Literature Review of International Models of Social Care

Lessons for Social Care Delivery, Sustainability and Funding in Scotland

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Executive Summary

Introduction

This rapid literature review report has been compiled to provide evidence for the Health, Social Care and Sport Committee's scrutiny of the National Care Service (Scotland) Bill, with funding for the review having been provided by the Scottish Parliamentary Corporate Body (SPCB). The report describes and compares international social care models focusing on the social care systems in: Australia, the United States, Japan, New Zealand, Switzerland, Alaska, the Nordic (Scandinavian) Countries (Sweden, Finland, Denmark, and Norway), EU Countries (The Netherlands, Germany, and France) and UK Countries (Scotland, Northern Ireland, Wales, and England). The review considers: 1) how social care is structured, delivered, funded and governed in each country, 2) the benefits and limitations associated with each model of social care and the evidence for these benefits and limitations, 3) the impacts of each model of social care on population health outcomes and health care service delivery, 4) enablers and barriers to the effective implementation and delivery of each model of social care (including reforms to existing models) and the lessons learned/ recommendations for good/best practice identified in the literature, 5) enablers and barriers to the long-term sustainability of each model of social care, and 6) key considerations required for considering the potential transfer of one model for implementation in another context. The purpose of this report is to provide a descriptive overview of the relevant literature available to help aid decision makers seeking to explore the potential for implementation of similar models within Scotland as part of the establishment of a new National Care Service (NCS) for Scotland.

Methodology

The rapid review of the academic research and policy-relevant (grey) literature combines systematic with narrative and abridged Delphi Method techniques to review the existing literature focusing on the different national social care models and their associated impacts, successes, challenges, and limitations. This allowed the literature search and evaluation to be conducted in a way that adhered to the key principles of systemic reviewing in the applied social sciences and best practice in the health and medical sciences, while simultaneously allowing for subjective and expert-led evaluation of the literature to determine relevance to the research questions. The total number of documents selected for inclusion in the final sample for review was 166.

Findings

Analysis of the available literature revealed important differences between the social care systems of each of the different countries. Fundamental differences in exist in how social care services are funded, delivered, structured and governed across high-income countries in the international context. The review also highlighted the key strengths and limitations of each of the different models of social care. The review also highlighted important barriers to sustaining the existing social care models and the enablers and challenges of improving the integration of health and social care services.

Australia

In Australia, social care services are determined on the basis of need and charges to the individual are means tested. Financing of social care comes from tax revenue and user charges, which means the wealthiest people have to pay all or the majority of their care costs themselves up to a specified government defined limit. It can be difficult to obtain private forms of insurance to cover these costs. Provision of health services falls to state governments, while the provision of pensions and funding for welfare services is a federal responsibility, resulting in an unclear definition of responsibility for social care. While increasing care provision from private service providers has been identified as a way to reduce the fiscal demand on the federal government, concerns have risen about increasing inequalities in care provision as a result of increased private sector involvement. Lack of integration between health and social care providers negatively impacts the delivery of care for users with complex care needs. However, the Australian emphasis on external care provision reduces the need for informal care provision. Care user choice is emphasised in determining care providers. The provision of basic social care services based on need is linked to improved health outcomes. However, limitations in access to services in certain geographic areas (including rural areas) hampers efforts to achieve more integrated care. Attempts to increase user choice also must be responsive to existing structural inequalities, as otherwise it risks increasing social and health-related inequalities. Several barriers exist to the long-term sustainability of the Australian social care model: lack of forward planning and significant investment, as well as the need to increase government funding costs for sustaining future care provision. Ongoing financial instability means that that user contributions will likely need to increase further in the future. Changing patterns of care needs, with more people requiring care at home, also means that more individuals will be required to pay more for their care in the future because individuals with incomes higher than the full state pension pay more towards their care.

United States

In the US, all social care costs are paid for privately by individuals. The US Medicaid programme is a publicly funded system which provides a safety net by covering the costs of health care and health care-related services for those with low incomes, but does not cover social care per se. The US model is associated with exacerbating socio-economic and racial health inequalities. The US has done little to date to integrate health and social care compared to other high-income countries. Under this model, potential ability of reforms to improve outcomes and generate reserves – whether public or private – is dependent on the broader economic situation. The future long-term sustainability of the US model is highly dependent on changes in the wider economy.

Japan

Japan’s social care system is based on a mandatory social insurance scheme that is separate from its mandatory health insurance scheme. Half the revenue for the long-term care insurance scheme comes from general taxation, with one-third coming from insurance premiums from people aged between 40–64 (at a rate of 1 per cent of income) and one-sixth from people over 65 (according to a fixed tariff of premium rates). User co-payments account for the rest. Municipalities operate the public long-term care insurance system and have the responsibility for planning long-term care in each jurisdiction. For people in employment, individuals' contributions are shared with employers and premiums are determined and collected nationally and redistributed to municipalities according to need. Benefits in Japan are generous and designed to cover the costs of a wider range of care services, with less than a 10 per cent co-payment required from individuals, which is further reduced on a means-tested basis for people on lower incomes. Social care policy in Japan is paternalistic and involves medical expertise in assessing eligibility to services and leaves little scope for individuals to express their agency, choice, and decision-making capacities. Japan also places a high level of expectation on families to provide high levels of informal care. This creates challenges in an increasingly aging society where increasingly older people will bear the brunt of caring for the oldest members of society. Medical approaches to social care provision come at the expense of general wellbeing and quality of life. However, access to care is standardised. The long-term impacts of major social care reforms in the early 2000s are not fully known, but have been linked to improving quality of life amongst people with disabilities. The rapid growth of the aging population in Japan means that sustaining the system depends on willingness to expand welfare and insurance schemes for the provision of long-term care. Sustaining the care workforce also presents a huge challenge.

New Zealand

New Zealand differs from other countries in that social care and services are all part of a health board's allocation. Care service provision is subject to a needs assessment and the health ministry funds and purchases care for people with disabilities under the age of 65. New Zealand has a large range of private sector care provision and primary health organisations contract with district health boards to provide a range of primary and community services. Integrated care provision embedded upon an ethos of respect for socio-cultural diversity has enabled positive steps to be made towards addressing health and social inequalities between Indigenous people and other New Zealand citizens. The integrated system is associated with improved health and quality of life outcomes, particularly in relation to mental health. The system also helps address the care needs of those with complex needs. Lessons learned from the success of the New Zealand Canterbury model demonstrates that having a clear vision of a 'one system, one budget' approach and investment in staff through training and skills development, helps achieve positive outcomes. While integrated health and social care systems help reduce spending on emergency hospital care and medical services, this is dependent on increased spending on community-based services. Funding provision for the system through taxation may be difficult to sustain in the future owing to the aging population.

Switzerland

Social care in Switzerland is financed directly by contributions from taxation and a compulsory health insurance system that also provides for social care service provision. People on lower incomes are eligible for subsidies and those with the lowest incomes have their premium paid for by the government. However, all earners earning above a certain income level all have to pay the same premium. Internationally, the Swiss system ranks well regarding quality of care, access, efficiency, equity, and promotion of healthy lives. However, fragmentation of governance and delivery, with responsibilities divided between the federal, cantonal, and local levels, is associated with an increasing risk of sub-optimal care quality. The literature does not specify the impacts of the system on population health outcomes. The 2017-2020 Promotion of Interprofessional Collaboration in Healthcare helped identify good practice in fostering the coordination of care and interprofessional collaborations, highlighting the need for legal clarification about the responsibilities of non-medical care providers in the development of a more integrated system. Different organisational cultures and interests and a lack of accountability among managers hindered improvement processes. Participatory approaches where care delivery improvements were co-created and tailored to local priorities were found to be enablers of success. The long-term sustainability of the model is likely to come under pressure as a result of the aging population and declining funding for welfare and service provision.

Alaska

The delivery, structure, and governance of social care services in Alaska differs slightly from that of the other US states as it has its own particular arrangements regarding the coordination and provision of care for Indigenous Alaskans. Alaska also has its own version of Medicaid, which covers some of the costs associated with home care and is administered by the Alaska Department of Health and Social Services Division of Public Assistance. Eligibility is determined by financial need. The literature did not specify evidence of the impacts of its model of social care for population health outcomes amongst all Alaskans, however both the Maniilaq and SCFNuka programs for Indigenous Alaskans are associated with significant reductions in emergency department visits and hospital admissions, and improvements in the diagnosis and treatment of chronic diseases. Experience of implementing the SCFNuka system in Alaska demonstrates how structural integration across services is important for achieving success in the integration of health and social care. However, the Alaskan models are, for the most part, primary care systems, with very little social care been integrated into the systems.

Nordic (Scandinavian) Countries (Sweden, Denmark, Finland and Norway)

Nordic models are underpinned by the principle of universalism. Eligibility for all social care services is based on need rather than contributions. Until the 1990s, services were based almost completely on public provision. The state and local authorities heavily subsidise care services, financed through income and local taxes. Since the 1990s, changes in policy have transformed service delivery into a more hybrid public-private approach, with greater involvement of the market in service provision. However, care services are still provided to all citizens who require it. Local authorities have the freedom to organise care delivery, but the system is supported by national level legislation which ensures equality in levels of state-funded care provided. Since the 1990s, care users have also had the option to pay for additional services. However, evidence suggests that increased marketisation of at-home social care services is linked to widening health inequalities and unmet care needs. However, the literature also shows that universalism can be maintained if attention is given to how the use of additional services are distributed and how this interacts with the political commitment to finance care. While Nordic social care provision is based upon universality, general tax financing, high decommodification, high labour market participation, equality and generosity, a key question remains as to whether this model will be sustainable in the future owing to an aging population.

EU Countries (Germany, France and The Netherlands)

The Netherlands, Germany and France have social care systems that are based on mandatory social insurance schemes, which function separately from their health insurance schemes. In the Netherlands and Germany, these schemes are funded by general taxation at central government level. In France, it is funded both by taxation at central government level and at the regional government level. The system is designed to cover a basic level of care only, with informal carers expected to cover the majority of care needs. Insurance-based systems relying on a single source of funding can leave long-term care budgets more vulnerable to macroeconomic fluctuations. However, having a contribution-based system is associated with a reduced need for political bargaining, which can be more prevalent in systems that rely predominately on general taxation. It was not possible to ascertain the impacts of the French, German, and Dutch models of social care on population health impacts, but the literature revealed that enablers of improving integrated care included interprofessional meetings and improving communication between all stakeholders. Key challenges to the long-term sustainability of this model are: challenges to access linked to the underdevelopment of publicly funded formal long term care services, challenges to sustaining the quality of care due to significant increases in demand, challenges to the life opportunities of carers and gender equality resulting from increased informal care being required to plug the gaps in future care access, and challenges to the financial sustainability of the system due to a need to increase public spending to fund care services for an ageing population.

