Guest editorial

Marketing as an Integrator in Integrated Care

Integrated care has been heralded as a primary health sector policy objective not only across Europe but also globally (WHO, 2015, 2016). The two major drivers are:

(1) the desire for more person-sensitive approaches to the delivery of health and social care services; and

(2) the spiralling and unsustainable rises in the cost of health care.

Integrated care is not disease or condition specific, instead it encompasses multiple chronic or acute diseases or complex single conditions and recognises the need to navigate through a labyrinth of services, especially under conditions when the patient has no or depleted resources through complications such as frailty, cognitive decline and social isolation. However, today's reality with regard to service provision, especially for vulnerable groups living in the community (e.g. older people, those with chronic or mental health conditions and children with complex needs), is one of fragmentation resulting in disjointed, inefficient and patchy care that is not patient-centred and raises problems associated with polypharmacy and professional disharmony. There is a desperate need for new conceptual and organisational approaches to care that link multiple stakeholders into a single integrated response. Achieving this goal is a recognised contemporary grand challenge, not least because of the diversity in perspectives of the multiple stakeholders involved and the fragmentation of health-care delivery systems.

Active projects across Europe have made valuable steps forward in integrated care. Pilot initiatives can be found in a number of countries including Denmark, Estonia, The Netherlands, Sweden and the UK, and the concept of integrated care is being encouraged widely as both a service and professional philosophy. The European Federation for Medical Informatics (EFMI) organised the "Village of the Future" (MIE2012) visioning the integration of social and health care, followed by "The Caring Village of the Future" (Medinfo, 2013) and the Kurhaus Conference (PCSI 2015). The International Foundation for Integrated Care, the principal NGO for Integrated Care, is active in promoting delivery and organisational innovation globally, but has much less focus on applied informatics innovation. Other examples of contemporary projects are: Project INTEGRATE (projectintegrate.eu.com); SCIROCCO (scirocco-project.eu); SmartCare (pilotsmartcare.eu); INDEPENDENT (independent-project.eu); CommonWell (commonwell.eu); Health@Home; Beyond Silos; and CareWell. Projects analysing business/funding models of providing health and social care e-solutions include: eCareBench; SALT; PSYCHE; and Older Person Services (Dublin, Ireland). Other projects are working on accessibility, functional and infrastructure aspects, including interoperability between electronic health record systems across Europe: MeAC (eaccessibility-progress.eu); epSOS (epsos.eu); Promoting Effective Homecare and Telemonitoring; and Palante (palante-project.eu). Finally, projects focussing on enhancing communications between stakeholders with supporting information structures include KITE and CancerStories (cancerstories.info).

Achieving integrated care is a multidisciplinary problem, yet with a few notable exceptions across disciplines, there is a lack of coordination efforts between disciplines to effectively integrate knowledge and approaches. Also, much attention is focussed on the

European Journal of Marketing
Vol. 52 No. 11, 2018
pp. 2194-2206

0309-0566
DOI 10.1108/EJM-11-2018-899

review and redesign of health processes for improved efficiencies, rather than focussing more innovatively on how services present to users and drawing on other disciplines with strengths in service-user centricity, such as, marketing. The main aim of this special section is, thus, to provide a platform that explicitly coordinates and curates multidisciplinary research aimed at providing a shared understanding and knowledge base that directly addresses the fragmentation in this field. Within the marketing discipline there is a strong and well-established theoretical knowledge base that can make a significant contribution to realising integrated care. In particular, marketing can perform the role of lynchpin between care disciplines, not least in providing fresh understandings of patients as service users and their networks. A recent review that specifically integrates health care and services research demonstrates the promise of such multidisciplinary thinking (McColl-Kennedy *et al.*, 2017a), and in confirmation, most recently, the specific role of marketing in health care has been explored (Anderson *et al.*, 2018). Notwithstanding, marketing is often the overlooked and misunderstood possible partner in major health and care projects at National and European levels, which has constrained its potential impact on this area. Thus, this special section showcases how research in various domains of marketing can play a central integrator role in drawing together multiple disciplines around integrated care in addressing the challenges that consumers, practitioners and policymakers face. Moreover, we provide insights into how research in integrated care can in turn inform and advance marketing theory and the formation of multidisciplinary research networks to play a leading role in this important arena. We do so by identifying four big challenges in integrated care to which we believe marketing can contribute and each of the articles, and accompanying commentaries, in this special section provides an example of this potential contribution.

