RESEARCH PAPER

IFIC's Nine Pillars of Integrated Care

REVISION AND VALIDATION 2024-2025

Lead and corresponding author

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Introducing the Nine Pillars of Integrated Care

The International Foundation for Integrated Care (IFIC) has been the global leader in generating, curating and sharing knowledge and evidence on integrated care policy and practice since 2011.

IFIC is a trusted source of information and knowledge in relation to integrated care. We use this knowledge to promote our mission to inspire, influence and facilitate the adoption of inclusive community-centred integrated care in policy and practice around the world.

We know that policy-makers, system leaders and health and care professionals come to us when they need accessible knowledge that can be applied in practice. We also know that leading academics and researchers in the field of integrated care use our resources, such as the International Journal of Integrated Care, the International Conference on Integrated Care and our networks to share and disseminate their research. IFIC's goal is to bring these two constituencies and act to mobilise knowledge to action. The Nine Pillars of Integrated Care is the framework within which we do that.

In 2020, IFIC published the Nine Pillars of Integrated Care in a paper that set out IFIC's Call to Action to speed up the shift to integrated care across the world(1). This paper, authored by IFIC's research team with contributions from integrated care experts across the global network, identified the Nine Pillars as the conditions of any health and care system that need to be in place for integrated care to sustain and scale. The original Nine Pillars can be found in Appendix 1.

At IFIC we use the Nine Pillars as a meta-framework, that is, a higher-level framework that combines and includes other frameworks. A framework is generally understood as a broad structure that identifies and organises key concepts, variables, or domains relevant to a phenomenon, without necessarily specifying the causal or mechanistic relationships between them (2). As a meta-framework, the Nine Pillars is a higher-order construct that synthesises, integrates, or organises multiple existing frameworks into a unified structure (3). Thus, the intent is to complement the many approaches to integrated care design and evaluation that have proliferated over the past decade.

This meta-framework has served as a strategic framework for us at IFIC, guiding the organisation of conferences and events, structuring our knowledge and informing empirical research during independent evaluations. This use has highlighted the contribution the Pillars make to the policy and practice of integrated care in different contexts. Our goal is that this meta-framework will enable IFIC to categorise and compare these frameworks and help researchers and practitioners identify the most suitable tools for designing, implementing, and evaluating integrated care initiatives across diverse contexts.

The Nine Pillars published in 2020 had not been formally tested or validated as part of the first publication. The framework has been widely used as a reference by policy makers and practitioners within IFIC's network. To build on this, it is essential to strengthen its conceptual development and validate the Nine Pillars ensuring the meta-framework is consistent with what we know from research and practice in integrated care.

To address this validation gap, a methodology to revise and validate the Nine Pillars of Integrated Care was designed and conducted. This document summarises the revision and validation work which was undertaken over 14 months. It also presents the revised Nine Pillars of Integrated Care, the descriptions of each Pillar and the next steps for the development of the Nine Pillars.

Concepts, definitions and frameworks for integrated care

Over the past 15 years, a wide variety of approaches have been developed to support the design, implementation, and evaluation of integrated care (4). Rather than replace these, the Nine Pillars of Integrated Care as a meta-framework, serves as a structured lens though which such approaches and strategies can be compared, assessed, and strengthened.

A recent review of peer-reviewed, and grey literature conducted by IFIC's research team with consortium partners as part of LAUREL[1] project identified 69 integrated care frameworks, using defined inclusion and exclusion criteria (5) (Appendix 2). The frameworks identified were developed and applied by researchers, policymakers and implementers of integrated care initiatives. Each was assessed for integrated care comprehensiveness, generalisability and real-world application, resulting in a shortlist of 26. These selected approaches were then systematically analysed against the Nine Pillars, enabling IFIC to answer the following questions in this review:

1. Which Pillars are well represented in integrated care frameworks?
2. Which Pillars remain underdeveloped in frameworks?
3. Where would the Nine Pillars themselves benefit from greater specificity or refinement?

[1] LAUREL is a project funded by the EU Commission to develop actionable policy insights on integrated long-term care. Grant Agreement Number 10132643. More information can be found at https://laurelproject.eu/

The Nine Pillars of Integrated Care 2020

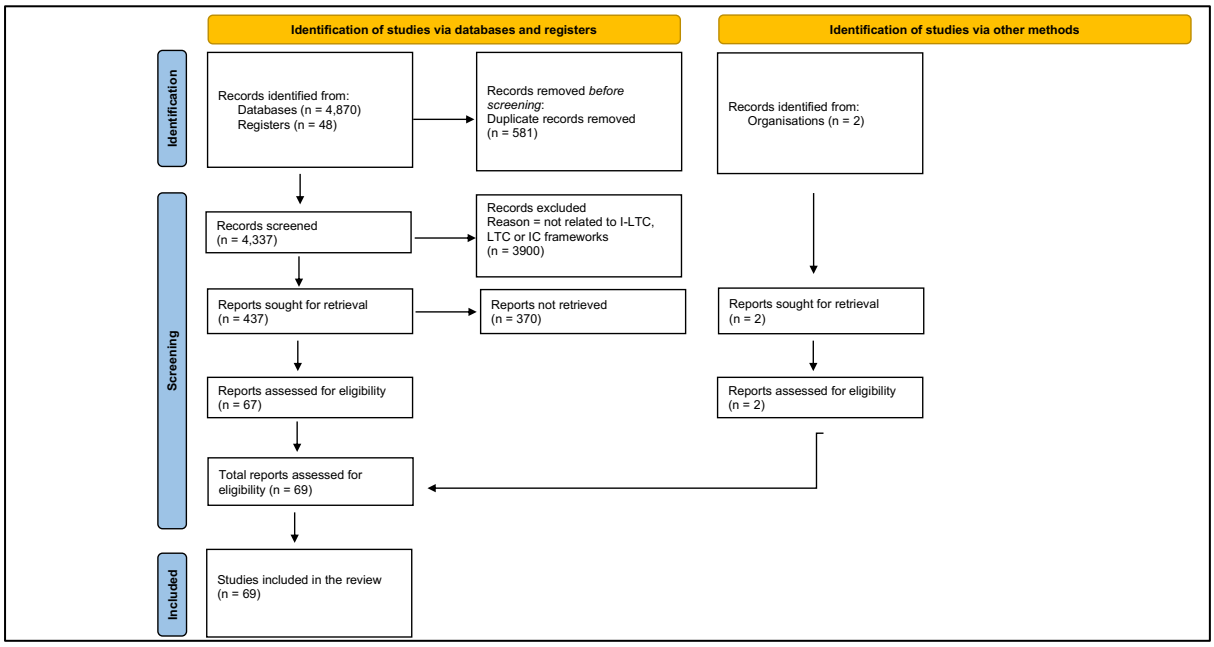
The original Nine Pillars of Integrated Care (2020) are presented in Figure 1 below. The detailed descriptions under each Pillars were described in some detail in the original publication. Short summaries of these descriptions are listed in Appendix 1. The original work was developed and published at the beginning of the Covid-19 pandemic and as such the context of the pandemic and the health system challenges being faced at the time dominate the narrative. The revision of the Nine Pillars takes the meta-framework out of this specific context to provide greater generalisation.

Figure 1: IFIC's Nine Pillars of Integrated Care (2020)

Review method

The literature review used the rapid literature review method (6) to collate and summarise the literature on integrated care frameworks across health and relevant social science disciplines. Our aim was to identify integrated care frameworks that have been theorised and applied in policy and practice in a range of different settings and for different population groups, consider how they been variably conceptualised, theorised and used empirically by researchers and practitioners and highlight the range of scope of the frameworks in terms of the system levels (micro, meso and macro). The figure below summarises the review process undertaken (7) using PRISMA 2020. The abstract screening process was supported using the Rayyan application and used inclusion / exclusion criteria as summarised in Appendix 2.