Canada

Responsibility for social care comes entirely under the jurisdiction of provinces and territories. While the Canada Health Act specifies a set of criteria in which health care services deemed medically necessary must be covered by provincial health-insurance programs, municipal governments have the freedom to plan their own particular arrangements. In addition, the Canada Health Act also excludes long term and other social care services. Instead, social care is considered an extended health service that can be provided at the discretion of the provinces and territories. The system is dominated by a medical approach to care and the vast majority of long-term care is still provided in residential institutions. For those requiring support at home, waiting lists can be long. Differences in provincial arrangements for care provision has resulted in inequalities in distribution of services between provinces. However, efforts to more closely integrate health and social care over the past few decades have helped improve the provision and coordination of long-term services. Provincial control allows services to be more specifically tailored to the needs of local geographic areas. In Canada, the impacts of programs aiming to integrate health and social care more closely on population health outcomes cannot be ascertained from the literature alone. However, health outcomes continue to lag behind those of other high-income countries and health inequality remains high. In addition, greater amounts of care being delivered within residential settings has a negative impact on health care services, as lengthy waiting lists for residential care means that people occupy beds in hospitals during the time they wait for a place in a residential care facility. The literature identifies the importance of governance in enabling improved integration of care and moving towards a wellness model. Research shows how provincial amalgamation of district health authorities into a single provincial health authority have helped to increase access to care, provide greater coordination of care for those with complex care needs, enhance the quality of care delivered, and improve targeting towards population care needs. The literature also asserts that quality, not finance, needs to be the driving force behind integration if it is to prove to be successful in practice in improving access and quality of care.

UK Countries (Scotland, Northern Ireland, Wales, England)

In the UK context of devolution, health and social care are wholly devolved matters, with Scotland, Northern Ireland and Wales having subtle differences in the funding and financing social care to that of England. Each of the four National Health Services are funded primarily from general taxation gathered at a UK level, but funds are distributed to the Scottish, Welsh, and Northern Irish governments through the Barnett formula, based on current and historical population size. The Scottish and Welsh governments also set some devolved taxes and have limited powers to raise or lower income tax bands with revenue going to them. Since 1973 Northern Ireland has operated under an integrated structure of health and social care. Scotland, England, and Wales are gradually moving towards increasing integration of their health and social care systems. While increased integration of health and social care in Wales, Scotland and England is associated with the potential to provide a more holistic approach to care, the system in Northern Ireland has come under criticism for having multiple layers of decision-making and unclear lines of accountability. Similarly, complex arrangements between the local authorities and health boards in Scotland have not always resulted in the well-integrated services, with health emerging as the dominant partner in integrated boards and being better financed. The lack of statutory basis in England for integration, means that England’s health and social care partnerships often rely on voluntary commitment and lack designated resources to fully deliver integrated ways of working. In all four UK countries, evidence suggests that the increased integration of care has had a relatively limited effect on population health outcomes and on reducing existing health inequalities. Important lessons can also be learned from the case of Northern Ireland, where commissioning systems make it difficult to reshape service provision for the future. Literature focusing on Scottish efforts to integrate health and social care have shown that one of the most significant barriers to integration is that the development of integrated care bodies does not necessarily lead to more effective partnership working. Underlying challenges, such as social care being more financially overstretched than health relative to the level of need, remain unaddressed in joint arrangements alone. Integrating finances effectively requires reliable information sharing across all aspects of care and a financial framework that can adequately share risks and benefits across different commissioners. Integrated finances have also been shown to be unlikely to make much difference until underlying funding pressures are addressed, as budgets intended to be allocated to integrated care boards can end up offsetting overspends in acute care. Lessons learnt from Wales have revealed the need to adopt a place-based approach to ensure that care services are responsive to the needs of population. In England, it has been shown that while integrated finance arrangements can help lead to improvements in collaborative working, this will not necessarily lead to financial savings, especially in the short term. In all four UK countries, social care is experiencing pressure as the population ages. Growing rates of health inequality between the wealthiest and poorest social groups in each country and falling birth rates suggest that demands for long-term care will likely increase further in the future.

Factors to Consider when Determining the Feasibility of Transferring a Social Care Model from One Context to Another

The review identified factors that need to be considered when assessing the transferability of one model of social care from one context to another. The literature also reveals that: prior acceptance of the program amongst relevant stakeholders is fundamental for effective transfer; the abilities of each model to succeed and generate revenues inevitably depends on the wider economy; and there is need to consider fundamental principles that underpin a country's model of social care when thinking about its transferability, as a widely supported principle in one country as a basis for care provision (e.g., universalism) may not be as strongly upheld in another. Important demographic information is provided for each country that can be used to infer whether the model might face similar future challenges if it were implemented another context. Important factors to consider when assessing the suitability of each model for transfer are: the rate of population ageing in both countries, the geographic location of the population, projected levels of health and income inequality, governance structures, population diversity, socio-cultural values and expectations about responsibility over care provision, and public willingness for public spending to be increased.

Conclusion

The review concludes with a comparative discussion of the similarities, differences, strengths, and limitations of each of the different models of social care. The discussion also highlights the key recommendations and lessons that can be learned from the international literature for improving the provision of social care in countries facing the challenge of responding to the care needs of an increasingly aging population. Important enablers and barriers to the sustainability of the existing social care models are emphasised, including the financing of these models, and to improving the integration of health and social care services. From this, a series of ten specific recommendations is presented for decision-makers involved in the development of a National Care Service in Scotland.

1. Introduction

The Scottish Government announced its intention to establish a National Care Service (NCS) for Scotland in its 2021-22 Programme for Government (Scottish Government 2022). The National Care Service will build on the recommendations made in the Independent Review of Adult Social Care in Scotland (Scottish Government 2021) to create a social care system that addresses current challenges in the Social Care system and which ensures consistent and fair access to social care and support and improves outcomes for people. This report details the findings obtained from conducting a systematic rapid literature review (SRLR) to explore the existing published scholarly research (research literature) and publicly available policy-relevant research reports (grey literature) to describe and compare international social care models and funding within the context of an ageing population. The review was undertaken between August and October 2022 in order to provide evidence for the Health, Social Care and Sport Committee's scrutiny of the National Service (Scotland) Bill, with funding provided by the Scottish Parliamentary Corporate Body (SPCB). The review considers the features of each of the different social care models, their strengths and weaknesses, enablers of and barriers to success, challenges to their sustainability, and the potential of the different models model for improving health care delivery and population health outcomes to help aid decision makers seeking to explore the potential for implementation of similar models within the Scottish context.

The systematic rapid literature review examined and compared the social care systems in Scotland, England, Wales, Northern Ireland, selected EU Countries, Switzerland, Alaska, the United States, Japan, Australia, Canada, New Zealand, and the Nordic (Scandinavian) countries. It explored how each model is funded, governed, structured, delivered, and facilitated. As such, this review also builds upon previous research published by the Scottish Government focusing on social care models in the Nordic Countries (Scobie et al., 2022a), and in the Alaskan and New Zealand (Scobie et al., 2022b) contexts.

1.1: Background and Rationale

Establishing a National Care Service (NCS) in Scotland aims 'to improve the consistency and quality of care and support across Scotland' (Scottish Government 2022: 1), and local responsibility for the design and responsiveness of care and support to communities. In Scotland, social care services and support cover a wide range of services and are aimed at providing direct support to people to help them meet their personal outcomes. Social work is a statutory role which involves assessing need, managing risk, and promoting and protecting the wellbeing of individuals and communities. The population receiving social care and social work support in Scotland is diverse and represents a wide range of needs and circumstances. For example, people may receive care and support owing to age, physical disability or frailty, learning disabilities, mental health conditions, addiction, or experience of homelessness. Social care and support services also support unpaid carers, including young carers, and provide help for children and families who may need additional support, or where children are unable to live with their own families. Justice Social workers work with people to address offending and its causes.

A recent Scottish Government report explains that although many examples exist of how social care and support have provided positive life changes to Scottish citizens, there is evidence of a need for improvement in how social care, social work, and community health work for people (2022: 1-3). To improve outcomes, it is fundamental that the National Care Service is responsive to the present and predicted future needs of the Scottish people and society. Development of the NCS offers an opportunity to address the existing challenges and limitations evidenced in current social care services. In 2021, the Independent Review of Adult Social Care (IRASC) made a series of recommendations to the Scottish Government for improving adult social care. In Autumn 2021, Scottish Government consultation proposals then considered widening the National Care Service scope to include children's social work and social care, justice social work, addiction and rehabilitation and related services. Proposals made sought to ensure that: a) social care services and support is consistent in the quality of delivery to all citizens requiring the services across Scotland, b) better support is provided for unpaid carers, and c) social care workers are respected and valued. NCS consultation responses supported making changes to the delivery of care across Scotland, including the need for greater integration of health and social care services, as well as for improvements in the accessibility of referral processes and in the provision of information about support available (Scottish Government 2022: 3). This is because existing evidence demonstrated that the interrelationship between health and social care issues is strong and can also be complex, with people often requiring access to multiple services simultaneously and having to transition between services from across the social and health care spectrum (Scottish Government 2022: 3).

It was subsequently decided that the National Care Service will be responsible for all areas of social work and social care support, including support for carers, and will also be responsible for planning and commissioning primary care and community health services The NCS consists of eight key aims: 1) to enable people of all ages to access timely, consistent, equitable and fair, quality health and social care support across Scotland; 2) to provide services that are co-designed with people who access and deliver care and support in ways that respect, protect and fulfil human rights; 3) to provide support for unpaid carers; 4) to support and value the workforce and unpaid carers; 5) to ensure that health, social work and social care support are integrated to improve outcomes for individuals and communities; 6) to place continuous improvement at the centre of all plans and developments; 7) to provide opportunities for training and development, and 8) to enhance recognition of the value of investment in social care. The Scottish Government is committed to establishing a functioning NCS by the end of the current parliamentary term in 2026. The NCS Bill was introduced to Parliament in June 2022. This Bill sets out a framework for the changes proposed and provides Scottish Ministers with the powers to gradually work through the detail and co-design new approaches to the funding, delivery, governance and regulation of social care services and support through: a) continued engagement with people with experience of accessing and providing support and b) by scrutinizing evidence of the strengths and limitations of different possible potential approaches to the funding, delivery, structure and governance of integrated care services for improving social care, support and population health outcomes in Scotland, as well as for ensuring that the approaches chosen and their associated positive outcomes may be sustained on a long-term basis.

