ICS partnerships bring together hospitals, primary care networks, and mental health trusts to plan services around local populations (NHS England, 2022). Results show improved collaboration and reduced delayed discharges in areas with strong data sharing. However, financial austerity, severe workforce shortages, and cultural resistance between acute hospital managers and community providers have slowed progress in achieving full service transformation.

Case Study 2: New Zealand - Canterbury District Health Board Integration
New Zealand's Canterbury health system gained international acclaim for its 'Alliances' model, which aligned hospital and primary care budgets to discourage unnecessary hospital admissions (The King's Fund, 2018). By investing heavily in community support, community nursing, and shared electronic referrals, Canterbury successfully flattened its growth in acute hospital bed days despite an aging population. The key lesson from Canterbury is that clinical leadership, shared vision, and relational trust between primary and secondary care providers are more vital than complex administrative restructuring.

Comparative Synthesis:
Both case studies demonstrate that successful integration requires aligning financial incentives, empowering primary care leadership, and overcoming institutional inertia. Where structural reforms are imposed without cultural alignment, integration efforts face significant friction.

7. Model of Integrated Care for Elderly Patients with Multimorbidity

Based on international best practices, this section proposes an integrated care framework tailored for elderly patients suffering from multimorbidity (two or more chronic conditions) within a regional health district.

REGIONAL ELDERLY INTEGRATED CARE FRAMEWORK

1. Organisational Framework (Multidisciplinary Hubs):
Establish local community health hubs bringing together general practitioners, geriatricians, community nurses, and social workers under a single shared clinical governance structure.

2. Care Process (Proactive Risk Stratification & Care Plans):
Use electronic health record data to identify high-risk elderly patients, assign a dedicated care coordinator (case manager), and develop a single personalized care plan shared across all providers.

3. Performance & Evaluation Metrics:
Measure success using 30-day emergency readmission rates, patient-reported experience measures (PREMs), total acute bed-day utilization, and caregiver burden scores.

8. Conclusion & Recommendations

In conclusion, moving from hospital-centric care to integrated community-based models is essential for the long-term sustainability of modern health systems.

Recommendations for Healthcare Managers:
1. Invest in digital interoperability to allow seamless patient record sharing between hospitals and community providers.
2. Shift financial resources toward primary and preventative care to reduce costly emergency hospital admissions.
3. Empower multidisciplinary community teams to manage chronic patients directly within their home environments.

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10. Appendices

Appendix A: Comparative Evaluation Matrix of Integrated Care Models

Model Type	Core Mechanism	Primary Benefit	Key Implementation Challenge
Accountable Care Organisations (ACOs)	Shared financial savings & quality targets	Reduces hospital admissions & coordinates care	Complex risk adjustment & data tracking
Integrated Care Systems (ICS)	Regional health & social care commissioning	Whole-system population health planning	Organizational silos & staff shortages
Population Health Management	Risk stratification of patient panels	Proactive early intervention for high-risk groups	Data privacy concerns & analytics capacity
Multidisciplinary Community Teams	Co-located primary & social care providers	Seamless patient-centred home support	Professional cultural differences & funding friction