New thinking to address fragmentation in integrated care

Tackling the barriers to integrated care and hence facilitating its delivery would produce significant positive impact, as health, social and other care systems struggle with this issue. A core problem from the health and care provider perspective is that the field is fragmented with no one agency having overall responsibility, thus hindering innovation in integrated care, and the consumer perspective shares this lack of a single supplier point. The essential vision of person-centred integrated care challenges established practices and care delivery processes, necessitating changes in service policy, delivery and the development of innovative technology solutions, while also changing societal thinking about health-care professions and the role of patients and their advocates. What is clear is that integrated care must progress beyond harmonisation of parallel services, to mutual understanding and complementarity in a person-specific, sensitive, inclusive and accountable way. Such an integrated approach will optimise the co-production of health (Palumbo, 2016; Rycroft-Malone *et al.*, 2016), whereby individuals take on appropriate responsibility for aspects of their health maintenance and support, assisted (within their capacity and mutual permissions) by family and close social contacts. Co-production implies that individuals exercise autonomy, which requires decision-making capacity. The most vulnerable groups often experience impaired decision-making ability for many reasons (transient or enduring). Assisting such individuals to engage in decisions about care is a complex ethical, legal and human rights issue. Rather than taking a discipline-centred approach, integrated care requires a challenges approach. To achieve true person-centric integrated care is complex and can only be achieved by integrating concepts, objectives and methods across a diverse array of disciplines; incorporating social

sciences, health and care sciences, informatics, medical engineering, ethics, systems and policy studies, to name just a few. Yet it should also be simple – meeting a person's well-being needs in a sensitive joined up way.

The use of digital tools may play a key role in delivering integrated care, but raises challenges of acceptability, responsibility, accessibility, financing and ethics; yet debates continue to focus on the technical aspects of ICT development (Stroetmann *et al.*, 2010). Instead, the European Science Foundation report on Developing a New Understanding of Enabling Health and Wellbeing in Europe (Rigby *et al.*, 2013) and the OECD (2013) report on Smarter Health and Wellness Models emphasise the need for innovative social science research, alongside innovative ICT support. Marketing is an obvious but overlooked key social science player here.

The four big challenges to achieving integrated care

We identify four challenges that consumers, practitioners and policymakers face in developing and implementing integrated care and label these as: self; society; micro (person-level) systems; and macro (service level) systems. For each of these four challenges we present examples of past research activity that have emerged from marketing in Table I. Whilst this is by no means an exhaustive list, it is an illustrative inventory of the advances that can be made and the possible key value areas offered by marketing to the study and realisation of integrated care. In the following section, we outline how each of the papers in this special section contribute to forwarding the role of marketing as an integrator of integrated care and formulate some challenge issues that accompany that role.

Challenge 1: self

Central to integrated care must be self, referring to the person at the centre of care – the patient or the consumer of care services. Self encompasses more than asking patient consent and preferences at the point-of-care delivery, but includes meaningful recognition of voice, choice, autonomy and accommodation of gradual changes in self-expression ability. In relation to the self, there is a clear, acknowledged need for identifying shared priorities for governance and safeguarding patients in an integrated system of care. Yet therein lies the danger of overlooking or misunderstanding the values and perspectives of both the person in need of care and diversity within the wider society. Innovations fail if they do not take adequate account of human and social issues. Policymakers, politicians and developers often base their thinking on people they know and interest with (usually an educated subset of the population). Such design by professionals and policymakers for "People Like Us" disadvantages those vulnerable groups most in need of support, who are inadequately understood and thus comparatively disenfranchised and disconnected (Showell and Turner 2013, Dietrich *et al.*, 2017). Identifying values and designing systems of care aligned to a person's values, competencies and resources will act as a catalyst for more readily and universally accepted and adopted systems. Harnessing the potential of technology (especially mobile) for integrated care must fully consider the ethical issues raised by the use of technology as a solution. For vulnerable persons technology can be daunting, hence the need to evaluate consumer-facing technologies for their applicability for integrated care and their ability to promote social inclusion (Keeling *et al.*, 2018).