This report contributes to the evidence base available for Member scrutiny of the different approaches available for consideration and implementation within the Scottish NCS. It provides an outline of the evidence available from the existing international scholarly and policy-relevant research to compare selected different models of social care funding, delivery, structure, and governance available, and highlights the lessons that can be learned from the existing research concerning the strengths, limitations and challenges associated with each of these different approaches to social care.

1.2: Aims and Objectives

The objectives of the rapid review were threefold:

1. To inform Members of the Scottish Parliament of the similarities and differences of the different models available to help support the Health, Social Care and Sport Committees scrutiny of the National Care Services (Scotland) Bill.

2. To provide evidence-informed recommendations for good practice and to inform Members of the Scottish Parliament about the opportunities, limitations, challenges, and barriers associated with each model of social care.

3. To expand on the findings and scope of the recent rapid review reports of the Nordic Countries social care model and the Alaska and New Zealand systems by exploring a broader range of international social care models (Scobie et al., 2022a).

With these objectives in mind, the review aimed to achieve the following:

a) To provide an outline each of the different social care models available in the high-income international context,

b) To provide evidence from the available literature and devise recommendations based on this evidence to aid government decision making for achieving long-term sustainable and effective social care delivery in Scotland, and

c) To outline the main strengths, limitations, barriers, and enablers associated with each social care model and highlight key contextual information relevant for consideration when thinking about the feasibility of these models for implementation within the Scottish context.

1.3: Research Questions

To achieve these aims, the rapid systematic review of the literature focused on answering the following six research questions and associated sub-level questions:

Research question 1: How is social care structured, delivered, funded, and governed in each of the different countries?

The question was broken down into the following five associated sub-level questions to help identify key similarities and differences between the funding, structure, governance, and delivery associated with each model:

- 1 a) How are social care services associated with each model integrated and at what scale?
- 1 b) How is the provision of social care distributed between the different sectors (public, private, voluntary, and informal) for each of the different models of social care?
- 1 c) How are social care services integrated with health care services for each of the different models?
- 1 d) How is funding provided within each of the different models?
- 1 e) What are the key governance and regulatory frameworks associated with each of the different models?

Research question 2: What are the benefits and limitations associated with each model of social care and what evidence is available within the academic and policy-relevant literature of these benefits and limitations?

This question considered the strengths and limitations of each of the different models in question and from the perspectives of the following:

- Evidence from service users (user experience)
- Evidence from professionals (including experiences of providing person-centred care)
- Evidence from informal/familial care providers
- Evidence from policy makers
- Evidence from economists

Research question 3: What evidence is there of the impacts of the each of the different models in terms of population health outcomes?

This question is answered by exploring each of the following sub-level questions:

- 3 a) What has been the impact of each model on population health outcomes and what evidence is available to support this?
- 3 b) What has been the impact of each model on health care systems and what evidence is available to support this?
- 3 c) How effective is each model in reducing health inequalities and what evidence is available in to support this?

Research question 4: According to the literature, what are the enablers and barriers to the effective implementation and delivery of each model of social care and what recommendations can be made for good practice?

Answers to this question were obtained by examining the following:

- 4 a) What lessons can be learnt from the trials and implementation of the different social care models or aspects of these models across different national contexts?
- 4 b) What recommendations can be made from lessons learned in other countries for improving social care provision?

Research question 5: According to the available literature, what are the enablers and barriers to the long-term sustainability of each model of social care?

And

Research question 6: What information/considerations are required when considering the potential transfer of the different models for implementation within the Scottish context?

1.4: Structure of Report

This report is divided into several sections. The next section presents an overview of the methodology used to conduct the systematic rapid review of the literature. This is followed by discussion of the findings. The findings are broken down into different sub-sections corresponding each of the different models examined to aid ease of accessibility. The final section of the report consists of comparative concluding discussion, which highlights the main strengths and weaknesses associated with each model. From this, a set of detailed recommendations is presented for consideration by decision-makers.

2. Methodology

The rapid review combined systematic, narrative, and abridged Delphi Method techniques to review the existing academic and policy-relevant research literature focusing on the different national social care models and their associated impacts, successes, challenges, and limitations. This allowed the literature search and evaluation to be conducted in a way that adhered to the key principles of systemic reviewing in the applied social sciences (Bryman 2012) and best practice in the health and medical sciences (Munn et al., 2018, Methley et al. 2014), while simultaneously allowing for subjective and expert-led evaluation of the literature to determine relevance to the research questions (Snilstveit et al., 2012).

Selection of the research questions was determined by the aims of the review. The review focused on the following countries and social care systems, as per the requirements of the research: UK Countries (Scotland, England, Wales, Northern Ireland), EU Countries (Germany, The Netherlands, France), Switzerland, Alaska, the USA, Canada, Japan, Australia, New Zealand, and the Nordic countries (Sweden, Denmark, Finland, Norway).

2.1: Data Collection

Data collection consisted of two main components:

1. Systematic search of the published academic and policy-relevant (grey) research literature focusing on the different national social care models, and the social, regulatory context and policy context that they exist within.

2. Web-based search for additional relevant policy-relevant literature consisting of reports and policy documents that may not be available through the academic research literature databases.

2.1.1: Component 1: Systematic Review of the Academic Literature

The systematic aspect of the review drew upon Bryman's (2012) approach to conducting a systematic review and was used to conduct a database search of the published academic research literature. Seven academic research databases from which to perform keyword searches were identified, which reflected both the purpose of the research and the interdisciplinary nature of the research problem which required consideration of the evidence spanning across the social care, social sciences, health and medical sciences, and policy-relevant research. Databases selected as being most appropriate for these purposes were: Web of Science (multidisciplinary, including medical, health and social sciences), Scopus (multidisciplinary), Medline (medical and health sciences), Embase (medical sciences), ProQuest (policy-relevant literature), CINAHL (health sciences), and SCIE (social care). Key words relevant to the research questions were identified to enable keyword searches of the databases to be performed using multiple combinations of keywords. The same combinations of keywords were used for each of the different countries in question. This allowed articles of potential relevance to the research questions to be identified for each specific country and associated social care model. Keywords included (but not limited to) were: integrated care, social care, social care funding, social care governance, social care delivery, social care experience, social care outcomes, strengths, limitations, and evidence.

These searches generated articles and reports of potential relevance to the research questions, with an initial total of 3107 articles of potential relevance being identified. Initial systematic evaluation of the relevance involved developing and applying an inclusionary/ exclusionary based on the research questions, adoption of a PICOS framework (Methley et al., 2014) and the screening of references using Covidence systematic review software. Due to the limited timeframe in which to conduct the review, articles older than ten years were excluded. This ensured that only articles that included the most up-to-date research evidence were included in the final sample. This also helped ensure that the strengths and limitations identified were applicable to the present funding, governance, structure, and delivery context of each country, whereas older research papers may not account for more recent reforms in each country's social care model when discussing associated strengths and weaknesses. Articles that had not been peer-reviewed in scholarly academic journals and those published in languages other than English were then also removed from the final sample. Duplicates in the number of articles were then removed. This resulted in bringing the total number of articles selected for possible inclusion and evaluation down to 457. All references were then screened in Covidence, a commercial reference manager software tool. Further criteria for inclusion/exclusion were applied based on the PICOS framework - Population, Intervention, Comparison, Outcomes and Study design. This brought down the total number further to 221. Abstracts where the full article was not available from the research databases were also removed to ensure that only articles which could readily be drawn upon by decision-makers were included in the final sample. This brought the number of articles selected for inclusion down further to 195.

2.1.2: Component 2: Search for additional policy-relevant literature and policy documents

An additional 39 references were retrieved from the grey literature using the Google web search engine. The same keywords and combinations used to perform the searches of the research databases was deployed in the online Google search to ensure consistency and relevance to the objectives of the research. A preliminary first screen of the grey literature was undertaken to remove reports such as blogs and websites. The process resulted in 24 references being added to the pool for potential inclusion.

2.2: Evaluation, Review and Quality Check

The narrative, subjective aspects of the review involved: 1) researcher screening and evaluation of all the titles and abstracts (and where applicable, report executive summaries) of references indicated as potentially being of relevance via the systematic database searches for their actual relevance to the key research questions and objectives of the project, and 2) application of an abridged version of the Delphi Technique to verify the quality and evaluate the relevance of the grey literature obtained through the Google web-based search.

The Delphi Method is a research technique that involves drawing on the extensive knowledge and expertise of academic experts and/or practitioners working in the field of the issue of relevance (Barrett and Heale 2020, Dalkey and Helmer 1963). Given that with policy-relevant literature, publication may not necessarily guarantee the same level of quality control as can be expected by the peer-review process for academic literature published in academic journals (Adams 2017), it was deemed important to seek expert verification that grey literature documents obtained for review were of sufficient quality for inclusion. For this purpose, a Co-Investigator from the Assembly of Social Care, and an international leader in research on social care currently based in the Department of Social Work at the University of Stirling, helped provide checks on the quality and relevance as part of a quality assurance process. The Assembly of Social Care is a multisectoral advisory group that was formed through the IMPACT partnership and which consists of members from private, public, and voluntary care providers, from the academic sector, from communities and third sector providers, as well as service users, informal care providers and care recipients.

Articles, reports, and documents not deemed to be of sufficient quality or relevance were removed from the pool. **This brought the total number of articles for inclusion in the final sample to 166.**

A summary of the reduction process used to determine the final number of articles selected for inclusion in the final sample for detailed analysis and scrutiny can be seen in the flow chart on the following page. This shows the number of articles included and excluded at each stage of the process.

