Article

Users’ and Providers’ Perceptions about Integrated Health Care in Southern Denmark

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Abstract: Health care systems are increasingly complex, and evidence shows poor coordination of care within and between providers, as well as at the interface between different levels of care. The purpose of this study is to explore users’ and providers’ (stakeholders’) perspectives of integrated care in Denmark. We conducted qualitative interviews with 19 providers and 18 users that were analysed through inductive content analysis. Providers’ and stakeholders’ perceived deficits in system-level factors, lack of organizational culture, weaknesses in communication, a need for a shift towards considering equity in access to health services and focus on person-centeredness. Fundamental changes suggested by participants were better sharing of information and knowledge, focus on stronger trust building, efforts in making communication more effective, and changes in incentive structure. Users perceived poor navigation in the health care system, frustration when they experienced that the services were not based on their needs and lack of support for improving their health literacy. The study showed health care weaknesses in improving user involvement in decision-making, enhancing the user–provider relationship, coordination, and access to services. Public health within integrated care requires policies and management practices that promote system awareness, relationship-building and information-sharing and provides incentive structures that support integration.

Keywords: integrated care; public health; health care system; Denmark

1. Introduction

Integrated care has evolved into a dominant topic in health care systems around the world, including Denmark [1–4]. Integrated care is a major concern in welfare states across Europe and thus raises the question of how to develop sustainable structures, incentives, and regulative arrangements to support integration across different government levels. A wide range of approaches and models of integrated care have been developed and implemented, extending from disease management programs to complex population-oriented whole system models [5–10]. Integrated care is a broad concept with a multicomponent set of ideas and approaches aimed at improving service efficiency, patient experience, and quality of care. In 2008, the World Health Organization (WHO) defined integrated care as “the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system” [11].

Health care systems are increasingly complex, encompassing the provision of public health services, primary health care, secondary health care, and acute care in a variety of contexts [12–14]. The fragmentation of care occurs within and between providers, as well as at the interface between primary and secondary care, public health services, and health and social care [14]. Poor coordination results in duplication between health and social care services and unnecessary hospital stays, further increasing the financial burden on the system. Differences in cultures, conflicting remuneration and incentive systems, budget constraints, IT systems [15–20], and different locations within and across organizations continue to create barriers to the seamless provision of care.
Increasingly, health care systems are facing persistent pressures that result in poor performance and growing inequities in services [21,22]. The coordination of services and support for citizens have historically been poor, resulting in people falling in gaps in service provision, being ‘bounced around’ different services, and having to explain their needs multiple times to different providers [23–26]. The failure to improve the underlying conditions for health is compounded by the insufficient allocation of resources to address population needs.

A scoping review conducted by Davidson et al. [23] found that people with complex needs experience a lack of coordination across health care teams and wider community resources. Furthermore, limited associations were made between integration processes and patient experience. The views of citizens and patients would ensure that the services provided fit with their values and health needs. Another systematic review conducted by Sadler et al. [24] found that users particularly valued relational elements of continuity of care, which included addressing the quality of user–provider relationships and access to appropriate and timely service support. Providers emphasized the importance of improving the coordination of services between providers working in different care settings. However, the focus has been on better coordination and integration among health care sectors to manage specific chronic diseases [27]. It has become evident that to provide public health services that improve population health, the scope of integrated care needs to be expanded to bridge the gaps not only within the health system, but also between the various sectors of health and social systems [22,28–32].

Considerable attention has been given to organizational structures, access to health care services, effects on clinical outcomes, and cost-effectiveness of integrated care [10,33], but little is known about the perceptions and experiences of patients or health care providers working in an integrated care setting. The literature emphasizes, e.g., person-centredness as the core element of integrated care, but there is no research in Denmark on whether this exists in practice. Central to integrated care is also ensuring that health services are coordinated around the needs of citizens and patients to provide a seamless service experience [34].

Danish Health Care System and Integrated Care

The Danish health care system is a Beveridge-type system similar to that in the other Nordic countries and the UK [35]. The national government, which includes the Ministry of Health, is considered the highest level of authority and is in charge of the overall structure and regulatory framework of the health care system. The regions and municipalities, which are governed by elected officials, play a more direct role in the delivery of health care services [36,37]. This differentiation has resulted in differences in funding approaches, decision-making bodies, service delivery, governance, and accountability structures.

