



# Integrating Health- and Social Care Systems

# 6

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## 6.1 Introduction

It has long been recognised that social issues have a strong bearing on people's health and well-being. Whilst medical treatments are essential to address underlying infections and physical malfunctioning, these are insufficient by themselves to maintain and promote the health of a population. Wider social contexts such as poverty, housing, hygiene, employment and education play a fundamental role in the incidence of disease. These must be considered and connected issues addressed to achieve better health for all. Vaccines can provide important immunity that will help to eradicate a disease, but it is only by societal coordination and development of associated social norms that vaccines are successfully introduced. Health interventions may be able to prolong the life of people with a long-term health condition, but social issues enable life to be of better quality—i.e. a life worth living and acute care can only successfully operate if people are supported post-crisis to return or access support in the community. In relation to mental health, social networks and access to employment are often the most influential in achieving better well-being.

Given that health and social care should be at the heart of all integrated care it could therefore be questioned as to why there is a need for a separate chapter on this topic within this compendium. And yet practitioners of integrated care are well aware that we are far from achieving integration of health and social care in either

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policy or practice. Integrated care is often still interpreted as being about integrating primary and secondary medical services, and attempts remain disconnected from the social system upon which people rely for the essentials of living. This narrow view of integrated care should be challenged and the principles of integrated care systems extended across sectors in partnership with communities and their citizens. Integration of health and social care has been difficult to achieve using structural and organisational approaches given the significantly different funding streams, regulatory frameworks and professional and organisational cultures. Given the demonstrated importance of the social determinants of health, it is only by putting the social needs of individuals, and their families, at the centre, can we achieve the integration we strive for.

In taking a person-centred approach to the provision of care and support, it is necessary to keep ‘all matters in scope’ including biological, psychological, physical and social environments and life-course. In this chapter, we will consider integration of health and social care in relation to the direct delivery of support to individuals and their families (i.e. clinical and service integration) and integration of health and social care in relation to addressing the social determinants of health (i.e. population and system integration). We will then focus on the importance of workforce and what practically can be done to enable health- and social care professionals to collaborate better. We will begin though by considering what is meant by social care.

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## 6.2 What Do We Mean by Social Care?

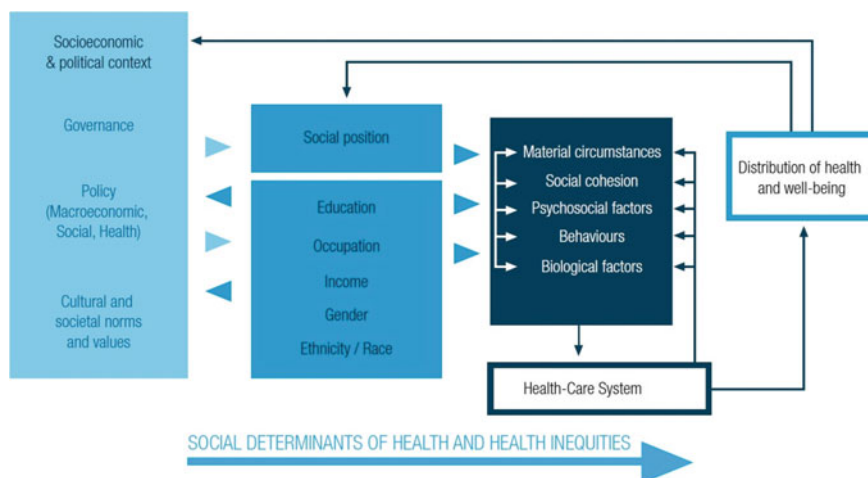
Whilst the individual concepts of ‘social’ and ‘care’ are ones that transcend boundaries, the term ‘social care’ is not widely used or consistently understood internationally. In relation to the delivery of services, in the UK (which has been influential in relation to integrated care developments), social care refers to a range of direct support to people who are vulnerable and/or have lost independence due to age, disability, mental health or other issue. Classically, this involves support such as tending to personal care (i.e. washing, toileting and dressing), maintaining a household (i.e. cleaning and shopping), supervision (through staff and/or electronic devices) and support for informal carers (i.e. home- or residential-based respite). The support can be provided in the person’s own home or in designated facilities such as residential care or supported housing. In many other countries, such services are not separately denoted as ‘social care’, but rather included within the concept of ‘long-term care’. The OECD (2019) defines this as a ‘range of medical, personal care and assistance services that are provided with the primary goal of alleviating pain and reducing or managing the deterioration in health status for people with a degree of long-term dependency’ (OECD 2019, p. 1). Long-term care therefore includes community-based health services as well as the UK-defined social care. Other terms are also deployed—in Australia—for example, ‘aged care’ denotes long-term care for older people. Alongside long-term care, another commonly used terms are ‘social

services' or 'human services'—this incorporates the support outlined above but also wider services to promote someone's well-being, such as those related to employment, education, leisure and financial support. These sectors also often have responsibilities in relation to safeguarding people who are vulnerable from exploitation and/or abuse.