Figure 2: PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources



Review findings

The full text reviews of the 69 studies identified through abstract screening were then reviewed by IFIC's research team with further exclusion criteria applied through a process of full text screening (Appendix 2). 26 studies were included in the final stage of review. The purpose of this final review was to use the 26 frameworks to assess the comprehensiveness of the Nine Pillars of Integrated Care and identify any gaps in the meta-framework.

The 26 frameworks identified by the full text screening (Appendix 3) were analysed by mapping in two stages. The first stage involved mapping the scope of the frameworks against the system levels they covered – macro, meso, micro. To support this analysis, the team first defined the system levels.

Table 1: Definitions of systems levels

Level	Definition
Macro	The supra-system level and the milieu that directly or indirectly affects the existence and functioning of the public health system. It incorporates phenomena such as the social, political, and economic forces operating in the overall society(8).
Meso	Regional, district/county, or institutional / organisational level(9,10).
Micro	Clinical teams, programmes and community interventions (any level below institutional)(10,11).

Analysis was based on information published in the source document (published study in peer-reviewed journal or briefing paper to accompany the framework in the case of grey literature). It

is possible that these frameworks have been used at levels other than those mapped here, but this was not identified in the full text screen. The second step mapped each framework's content against the Nine Pillars of Integrated Care.

Step 1: Mapping the frameworks against the levels of analysis

As a meta-framework, IFIC's Nine Pillars of Integrated Care needs to be used at all three system levels. Not all the 26 integrated care frameworks reviewed will have been intended for use at all three levels. Some may have been very purposefully designed to be used at one level only. A table summarising the system level mapping is included in Appendix 4.

Frameworks that can be applied at all three levels of the system

14 of the 26 frameworks were found to be applicable at micro, meso and macro levels. A further six frameworks could be applied at all three levels but at least one level was only partially addressed.

Frameworks that can be applied at only one level of the system

Three frameworks can only be applied at one level of the system. Two of these are applied at micro level, the interface between the person at the centre of care and health and care providers and one is applied at macro level only.

Frameworks that can be applied at two levels of the system

The remaining three frameworks can be applied at two levels of the system. Two of these focused on the micro and meso levels and one on the meso and macro levels.

Step 2: Mapping the content of the frameworks to the Nine Pillars

The team used the Nine Pillars (2020) to map the content of the 26 frameworks against the Pillars. This allowed us to compare the frameworks against the Nine Pillars and answer the questions for the review:

1. Which Pillars are well represented in integrated care frameworks?
2. Which Pillars remain underdeveloped in frameworks?
3. Where would the Nine Pillars themselves benefit from greater specificity or refinement?

Which Pillars are well represented in integrated care frameworks?

The Pillar consistently included in some form in all 26 frameworks was "people as partners in care". "Workforce capacity and capability" was included by 20 out of 26. There was inclusion of some form of "transparency of impact" in 17 frameworks, usually reference to a specific set of measures to be used when monitoring integrated care.

Which Pillars remain underdeveloped in frameworks?

"Aligned payment systems" was the Pillar least referenced by other frameworks. It was included in 13 out of 26 frameworks. The other Pillars were covered by 15-16 frameworks each.

Within the "workforce capacity and capability" Pillar, the reviewed frameworks commonly referenced "interprofessional", "interdisciplinary" or "multidisciplinary" teamwork as primary mechanisms of integrated care. The original Pillar description referred to "blurring of roles" in

integrated care but did not explicitly reference the kind of teamwork referred to in the reviewed frameworks.

It was also clear from the framework review that many of the frameworks had been through a lengthy and rigorous process of design, testing and validation in context. Some of the frameworks were the products of multi-year, multi-country, inter-disciplinary research.

Where would the Nine Pillars themselves benefit from greater specificity or refinement?

Eight of the 26 frameworks included content related to service design in some cases specific to a population group (for example, older people). This had not previously been included in the Nine Pillars. This raised the question for the IFIC research team: Should the Nine Pillars include a Pillar related to service design? This question was taken forward into the next stage of the Nine Pillar revision.

Revising the Nine Pillars of Integrated Care

The Nine Pillar Labels

The mapping exercise highlighted further the pandemic-specific nature of the descriptions on the Nine Pillars. The labels and the descriptions lacked specificity (capable of being sufficiently context specific to a health and care system at any level) and their generalisability (wide application across many systems) had not been validated. To start this process of validation, the IFIC research team developed changes to the labels and short description of the Nine Pillars to reflect the scope of research and practice in integrated care across the world, enhancing the specificness and generalisability of the Nine Pillars as a meta-framework.

The IFIC research team worked collaboratively to refine the current set of short titles used for the Nine Pillars based on the framework review. Consensus was reached on a revised set of titles used for the Nine Pillars[2] and they are summarised below. The intent of the title is to provide a shorthand that can be used for graphics. Each title needed to balance breadth and inclusiveness with specificity. The short descriptions are intended to be used alongside the titles and provide additional information.

Table 2: Nine Pillar labels - 2020 and revision in 2025

2020 PILLAR TITLE	2025 PILLAR TITLE	2025 PILLAR SHORT DESCRIPTION
Shared values and vision	Purpose	Shared purpose
Population health and local context	Health in context	Understanding of the determinants of health in context
People as partners in care	People as partners	People and communities as partners in care
Resilient communities and new alliances		
Workforce capacity and capability	Teamwork	Integrated teamwork that is person and community-centred
Sub-domain of Workforce: Professional practice		
Sub-domain of Workforce: Care coordination	Coordinated care	Service delivery models that promote care coordination
System wide governance and leadership	Governance	Shared accountability, governance and leadership

[2] Five senior researchers with expertise in integrated care research independently reviewed the original labels and descriptions and assessed proposed new levels and descriptions. A consensus meeting was convened to arrive at consensus for those labels where there was most dissensus.

Digital solutions	Information and technology	Shared information and digital technology
Aligned payment systems	Finance	Aligned payment and funding systems
Transparency of progress, results and impact	Learning	Learning from results and impact

The short descriptions outlined above were the titles used for the meta-framework validation using the modified Delphi method. The only exception to this was the short description used for *Information and technology.* The first round of the Delphi used the description *Digital technology and information enabled integrated care* but feedback from the Delphi panel was that this did not reflect the priority order of the related concepts of information and technology, so this was adapted to *Shared information and digital technology.*

The Nine Pillar descriptions

Using the analysis of frameworks and our experience of using the Nine Pillars, the IFIC research team drafted revised explanatory descriptions of the Nine Pillars. These descriptions were presented to the group of experts using a modified Delphi method.

The modified Delphi method

A panel of 50 international experts in integrated care from 20 countries were invited to take part in the Delphi process. Experts were drawn from The Scientific Committee of IFIC's annual International Conference on Integrated Care and included academics, policymakers and practitioners of integrated care who have been participants in the network for at least a decade. Of these 36 invitees expressed an interest in being involved in the Delphi panel.

The aim of the panel was to work towards consensus on the descriptions of IFIC's Nine Pillars of Integrated Care. There were three rounds of the Delphi Panel over 6 months from September 2024 to February 2025.

ROUND 1

In the preliminary round (ROUND 1), the 36 panellists were sent background materials to read including the review of the integrated care frameworks. The survey presented the panellists with the proposed descriptions for each of the Nine Pillars. They were asked to highlight any missing information from the descriptions and any wording they did not agree with. They were asked to provide alternative wording for inclusion in revised descriptions. 29 panellists responded to this round.