The Danish health care system was reformed in 2007. One element of the reform was the introduction of the “health agreement” as a tool to improve the integration of health care and social services [36,38]. A health agreement functions as a guiding document that constitutes an overall general framework for coordination between municipalities and regions, including general practitioners (GPs), nurses, hospital doctors, etc. Health agreements also describe patient pathways across the health care and social services continuum, and they, therefore, have the potential to support integrated care. The integrated care emphasis in Denmark is on improving the quality of care, health outcomes, and citizen/patient experience [36]. The goal is that integrated care reflects the views of citizens and patients to ensure that the services provided fit with their values and health needs [38]. The challenge in the future for the Danish health care system is to address health broadly, including public health, rather than being concentrated within the boundaries of traditional health care services. The Danish health care system structure seems to be optimal for promoting health, preventing diseases, and tackling chronic diseases via integrated care actions. However, there is sparse knowledge in Denmark on how integrated care works in practice and whether it includes public health elements.
Therefore, this paper proposes to explore users’ and providers’ views and perspectives of integrated care in Denmark.

2. Materials and Methods

2.1. Participants and Data Collection

The research presented in this study was conducted in the Region of Southern Denmark. Ten out of twenty-two municipalities were invited to participate. (The objective was to select different sizes of communities; some small, few medium and large municipalities). Eight of them (Odense, Esbjerg, Kolding, Vejle, Svendborg, Tønder, Aabenraa, and Varde) responded positively. The informants were selected for interviews with the goal of ensuring a broad range of demographic and professional characteristics. Invitations to health directors working in the abovementioned municipalities were sent out via a general email or written invitation letters. All other participants were invited by email except for the GPs who received an invitation by letter.

For the interviews, we prepared an interview guide that was based on the core literature about integrated care (presented in the introduction). The guide was adapted for use in the two distinguished informant groups (patients and health care professionals) to capture this group’s perspective. The guide consisted of general themes of collaboration and interaction between stakeholders, patient pathways and navigation in the health care system. For providers, we also presented specific questions about health agreements and about integrated care work. For patients, we had additional questions, e.g., about how they perceived the support from various services and their relationship with the health care providers. To test the guide and enhance the reliability and validity of the study, a pilot interview was conducted with three informants from the region prior to the general interviews [39]. Data were collected through semi-structured interviews with the providers (n = 19) (health professionals and other stakeholders and health directors working in the following institutions: health department consultants of eight municipalities, four GPs, three representatives of the Region of Southern Denmark, two hospital doctors, one nurse, and one representative of the National Board of Health) (Table 1). The informants’ areas of expertise included health policies, health promotion, disease prevention, diagnosis, treatment, nursing, and rehabilitation. Two focus group interviews were conducted with users from Esbjerg and Vejle municipalities (patients, N = 18; 6 females and 12 males aged between 45–83 years having one or more chronic diseases) (Table 1). The users were invited with the help of municipality health providers who carried out intervention programs the patients attended. The user participants were chosen because they were frequent consumers of the health care system.

Table 1. Number of individuals in different types of interviews.

| Informants                          | Individual Interw. | Pair Interw. | Focus Group Interw. | Total |
|-------------------------------------|--------------------|--------------|----------------------|-------|
| Representative of the National Board of Health | 1                  | -            | -                    | -     |
| Representatives of the Region of Southern Denmark | 1                  | 2            | -                    | -     |
| Health Department Consultants       | 8                  | -            | -                    | -     |
| General practitioners               | 4                  | -            | -                    | -     |
| Hospital doctors                    | 2                  | -            | -                    | -     |
| Nurse                               | 1                  | -            | -                    | -     |
| Total providers                     | (n = 17)           | (n = 2)      | (n = 0)              | (n = 19) |

| Informants                          | Individual interw. | Pair interw. | Focus group interw. | Total |
|-------------------------------------|--------------------|--------------|---------------------|-------|
| Patients, group Esbjerg             | -                  | -            | 8                   | 8     |
| Patients, group Vejle               | -                  | -            | 10                  | 10    |
| Total patients                      | (n = 0)            | (n = 0)      | (n = 18)            | (n = 18) |
The respondents signed an informed consent form before participating in the interviews. All interviews were audio-recorded and transcribed, and NVivo software was applied to save, organize, and code the transcripts.

2.2. Data Analysis Methods

A qualitative content analysis was conducted following the four distinct main stages described by Bengtsson [40]: de- and recontextualisation, categorisation, and compilation (Figure 1). In the decontextualisation stage, we familiarized ourselves with the data and read through the transcribed text to obtain the sense of the whole before the text was broken down into smaller meaning units important to the research question. Each identified meaning unit was labelled with a code. In the analysis process, the codes facilitated the identification of concepts around which the data were assembled into blocks and patterns. These codes were created inductively. Interpretations of the meaning units that seemed clear at the beginning were obscured during the process. Therefore, the coding process was performed repeatedly, starting on different pages of the text each time to increase the stability and reliability. Recontextualisation: After the meaning units were identified, we checked whether all aspects of the content had been covered in relation to the goal. The original text was reread alongside the final list of meaning units. We coded each meaning unit in the original transcript using NVivo.

