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D1.1 Desktop Review of Literature

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Statement of originality

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10.06.2024	1.0	V1. New release with updates
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05.07.2024	2.0	Final version

Executive summary

D1.1 Desktop review of literature reports the common work completed by Laurel consortium members. A rapid realist review has been performed to identify and compare frameworks for integrated and long-term care. The goal has been the understanding of integrated care and support solutions to enhance the quality of long-term care services. The rapid review has included white and grey literature published in the English language from 2010 onwards. Sixty-six frameworks were identified, that were the basis of the work performed under Task 1.2 to develop an overarching framework for integrated long-term care (I-LTC).

For the analysis of the identified frameworks, the key policy dimensions included in the Topic Call and further iterated by the consortium partners were used: governance, territorial, gender, stakeholders, funding and affordability, social economy, life-course and digital technologies. For each dimension, a brief context, relevant policies to that dimension (mechanisms) and a Table identifying the relevant frameworks and building blocks were created and are reported (outcomes).

Additional frameworks for integrated long-term care were searched for by Laurel consortium members, who added two more frameworks. According to the relevance criteria used by Laurel consortium, the final list of relevant frameworks was reduced to thirty-four. Their building blocks reflect the importance of the governance or management of the processes of implementation, but also the lower relative importance covered in the literature of other aspects such as gender or digital technologies.

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ABBREVIATIONS

AGE	AGE Platform Europe
CMO	Context-Mechanisms-Outcomes
D	Deliverable
EHTEL	European Health Telematics Association
EPSR	European Pillar of Social Rights
EU	European Union
EU27	Twenty-seven countries that belong to the EU
GDPR	General Data Protection Regulation
GDP	Gross Domestic Product
IFIC	International Foundation for Integrated Care
I-LTC	Integrated long-term care
RRF	Recovery and Resilience Facility
SEAP	Social Economy Action Plan
SHARE	Survey of Health, Ageing and Retirement in Europe
ToC	Table of Contents
WP	Work Package
WHO	World Health Organization

1 Introduction to the deliverable

The introduction to this literature review outlines the deliverable objectives and scope (Section 1.1) and describes how it complements work in other deliverables (Section 1.2).

1.1 Deliverable objectives and scope

The goal of Task 1.1 Desktop Review of Literature has been to identify and compare existing frameworks on integrated care and long-term care for the understanding of integrated care and support policies to enhance the quality of integrated long-term care (I-LTC) services. Some of the results of the Task 1.1 have fed into the work under T1.2 Provision of Strategy of Investigation and Analysis.

This report presents the outcome of T1.1 detailing the frameworks that could be used to understand the state of I-LTC. I-LTC is defined as care that combines different types of services and assistance with the objective of optimising their delivery to people who need help with daily living activities and/or are in need of some permanent nursing care. This report presents the results of the analysis of the identified frameworks and how this informs D1.2.

Historically, the fields of policy and practice of integrated care and long-term care have remained separate, despite the clear overlap between them. Possible explanations for this include the positioning of integrated care as a health system initiative (1) with relatively recent expansion to include formal social care in the scope of care integration and the positioning of long-term care as being exclusively social and personal care provided by multiple agencies and institutions as well as the social economy and informal sector.

Fragmentation of care in the long-term care sector has been an acknowledged problem (2) leading to poor experience of care for people with care needs and informal carers, inefficiency and waste in care provision and healthcare, and fragmented governance and funding (3). The Covid-19 pandemic highlighted the fragility of fragmented long-term care and in the same period long-term care become part of the European Union (EU) Pillar of Social Rights and of the United Nations (UN) Decade of Healthy Ageing 2020-2030. In the European Union a wide range of national, regional and local initiatives aim at addressing the challenges of health and social care policy integration.

T1.1 reviewed frameworks currently applied in the field of policy and practice of integrated care, long-term care and integrated long-term care in respect of the building blocks of integration and EU policy dimensions. The iterative outputs of this task informed T1.2 and the initial development of the FLINT framework ahead of T1.3.

The Laurel Rapid Realist Review has been completed in two stages, (4) identification and (2) analysis, using the realist methodology. Section 2 introduces Laurel Rapid Realist Review methodology and reports the initial list of I-LTC frameworks identified. Section 3 presents the context, mechanisms and outcomes (CMO) of the rapid realist review, by the EU Commission policy dimensions identified in the Call and a synthesis of the findings across all dimensions and selected frameworks. Section 4 presents the conclusions of the document. The Annexes includes the Table with the initial list of identified frameworks and the analysis of them by policy dimension, together with their building blocks.

1.2 Complementarity with other deliverables

The Laurel project aims at gathering insights into regional differences of integrated long-term care (I-LTC) provision and their support solutions in Europe. Using this intelligence, it will develop actionable policies to respond to the challenges of growing demand, economic constraints, accessibility, affordability, quality of services, shortages of members of the workforce, and systemic reforms. Workforce appears in most of the policy dimensions: governance, gender, stakeholders, social economy, across the life course and digital technologies, reflecting its relative importance. These aspects covering formal workforce carers and informal carers will be picked up more intensively in the case studies fieldwork (T1.3), and in the M13 analysis (T1.4 and D1.4).

Identified I-LTC frameworks through the rapid literature review were shared as early results with the leaders of T1.2 by the middle of the implementation period for T1.1, providing feedback for the development under T1.2 to develop a validated framework and guide for the investigation of integrated care and support solutions. Analysis of the frameworks by its key policy dimensions was completed after the rapid literature review.

Additionally, D1.1 results will also be used for Task 1.3: Conduct data collection and Task 1.4: Analysis of Results & Report", whose results will be used for the planned work under WP2 Development of Actionable Policy Recommendations. D1.1 is also connected with WP3 Technological Radar, particularly Task 3.1: Identification and mapping of State-of-the-Art initiatives for LTC.

2 Laurel Rapid Realist Review

A rapid realist review is a method for *"*studying complex interventions in response to the perceived limitations of conventional systematic review methodology. By identifying contexts, mechanisms, and outcomes of complex interventions or programmes, realist reviews can address the question of what works, for whom, and under what circumstances. A rapid realist review thus involves developing a narrative evidence synthesis that focuses on understanding complex interventions. It is expected to contribute to the development of a transferable programme theory able to reflect the context, mechanism, and outcomes*"* (5). Seven steps have been followed to complete the Laurel Rapid Realist Review, adapted from a previous source (6).

Step 1. Development of focused research question.

Step 2. Definition of inclusion and exclusion criteria.

Step 3. Formulation of relevant search terms/key words.

Step 4. Conduct of systematic search.

Step 5. Selection of frameworks.

Step 6. Analysis and addition of I-LTC frameworks, by dimensions

Step 7. Interpretation and reporting of results.

Research question: What frameworks have been published that apply to integrated long-term care and how comprehensive are these frameworks in terms of the policy dimensions relevant to long-term care?

Realist approaches respond to the questions of how, why, for whom, in what contexts and to what extent health systems, programmes and/or policies work (7). The realist approach is founded on the idea that each observed outcome can be attributed to multiple causal processes (mechanisms) that are activated only in specific contexts. Thus, the combination of Context (C) + Mechanism (M) = Outcome (O) forms the basis of Laurel's framework analysis (8). Realist approach is based on a hypothesised explanation of how the object of study works, that is called in realist reviews "a programme theory" (9) that would intend to explain differences on the context and the people affected. The realist review does not predetermine the programme theory of change but rather is the lens through which the identified frameworks are analysed using CMO. The policy dimensions of governance, territorial, gender, stakeholders, funding and affordability, social economy, life-course and digital technologies fall into context and mechanism categories.

The Laurel Rapid Realist Review methodology included a literature review of white and grey literature. Originally, the geographical scope was the twenty-seven countries in the EU (EU27), and the search language was English. This was later expanded to include countries beyond the EU27 and other languages provided they could be read by the researchers.

For the literature review, the concepts of integrated long-term care, integrated care and long-term care were defined following the operational terminology and definitions determined at an early stage of the Laurel project.

- **Integrated long-term care:** Integrated long-term care (I-LTC) is the result of combining different types of services and assistance with the objective of optimising their delivery to the people who need help with daily living activities and/or need some permanent nursing care.

The search strategy did not limit integrated care to a single perspective and accepted any definition from whole system to person-centred perspective. “Integrated care includes initiatives seeking to improve outcomes of care by overcoming issues of fragmentation through linkage or co-ordination of services of providers along the continuum of care” (10).

- **Long-term care**: Long-term care is a range of services and assistance for people who, because of mental and/or physical frailty and/or disability over an extended period, depend on help with daily living activities and/or are in need of some permanent nursing care. The daily living activities for which help is needed may be the self-care activities that a person must perform every day (Activities of Daily Living) such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions or may be related to independent living (Instrumental Activities of Daily Living) such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

- **Framework**: A graphical or narrative representation of the key factors, concepts, components, elements, or domains that explain the key features of long-term care or integrated care.

This definition of a framework was purposely maintained as broad and inclusive as possible to capture the most advanced and vanguard domains and themes that could be valuable for I-LTC. The most known and referenced frameworks for LTC do not sufficiently capture the complex nature of I-LTC, lack connectedness of the “Why, How and What” of I-LTC, and over-emphasise the organisational domain to redesign health service delivery.

Inclusion criteria: Papers were included if they fulfilled any of the following criteria:

- Proposed an integrated long-term care framework or an integrated care framework that could be transferable to long-term care.

- Referred to the core elements of integrated care such as person-centred (or similar terms), community oriented, coordination and continuity.
- Were focused on chronic conditions or long-term needs referring to long-term care support (i.e. home care, residential care).
- Proposed a framework, conceptual model, or building blocks (accepted as synonyms the words components, pillars, or key elements).
- Descriptive, prescriptive, explanatory, and predictive frameworks were considered eligible.
- Quality improvement frameworks, which refer to frameworks about processes and systems to improve in a systematic way, were also included.

Exclusion criteria. Frameworks were excluded if they were:

- Not focused on long-term care or components of long-term care.
- Not focused on an integrated care or care integration component.
- Focused on only one specific domain, factor, or element.
- Studies applying or validating a framework without proposing a change to the framework.
- Based on a single case study.
- Focused on a model of patient/user care.
- Focused only on implementation science or knowledge translation.
- Written in languages that the consortium members cannot understand.
- Published before 2010.

The Laurel literature review was carried out over the period of February through April 2024 using the discovery tool Cercabib from the University of Barcelona and Google Scholar.

The search terms used in Cercabib are shown in the Table 1 below.

Table 1. Search strings and keywords Laurel realist rapid review

Search Strings	Keywords
1	Any field that contains:
2	(“long-term” OR “long-term” OR “ageing” OR “older people” OR “elderly” OR “geriatric” OR “gerontological” OR “disability care” OR “dependent” OR “complex care” OR “chronic care” OR “multimorbidity” OR “developmental problems” OR “severe physical limitations” OR “extended care” OR “cognitive disorder” OR “mental health” OR “home care” OR “nursing care” OR “care homes”)
3	Title field that contains:
4	(“integrated care” OR “person-centred” OR “patient centred” OR “coordinated” OR “continuous” OR “continuity” OR “integration” OR “collaboration” OR “collaborative care”)

The identified papers from Cercabib and Google Scholar were exported to Mendeley reference manager and merged. The selection was then imported to Rayaan for duplication exclusion

and review. Cercabib provided four thousand, eight hundred forty results and Google Scholar provided forty-eight, and then we deleted duplications (N=581) using Rayyan.

Selection of the papers: One member of the research team reviewed all the papers in three iterations and papers were accepted or not depending on the inclusion and exclusion criteria described above.

The first iteration involved screening titles, the second iteration focused on screening abstracts, and the third iteration involved screening the full texts. Papers were excluded during the title or abstract screening if it was evident that they did not meet the criteria. If there was any doubt, they were kept for the full text screening.

Sixty-six frameworks were considered eligible at the end of the screening phase of the papers identified with Cercabib and Google Scholar. The results were shared with the consortium partners to revise and add any other relevant framework that had not been identified. Consortium members added two more frameworks which provided with the final number of sixty-eight eligible Integrated and/or long-term care frameworks (see PRISMA flow diagram below, Figure 1). Results have been summarised in Tables 23 and 24, located in the Annexes.

