REVIEW AND DISCUSSION PAPERS

The origin, evolution and definition of comprehensive care: A discussion paper

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ABSTRACT

Objective: To synthesise the origin, evolution, and definition of comprehensive care.

Background: Understanding comprehensive care is of great importance for rapidly evolving modern healthcare systems to adapt to a more holistic approach to care delivery. However, its concept remains poorly defined and inconsistently applied.

Study design and methods: We searched literature via PubMed, Scopus, and CINAHL as well as Google Scholar, supplemented by our prior review and empirical research. Findings were synthesised narratively to support a critical discussion of the origin, evolution, and definition of comprehensive care.

Results: Comprehensive care emerged in the 1950s-1960s. Its concept has evolved significantly since its inception. Different interpretations and applications emerged as this term became more widely referenced. We identified three defining characteristics of comprehensive care (person-centredness, multidisciplinary collaboration, and care coordination), and proposed an operational definition grounded in these principles.

Conclusion: This paper proposes an operational definition of comprehensive care to support consistent understanding and practice. Aligning policy with comprehensive care principles is essential for translating the concept into practice.

Implications for research, policy, and practice: This paper contributes to the theoretical development of comprehensive care by clarifying its fundamental characteristics, which can support a more consistent understanding that can inform future standards, research, and implementation efforts.

What is already known about the topic?

- The traditional disease-specific approach to care delivery cannot meet the complex needs of patients.
- Comprehensive care is increasingly recognised not only for its potential to improve care quality but also for its cost-effectiveness.
- The concept of comprehensive care remains poorly defined and inconsistently applied.

What this paper adds:

- Comprehensive care emerged in the 1950s-1960s, and different interpretations and applications emerged as this term became popular.
- This paper clarified the conceptual foundations of comprehensive care and proposed an operational definition to guide implementation and policy development.
- To embed comprehensive care meaningfully into health systems, greater alignment is needed between definitions, workforce roles, and regulatory frameworks.

Keywords: comprehensive health care; patient-centred care; coordinated care; history

OBJECTIVE

Modern healthcare recognises that patients are an entity that have not only medical needs but also social and psychological needs. Gaps in patient safety and quality are often recognised as failures to address these needs holistically. The concept of comprehensive care was introduced to promote care that considers the full spectrum of patient needs.

However, its concept remains poorly defined and inconsistently applied in the literature. The objective of this paper was to synthesise the origin, evolution, and definition of comprehensive care, and to develop a clearer, more operational understanding to inform future implementation, research, and policy.

BACKGROUND

The traditional disease-specific approach to care delivery is often unable to meet the complex and multidimensional needs of patients. When care is fragmented across several care providers, it often results in inefficiencies, poor clinical outcomes, and unsatisfactory care expriences.[1,2] To address these challenges, the concept of **comprehensive care** has received growing attention in policy and practice.[3] In 2017, the Australian Commission on Safety and Quality in Health Care (ACSQHC) released and mandated the Comprehensive Care Standard to ensure patients receive comprehensive care that meets their needs and preferences.[4]

Comprehensive care is increasingly recognised not only for its potential to improve care quality but also for its cost-effectiveness for both care providers and patients.[3,5,6] A rapid review identifying 16 articles on the effectiveness of comprehensive care found that comprehensive care can improve health service delivery and positively impact both patient-centred care and clinical outcomes in acute care settings, including increased patient satisfaction, reduced length of stay, lower cost of care, few readmissions, and improved shared decision making and goals setting.[3]

However, the concept of comprehensive care is poorly defined and inconsistently applied in the literature. There is no universally accepted definition of comprehensive care, and its definition varies widely.[7,8] Many existing definitions are either outdated, failing to consider changes in its scope, or too obscure to provide clinical guidance to care providers. For example, the term "comprehensive care" is often used to refer to complete care from a multidisciplinary team,[9] which lacks explicit emphasis on patient-centeredness. Additionally, the term is often used interchangeably with other concepts, such as multidisciplinary care, holistic care, and integrated care, further complicating its understanding and application.

This lack of definitional clarity remains a barrier to the effective implementation of comprehensive care.[10] Without a clear understanding of its key characteristics, healthcare providers and systems may struggle to apply the concept meaningfully or evaluate its outcomes. There is, therefore, a pressing need to examine how comprehensive care has been historically conceptualised, how its scope has evolved across different settings, and how it should be defined and understood in future policy and practice.