Categorisation: To extract the sense of the data, the coded material was divided into categories that were broad groups based on different aspects of the study. A concept map was developed in several meetings with all co-authors, where meaning units were moved back and forth between categories and progressively elaborated the category outcome. In this step, several preliminary categories were generated, but the number was reduced after the consensus between researchers was reached. In the compilation stage, an attempt was made to find the essence of the studied phenomenon. A manifest analysis was chosen that gradually worked through each identified category. The final categories were illustrated with quotations from the informants. In this way, it was possible to stay closer to the original meanings and context. Furthermore, maps of categories and their subcategories (compiling the results) are presented in Figures 2 and 3.
Figure 1. The process of qualitative content analysis (adapted from Bengtsson [41]).
Figure 2. Concept map of providers' perception about integrated.
Figure 2. Concept map of providers’ perception about integrated care.

Figure 3. Concept map of users’ perception about integrated care.
3. Results

The results were organised according to the research question, distinguishing the providers’ (health care stakeholders and policy-makers) and users’ (patients and health care costumers) opinions and perceptions about integrated care and the health agreements. We identified 4 broad categories of provider’s and stakeholders’ perceptions about integrated care, 8 subcategories and 39 factors (Figure 2). Furthermore, 2 broad categories, 4 subcategories and 17 factors from the perspective of the users emerged from the interviews (Figure 3).

3.1. Providers’ Perspectives on Integrated Care

3.1.1. System-Level Factors

The most often mentioned areas of system-level factors described by the interviewed providers were connected to health policy issues, deficits in legislation, and incentive structures of health care.

Health Policy Issues

According to the perceptions of the providers, relevant policy initiatives were recognized as important for integrating services so that providers can coordinate and work within a common system. The providers were also of the opinion that clearer policy guidelines may facilitate professional engagement, leadership, credibility, and shared values. Structural limitations were mentioned as a significant barrier to integration. The providers suggested that policy-makers at the system level should enable the different organizations to effectively work together by providing clear guidelines.

A regional health consultant said:

*It is not always the resource, which is a limitation; we have to be true to ourselves; in many cases, it could be different traditions or sector limitations. You know the barriers with incentives or other things, which makes it really difficult. Sometimes it is limitations in the general structure that is decided from the highest level. It becomes interesting to see where we will get; nevertheless, we are still running against barriers regardless of resources.* (Health consultant from the region)

Deficits of Legislation as a Hinderance for Communication and Coordination

The participants also described that carefully developed partnerships, finance structure, and information technology platforms would be crucial to implement integrated care effectively. The providers, however, experienced a lack of shared access to IT systems among professionals working in different care sectors, hindering communication between different stakeholders and coordination of health and social care services.

*“Another important factor is the data sharing. It is both the law we are fighting and the issue that there are different systems that are not able to communicate. We are fully aware of the challenges this causes for integrated care work and the different organizations; it is not something we can solve right away. But we also must admit it will take time when it comes to issues like these”.* (Manager National Board of Health)

The informant further explained that a factor that hinders integrated care work is connected to legislation on data sharing:

*“One of the elements in creating good coherent processes is that you have updated relevant knowledge about the citizen regardless of what sector. And there is legal discrepancy between the different sectors in relation to data sharing. Legislation is conservative to what the patients or citizens themselves are expecting . . . It is obviously also a barrier. This is probably one of the most important issues concerning integrated care”*. (Health manager National Board of Health)
Weaknesses in Incentive Structure

Most of the stakeholders and health care providers experienced the general incentive structure as challenging for the implementation of integrated care. Financial incentives may take the form of rewards or penalizations to inspire and motivate providers and organizations to work towards defined objectives; in this case, integrated care is usually in a contractual relationship. Financial incentives were seen to support the change in current health and social care delivery by stimulating both immediate and long-term improvements in performance. Furthermore, the informants highlighted the weakness of the system regarding public health functions and the lack of general incentives, which they expressed could support functions.

Incentive structures [are] so basic. What do you get money for? The hospital is rewarded for activity and productivity and not so much for quality. General practice is paid by the service, so they do not necessarily get incentives for health promotion and disease prevention or refer to community activities or to create coherence for citizens at all . . . In fact, integrated care may be time-consuming for GPs. (Regional Consultant)

Another barrier to integrated care from the perspectives of hospital doctors and GPs is the support for the project, which is based on “pulje” (call for project proposals). The health agreements serve as overall guidelines to standardize coordination between different sectors and especially between social and health care services and practices. However, each municipality can independently structure and develop services targeted to their local needs and resources, leading to significant differences and diversity between Danish municipalities. Several GPs and hospital doctors reported frustration at seeing no sustainable benefits (for the integrated care) of the interventions provided by the municipality. They also perceived these interventions as temporary.