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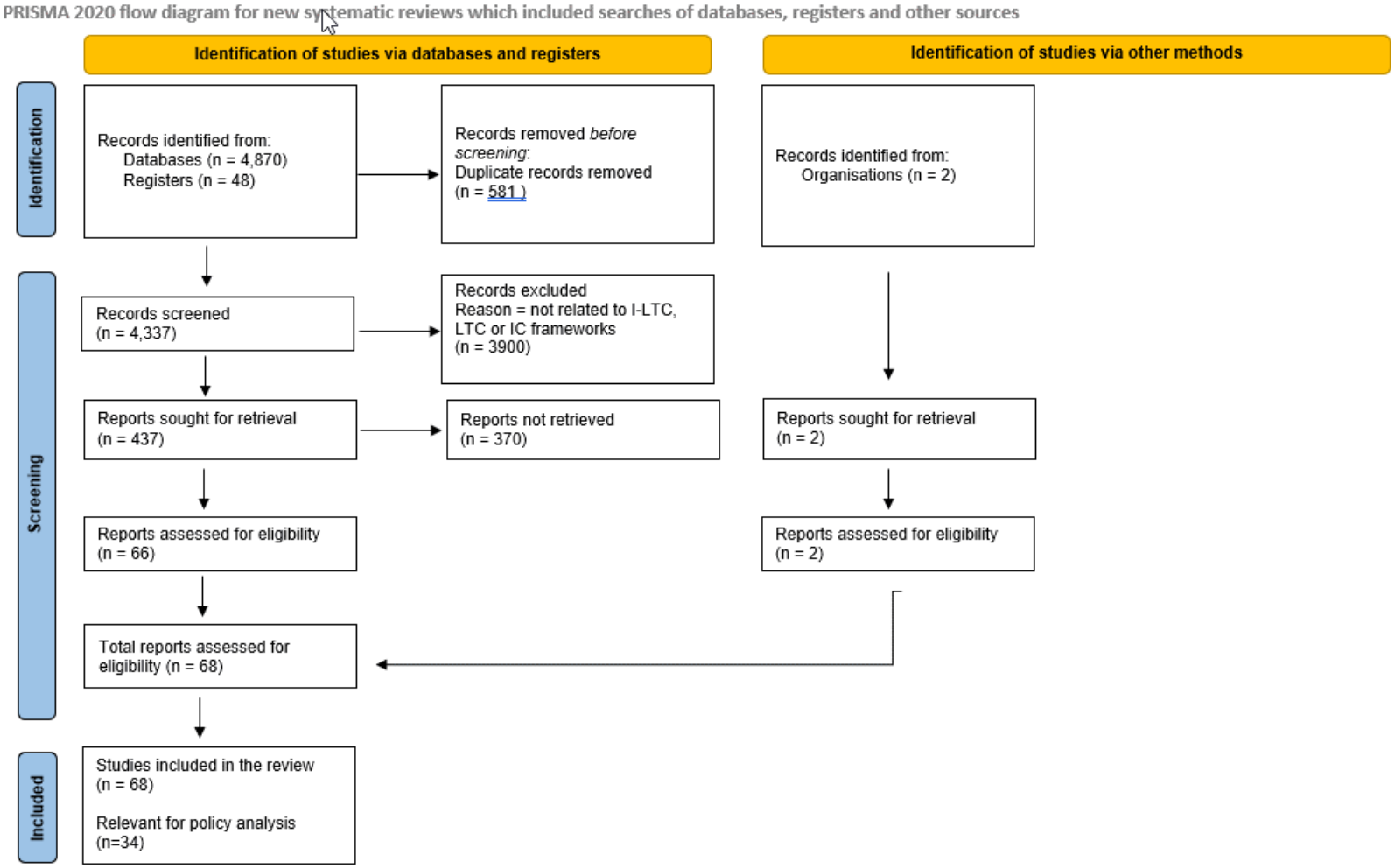

Figure 1 PRISMA Laurel rapid realist review.

3 Analysis of the frameworks from EU policy dimensions

Analysis of the frameworks identified in the literature review was undertaken using the rapid realist approach which was outlined in the methodology.

The purpose of this rapid realist analysis of the frameworks has been to identify the components (or related components) in each of these policy dimensions listed below. The policy dimensions were derived through consensus building across consortium partners from the Topic Call and the known policy priorities of the EU, each analysed by the Laurel consortium partners more expert on the specific topic (see Table 2 below). In each of the subsections of point 3, there will be included the methodology used by each partner in this task that was undertaken by them.

Table 2. EU policy dimensions pertaining to I-LTC

EU Commission Policy	Impact on I-LTC	Analytical teams
Governance	Local, regional and national integration of governance of LTC is seen as a critical enabler of sustainable long-term care for the population (11).	FRCB-IDIBAPS
Territorial	Territorial inequality in access to long-term care (12,13) exacerbates further the fragmentation of LTC.	SEE, IFIC
Gender	Issues around integrated LTC are deeply enmeshed with gender equality, given that much LTC is provided by women (as formal and informal carers) (14).	SEE, IFIC
Stakeholders	The impact of fragmented LTC is felt by people and institutions: people who need care, informal carers, formal carers, organisations that provide care (from a variety of sectors), policy makers, decision-makers and payers. All have an interest and influence on the integration of LTC.	EUROCARERS, EHTEL, IFIC
Funding and affordability	The affordability of LTC is a priority for policy makers across the EU (15) and in the World Health Organization (WHO) Europe Region. The Council of the European Union adopted a recommendation on 8 December 2022, for EU MS to focus on access to affordable high-quality LTC (16).	ESN
Social economy	The social economy or third sector plays a vital role in the provision of formal and informal LTC (17). The exclusion of this sector from much of the policy and practice of LTC contributes to fragmentation.	SEE, IFIC
Across the life-course	LTC is needed for children, young people and adults of all ages. Whilst much of the focus is on older adults (18), One in four people in Europe is living with a disability and this group is four times more likely to have an unmet health need (19).	AGE, EUROCARERS, IFIC
Digital technologies	“EU's commitment to a secure, safe and sustainable digital transformation that puts people at the centre, in line with core EU values and fundamental rights” (20) being potentially a key enabler of integration of LTC.	UPM, EHTEL

In the Table 3 below is included the methodology used by each partner in the task related to inclusion and exclusion criteria.

Table 3. EU Policy Dimensions. Inclusion and Exclusion criteria

EU Policy	Inclusion criteria	Exclusion criteria
Governance	• Explicit reference to governance. • Implicit reference to governance. • Accessibility of governance. • Reliability of governance.	• Absence of reference to governance. • Irrelevance of the framework to governance. • Lack of focus on accessibility and reliability.
Territorial	• Explicit reference to the territorial dimension. • Implicit reference to the territorial dimension.	• Absence of reference to territorial aspects. • Not frameworks, but articles, models, or other • Irrelevance of the framework to the territorial dimension
Gender	• Gender related terminology appear in the frameworks: “gender”, “woman”, “women”, “mainstreaming”, “sex” appear in the frameworks. • Data are presented by gender, following gender mainstreaming recommendations.	• Documents that are not frameworks, such as models, randomized controlled trials (RCTs), and scoping reviews. • Gender not included as a building block or a minor role in the overall framework.
Stakeholders	• Frameworks were shortlisted if they included elements (here referred to as ‘building blocks’) that are conducive to better ways for stakeholders to work together, regardless of whether the terms ‘coordination’ and ‘integration’ were explicitly mentioned	• Frameworks that focus solely on one stakeholder group, without mentions to inter-relations with other groups. • Frameworks that do not contain clearly identifiable ‘building blocks’ that could be used for the following steps of the analysis. • Documents that are not frameworks, such as models, randomized controlled trials (RCTs), and scoping reviews.
Funding and affordability	• Explicit reference to the funding and affordability: Frameworks that explicitly mentioned the following terminology or key building blocks: funding, affordability, financing, expenditure and incentives.	• Absence of reference to aspects related to funding and affordability. • Irrelevance of the framework to the funding and affordability.
Social economy	• Explicit reference to the social economy: Frameworks including the following terminology: social economy, mutual, cooperatives, associations, foundations, non-for profit, third sector and voluntary work. • Implicit reference to the social: Some frameworks don´t mention directly the terminology included above but address related terms and aspects that are intrinsically related to the social economy’s values, such as the person-	• Absence of reference to aspects related to social economy

EU Policy	Inclusion criteria	Exclusion criteria
	centeredness or the participatory governance	
Across the life-course	• Frameworks were assessed based on their applicability to a life-course approach, regardless of whether the term "life-course" was explicitly mentioned.	• Frameworks that focus exclusively on specific age groups (e.g., children, older adults). • Documents that are not frameworks, such as models, randomized controlled trials (RCTs), and scoping reviews. • Frameworks that solely focus on integrating healthcare services without considering both health and social care. • Frameworks that primarily address stakeholders other than individuals with I-LTC needs (e.g., family physicians, family carers, nurses).
Digital technologies	• Frameworks, models, and documents describing use cases and trials were all in principle considered, if there were mentions of several key words: eHealth, mHealth, electronic records, electronic, technologies, digital health, digital technologies and innovation were the bulk of the search words.	• Frameworks only focusing on healthcare services were considered if they provided a cohesive approach to integrating technologies and aspects related to technologies. • Frameworks only focusing on certain citizen profiles (i.e. patients of neurodegenerative diseases or older people) were considered if they provided a cohesive approach to integrating technologies and aspects related to technologies.

3.1 Context-Mechanisms-Outcomes (CMO)

This section provides the comparative analysis results using qualitative analysis and presenting the results under the three categories of the Laurel Rapid Realist Review: CMO.

Context for each of the policy dimensions has been identified. For example, long-term care is a policy priority in the EU agenda, linked to the European Pillar of Social Rights, aiming at “mitigating the social and economic consequences of demographic change and population ageing” (21). Although long-term care is a national responsibility, EU is supporting it through different initiatives, since EU countries share the same challenges. The fragmentation of long-term care services in the EU is another major challenge that requires priority attention. Disparity in service provision between Member States can lead to inequality in access to adequate care, creating significant gaps in the care.

WHO and the EU have also established a new partnership for better long-term care, while offering support to informal carers (22). The European Social Dialogue Committee for Social Services (23) was also established with the aim at improving working conditions, professional development, skills and attracting employment in the social services sector.

The EU funds social policies through the European Social Fund Plus and the Recovery and Resilience Mechanism. In the related national recovery and resilience plans, fourteen countries included reforms related to long-term care, although investment was mostly focused on infrastructure projects.

Mechanisms considered for this review are the already existing policies and practices relevant to integrated long-term care under each policy dimension. Some of the EU Policies are affecting all the dimensions, such as the European Care Strategy (24) or the Directive on work-life balance for parents and carers (15). A description of relevant EU policy plans and recommendations can be found for each specific policy dimension.

Outcomes of the Laurel Rapid Realist Review have been to identify those frameworks that could be used in the context of I-LTC including the building blocks for each policy dimension. To extract the building blocks that are more relevant to the different policy dimension under investigation, a process of detailed analysis of each framework was carried out. Relevant elements were extracted and categorised according to their nature and function of the framework. All sixty-eight frameworks were provided for analysis and for each policy dimension, the analytical team identified inclusion and exclusion criteria to focus on those frameworks most pertinent to the dimension under examination.

For each policy dimension, a Table is provided that includes the relevant frameworks and building blocks. To create the Tables of building blocks, we compiled and analysed the content of each selected framework based on the specified inclusion and exclusion criteria. This process identified the specific building blocks in each framework. The information was then organized into a Table to present it clearly and concisely. A review and validation of the Table was carried out to ensure the accuracy and completeness of the information collected. By identifying and understanding these common building blocks, a solid framework can help to guide the implementation and continuous improvement of integrated care systems in various settings and contexts.

3.1.1 Governance

Table 4. CMO governance

CONTEXT GOVERNANCE
In the context of long-term care (LTC), governance faces significant challenges due to fragmentation in the provision of long-term care services. In many Member States, long-term care provision is organised through a complex system encompassing health care, social care, and other support services. "This system is subject to a distribution of responsibilities at national, regional, or local level" (25). The European Pillar of Social Rights Action Plan, launched in 2021, aims to ensure fair working conditions, equal opportunities, and social protection across the EU. Specifically, it emphasizes the importance of accessible, affordable, and high-quality care services, including long-term care, to support people in balancing their work and family responsibilities (25). The provision of long-term care affects not only the people who need these services, but also their families and various organisations that represent them (20) The 2021 Long-term Care Report, jointly prepared by the European Commission and the Social Protection Committee, provides an in-depth analysis of the state of long-term care in the EU. The report emphasizes significant reforms across Member States, particularly focusing on improvements in the support for informal carers, enhanced access, affordability, and quality of homecare and residential care services, as well as advancements in the professional long-term care workforce (22).
MECHANISMS GOVERNANCE
Although responsibility for care lies with the Member States, the European Union (EU) supports them through legislation. The Technical Support Instrument (TSI) supports member states to design and implement reforms, including in "Health and long-term care" and "Governance and public administration" (26). Additionally, in order to improve coordination between the health and social care sectors, as well as the integration of different levels of care delivery, the Commission has implemented the Flagship Technical Support Project (26). This project is designed to assist ministries of health and social affairs in the creation and implementation of reforms in the areas of health, social care, and long-term care.
OUTCOMES GOVERNANCE
Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to seventeen. The core building blocks are governance for integrated care, regulations and policies for integrated care and performance management to reach agreements across the different actors involved.

The Table 4 summarises the CMO of the frameworks from the governance perspective. Table 5 below presents the relevant building blocks of the accepted frameworks in the field of I-LTC governance. Its core building blocks are **governance for integrated care, regulations and**

policies for integrated care and **performance management** to reach agreements across the different actors involved.

All the identified frameworks included the **1.2 Coordination and collaboration** building block. Coordination involves the synchronisation of services and resources to ensure consistent and seamless care for patients. Collaboration involves working together towards common goals, sharing information, resources and responsibilities.