2.3: Breakdown of the Final Sample

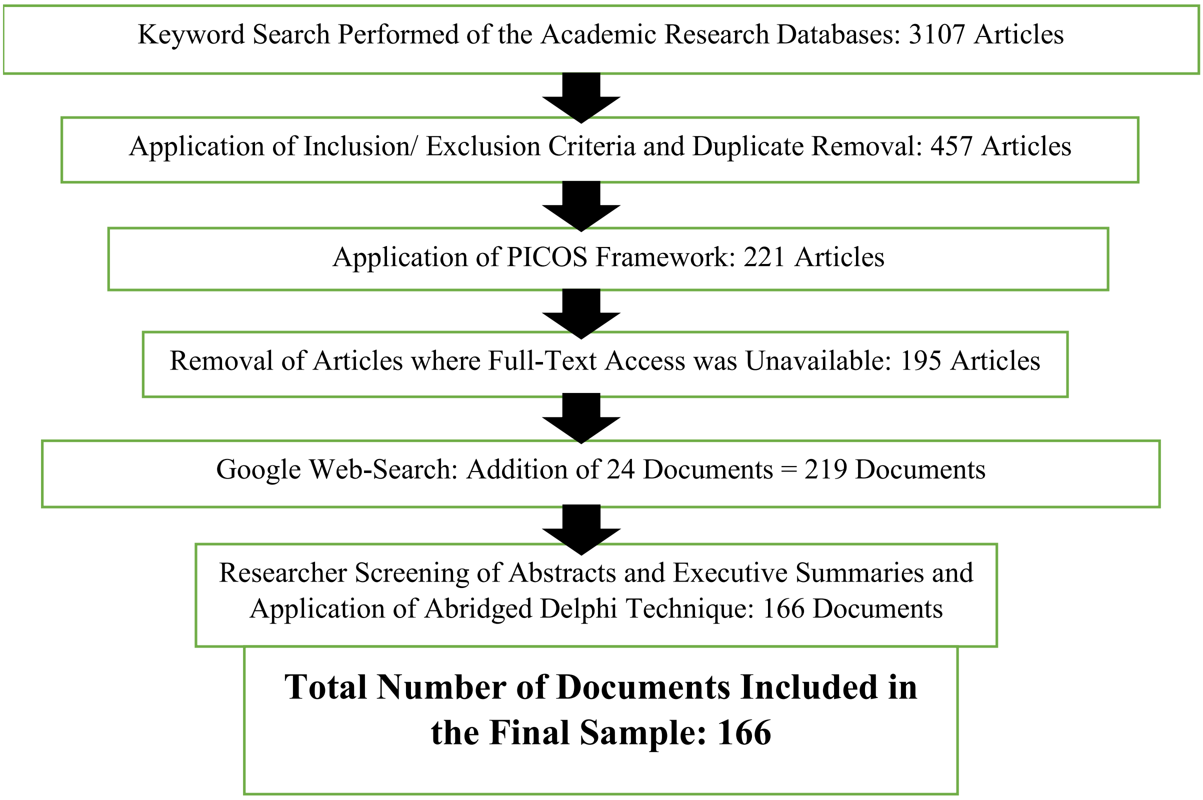
The 166 documents included in the final sample were grouped according to each specific country (or state or nation) and associated social care model. 160 focused on one country (state or nation), with 6 focusing on two or more countries. Those which focused on more than one country were included for each country that they discussed. As a result, 6 of the documents were grouped more than once. Out of the total 166 documents included, the total numbers that discussed each country (or nation or state's) social care system was as follows:

- EU Countries: 26 documents
- Nordic (Scandinavian) Countries: 23 documents
- Australia: 19 documents
- Switzerland: 15 documents
- Japan: 12 documents
- New Zealand: 9 documents
- USA (excluding Alaska): 15 documents
- Canada: 8 documents
- Alaska: 7 documents
- Scotland: 10 documents
- England: 10 documents
- Wales: 7 documents
- Northern Ireland: 5 documents

2.4: Analysis and Coding

Analysis and coding of the 166 documents included in the final sample was undertaken using qualitative descriptive analysis of the abstracts, executive summaries and contents of each document to identify, assess, and code for key themes (Sandelowski 2000). The coding process enabled the analysis to address the research questions for each of the different countries and associated social care models. Some of the documents were relevant for answering only one of the research questions, while the majority were relevant for answering two or more of the questions. Articles were then coded according to: a) the components of the different national models of social care (governance, structure, delivery and funding), b) recommendations/lessons learnt for good practice in trialling, implementing and reforming these different models, c) qualitative and quantitative evidence of the strengths and limitations associated with each model, d) evidence of the impact of the model on population health outcomes, addressing inequalities, and on health care systems, and e) social, demographic, economic, geographic, regulatory and policy factors associated with each country as relevant to its associated model of social care.

Figure 1: Flow chart summarising the reduction process to determine the number of documents included in the final sample



3. Findings

The findings are discussed below for each of the different countries and associated models reviewed. Greater detail is provided in the discussion of the findings for some of the models owing to differences in the amount, content, and topic diversity of literature and research evidence available.

3.1: Australia

3.1.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

The Australian social care sector focusses on the most vulnerable people, with the greatest and most complex needs. The social care sector includes child and family services, child protection, mental health, and aged care. It includes provision of residential care for people with high levels of need requiring complex care and provision for care needs such as everyday accommodation, personal care services, and community care packages for those eligible for residential care, but who prefer to stay at home.

The Australian system is not universal and government assistance focuses on those with low incomes. Service provision is determined on assessment of an individual's need and charges to the individual are determined on the basis of means testing. In residential care, individuals make a means-tested contribution to their care costs and pay the accommodation costs and daily living expenses themselves. Regulations specify a maximum amount each person can be charged for accommodation, as based on their assets, and a maximum daily living charge. In low-level residential care, residents can be asked to buy an accommodation bond to cover their accommodation costs, which takes the form of an interest free loan to the residential provider. In low-level residential care, user contributions are higher and the majority of individuals pay approximately half of the costs themselves. Users pay approximately between 4 and 10 per cent for community care costs. The basic daily fee payable by consumers covers living costs. For those in residential care or home care, this is set at broadly 85% and 17.5% respectively of the single-person state pension.

The government covers the full cost of lower-level community support services such as cleaning in states that signed up to the National Health Reform Agreement. Since 2012, individuals have been able to receive a personal budget to tailor services to their own needs. Community and residential services are rationed by limiting entitlement approvals and operating waiting lists. There exists a maximum number of people who can receive care services at any one time, based on a set proportion of the at-risk population. Lower-level care services are prioritised within a set budget based on need.

Social care services are financed through tax revenue and user charges, with the wealthiest people having to pay all or the majority of their care costs themselves up to a specified government defined limit. It can be difficult to obtain private forms of insurance to cover these additional costs. Approximately, two-thirds of government spending on social care goes towards residential care, while the remaining third is spent on community, assessment, and information services (Robertson et al., 2014). While the provision of health services falls to State governments, the provision of pensions and funding for welfare services is a federal government responsibility. As such, aged care policy and legislation, funding and regulation come under the responsibility of the Federal government (Brennan et al., 2012). Since 2014, residential aged care in Australia has undergone significant reform as a result of the 2011 enquiry into aged care by the Productivity Commission, which highlighted the need to ensure an adequate aged care workforce while identifying means of reducing the fiscal burden of aged care on government. Recommendations of the enquiry included allowing service users to contribute more towards the cost of care, and a reduction in reporting requirements (Robertson et al., 2014).

Non-profit social care organisations provide the majority of residential care, but over a third is provided by for-profit organisations. Less than 6 per cent is provided by national and state governments (Robertson et al., 2014). Over 80% of community care is provided by non-profit organisations, with the remainder being provided by for-profit and government organisations (Robertson et al., 2014).

3.1.2: Benefits and Limitations of the Australian Model of Social Care

Of the 19 documents focusing on the Australian social care system, 17 discussed evidence from research to identify key strengths and limitations associated with this model of care. Important limitations identified were:

- Difficulties for individuals in obtaining insurance to cover the costs to the individual for long-term care (Robertson et al., 2014.
- Individuals' vulnerability to market fluctuations in financing the private costs of long-term care (Fitzgerald et al., 2019).
- Difficulties navigating increasingly complex systems of care provision (Fitzgerald et al., 2019; Henderson and Willis 2020).
- Pressure caused by increases in demand and costs to the federal government under the current system for aged care resulting from an increasingly aging population (Henderson and Willis 2020).
- Concerns about standards of care as a result of increasing private sector involvement in care provision (Fitzgerald et al., 2019).
- Problems associated with increasing deregulation of services (Henderson and Willis 2020).
- Increasing inequalities in care provision (Chesterman 2019, Fitzgerald et al., 2019; Hummell et al., 2020).
- Power imbalances in leadership and service delivery (Henderson and Willis 2020).
- Lack of integration between different providers in the delivery of care for complex needs, especially in disability service provision (Eastwood et al., 2019; Gill et al., 2018; Hummell et al., 2020).
- Problems relating to service user ability to exercise decision-making and choice in personal care services and provision, especially in relation to aged care for people affected by dementia (Fitzgerald et al., 2019; Gill et al., 2018; Tatangelo et al., 2018).

- Coordination and integration of services for young people and vulnerable families, especially in rural areas where service provision remains more limited (Eastwood et al., 2019; Hickie et al., 2019).
- Means testing rules can be difficult to understand, resulting in people selecting a type of care based on financial rather than needs-based considerations (Hummell et al., 2020).
- Workforce challenges in the context of an aging population (Hummell et al., 2020).

For example, Henderson and Willis (2020) discussed how increasing privatisation of services can lead to poorer service quality due to incentives to cut costs to achieve profits. For-profit private services in Australia have a higher proportion of sanctions applied for failure to meet minimum care standards (ibid). Fitzgerald et al., (2019), who used evidence from service-users living with dementia in Australia and their carers to explore experiences of navigating the Australian care system, found that diversity in care coordination, affected quality of life outcomes. Information about services, their purpose and eligibility criteria were difficult to obtain, and potential care pathways were largely unexplained. In addition, support provision tended to be reactive rather than proactive (ibid).