In this paper, we aimed to explore the **origins, evolution**, and **definitions** of comprehensive care. It contributes to the theoretical development of comprehensive care by clarifying its fundamental characteristics, which can support a more consistent understanding that can inform future standards, research, and implementation efforts.

The Research Questions are

- When was comprehensive care developed (origin)?
- How has comprehensive care evolved?
- What is the definition of comprehensive care?

To inform discussion, we searched literature in PubMed, Scopus, CINAHL, and Google Scholar on 10th January 2024 (See Supplementary Files 1 and 2), reviewed reference lists of the included papers, and applied pre-specified inclusion and exclusion criteria. Data extraction was conducted using a structured charting method. In addition to the literature identified through this search, our discussion draws on findings from our previous research on the implementation and impacts of the Comprehensive Care Standard.[6,10-16] This paper does not aim to comprehensively map the literature, but rather to synthesise and discuss the historical development, evolutions, and conceptual foundations of comprehensive care.

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THE ORIGINS OF COMPREHENSIVE CARE

The term "comprehensive care" began to appear in the early 1950s, during a period of immense growth and change in medicine, with increasing interest in the social and psychological aspects of medicine.[17] It was recognised that existing models of care often treated physiological pathology while neglecting patients' psychological, social, and economic situations.[18] This aligned with the classic purpose of medicine, which is "to help sick people find their way back to the integrity of body, mind, and spirit".[19(p1177)] Fragmentation in care delivery became a growing concern, driving the adoption of a more holistic approach.

Medical professionals stressed the importance of caring for patients as individuals rather than as demonstrations of disease entities or examples of anatomical abnormalities.[20,21] Comprehensive care emerged as a response to this need, guided by the conviction that improved care can be achieved by integrating and applying existing knowledge and skills from psychiatric, behavioural, and social sciences into medical practices.[22] Central to this shift in thinking was the recognition that the patient should not be defined by the specific illness they have, but as a person experiencing illness in a broader context.[22]

Early literature on comprehensive care included a range of interpretations.[23] For example, some authors referred to the "person behind the disease" and "the whole person" as central ideas, thought these phrases were often seen as too imprecise to guide clinical practice.[22] To emphasise that it addressed the social and psychological aspects, comprehensive care was defined as "an integrated, aggressive approach to the physical, emotional and social health problems of people".[24(p371)] While this definition acknowledged broader dimensions of care, it remained simplistic and lacked detail on how such care should be delivered or by whom.

Others worked to define the concept more clearly. Over time, comprehensive care came to be described as an "intelligent and disciplined appreciation of the patient as a person whose pathology may be somatic, psychic, environmental, or any combination thereof, including consideration and treatment of the patient's structural and physiological pathology together with and in the context of his psychological, social and economic adjustment".[18(p353)] This definition introduced more nuance and attempted to capture the complexity of real-world care, but its language was abstract and remained grounded in physician-led models of care.

From the perspective of care professionals, comprehensive care was also framed in terms of attributes and competencies: "scientific knowledge, intellectual curiosity, conscientious attention to detail, and constant stimulation of research" combined with "an awareness of the psychological and social factors affecting the patient's total health", "the value of preventive techniques," and "the ability and willingness to bring to bear on the patient's problem . . . whatever specialised knowledge and advice".[25(p198)] This perspective highlighted the breadth of knowledge and attitude expected of professionals, but again did not define the structural components of care delivery.

In paediatrics, comprehensive care was defined as "the systematic inclusion and addition of psychosocial dynamics and personality development to the practice of paediatrics, within a family and community context".[23(p1099)] While this was one of the earliest recognitions of family-centred care, this definition was specific to one discipline and setting, limiting its generalisability.