For governance, **1.4 Cross-sectoral governance** is of utmost importance. It involves the coordination and alignment of policies and practices across different sectors, such as health, education, housing and social services. It recognises that the social determinants of health, such as access to safe housing or education, have a significant impact on people's health.

1.5 Shared decision-making is closely connected with **1.10 Inter-professional governance**, involving the key actors to take decisions together through structures and processes to promote collaboration, care coordination and information sharing among the various members of the health care team. This component fosters collaboration and communication between different health professionals, such as doctors, nurses, social workers, therapists and others.

Participatory governance is reflected in **1.12 Bolstering participatory governance** that means involving a wide range of stakeholders, including people with integrated care needs, families, carers, community organisations and local leaders, in the decision-making process about health and social care. Among those to be involved, it is highlighted the **1.21 Importance of local level,** and the **1.20 Community networks** are to be noted. Community networks are local organisations, groups and resources that support integrated care by providing services, information and support at the community level.

The need to establish accountability mechanisms that ensure that all actors within the integrated care system fulfil their roles and responsibilities is reflected in **1.13 Enhancing mutual accountability**.

Finally, the **2.2 Integrate policies** building block recognises the interconnectedness between various social determinants of health and seeks deep and meaningful integration of policies across all levels of government and relevant sectors.

Table 5. Frameworks and building blocks, governance

Building blocks	1. WHO int. del. LTC	2. WHO IC-LTC	4. SUSTAIN	7. ILO LTC	8. INTERLINKS	10. INTEGRATE	11. 9 Pillars	12. WHO-IPCHS	15. LMIC	20. SCIROCCO	21. Patient Chronic	26. SELFIE	30.IC Frail Elder	40. Cultural change	48.Vilans.	54. Comm MentalH	57. IC Older Adults
1. Governance for integrated care																	
1.1 Organization of providers and settings	■																
1.2 Coordination & collaboration	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
1.3 Management	■			■						■					■		
1.4 Cross-sectoral governance	■								■				■			■	
1.5 Shared decision-making	■	■	■		■	■		■				■	■	■		■	■
1.6 Shared vision / culture								■	■	■		■				■	
1.7 Sound clinical governance																■	
1.8 Membership reflects key stakeholders			■	■										■			
1.9 Inter-organisational governance						■											
1.10 Inter-professional governance			■		■	■					■						
1.11 System wide governance and leadership			■				■		■	■			■				
1.12 Bolstering participatory governance		■		■				■	■					■			
1.13 Enhancing mutual accountability		■	■					■	■								
1.14 (Macro level) Political commitment												■					

Building blocks	1. WHO int. del. LTC	2. WHO IC-LTC	4. SUSTAIN	7. ILO LTC	8. INTERLINKS	10. INTEGRATE	11. 9 Pillars	12. WHO-IPCHS	15. LMIC	20. SCIROCCO	21. Patient Chronic	26. SELFIE	30.IC Frail Elder	40. Cultural change	48.Vilans.	54. Comm MentalH	57. IC Older Adults
1.15 (Meso level) Supportive leadership												■					
1.16 (Meso level) Clear accountability												■					
1.17 Steering mechanisms					■												
1.18 Network governance model							■										
1.19 Community networks		■	■					■			■		■			■	
1.20 Importance of local level		■		■				■	■		■					■	
1.21 Collaborative and distributed leadership		■		■				■	■		■					■	
1.22 Multiple governance mechanisms				■	■												
1.23 Organisational transparency												■					
1.24 Tripartite governance				■													
1.25 Social dialogue in social security governance				■													
2. Regulations and policies for integrated care																	
2.1 Alignment of regulatory frameworks with goals of integrated care		■			■	■			■								
2.2 Integrate policies: collaboration/coordination across health-related policy fields (e.g. environment, education, transportation, housing)		■		■	■	■				■			■			■	
3. Performance management																	
3.1 Reaching agreements about the uniform use of performance indicators in the chain care						■											

The need to establish accountability mechanisms that ensure that all actors within the integrated care system fulfil their roles and responsibilities is reflected in **1.13 Enhancing mutual accountability.**

Finally, **2.2 Integrate policies** building block recognises the interconnectedness between various social determinants of health and seeks deep and meaningful integration of policies across all levels of government and relevant sectors.

3.1.2 Territorial

Table 6. CMO territorial

CONTEXT TERRITORIAL
Rural areas cover 83% of the EU's territory, where 137 million people live, corresponding to 30% of the EU population (13). Rural and remote areas often lack adequate access to health and social care, including long-term care (27) There are enormous differences across Member States in the supply and organisation of long-term care, and in the corresponding social protection systems and public expenditure levels (13). The population is already older on average than people living in urban areas in the EU. Additionally, young women are more likely to move from rural to urban areas than young men, adding demographic challenges to the issues of lower digital connectivity and lower access to public services such as education or care. The Gross Domestic Product (GDP) per capita is also lower in the rural regions (28). Achieving health equity through higher retention of health workers in remote and rural areas has also been highlighted as a challenge by WHO (29). Data from the survey of health, ageing and retirement in Europe (SHARE) shows that people aged 65 or over in rural areas faced severe limitations (16.9 %) more frequently than people in cities (14.0 %). There is also a regional dimension in the coverage by homecare services. In cities, 23.1 % of older people in need used homecare services, compared with 22.7 % in towns and suburbs, and only 20.9 % in rural areas. Effective access to care is often hindered in rural and remote areas. De-institutionalisation has been pointed out as part of a wider strategy of ensuring accessible and affordable long-term care services, adapted to the regional situation (30). WHO guidelines for community level interventions to manage declines in intrinsic capacity through integrated care for older people (ICOPE Guidelines) are relevant, since they suggest considering the local context (31).
MECHANISMS TERRITORIAL
The EU's 'A long-term vision for the EU's rural areas' (2021) (32) paved the way for the EU Rural Action Plan and the Rural Pact, that includes ten shared goals for EU's rural vision for 2040 (33) for stronger, connected, resilient and prosperous rural areas in the EU (34). EU Regional policy invest in regional measures "to boost economic growth and jobs and improve quality of life through strategic investment". Health is one of the areas in which the Cohesion policy invests in to promote equal access to quality healthcare services in rural areas. The support for healthcare and long-term care services is included in the policy objective: More Social Europe (34).

Several EU funds are involved in providing resources to advance on the EU Regional cohesion: European Regional Development Fund, European Social Fund+, Cohesion Fund, Just Transition Fund, and Interreg programmes. Some of the key objectives of EU cohesion policy are closely connected with I-LTC, such as increased access to and use of quality information and communication technologies (objective 2); promoting sustainable and quality employment (objective 8); promoting social inclusion (objective 9); investing in education, training, and lifelong training.
OUTCOMES TERRITORIAL
Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to eight. The core building blocks are people centred care and population approach, readiness to change, integrated care implementation, governance and evaluation.

Applying these inclusion and exclusion criteria, the list of sixty-six initial frameworks has been reduced to eight frameworks. Table 6 summarises the CMO of the rapid realist review from the territorial perspective. Table 7 below summarise the relevant I-LTC frameworks and their building blocks, from the territorial perspective.

The analysis reflected in Table 7 shows the relative low importance that the territorial dimension was given by the selected frameworks. Only eight of them included building blocks specifically focused on the urban/rural divide, or to any territorial level. The core building blocks for the territorial dimension are **people centred care and population approach**, **readiness to change, integrated care implementation, governance and evaluation.** Most of the identified building blocks are not specific to the territorial perspective, providing only minor references to the territorial differences.

Laurel consortium members have identified an additional framework, CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, that has provided the only five building blocks that explicitly focus on rural areas: **1.7 Community informed geographic lens; 2.3 Creating an enabling environment (using continuous partnership with local communities); 2.4 Increase Collection and Use of Standardized Data to Improve Health Care for Rural, Tribal, and Geographically Isolated Communities; 4.12 Strengthen and Support Health Care Professionals in Rural, Tribal, and Geographically Isolated Communities; 4.13 Drive Innovation and Value-Based Care in Rural, Tribal, and Geographically Isolated Communities.**

Table 7. Frameworks and building blocks, territorial

Building blocks	2. WHO IC-LTC	3. NICPOP	8. INTERLINKS	12. WHO-IPCHS	20. SCIROCCO	26. SELFIE	54. Comm MentalH	67. CMS Framework
1. Person-centred Care and population approach								
1.1 Person-centred Care Planning and Service Delivery			■	■				
1.2 Empowering and engaging people and communities			■	■				
1.3 Citizen empowerment			■	■	■			
1.4 Population approach		■						
1.5 Understanding and respecting the importance of communities							■	
1.6 Putting the person at the centre of their care							■	
1.7 Community informed geographic lens								■
2. Readiness to Change								
2.1 Readiness to Change		■			■			
2.2 Supports to Live Well		■						
2.3 Creating an enabling environment (using continuous partnership with local communities)					■			
2.4 Increase Collection and Use of Standardized Data to Improve Health Care for Rural, Tribal, and Geographically Isolated Communities								■
3. Integrated care implementation								
3.1 Reorienting the model of care (based on local needs assessment)			■	■				
3.2 Coordinating services within and across sectors			■	■				
3.3 Innovation management					■			
3.4 Information and research	■					■		
3.5 Technologies and medical products						■		

Building blocks	2. WHO IC-LTC	3. NICPOP	8. INTERLINKS	12. WHO-IPCHS	20. SCIROCCO	26. SELFIE	54. Comm MentalH	67. CMS Framework
3.6 eHealth services					■			
3.7 Funding	■							
3.8 Financing						■		
3.9 Standardisation and simplification					■			
3.10 Dissolving barriers between services							■	
3.11 Addressing physical health needs							■	
3.12 Management and leadership								
3.13 Optimize Medical and Communication Technology for Rural, Tribal, and Geographically Isolated Communities								■
3.14 Expand Access to Comprehensive Health Care Coverage, Benefits, and Services and Supports for Individuals in Rural, Tribal, and Geographically Isolated Communities								■
4. Governance								
4.1 Leadership and governance						■		
4.2 Structure and Governance			■	■				
4.3 Strengthening governance and accountability (from subnational levels)	■	■						
4.4 Service delivery	■							
4.5 Workforce	■					■		
4.6 Integrated commissioning of services							■	
4.7 System and organisational levels								
4.8 Policy and governance								
4.9 Organisational structures								
4.10 Pathways and processes								

Building blocks	2. WHO IC-LTC	3. NICPOP	8. INTERLINKS	12. WHO-IPCHS	20. SCIROCCO	26. SELFIE	54. Comm MentalH	67. CMS Framework
4.11 Means and resources								
4.12 Strengthen and Support Health Care Professionals in Rural, Tribal, and Geographically Isolated Communities								
4.13 Drive Innovation and Value-Based Care in Rural, Tribal, and Geographically Isolated Communities								
5. Evaluation								
5.1 Evaluation methods								
5.2 Monitor and Evaluate								

3.1.3 Gender

Table 8. CMO gender

CONTEXT GENDER
Care responsibilities are shared between men and women in only around one-third of the EU families (35). Women live longer than men but often do so in bad health (36). In addition, women have lower earnings across the EU27 and are exposed to a higher risk of poverty or social exclusion in all Member States (35) and in the world (37). Older women have also lower pensions (38), and thus are potentially less able to afford care, while 32 % of all women aged 65 or over need long-term care compared with only 19% of older men (39). From the demand side of long-term care services, more older women than older men may need services because older women are more likely to live alone and thus may not be able to rely on support from other household members. From the supply side of care services, the formal care workforce is predominantly made up of women (90 % of workers in the long-term care sector are women). Long-term care is often provided informally by family members, mostly women (40). “On average across OECD countries, 62% of those providing daily informal care were women in 2019. Spain, Greece and Portugal had the greatest gender imbalance: over 70% of informal carers were women” (41). “Around 39 % of women and 38 % of men who provide informal LTC have difficulties combining paid work with caring responsibilities at least 4 days a week. When carers use formal LTC services, the percentage of individuals facing daily work–life conflicts decrease” (42).
MECHANISMS GENDER
The European Care Strategy (2022) (41) addresses the needs of caregivers and care receivers, aiming to support “high quality, affordable and accessible care services with better working conditions and work-life balance for carers”, highlighting that informal care responsibilities have a disproportionate impact on women. Almost all women in the EU (92%) are carers regularly, compared to 68% of men. 81% of women care on a daily basis, compared to 48% of men in the EU. There is a link between care policies and gender equality outcomes (43). The EU Gender Equality Strategy (44) connects with the Article 8 of the Treaty of the Functioning of the European Union, seeking to “eliminate inequalities, and to promote equality, between men and women”. The Strategy 2020-2025 aims to advancing towards a gender-equal Europe, being based on gender mainstreaming and intersectionality. Despite the advances in gender equality, it is acknowledged that “no member state has achieved full gender equality and progress is slow”. The Gender Equality Strategy 2020-2025 presents policy objectives and actions to make significant progress by 2025 towards a gender-equal Europe. Its key objectives are ending gender-based violence; challenging gender stereotypes; closing gender gaps in the labour market; achieving equal participation across different sectors of the economy; addressing the gender pay and pension gaps; closing the gender care gap and achieving gender balance in decision-making and in politics (20,23).