3.1.2. Organizational Culture
Need for Strong Leadership

According to the interviewees, one of the core challenges for the successful adaptation of integrated care services is the establishment of strong leadership. Leadership was seen to be challenging in complex interorganizational collaboration due to the existence of the different sectors with a wide range of services involving the coordination of activities among multiple organizations at different levels. The managers and health professionals argued that strong leadership depends on credible and committed actors who promote collaboration and can build strong relationships with other leaders and professionals. Other aspects that were experienced to facilitate good leadership were the ability to exert influence and deliver strong messages that advocate collaboration and coordination. The informants emphasized the need for leadership that inspires their team for integrated care with a clear vision of and passion for integration. They further mentioned several crucial characteristics of a committed leader, such as the ability to gain trust and respect of others, communicate effectively, develop strong relationships with colleagues, and build a culture of interdependency, accountability, and collaboration.

A lack of common management and leadership for GPs made the integration of care even more challenging.

So, I think the biggest challenge in general practice as a sector is that it's a lot of small private units. Hospitals and municipalities have management and leadership, and if you want something at the director level, you have at least a hierarchical system to get things done, with the challenges that are of course also internal to large systems. But with general practice, there are about 400 private units that do not have a common board of directors. They have a common association, but it's just not the same. And that makes it unequal to implementing new initiatives, difficult to communicate, difficult to be in dialogue with them as a sector. And they are struggling to represent each other, also internally at the municipal level. (Regional Consultant)
Informants identified differing organizational working cultures as a main barrier to developing integrated care pathways. They said that care in hospitals was focused on acute and episodic care, which contrasted sharply with the holistic and long-term perspective in municipality centres, which aims to focus on the social determinants of health. The services provided by the municipalities are, in principle, aimed at improving the health and well-being of their citizens by addressing the underlying cause of poor health and to improve health equity. However, GPs often feel frustrated when faced with the complex intertwined health and social challenges of their patients due to, e.g., a shortage of time.

“I feel integrated care is random; there are no guidelines. I cannot say it does not exist at all, but there are too many barriers such as lack of time to speak to patients who are suffering from several chronic diseases and have social challenges.” (GP)

Establishment of Personal Relations and Agreements

Informants shared a common understanding that building respect and trust across the different organizations, both the health and social sectors, are essential aspects to enhance successful integration and that time is required to build and sustain these qualities. The interviewed managers and health care professionals noted that there is a need for progress in relation to building mutual respect and trust, although some professionals described this as an ongoing process. Health care providers in municipalities sometimes perceived that hospital doctors and GPs mistrusted their competencies in providing health services and experienced an attitude that their work was less important.

But there are some municipalities that are not geared to do it; they did not obtain competencies to carry out the task. How can they get the skills, should it be with help from us? Or how? I don’t think they have the competences that it requires to work in the health field. I think the municipality fears an official integration because they do not have the resources. (GP)

The informants noted that there was a higher level of trust and respect between GPs and health care providers at the hospitals due to their similar educational background and ability to communicate with joint medical terms. However, GPs stated that it was a continuing challenge that hospital specialists seemed to focus only on the treatment of the disease without taking the whole person into consideration or the existence of comorbidities into consideration.

It is essential that we have trust in each other, and that each organization carry out work with high professionalism and we respect each other’s conditions and work. And respect each other’s professional background. And we get in dialogue about the citizen/patient individually. (health provider in municipality)

Differing perspectives, cultures, lack of personal relations, and knowledge of available services across different sectors were identified as barriers to integrated care. Municipality health providers perceived it as very problematic that only a few general practitioners and hospital clinicians knew about their available services. However, the GPs and hospital doctors noted that they could not find updated information on services on the websites. Participants identified strategies to help bring the sectors together, enabling them to understand each other’s roles and responsibilities. They mentioned meetings and workshops where they could share knowledge about barriers, facilitators, and opportunities to provide high-quality integrated care and knowledge about patient/citizen pathways in the health system. All informants shared the perspective that physical meetings created a form of binding relationship and a culture of mutual respect for integrated care thinking and task distribution. Knowledge-sharing meetings had taken place a few times, but they were not prioritized, and general practitioners rarely attended the meetings due to time constraints.

The informants perceived that the GPs were less likely to have knowledge of the health care agreement/disease management program and to become engaged and committed to the agreement. They said that this is because they were not compensated for the time; they were involved in multidisciplinary team meetings or other program activities. The
interviewees perceived that the GP’s engagement in creating integrated care services would have been critical for the implementation due to their role as gatekeepers and linkages with the rest of the health care system. All informants stated that participation from all sectors was a crucial factor to ensure successful implementation of integrated care.