However one denotes such provision (and we shall refer to them as 'direct social care services'), an important context is that much of the non-health components of long-term care are provided by families and other informal networks, rather than by formal agencies. Furthermore, such care is largely provided by women. This can restrict women's ability to access paid work and progress careers of choice. Informal care giving is also related to higher poverty rates and prevalence of mental health problems. Formal direct social care services are commonly provided by a mixed economy of public, private and charitable organisations and public funding routes include social insurance, taxation and/or user charges. Whatever the funding model, there are common concerns regarding the capacity of formal provision to cope with increasing demand, ensure the quality of care due to tensions between funding and pressures and manage the economic impacts of populations living longer and with multiple conditions (Spasova et al. 2018). In response to the latter, one common strategy being pursued by many countries is to reduce reliance on institutional care through strengthening home-based care.

Many countries experience challenges relating to the recruiting of a skilled workforce due to restricted pay, unsociable hours and low status of such roles. Such concerns are not limited to advanced market economies. For example, the (WHO 2017) has estimated that in Ghana, more than 50% of people between the ages of 65 and 75 years require some assistance with daily activities. For those 75 years and older, the percentage jumps to more than 65%. This compares with Switzerland in which the proportion is less than 5% and 20%, respectively.

Alongside direct services to individuals and their families are 'activities that address health-related social risk factors and social needs' (National Academies of Sciences 2019, p. 28). Social variation in health outcomes has been long studied and appreciated. A historical social epidemiological perspective is provided by Berkman and Kawachi (2000). The authors discuss several relevant concepts including a population perspective, the social context of behaviour, multilevel context, a developmental and life-course perspective and the possibility of a general susceptibility to disease linked to the cumulative effects of stress. Pearlin (1981) hypothesised that health disparities arose to a substantial degree from differences in life-time exposure to social stress (Turner 2010). Social determinants of health can be defined as the economic and social conditions that influence both individual and group differences in health and well-being. The 2011 World Conference on Social Determinants of Health affirmed that health inequities are unacceptable and noted that these 'inequities arise from the societal conditions in which people are born, grow, live, work and age, including early childhood development, education, economic status, employment and decent work, housing environment and effective prevention and treatment of health problems' (World Health Organization 2011).



**Fig. 6.1** Commission on social determinants of health conceptual framework (WHO 2011)

Whilst the determinants are primarily rooted in macro-resource allocation, the effects are experienced by individuals and families in their daily lives and across generations (Fig. 6.1).

Lantz and colleagues observe that “public health activities in the late nineteenth and early twentieth centuries focused on ‘upstream’ causes of poor health, including poor sanitation, overcrowded and squalid housing conditions, work-related hazards, food security and nutrition” with consequential sharp declines in mortality. Coming from a *population health* perspective the authors argue for continued attention to key social and economic causes and caution against the medicalisation of the social determinants of health (Lantz et al. 2007). The US Healthy People 2020 Plan (Health and Services 2001) identifies four key aspects of society to be addressed in regards to the social determinants alongside healthcare services: economic stability, education, social and community context, neighbourhood and built environment. Social care from this perspective refers to activities that seek to address these wider determinants of health. There is increasing recognition in such approaches that all communities, even those which face considerable disadvantage, will have their strengths based on local social and cultural networks. Building on these local assets, rather than solely problematising the people and their communities, provides a more constructive, enabling and sustainable solution to underlying and embedded challenges.

## 6.3 Integrating Health- and Social Care for Populations

### 6.3.1 Population Health Improvement Approach

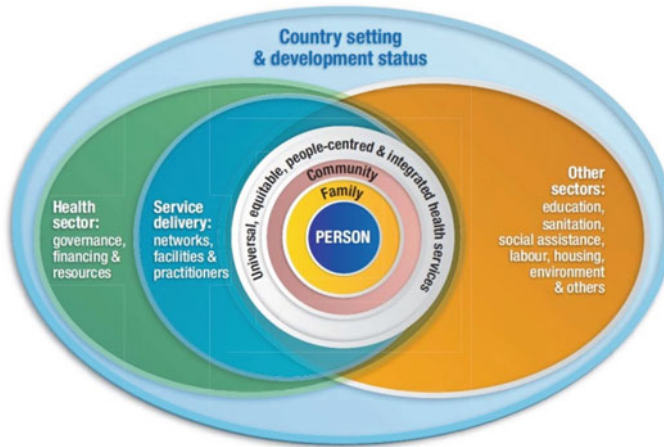
Lantz and colleagues (2007) observe that healthcare and public health professionals may have different interpretations of the term population health, with healthcare

leaders using the term to describe cohorts of individuals served by health plans or clinical services. By contrast, for public health leaders, the population of interest is all people living in a geographical area, such as country or region. The differences between these two views may be more profound and influenced by quite different beliefs and values.

The modern population health approach has a pedigree that includes the Alma-Ata Declaration on Primary Health Care (WHO 1978) and the Ottawa Charter of Health Promotion (WHO 1986). The Alma-Ata Declaration of 1978 was a major milestone in the field of public health, and it identified primary health care as the key to the attainment of the goal of 'Health for All' around the globe. It was based on the principles of equity and community participation in health planning and policy making, through an inter-sectoral approach. The Ottawa Charter for Health Promotion incorporated five key actions of: (1) building healthy public policy; (2) creating supportive environments for health; (3) strengthening community action for health; (4) developing personal skills; and (5) re-orienting health services.