Closing the gender care gap has been included as key objective of the Gender Equality Strategy, as well as in the European Care Strategy that will also support the implementation of the principles on gender equality, work-life balance and long-term care. Adequate and affordable formal long-term care services, together with policies to improve working conditions in the sector and reconcile paid employment and caring responsibilities, could help support gender equality (45).
OUTCOMES GENDER
Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to five. The core building blocks are social, cultural determinants, health needs, service delivery, system enablers and population coverage, governance, innovation and research, funding and performance, monitoring, and evaluation.

Table 8 has summarised briefly the CMO of the realist rapid review from the gender perspective. Table 9 below presents the relevant five frameworks with their building blocks, from gender dimension.

No specific gender framework was identified, and only five out of sixty-six frameworks mentioned gender briefly. No building block focused specifically on gender.

The building blocks identified have been **social, cultural determinants, health needs, service delivery, system enablers and population coverage, governance, innovation and research, funding and performance, monitoring, and evaluation.**

Table 9. Frameworks and building blocks, gender

Building blocks	1. WHO int. del. LTC	2. WHO IC-LTC	7. ILO LTC	54. Comm MentalH	63. Digital Health Equity
1. Social, cultural determinants. Health needs					
1.1 Health and social needs	■				
1.2 Sociocultural environment and other domains of influence				■	■
1.3 Community approach from gender, among others					
2. Service delivery, system enablers and population coverage					
2.1 Performance	■				
2.2 Services delivery	■	■			
2.3 Coverage of the population			■		
2.4 System enablers	■				
2.5 Health care system				■	■
2.6 Gender Based treatment and interventions					
3. Governance					
3.1 Governance		■			
4. Innovation and research					
4.1 Governance and administration		■			
4.2 Innovation and research		■			
5 Funding					
5.1 Sustainable funding		■	■		
5.2 Financing			■		
5.3 Sustainable financing		■			
6. Performance, monitoring and evaluation					
6.1 Information, monitoring and evaluation		■		■	■
6.2 Adequacy			■		

3.1.4 Stakeholders

When addressing the role of 'stakeholders', this section refers to the 14 key stakeholders identified by Laurel and summarised in Table 10 below. The identification of key stakeholders has been led under WP5.

Table 10. Laurel key stakeholder groups

LAUREL STAKEHOLDERS GROUPS
Cluster 1: high interest and high influence
Policymakers and lawmakers
Municipalities and local authorities
Insurance companies and payers
Health and social care managers
Cluster 2: middle influence and high interest
Volunteer organisations
Patients' associations
Health and social care workforce
Community organisations and advocates
Research and academic institutions
Health technology providers
International networks and associations in LTC
Social inclusion actors. Social protection institutions
Cluster 3: low influence and high interest
People with LTC needs
Family members and caregivers

The following Table 11 presents briefly the CMO of Laurel key stakeholders.

Table 11.CMO stakeholders

CONTEXT STAKEHOLDERS
One of the key aspects of Integrated Long-Term Care systems, is the way the different stakeholders work together. The fragmentation of stakeholder originates from the fragmented governance of LTC, which falls within the competence of a plurality of actors such as national, regional and local authorities, as well as between health and social services in both the public and private sectors.
MECHANISMS STAKEHOLDERS
In the aftermath of the COVID-19 pandemic, efforts surged for the creation of a European Health Union with the goal of having concerted action at EU level to 'protect our health together' (45). While this initiative represents an attempt to improve coordination in the space of health, it does not go as

far as calling for an integrated care system - notably, it overlooks the provision of social care, which remains outside of this vision.

In 2023, however, the European Commission launched a call of its Flagship Technical Support Project focusing specifically on person-centred integrated care (26). The initiative aims to 'help strengthen the coordination between [these] sectors and the integration of the different levels of care provision, by putting the person at the centre of services to ensure better access and better quality of care at every stage of life"'.

The EU Care Strategy (41), launched in September 2022 by the European Commission, constitutes an important soft policy measure for the EU to inspire LTC policy at national level. The strategy calls for an integrated approach to care, focusing especially on the integration between long-term care and healthcare, informal care, home care, community-based and residential care. The document remarks that "The successful implementation of the European care strategy requires a shared commitment of all stakeholders. In taking forward this strategy, the Commission will work in close partnership with other EU institutions and bodies, notably the European Parliament, the Council, the Committee of the Regions and the European Economic and Social Committee, Member States, social partners, social economy actors, civil society organisations and other stakeholders".

OUTCOMES STAKEHOLDERS

Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to twenty-one. The core building blocks are person-centeredness, service delivery, governance; innovation, research and technology, workforce, community and environment, financing; and culture, values and vision.

Building blocks

The relevant building blocks were categorised in eight thematic dimensions: **Person-centeredness; Service Delivery; Governance; Innovation, research and technology; Workforce; Community and environment; Financing; and Culture, values and vision**, as depicted in Tables 12 and 13. The two tables represent all the frameworks investigated under the category of 'stakeholders'. The large volume of frameworks to be assessed that involve stakeholders required their division into two separate tables.

Many of the twenty-one frameworks selected considering their relevance for stakeholder coordination and integration consider each of the key stakeholders. Four stakeholders though, are considerably under-represented: insurance companies and payers; patient organisations; volunteer organisations; and international networks and associations on I-LTC.

1. Person-centeredness entails having the **1.1 Person at the centre** of care systems. Care should be based around a person's lifestyle, values, priorities, social context, and their role in the community. The creation of **1.2 Care pathways** is a crucial to have structures in place to supports connections among stakeholders. It is also important that care services prioritise **1.3**

Co-creation with stakeholders, in particular amplifying the perspective of care recipients and carers, considering them partners in care.

2. Service delivery should aim for the **2.1 Centralisation** of information, referral and intake, and create single access points to reduce the complexity of care systems. Another key building block is **2.2 Collaboration,** which entails creating opportunities for stakeholders to work with one another in a shared way, ensuring they truly are *partners* in care. Not to forget **2.3 Coordination** (i.e., ensuring that there are clear principles and guidance to inform the way stakeholders work together) and **2.4 Standardisation**, since having common standards and objectives allows all stakeholders to be on the same page, reduce complexity, and streamline the interface between different partners.

3.1 Governance for Integrated Care has appeared in several of the previous sections and is also key for its stakeholders. Governance includes collaborative and distributed leadership, cross-sectoral and participatory governance, mutual accountability, shared decision-making. Closely linked with common standards, are **3.2. Regulations and policies for Integrated Care** and **3.3 Performance management**. One direct application of how governance can contribute to standardisation is through agreements on the uniform use of performance indicators across the care chain.

4. Innovation, research and technology is essential for **4.1 Information sharing**, for example through shared information systems, digital records, electronic tools for patients, and by supporting information sharing across settings (e.g. between the hospital and the home). Digital tools have great potential to support **4.2 Centralisation and coordination** of stakeholders. Another building block linked to technology is **4.3 Innovative care practices enhanced by technology**, for example in the form of telehealth and assistive technologies. Finally, this group of building blocks also includes **4.4 Enablers of technological innovation,** such as rules and regulations around information governance, data sharing, privacy regulations, but also policies that stimulate investments in these applications of technology.

For integrated care to advance, its **5. Workforce** needs to be supported to bring forward **5.1 Collaboration and coordination**. This building block calls for reaching agreements among care partners on tasks and responsibilities, investing to improve care coordination, creating new organisations and structures that support workforce collaboration, raising awareness among professionals about each other's role and expertise. Efforts to strengthen **5.2 Multidisciplinarity** are another effective way to foster integration among stakeholders who would otherwise work in silos. All these changes to the way the workforce operate should be supported by adequate **5.3 Training.**

Not to miss considering the **6. Community and environment,** starting with **6.1 Community care integration**. This building block calls for treating people and communities as partners in

care and **6.2 Community as key stakeholder**. Community-level interventions can play a vital role in supporting care recipients in unique ways, strengthening the social aspect of care and giving rise to new alliances, pivotal to understand the needs and priorities of local populations. A key part of the care ecosystem, **6.3 Informal carers integration** needs to be addressed as well. Informal carers often are the connecting factor that links up different systems of care, when they operate in silos (e.g. passing information among different care professionals that work in separate facilities, which are not integrated in one system).

7.1 Joint financing entails bundled payments across different stakeholders, creating financial and regulatory incentives to encourage cooperation among health and social care, financing mechanisms to allow the pooling of resources across services, shared funding and savings. In brief, this means prioritising an approach that allows to mobilise and coordinate resources, and ensuring there are adequate **7.2 Resources allocated to implement integration**.

Finally, I-LTC can only be advanced by stakeholders if it is based on **8.1 Shared vision for integrated care**, since values and culture are the first step to orient the provision of care towards an integrated model. Not to underestimate the importance to assure **8.2 Institutional culture supporting integration**. A culture of openness and transparency encourages stakeholders to come forward with issues, problems, and ideas for improvement. This collective process of growth binds stakeholders together and strengthens their integration.

Table 12. Frameworks and building blocks, stakeholders (1 out of 2)

Building Blocks (1)	1. WHO int. del. LTC	2. WHO IC-LTC	3. NICPOP	8. INTERLINKS	10. INTEGRATE	11. 9 Pillars	12. WHO-IPCHS	14. RMIC	15. LMIC	19. Comm care
1. Person-centeredness										
1.1 Person at the centre	■		■		■			■		
1.2 Care pathways		■	■		■			■	■	
1.3 Co-creation			■	■		■				■
2. Service delivery										
2.1 Centralisation			■		■				■	
2.2 Collaboration					■			■	■	■
2.3 Coordination			■		■		■	■		
2.4 Standardisation					■					
3. Governance										
3.1 Governance for integrated care	■		■		■	■	■	■		
3.2 Regulations and policies for integrated care					■					
3.3 Performance management					■					
4. Innovation, research and technology										
4.1 Information sharing	■		■		■				■	
4.2 Centralisation and coordination			■		■					
4.3 Innovative care practices enhanced by technology			■							
4.4 Enablers of technological innovation										

Building Blocks (1)	1. WHO int. del. LTC	2. WHO IC-LTC	3. NICPOP	8. INTERLINKS	10. INTEGRATE	11. 9 Pillars	12. WHO-IPCHS	14. RMIC	15. LMIC	19. Comm care
5. Workforce										
5.1 Collaboration and coordination										
5.2 Multidisciplinarity										
5.3 Training										
6. Community and environment										
6.1 Community care integration										
6.2 Community as key stakeholder										
6.3 Informal carers integration										
7. Financing										
7.1 Joint financing										
7.2 Resources allocated to implement integration										
8. Culture, values and vision										
8.1 Shared vision for integrated care										
8.2 Institutional culture supporting integration										

Table 13. Frameworks and building blocks, stakeholders (2 out of 2)

Building Blocks (2)	20. SCIROCCO	26. SELFIE	27. ICARE4EU	30. IC frail elderly	34. ICOPE	35. CC_Children	38. DementiaCM	39. Transitional Care	41. Parkinson' s	54. Comm MentalH	68. Biscay LTC empowerment model
1. Person-centeredness											
1.1 Person at the centre		■	■		■				■		■
1.2 Care pathways	■	■	■	■	■		■				■
1.3 Co-creation								■			
2. Service delivery											
2.1 Centralisation							■		■	■	
2.2 Collaboration		■	■				■				
2.3 Coordination	■	■				■	■	■		■	
2.4 Standardisation	■								■		
3. Governance											
3.1 Governance for integrated care		■									■
3.2 Regulations and policies for integrated care											
3.3 Performance management											
4. Innovation, research and technology											
4.1 Information sharing		■		■							
4.2 Digital Centralisation and coordination		■					■		■		■
4.3 Innovative care practices enhanced by technology											
4.4 Enablers of technological innovation	■	■									

Building Blocks (2)	20. SCIROCCO	26. SELFIE	27. ICARE4EU	30. IC frail elderly	34. ICOPE	35. CC_Children	38. DementiaCM	39. Transitional Care	41. Parkinson's	54. Comm MentalH	68. Biscay LTC empowerment model
5. Workforce											
5.1 Collaboration and coordination	■	■	■			■					
5.2 Multidisciplinarity		■		■	■			■			
5.3 Training									■		■
6. Community and environment											
6.1 Community care integration								■			
6.2 Community as key stakeholder	■				■					■	
6.3 Informal carers integration					■			■			■
7. Financing											
7.1 Joint financing		■		■							
7.2 Resources allocated to implement integration											
8. Culture, values and vision											
8.1 Shared vision for integrated care		■									
8.2 Institutional culture supporting integration	■										