I really think that the more we know each other, the more it will lead to good integration. To create personal relations. For instance, one day, we invited the general practice staff, GPs and nurses for a workshop. We met face to face and had conversations about what works and what doesn’t work. It really helped because now you know them personally and have seen their faces. I think it’s relevant that we keep meeting across cultures and educational backgrounds. (Municipal health provider)

The providers perceived the idea of integrated care as very important, but they pointed out that there was a lack of clear guidelines regarding responsibilities and content of integration. Providers experienced an overlap in referrals and transition to rehabilitation services between hospitals and municipalities, which they explained further complicated the users’ navigation in the health system.

A study has been carried out with focus on the implementation of existing health agreement/disease management programs. The programs are not well implemented every place. I think it is very important that we have health agreements, where it the different responsibilities of the municipality region/hospital and GP are described. (Health director from the region)

There was a general agreement among informants that general practice played a crucial role in integrating and coordinating care for patients with chronic conditions and multiple morbidities. General practitioners’ role as gatekeepers to more specialized treatment and municipal health services was highlighted as particularly important, and they were seen as central to facilitating smooth navigation across organizational boundaries. However, GPs stated that there was a lack of clear clinical guidelines for multimorbid patients, further complicating referrals to other services. It is important to note that the informants did not mention the health agreements in this connection, even though these agreements were planned to function as guidance in this area and function as tools for better integration into health care.

Lack of Continuity of Care and Disease Orientation

The informants expressed that there is a lack of consistent services for citizens/patients. Some municipality services are not always updated, the services are not visible on municipality websites, and the services and duration change frequently.

Municipalities seek “pulje” money for all possible projects, but they never have an intention to introduce them as a fixed procedure. It is only their intention that, in my opinion, I feel that there will be no changes, you will find a new project that you can apply for money and then run it. And we are so terribly tired of being involved in projects that do not lead to permanent changes, there is no goal to improve what we are doing now. It does not contribute to integrated care. (Hospital doctor)

Another barrier highlighted by managers and providers is that the health care system is still heavily focusing on illness. The system does relatively little to optimize health and minimize illness burdens, especially for vulnerable groups. In addition, the informants added that this failure to improve the underlying conditions for health is compounded by insufficient allocation of resources to address local health needs and priorities.

3.1.3. Weaknesses in Communication

Deficits in IT Information Sharing and Communication

The informants suggested that effective communication is crucial to enhance the efficiency of system-level functioning and outcomes, as well as service users’ overall experience of using services. Effective communication and information transfer across the interface between primary and secondary care was seen as the factor most vital to integrated care.
However, providers experienced poor communication between the different organizations, which often led to complicated care pathways and duplications in services provided for users. Providers raised issues related to both the weakness of information technology systems and deficits in the content of transferred information.

Our aim is that when the citizen comes in that he/she feels there is a coherent flow. It is all about the citizens. And that is not a coincidence that their information is in one system and not the other. What is important is information is connected. But unfortunately, it is NOT. Each setting has their own system and approach. But we do everything to make it work and support the citizens, but my experience is that is does not work. (Municipal health provider)

When discussing information technology systems, informants agreed that a major barrier to effective care transitions was a lack of a shared system to facilitate the transfer of information across settings. Transfer of information mainly occurred by e-mail, electronic data interchange or correspondence messages (an electronic tool that can be used instead of emails and phone calls to send short messages about a patient across settings). The interviewed providers reported that none of these solutions were adequate, although they varied considerably in the use of electronic data interchange and correspondence messages. The latter were available in each setting but used only to transfer information between general practice and the municipality. Informants expressed a common desire for a standardized electronic system that was accessible across settings and could be searched for relevant patient information, e.g., participation in intervention activities in municipality, referrals, discharge letters, test results about patients and their treatment from general practice.

3.1.4. Need for Shifting Focus to Vulnerable People and Citizen Engagement

Complexity in Service Provision for Vulnerable Users

Most of the providers emphasized the importance of focusing on vulnerable citizens/patients.