This population health 'improvement' approach to the social determinants of health (SDOH) seeks to address the underlying structural factors such as economic, education, housing and income security policy and the broader values, cultural and institutional contexts that shape the distribution of resources. The approach is intended to improve the health and well-being of the whole society and not just the poorest or most marginalised. When integrating health and social service systems, this approach is operationalised through a whole of society approach to 'health in all policies', universal health care, housing, education and full employment. At a local level, population-based initiatives may be represented by safe communities and healthy city initiatives. Through such approaches, all citizens benefit from reduced crime, strong social cohesion and clean air.

The relevance of the population health 'improvement' approach to integrated care may not be immediately apparent, but it can be advanced that integrated health and social care will benefit from strong community social cohesion, health literacy, coordinated services and shared governance. This is what the Ottawa Charter calls 'Supportive Environments for Health'. The recently ratified WHO framework on integrated people-centred services (WHO 2016) takes a similar population health approach and has echoes of both the Alma-Ata Declaration and Ottawa Charter. The framework has five interwoven strategies: (1) empowering and engaging people and communities; (2) strengthening governance and accountability; (3) re-orienting models of care; (4) coordinating services within and across sectors; and (5) creating enabling environments. As with the Alma-Ata Declaration, the WHO framework on integrated people-centred services, places a strong emphasis on the role played by other sectors as illustrated in the conceptual framework (Fig. 6.2).



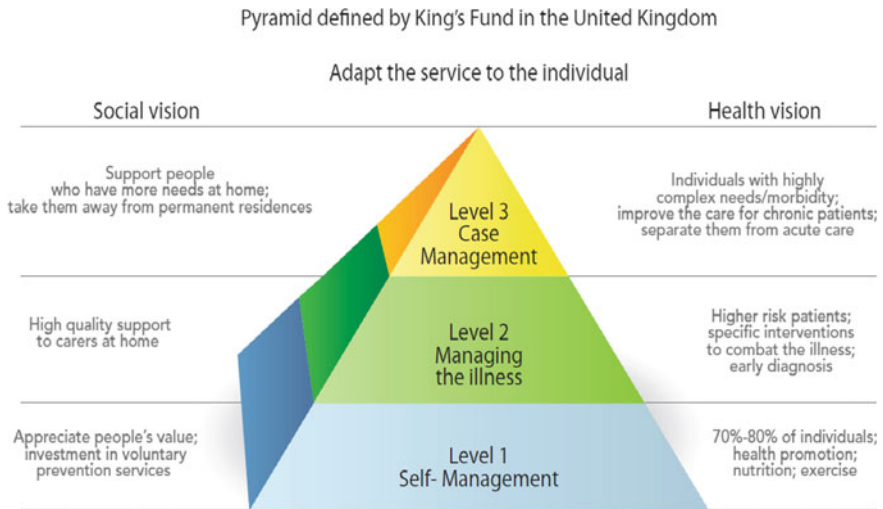
**Fig. 6.2** WHO conceptual framework for people-centred and integrated health services (WHO 2016)

### 6.3.2 Population Health Management Approach

By contrast, the population health ‘management’ approach is a person-centred approach to meeting the needs of those with identified health- and social care needs. This approach focuses on groups of patients included in insurance plans, hospital patient cohorts, accountable-care organisations or other health- and social care organisations. In its narrowest conceptual form, the population health ‘management’ approach will focus on medical conditions with little consideration for the social or prevention dimensions. Of particular significance, here is the population health ‘management’ approach developed by Kaiser Permanente (KP) which includes health promotion and disease prevention elements. The approach was modified by the Kings Fund (UK) for the Barcelona Integrated Care Strategy (Ham 2003) to include the social dimension (Fig. 6.3).

### 6.3.3 Combined Population Health Improvement and Management

Some healthcare systems, by contrast, will pursue both population health improvement and population health management strategies at the same time. In this way, they collaborate with other sectors for both: improving the care of their patient population and improving the health and well-being of the wider geographical population. A further aspect of more mature systems is strong advocacy to address the upstream macro-structural determinants of health and well-being. This approach has been incorporated into the National Academy of Sciences (USA) report: *Integrating social care into the delivery of health care: Moving upstream to improve*



**Fig. 6.3** Kaiser Permanente (KP) pyramid as adapted by the Kings Fund (UK) (Ham 2003)

*the nation's health* (National Academies of Sciences 2019). The report identifies five complementary activities in the healthcare setting to facilitate the integration of social care (defined as activities that address health-related social risk factors and social needs) into the delivery of health care (Table 6.1) (Bibbins-Domingo 2019). Bibbins-Domingo (2019) further note that the activities of 'alignment and advocacy recognise that some social needs may broadly affect a community and the most effective role for the healthcare system is to tackle these needs collectively and not just one patient at a time'.

It is becoming increasingly clear to health funders that social risk factors are impacting on their health costs as evidenced by longer length of stay, frequent representations and more complex morbidity. It is in this context that population health management systems are increasingly asking their patients about the SDOH in clinical settings.

An alternative to the top-down structural approach to the integration of health- and social care services is to adopt a bottom-up person-centred and locally driven approach that puts individuals and their families at the centre and incorporates place-based and local system change elements. Such an approach draws on the foundations of the Alma-Ata Declaration in the context of person-centred integrated health (and social) services.