Two members of IFIC research team independently analysed anonymised responses to the ROUND 1 survey contemporaneously, then met and compared their analysis resolving through discussion any differences in analysis. Three researchers then synthesized the proposed changes to the descriptions. Feedback from this round prompted the researchers to develop a general description for each Pillar and additionally a description from the points of view of three groups, (1) people and communities, (2) care providers, and (3) system-level decision-makers.

ROUND 2

The revised descriptions were presented to the 29 panellists in ROUND 2. The experts were asked to score the content and wording of each description on a seven-point scale (strongly agree – strongly disagree). If they scored "disagree", they were asked to provide the wording they would prefer in an amended version. 25 experts completed ROUND 2.

A member of the IFIC research team analysed the level of consensus from the scoring of the 25 responses. The consensus threshold was set at ≥75% (12). The wording suggestions were reviewed, and the descriptions were further modified for ROUND 3. These modifications were changes in emphasis and providing greater clarity rather than the more substantive modifications after ROUND 1.

ROUND 3

In the final round, ROUND 3, each of the 25 experts was sent a survey with the consensus score from ROUND 2 and their response to ROUND 2. They were invited at that point to amend their score using a five-point scale (strongly agree – strongly disagree) or if they wished to retain their previous score, explain why it should remain as it is. The data collected from the 22 panellists how responded was analysed for consensus by a member of the IFIC research team and subsequently checked by one other. In this round, the consensus levels did not drop below 86% for any Pillar. A summary of the levels of consensus for each Pillar in ROUND 2 and 3 are found in Appendix 5.

The participation rates at each stage of the Delphi process are summarised in the table below.

Table 3: Delphi panel participation rates

Milestone	Number of experts	Proportion of all experts	Proportion of previous round
Invited to take part	50	n/a	n/a
Expressed interest in taking part	36	72%	72%
Round 1 response	29	58%	81%
Round 2 responses	25	50%	86%
Round 3 responses	22	44%	88%

The results of the modified Delphi panel – consensus and disagreement

The final descriptions for each Pillar that emerged from the Delphi panel process are presented in Appendix 6. For four of the nine Pillars, while a good level of consensus was reached, there remained some dissent and debate.

A notable comment from one panellist repeated for multiple Pillar's related to the how the descriptions were framed. The descriptions were deliberately framed as "what good looks like", that is, the ideal description if the Pillar were to be present in a mature integrated care system. This panellist pointed out that such a framing may be counter-productive, being so far from reality that it would be difficult to see how it could be delivered and progress to delivery

measured. We acknowledge this challenge and one of the tools we are developing is a maturity self-assessment tool that can be adapted to the local context and enable those conversations about delivery and progress to be had.

Another common reflection which resonated for the IFIC research team, was how to represent the inter-dependencies between the Pillars in the descriptions. This will be addressed in the as part of our ongoing development of the Pillars as IFIC shares working examples of those inter-dependencies from practice through case studies and practice sharing.

An outstanding dissent which emerged over multiple Pillars which should also be addressed in the ongoing iteration of the Nine Pillars, was the focus on universal coverage. This, and the tendency of Pillar descriptions to be ideologically aligned to a social justice perspective on health and care and assume predominantly single funder (state) models, led to some criticism from panellists that the Nine Pillars were not inclusive of other perspectives, such as the business case for integrated care in social insurance and privately financed health and care system, and jurisdictions where universal coverage is not the reality.

*Shared **purpose** for integrated care*

There was strong consensus on the importance of this Pillar in all rounds of the Delphi process. There was also consensus on the proposed wording with suggestions to expand the scope to be more explicitly inclusive of the policy-making realm.

*Determinants of population **health in context***

This was one of the Pillars in which there was more dissent. This dissent related mainly to the use of language, definition of concepts and the relationship between the wider determinants of population health and integrated care. ROUND 2 and 3 both focused on clarifying and refining the language used and the relationship between integrated care and population health. The detailed descriptions from the point of view of different groups provided an opportunity to stipulate this additional clarity. Nonetheless, there remained dissent on the relationship between integrated care and population health with two panellists holding the view that population health is an outcome of integrated care and much else besides. We acknowledge that this remains an ongoing and constructive debate in the movement.

***People** and communities **as partners** in care*

As with “Purpose”, there was strong consensus on the importance of this Pillar in all rounds of the Delphi process. There was also consensus on the proposed wording with suggestions to expand the scope to be more explicitly inclusive of the co-production with people and communities from all stakeholder points of view.

*Integrated **teamwork** for person- and community-centred care*

There was very strong consensus on the importance of this Pillar in all rounds. In ROUND 1, there were suggestions to include education and training as enablers of integrated teamwork as well as acknowledging the role that professional hierarchies and power relations play in such teamwork. Much of the focus in subsequent rounds was on clarifying the language used in the description.

*Service delivery for **coordinated** and integrated **care***

This was a new Pillar introduced to address the gap in the Nine Pillars identified in the framework review. There was strong consensus on the description of this Pillar but ROUND 1 identified some important clarifying requirements. While there is a diversity of service delivery options for integrated care, a clear emphasis should be placed on coordination as a mechanism for integration at micro and meso levels. Another clarification related to the scope of service delivery as inclusive of not-for-profit and for-profit providers of health and care and explicit mention of social care. The description was also expanded to include a range of populations on a continuum from disease-specific through to whole populations.

*Shared accountability, **governance** and leadership*

There was strong consensus among the panellists that all three elements of accountability, governance and leadership are important scaffolding for the delivery of integrated care. Context is particularly important here. Systems have varied history, ideology and structure and the description needs to be adaptive to a wide range of situations. Some of the areas of dissent were specific to certain types of systems. This reinforces our approach of balancing specificity of the Nine Pillar descriptions with adaptability to context.

*Digital technology and information enabled integrated care (**Information and technology**)*

While there was consensus around this Pillar overall, this is one of the Pillars where that consensus was weaker with panellists more likely to “agree” with a description than “strongly agree”. There was consensus that shared information was essential for effective inter-disciplinary team working. There were suggestions to include greater specificity on how this could be realised at the micro level, but these were high income country specific. One panellist did not agree that this was an essential Pillar for inclusion seeing it as a “tool” to enable integration. For others, the focus needed to be more on “information” with “digital” as one mechanism to deliver the information needed at micro, meso and macro levels to enable integrated care.

*Aligned payment and funding (**Financing**)*

There was generally strong consensus on this Pillar, but some panellists in ROUND 1 Pillar pointed out that the description was too focused on state-funded universal coverage financing models. The final version has attempted to open up the description, but this will need to continue to be iterated in collaboration with IFIC's network in the field of practice.

***Learning** from results and impact*

This was another Pillar where consensus was weaker. Three panellists were unsure that the description was sufficiently detailed. Again, a balance was sought between including enough detail to be useful while acknowledging that contexts are different and the description needs to be inclusive of this difference. There were common reflections on the dependency of this Pillar with other Pillars such as Governance, Information and Finance. The feedback from panellists in ROUND 1 and 2 highlighted the importance of learning at all levels, that is, where care is delivered, across organisations and at the level of the wider system. This was incorporated into the final descriptions for ROUND 3.

Refining the language of the Nine Pillars

One feedback from the Delphi panellists in ROUND 1 was the complexity of the concepts and language that the Nine Pillars of Integrated Care is trying to synthesise. This is an acknowledged problem and has been the source of criticism of the many of the frameworks that were reviewed in the initial phase of this work. This was resolved to some extent through subsequent rounds of the Delphi panel. However, even accounting for the different perspectives, the group of Delphi panellists are all very familiar with the language and concepts of integrated care.