3.1.5 Funding, affordability

Table 14. CMO funding

CONTEXT FUNDING & AFFORDABILITY
The funding system for long-term care services takes many forms, such as via public (taxation), insurance based, private or individual funding (46). Despite the global need for long-term care, publicly funded LTC services are scarce. Data indicates that 48% of older individuals lack access to formal services, 46% are excluded by means testing, and only 5.6% have comprehensive national coverage. Public expenditure on LTC averages less than 1% of GDP worldwide, severely limiting access, particularly in low- and middle-income countries. “European Commission expected the number of people potentially in need of LTC to rise from 30.8 million in 2019 to 38.1 million in 2050 and LTC expenditure to increase from 1.7 %to 2.5 % of gross domestic product (GDP) over the same period, becoming one of the fastest rising areas of social spending” (47). At the same time, the economic value of the time spent on informal care was estimated at 2.4 to 2.7% of EU27 GDP, more than most EU countries spend on formal care. No single best financing mechanism exists, but countries need clear, protected funding sources and spending measures to ensure coverage for older people and their caregivers. Countries should focus on targeted care benefits, forward-looking financing policies, and financial instruments for residential LTC costs. To maximize value, home and community care should be prioritized, along with productivity improvements, healthy aging, prevention, care coordination, and institutional efficiency. Financial systems often suffer from fragmentation, with separate funding streams and governance structures, inadequate provider payment mechanisms, and volume-based incentives that hinder care coordination. Many countries are transitioning to value-based care, emphasizing health and social service integration, though integration can succeed without merged financial flows if collaborative structures are in place. Generous coverage and reimbursement for integrated care programs are crucial for financial equity, along with minimizing out-of-pocket costs. Financial incentives for those with multi-morbidity, such as vouchers or free memberships, and new payment models like pay-for-coordination and bundled payments, are emerging (48). Public expenditure and financing range from small budget lines within social assistance schemes, as in many Eastern European countries, to expenditures for LTC that amount to more than 3% of GDP such as in the Netherlands or Sweden. This difference in expenditure also reflects the extent to which access to services is guaranteed and which rights and entitlements are granted by legislation. While in Germany, Luxembourg, and the Netherlands there are social insurance branches granting access to LTC, countries such as Ireland, Switzerland or Poland grant access to services and facilities based on a social assistance rationale. Differences in expenditure are also linked to the extent to which LTC schemes grant services in kind, such as in the Nordic countries and the Netherlands, rather than cash benefits, as in Continental welfare regimes (ari, France, Germany, Czech Republic). Provision Another area of variation is the extent to which services and facilities are delivered by public, private not-for-profit or for-profit providers. While in the UK and

Germany the share of private providers is comparatively high, the Nordic countries are still characterised by extended public service provision. Also, the role of not-for-profit organisations is dependent on national traditions. For instance, in Germany and Austria not-for-profit organisations have traditionally delivered LTC services, which led to their expansion in recent decades. In Eastern Europe, where not-for-profit organisations had to be reintroduced during the transition to market economies, there is still a lack of such providers in LTC. There is a general tendency to organise LTC services at local level, be it in the Nordic or in Mediterranean countries – and local authorities are characteristically of various sizes with significantly different scopes of autonomy. For instance, municipalities in Nordic countries are larger than in Southern Europe, they levy local taxes and enjoy autonomy within national framework legislation. In Spain, this autonomy, except for taxes, is granted to the regions, while in Italy there are inter-communal entities that manage health and social care within the regions and impact the organisation of LTC (49).

MECHANISMS FUNDING & AFFORDABILITY

Key policies in the context of funding long-term care (LTC) are:

- European Care strategy which seeks to enhance the quality, accessibility, and affordability of care services across the EU.
- European Pillar of Social Rights (EPSR) (25) includes a commitment to providing affordable, high-quality long-term care.
- The Recovery and Resilience Facility (RRF) (50) provides financial support to member states for reforms and investments that boost economic and social resilience. This includes funding for improving long-term care services.

OUTCOMES FUNDING & AFFORDABILITY

Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to seven. The core building blocks are funding sources, fragmentation of financing, financial indicators, incentives and financing mechanisms.

Table 14 has summarised the CMO of the funding and affordability policy dimension. Only seven of the frameworks included building blocks mentioning or connecting with aspects of funding and affordability. Table 15 below presents the relevant frameworks of funding and affordability, together with their building blocks:

1. Funding sources: Funding sources are the main area of differentiation across the EU and elsewhere. Each of the three sub blocks has its own benefits and challenges, and the choice often depends on the project's nature, scale, and strategic goals. Combining different funding types can optimize resource utilization and enhance feasibility and sustainability.

2. Fragmentation of financing: In many EU countries there is not only one funding source of LTC services, but many. Fragmented financing can increase the total resources available for provision of LTC but introduces complexity that needs to be carefully managed to ensure efficiency, compliance, and alignment different funds.

3. Financial indicators: These financial indicators help stakeholders evaluate the efficiency, sustainability, and distribution of funding, providing a clear picture of the financial landscape and informing strategic decisions. From stakeholders' perspective it is important to know the expenditure/costs and the proportion that comes from a specific source.

4. Incentives: Financial incentives are designed to encourage the development, provision, and improvement of integrated long-term care services. They are essential for fostering a sustainable and effective long-term care system that can meet the growing needs of aging populations and individuals requiring extended care services.

5. Financing mechanism/types of funding: Diverse financing mechanisms play a vital role in ensuring the sustainability, accessibility, and quality of long-term care services. By combining public, insurance-based, private, and individual funding sources, a more resilient and comprehensive funding system can be achieved.

Table 15. Frameworks and building blocks, funding and affordability

Building Blocks	1.WHO int. del. LTC	2. WHO IC-LTC	8. INTERLINKS	11. 9 Pillars	12. WHO-IPCHS	13. Develop IC	26. SELFIE
1. Funding sources							
1.1 Public/private or mixed funding	■				■	■	■
1.2 EU grants					■	■	■
1.3 Innovative funding	■					■	
2. Fragmentation of financing							
2.1 Fragmentation of financing					■	■	■
3. Financial indicators							
3.1 Expenditure costs per person/ expenditure as % of GDP	■	■					
3.2 Percentage of funding			■				
4. Incentives							
4.1 Financial incentives for provision of I-LTC	■	■	■	■		■	
5.Financing mechanism/types of funding							
5.1 Public funding	■		■			■	
5.2 insurance based,	■		■			■	
5.3 Private funding	■		■			■	
5.4 individual funding							

3.1.6 Social economy

Table 16. CMO social economy

CONTEXT SOCIAL ECONOMY
Social economy encompasses a wide range of enterprises and organizations: cooperatives, mutual benefit societies, associations, foundations and social enterprises that share the following key principles and features: the primacy of people as well as social and/or environmental purpose over profit; the reinvestment of most of the profits and surpluses to further pursue their social and/or environmental purposes and carry out activities in the interest of members/users ('collective interest') and/or society at large ('general interest'); and democratic and/or participatory governance (openness of management to stakeholders, democratic decision-making process, participation of members and/or employees in decision-making) (51). Social economy is present in all economic sectors including care and long-term care and health and social services for which it constitutes an important provider, highlighting the mutuals, which operate in the health and care sector, but also cooperatives, associations, foundations and the like, with focus on health and care, including the voluntary work and the third sector (an intrinsic part of Social Economy) providing long-term care services. A large number of the fourteen key stakeholders in LTC identified by Laurel belong to the social economy in the clusters identified in Table 10. Half of the stakeholders included in cluster 2 and characterised by having middle influence and high interest are part of the social economy: volunteer organisations, patient´s associations, community organisations and international networks and associations in LTC. As part of the stakeholders, social economy is also present in the governance of I-LTC characterised by collaboration between multiple actors and levels of government. For that reason, it is important to ensure a proper inclusion of the social economy actors in the governance of I-LTC and an effective coordination with the rest of stakeholders involved to get a more cohesive and efficient system. It is important to include the social economy actors in the funding scheme of I-LTC given the importance of social economy in the provision of I-LTC services and in the representation of the interests of the stakeholders involved. The provision made by social economy actors can be a key complement to the provision of services made by the public administrations in some EU countries, particularly those that often lack of the adequate funding to carry out their services and activities.
MECHANISMS SOCIAL ECONOMY
The Social Economy Action Plan (SEAP) (52) published in 2021 by the European Commission recognises the social economy organizations and enterprises as important partners for public authorities in the provision of social, health and care services. The SEAP also recognizes the key role of the social economy in the creation of employment with fair working conditions in the care sector. It also points out that the European Care Strategy will provide, amongst others, an opportunity for boosting the care economy raising the profile of the strong added value of the social

economy in this sector, also to help improve working conditions. The Council Recommendation on developing social economy framework conditions (European Commission, 2023) (53) points out that to successfully implement the European Care Strategy and improve the situation for both care receivers and caregivers across the EU, it is essential to secure the shared commitment of all stakeholders. Social economy entities bring an added value to the provision of high-quality care services as they take a people-centred approach and reinvest their profits into their mission and local communities. Furthermore, Social Economy has a unique approach to democratic and multi-stakeholders governance as well as in coordination of diverse stakeholders, which can be most useful to an I-LTC approach. Creating a supportive environment for the social economy, including greater access to funding, can help reach the goal of providing quality, affordable, and accessible care services across the EU. It can also lead to fairer working conditions for its workers, especially through the promotion of social dialogue in line with the proposal for a Council recommendation on strengthening social dialogue in the European Union.

The Council Recommendation also encourages Member States to acknowledge and support the contribution of social economy entities to social inclusion and include them in the design and delivery of social and care services. The social economy can make a valuable contribution to the design and delivery of residential, home and community-based care services. Through partnership initiatives, public authorities and social economy entities can provide high quality, accessible and affordable care services, including long-term care.

The Transition Pathways for the Proximity and Social Economy ecosystem (European Commission, 2022) (54), which includes sixty actions in fourteen areas to achieve the green and digital transition of the ecosystem, also recognises the potential and the solutions brought by digital social innovation, which are inspiring technology-based initiatives in the social economy.

OUTCOMES SOCIAL ECONOMY

Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to eight. The core building blocks are person-centred care and population approach, readiness to change, implementing change, governance, evaluation.

Table 16 has summarised the CMO for social economy dimension. Only eight of the frameworks included building blocks mentioning or connecting with aspects of social economy. None of the identified building blocks are specific of this approach. The aggregated building blocks are described from the social economy perspective, but not each of the building blocks, due to their generic nature.

Table 17 below presents the relevant frameworks to social economy, together with their building blocks. **1. Person-centred Care and population approach** is an intrinsic feature of social economy as it is one of its core values. I-LTC must be provided considering the specific needs of the person for an efficient service delivery that puts the person at the centre. The empowerment of citizens and communities is also addressed as way to achieve a correct coverage of the needs in I-LTC without leaving anyone behind.

2. Readiness to change.The current systems of care are unsustainable and need to change. For that, it is necessary to take into account the different stakeholders vision including the social economy and to integrate the healthcare system and other care services from the social economy, including the social and voluntary work.

3. Implementing change. The necessity of reorienting the model of care needs better coordination services within and across sectors, including the social economy ecosystem, which has the particularity of being present in all the economic sectors. Social innovation is a core element for I-LTC including digital solutions like eHealth services and the development of services and new ways of working as well as horizontal management.

4. Governance: The democratic and/or participatory governance is another core value of social economy. Governance models should help break down barriers between silos, enable collaboration, and facilitate the move towards a model of co-operation over competition. New models of care and large system transformation require more collaborative, distributed forms of leadership and approaches to change management that can be undoubtedly addressed from the social economy. The workforce is another element included in this building block. The social economy plays an important role in the provision of I-LTC offering better working conditions.

5. Evaluation: The selected frameworks consider the importance of evaluating the socioeconomic impact of I-LTC services in order to assess the services and meet the actual needs of the individual with an holistic perspective. Adapted impact measurement to be used for social economy evaluation.