An example is the *Healthy Homes and Neighbourhoods* Integrated Care Initiative in Sydney, Australia, which was collaboratively designed as part of a local district 'whole of system' approach to child, youth and family health and well-being. The design intentionally drew on both population health improvement and population health management approaches as discussed above. The design elements included: identification of vulnerable family cohorts; care coordination;

**Table 6.1** Five categories of healthcare activities that facilitate addressing social needs applied to a transportation-related example

Activity	Definition	Transportation-related example
Awareness	Activities that identify the social risk and assets of defined patients and populations	Ask patients about their access to transportation
Adjustment	Activities that focus on altering clinical care to accommodate identified social barriers	Reduce the need for in-person healthcare appointment by using other options such as telehealth appointments
Assistance	Activities that reduce social risk by providing assistance in connecting patients with relevant social care resources	Provide transportation vouchers so that patients can travel to healthcare appointments; vouchers can be used for ride-sharing services or public transit
Alignment	Activities undertaken by healthcare systems to understand existing social care assets in the community, organise them to facilitate synergies and invest in and deploy them to positively affect health outcomes	Invest in community ride-sharing
Advocacy	Activities in which healthcare organisations work with partner social care organisations to promote policies that facilitate the creation and redeployment of assets or resources to address health and social needs	Work to promote policies that fundamentally change the transportation infrastructure within the community

Source Bibbins-Domingo (2019)

evidence-informed intervention(s); general practice engagement and support; family health improvement; place-based neighbourhood initiatives; interagency system change and collaborative planning; monitoring of individual and family outcomes; and evaluation (Eastwood et al. 2019a). The person-centred intervention is supported by other tiered components that function at professional and organisational levels (see Box 1).

**Box 1: Healthy Homes and Neighbourhoods Key Features (Eastwood et al. 2019b)**

**Healthy Homes and Neighbourhoods**

The Healthy Homes and Neighbourhoods Integrated Care Initiative uses a stratified population-based approach to address the needs of families who are experiencing adversity, whilst supporting parallel interventions for families more generally. The approach to identifying the most vulnerable families who are disconnected from key services has been developed using existing perinatal risk-assessment systems, developing new cross-agency assessment and



referral pathways, and improved hospital recognition of the needs of families using an e-health solution.

The initiative has the following key features:

1. Multiple core and non-core agencies **working together over a sustained period of time** (i.e. 5 years) with families with complex health and social needs
2. Co-design and co-production of the initiative in **partnership** with families and service partners
3. **All the needs of enrolled families are in scope** for the intervention, including housing, employment, income support and legal advice
4. An **early intervention and public health approach** to interrupting cycles of family disadvantage, poor health and psychological trauma
5. A **focus on efficiency** through the maximum use of, and leverage from, existing family, societal and government resources, including Medicare scheduled services
6. Use of **evidence-informed integrated care methods** by service partners, including family case conferencing, and ‘wrap-around’ care delivery
7. Encouraging families to have a **‘health home’** for all their health needs and supporting progress towards self-efficacy
8. **Providing a supporting structure to general practice** providers to care for families that are often seen to be ‘too difficult’
9. Development and implementation of **shared assessment tools and referral criteria**
10. Implementation of **family assessment and engagement tools** that can be used over the long-term to monitor the health and well-being of family members.

A central element of the initiative is targeted long-term sustained cross-agency care coordination. The design acknowledges the need for significant system redesign and commitment from partners. The initial model required a care coordination team with both project-funded and partner-funded components as a means of ensuring sustainable ‘collaboration’. The initiative also includes local elements through deliberate recruitment of families and service partnerships in the City of Canterbury and City of Sydney local government areas. This last component enabled the development of ‘demonstration-site’ place-based partnerships with local general practice, schools, family support agencies, local government, religious and faith-based organisations and community members.

## 6.4 Integrating Health and Social Care for Individuals

Coordination between health and social services reflects the general challenges found within all forms of integrated care that seek to bring together professionals, services and organisations from different backgrounds and sectors around the needs of individuals and their families (Hujala et al. 2017; Auschra 2018; Seaton et al. 2018). Research highlights that the particular contexts and cultures of health- and social care services result in such general challenges being commonly experienced in distinct ways (Petch 2012; Cameron et al. 2014; Miller et al. 2016). The distinctive challenges within health- and social care integration include:

- (1) Professional rivalry between social workers and doctors based on the perceived conflicts between their traditional philosophies of care (i.e. ‘medical’ and ‘social’ models). Furthermore, these professions are dominant in their own sectors and therefore not familiar with their professional judgements being challenged by another profession of ‘equal’ standing.
- (2) The high proportion of staff within social care who do not have the formal status of a ‘registered professional’. This can lead to them having lower status to more professionalised health colleagues and excluded from decision making, despite often having a detailed knowledge of a person and their day-to-day life.
- (3) Healthcare receives more funding than social care. This results in disparities in technical capabilities, standard of facilities and accommodation and overall workforce capacity. Health care is often more able to lead on integrated care initiatives due to their greater infrastructure. This can result in their perspective dominating the objective setting and implementation process.
- (4) Public interest in health care is greater because it is accessed by all of a population at some point in their life, and its professions have traditionally been held in high esteem. This leads to its prioritisation by politicians over the less popular social care sector which is accessed only by a proportion of the population, is not always seen favourably, and which supports stigmatised and excluded groups.
- (5) Social care services are delivered by a myriad of agencies from private and non-governmental organisations. The fragmentation of the sector can give it less influence than the large provider organisations within health care such as hospitals and the powerful professional colleges.
- (6) The policy development and governance of health- and social care services commonly fall under different parts of government and/or public entities. Social care is commonly coordinated at a local level while health care is often led nationally. Performance targets and inspection regimes may be therefore different leading to organisations focussing on their own sector’s objectives and requirements to the detriment of a local system as a whole.
- (7) Reflecting in part the financial differentials, there has been much less research in social care than health care, and in particular clinical care and pharmaceuticals. This can result in healthcare interventions being seen as better supported by evidence and therefore more worthy of investment than the under investigated social care support.

There are important consequences for individuals and their families from direct health- and social care services not collaborating. Social care support is often central to people being discharged from hospital following admissions for physical and/or mental health crisis and/or planned treatment. A lack of coordination results in people having to remain longer in such settings, which can result in frustration and uncertainty for them and their informal carers. Similarly, those with long-term physical and/or mental health conditions are admitted into crisis and/or hospital care because their social issues have not been addressed. Difficult social contexts can result in people's health deteriorating and reduce their resilience to cope with their health condition. Particular difficulties in relation to integration between health and social care are experienced at times of transition. For example, when young people with disabilities and/or mental health difficulties are moving into adulthood, this will often involve them leaving behind the health, education and care services that have supported them through childhood and adolescence to access an unfamiliar range of support. This process commonly involves them also losing their care coordinator and this further complicates navigating this new environment. Social work's central role in many countries in relation to safeguarding means that good collaboration with health professionals is vital to identify concerns at an early point and ensure that interventions are in the best interest of the child or young person.

**Box 2: Example of Benefits of Better Integration Between Health and Social Care (Cornell et al. 2020)**

**Social care within Patient Aligned Care Team**

The Veterans Health Administration describes itself as America's largest integrated healthcare system, providing care at 1255 healthcare facilities, including 170 medical centres and 1074 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year (<https://www.va.gov/health/>). The Patient Aligned Care Team (PACT) was launched by VHA in 2010 to introduce the primary care medical home model to improve patient-centredness, coordination and continuity of care. PACTs involve 'teamlets' of professionals including primary care physician, nurse, clinical associate and administrative staff member supporting around 1,200 patients. Social workers were seen as bringing expertise in responding to psychological needs of veterans, supporting informal carers, arranging support in the home and addressing wider social issues including isolation and housing. VHA recognised that many of the PACTs in rural settings did not include social workers and therefore introduced a programme to recruit social workers for these teams in 2016. Between 2016 and 2019, ninety-five social work positions were created which enabled ninety-three primary care sites to have social workers present on a full- or part-time basis. Cornell et al. (2020) undertook a study of the programme which exploited the staggered implementation to identify comparison groups (i.e. early implementers and late implementers). They found that visits to emergency departments by veterans decreased following the introduction of a new social

worker. This appeared to be due to reductions in the number of visits connected with preventable causes such as non-urgent concerns and those that could be addressed through more thorough management of their conditions. In addition to the reduction in use of costly hospital resources, they highlight that veterans having better access to social workers could result in other benefits including reducing stress, improved coordination and wider social supports.

Fragmentation between health- and social care services also has major implications for efficiency and productivity. Acute health services are generally more expensive than community-based social care and therefore avoiding unnecessary admissions and securing timely discharge has become a major focus for governmental policy. Similarly, insufficient collaboration can result in people becoming admitted to long-term institutional settings following a time of crisis. Hospitals can apply pressure for patients to be discharged as soon as they deemed medically fit in order to free up ward capacity. This can result in older people moving into care homes on a permanent basis when a longer period of rehabilitation could have enabled them to return to a community setting. Such inefficient use of resources due to fragmentation between health and social care is also recognised for other populations. For example, people with a learning disability and/or complex mental health difficulty may be subject to long admissions to assessment and treatment facilities due to a failure of community-based health- and social care services to provide intensive support during a time of crisis (Miller et al. 2018).

This combination of improving outcomes for people and families and ensuring that resources are used more effectively has convinced policymakers that better integration between health- and social care services should be a priority. This has only heightened with ageing demographics and increasing proportion of populations with multiple long-term conditions. Reflecting the distinct challenges outlined above and our understanding of how to support integrated care in general, it is evident that better integration between health and social care will require change at all levels of the health and care system. Whilst often seen as an amorphous whole, health and care policy in the UK has been devolved to the home nations (i.e. Northern Ireland, Wales, Scotland and England) which lead to differences in how they frame similar challenges for their populations and the solutions that they propose (Kaehne 2017; Miller 2019). Health- and social care integration is though a common aspiration, and all of the home nations have introduced over the past decade a similar blend of policy and practice approaches to facilitate more coordinated care (Table 6.2). These include system-level outcomes and population-based planning, integrated organisations and/or partnership boards, multidisciplinary health- and social care teams, an overall narrative of community based and person-centred care and addressing functional barriers such as siloed budgets and workforce planning. Some progress has been made, for example in relation to slowing increasing rates of hospital admissions within the UK regions