In summary, these early definitions established a foundation for comprehensive care but revealed several limitations. They were either too simplistic or too abstract and rarely addressed how comprehensive care should be operationalised in clinical practice. The most significant feature of comprehensive care, as consistently highlighted even in its early formulations, is that it is patient-oriented as opposed to disease-oriented.[22]

THE EVOLUTION OF COMPREHENSIVE CARE OVER TIME

Following its emergence in the 1950s, comprehensive care gradually expanded in scope. What began as a call to consider the patient as a whole person, addressing not only physical illness but also psychological and social needs, evolved into broader models that integrated team-based approaches, service coordination, continuity of care, and patient-centeredness.[26,27]

In the early decades, the focus of comprehensive care remained on individualised, patient-oriented approach.[22] By the 1960s, the concept began to incorporate multidisciplinary collaboration. A multidisciplinary team (MDT), consisting of associate professionals such as nurses, therapists, social workers, and counsellors,[19] were recognised as essential for delivering comprehensive care. This reflected the growing understanding that no single professional could meet the full range of patient needs. As Worthingham (1957) noted, securing and coordinating the services of associate professionals was a challenge for many physicians,[21] underscoring the importance of structured coordination in comprehensive care.

In the 1970s, the scope of comprehensive care also shifted geographically and institutionally, from hospital care to primary care in the community, with an emphasis on the integration of various services.[28,29] The role of case coordinator or advocate emerged, previously undertaken by physicians. This role needed to have knowledge of available resources, medical understanding, and counselling skills and to act as a coordinator of the team of professionals who worked together to develop a comprehensive care plan for the patient.[28]

Falk (1972) further advanced the idea by introducing the principle of continuity of care, defining it as "the organised provision of health services to the entire family, including a full spectrum of services from prevention through rehabilitation, continuity of care for the individual, emphasis upon the social and personal aspects of disease and its management, use of the health team concept with personal physician responsibility, and coordination of the diverse elements of modern scientific medical practice".[30(p472)] While Falk's definition broadened the scope of care and acknowledged team-based delivery, the emphasis on personal physician responsibility reflects a hierarchical model that may limit true interdisciplinary collaboration.

Formicola (2008) noted that the comprehensive care movement contributed to the development of patient-centred clinics focused on efficient, quality patient care.[31] Later interpretations increasingly emphasised patient-centredness. Family-centred and person-centred care became closely associated with the comprehensive care model in fields such as paediatrics and primary care,[32] reflecting a growing emphasis on shared decision-making and responsiveness to patient preferences.

In recent decades, comprehensive care often relates both to the scope of services offered and to a whole-person clinical approach.[33] Therefore, it may be defined in terms of either the breadth or depth of services offered, with generalist physicians capable of addressing most of their patients' healthcare needs.[34]

Overall, the scope of comprehensive care has broadened significantly over time. While this evolution reflects the growing intent of the concept, it has also introduced complexity. Clarifying what comprehensive care fundamentally involves, beyond its practical adaptations, remains essential for its consistent application and evaluation.

NOT COMPREHENSIVE CARE – THE TERM IS USED LOOSELY

As the term "comprehensive care" became more widely referenced, different interpretations and applications emerged.[35] Many publications included the term in their titles, but without defining it in the main text.[9,36] In some studies, comprehensive care refers simply to a multidisciplinary approach to care.[9,37] In others, it refers to "better care" with extra care (e.g. patient education, psychological comfort) added to routine care, without any multidisciplinary involvement.[38] Some researchers used the term to refer to "comprehensiveness of care", focusing on the breadth or depth of services offered.[39] Other studies focused on the coordination of care or continuity of care across services and time.[27,40] The US Institute of Medicine, for example, associated comprehensive care with the management of "any health problem at any given stage of a patient's life cycle".[35(p522)] In other cases, this term has been applied to specific patient groups, such as those with all but very uncommon or unusual conditions or multiple chronic conditions.[35-37]

In recent decades, the definition of comprehensive care has also varied considerably across disease contexts, further highlighting its conceptual ambiguity. For instance, in multiple sclerosis, comprehensive care typically involves a neurologist supported by at least two types of extra-neurologic services, such as physical therapy, occupational therapy, speech therapy, and psychological services.[41] In haemophilia, the concept emerged in the 1960s and has since been defined as the continuous supervision of all medical and psychosocial factors affecting the patient and their family.[42-45] For Dravet syndrome (genetic paediatric epilepsy), comprehensive care includes a multidisciplinary, physician-guided approach centred on the patient and caregivers through diagnosis, treatments, and ongoing management.[46] These examples illustrate how the meaning and scope of comprehensive care were shaped by clinical contexts, but also underscore the lack of a unified definition applicable across conditions.