Table 17. Frameworks and building blocks, social economy

Building blocks	2. WHO IC-LTC	3. NICPOP	8. INTERLINKS	7. ILO LTC	11. 9 Pillars	12. WHO-IPCHS	20. SCIROCCO	26.SELFIE
1. Person-centred Care and population approach								
1.1 Person-centred Care Planning and Service Delivery		■						
1.2 Citizen empowerment					■	■	■	
1.3 Population approach					■	■	■	
1.4 Undertake population planning for older persons		■						
1.5 Coverage of the population				■				
1.6 Shared values and vision					■			
1.7 People as partners in health and care					■			
1.8 Community informed geographic lens					■			
2. Readiness to Change								
2.1 Readiness to Change					■	■	■	
2.2 Supports to Live Well		■						
2.3 Enablers		■						
2.4 Breath of ambition					■	■	■	
2.5 Map local care resources		■						
3. Implementing change								
3.1 Reorienting the model of care			■					
3.2 Coordinating services within and across sectors			■					
3.3 Innovation management					■	■	■	
3.4 Information and research	■							■
3.5 Technologies and medical products								■
3.6 Funding			■					

Building blocks	2. WHO IC-LTC	3. NICPOP	8. INTERLINKS	7. ILO LTC	11. 9 Pillars	12. WHO-IPCHS	20. SCIROCCO	26.SELFIE
3.7 Financing				■				■
3.8 Standardisation and simplification			■					
3.9 Capacity building					■	■	■	
3.10 Develop services and care pathways		■						
3.11 Develop new ways of working		■						
3.12 Develop MDT Teamwork and create clinical network hub		■						
3.13 Sustainable financing	■							
3.14 Coordination of the various actors across the continuum of care				■				
3.15 Digital solutions						■		
3.16 Aligned payment systems						■		
3.17 Service delivery								■
4. Governance								
4.1 Governance	■							
4.2 Governance and administration				■				
4.3 Leadership and governance								■
4.4 Structure and Governance			■		■	■	■	
4.5 Service delivery	■		■					■
4.6 Workforce	■		■					■
4.7 Strengthening governance and accountability	■							
4.8 Establish governance structures		■						
5. Evaluation								
5.1 Evaluation methods	■		■		■	■	■	
5.2 Monitor and evaluate		■						

3.1.7 Across the life-course

Table 18 CMO, across the life-course

CONTEXT LIFE-COURSE
Unlike the lifecycle approach, which is overly focused on biological underpinnings of life stages, the life-course approach pays due attention to the social context, roles, and individual trajectories (55). A life-course approach reflects the idea of non-linear and more flexible life stages put forward. Applied to long-term care, adopting a life-course perspective helps to understand that ageing starts at birth, continues throughout life, and reflects the importance of promoting healthy ageing, gender and social equality. It underlines the need to consider the vast diversity that exists among members of the older population, as well as people's changing needs and capacities as they age. It recognises that past and present experiences are shaped both by people's own choices but also by wider social and economic circumstances, including ageism, which hampers the equal enjoyment of human rights at all ages (56). The fact that "long-term" can be associated with "life-course" (i.e., throughout the "lifetime") is of particular relevance. Long-term care systems should support individuals to remain included and participate in society at all stages of life. Services and support should not be the end goal, but the means to achieve integration and inclusion (57). The key principles of the life-course approach were most strongly set out in the Minsk Declaration on the Life-course Approach (58) in the Context of Health 2020 adopted by all Member States in the WHO European Region at the WHO European Ministerial Conference on the Life-Course Approach. Adopting a life-course approach according to the Minsk Declaration means: • recognizing that all stages of a person's life are intricately intertwined with each other, with the lives of other people in society, and with past and future generations of their families. • understanding that health and well-being depend on interactions between risk and protective factors throughout people's lives. • taking action: early to ensure the best start in life; appropriately to protect and promote health during life's transition periods; and together, as a whole society, to create healthy environments, improve conditions of daily life, and strengthen people-centred health systems.
MECHANISMS LIFE-COURSE
As a response to the findings of the report on the impact of demographic change (59) in June 2020, the European Commission launched the 'Green Paper on Ageing' (60) a 24-page document covering a wide range of issues starting with health and education, life-long learning, employment to finally address old-age poverty, pensions, and long-term care. The Green Paper on Ageing highlights the life-course approach, showing for example how much socio-economic inequalities accumulated across one's life have a strong impact in older age.
OUTCOMES LIFE-COURSE

Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to eleven. The core building blocks are person-centeredness, engagement and empowerment, shared decision making, community inclusion.

Table 18 summarises the CMO of the review of the I-LTC frameworks from the life-course dimension. Like in previous dimensions, although some of the frameworks relate to the life-course, no specific framework or building blocks focused on life-course for I-LTC. Table 19 below presents the relevant frameworks for I-LTC from the life-course dimension and their respective building blocks.

1. Persons with LTC-needs require a 1.1 person-centeredness approach. Every individual requires care and support throughout life. What may vary is the kind of services and the intensity to which we need them. Person-centeredness ensures that the I-LTC needs are met across our life-course, services are adapted and tailored to the individual along the life-course in line with the persons needs and preferences. **1.2 People with I-LTC needs engagement and empowerment** are critical across the life-course and facilitate effective self-management and social inclusion of people. In line with a human-rights based approach, engagement and empowerment highlight two of its key principles (61): Participation, everyone is entitled to active participation in decision-making processes which affect the enjoyment of their rights; Empowerment – everyone is entitled to claim and exercise their rights. Individuals and communities need to understand their rights and participate in the development of policies which affect their lives. **1.3 Shared decision-making** is pertinent across the life-course, so that people with I-LTC needs are involved in decisions about their care plans and subsequently about their current and future lives.

1.4 Community inclusion initiatives aim at enhancing patient access to community-based resources and support networks, promoting social integration and well-being. The vision of a society for all ages (62) can only be realised if people across the life-course – independent of their I-LTC needs – are included in their communities.

Table 19. Frameworks and building blocks, across the life-course

Building blocks	2. WHO Integrated Continuum LTC	1. WHO country assessment	10. INTEGRATE	14. Develop IC	16. LMIC	17. COMIC	21. SCIROCCO	24. JA-CHRODIS	25. ICCC	27. SELFIE	28. ICARE4EU
1. Persons with LTC-need											
1.1 Person-centeredness	■	■	■	■		■				■	■
1.2 Persons with I-LTC needs engagement and empowerment		■	■			■	■	■	■	■	■
1.3 Shared decision-making		■	■				■	■		■	■
1.4 Community inclusion		■	■		■	■		■	■	■	
2. Service delivery											
2.1 Define (minimum) types of services and settings	■	■				■	■	■		X	
2.2 Clear and equitable criteria for service coverage	■	■				■				X	
2.3 Integration LTC-services: continuity and coordination	■	■	■	■		■	■		■	■	■
3. Governance											
3.1 Clear governance structure	■	■	■		■	■	■				
3.2 I-LTC legislation and strategy	■		■			■	■		■	■	■
4. Sustainable financing											
4.1 Financing mechanism	■	■	■		■		■		X	X	X
5. Monitoring and evaluation											
5.1 Population approach: Gather information and monitor health status, service needs and workforce	■	■	■		■		■			■	
6. Innovation, research, and technologies											
New technologies and platforms	■	■			■	■	■	■		■	■

2. Service delivery involves to **2.1 Define (minimum) types of services and settings.** In terms of settings, I-LTC systems should offer individuals the autonomy to choose their living arrangements, ensuring environments conducive to aging with well-being (46). Types of services and settings need to be defined independent of age and across the life-course. For example, clear guidelines (63) exist for deinstitutionalisation concerning people with disabilities, whereas no equally strong framework exists for older people and care provided in institutional settings. Furthermore, certain types of care services may only be provided to people of a specific age group e.g. upper age limits on funding for diagnostic tests, screening procedures, and health-related social benefits are part of policy in many European countries (56). Service delivery must also be based on **2.2 Clear and equitable criteria for service coverage.** Achieving sustainable and fair I-LTC necessitates universal health and social care coverage, acknowledging the intertwining of social support and healthcare services (46,48).

I-LTC requires continuity and coordination vertically (i.e. healthcare needs) and horizontally (e.g. including social and informal care), among primary and secondary care, care services, organisations, sectors, and professions, to provide seamless care for the person with I-LTC needs, as reflected in building block **2.3 Integration LTC-services: continuity and coordination.** Jointly developed integrated care pathways and robust data systems facilitate continuity and coordination, ensuring smooth and monitored transitions. In delivery systems, the focus is on streamlining the care process through logistical and coordination mechanisms: agreements on logistics and sharing expertise, procedures e.g. exchanging information, or the use of specific tools such as care plans (46,48,64,65).

3. Governance has already appeared as a building block of several previous policy dimensions. Its main features would be to have a **3.1 Clear governance structure** and **3.2 I-LTC legislation and strategy.**

4. Sustainable financing requires clear and protected funding sources and transparent spending measures, ensuring accessibility and quality for all persons with I-LTC needs. Policymakers should consider funding mechanisms that provide both short- and long-term support for integrated care programs, fostering innovation and improving care outcomes for people with I-LTC needs (3,46,65,66).

All processes should be properly monitored and evaluated, as reflected in the building block **5. Monitoring and Evaluation,** from a **5.1 Population approach** that involves gathering information and monitoring health status, service needs and workforce. Population monitoring not only addresses current demands but also anticipates future health risks, contributing to better care system resilience, health equity, efficiency in service delivery, and improved health outcomes (3,46,48). Population-based surveys need to cover all age groups – without an upper

age limit - and be disaggregated by age. Similarly, information on service needs of all age groups – not just older people – need to be gathered.

Finally, **6. Innovation, research and technologies** may serve as a facilitator in I-LTC, however low digital literacy and/or technology usage (partly due to ageism and ableism) must be taken into consideration. Efforts to enhance digital literacy and provide assistive technologies should be inclusive and tailored to individual needs, aiming to promote independence and well-being (3,46,48).

3.1.8 Digital technologies

Table 20. CMO digital technologies

CONTEXT DIGITAL
Technology can enhance service quality by reducing errors, ensuring timely visits, freeing up carers' time to socialize more with users, personalizing services, and increasing users' independence. Additionally, technology can aid quality assurance by electronically monitoring aspects such as visit timing and duration, and medication logging. Remote surveillance could also protect against abuse, providing a means to monitor vulnerable individuals remotely to ensure their safety. However, these tools must balance the privacy concerns of both users and care professionals (14). From the technological innovation and adoption point of view, it is crucial to consider: the Electronic Health Records (EHRs), which are recognized as fundamental to I-LTC (66), providing a cohesive view of patient data across different care settings. They enhance communication among providers and ensure that information is up-to-date and accessible. Particularly telemedicine and remote monitoring have been accelerated by the COVID-19 pandemic, which pushed many healthcare systems to adopt remote care technologies rapidly. Remote monitoring technologies are increasingly used for chronic disease management, allowing for continuous care without the need for frequent hospital visits; mobile health applications, which are used extensively for patient engagement and health monitoring. Mobile apps can help manage chronic conditions, medication adherence, and provide direct communication channels between patients and healthcare providers. To what concerns service delivery, the main aspects are: integrated care pathways, which can be more streamlined and efficient thanks to the use of digital technologies. This includes automated alerts for care providers when intervention is needed, as well as decision support systems that can suggest optimal care plans based on patient data; virtual health assistants, to be integrated into the patient care journey, providing reminders, health education, and support in managing one's health. For example, the Digital care horizon framework is designed to guide the digital transformation of healthcare services, expanding beyond traditional care settings, where the intensity of healthcare services can be customized to patient needs by utilizing digital tools and services, providing a range of digital options tailored to individual patient requirements. This digital transformation in care delivery will facilitate more efficient use of healthcare resources, enhancing patient experience and reducing overall costs (67).

Although not focused on I-LTC, the digital care horizon framework is presented in the Figure 2 below (Framework number sixty-five). It is highlighted because of the way this framework structures a possible tech-based roadmap for the care model evolution.

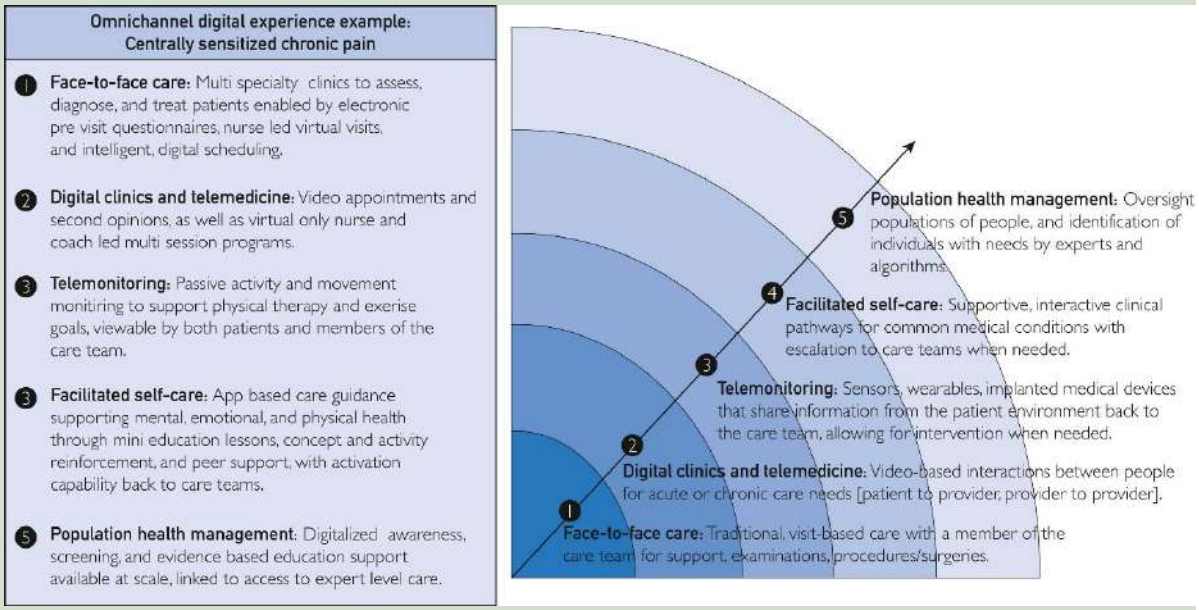

Figure 2 Digital care horizon and example capabilities for patients experiencing chronic pain conditions across the digital care horizon (67).

MECHANISMS DIGITAL TECHNOLOGIES

For the governance and policy, aspects to consider are data privacy and security, due to the increase of digital health data which require protection measures. Regulations such as the GDPR in Europe have set a precedent for data privacy in healthcare, interoperability standards between different systems and devices. To ensure the right uptake of digital solutions and interventions, the sustainable financing aspect should consider the reimbursement models, which recognize the cost-saving potential of digital health, such as reduced hospital admissions and improved management of chronic diseases. Moreover, the monitoring and evaluation should be ensured with detailed tracking of health outcomes, which are essential for evaluating the effectiveness of I-LTC interventions and for continuous improvement. Finally, the interventions on healthcare workforce, informal workforce and caregivers imply the delivery of training to adapt new digital tools and methodologies to healthcare users' needs and the integration of digital health records into daily practice and how to utilize data analytics for patient care. Crucial interprofessional skills should be included in healthcare workers' training, furthermore digital health frameworks need to be frequently updated to incorporate new digital health technologies, be relevant for low- and middle-income countries, and encompass often-overlooked healthcare worker groups, such as allied health professionals (68).