Strengths of the current system identified from the literature were:

- Personalisation of services can, at least potentially, better meet individual need (Fitzgerald et al., 2019).
- Care is means tested and the Australian system is more generous than the English system, with public spending per capita for those aged over 65 being 60 per cent higher and with greater government coverage of community services and lower user contributions are lower (Robertson et al., 2014).
- Consumer expectations create demand for high quality service provision (Wang et al., 2022; While et al., 2020).
- The system allows people to receive care in their own homes and as part of an aging-in-place approach which has positive impacts on quality of life (While et al., 2020).
- Integration of services can potentially lead to better care planning, monitoring and evaluation of services (Eastwood et al., 2019).
- Integrated service provision leads to an approach to care that is responsive to the social determinants of wellbeing (Eastwood et al., 2019).
- Emphasis on external care provision reduces informal care provision and associated negative impacts, including lower workforce participation of working adults and the negative impacts on the health and wellbeing of informal (familial) care providers (Mohanty and Niyonsenga 2019).
- Increasing the opening up of care provision to private service providers and market forces has been identified as a way to reduce the fiscal demand on the federal government (Fitzgerald et al., 2019).

3.1.3: Impacts of the Australian Model on Health Care and Population Health Outcomes

Six of the documents reviewed discussed the impacts on population health outcomes and impacts on health care systems. The findings were mixed. Henderson and Willis (2020) reviewed secondary literature from the Australian context and described how increasing marketisation of aged-care in Australia and the increased presence of private-for-profit service delivery has resulted in falling care standards and has not helped to improve equality in care service provision. Similarly, Malbon et al., (2019) showed that the personalisation of social care has led to growing social and health inequalities, owing to how social and structural inequalities manifest in abilities to access the full range of service providers and to exercise decision making in care choices. However, as the system allows people to live in their own homes as they age, this benefits health and quality of life amongst older people (While et al., 2020).

Integrated care service provision was linked to positive outcomes in relation to mental health and improved quality of life for people with complex disabilities. For example, Parker et al., (2020) argues, using long term data from service user records and statistical analyses, that the integration of care services in the rehabilitation of service users with complex mental health needs improves long-term outcomes, especially in terms of social functioning, and also helps to reduce hospital admissions and emergency mental health service provision. Du et al., (2021) shows that integrated health and social care can help to alleviate psychological distress amongst people living with disabilities, using evidence obtained from a national survey and cross-sectional study. However, Malatzky et al., (2022) used qualitative evidence obtained from semi structured interviews with young people and argued that increased integration of service provision may reinforce biomedical approaches to care provision in the context of youth mental health. This can potentially reduce impacts on wellbeing, owing to failure to fully account for individual circumstances and social, cultural, and political contexts in care service provision.

3.1.4: Enablers and Barriers to Effective Implementation and Delivery of the Australian Model of Social Care: Recommendations for Good Practice

Seven of the documents reviewed discussed enablers and barriers to the effective implementation and delivery of the Australian model of social care, particularly in relation to the integration of health and social care services. Several key recommendations can be drawn from this for ethical, and effective practice that may be applicable to other national contexts.

In the context of greater integration of health and social care, Bosco et al., (2019) drew on evidence from ethnographic and qualitative data to devise recommendations to overcome barriers in the provision of person-centred care for people living with dementia. They argue that best practice in integrated care should involve efforts to maintain personhood, sense of belonging and dignity in care planning and delivery. While et al., (2020) explored how increased teamworking can help to overcome problems with care integration resulting from poor communication and poor staff retention and help to increase trust between multiple care providers. Wang et al., (2022) used evidence from a cross sectional survey of service users accessing aged-care in Australia and concluded that in the context of multiple care providers and person choice over selection of care services, people prefer to decide by themselves rather than having professionals make decisions for them. They also highlight the importance of the role of social workers in providing information about the full range of options available to individual care users. Eastwood et al., (2019) used evidence from a research trial to improve integration of health and social care for vulnerable families in Sydney to demonstrate that integration of care services can help to break intergenerational cycles of poverty, reduce crime and poor educational outcomes, and improve employment opportunities, health, and lifestyle behaviours by adopting a social determinants of wellbeing approach to care provision. However, they also highlight that limitations in access to services in certain geographic areas (including rural areas) can hamper efforts to achieve more holistic approaches to integrated care provision. Similarly, Malbon et al., (2019) argue that integrated care systems and user choice models need to be responsive to existing structural inequalities, because if they fail to do so, they risk increasing social inequalities. They argue that government policy should address existing structural inequalities to enable an integrated health and social care system to achieve its maximum potential.

Similarly, Hummell et al., (2020) use evidence from a rapid review of the literature on inter-organisational collaboration was undertaken to identify and describe key barriers and enablers of relevance to current social care policy and delivery for people with disabilities in Australia. They identify a series of macro, meso and micro level factors that help to improve the integration of health and social care and help to overcome existing limitations. They explain that legislation, policies, regulation, and governance rules need to help tackle legal, administrative, and bureaucratic barriers to collaborative engagement and working, ensuring that differing levels of rules do not conflict. They also demonstrate how financial resources are key to the success of integration, as inadequate funding and fragmentation in funding limits potential success. Organisational purposes and roles must be clearly defined and non-ambiguous, while appropriate IT systems for data management across shared organisations is important for optimising service delivery. Focusing on building personal relationships and establishing mutual trust between service providers rather than imposing structures to build collaboration was also seen as a key enabler of inter-organisational collaboration.

One article draws on evidence from research from the impacts of increasing privatization of social care in Australia to devise a set of recommendations for overcoming the limitations associated with this model of care (Chesterman 2019). Chesterman’s (2019) 10 Principles for safeguarding adult social care in an era of privatization are drawn from lessons learned and also consider human rights and their role in relation to care provision. These 10 principles specify that:

1. The target “at-risk adult population” needs to be defined carefully so as to ensure an appropriate nexus exists between a person’s right to make their own decisions and society’s protective responsibilities.
2. A functionally independent agency must be empowered to investigate, both on its own and following a complaint or notification, any situation of concern
3. An assessment power, which enables experts to see and speak with the person in question, is fundamental.
4. The person’s wishes must be a key consideration.
5. Consistent with the principle of the “dignity of risk,” where the person in question has the capacity to do so, he or she must be able to refuse to be assisted by an agency.

6. A “supportive intervention” approach by the agency that enables it to identify and, where necessary, coordinate support services (e.g., aged care, disability, mental health, family violence support services) is central to controlling its effectiveness.
7. Appropriate safeguarding mechanisms must be in place.
8. Responses must be commensurate with the risk faced by the person in question
9. Access to personal data should be regulated and be subject to monitoring and review.
10. Information sharing laws need to enable relevant agencies to communicate necessary information.

Fitzgerald et al., (2019) make specific recommendations for improving personalised care approaches specifically for people with dementia, based on the findings from focus groups with service users and their carers. They argue that centralising access to information and services would help tackle the problem of practice inconsistency and help to promote holistic integrated care. They also recommended the establishment of ‘systems navigator’ roles to be the first point of contact for consumers and carers, responding to queries, giving service advice and confirming eligibility, which would help people understand possible care pathways and reduce stress and anxiety amongst users by providing clear outlines of what supports and services they would receive and when and to whom they should direct questions or escalate issues.

3.1.5: Enablers and Barriers to the Long-term Sustainability of the Australian Model of Social Care

The literature identified several barriers to the long-term sustainability of the Australian social care model. These were:

- Lack of forward planning and significant investment (Hummell et al., 2020).
- The need to increase government funding costs for sustaining future care provision (Schofield et al., 2019).
- Concerns about ongoing financial instability and the likelihood that user contributions will need to increase further (Schofield et al., 2019).
- Due to the way the subsidy is calculated for residential care, providers still bear some of the accommodation costs of low-income residents themselves (Khadka et al., 2019).
- Changing patterns of care provision with more people accessing care at home rather than permanent residential care mean that individuals will be required to pay more for their care in the future, as individuals with incomes higher than the full state pension pay more towards their care. This means it financially benefits providers to seek out patients with higher incomes and could result in working inequalities (Khadka et al., 2019).

However, several interventions may help to enhance the sustainability of the model in the long-term. The Australian Productivity Commission’s Inquiry into Aged Care investigated three different options for the future funding of older people’s care (Robertson et al., 2014). Encouraging working-age individuals to save money during their working lives to pay for care in older age, either via private savings accounts or superannuation, could help to avoid long-term problems with care finance. However, long-term care costs can be unpredictable and most people will have moderate care costs and will save more than is needed to cover them, while a small number of those least likely to be able to save will have very high care costs and will be unlikely to be able to pay for their care. Because of this, the Commission viewed the ideal policy solution as one that protects people from high social care costs, while encouraging them to save money during their lifetime to cover the predictable costs of long-term care. A home equity release scheme, which already exists in Australia, was also viewed as a potential solution allowing people to draw on the equity in their homes to pay for care. However, these are vulnerable to changes in property prices and interest rates. The Commission also considered the role of long-term care insurance policies in redistributing money from low- to high-intensity users but concluded that voluntary long-term care insurance was unlikely to be financially workable and, due to the ageing population, it would now be too late to establish a compulsory insurance system that would collect enough money from the working-age population to cover the increasing care needs of the ageing population (Robertson et al., 2014).

3.1.6: Information/Considerations Required when Considering the Potential Transfer of the Australian Model

While the literature itself did not specify any particular considerations that should be made if its social care model were to be adopted elsewhere, including in Scotland, several key issues were implicated that have relevance when considering the feasibility of the Australian model for the Scottish context. These are:

- Rate of population aging. There are four million people aged between 65–84 years with predicted rapid acceleration of the aging population trend in the next ten years. Demand for aged care is expected to outstrip supply in the next 30 years (Schofield et al., 2019).
- Australia has a population of 22 million, the overwhelming majority of whom (89 per cent) live in urban areas (Hummell et al., 2020).
- Average life expectancy of 82 years is one of the highest in the world (Hummell et al., 2020).
- The care sector is highly regulated by the Federal Government, but the devolved state governments have discretion in deciding how to organise health and social care services for which they have responsibility (Robertson et al., 2014).
- Public spending per capita for those aged over 65 was approximately 30 per cent higher than in Scotland in and nearly 60 per cent higher than in England in 2014 (Robertson et al., 2014).

3.2: United States

3.2.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

Spending estimates within the U.S. social services sector are less well defined than those for health care. International economic analyses (e.g., among OECD countries) shows that social spending accounts for a considerably lower percentage of GDP than social spending in other countries. Among the OECD industrialized countries, the United States has the lowest ratio of social-to-health spending: for every $1 spent on health care in the United States, about $0.90 is spent on social services, while in OECD countries, for every $1 spent on health care, an average of $2 is spent on social services (Bradley et al., 2016). According to a 2016 RAND Europe report, although U.S. social care spending is lower than it is in other member countries in the OECD, spending on old age (e.g., pensions and home-help and residential services) is higher than comparative OECD countries (Ling et al., 2018). In recent years there has been greater integration of health and social care (ibid).