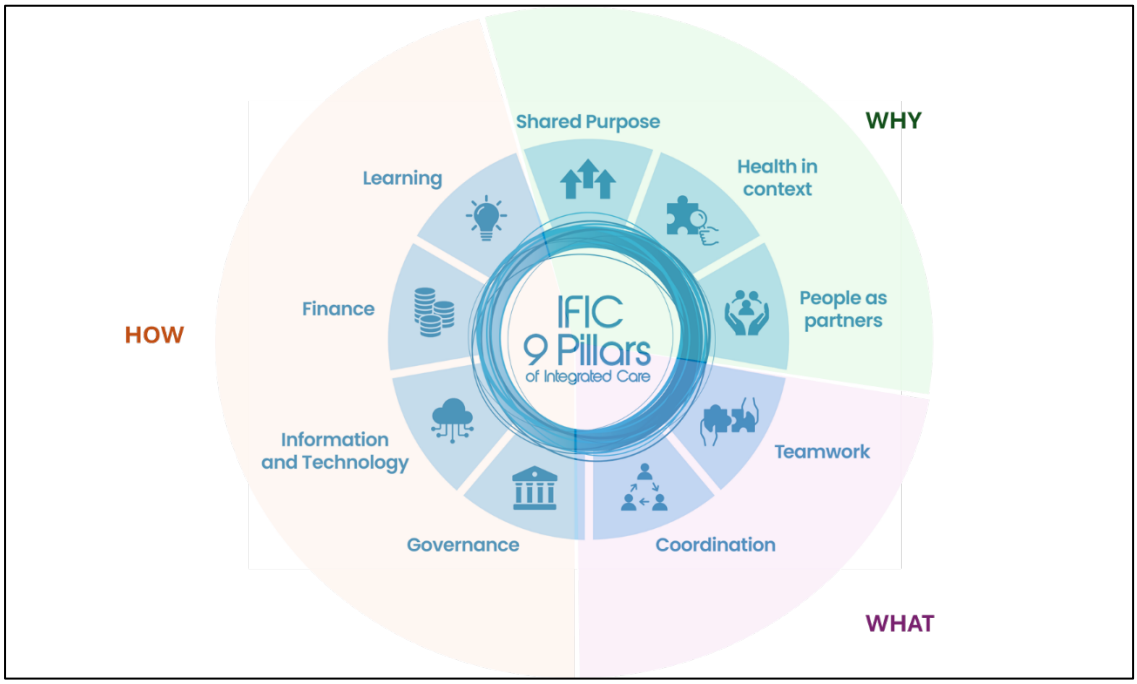
For IFIC, an important next step, is to refine the language of the Nine Pillars to make it easier for non-experts to understand and apply.

The IFIC research team used the opportunity, when commissioned to develop an introductory course on integrated care, to seek feedback on the understandability of the general descriptions for each Pillar to a non-expert audience of policymakers and care providers. This feedback came from multiple high income country policy makers and care providers in one European country working within the state-funded health and care system.

The output of this work is summarised in Appendix 7.

This work prompted the IFIC team to align the Pillars to the WHY WHAT and HOW of integrated care, addressing one of the queries from users about distinguishing between Pillars beyond a simple categorisation of enablers or conditions that need to be present for integrated care to happen. This is presented in Figure 3 below.

Figure 3: The Nine Pillars and the WHY, WHAT and HOW of integrated care



Next steps for the Nine Pillars

IFIC will test this version of the Nine Pillars with community groups and people with lived experience over the next 24 months.

It is likely that multiple versions of the Nine Pillars will be developed. Versions that are specific to context based on social norms, socio-political history, health and care system structures and priorities, and many other variables. To accommodate this, IFIC will host a repository where further community-based development of the Nine Pillars can be shared.

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APPENDIX 1

IFIC's Nine Pillars of Integrated Care (2020)

Pillar	Description
Shared values and vision	This is a system-wide responsibility that is heavily influenced by what our societies and organisations value and the extent to which we are prepared to work together to achieve our shared vision. Harnessing the power of multisectoral, interdisciplinary, collective action, begins through co-creating shared values, societal goals and vision among all partners.
Population health and local context	In most places, attempts to achieve better population health and wellbeing fall short because efforts tend not to focus on addressing the root causes - the determinants of health and the reduction of health disparities. The current appetite for more radical options to transform public services to ensure that public funds and institutions are adequately resourced and that they are shaped by the people who need them.
People as partners in care	In tackling COVID-19 we – citizens, patients, carers and professionals together – need to recognise that our actions will only be effective if people are engaged, informed, and supported to look after their own health and wellbeing, reducing demand on services, while at the same time ensuring they understand when they should seek help.
Resilient communities and new alliances	The current pandemic has heightened our sense of solidarity on the one hand, but increased protectionism on the other and illustrates that we cannot overcome a crisis of this scale on our own. One example is the spread of compassionate communities, including asset-based approaches to create a vibrant global movement that recognises that caring for one another is everyone's business.
Workforce capacity and capability	The current pandemic has stretched our workforce beyond what we could have imagined. They have stepped up by extending scope of practice, blurring roles to support each other, and rapidly acquiring new caring and remote consultation skills to offer the best possible care and support in extremely difficult circumstance – this augurs well for workforce reform. We have a unique opportunity to test integrated workforce solutions that will strengthen our systems and lead to better health, better care and better value.
System wide governance and leadership	Network governance models can be used to rethink the way cross-organisational services and joint actions are contracted and funded, coordinated, inspected and regulated, and on how outcomes and benefits are assessed for the care recipient, care teams and the system.

	Far from command-and-control leadership, the current crisis is teaching us that successful leaders are those leading in a compassionate, inclusive and dynamic manner.
Digital solutions	Since the outbreak of COVID-19, countries have seen a rapid citizen-led proliferation of digital solutions being used for remote working, socialisation between family, friends and communities, and education, to name but a few. This rapid pace of change has been mirrored by national and local government and public health using social media and other communication channels to effectively reach individuals to provide guidance, care, support, collect wellbeing and COVID-19 infection data, and undertake tracing through Apps.
Aligned payment systems	Payment systems in most healthcare systems have evolved piecemeal over time and reflect all the fragmentation of our health and social care systems across public, for-profit and not-for-profit provider sectors. This gets in the way of delivering integrated care more often than not. COVID-19 has seen unprecedented investment in many health systems. This needs to deliver a return on investment for our populations well beyond that pandemic. That will mean thinking more systemically about how payment systems reward value-based care where people and clinicians as partners in care determine what that value is.
Transparency of progress, results & impact	Just as there is no 'one size fits all' model of integrated care that suits all ambitions, situations and contexts, there is no one single tool or approach that can be used to measure the progress, results and impact. Continuing to base our integrated care evaluations and assessments primarily on available health data and information will go nowhere near capturing the unprecedented responses and scenarios that are emerging around the world from COVID-19.