**Table 6.2** Examples of development to promote integration between health and social care in the four home nations of the UK

	Scotland	Northern Ireland	Wales	England
System	National health and well-being outcomes	Integrated Care Partnerships	National Outcomes	Integrated Care Systems
Organisational bodies	Lead Agency for delivery of health and social care	Joint health and social care trusts	Regional Partnership Boards	Transfer of public health to Local Authorities
Professional	House of Care	MDTs in Primary Care	Primary Care Clusters	Multi-Speciality Community Providers
Service	Lead professionals	Family Support Hubs	Integrated Family Support Teams	Integrated personal budgets
Normative	Live longer healthier lives at home (or in homely setting)	New model of person-centred care	Healthier and happier lives through whole system approach	<i>"I can plan my care"</i> I statements
Functional	Pooled budgets for social care and primary care Workforce Plan	Patient e-Portal Electronic Patient Record	National Transformation Fund	Better Care Fund Health and Care Record Exemplars

Source Miller (2019)

that adopted multi-speciality community providers and reducing delayed transfers of care in Scotland. However, it is clear that despite all of the attention and investment, there remains fundamental divisions and more must be done to achieve sustained integration between health- and social care services (Box 3).

**Box 3: Examples of Criticisms of the Extent of Health- and Social Care Integration From National Audit Reports in the Home Nations (UK)**

“The Integrated Care Fund has helped to bring organisations together to plan and provide services .... The fund has provided an impetus for partners to develop integrated services and to move to joint funding arrangements in the context of wider policy and legislation ... [however] the overall impact of the fund in improving outcomes for service users remains unclear, with little evidence of successful projects yet being mainstreamed” (Welsh Audit Office 2019).

“The HSC system continues to be under mounting pressure and the costs associated with maintaining existing models of service continue to increase at a pace which cannot be sustained within the budget available. There is a clear need for successful transformation of service delivery models ... However the successful delivery of this vision will require new ways of working, including with partners outside of HSC Trusts” (Northern Ireland Audit Office 2018).

“Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital ... Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support ... [making] it difficult for IAs to achieve meaningful change” (Audit Scotland 2018).

“[Government] expectations of the rate of progress of integration are over-optimistic. Embedding new ways of working and developing trust and understanding between organisations and their leaders are vital to successful integration. This can take many years because the cultures and working practices in the health and local government sectors are very different” (National Audit Office 2018).

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## 6.5 Integrating Health and Social Care Through the Workforce

When approaching integrated care from a medical perspective the workforce considerations focus often on interdisciplinary teams where the members are subspecialty doctors and nurses with perhaps some consideration of the allied health professions that support treatment modalities of care. Professional and regulatory agencies provide in these circumstances clear clinical governance regarding matters such as accreditation, scope of practice and clinical standards. To address the complex social needs of patients and families, there is a requirement for collaboration beyond the traditional healthcare teams to include staff from social care services, housing, schools, residential institutions, correction facilities, local government and community-based organisations. The ability of these interdisciplinary teams to function effectively is dependant of a wide range of factors many of which relate to workforce capacity, relationships and governance. Furthermore, it is important to recognise that it is not only those working in the frontline who have to adapt their practice to achieve better integration. Those who are responsible for the planning, funding, policymaking and managing of the health- and social care sectors must demonstrate new collaborative behaviours in order to address these long-standing and embedded barriers and missed opportunities to address inequalities.

### 6.5.1 Inter-Professional Competence

As highlighted above, there are long-standing challenges in relation to the ability of health- and social care staff to collaborate constructively due to professional tensions and/or perceived differences in status and expertise. One issue is the willingness of this workforce even to consider such engagement on the basis that it is out of their area of concern and/or they are sceptical that it will lead to any benefit. A second issue is that even if they do recognise the importance of working better with those from the different sector they may not have the underlying competence to do so successfully (Xyrichis and Lowton 2008; Mangan et al. 2015; Carpenter and Dickinson 2016). This is despite the underpinning values, skills and knowledge necessary for health- and social care integration to be well recognised at a practice level and receiving greater attention for those within management and leadership roles (see below) (CIHC 2010; IPEC 2016; Miller and Stein 2020).

One approach to support the development of such competencies is through inter-professional education (IPE) in which health- and social care professionals learn alongside and from each other (Baker 2010; Carpenter and Dickinson 2016; Miller et al. 2019). IPE is becoming more common within education settings delivering qualifying/post-qualifying programmes and within on-going professional education. Often though, this is limited to health professionals and further limited to formal ‘professionals’ rather than involving those with other roles and backgrounds. Reflecting the wider context of integration between health and social care, such limitations can reflect a lack of awareness from educators rather than an opposition to opening up training wider as such. Engaging multiple professions in a learning process can be extremely challenging, and this is amplified if (as can be the case with social care) the students or staff are based in or employed within different colleges or organisations. There is also an issue of appropriate design and quality of delivery in relation to inter-professional education with health and social care (Mertens et al. 2018). Simply getting sufficient funding, institutional agreement, timetable co-ordination and faculty support can be enormously challenging. This can then result in insufficient capacity to develop learning opportunities that will facilitate changes in professional behaviour into the long term despite the enablers of inter-professional education being recognised in research and practice (Table 6.3).