The majority of all social care costs are paid for privately by individuals. The main source of public funding is the Medicaid programme, which covers nursing home and some home nursing care for those with low incomes who have spent their assets. Medicare does not cover social care costs, except for a small amount of rehabilitative residential care for up to 100 days. This means that in the US, most people requiring residential care are private payers and required to spend their own finances until they qualify for coverage from the Medicaid programme, which provides a safety net for those with low incomes. As residential care is expensive, averaging above £45,800 a year, most people qualify for Medicaid assistance after only a few years (Sandhu et al., 2021). For those not requiring nursing care, residential assisted living centres are available, but these are not covered by private health insurance or Medicare. However, in 40 states, waivers are available so that low-income residents are covered by Medicaid. Home and community care is expensive and most private health insurance policies and Medicare do not cover these expenses, and the Medicaid programme only covers these expenses in certain states. Wealthy people may obtain private long-term care insurance to cover the costs of residential and long-term nursing care but take up is low (approx. 5 per cent) and policies are often liability capped which limits their ability to protect against the high costs of care (Robertson et al., 2014). Administration of the Medicaid program is undertaken at the state level and the federal government has given states flexibility in the types of service delivery models each state employs and what benefits are afforded to beneficiaries (Sandhu et al., 2021). Medicaid agencies use payment levers to incentivize or reward private healthcare payers to invest in social care interventions.

Plans for a national, voluntary, self-financed long-term care insurance scheme called the Community Living Assistance Services and Support (CLASS) Act, were included in the Affordable Care Act of 2010 (Commonwealth Fund 2014), but this Act was repealed in January 2013 before implementation, following concerns about financial stability and the need to find savings during budget reconciliation negotiations. Congress established the Federal Commission on Long-term Care to look for an alternative solution to financing the costs of social care but did not reach agreement owing to different underlying beliefs about whether responsibility for financing long-term care needs ultimately lies with society or with the individual. Over the last decade, federal and state governments in the US have demonstrated a newfound and robust commitment to health and social care integration, however as service delivery is largely driven by private companies, policy action has focused primarily on financing and payment structures rather than quality of care (Sandhu et al., 2021).

The majority of residential nursing homes in the United States are for-profit (61 per cent), one-third are run by non-profit providers (31 per cent) and a small number are government-run facilities (8 per cent).

Funding for children’s social services and care is different and is facilitated by the Federal government directly and also via State and Tribal child welfare agencies. Types of child welfare services provided by States and counties vary and include family support and preservation services; child abuse prevention; and supports for out-of-home care, adoption, and guardianship. The largest Federal source of child welfare funding is title IV-E of the Social Security Act, which supports foster care, adoption assistance, and guardianship assistance programs, The Family First Transition Act, passed in 2019, provides one-time, flexible funding to help States and Tribes implement Family First. Federal funds are also provided through the Children's Bureau, which administers several Federal programs dedicated to child welfare services and prevention.

3.2.2: Benefits and Limitations of the US Model of Social Care

Of the 15 documents examining the US model of social care, only three discussed key limitations of the system (Carter et al., 2018; Sandhu et al., 2021; Stokes et al., 2018) and only one identified potential strengths associated with the system (Sandhu et al., 2021). Key limitations identified were:

- Financing social care now as well as in the future given that over the last decade the burden of chronic disease and fragmented care delivery have increased at alarming rates (Sandhu et al., 2021).
- Fragmentation and gaps in service delivery for private care provision (Carter et al., 2018).
- Inequalities in access to aged care (Sandhu et al., 2021).
- Lack of government policy and regulation of care providers (Sandhu et al., 2021)
- Traditional provider payment mechanisms do not create appropriate incentives for integrating health and social care (Stokes et al., 2018).
- Integrated care tends to be sector and disease specific and unable to fully meet the needs of those with complex needs (Stokes et al., 2018).
- Lack of standardised reporting and monitoring of care (Stokes et al., 2018).
- Lack of policy action from public actors other than on financing and payment structures (Sandhu et al., 2021).
- Health care-centred integration efforts risk inadvertently medicalizing social care, with social care needs being viewed as being like a pathology to diagnose and treat
  at the point of care, with little acknowledgement of the root causes. (Sandhu et al., 2021).

- Interventions are focused on individual-level social needs which fail to address the upstream, community level and systemic root causes of health and social inequality (Sandhu et al., 2021).

In contrast, a potential strength of the US system is that the decentralized approach to care, in which the government provides incentives and flexibility for care re-design, private actors and community-based organizations, can result in better tailoring of care services to specific states or individual need (Sandhu et al., 2021).

3.2.3: Impacts of the US Model on Health Care and Population Health Outcomes

One of the articles reviewed specifically focused on inequalities in health under the US system. Williams and Cooper (2019) explain that huge inequalities in chronic disease levels are evident in the US, with adverse social determinants of health being the major drivers of poor health and health inequalities. They argue that poor efforts to integrate health and social care compared to other high-income countries contributes significantly to these health inequalities. They also highlight how this model of social care delivery exacerbates racial health inequalities, including via unconscious bias in care service promotion and delivery.

3.2.4: Enablers and Barriers to Effective Implementation and Delivery of the US Model of Social Care: Lessons Learnt and Recommendations for Good Practice

Nine of the reports discuss enablers and barriers to the effective implementation and delivery of the US model. For example, Stokes et al., (2018) and McGilton et al., (2018) discuss how incentivising payments for integrated care can help to more closely align social and health care to address the social determinants of health and wellbeing more effectively. Cylus et al., (2018) discuss funding reforms and policy, explaining that changes tend to be incremental and arguing that the ability of reforms to improve outcomes and generate reserves – public or private – is dependent on the broader economic situation. However, they suggest that increased spending from public sources paid for by federal tax revenues would help to improve the financing of care and reduce inequalities and limitations in social care delivery and quality of life outcomes.

Beresford et al., (2019) discuss lessons learned for improving outcomes for recipients of care and suggest that greater public participation in social care decision making could help to bring improvements, but only if regulation and support are present to help people exercise their rights as service users. However, they also explain that neoliberal ideology in social care policy has resulted in it becoming increasingly residual with users having become increasingly disempowered and that more options need to be made available for people to exercise choice and person-centred care that responds to their needs. Williams and Cooper (2019) argue that greater integration of community health workers and social workers could help to address the social determinants of health to reduce inequalities and argue for an integrated social needs care service. They also argue that training and workforce recruitment should be better integrated to help promote greater interaction between care providers. Similarly, Bunn et al., (2018) show, using stakeholder interview data, that increased integrated decision making for older people and those with multiple care needs could help to improve delivery outcomes in the context of multiple care provision. Chute and French (2019) discuss how digital technology developments could help optimise health and social care provision to achieve greater integration for delivering a person-centred approach. Greater attention should also be given to ensuring equality in access to information about care to help to improve equality in care receipt and better matching of services with personal need (McGilton et al., 2018).

Sandhu et al., (2021) examines the impact of prioritizing three major national and state policy initiatives to improve integrated health and social care over the last ten years in the US, with a focus on the Medicaid public insurance program for Americans with low incomes, to outline the effectiveness of these efforts and the lessons learned from translating policy to practice. They explain that policy development enabled initiatives to test new integrated health and social care models and argue that the findings demonstrated a need for greater engagement across levels of organizational leadership and frontline staff, and greater flexibility from national policymakers in order to better align incentives across sectors.

3.2.5: Enablers and Barriers to the Long-term Sustainability of the US Social Care Model: Recommendations for Best Practice

Only one of the articles reviewed discussed challenges to the financial sustainability of the US social care model and recent efforts to expand integration between health and social care. Cylus et al., (2018) explained that changes in the wider economy pose challenges to the sustainability of the funding of US social care services and explain how the socio-cultural and political context may influence long-term outcomes, by discussing how societal and political values in relation to norms and ideas of fairness will shape future reform.

3.2.6: Considerations for the potential transfer of the US Model

While the literature itself did not specify any particular considerations that should be made if the US social care model were to be adopted elsewhere, several key issues were implicated that have relevance when considering the feasibility of the US model for transfer. These are:

- The US currently faces challenges from rapid increases in the number of people living with complex health and care needs and rising health and socio-economic inequalities (Sandhu et al., 2021).
- The US has a strong, long-term history of private sector provision of services, including for health and social care (Beresford et al., 2019).
- The strength of the US individual rights-based approach to governance and service provision is an important consideration (Sandhu et al., 2021).
- Public spending on social services remains the lowest amongst OECD countries (Sandhu et al., 2021).

3.3: Japan

3.3.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

Japan has a compulsory long-term care insurance scheme (Kaigo Hoken) that covers the social care needs of the population aged 40 and over and which is separate from the health care insurance regime. The public long-term care insurance (LTCI) system was launched in April 2000 by reorganising the existing elderly care system in combination with related medical services (Robertson et al., 2014). It aimed to offer a conventional welfare service through social insurance. Municipalities operate the public long-term care insurance system and have the responsibility for planning long-term care in their jurisdictions and developing infrastructure for care services. This system was introduced to replace the tax-based bureaucratic decision of granting access to services to poorer people with an insurance-based system in which all citizens were allowed to make individual choices as to the care they received. This allows competition among service providers, including the existing social welfare corporations and for-profit companies, cooperatives, and not-for-profit providers. Existing health care providers also expanded into social care, hoping to attract patients by offering more integrated health and social care (Curry et al., 2018). Individuals are assessed by a team to determine eligibility for care and the individual then chooses a care manager who then commissions services from a range of providers.

Benefits are designed to cover the costs of care, with less than a 10 per cent co-payment required from individuals. This is further reduced on a means-tested basis for people on lower incomes. One third of accommodation costs are covered, with the remainder subject to means testing. Assessment does not take informal care provided by an individual's community into account and the intention is that social care services will provide a substitute for informal care (Robertson et al., 2014). The scheme is designed to cover the care needs of those aged 65 and over. Adults aged 40-64 are only covered for long-term care needs arising from particular age-related issues, such as dementia and osteoporosis. Unlike other countries, familial and informal care provision levels remain particularly high.