APPENDIX 2

Inclusion and exclusion criteria used in selecting integrated care frameworks: abstract screening stage

Criteria	Inclusion	Exclusion
1. Geography	All countries	
2. Publication content	Peer reviewed papers that summarise: a) Including Integrated Older People frameworks) b) Generic Long-Term Care Frameworks (Integrated) c) Generic Integrated Care Framework (Long-term) d) Generic Chronic Care Frameworks e) Generic Older People/Aging Frameworks f) Frameworks of specific components of integrated care g) Frameworks for specific conditions or contexts h) Specific frameworks for integrated digital care Plus, grey literature that summarises a framework for analysing or designing integrated care models but	Peer reviewed papers and grey literature that: a) involve animals or were not on humans b) are not published in English c) do not explicitly reference "framework", "building blocks", "domains", "dimensions" or "pillars" d) generic Chronic Care Frameworks unless integrated care / care coordination / care continuity explicitly referenced e) generic Older People/Aging Frameworks unless integrated care / care coordination / care continuity explicitly referenced f) frameworks for specific conditions or contexts unless integrated care / care coordination / care continuity explicitly referenced g) specific frameworks for digital care unless integrated care / care coordination / care continuity explicitly referenced h) cover specific topics (for example, tourism, farming) and study types (for example, cost-effectiveness models, protocols

	are not original research papers. Published between January 2010 and June 2024 Published in English or with an English translation Original research; validation of a framework; review.	or simulations) that were not relevant to our review Published before January 2010 Published in a language other than English with no translation available Commentary of editorials
3. Timeframe		
4. Language		
5. Type of study		

Further exclusion criteria used in selecting integrated care frameworks: full text screening stage

1. Removed studies that do not explicitly reference “framework”, “building blocks”, “domains”, “dimensions” or “pillars”
2. Removed generic Long-Term Care Frameworks
3. Removed generic Chronic Care Frameworks unless IC / care coordination / care continuity explicitly referenced
4. Removed generic Older People/Aging Frameworks unless IC / care coordination / care continuity explicitly referenced
5. Removed frameworks for specific conditions or contexts unless IC / care coordination / care continuity explicitly referenced
6. Removed specific frameworks for Digital Care unless IC / care coordination / care continuity explicitly referenced

APPENDIX 3

Integrated care research and implementation frameworks included in the full text review

#	Framework *(with link to source)*	Brief description	Date
1	WHO Country Assessment for the integrated delivery of long-term care	Guidance for assessing the integrated delivery of health and social services for long-term care	2019
2	WHO Integrated Continuum of Long-Term Care	Identifies key aspects necessary to achieve an integrated continuum of long-term care service provision and to facilitate the integration of long-term services within existing health and social care systems.	2021
3	10 Step integrated care framework for older persons	Describes the 10 key essential steps that are needed to enable integrated care for older people to be implemented, evaluated and sustained in all locations.	2019
4	SMARTCARE	Digital pathways designed to meet the needs of individuals who face discharge from hospital and transfer to their home setting.	2016
5	WHO Framework on integrated people-centred health services (IPCHS)	Proposes five interdependent strategies for health services to become more integrated and people-centred	2016
6	Project Integrate Framework	Identifies the core dimensions of integrated care based on a review of previous literature on the topic and empirical testing in four cases in the EU.	2016
7	Development Model for Integrated Care	A generic and validated quality management model for integrated care.	2016
8	Rainbow of Chaos	Developed to assess integrated care as a continuous quality improvement strategy.	2015
9	Logic Model for Integrated Care	Describes what good looks like, providing a visual depiction of how a fully integrated health and care system might be structured and function, and the	2018 (digital

		outcomes and benefits it should deliver for those who use services and their carers.	version 2024)
10	Comprehensive theory of integration	A comprehensive theoretical model of relationships between types of integration and propose how to measure them	2018
11	Social ecology networks in supporting integrated care	The conceptual model developed from this combination offers to bridge the apparent disconnect between service integration levels and patient needs.	2019
12	Transform Integrated Community Care	Presents the core concepts of ICC, namely temporality, local area, health care, social care, proximity and integration.	2021
13	SCIROCCO	Self-assessment tool is an online self- assessment tool with an objective to assess a region's readiness for integrated care. The tool has been tested and applied in more than 75 regions and organisations in Europe and beyond, including Australia, New Zealand, Singapore, Canada and the US.	2018 (digital updates since then)
14	Implementing patient centred care for multiple chronic conditions	Specifies effective, evidence-informed components of interventions in patient-centred integrated care that can improve outcomes for patients with multimorbidity.	2021
15	Integrated care for chronic conditions / Chronic care model	Roadmap for policy development and health system redesign. The "building blocks" of the ICCC Framework can be used to create or redesign healthcare systems. It also provides a global framework to harmonise initiatives aimed at improving chronic patient care.	2012
16	Complex case and recovery management framework	6 value-making themes for building collaborative value over time, alongside case management. Applied in services focused on people with learning disabilities.	2023

17	SELFIE	A taxonomy for integrated care programmes for people with multi-morbidity. Provides evidence-based advice on matching financing/payment schemes with adequate incentives to implement integrated care.	2017
18	Multimorbidity ICARE4EU Framework	To facilitate policymakers in the development of policies directed at patient-centred care for people with multimorbidity.	2017
19	Integrated Care for Older People (ICOPE)	Inform health-care workers whose specialized knowledge will be called on, as needed, to assess and to plan care for people with losses in intrinsic capacity and functional ability.	2019
20	Collaborative care model as a framework for mental health integration	Oriented around five guidelines: patient-centred care, population-based care, measurement-based care, evidence-based care, and accountable care with continuous quality improvement.	2023
21	Community mental health framework for adults and older adults	Will enable health and social care providers and commissioners to move towards a new place-based community mental health model that provides more effective support, care and treatment for adults within a community network.	2021
22	A framework for digital equity	Details key digital determinants of health (DDoH) and examines DDoHs at the individual, interpersonal, community, and societal levels.	2022
23	eHealth Enhanced Chronic Care Model	Shows how eHealth tools can be used to increase efficiency of how patients manage their own chronic illnesses.	2015
24	Blocks report factors that enable integration	Identifies success factors and transferable elements from several integrated care programmes in Europe.	2017
25	COMIC (Context, Outcomes and Mechanisms of Integrated Care interventions)	Provides insights into when, why and how successful outcomes can be achieved.	2016

26	Integrated Care Assessment Framework	Indicators to assess the performance of integrated care.	2018

APPENDIX 4

Integrated care research and implementation frameworks mapped against system levels

	SYSTEM LEVEL FRAMEWORK APPLIES TO			
FRAMEWORK NAME	MICRO	MESO	MACRO	ALL
WHO Country Assessment for the integrated delivery of long-term care			✓	
WHO Integrated Continuum of Long-Term Care			✓	
10 Step integrated care framework for older people				✓
SMARTCARE	✓			
WHO Framework on integrated people-centred health services (IPCHS)				✓
Project Integrate Framework				✓
Development Model for Integrated Care				✓
Rainbow of Chaos				✓
Logic Model for Integrated Care	✓	✓		
Comprehensive theory of integration	✓	✓		
Social ecology networks in supporting integrated care	✓			
Transform Integrated Community Care	✓	✓		
SCIROCCO				✓
Implementing patient centred care for multiple chronic conditions	✓			
Integrated care for chronic conditions / Chronic care model	✓	✓		
Complex case and recovery management framework	✓			

SELFIE				✓
Multimorbidity ICARE4EU Framework				✓
Integrated Care for Older People (ICOPE)				✓
Collaborative care model as a framework for mental health integration	✓	✓		
Community mental health framework for adults and older adults				✓
A framework for digital equity		✓		
eHealth Enhanced Chronic Care Model				✓
Blocks report factors that enable integration				✓
COMIC (Context, Outcomes and Mechanisms of Integrated Care interventions)				✓
Integrated Care Assessment Framework				✓

APPENDIX 5

ROUND 2 and 3 Consensus Levels

Pillar Short Description	ROUND 2 Consensus Level	ROUND 3 Consensus Level
Shared purpose for integrated care	84%	95%
Determinants of population health in context	52%	86%
People and communities as partners in care	68%	95%
Integrated teamwork for person- and community-centred care	80%	100%
Service delivery for coordinated and integrated care	72%	91%
Shared accountability, governance, and leadership	68%	86%
Digital technology and information enabled integrated care	64%	86%
Aligned payment and funding	76%	90%
Learning from results and impact	56%	86%

APPENDIX 6

Nine Pillars of Integrated Care Descriptions – Post Delphi Panel

1. SHARED PURPOSE FOR INTEGRATED CARE

Description The shared purpose for integrated care that helps promote the integration of health and care systems is collectively built and implemented by partners potentially including community sector organisations, public health, primary care, social care, hospitals, long-term care providers, local, regional and national decision-makers. It does this by aligning services and people to provide people- and community-centred, coordinated, continuous, fair, and locally responsive care. It leads to shared goals, greater ability to work collaboratively and is linked to desired health outcomes for the local population.
From the point of view of people and communities The shared purpose is co-created by the people seeking care and support, people providing care and the wider community. At the local level, everyone understands the shared purpose for integrated care in their area.
From the point of view of care providers Care providers understand the local context and build and implement the shared purpose through collaboration across health, social care and other relevant organisations and groups. This includes working with wider partners such as those supporting education, housing, and community groups, and ensuring everyone has a say.
From the point of view of system-level decision-makers At the system level, decision-makers from health, social care, and other sectors collaborate based on a shared understanding of common challenges, goals, and the principles of integrated care. Joint action is aligned with the purpose of partner organisations and local communities and appropriate to the specifics of the local context. This joint action is supported by policy at all the relevant territorial levels.