OUTCOMES DIGITAL TECHNOLOGIES

Applying inclusion and exclusion criteria, the list of sixty-six initial frameworks was reduced to four. The core building blocks are person-centred care and population approach, service delivery, and innovation, research and technology,

Table 20 has summarised the CMO of the I-LTC frameworks, from the digital dimension. Table 21 presents the relevant frameworks for the digital dimension and their building blocks.

Building blocks

The first comment on building blocks for the digital perspective is that in discussions in WP3, the overall view of how technologies are considered can be two-fold. On one hand, if we consider technologies (and by extension innovation and innovation policies) on their own, it can be argued that there are not really building blocks specific for digital technologies, but generic and common to previously introduced dimensions, particularly to the generic building block **3. Innovation, research, and technology.**

However, it is also possible to consider technologies as a support to all the rest of the building blocks of the social-health-care framework. One example would be the building block of 'person-centeredness' of the framework. This have been said of technological solutions for a long time. And yet, user-centred technologies cannot be developed without considering other conditions, restrictions, objectives or aims. The technical view of person-centeredness is not going to be different from other person-centred descriptions above: prioritizing the needs and preferences of the person with I-LTC needs, ensuring solutions are delivered in a non-fragmented way and in alignment with their values. This approach will involve adapting the technological solutions to each person's capacity and preferences through tailored, understandable information provision, collaborative decision making with other stakeholders. Environmental factors need to be considered as well. Therefore, two implementations of the same technological solution (let us think mHealth app for diagnosis, follow-up, and lifestyle recommendations) will vary depending on several factors around the person receiving care.

In the below Table, we highlighted some of the building-blocks for the digital dimension in some selected frameworks. The reason these aspects were highlighted is due to the relative perceived importance not only in terms of digital solutions for LTC, but rather in terms of the importance of their interactions with other framework dimensions.

1. Person-centred Care and population approach is a central aspect of citizen's well-being, and the transition from a face-2-face care to a digitally facilitated self-care and population health management model that is being proposed in some frameworks. The tools and solutions required to make the transition are included in every dimension of LTC, and in turn require specific technological advances in education, guidance, access to information, coordination of care pathways stakeholders, etc.

2. Service delivery. The transition to a person-centred care model can also have an impact on how care and social services must be delivered to the citizens. The current face-to-face care model is characterised by scheduled visits and interactions. It can be enhanced through

virtual interactions, with remote collection of data outside the office visit, and augmented with virtual and mixed reality to aid in learning and healing. Telemedicine and digital clinics would be the next step in this transition, aiming to increase the number of virtual interactions and processes. Further efforts towards self-care would be the final goal, empowering citizens to have access and self-manage care and social services. Education, training, and platforms, and the underlying organisational structures, information exchanges and so on, are the keystones to advancing towards this paradigm.

3. Innovation, research and technology. Building blocks in relation to innovation, research and technology are the logical bricks and functionalities that are necessary to implement and put into practice the other building blocks areas identified. Thus, some of the groups of initiatives from the digital perspective must be considered as relevant building blocks for the LTC framework are:

- Electronic health records, digital health data exchange interfaces and systems, citizen platforms.
- Digital literacy, digital self-efficacy, technology towards use, actors' interactions, infrastructures, environments and stakeholders.
- Policies for the use and research of technologies, industry standards, study protocols and validation procedures.
- Remote health monitoring solutions, medication tracking applications, risk assessment algorithms and decision support algorithms, assisted living solutions.

Table 21. Frameworks and building blocks, digital technologies

Building blocks	1. WHO int. del. LTC	27. SELFIE	64. Digital Health Equity	65. Digital Care Horizon
1. Person-centred care and population approach				
1.1 Patient engagement	■	■		■
1.2 Self-management support	■	■	■	■
1.3 Patient education	■		■	■
1.4 Care coordination	■			
1.5 Shared-decision making		■		
2. Service delivery				
2.1 Facility management	■			
2.2 Long-term care settings	■			
2.3 Pathways and integrated services delivery	■			
2.4 Organisational and structural integration		■		
2.5 Service availability and access		■		
3. Innovation, research and technology				
3.1 Electronic medical records system	■	■		■
3.2 Measures for secure and safe data access and data protection	■		■	■
3.3 Online platforms and patient portals	■	■	■	■
3.4 Information transfer between services	■			■
3.5 Strategies for encouraging technological innovation adoption	■	■	■	■
3.6 Shared information systems		■	■	■
3.7 Assistive technologies		■		■
3.8 Remote monitoring		■		■
3.9 Individual risk prediction and stratification		■		
4. Workforce				
4.1 Continuous professional development	■	■		

3.2 Synthesis of findings

The rapid realist analysis conducted by the analytical team resulted in further refinement of the sixty-six frameworks identified in the literature search, with two further identified by consortium partners, to thirty-four that include building blocks relevant to the eight policy dimensions of governance, territorial, gender, stakeholders, funding, social economy, life-course and digital technologies.

Moving beyond the detailed analysis of each dimension presented above, the frameworks that have been analysed as including five or more policy dimensions are listed in the Table 22 below, seven frameworks in total. Of the most frequently identified frameworks below, five were included in the initial development of the FLINT framework in T1.2; WHO Country assessment framework for the integrated delivery of long-term care; WHO Framework for countries to achieve an integrated continuum of LTC; INTERLINKS; WHO Framework on ICPHS; and SELFIE. The full list of thirty-four frameworks identified in the analysis mapped against the policy dimensions is included in the Annexes (Table 24).

Table 22. Frameworks relevant for between four and seven policy dimensions

No	Frameworks and conceptual models/ policy dimensions	Governance	Territorial	Gender	Stakeholders	Funding	Social economy	Life-course	Digital technologies
1	WHO Country assessment framework for the integrated delivery of long-term care (WHO int. del. LTC)	■		■	■	■		■	■
2	WHO Framework for countries to achieve an integrated continuum of long-term care (WHO IC-LTC)	■	■	■	■	■	■	■	
8	A Europe-wide resource that aims to improve long-term care for older people (INTERLINKS)	■	■		■	■	■		
12	WHO Framework on integrated, people-centred health services (WHO-ICPHS)	■	■		■	■	■		
21	Scaling Integrated Care in Context (SCIROCCO)	■	■		■		■	■	
27	Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and Performance (SELFIE)	■	■		■	■	■	■	■
55	The Community Mental Health Framework for Adults and Older Adults (Socio-Eco Older)	■	■	■	■				

Stakeholders is the most commonly cited policy dimension in the frameworks reviewed (appears in twenty-one of thirty-four frameworks) with governance the next most cited (appears

in seventeen of thirty-four frameworks) and gender and digital technologies the least cited (appears in four and five respectively of thirty-four frameworks).

As part of the process of synthesizing the findings, a conceptual map has been designed to visually summarise the building blocks by policy dimensions (see Figure 3). The conceptual map is to be read clockwise, starting from governance.

The map clarifies where there are gaps in our current state of understanding and assessment of I-LTC. These are gaps which any new framework needs to specifically address. Governance appears in all the policy dimensions, highlighting the importance already granted to this building block. A lot of the focus of the current frameworks has been to providing tools to guide a proper implementation of I-LTC, offering detailed guidance on the LTC management related building blocks. Other repeated elements relate to integration of care: people centeredness (including workforce as key stakeholders), population approach, community involvement, management of the implementation to bring forward increased continuity and coordination. Governance and stakeholders appear more often in the identified LTC frameworks, while other policy dimensions appear as a cross-cutting priority (eHealth and digitally enabled integrated care) or are at times not present at all, such as gender or territorial (urban /rural). These repeated building blocks and gaps will be considered when developing Laurel actionable policy recommendations.

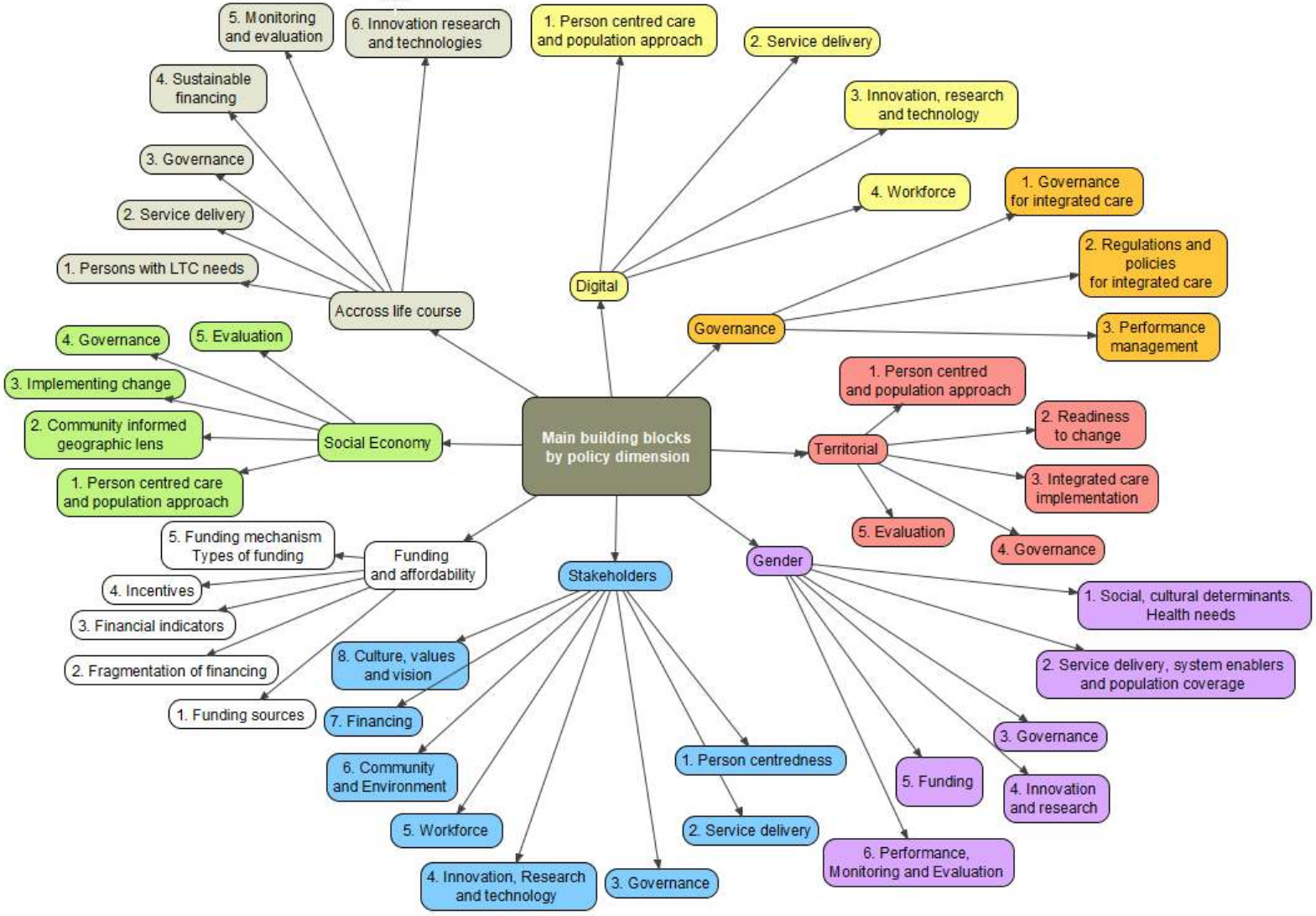

Figure 3. Laurel rapid realist review: building blocks by dimension

4 Conclusions

Laurel rapid realist review has been completed and reported in D1.1 Desktop review of literature. The CMO of the rapid realist review have been addressed from the perspective of I-LTC and integrated care frameworks and building blocks and their policy dimensions. A list of sixty-six frameworks was identified through the literature search.

This list of frameworks served as input for T1.2, which focuses on the development of a novel overarching framework for I-LTC, FLINT. This FLINT framework will be the basis for the fieldwork performed in T1.3.

In parallel, the analysis teams for T1.1 used their specialist knowledge and networks to further expand the list of frameworks with 2 additional ones and to assess the initial list of frameworks from the policy dimensions included in the Topic Call: governance, territorial, gender, stakeholders, funding and affordability, social economy, life-course and digital technologies.

The final list of relevant frameworks was reduced to 34. Each policy dimension analysis has been reported following a common structure:

- Context: Brief state of the art characterisation
- Mechanisms: Brief policy context
- Outcomes: number of frameworks after applying inclusion and exclusion criteria. Relevant building blocks identified. Table(s) by policy dimension, including frameworks and relevant building blocks.