Comprehensive care also has different interpretations in different countries. In Canada, family physicians defined comprehensive care as "the type of care family physicians provide (either on their own or with a team) to a defined population of patients across the life cycle in multiple clinical settings, addressing a spectrum of clinical issues".[35(p522)] In China, it is most often understood as a patient-centred nursing mode.[47-50] For example, Pan (2021) defined comprehensive care as a nursing method organised based on the framework of nursing procedure, delivered by a group of nursing staff who contribute together in working for a group of patients.[47] In Australia, ACSQHC defined comprehensive care as "the coordinated delivery of total health care required or requested by a patient".[4(p44)]

These variations, across both clinical contexts and national health systems, reflect the conceptual ambiguity surrounding comprehensive care and reinforce the need for definitional clarity. Without a clear and consistent definition, the term is used loosely in the literature, making it difficult to compare studies, implement interventions, or evaluate outcomes consistently across settings and populations.

DEFINING COMPREHENSIVE CARE

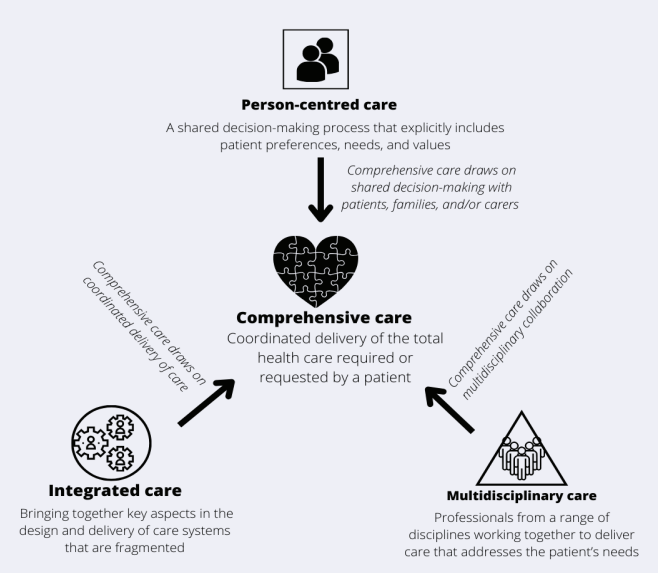
Although there is no consistent definition of comprehensive care, we propose that the concept generally consists of three key characteristics. First, patients must be involved in decision-making and care planning, and care must be guided by the needs of patients along with their families and/or carers.[4,18,51] This characteristic reflects the principle that comprehensive care addresses all aspects of a patient's needs rather than solely medical issues. Second, it requires

professionals from multiple disciplines to work together to deliver care that addresses the patient's needs and preferences.[18,19,52] This highlights the recognition that no single professional is equipped to meet the full spectrum of patient needs. Third, a coordinated and proactive approach to health and social care needs is necessary to address the fragmentation of care.[20,51] This reflects the need for continuity across settings and providers, ensuring that care remains connected and responsive throughout the patient journey. Together, these elements form a foundation for the operationalisation of comprehensive care in practice.

Building upon the three key characteristics and ACSQHC's definition, we suggest that the operational definition of comprehensive care is "the coordinated delivery of the total health care required or requested by a patient through multidisciplinary collaboration after shared decision-making with the patient, family and/or carers". This definition emphasises the fundamental philosophy of patient-centred comprehensive care by explicitly incorporating shared decision-making, coordination, and interdisciplinary input.

Many different terms are being applied to refer to the concept of "comprehensive care", including "holistic care", "person-centred care", "integrated care", "integrated comprehensive care", "coordinated care", "multidisciplinary care", and "primary care" or "family medicine".[51,53,54] While these terms overlap with comprehensive care, they each emphasise different elements. For example, "Integrated care" or "coordinated care" focuses on bringing together fragmented services, particularly at the systems level".[55,56] "Person-centred care" (or "patient-centred care") focuses on a shared decision-making process that explicitly includes patient needs, preferences, and values in goal setting and development.[57,58] "Holistic care" emphasises addressing physical, mental, emotional, spiritual, social and economic aspects of the patient but often neglects the role of patient in their care.[53] "Multidisciplinary care" focuses on multidisciplinary collobration,[59] while "primary care" uses a generalist approach that considers common conditions in community settings exclusively.[60]

We developed a concept map[12] to illustrate the concept of comprehensive care and its relationship with commonly used terms – person-centred care, multidisciplinary care, and integrated care (Figure 1).