2. DETERMINANTS OF POPULATION HEALTH IN CONTEXT

Description

Integrating care across the continuum of prevention and early intervention, self-care, chronic care, social care, acute care, long-term care, and end-of-life care, requires a deep understanding of the wider determinants influencing health, wellbeing, and access to quality care, both individual and collective, such as access to good quality housing, food security, sense of belonging and secure employment.

All actors in the care system are committed to address these determinants to reduce inequalities in health, wellbeing, and care opportunities, ultimately supporting individuals and communities in leading fulfilling and healthy lives.

From the point of view of people and communities

People and communities have access to an adequate start in life, including education that maximises their opportunities, fair employment, secure housing and healthy communities supported by well-resourced public health, prevention and early intervention. Access to equitable health care is assured for the whole population, no matter their socioeconomic status or living environment, including rural and remote areas, from prevention to end-of-life care, ensuring comprehensive support throughout their lifetime.

From the point of view of care providers

Care providers include prevention of ill-health explicitly in their provision and interventions and work closely with public health professionals, local government / municipal officers, citizens and community partners to identify population health needs and co-create care to address these. When providing care, providers deploy personalised strategies to integrate care for people and communities. They have the competencies and resources to effectively deliver and adapt care services that meet the needs of the different people and communities.

From the point of view of system-level decision-makers

System-level decision-makers understand the wider determinants of health that shape the needs of the population. They build collaborative relationships across departments at national, regional and local level and draw up and agree policies accordingly that create the condition to address the wider determinants and the identified needs of the population. This means articulating a case for change that shifts from how services are currently resourced, to providing the resources the local population needs. Systems adapt to meet the evolving needs of different community members through equitable and inclusive policies and resources.

3. PEOPLE AND COMMUNITIES AS PARTNERS IN CARE

Description

All actors involved in care, including individuals, family members and communities, recognise one another as partners and the essential role of people and communities as partners in care integration, appreciating distinct roles and responsibilities while collaborating to achieve shared purpose. The priorities of each context will depend on their shared purpose, goals and desired health outcomes agreed locally by all partners. The involvement of relevant partners including people and communities can enable place-based partnerships for better use of all the combined local resources.

From the point of view of people and communities

People and families actively direct their own care with agency, making informed choices and influencing decisions, ensuring that care aligns with their needs, preferences, and goals. Communities have the opportunity to co-create care, redesign and participate in citizen-led planning. Community sector organisations are actively involved in integrated care as part of a drive to build new alliances to address the wider determinants of health and develop healthy and sustainable places and communities.

From the point of view of care providers

Care providers organise themselves to support co-creation with individual people with care needs and communities. Care professionals work with people and communities collaboratively, sharing care planning and decision-making to deliver person-centred, coordinated and continuous care that builds on their existing health and wellbeing assets and strengths.

Care providers co-create integrated care services involving community sector organisations and the local population in the design, delivery and evaluation of the integrated care provision.

From the point of view of system-level decision-makers

System-level decision-makers nurture equal partnerships and create the conditions for the local population and those who use services to co-create integrated care based on collective action. System-level decision-makers share the information they have about population health with local people and care providers and work with them to build on their existing health and wellbeing assets and strengths. To support this, decision-makers create conditions that facilitate co-production and the establishment of new alliances for care and ensure culturally sensitive approaches to collective action, recognising power imbalances that may influence decision-making.

4. INTEGRATED TEAMWORK FOR PERSON- AND COMMUNITY-CENTRED CARE

Description

Integrated care teamwork is the point at which most people experience integration, coordination and continuity. Professionals and non-professionals paid and unpaid carers, from different backgrounds and with different competencies, roles and responsibilities work together in inter-disciplinary and inter-organisational teams that include people who need care. New inter-disciplinary ways of working are developed and new inter-disciplinary knowledge created to promote integrated care. The relationship between care providers and people and communities shifts to a more equal basis.

From the point of view of people and communities

People and family carers are provided with the opportunity to be equal members of the interdisciplinary team. They experience the support and are given the tools they need to take ownership of their own care based on their life goals, and the decision to do so is made with them. They have access to understand the existing evidence which has been shared with them in an accessible way to make informed shared decisions and manage their care to ensure a positive experience. Information is shared as appropriate, including with the individual and any nominated family carers, at the centre of care.

From the point of view of care providers

Care providers from different disciplines and sectors work together in an interdisciplinary way. Teams are led with this as an operating principle; roles, responsibilities, and professional accountabilities are clear. Information is shared as appropriate, including with the individual at the centre of care. The team collaborate to enable individuals to make informed decisions and address their care needs, ensuring continuous and coordinated care. Ongoing education and training foster interdisciplinary collaboration and develop their ability to work within integrated care teams.

From the point of view of system-level decision-makers

System-level decision-makers recognise that integrated inter-disciplinary teams are vital for delivering integrated care. They pool resources to invest in the development of an effective, capable, flexible, and adaptable workforce.

Policy and decision-makers also play a key role in creating policies, guidance, and regulations that promote collaboration across disciplines and sectors, and they prioritise investment in education and interdisciplinary training to equip the workforce with the skills needed for collaborative practice and ensure resources are provided for measurement, evaluation and learning.

5. SERVICE DELIVERY FOR COORDINATED AND INTEGRATED CARE

Description

Coordination and continuity of care are central features of integrated care services. With these central features in mind, integrated care service delivery is co-created with individuals, families, communities, public health, primary care, secondary care (hospitals), social care, care homes, care at home and others including private providers. It is focused on the health outcomes desired by the population and builds on the assets they already have, is informed by evidence, and covers the care journey from prevention through to end-of-life care. The cycle of delivery encompasses integrated care service design, testing, implementation and expansion, monitoring and evaluation and continuous improvement.

From the point of view of people and communities

Care that is integrated enables people to lead on their own care and meaningfully shape the delivery of seamless and responsive services across various health and care settings. Integrated services nurture collaboration between people with lived experience and care providers. Through co-creation, people's lived knowledge, life goals and perspectives are valued alongside professional expertise. Care is personalised, proactive, comprehensive, coordinated, and continuous, with shared decision-making guiding assessments, care planning, and delivery.

Integrated service models may focus on one or more specific conditions (for example, integrated diabetes care), on populations with similar needs (for example, integrated neighbourhood teams for people who need care and support at home), equity-deserving populations, whole populations in a locality of identify-sharing groups (for example, migrants, indigenous and other culture-sharing groups).

From the point of view of care providers

Care providers bring a range of professional and other skills and competencies that inform the design, testing, implementation and expansion, monitoring and evaluation and continuous improvement of integrated care. It may focus on one or more specific conditions (for example, integrated diabetes care) but should also take into consideration other co-morbidities and/or needs of the person. It may also focus on multiple conditions simultaneously (for example, integrated neighbourhood teams). Approaches such as case management, care coordination and integrated care pathways are three examples of approaches that care providers use when developing integrated care. These are used co-creatively with people and communities to ensure the population needs, local context, living spaces, and available resources are included. Service delivery is dynamic and responsive to the changing coordination needs of people.