### 6.5.2 Professional Accountabilities

Practice governance frameworks are well developed within most of the sectors that will partner in the integrated health- and social care setting. The funding mechanisms will usually include requirements for accreditation against national and international standards that include workforce-related standards. Complications begin to occur when health practitioners are employed by non-health organisations where supervisors are either not from a health background or not from that specific clinical speciality. Clinical supervision arrangements may not be sufficient to

**Table 6.3** Enablers of inter-professional education

Aspect	Description
Involved patients	Patient stories, home visits, co-designed, patient led
Holistic focus	Multi-professional assessment, patient experience, determinants of health
Practical orientation	Supporting individuals. Undertaking shared project, community action
Multi-modal	Lectures, on-line learning platforms, group discussions, team tasks, collective reflections, observations
Multi-professional	Professions, disciplines, agencies, sectors
Robust evaluation	Formative and summative, impact, mixed methods

Source Miller (2019)

adequately support that staff member. Similar situations occur within the health sector when a sub-speciality practitioner is deployed away from their core team (i.e. community social worker in a dental hospital). Even more difficult challenges can occur where non-licensed social care staff work in close partnership within healthcare teams. That workforce includes: (1) community workers and community health workers; (2) case managers, care coordinators and care navigators; (3) home health aides and personal care aides; (4) family caregivers; and (5) other professionals such as community lawyers (Table 6.4).

Apart from the legal profession, many of the above categories of workers are not registered by statutory professional regulatory agencies. Consequently clinical governance concerns are often raised in relation to scope of practice. This then becomes a barrier to full integration of the social care workforce into transdisciplinary care teams. It is also used as reason for not sharing both personal and clinical information even when the practitioner is closely involved in a shared-care relationship with a patient.

### 6.5.3 Information Sharing

Information sharing among agencies and practitioners is essential for the provision of high quality health and social care. As noted above modern high-quality health care has moved towards utilisation of integrated systems that include multidisciplinary teams, bio-psycho-social interventions and follow-up care often by other professionals and agencies. Such approaches are considered to be part of an evidence-informed ‘duty of care’. But an approach that aims to act in the best interest of patients is also in tension with the principle of respect for patient autonomy.

Central to clinical integration is the sharing of clinical information between providers of care to patients. Some of those providers will be known to the patient whilst others (i.e. clinical supervisors, pathology and imaging services) will not. A further complexity is that some practitioners may not be considered members of the traditional healthcare team (i.e. school educational psychologists, security staff,



**Table 6.4** Non-licensed social care workforce examples

Category	Description
Community Health Workers	Community health workers (CHWs) provide linkages among health, social services and the community. Often recruited from the communities they serve CHWs work in health systems, social service agencies and community-based organisations. They are engaged in awareness, assistance and advocacy activities
Social Service Navigators, aides and assistants	Social service navigators, aides and assistants and also trained volunteers often work outside of the healthcare sector in awareness, assistance and advocacy roles in social service agencies and community-based organisations. Examples include housing and transportation experts, people who work at food banks, people who provide employment assistance, outreach and enrolment workers, navigators and trained volunteers
Home Health Aides and Personal Care Aides	Within the healthcare sector, home health aides and personal care aides provide extensive social support services to assist older adults and disabled and post-acute care patients in their homes. These direct care workers have close contact with the country's most disadvantaged patients
Family Caregivers	People who provide care for their family members (family caregivers) are another critical part of the care team and provide assistance to many individuals. Because they spend time in the home, family caregivers, similar to home health aides and personal care aides, have a valuable perspective on the social needs of patients. I
Case Managers	Case managers (and care managers) work intensively with individuals with complex social needs, whether in the healthcare system or with social service agencies. They can be based in hospitals, at home care agencies, in skilled nursing and rehabilitation facilities, or with community-based organisations. Case managers also are found in social services agencies, such as foster care agencies, child welfare agencies, senior centres and homeless shelters. Often, the role of case managers is filled by licensed clinical social workers and licensed nurses
Lawyers	Lawyers who address the social needs of patients and families are increasingly being used in community-based organisations, including some federally qualified health centres, to assist patients and families with legal matters that can compromise health, such as inadequate housing or a loss of housing

Adapted from National Academies of Sciences (2019)

religious counsellors, disability support workers and practitioners working in the criminal justice sector). Thus, the provision of excellent integrated clinical care requires the sharing of clinical information with a multidisciplinary healthcare team of clinicians from across a wide range of sectors and disciplines.

With the development of digital technology, clinical information can be rapidly shared between healthcare teams, institutions and actors involved in system management and evaluation. At the agency and system levels of an integrated service system, there is also an increasing focus on personal health data integration within health care as evident by the implementation of the various forms of shared health records. The sharing of information is often problematic and is often reported as a barrier to integration of health and social services. Barriers exist for both identifiable and non-identifiable information sharing.