Marketing scholars have been actively building a strong knowledge base about consumers and health and social care and such works as these and many others in the field can make a significant contribution to designing systems of care that align with person

Challenge area	Themes	Authors
Self	Co-creation and co-production	Anderson *et al.* (2018) Essén *et al.* (2016) McColl-Kennedy *et al.* (2017b) Sweeney *et al.* (2015)
	Empowerment and engagement	Keeling *et al.* (2018) Ouschan *et al.* (2000,2006) Seiders *et al.* (2015)
	Emotions	Gallan *et al.* (2013) McColl-Kennedy *et al.* (2017c)
	Search, decision-making and prevention	Larson and Bock 2016 Zainuddin *et al.* (2013)
	Technology and (self) health-management	Erdem and Harrison-Walker (2006) Nieroda *et al.* (2015) Schuster *et al.* (2013) Tian *et al.* (2014)
	Journey	Tax *et al.* (2013)
Society	Economics and societal benefits	Chan *et al.* (2015) Dagger and Sweeney (2006)
	Capacity building	El-Manstrly and Rosenbaum (2018) Keeling *et al.* (2015,2018)
	Restorative servicescapes	Rosenbaum and Smallwood (2011, 2013)
Micro systems	Co-creation in ecosystems	Dahl *et al.* (2018) Dietrich *et al.* (2017) Elg *et al.* (2012) Frow *et al.* (2016) Osei-Frimpong *et al.* (2015) Spanjol *et al.* (2015)
	Roles, structures and relationships	Danaher *et al.* (2008) Keeling *et al.* (2018)
	Physician prescribing behaviours and decision-making	Chan *et al.* (2013) Nair *et al.* (2010) Stern and Wright (2016)
Macro systems	Health Service Quality	Dagger *et al.* (2007) Faulkner *et al.* (2017)
	Role of Pharma	Manchanda and Honka (2005) Stros and Lee (2015) Wieringa *et al.* (2014)
	Technologisation of Service and Service Design	Green *et al.* 2016 Rosenbaum and Wong (2012) Rosenbaum *et al.* (2017)

Table I.
Examples of research activity in the marketing discipline within challenge areas

values, competencies and resources and aid in the acceptance, adoption and engagement with such systems (Table I). One of the key challenges with regard to self is making the consumer's voice heard right at the conception of care and care design. This is emphasised by one of our practitioner commentators, Dr Áine Carroll. Ferguson (this issue) gives a very personal account and demonstrates how reflexive introspection can be effectively used, beyond its therapeutic benefits, to bring a deeper understanding of the meaning of illness and treatments from a patient's perspective. This is not only in terms of the distinct meaning separate to professional understandings, but also the transformation of meaning across the course of illness and treatment and its impact on a patient's agency. As Carroll (this issue) comments, exploring the power of such methodologies is

likely to inform practice and service design, not just by offering a patient perspective, but also by helping to define the voice that is present at different stages of the patient journey. Ferguson (this issue) emphasises the importance of the personal ontologies of health that develop (and change) across a journey. Hence, we can more clearly understand patient choices (and those that they do not want to make), the level of engagement they desire (if any) and the challenges they are facing that compete for their resources in the face of major life decisions. From an integrated care perspective such understandings provide us with an understanding of the fluidity of the patient voice and the flexibility in the constellations of care required for a truly patient-sensitive approach. This is not only applicable to the patient, but also the other, often neglected voice, that of the informal carer.

Ferguson's article and its accompanying commentary serve as one example of the contribution to be made by marketing to the realisation of integrated care. While translating the challenge of self into other pertinent issues for integrated care, we identify three key development areas for further research. Patient and carer perspectives within integrated care are difficult to study, as they require a longitudinal perspective over a period of years, but a thorough understanding of the following three areas would inform and facilitate development of more effective models of patient-centred care:

(1) Understanding of how consumers (patients and carers) utilise self-service within health and social care and how this disrupts and/or contributes to formal care provision (with reference to the systems layers identified later). This aligns with the need to adopt and further develop the concepts of participation, engagement and co-creation as theoretical underpinnings for adopting responsibility for self-management of care.