From the point of view of <u>system-level decision-makers</u>

System-level decision-makers create conditions in which care and support services develop integrated and coordinated care focusing on providing the necessary resources (financial, human, development and infrastructural) to deliver proactive and preventative care and services and monitoring performance to outcomes. The overall care provision is based on collective planning and shared decision-making among all the relevant partners.

6. SHARED ACCOUNTABILITY, GOVERNANCE AND LEADERSHIP

Description

Governance, and leadership are key mechanisms for sharing accountability for integrated care. Through these mechanisms, people and organisations share accountability at the local and system level to deliver the shared purpose for integrated care, ensuring that decisions are made collectively, action is taken collectively and aligned with the goals of people and communities.

From the point of view of people and communities

Community sector organisations, citizen leaders and people with lived experience are involved in the governance of integrated care as equal partners. Collaborating with health and care providers and system-level decision-makers, they co-create enabling local policies, oversee integrated care performance, and ensure the integrated care system is accountable to the population. Their involvement in decision-making and leadership roles strengthens the system's legitimacy, equity, and responsiveness, ensuring that services align with the values of people and communities.

From the point of view of care providers

Care providers are clear in their definition of roles, competencies and responsibilities to ensure effective and safe integrated care delivery. Governance arrangements foster collaboration and integration of care to deliver the shared purpose and goals. Lines of accountability are established, focusing on financial sustainability, value, health outcomes, and people's and communities' experience of care. Collective continuous monitoring and learning ensures care standards and needs are met. Inter-disciplinary leadership aligns care provision towards people-centred goals, prioritising the integration while maintaining safety, quality, ethical oversight and regulatory compliance.

From the point of view of system-level decision-makers

System-level decision-makers provide enabling policies and guidance to allow partners to create governance arrangements that cultivate collaboration and cooperation for integration (for example, pooled budgets). These mechanisms are the means through which they collectively share authority, legitimacy and capacity to oversee integrated care across the system and make collective decisions. Leadership at this level also models and promotes collaboration across multiple disciplines and sectors, aligning them with the overarching goals of people- and community-centred care.

Through coordinated leadership efforts, the system delivers care that addresses the needs of the population while maintaining strong oversight and accountability. Where accountability lies is determined by legislation or locally agreed practice. Information is shared transparently, ensuring that all care partners are open about their performance and decision-making.

7. DIGITAL TECHNOLOGY AND INFORMATION-ENABLED INTEGRATED CARE

Description

Digital technology is essential to the delivery of integrated care using digital systems, data, and technologies to provide integrated information for individual care and population health planning. For individuals seeking care, they enhance communication, coordination, and continuity of care while supporting self-management and monitoring. At the population level, digital tools provide insights into the distribution of health outcomes and wider determinants of health, helping inform population-level policies, services and interventions to improve population health outcomes. This approach requires a focus on stewardship, trust, fair access to digital tools and personalised digital literacy to ensure that technology is accessible and effective for all, addressing health equity.

From the point of view of people and communities

The priorities for digital and information-sharing solutions are determined by the needs of the people and communities, and they are involved in the design, development, and ongoing use of digital and information-sharing solutions. People-led technology development supports digital solutions that meet the real-world needs of people and communities and are responsive to the needs of all population groups.

Digital technologies are used to support people accessing care, improving their health literacy and managing their health and wellbeing. They should enable equitable access to care. Data stewardship and access to information enable trust, autonomy and decision-making while improving data quality and transparency. Digital tools support individual shared care plans.

From the point of view of care providers

For care providers, digital technology enables the safe collection, storage and sharing of data and information between professionals, other care providers and people to enhance, shared decision-making, continuity and coordination of care and inter-disciplinary team working. The technology also facilitates reporting back to the integrated care system on performance against targets and assessing population health needs with minimal additional effort by care providers. The resulting information is used for population risk stratification, monitoring, learning and performance improvement. Care providers are given personalised digital and data literacy support to manage data and understand information to inform decision-making.

From the point of view of system-level decision-makers

System-level decision-makers procure fit-for-purpose digital systems and applications to enable integrated care supporting collaboration across providers and the care continuum. These systems foster interoperability, ensuring safe, seamless data

collection, storage and information exchange and integration across diverse health and care settings. They also incorporate intelligence to analyse data, driving continuous improvement and informed decision-making. System-level decision-makers have the digital and data literacy to understand population-level data and identify relevant changes, service and pathway redesign to respond to the needs of the population.

8. ALIGNED PAYMENT AND FUNDING

Description

Financial structures, payment and funding mechanisms are designed to incentivise integration, collaboration and delivery of shared health outcomes at scale, ensure fair and equitable resource allocation and value-based care. Financial structures, payment and funding systems that encourage fragmentation are removed, phased out or mitigated.

Aligned payments and funding mechanisms incentivise collaboration between all care providers and encourage teamwork across sectors to support care coordination, reduce fragmentation, and improve the quality of care.

From the point of view of people and communities

People and communities' benefit from payment and funding mechanisms that enable more personalised, equitable, coordinated and continuous care and include resource sharing with community sector organisations. Wider determinants of health are considered, and funding systems incentivise health promotion and prevention, as well as care quality and safety. By promoting collaboration among care providers, including community sector organisations, funding mechanisms support people and communities by improving their access to health and care, together with their experiences and outcomes.

From the point of view of care providers

Payment models are redesigned with all care providers to encourage collaboration across sectors and team-based care, removing silos and promoting joint efforts for comprehensive care. Care providers understand the effect of these mechanisms on behaviours that incentivise care integration actions and coordination across organisations and adjust accordingly.

Care provider leaders monitor the performance of alignment against the goals of integrated care to ensure the alignment fosters more efficient, person-centred care delivery, improving both population outcomes and collective provider and community sustainability.

From the point of view of system-level decision-makers

By aligning or pooling funding and payment flows at the system level, according to a people-centred perspective and aiming to advance coordinated and continuous care, policymakers facilitate the context for adopting integrated care and improving equity. Policy and decision-makers advocate for policy changes to remove barriers to integrated funding, ensuring that regulations

support financial arrangements that in turn enable fair and equitable resource allocation among partners and resulting in funding following the care pathway journey of the person.

Public, private, and voluntary sector partners are incentivised to work toward collective shared purpose and goals, with systems that reduce fragmentation and avoid conflicting financial incentives. System decision-makers monitor alignment to ensure cost-effectiveness and sustainability goals are met.

9. LEARNING FROM RESULTS AND IMPACT

Description

The integrated care ambition is seen as a learning system, co-created with people and communities based on their lived experience and what matters to them that continuously adapts and improves based on evidence, including data and feedback embedded into everyday practice. Care is delivered; data is collected, analysed, and transformed into actionable insights that drive continuous improvement in real-time continuously adapts and improves. It uses qualitative and quantitative evidence from all relevant partners and initiatives to ensure that measures of results and impact are comprehensive and understandable. Feedback processes ensure partners can continue evolving and improving together.

From the point of view of people and communities

People and communities are central to the learning and improvement of integrated care services. They should be involved in the evaluation and monitoring of service integration from design through continuous monitoring and improvement. Individuals also play an essential role in the evaluation and monitoring of their own care integration and that of those they care for. This includes access to accurate and timely information.

From the point of view of care providers

Care providers have access to accurate and timely information on individual care, and at the population level, they have information on progress against expected outcomes for the population. Care providers can use this information to support their decision-making, and it helps them understand how their efforts contribute to population-level health improvement.