Cross-agency sharing of de-identified personal information is usually for advancing a shared understanding of population health and well-being and for improving the delivery of health and social services. Despite this common purpose, the sharing of de-identified information can be difficult in some jurisdictions. The challenges of sharing identifiable personal and clinical information are many. That cross-agency sharing of identifiable personal information can be for: (1) clinical care of individuals who have consented for the shared use of their information; (2) clinical care of individuals who have not consented for the sharing of their information but where the use is covered by that jurisdiction's privacy codes; or (3) protection of the individual and others as is covered in that jurisdiction's statutory legislation (i.e. mental health, child protection, public health and criminal legislation).

Each country and statutory jurisdiction will have different statutory provisions. Within New South Wales (NSW), Australia, for example, it seems clear that both the Australian Privacy Principles and NSW Health Privacy Principles make provision for clinicians to share information within the 'healthcare' team, and with closely affiliated clinicians where there has been informed consent from the patient. It is also clear that where informed consent has not been obtained, health information can be used and disclosed (shared) for the purpose for which it was collected (the primary purpose) and for other purposes that are related to the primary purpose and that are within the individual's reasonable expectations.

It seems, therefore, that multidisciplinary interagency healthcare teams can collect and share health information, without consent, provided the purpose is closely related to the primary purpose for which it was collected. Given that the holistic nature of health and social care is not always fully appreciated, the 'sharing' of sensitive information with others in the 'team' will not always be fully understood. It is, therefore, appropriate to inform patients of the nature of the 'multi-disciplinary health- and social care team' and to advise them of the practice of sharing health information among team members. The sharing of health information between health- and social care team members is an important component of the drive to improve the quality and safety of care. Barriers to such information exchange are often advanced as the underlying reasons for mishaps in the provision of care and the failure to implement change.

### 6.5.4 Leadership and Followership

Clinical leadership is now seen an important enabler of quality practice by health professionals (Ezziane 2012; Daly et al. 2014; Mulla et al. 2014). Such leadership builds on socialisation processes within professional training, registration and bodies and the powerful influence of peers and ‘esteemed’ colleagues. Whilst in many ways a strength of health care, clinical leadership can reinforce an isolation mentality if focussed on the preservation and status of the profession rather than the interests of individuals and their families. Professions are particularly susceptible to separatist behaviour when they perceive that aspects of their traditional scope of practice are being encroached upon, or they believe that their professional autonomy is being diluted through more shared and open decision-making (Braithwaite 2013; MacMillan and Reeves 2014). Integrated care can of course introduce both such dynamics, with multidisciplinary team structures being a common vehicle to bring together different professionals (Jelphs et al. 2016). The addition of social care to such teams can add further disruption, due to the lack of traditional professional hierarchy and/or an unfamiliarity of health professions and practice roles within social care. Similar challenges can be experienced within senior management and governmental roles with leaders familiar with their own health- or social care contexts finding it difficult to engage and influence those from an alternative sector (Miller and Stein 2020).

There is therefore a need for leaders at a clinical and senior level to demonstrate a new form of leadership. Rather than being limited to their own profession or organisation, this must instead be able to connect and inspire those within different roles and sectors (Ghate et al. 2013). Systems leadership is being promoted in other areas than health and social care, but there is increasing recognition that it is a necessary component of achieving the benefits of integration (Senge et al. 2015; SCIE 2018). There is not one model of system leadership as such, but there are common elements: system leaders are best placed to tackle ‘wicked’ issues which involve many stakeholders and uncertain solutions; system leaders work collaboratively with others to encourage a sharing of resources and creative thinking; system leaders are focused on goals of collective interest and are willing to sacrifice personal benefits to achieve this greater good; and system leaders enable those with lived experience and communities to participate in decision-making and contribute as partners (Miller 2020). System leaders at a senior level will often work through partnership structures and management networks, whereas system leaders at a clinical level will work through care pathways, multidisciplinary teams, and professional networks. Both will need a similar set of skills, values and facilitative style of leadership (Evans et al. 2016). Whilst sometimes overlooked, as important as the system leaders is the readiness of ‘followers’ who are willing to follow this new vision and alternative ways of working.

## 6.6 Conclusion

In this chapter, we have examined the impact of social issues on people's health and well-being and presented the argument that integration at both population-level and in delivery of direct services are necessary to achieve better outcomes and address inequalities. Different approaches to responding to social need are taken within and between countries and regions. This is influenced by macro-economic, funding and delivery structures, and also their cultural traditions of how best to care for those with social needs. Despite such differences, there are common lessons that can be shared internationally. Common challenges include: professional rivalry between professionals, perceived lower status of consumers and 'unregistered' workers, siloed funding structures; multiple agencies and performance frameworks non-incentivising integrated working. Arrangements that on paper offer a one-stop solution are not successful in isolation. The existence of a single agency for health and social care does not mean that people will experience person-centred and coordinated care. Population health improvement and population health management approaches fail due to the lack of a common vision, strong leadership and appropriate governance structures. Addressing the long-standing fragmentation between health and social care requires a fundamental shift in the recognition of professionals and those in senior leadership regarding the potential for better working between these sectors and their own contribution to achieving this in practice. Identifying what will work in a locality requires open and honest debate of the policy and practice context, including underlying assumptions about the relative merits and the historical tensions and differences that need to be addressed. Whatever arrangements are introduced, 'trust', 'partnership' and 'working in teams' will be central to the solutions.

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