Adapted from Xiong B, Stirling C, Martin-Khan M. *The implementation and impacts of national standards for comprehensive care in acute care hospitals: An integrative review. International Journal of Nursing Sciences.* 2023;10:425–34.

FIGURE 1. COMPREHENSIVE CARE CONCEPT MAP

THE IMPLEMENTATION OF COMPREHENSIVE CARE IN PRACTICE

Over the past several decades, various attempts have been made to implement comprehensive care in both education and practice. Early efforts to operationalise the concept through medical education provide insights into the challenges of translating philosophy into practice. In the 1950s and 1960s, comprehensive care was introduced into medical education through programs such as the University of Colorado experiment and the Cornell Comprehensive Care and Teaching Program.[20,25,29,61-63] These initiatives aimed to familiarise students with the whole-person approach in care in the outpatient settings, but their long-term impact was limited. Reader (1976) found while most medical educators expressed a strong desire to teach and practice comprehensive care, they often viewed their programs as inadequate.[29] The effectiveness of these programs depended heavily on factors such as the setting, including the presence of a multidisciplinary team and a compassionate, friendly environment and appropriate patient selection for teaching. A hectic environment and heavy workloads were seen as barriers to fostering the desired attitudes and teamwork.

Efforts to implement comprehensive care in clinical settings have also faced significant challenges. In the 1960s-1970s, a series of hospital-based projects were initiated, attempting to apply comprehensive care to larger patient groups.[61] However, many were eventually terminated due to a lack of financial and faculty support, infrastructure limitations, and staff shortage.[29,61] Goodrich et al. (1972) highlighted limitations in hospital settings for implementing comprehensive care and recommended a community-based approach with coordination provided by community agencies such as the health department.[61]

Since the 1970s, the comprehensive care model has shifted toward the community, changing the perspective from hospitals 'reaching out' to the patients, to communities 'reaching in' to hospitals for specialised services.[61(p. 367)] This shift responded to both the limitations of hospital-focused implementation and the growing emphasis on community-based care and integrated service delivery across settings.

As a result, comprehensive care became increasingly associated with the principles of primary care, particularly in relation to continuity of care and the integration of services. Falk (1972) noted, "primary care is the cornerstone of comprehensive care upon which all other components can readily be built".[30(p.473)] While some consider comprehensive care synonymous with family medicine or general practice, the two are not interchangeable. Unlike comprehensive care, which encompasses a broad spectrum of care, family medicine typically emphasises common illnesses within its scope of practice.[60]

Comprehensive care has since been implemented in various healthcare settings, with a primary focus on acute care settings. It has taken various forms, such as comprehensive care clinics or departments within hospitals, standalone comprehensive care centres, or even national standards embedded in health policy.[64] In some systems, comprehensive care has been formalised through national frameworks, for example, the Australian Comprehensive Care Standard,[4] which mandates comprehensive care across hospitals, day procedure services, and public dental services and actively promote its adoption in other care settings.[12]

Despite policy mandates and national guidelines, implementing comprehensive care remains challenging. Common barriers include staff shortages, high turnover, heavy workloads, and limited training. Organisational and clinical challenges such as poorly integrated documentation systems, excessive paperwork, lack of standardised care plans, nursing dependency, and weak multidisciplinary collaboration also impede adoption.[10,65] Difficulties in governance processes further complicate implementation.[66,67] Key facilitators include strong leadership, integrated electronic documentation tools such as care plan templates, access to training, a culture of patient-centredness, and active engagement from both staff and patients in planning and delivery.[10]

DISCUSSION

This review provided an overview of the origin, evolution, and definition of comprehensive care. Historically, comprehensive care emerged as a response to fragmented, disease-focused models by promoting a patient-oriented approach that considers patients' social and psychological aspects. Over time, the scope of comprehensive care has evolved to incorporate multidisciplinary teamwork, integration of services, care coordination, continuity of care, and person-centredness. Building on this historical perspective, we proposed an operational definition that captures the key characteristics of comprehensive care and offers a clearer and more actionable basis for implementation.