Their building blocks reflect the importance of the governance and management of the processes of implementation, but also the relative importance of other aspects such as life-course or stakeholders. Gaps were found in the building blocks of the frameworks in the areas of gender, territorial and digital technologies that will deserve a more careful attention in the upcoming research and advisory work.

The results of this extensive analysis will be used in the development of the FLINT framework for I-LTC, use cases, case studies and will support the identification of Laurel relevant actionable policies.

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6 Annexes

Table 23. Frameworks and models identified. Initial list

No	Framework	Abbreviation	Link
1	WHO Country assessment framework for the integrated delivery of long-term care	WHO int. del. LTC	https://www.who.int/europe/publications/i/item/WHO-EURO-2019-3522-43281-60659
2	WHO Framework for countries to achieve an integrated continuum of long-term care	WHO IC-LTC	https://iris.who.int/bitstream/handle/10665/349911/9789240038844-eng.pdf?sequence=1
3	National Integrated Care Programme for Older Persons (NICPOP)	NICPOP	a-practical-guide-to-the-local-implementation-of-integrated-care-programmes-for-older-persons.pdf (hse.ie)
4	Sustain tailored integrated care for older people in Europe (SUSTAIN)	SUSTAIN	https://www.sustain-eu.org/wp-content/uploads/sites/4/2019/03/SUSTAIN-Roadmap-Summary.pdf https://www.sustain-eu.org/wp-content/uploads/sites/4/2019/03/SUSTAIN-Roadmap.pdf
5	Delivering integrated eCare (SMARTCARE)	SMARTCARE	https://pilotsmartcare.eu/topics/integrated-ecare-pathways/the-smartcare-pathways/
6	Qida	Qida	https://qida.es/sobre-qida
7	ILO Long-Term care in the context of population ageing: a rights-based approach to universal coverage	ILO LTC	https://www.ilo.org/publications/long-term-care-context-population-ageing-rights-based-approach-universal-1
8	A Europe-wide resource that aims to improve long-term care for older people (INTERLINKS)	INTERLINKS	https://interlinks.euro.centre.org/framework
9	Care by Design. New model of coordinated on-site primary and acute care in long-term care facilities.	CARE BY DESIGN	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4369619/
10	Benchmarking Integrated Care for better Management of Chronic and Age-related Conditions in Europe (INTEGRATE)	INTEGRATE	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6137610/ https://integratedcarefoundation.org/wp-content/uploads/2019/07/Hazel-Dalton-Project-Integrate-Framework-Elements.pdf

No	Framework	Abbreviation	Link
			https://integratedcarefoundation.org/wp-content/uploads/2019/07/Hazel-Dalton-Project-Integrate-Framework-Elements.pdf
11	The Nine Pillars of Integrated Care	9 PILLARS	https://integratedcarefoundation.org/nine-pillars-of-integrated-care
12	WHO Framework on integrated, people-centred health services	WHO-IPCHS	https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf
13	The Development Model for Integrated Care: a validated tool for evaluation and development	Develop IC	https://careknowledge.blob.core.windows.net/media/31266/jica-01-2016-0005.pdf
14	Rainbow Model for Integrated Care	RMIC	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5015532/
15	Logic Model for Integrated Care	LMIC	https://www.scie.org.uk/integrated-care/logic-model/
16	COMIC Model for the comprehensive evaluation of integrated care interventions	COMIC	https://journals.sagepub.com/doi/abs/10.1177/2053434516661700
17	A comprehensive Theory of Integration	Theory Int.	A Comprehensive Theory of Integration - PubMed (nih.gov)
18	Social Ecology Networks	Soc. Ecology	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6598617/
19	Community Care	Comm Care	https://ijic.org/articles/10.5334/ijic.5555
20	Scaling Integrated Care in Context (SCIROCCO)	Scirocco	https://www.sciroccoexchange.com/maturity-model
21	Patient-centred integrated care for multiple chronic conditions	Patient Chronic	https://www.semanticscholar.org/paper/Implementing-patient-centred-integrated-care-for-Fortin-Stewart/30c53a5dccd505f3f84bbdeb7d2a8587701c7d74
22	Chronic Disease Implementation and Management (CDPM)	CDPM	https://www.semanticscholar.org/paper/Implementing-patient-centred-integrated-care-for-Fortin-Stewart/30c53a5dccd505f3f84bbdeb7d2a8587701c7d74
23	EU Joint Action on Chronic Diseases and promoting healthy ageing across the life cycle (JA-CHRODIS)	JA-CHRODIS	http://chrodis.eu/outcomes-results/
24	Integrated Care for Chronic Conditions (ICCC)	ICCC	Integrated care for chronic conditions: the contribution of the ICCC Framework - PubMed (nih.gov)
25	Complex Case and Recovery Management Framework (The CCaRM)	CCaRM	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9838237/

No	Framework	Abbreviation	Link
26	Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and Performance (SELFIE)	SELFIE	https://www.selfie2020.eu/wp-content/uploads/2017/11/Eurohealth_SELFIE-article_final.pdf
27	Innovating care for people with multiple chronic conditions in Europe (ICARE4EU)	ICARE4EU	https://www.ncbi.nlm.nih.gov/books/NBK464548/
28	Person-Centred Integrated Care Programme for People with Complex Chronic Conditions (ProPCC)	ProPCC	https://pubmed.ncbi.nlm.nih.gov/38107836/
29	Diversity Conceptual Model for aged care	Conceptual Aged	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5108464/
30	Integrated Care for Frail Elderly	IC Frail Elder	https://www.semanticscholar.org/paper/Integrated-Care-for-Frail-Elderly%3A-A-Qualitative-of-Hoedemakers-Leijten/aa393ae0957cc25a4b7d15a9c36c979ef4dd340b/figure/0
31	DANP-V Model	DANP-V	https://www.mdpi.com/2071-1050/9/3/420
32	Model of compassionate, person-centred care	Compassionate	https://onlinelibrary.wiley.com/doi/abs/10.1111/jocn.13142
33	Model for continuous care	Continuous Care	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5177449/pdf/nihms817403.pdf
34	WHO Integrated Care for Older People (ICOPE)	ICOPE	Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care (who.int). https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1
35	Care coordination for children with complex care needs	CC_Children	https://ijic.org/articles/10.5334/ijic.2250
36	Everyday Life Rehabilitation Model for persons with long-term and complex mental health needs	Rehab_Mental	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9424656/pdf/fpsyt-13-954068.pdf
37	TakingAIM: A precision health framework for promoting person-centered advance care planning	TakingAIM	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6778495/
38	Established Dementia Care Model	DementiaCM	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6371121/#B11-geriatrics-02-00001
39	Informal carers' support needs, facilitators and barriers in the transitional care of older adults:	Transitional Care	https://onlinelibrary.wiley.com/doi/full/10.1111/hex.13596

No	Framework	Abbreviation	Link
40	Theoretical Foundations guiding culture change	Culture Change	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4674759/
41	Proactive and Integrated Management and Empowerment in Parkinson's Disease New Model of Care	Parkinson's	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7149455/
42	Multifaceted shared care intervention for late life depression in residential care: randomised controlled trial	Multifaceted	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC28220/
43	Key Components of Effective Paediatric Integrated Mental Health Care Models	Paediatric Mental	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7483725/
44	Collaborative Care Model to Palliative Care	Collaborative Care	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9062981/
45	Community-Based Diabetes Prevention Program	Comm Diabetes	https://www.frontiersin.org/journals/endocrinology/articles/10.3389/fendo.2022.816385/full
46	Caregiver engagement in Stroke Care	Carer Stroke	https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2021.758808/full
47	Program Theory for Family-Focused Practice in Adult Mental Health Care Settings	Programme Theory	https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2021.741225/full
48	Dutch government funded support programme	Vilans	https://www.vilans.org/wp-content/uploads/2023/11/Vermunt-et-al-BMC-HSR-2023.pdf
49	Biopsychosocial-Ecological Framework for Family-Framed Dementia Care	Bio_Eco	https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2021.744806/full
50	Investigating what works to support family carers of people with dementia: a rapid realist review	Family_Dementia	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5939885/
51	Model Homes. Patient-centered Medical Home Implementation	Model Homes	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7993910/
52	The 6S-model for person-centred palliative care theoretical framework	6S-Model	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8243997/
53	Alberta Healthy Living Program	Healthy living	https://www.canadianjournalofdiabetes.com/article/S1499-2671(13)00662-X/abstract

No	Framework	Abbreviation	Link
54	The Community Mental Health Framework for Adults and Older Adults	Comm MentalH	https://www.rcpsych.ac.uk/improving-care/nccmh/service-design-and-development/community-framework
55	Socio-ecological determinants of older people's mental health and well-being during COVID-19: A qualitative analysis within the Irish context	Socio-Eco Older	https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1148758/full
56	Facilitators and barriers to participation in mental well-being programs by older Australians with vision impairment: community and stakeholder perspectives	Mental wellbeing	https://www.nature.com/articles/s41433-020-0992-z
57	Integrated Care Models for Older Adults with Depression and Physical Comorbidity: A Scoping Review	IC older adults	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10786096/
58	The Epital Care Model: A New Person-Centered Model of Technology-Enabled Integrated Care for People with Long-term Conditions	Epital	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5282450/
59	Health@Home	Health@Home	https://www.tandfonline.com/doi/full/10.1080/17538157.2021.1895167
60	Partnership in iSupport program	iSupport	https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-08148-2
61	A Collaborative Framework with Artificial Intelligence for Long-Term Care	AI LTC	https://ieeexplore.ieee.org/document/9018259
62	Connected Care Model	Connected Care	https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2022.1095001/full
63	A framework for digital health equity	Digital Health Equity	https://www.nature.com/articles/s41746-022-00663-0
64	Digital Transformation in Healthcare: Value Creation	ValueCreation	https://www.researchgate.net/publication/360366323_Digital_Transformation_in_Healthcare_Insights_on_Value_Creation/figures?lo=1
65	Digital Care Horizon	Digital Care Horizon	https://www.sciencedirect.com/science/article/pii/S2949761223000378
66	eHealth Enhanced Chronic Care Model	eHealth CCM	https://pubmed.ncbi.nlm.nih.gov/25842005/

Table 24. Selected frameworks policy dimensions

No	Frameworks policy dimensions	Governance	Territorial	Gender	Stakeholders	Funding and affordability	Social economy	Life-course	Digital	N total
1	WHO Country assessment framework for the integrated delivery of long-term care	■		■	■	■		■	■	6
2	WHO Framework for countries to achieve an integrated continuum of long-term care	■	■	■	■	■	■	■		7
3	National Integrated Care Programme for Older Persons (NICPOP)		■		■		■			3
4	Sustain tailored integrated care for older people in Europe (SUSTAIN)	■								1
7	ILO Long-Term care in the context of population ageing: a rights-based approach to universal coverage	■		■			■			3
8	A Europe-wide resource that aims to improve long-term care for older people (INTERLINKS)	■	■		■	■	■			5
10	Benchmarking Integrated Care for better Management of Chronic and Age-related Conditions in Europe (INTEGRATE)	■			■			■		3
11	The Nine Pillars of Integrated Care	■			■	■	■			4
12	WHO Framework on integrated, people-centred health services (ICPHS)	■	■		■	■	■			5
13	The Development Model for Integrated Care: a validated tool for evaluation and development					■		■		2
14	Rainbow Model for Integrated Care				■					1
15	Logic Model for Integrated Care	■			■			■		3
16	COMIC Model for the comprehensive evaluation of integrated care interventions							■		1
19	Community Care				■					1
20	Scaling Integrated Care in Context (SCIROCCO)	■	■		■		■	■		5
21	Patient-centred integrated care for multiple chronic conditions	■								1
23	EU Joint Action on Chronic Diseases and promoting healthy ageing across the life cycle (JA-CHRODIS)							■		1

No	Frameworks policy dimensions	Governance	Territorial	Gender	Stakeholders	Funding and affordability	Social economy	Life-course	Digital	N total
24	Integrated Care for Chronic Conditions (ICCC)							■		1
26	Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and Performance (SELFIE)	■	■		■	■	■	■	■	7
27	Innovating care for people with multiple chronic conditions in Europe (ICARE4EU)				■			■		2
30	Integrated Care for Frail Elderly	■			■					2
34	WHO Integrated Care for Older People (ICOPE)				■					1
35	Care coordination for children with complex care needs				■					1
38	Established Dementia Care Model				■					1
39	Informal carers' support needs, facilitators and barriers in the transitional care of older adults:				■					1
40	Theoretical Foundations guiding culture change	■								1
41	Proactive and Integrated Management and Empowerment in Parkinson's Disease New Model of Care				■					1
48	Dutch government funded support programme	■								1
54	The Community Mental Health Framework for Adults and Older Adults	■	■	■	■					4
57	Integrated Care Models for Older Adults with Depression and Physical Comorbidity: A Scoping Review	■								1
63	A framework for digital health equity			■					■	2
64	Digital Transformation in Healthcare: Value Creation								■	1
67	CMS Framework for Advancing Health Care in Rural, Tribal, and geographically isolated		■							1
68	Biscay LTC empowerment model				■					1
Nº	**34 I-LTC frameworks relevant for policy dimensions**	**17**	**8**	**5**	**21**	**7**	**8**	**11**	**4**	