The informants noted, however, that the vulnerable patients are suffering from the gaps in the service provision; they are being ‘bounced around’ different services and having to explain themselves and their needs multiple times to different providers. Their navigation in the health care system is complicated, and sometimes they are “lost” in the system due to several barriers, such as limited health literacy, lack of resources, and long waiting times for services. GPs and hospital doctors noted that vulnerable citizens/patients do not attend the services provided, they sometimes come to the GP when it is too late, and they have already developed complications from their disease (many of them from multimorbidity). An informant suggested that:

There is a need to focus on the vulnerable citizens and to develop specific integrated care programs, including community services guidelines for vulnerable users. Without implementation of successful integrated care, it is difficult to help this group of people. (GP)

Informants generally viewed user engagement as a very important factor in relation to integrated care. Providers from the municipality health centre and general practice articulated how shared decision-making, the use of patients’ own resources, and patient activation and responsibility were intended to have a crucial impact on health outcomes and patient experience. However, shared decision-making was limited in practice due to several barriers, such as a shortage of time, lack of clear guidelines, and complicated pathways for especially vulnerable users.

3.2. Users’ Perceptions of Integrated Care

Two broad categories were condensed from the data navigating in the health care system and the empowering and supportive environment, and the four subcategories were lack of a smooth patient pathway, deficits in health literacy and communication
between provider and users, abilities for self-management, and need for support for users. Seventeen factors from the perspective of the users emerged from the interviews (Figure 3).

3.2.1. Navigating in the Health Care System
Lack of Smooth Patient Pathways

The users stated that there was a lack of coherent patient flow, and they felt a lack of smooth flow through the general practices, hospital departments and municipal services. Often, they experienced a lack of communication between different social and health professionals (including social services, housing, education, etc.); for example, they reported that they had difficulties in passing on information about their health and other personal issues to different departments. Additionally, the informants noticed that GPs were not always aware of the different intervention programs offered in different municipality centres. In addition, hospital staff had difficulties referring patients to rehabilitation centres. Inadequate data sharing by GPs, lack of a standard process for GPs to inform patients about municipal activities, and health information that was not updated were among the challenges that informants mentioned.

We understand that it is not a requirement that doctors tell you about the services in the municipalities. It is obvious that the doctor does it of his/her own will; there are no requirements that he/she should make the referrals. But I actually think that the GP should inform you. Then, it is up to you to participate or not. At least the information should be given. GPs should be informed that more patients and citizens should be sent to the services provided by the municipality. Because I never heard of these services, it was my brother-in-law who informed me, and then I asked for a referral. (Informant 7 female)

Deficits in Health Literacy and Communication between Providers and Users

Users expressed a generally high degree of satisfaction with providers that were responsive to patient preferences in a respectful and supportive manner. They also described their frustration when they experienced services that were not centred on their needs. Their narratives reported that the providers were lacking understanding of their social situation and their difficulties in daily coping with long-term conditions. Furthermore, users noted that patient involvement and shared decision-making had a significant impact on their navigation in their health care system. However, most informants’ narratives conveyed a lack of possibilities for involvement in their care process. Furthermore, they emphasized the importance of being seen as a “whole person” from the providers’ perspectives and not only as their chronic disease. Despite their wishes, most of the participants experienced that the focus was more on clinical goals and medical symptoms, yet psychological needs and social life needs were neglected.

Every time we go to GP, you are rushing. You do not have enough time with your GP to talk, to discuss your problems and situation, we only have about 10–15 min, it seems as both the GP and patients are under pressure. There are many other patients in the waiting room, and the GP needs to call for the next patient. (Informant 11, female)

What the providers need to do is both talk about my condition and guiding me; however, they also need to separate the condition from me and see me as a person with a life outside the health care system. (Informant 15, male)

3.2.2. Empowering and Supportive Environment
Need for Support for Users

The users appreciated the importance of having a supportive environment. They all agreed that they experienced improvements in health through friendships and that the supportive environment (such as other chronic patients, family, etc.) was the primary reason they continued to participate in the health services. Users felt they had been supported by the providers, other patients, and their families. Other responses included that the
informants perceived improvements in their physical health, such as having more energy, being in better shape, and experiencing less stress. Examples of participants’ statements regarding developed friendships include the following statements:

*We have such a good team and unity here and we work so fantastically together, and I think it’s nice to know about each one. “And we can also share experiences and support each other. The group dynamic is also very important in such a process.* (Informant 4 male)

**Abilities for Self-Management**

The participants stated that they saw few changes in health since attending hospital-based and municipality-based activities; however, there was a need for more knowledge of healthy lifestyles. Most of the users indicated that they learned new knowledge, including increased awareness of chronic diseases and their related risk factors. Furthermore, they noticed improvement in their health after performing regular physical activity and healthy eating. In addition, many of the users reported losing weight. However, informants also identified barriers to integrated care. Some of the challenges discussed by the users were the lack of ability to understand health information. In this respect, they suggested that providers need to use plain language. Users experienced many times that information about their medical history, referrals, or treatment plans was not updated when they attended different appointments (GP, hospital, and municipality), which further complicated the user’s pathway. Many users did not understand why they were often expected to be experts of their own medical conditions, despite not fully understanding medical terms and details about diagnoses and past treatments. The results clearly show deficits in the health system’s ability to support patient health literacy. The user informants perceived that they did not understand the health information.