A clearer understanding of the key characteristics of comprehensive care is essential for improving implementation. Person-centredness emphasises responsiveness to patients' needs and preferences in shared decision-making processes across all aspects of care.[31,68] Multidisciplinary collaboration enables the integration of diverse professional perspectives to address the complex and long-term needs of patients. Care coordination, the third key element, ensures continuity and integration across services and providers.[30,69] Comprehensive care plans are a practical tool that can support all three elements by guiding care planning, clarifying roles, facilitating care delivery, and enabling regular review.[70-72] However, the effective use of care plans is often hindered by governance issues, time constraints, limited accessibility, limited ownership and participation among care team members, and logistical barriers.[73,74,75] The need for dynamic, electronic care plans that are easily accessible to all providers is frequently highlighted, alongside the importance of actively involving patients and families in developing and updating the plans.[72,75,76]

SCOPE OF PRACTICE AND REGULATORY ENVIRONMENT

The evolution of comprehensive care from hospitals to communities reflects a shift toward decentralised and accessible healthcare services. While this shift aligns with modern health policy priorities, translating it into practice remains difficult. Real-world implementation remains constrained not only by workforce and financial pressure, but also by the scope of practice regulations that define what health professionals are permitted to do. For instance, nurses, allied health professionals, and other team members may be restricted from initiating care plans or leading coordination efforts (e.g. make referrals) due to licensure or institutional policies, which can restrict the flexibility needed for collaborative, team-based care. Regulatory frameworks often reinforce physician-led models, making it difficult to achieve shared leadership or fully collaborative care.[29,61] Addressing these challenges requires supportive policy frameworks and sustainable funding models that allow all professionals to contribute meaningfully to comprehensive care.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

Standardising definitions and guidelines for comprehensive care in clinical practice can reduce confusion and promote consistent implementation. Early educational programs and clinical practice offered valuable insights but were often not sustained or systematised. To support the implementation of comprehensive care, policy and practice must shift from broad conceptual endorsement to system-wide operational support. This includes clarifying definitions and expectations for comprehensive care, promoting continuous professional development, supporting interdisciplinary collaboration,

and leveraging technology to develop dynamic, accessible care plans that facilitate team coordination. Engaging patients, families, and carers as active participants in care planning is crucial for enhancing the relevance and effectiveness of comprehensive care, thereby improving patient and provider experiences.

Future research could refine and validate the operational definition and examine the application of comprehensive care across various healthcare settings such as acute care, home care and nursing homes. Studies are also needed to identify barriers and facilitators to implementing comprehensive care, assess its impacts on patient outcomes, and evaluate effects on healthcare staff performance and costs. Longitudinal research could provide insights into the evolution of comprehensive care initiatives and their sustained impacts on care quality. Additionally, exploring the influence of regulatory factors and policies will help inform both practice improvements and policy development, ensuring that comprehensive care becomes a standard component of clinical practice.

LIMITATIONS

This study has some limitations. Due to the lack of a clear definition and standardised terminology for comprehensive care in the existing literature, some relevant publications may have been missed. Furthermore, the studies included in this review were mostly narrative reviews. While narrative reviews provide valuable insights, they are inherently subjective and may lack the rigorous methodology of systematic reviews or meta-analyses. This reliance on narrative reviews may have impacted the comprehensiveness and objectivity of our findings. Another limitation of this review is the reliance on older references, as much of the foundational literature on comprehensive care was established in earlier decades, and recent publications often use the term without providing clear definitions, limiting their inclusion in this analysis.

Despite these limitations, this paper offers a structured synthesis of the conceptual fundamentals of comprehensive care, with a level of rigour that includes at least two researchers involved in each step of the data screening and extraction process. This approach enhances the reliability and validity of our findings, providing a foundation for future research and practice in comprehensive care.

CONCLUSION

This review examined the origins, evolution, and definitions of comprehensive care. By synthesising historical perspectives and contemporary usage, we proposed a clearer operational definition grounded in person-centredness, multidisciplinary collaboration, and care coordination. While comprehensive care is widely endorsed, its definition and implementation remain inconsistent. To embed comprehensive care meaningfully into health systems, greater alignment is needed between definitions, workforce roles, and regulatory frameworks. Future research should focus on evaluating implementation strategies, barriers and facilitators, and impacts across diverse care settings. Understanding how comprehensive care functions in real-world hospital, community, and primary care contexts will be essential to building sustainable, patient-oriented models that translate policy into practice.

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