Half of the revenue for the long-term care insurance scheme comes from general taxation, with one-third coming from insurance premiums from people aged between 40–64 (at a rate of 1 per cent of income) and one-sixth from people over 65 (according to a fixed tariff of premium rates). User co-payments account for the rest. A small proportion of the population have private long-term care insurance as an alternative to the public system. Private plans are also available to cover cost-sharing obligations in the public system, but take-up is very low (Robertson et al., 2014).

Japan traditionally relied on hospitals and informal care settings to provide care for the long-term sick and disabled, but use of residential care is now increasing. For-profit residential care institutions are not allowed (Matsuda 2013). The majority of home help providers are private for-profit or non-profit organisations, with some publicly owned providers.

National and local governments are responsible for providing social care and social services to children requiring protection and people with disabilities to support their living and well-being.

3.3.2: Benefits and Limitations of the Japanese Model of Social Care

Six of the documents reviewed outline the strengths and limitations associated with the Japanese model of care and social service provision. Specific limitations identified were:

- Social care policy is paternalistic and involves medical expertise in assessing eligibility to disability services (Lindqvist and Lamichane 2018), which leaves little scope for individuals to express their agency, choice and decision-making capacities.
- Expectations for families to provide informal care remain the norm, creating challenges in an increasingly aging society where increasingly older people will bear the brunt of caring for the oldest members of society (ibid; Yamaguchi et al., 2022).
- Informal care provision is a gendered issue with the majority of informal care being carried out by women, resulting in lower employment opportunities and quality of life for women (Washio 2019).
- Social care services are dominated by medical models of care leading to issues relating to general wellbeing and quality of life (ibid; Kurimoto 2021).
- Rapid ageing of the workforce population leads to challenges with long-term care funding via state subsidies.
- Holistic care is not evenly achieved and people can be excluded through unemployment and low employment (Kurimoto 2021).
- The increasing number of migrant workers in Japan with poor safety nets has led to increasing pressure for means tested reductions (Lindqvist and Lamichane 2018).
- Widening discrepancies between urban and rural social care provision (ibid).
- Integrated services can be poorly coordinated (Kurimoto 2021).
- Middle class individuals may face difficulties paying for care as subsidies are applied only to those on a lower income (Steil 2022). For example, when Japan’s compulsory public long-term care insurance scheme was implemented in 2000, demand for services was higher than anticipated with 10 per cent of the over-65 population found to be eligible for social care services, which then rose to 16 per cent by 2005 (Curry et al., 2018). This led to the introduction of restrictions to entitlements including means testing for accommodation and restrictions of home help services to those with the most complex needs or to those who live alone (Curry et al., 2018).
- User contributions in the form of co-payments mean that fewer poorer people are taking up entitlements (Robertson et al., 2014).
- In 2009, 10 per cent of the population evaded compulsory insurance payments and either cannot access services or are more likely to delay entering services (Robertson et al., 2014).

The literature also shows that despite these limitations the Japanese system has several important strengths (Curry et al., 2018). Key strengths of the Japanese model are:

- Access to care is standardized.
- For people in employment, individuals' contributions are shared with employers. Premiums are determined and collected nationally and redistributed to municipalities according to need.
- Maximum co-payment towards the cost of care is capped at 30 per cent for the highest earners. This helps ensure equality of service receipt as if an individual wants more services beyond their entitlement, they must pay 100% of the costs out of their own pocket.
- State provision of services is generous and demand for additional services is low.
- As contributions start at the age of 40, by then most people know someone who requires care and can see the benefit of the system first-hand and, therefore, are more willing to contribute.

3.3.3: Impacts of the Japanese model on Health Care and Population Health *Outcomes*

None of the documents reviewed presented evidence of the impact that the social care system has on health care services and population health outcomes. This suggests that this is an area where future research could be undertaken, especially as the long-term impacts of major social care reform will only now be fully evident (20 years later). However, one article (Lee et al., 2020) discussed the impacts on quality of life amongst people with disabilities, showing that because young people with disabilities receive services from infancy to adulthood, there is consistency in care and service provision, which in turn, improves quality of life and independence.

3.3.4: Enablers and Barriers to Effective Implementation and Delivery of the Japanese Model of Social Care: Lessons Learnt and Recommendations for Good Practice

Two documents highlighted key enablers of the effective implementation of the Japanese model, with implications for best practice. Zhou and Zhang (2022) argue that elder care requires strong multi-level regulation and, in the case of Japan, it has been demonstrated that comprehensive and systematic policy for resource integration together with rigorous evaluation and continual improvement can aid in the successful national transformation of social care systems. Curry et al., (2018) show how clear communication of the benefits and the contribution system to the general public helped increase support for the new system. They also show the importance of the need to be flexible as a result of fluctuations in demands for care services and adjust eligibility criteria accordingly to control expenditure. In addition, they show how making services easy to navigate by having a care manager responsible for care plans can help to make an integrated system easier for users to navigate.

3.3.5: Enablers and Barriers to the Long-term Sustainability of the Japanese Social Service and Social Care Model: Recommendations for Best Practice

Okma and Gusmano (2020) and Curry et al (2018) provide details of enablers and barriers to the long-term sustainability of the Japanese social care system. Okma and Gusmano (2020) show that the main challenge is the growth of the aging population in Japan, which means that sustaining the system depends on willingness to expand its welfare and insurance scheme for the provision of longer-term care. Curry et al., (2018) show how sustaining the care workforce presents a huge challenge to the long-term sustainability of the current system. Wages in social care are relatively low compared to other professions and Japan faces a shortage of approximately 300,000 care workers in the next 10 years. In addition, without greater focus on prevention-focused health services and the promotion of wellbeing amongst younger adults to delay people’s need for formal care services, the sustainability of the model may face increasing challenges from the rise in people requiring coordinated care in future years.

3.3.6: Considerations for the Potential Transfer of the Japanese Model of Social Care

While the literature itself did not specify any particular considerations, several key issues were implicated that have relevance when considering the potential of the Japanese model for reforming social services and social care in Scotland:

- Japan has a much larger population than Scotland with 127.4 million people (Curry et al., 2018).
- It also has particularly stark demographic projections with an average life expectancy of 84 (ibid).
- By 2040, the number of people aged over 65 is projected to increase to over one third of the population (ibid), compared to nearly one quarter of the population in Scotland.
- The population aged 80 or older in Japan has risen sharply, from 0.9% in 1970 to 8.2% in 2016, nearly twice that of Scotland (Curry et al., 2018).
- Japan’s economic growth rate is slow compared to that of other countries and its total debt amounts to over 200% of its GDP (Plackett 2022).
- Japan’s low population growth in the 1990s means there are lower numbers of working age adults today than in previous decades (Robertson et al., 2014).

3.4: New Zealand

3.4.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

The New Zealand health care system is similar to that of the UK nations. However, the social care system is different with most social care being part of a health board's allocation. The budget covers both care in people's own homes and residential and nursing care. Both types of care are subject to a needs assessment. Residential care is asset and means tested. Personal care at home is included and provided for free, subject to the individual district health board resource allocation for community-based services (Morgan et al., 2019). Domestic care, such as cleaning and shopping, is means tested and charged for. The health ministry funds and purchases care for people with disabilities under the age of 65. A wide range of social service support is available and services are focused on individuals, families, and communities, and are delivered by a range of government agencies, non-government organisations and for-profit providers. New Zealand has a larger range of private sector care and service provision than the UK, and primary health organisations contract with district health boards to provide a range of primary and community services.

Social services for children and families cover a wide variety of activities and are funded by the central Government. The Pēpi, tamariki and rangatahi Māori Indigenous people of New Zealand have specific rights to health and wellbeing under Te Tiriti o Waitangi (Te Tiriti) (King et al., 2018; Moton et al., 2020), which forms the foundation of the contractual relationship between the Māori nation, as tāngata whenua of Aotearoa, and the Crown. Te Tiriti articulates tāngata whenua rights to health and wellbeing for pēpi, tamariki and rangatahi Māori under all four articles collectively with the intent of Te Tiriti as expressed through the phrasing and words of the text (King et al., 2018).

3.4.2: Benefits and Limitations of the New Zealand Model of Social Care

The following key strengths were identified from the literature focusing on the New Zealand model:

- Integration of health and social care helps facilitate collaborative care amongst providers (Morgan et al., 2019).
- Integration of health and social care services are better able to address the care needs of those with complex needs (Morgan et al., 2019).
- Integration helps reduce barriers to care access (Morgan et al., 2019).
- Integrated care provision embedded upon an ethos of respect for socio-cultural diversity has made positive steps towards addressing health and social inequalities between Indigenous people and other New Zealand citizens that result from the history and legacy of colonialism (Moton et al., 2022).
- Integrated care can reduce reliance on informal care provision, which is associated with lower workforce participation, poorer quality of life and mental ill health stemming from carer burnout (Chan et al., 2021).
- Having a single vision for a single model can help facilitate strong leadership and continuous staff development (Scobie et al., 2022b).

However, negotiating diverse agencies for care provision can impose difficulties in accessing care and support for service users (Morgan et al., 2019). In addition, funding the system faces challenges due to an aging population (Parsons et al., 2018). Recent studies have also highlighted functional deficits in provision for aged care recipients with dementia (Chan et al., 2021), and suggest that greater information support needs to be provided by allied-health organisations to improve quality of life for care recipients (ibid). Care service users identifying as LGBTQ+ are also reported to experience greater difficulties in accessing appropriate care services (Moton et al., 2022).

3.4.3: Impacts of the New Zealand model on Health Care and Population Health Outcomes

Moton et al., (2022) and Carlson et al., (2022) use findings from qualitative research with culturally diverse young people to demonstrate how integration of services for young people and an increasingly individualised approach to young people's wellbeing has helped to improve mental health outcomes in young people aged between 16 and 20. Chan et al. (2021) use evidence from a comparative study of New Zealand and Hong Kong to demonstrate that greater integration between health and social care is effective in improving cognitive performance, daily function and hospital stays amongst older people living with dementia. Scobie et al., (2022b) examine the impacts of the introduction of the Canterbury model of integrated care in New Zealand and suggest that redesigning and implementing different ways of providing health and social care can have beneficial outcomes, especially in reducing numbers of hospital admissions and emergency department visits amongst older adults.