*Sometimes it is difficult to understand all the different health information that come from the different providers who works on different departments.* (Informant 10 female)

**4. Discussion**

The purpose of the study was to explore users’ and providers’ perspectives of integrated care in Denmark. The main areas of concern by providers’ and stakeholders’ perceptions were deficits in system-level factors, lack of organizational culture, weakness in communication, and the need for a shift towards a focus on inequality in access to health services (Figure 2). Users perceived poor navigation in the health care system and a lack of support for users in increasing their health literacy (Figure 3). Based on existing evidence, integrated care is often challenged by system complexity, weak relationships and poor alignment among providers and organizations, along with a lack of incentive structures to support integration [12,13,41,42]. Our data suggest that to achieve integrated care from a public health perspective, an environment must be created that fosters connectivity among health service providers and organizations across health and social care. The coordination of different services from the citizen/patient perspective is key to better person-centredness. This will also contribute to positive citizen and patient experiences and health and well-being outcomes. However, several informants perceived that connectivity did not exist; others perceived limited connectivity. Well-functioning connectivity (such as new ways of organizing) will enhance collective insight and learning [14].

Kodner and Spreeuwenberg [43] argue that previous integrated care efforts have failed to achieve change at the service delivery level because there have been top-down approaches, even though the bottom-up approach has been highlighted as crucial for a public health approach [31,32] to enhance local leadership, citizens’ participation and local community action. Our results indicate that health care policies seem to have failed to promote good relationships and trust-building between care stakeholders and alignment across organizations and providers in Southern Denmark. Such efforts can begin with attention to fundamental issues pointed out by this study’s participants, including better sharing of information and knowledge, focus on stronger trust building, efforts in making
communication more effective, and fundamental changes in incentive structure. The incentive structure must support integration across services (public health and clinical) and sectors through pooled budgets, ensure equitability, and encourage GP involvement. Our study suggested that there was a lack of clear guidelines that promote integrated care and an increasing need for more interactions between providers in health and social care.

Edgren [13,42] found that the connection within the system requires that time and resources are dedicated to bringing providers and organizations together to support the adaptation of clear provider cultures to develop long-term working relationships rooted in a shared vision. Edgren indicated that building effective communication pathways allows best practices and data and knowledge sharing. Our study showed that the abovementioned factors were not successfully implemented in Denmark due to several barriers, such as differences in cultures, conflicting remuneration and incentive systems, weaknesses in IT systems, and lack of knowledge and implementation of the health agreements that were intended to facilitate integrated care.

Evidence [12,41,42,44] suggests that given the right circumstances, the health care system can and will self-organize into meaningful partnerships using its essential competencies. However, our study indicates that managers and leaders lack the ability to recognize their task to manage the uncertainties and the range of complexity issues when attempting to create smooth integrated care. There seemed to be a lack of facilitators (strong leaders) who would create such conditions and establish an infrastructure that would have enabled better self-organizing and integration to take place in Denmark.

The stakeholders and providers highlighted that the Danish health care system overemphasizes specialization and understates the holistic approach to citizens/patients (including factors related to employment, housing, education, and social services). This is in line with other studies found in the literature [19,21,22,30]. Petts et al. [45] found that patients in vulnerable communities had a higher concentration of chronic diseases, and they also reported lower satisfaction with health care, which may be related to experiences of mistrust of the health care system and poor patient–provider relationships. This highlights the ongoing need to address health inequities at the systems level by including public health elements such as focusing on health promotion, prevention, embracing intersectoral action and partnerships, addressing health in vulnerable groups, focusing on the social determinants of health, and understanding the need and solutions through community outreach. Our study showed that these public health elements were scarce and that there was an obvious need to focus on vulnerable citizens and to develop specific integrated care programs, including community services and specific guidelines for vulnerable users.

The results also showed clear deficits in the health system’s ability to support patient/user health literacy. Many of the users perceived difficulties related to understanding health information and engaging with health care providers, and they felt confronted with increasing demands to utilize health information. Haun et al. [46] shows that lower health literacy is a significant independent factor associated with increased health care utilization and costs. Based on several systematic reviews and surveys with European data [47–49], there seems to be strong evidence supporting the idea that people with adequate health literacy have better health knowledge, shorter periods of hospitalization, and less frequent use of different health care services and lower health care costs.

The Danish national health profile 2021 [50] showed that social inequality in health is one of the major challenges in Denmark and that there is a significant over presentation of vulnerable citizens with unhealthy behaviour and low health literacy. The Danish national report [50] also suggests that it requires solutions across sectoral and policy areas (health in all policies) to tackle health literacy and achieve more equality in health.