(2) Integrated care will entail consumers (patients, carers etc.) interacting with technology in some form. An urgent issue is to utilise marketing frameworks to aid in the development of assisted decision-making for vulnerable individuals. This goes beyond facilitating consumer acceptance/adoption of and engagement with technologies as a means of delivering integrated care, to understanding what consumers need from such technologies and how these needs (mis)align with the intentions of use within the care system.

(3) A fundamental principle of integrated care is that the patient is at the centre of care – not the disease. As such, we should continue recent efforts to develop understandings of patient and carer journeys with the person as the point of reference and not the formal system. This includes a focus on not only interactions within formal health systems, although those remain key to access of care, but also what occurs outside of these, which supports or thwarts the patient's recovery process. This is especially important in the case of very vulnerable consumers and their carers, who often lack a voice in society.

Challenge 2: society

Society should not just reclaim some of the non-technical responsibility for supporting those with frailty or chronic conditions who could be supported in their own homes, but should increasingly provide a major resource, if it can be appropriately coordinated, to ensure safe and reliable support. Society recognises the cost of care beyond the individual, especially of ineffective or neglectful care. Health care puts one person, the patient, at the centre of delivery, whereas social care recognises the importance of the family and community

setting. Integrated care demands recognition of the needs, competencies, resources and other commitments (including other caring) of patient, family and informal carers. Informal carers' needs are an important focus as this is perhaps the most neglected group in terms of research. The wider societal costs of care include: multiway interactions between professionals and lay persons/families and how to bridge these effectively, including e- and health-literacy; identifying what new types of training for persons, families and professionals are required to enable effective co-production within virtual care teams. Society can also offer those aspects of life which are not directly related to health or social care, but which nevertheless are known to be essential to a healthy and fulfilling life, including restorative green spaces, social activities, hobbies and interests, spiritual support and facilitated transport to access these activities and health services.

Marketing can contribute to these issues, particularly around building capacity and hence resilient supportive communities both off- and on-line (Table I). Underpinning such efforts, however, is the need for effective communication across stakeholder groups, emphasised by one of our practitioner commentators, Sonja Müller (this issue). Effective communication can be viewed as the 'lubricant' of collaboration. Marketing has a rich history and hence much to offer in this area. In a direct application of this expertise, Orazi and Newton (this issue) demonstrate how marketing communication theory can be used to effectively increase receptiveness to health messaging by focussing on the source of the communications. In particular, their work demonstrates that there is an appetite amongst consumers of health care for co-created messages. That is, those messages that combine professional credibility and competency with consumer validation are viewed as more authentic and hence more positively received. As Müller (this issue) emphasises, this work provides a foundation for going on to explore further challenges, especially around the core issue of facilitating effective collaborations. It is a given that marketing theory can aid the transformation of stakeholder communications and collaboration within integrated care. Specific areas to advance are:

- At the heart of enabling integrated care policy is collaboration, even co-creation, and the effective integration and application of resources amongst diverse stakeholders; not limited to patient-professional dyad but extending out to the local community and society. There are many challenges to developing communications that encourage interaction and contribution rather than simply playing an educational role. There is an urgent need to identify and put into practice marketing communications theories that can inform the facilitation and development of a collaborative culture, emphasising inclusiveness, team-working and person-centredness, rather than the (often) prevailing paternalistic culture.
- Marketing theories and practice can and do make a large contribution to addressing issues in society. Particular, areas to address within the field of integrated care are the reduction of stigmatisation around comorbidities, heightening awareness of neglect and how to address neglect and identifying and tackling disenfranchisement within care.
- Building health and social care capital to facilitate resilient societies will continue to increase in importance. Formal integrated care delivery has fuzzy boundaries – practitioners are not the owners of health and social care, nor are they the sole providers. There is a continuing struggle to effectively identify and support the large numbers of informal carers (children and adults) and

communities that provide intensive care but receive little support themselves. Important areas to pursue are the quality of interaction between carers and their loved ones and between carers and care teams, involvement in shared decision-making and care pathways, carer training and empowerment and innovative care support structures.