Provider and team leaders support a learning organisational culture, promoting continuous quality improvement at all levels. Learning and improvement are central to the practice of interdisciplinary integrated care teams at all levels.

From the point of view of system-level decision-makers

System-level decision-makers create a framework, resourcing and mechanisms for monitoring and evaluation including measuring key performance indicators, ensuring the integrated care system tracks progress towards the shared purpose and agreed population health outcomes. This may or may not be linked to the quintuple aim (better value, better experience of care, better workforce experience, greater health equity and better population health). Leaders also encourage local experimentation and learning, creating a less risk-averse environment where innovation can thrive. Additionally, they prioritise transparency, ensuring that relevant information and evidence are accessible to the public.

APPENDIX 7

Nine Pillars of Integrated Care Descriptions – after non-expert feedback

Pillar label	Short description	Full description
Purpose	Shared purpose	The first Pillar is shared purpose for integrated care. • This is collectively built and implemented by partners including community sector organisations, public health, primary care, social care, hospitals, long-term care providers, local, regional and national decision-makers. • This is done by aligning services and people to provide people- and community-centred, coordinated, continuous, fair, and locally responsive care. • It leads to shared goals, greater ability to work collaboratively and is linked to desired health outcomes for the local population.
Health in context.	Understanding of the determinants of health in context	The second Pillar is Determinants of population health in context. • Integrating care across the continuum of prevention and early intervention, self-care, chronic care, social care, acute care, long-term care, and end-of-life care, requires a deep understanding of the wider determinants influencing health, wellbeing, and access to quality care.

		• These determinants include
		  • access to good quality housing,
		  • food security,
		  • sense of belonging, and
		  • secure employment.
		• For integrated care to work, all actors in the care system are committed to address these determinants to reduce inequalities in health, wellbeing, and care opportunities.

People as partners	People and communities as partners in care	The third Pillar is People and communities as partners in care. • People who need care, their family members and the communities they live in, are recognised by care providers and system decision-makers as partners in integrated care. • As partners, they have an essential role in care integration, and with other team members their distinct roles and responsibilities are explicit and valued for collaborating to achieve shared purpose. • People as partners are involved in agreeing a set of local priorities based on their shared purpose, goals and desired health outcomes.

		• This involvement of people and communities as partners enables place-based partnerships for better use of all the combined local resources and assets.
Teamwork	Integrated teamwork that is person and community-centred	The fourth Pillar is Integrated teamwork for person- and community-centred care. • Integrated care teamwork is the point at which most people experience integration, coordination and continuity. It is about how people and professionals collaborate, formally and informally, to plan and deliver care around what matters most to people. • In this context, a "team" can mean many things: a formal multi or interdisciplinary team, an alliance across different organisations and sectors, or a care partnership between providers and the person receiving care. What matters is that all the people involved in supporting someone's care, including health and care professionals, community care, carers, and the person themselves, are connected, coordinated, and working together. • Professionals and non-professionals paid and unpaid carers, from different backgrounds and with different competencies, roles and responsibilities work together in

		inter-disciplinary and inter-organisational teams that include people who need care. • New inter-disciplinary ways of working are developed and new inter-disciplinary knowledge created to promote integrated care. • The relationship between care providers and people and communities shifts to a more equal basis.
Coordinated care	Service delivery models that promote care coordination	The fifth Pillar is Service delivery for coordinated and integrated care. • Coordination and continuity of care are central features of integrated care services. • With these central features in mind, integrated care service delivery is co-created with individuals, families, communities, public health, primary care, secondary care (hospitals), social care, care homes, care at home and others including private providers. • It is focused on the health outcomes desired by the population and builds on the assets they already have, is informed by evidence, and covers the care journey from prevention through to end-of-life care.

		• The cycle of delivery encompasses integrated care service design, testing, implementation and expansion, monitoring and evaluation and continuous improvement. • Approaches such as case management, care coordination and integrated care pathways are three examples of approaches that care providers use when developing integrated care. Service delivery is dynamic and responsive to the changing coordination needs of people.
Governance	Shared accountability, governance and leadership	The sixth Pillar is Shared accountability, governance and leadership • This Pillar can feel abstract, but in practice, it is about how decisions are made, who is involved, and how people work together to achieve shared goals. • Governance refers to how decisions are structured: who has a voice, how priorities are set, and how progress is tracked. The design of governance for integrated care is guided by shared decision-making. • Leadership for integrated care creates a shared direction and motivating people across teams, organisations, and communities to work together.

		• These two elements create accountability for delivering integrated care. They ensure that action happens with -or even by- people and communities, not just for them.
Information and technology	Shared information and digital technology	The seventh Pillar is Digital technology and information-enabled integrated care. • Integrated care depends on the ability to access, share, and act on the right information at the right time. Digital tools are one of the mechanisms that support this, but integrated care is also strengthened through low-tech or no-tech approaches to effective information sharing. • People have better access to their own health information, and this helps improve communication with their teams, supports self-management, and allows for more coordinated and continuous care. Something as simple as having a written care summary, care plan or a reference contact person makes a difference. • At the population level, shared data helps to understand the distribution of health outcomes and the broader social determinants of health. This data helps services plan and respond to local needs more effectively.

		• Making information systems equitable and effective also means investing in stewardship, trust, fair access, and the skills to use information confidently. That includes supporting digital and data literacy for all users, including people, communities and care providers.
Finance	Aligned payment and funding systems	The eighth Pillar is Aligned payment and funding. • Financial structures, payment and funding mechanisms are designed to incentivise integration, collaboration and delivery of shared health outcomes at scale, ensure fair and equitable resource allocation and value-based care. • Financial structures, payment and funding systems that encourage fragmentation are removed, phased out or mitigated. • Aligned payments and funding mechanisms incentivise collaboration between all care providers and encourage teamwork across sectors to support care coordination, reduce fragmentation, and improve the quality of care.
Learning	Learning from results and impact	The final and ninth Pillar is Learning from results and impact. • The integrated care system is a learning system, co-created with people and communities.

		• This learning system is based on people's lived experience and what matters to them, that continuously adapts and improves based on evidence that includes real-time data and feedback embedded into everyday practice. • Care is delivered; data is collected, analysed, and transformed into actionable insights that drive continuous improvement in real-time. • It uses qualitative and quantitative evidence from all relevant partners and initiatives to ensure that measures of results and impact are comprehensive and understandable. Feedback processes ensure partners can continue evolving and improving together.

About the International Foundation for Integrated Care (IFIC)

The International Foundation for Integrated Care (IFIC) is a not-for-profit foundation dedicated to improving the lives of people and communities by advancing the science, knowledge, and adoption of integrated care around the world.

Our vision is that individuals, families, and communities benefit from person-centred, coordinated care and support that enables them to live healthy and fulfilling lives. We work to overcome the fragmentation in health and care systems by promoting models of care that are holistic, co-produced, continuous, coordinated, equitable, and sustainable.

As the leading international voice for integrated care, IFIC brings together researchers, health and care professionals, policymakers and people, families and communities. We provide a unique platform for collaboration, knowledge exchange, and innovation to drive system change.

IFIC DELIVERS IMPACT THROUGH:

- **The International Journal of Integrated Care (IJIC)** – our open-access, peer reviewed publication sharing global evidence and best practice
- **International conferences and regional networks** – connecting people and ideas across sectors and borders
- **The Integrated Care Academy** – offering education and training to develop the workforce needed for transformation
- **Applied research and implementation support** – bridging policy and practice to build more effective and sustainable care systems
- **Knowledge platforms and solutions** – enabling shared learning and practical action across our global community

IFIC is recognised for its excellence, transparency, collaborative partnerships, and commitment to open access and continuous quality improvement.

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