Narratives from the health providers and users in our study note that there are deficits in the health system’s ability to support patient health literacy and access to health services. Findings from the user’s perspective showed that citizens/patients with complex needs continued to experience a lack of coordination across GP, hospital, and municipality services. Our findings are similar to those studies highlighting users’ perspectives of integrated
The interviewed patients experienced and emphasized how they would appreciate being seen as individuals (not just as health conditions) and in relation to family, life in general, and the environment [23,34]. Greenfield et al. [34] characterized patients’ experiences of person-centredness as a sense of space to be seen as a whole person with a whole life in addition to their medical conditions.

According to the results of our study, it became clear that a person-centred approach was viewed as a key requirement in integrated care services from the perspectives of both users and providers. However, users experienced obstacles to the full realization of this approach in practice because they did not feel the elements of person-centredness were taken into consideration when they attended services. Furthermore, our findings highlight the limitation of providing holistic elements in managing services for users in Denmark. In addition, the provision of services, including social determinants of health, addressing health in vulnerable groups, and community engagement, was scarce.

The greatest value of integrated care for people with multiple chronic conditions may not be connected to its potential to improve their health or reduce their use of services, but rather the potential to improve their care experience and care pathways by strengthening person-centredness and decision-making and delivering services and support accordingly. However, the experiences and perceptions of users in our study showed that these elements were limited in the Danish health care system. This also supports users’ and patients’ views found in the literature [23,30,52]. The results showed great deficits in being patient-centred or having smooth integration overall. The same result was found in earlier studies [52,53], which found that patients often feel less involved in decisions about their care.

The findings of barriers and facilitators for integrated care identified in our study are consistent with previous studies that stress the importance of clear guidelines, effective leadership, shared IT systems, organizational structures, and incentive structures that support integration [54,55]. However, activities that appear particularly significant for delivering integrated care include personal relations, shared values, shared understanding of roles, respect and trust-building, and effective communication [54,56].

5. Strengths and Limitations
This study was conducted among health care professionals working with citizens/patients with chronic diseases within a selected geographical area in Denmark and users with one or more chronic diseases; thus, the results are likely of limited representativeness. Only four GPs participated in the current study. The study might have been strengthened by the inclusion of more GPs, since they act as gatekeepers to other services and know the citizens/patients best. The qualitative nature of the study is an important strength because it offers rich insight into elements and processes crucial to integrated care.

6. Conclusions
The goal of this study was to explore users’ and providers’ perspectives on integrated care in Denmark. We identified deficits in system-level factors, lack of organizational culture, weakness in communication, and the need for a shift towards a focus on inequality in access to health services as the main areas of concern. The study participants pointed out that there is a need for better sharing of information and knowledge, strengthening the focus on trust-building, putting efforts into better communication, and changing the incentive structure. Providers emphasized a need for better information sharing across organizations, along with shared responsibility and a sense of all providers of the different services being consistent in the coordinating efforts of services.

In relation to users’ perceptions, the main areas were connected to difficulties in navigation in the health care system and lack of provision of support for users to increase their health literacy. Although their descriptions during the discussions sometimes included positive experiences when the health care system worked well, the users also described how poorly integrated care services and coordination resulted in negative experiences.
These negative experiences stood out in their memory and were described as duplication of services, lack of responsibility for sharing health records, lack of coherent care pathway, and lack of focus on improving patients’ health literacy. Both providers and users expressed dissatisfaction with the care and said that integrated care works poorly. Many of the interviewed health care providers did not know much about the health agreements, which means that much more effort should be made to introduce, make them understand, and implement the health agreements. In addition, the health agreements seemingly did not function as they should because they were largely experienced in supporting clinical care according to the informants.

Our study showed the weaknesses of the health care system in implementing integrated care to improve user experience by increasing user involvement in decision-making, enhancing the user–provider relationship, strengthening coordination, or providing easier access to services. Public health within integrated care requires policies and management practices that promote system awareness, relationship building, information sharing, and incentive structures that support integration.

Author Contributions: Conceptualization, G.G., L.E.K. and F.N.; methodology, L.E.K. and F.N.; software, F.N.; validation, F.N., L.E.K. and G.G.; formal analysis, F.N.; writing—original draft preparation, F.N., L.E.K.; writing—review and editing, F.N., L.E.K. and G.G.; visualization, F.N.; supervision, L.E.K.; project administration, L.E.K. and F.N. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: This study was waived from ethical clearance because no requirement for approval was needed, it did not involve any personal data or information.

Informed Consent Statement: Written informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Not applicable.

Conflicts of Interest: The authors declare no conflict of interest.

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