Challenge 3: micro (person-level) systems

Designing and delivering integrated care is demanding at the frontline. We should not underestimate the impact of new terms of service delivery and fundamental changes in roles across the service areas. Innovations in communications that integrate professional and lay person support require new constellations of collaborative working. Challenging issues include: linking 'other individuals' to the patient care plan; linking carers through remote e-links; aggregation of one informal carer's multiple caring roles; and the formation and coordination of virtual care teams. From table I we can see that marketing has already made advances in identifying and defining the various roles and relationships and competing needs amongst stakeholders.

Focussing on the frontline, Taiminen, Saraniemi and Parkinson (this issue) directly explore physician attitudes to computerised Cognitive Behavioural Therapy (cCBT), a digital self-help service available to mental health patients. Whilst digital self-services may be one way of addressing service efficiencies, improving accessibility and presenting patients with more empowering options; Taiminen, Saraniemi and Parkinson rightly point out that physicians, who may 'prescribe' such services to patients, are also consumers of such services. Their study highlights the potential ethical issues raised through introduction of these services such as blurring physician accountabilities and the need to responsibly delineate what the active role of the patient really means and requires. One of our practitioner commentators, Dr Rachel Davies (this issue), confirms that these conflicts emerge in everyday mental health practices. Davies finds the notion of physician as a 'value self-creation supervisor', proposed within the article, useful as it focusses on the facilitative role of the health-care professional and mirrors some observable shifts in current practice. She also identifies the role of training in supporting the development of this role for future practitioners.

The frontline of health and social care is not limited to easily identifiable groups nor are the roles of those involved sharply defined or equally understood between groups. Integrated care delivery brings further fuzziness to issues of accountability, responsibility and decision-making. The following three areas are suggested for future research:

(1) The renegotiation of roles and responsibilities of health-care professionals, carers and patients and all of those involved in integrated care needs to be documented. This would help identify the practical, social and cultural barriers and facilitators to collaboration at the frontline, and enable negotiation in multi-stakeholder projects around integrated care. There may be obvious divisions to bridge, such as those between formal care centres and community services (informal and formal), or less obvious divisions such as virtual care delivery (e.g., through online communities, such as PatientsLikeMe, or self-management through mobile and digital applications and wearable technologies).

(2) Innovative approaches are needed to help build sustainable health and social care systems. One valuable direction may be the application of marketing expertise to the recruitment and retention of informal carers. Another direction is the design,

implementation and utilisation of online service delivery to reach out to vulnerable communities. Yet another direction is evaluating the outcomes of current innovations in service delivery, such as group consultations for chronic patients, and how such practices can inform sustainable integrated care delivery with improved quality of life outcomes for patients and their families.

(3) Future research is needed to examine how frontline technology can instigate and enable learning and information exchange between patients, carers and care professionals. Marinova *et al.* (2017) identify a number of instances of how technology may substitute dyadic or triadic interactions between the key actors, such as health monitoring and sharing by mobile devices. In addition, the complementary role of technologies is discussed. As an example, AI-powered virtual agents are increasingly playing a role in mental health care, alongside health-care professionals, and can even assist with the informational and emotional needs of clients. However, as shown by the recent shelving of Nadia, the virtual Chabot with emotional intelligence who was to help clients navigate a national disability insurance scheme, some governments have low tolerance for risk (Probyn, 2017). Future research should extrapolate how technologies are best positioned to support integrated care functions, thereby presenting a clear evidence base for sound investment.

Challenge 4: macro (service-level) systems

The Macro Systems are complex, involving health, social care, welfare, housing and other social systems, and information and informatics systems. Much of the current research and innovation is focussed on system silos divorced from the people systems. Policy systems are increasingly the trigger, and often the impediment, to truly innovative integration, giving a concomitant need for policy to be evidence-based with a stable longer-term horizon. Applying an integrated research lens is essential to issues of how individual care, in personalised packages, can be made seamless and systematised to ensure effective delivery, harnessing heterogeneous resources. New approaches to understanding the setting of policy across boundaries; shared ICT 'ownership'; quality assurance; incentives, rewards and controls; governance; and equity, will be needed.

Cruz, Snuggs and Tsarenko (this issue) effectively demonstrate the fragility of integrating service systems. Focussing on the underlying social dynamics, they identify that empowering consumers at one level of the system, that is, the individual level, can facilitate fragmentation at another level, that is, the service system level. The labyrinth metaphor that they advance helps stakeholders in integrated care to effectively identify and understand the interactions and tensions that can lead to the fracturing of these services; thereby mitigating these in designing, delivering and being a part of integrated care services. Marilène Dols (this issue), one of our practitioner commentators, develops these ideas further by pointing out the additional complexities (and therefore opportunities for further fragmentation) that are introduced when patients feel empowered to choose complementary and alternative cures (CAC) as part of their care pathway. Dols (this issue) emphasises the need for professionals to acknowledge such patient choices as an integral part of empowering patients in their care.

Strategic marketing management plays an important role in devising new models of integrated care that effectively combine informal and formal collectives and organisations. Fruitful directions include:

- Exploring competition and co-opetition strategies in health and social care that could bring an innovative approach to integrated care design and delivery when combined with learnings from marketing that inform ethical practice in integrated care.
- Using stewardship to inform models of integrated care around issues of accountability, responsibility and sustainability of health and social care. As well as the role that health marketing theory could play in resolving common issues with polypharmacy at a professional, patient and carer level.
- Understanding smarter health as a means of delivering person-centred delivery, including issues around electronic health records, e-health and advances in AI.

Conclusion

This special section is a call for a deeper, more mature and reflective interaction between marketing researchers and health-care system researchers to actively seek out opportunities for multidisciplinary collaborations that work towards addressing the four big challenges identified here. Mutual misconceptions may initially hinder this. Within health care, marketing may be seen as primarily associated with the revenue maximisation activities of the pharmaceutical industry and private hospitals, together with some recognition of social marketing for public service messages. Indeed, public- and insurance-funded services do not want to increase market share as they are already over-loaded. Marketing scientists may hitherto not be fully aware of the consumer and transactional issues so vital within integrated care delivery. But an opening of minds to mutual interests and opportunities, as envisaged by this issue, should be mutually stimulating and beneficial, and hence contribute to developing effective integrated care. We believe that marketing as a discipline has great potential to play a pivotal role in multidisciplinary teams working on this important issue. Integrated care is about people and their needs for multiple health and allied services, and should transition away from inflexible product delivery – a transformation where marketing has much to offer. The articles and commentaries in this special section demonstrate how theory and methods can contribute to solution development as well as stimulate debate and creativity amongst professionals working in other disciplines. We know that there are many challenges to working across disciplines, not least issues around diverse terminologies, methods and accepted practices. But we see these as catalysts, and by addressing these differences across disciplines we directly work towards solutions that are based on integrated rather than parallel care systems.

Thank you

This special section would not have come about without the efforts and support of many, to whom we extend very grateful thanks. To the authors, we appreciate you submitting your works and, more especially, for your efforts in branching out into new fields of multidisciplinary research that promise such high practical impact as well as pushing the boundaries of conceptualisation beyond specific disciplines. To the reviewers, we thank you for contributing to the development of the papers published in this special section, and also for guiding the authors of those papers that did not make it through to publication, but showed great promise for the future. To the practitioners for taking the time out of their busy schedules to consider the value of the academic work published here. We thank you for your conversations, both the commentaries published

here, and also for those that extended beyond – it was particularly rewarding to learn about the value that we from the marketing discipline can add to the pursuit of integrated care. We thank the Editorial and Publisher Teams for making space allowing us to open up a dialogue between disciplines and between academia and practice – in line with the true spirit of the Integrated Care journey. Finally, to the readers, we hope that you enjoy the special section articles and commentaries and that they inspire you to take up the challenges that we detail here to push knowledge and practice in the multidisciplinary field of integrated care.

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