3.4.4: Enablers and Barriers to Effective Implementation and Delivery of the New Zealand Model of Social Care: Lessons Learnt and Recommendations for Good Practice

Five of the documents reviewed discuss important enablers and barriers to the effective implementation and delivery of the New Zealand model. Parsons et al., (2018) uses evidence from the development and trial of a Casemix funding solution for home-care services and user assessments from older people to improve flexibility in approaches to care funding. They conclude that adopting this system within home care services can help facilitate care that is more responsive to the changing needs of older people. Robinson et al., (2021) also uses evidence from experimental studies to examine how proactive primary care may help to reduce aged-residential care placements for frail older people and concludes that enhanced goal setting, care planning, regular follow-ups and enhanced assistance for health and social care navigation helps to achieve positive outcomes. Morgan et al., (2019) uses qualitative evidence with service users to reveal how integrated models founded on interagency collaborative can help to improve care delivery and how divergent organisational paradigms can compromise collaboration.

Scobie et al., (2022b) identify the following enablers as crucial to the success of the Canterbury model of integrated health and social care provision: having a clear vision of a 'one system, one budget' approach, investment in staff through training and skills development, and development of new models of service contracting and integrated working. They explore how Acute Demand Management Systems (ADMS) help to prevent patients being placed in hospital when they can be cared for in the community and help to allow discharged patients to receive specialist care in the community. They also show how electronic shared care record systems help to improve information sharing between different parts of the integrated system without increasing the risk of revealing confidential information. Wodchis et al., (2020) examine how policy support can help to improve integrated care delivery and argue that the frequent monitoring of indicators and quality in New Zealand helped to improve care delivery standards. In particular, policies that emphasised partnerships between health and social care organisations and non-governmental organisations, particularly Māori-led organisations, helped to emphasise connections between local providers of care. They also helped with the devising of programs of care that could better address the social as well as medical needs of care users.

3.4.5: Enablers and Barriers to the Long-term Sustainability of the New Zealand Social Service and Social Care Model: Recommendations for Best Practice

Only one of the documents reviewed discusses the barriers and enablers of the long-term sustainability of the New Zealand model. Scobie et al., (2022b) explains that the success of the Canterbury model may be at risk due to its financial position and significant changes of leadership. In addition, while the Canterbury model may result in lower spending on emergency hospital care compared to the rest of New Zealand, this requires increased spending on community-based services. Funding provision through the current system of taxation may also be difficult to sustain in the future owing to the aging population.

3.4.6: Considerations for the Potential Transfer of the New Zealand Model

While the literature itself did not specify any particular considerations, the following issues should be noted when considering the potential of the model for reforming social services and social care in Scotland:

- New Zealand has a similar population level to that of Scotland
- By 2051, there will be 1.18 million people aged 65 and over in New Zealand, representing an increase of 165% since 1999, with older people expected to make up 26% of the total New Zealand population of just under 5 million (Morgan et al., 2019).
- Adults over the age of 85 have the highest growth rate (ibid).
- Life expectancy is 81.7 years (ibid).
- While Scotland does not have an Indigenous minority population like New Zealand, lessons learned from experience of incorporating socio-cultural diversity in health and social care delivery to reduce the health and social inequalities prevalent amongst minority groups may provide valuable insights for enhancing care and services to better meet the needs of minority population groups.

3.5: Switzerland

3.5.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

Switzerland is a federal state divided into 26 cantons and its long-term care system is financed by directly by contributions from taxation and a compulsory health insurance system that also provides for social care service provision (Swiss Federal Social Insurance Office, 2015, in De Pietro et al., 2015). People on lower incomes are eligible for subsidies and those with the lowest incomes who receive welfare aid, have their premium paid for by the government. Approximately 40 per cent of the population have their premium subsidized or fully paid by the government. However, all earners earning above a certain income level all have to pay the same premium.

The Government provides non means tested long-term care allowances under the social insurance scheme according to acuity levels. For example, an older individual is defined as moderately dependent if they require regular assistance with at least two aspects of personal care or permanent personal supervision, whereas severely dependent people require regular and personal assistance to meet their care needs (Becker & Reinhard, 2018). Professional care can be delivered at home or via institutional care. However, the federal governance system means that social care is not delivered in the same way across the different cantons (Courbage et al., 2020).

Owing to the expansion of the older-age population, social care costs increased from CHF 10.8 billion to CHF 12.6 billion between 2012 and 2017 and now represent 2% of Swiss GDP. Various stakeholders are involved in financing social care. Using direct and indirect financing, the State Government takes over 10% of expenditures. Direct financing is provided through allowances paid to older adults in need of care, while indirect financing comes from covering parts of the institutional care costs. Another 30% of the costs fall under the responsibility of the social health insurance scheme. This covers medical care costs, but does not account for accommodation costs (e.g., lodging and meals). Households are responsible for covering the remaining 60% of the costs (Swiss Re, 2014). In the case of at-home care, this includes household and family assistance, monitoring and assistance, meals on wheels, and reduced mobility transportation. For institutional care, it includes costs related to accommodation services (lodging, feeding, and laundry) (Fuino et al., 2022). Care services are provided by an array of private and public providers.

3.5.2: Benefits and Limitations of the Swiss Model of Social Care

Specific strengths identifiable from the literature were:

- Internationally, the Swiss system ranks well regarding quality of care, access, efficiency, equity, and promotion of healthy lives (Fuino et al., 2022).
- Users are offered a large choice of services (ibid).
- Inter-institutional collaboration and integration of health and social care services help to enhance care provision (Filliettaz et al., 2018).

However, the following limitations were also identified:

- Fragmentation of social care governance and delivery, with responsibilities divided between the federal, cantonal, and local levels, increases the risk of sub-optimal quality of care (Gerritzen and Kirschgassner 2018).
- Reform in the integration of services has predominantly focused on health care rather than social care services (Felliettaz et al., 2018).
- Lack of federal regulatory frameworks and policies for integrated care
- High out of pocket contributions from care users (Filliettaz et al., 2018).
- An ageing population is putting strain on the current system of financing social care (Eling 2020; Schusselé Filliettaz et al., 2021).
- Lower income earners have to contribute a greater proportion of their income towards financing the system than those with higher incomes for both direct payments and mandatory insurance (Gerritzen and Kirschgassner 2018).
- Insurance premiums are determined by private health insurance providers. State-level actors can only indirectly influence this via regulation (Gerritzen and Kirschgassner 2018).
- Premium subsidies are the responsibility of the cantons. As a result, large cross-cantonal differences in eligibility conditions and premium subsidy levels exist (Gerritzen and Kirschgassner 2018).
- Limitations in professional support available for informal care providers, especially young care providers (Frech et al., 2021).
- System complexity can make options for care delivery difficult for users to navigate (Nicolet et al., 2022).

3.5.3: Impacts of the Swiss model on Health Care and Population Health Outcomes

None of the documents reviewed presented evidence of impacts of social care delivery for health care systems and on population health outcomes.

3.5.4: Enablers and Barriers to Effective Implementation and Delivery of the Swiss Model of Social Care: Lessons Learned and Recommendations for Good Practice

The literature identifies several important enablers and barriers to the delivery of the Swiss model of social care. Eling (2020) explains that many international studies and the World Bank have concluded that Switzerland has a good retirement system and good healthcare provision, with the combination of a mandatory health insurance scheme, taxes at the municipal level, and out-of-pocket expenses, making the financing of long-term care more diversified and less vulnerable than systems funded by one means alone.

Nicolet et al., (2022) explain that the diversification of responsibilities in care service provision make chronic care integration particularly challenging. However, they also acknowledge that better integration of health and social care services can help eliminate inefficiencies in the system through enhanced coordination and better alignment with user needs.

Schusselé Filliettaz et al., (2021) identify various programs and policy developments that have helped to enable greater integration of health and social care services for better delivery and user outcomes. They explain that the National Dementia Care Strategy helped to develop common frameworks for managing dementia and led to the development of recommendations to improve the continuity of care and inter-agency coordination of services. In addition, the 2015 Onwards: National Project on the Coordination of Care set out recommendations for improving care quality by focusing on improved processes for meeting user needs. The 2017-2020 Promotion of Interprofessional Collaboration in Healthcare helped identify good practice in fostering the coordination of care and interprofessional collaborations and highlighted the need for quality indicators and greater legal clarification about the responsibilities of non-medical care providers. The 2020-2030 Federal Council's Health Strategy has eight main objectives aimed at improving outcomes, including improving healthy ageing and increasing the quality and coordination of care. In addition, the strategy aims to control costs and their burden on low-income households and promotes greater coordination of services and resources between stakeholders.

3.5.5: Enablers and Barriers to the Long-term Sustainability of the Swiss Model

Only one of the documents focuses on the long-term sustainability of the Swiss model. Eling (2020) explains that, at present, the personal contributions of those in need of care account for a high proportion of total financing in Switzerland compared with other countries (30%, while the average internationally is only 13.5%). If this is maintained, the financial burden on those in need of care and on the municipals will reach the limits of feasibility in the near future.

3.5.6: Considerations for the Potential Transfer and Implementation of the Swiss Model

The following contextual factors should be noted when considering the feasibility of adoption the Swiss model:

- Swiss residents have a high life expectancy compared to other Europeans (e.g. 85.6
  years for women in 2020) (Nicolet et al., 2022).
- Switzerland is a federal state with differences in governance present in each of the cantons.
- The principles of subsidiarity, liberalism, federalism, pragmatism, and direct democracy are considered to be important foundations of the political culture in Switzerland and are reflected in the constitution, in federal and cantonal laws. and in the legal and institutional framework governing health and social care provision (Robertson et al., 2014).
- According to the principle of subsidiarity, responsibility for public provision should be assigned to the lowest possible level. This explains why health policy is first and foremost a cantonal competence and why only tasks that cannot be taken care of by the cantonal authorities are delegated to the federal level (Eling 2020).
- The influence of direct-democratic institutions is considerably high in Switzerland and interest groups have important leverage in care policy reform (Eling 2020).

3.6: Alaska

3.6.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

The delivery, structure, and governance of social care services in the state of Alaska differs from that of the other US states. Alaska also has particular arrangements regarding the provision of care for Indigenous Alaskans. The Cost of In-Home Care in Alaska costs $763 more per month than the national US average of $4,957, according to the 2021 Genworth Cost of Care Survey. Residential care costs in Alaska are $1,331 above the US national average of $4,290 and significantly higher than the majority of other states. Alaska also has its own version of Medicaid, known as DenaliCare, which covers some of the costs associated with home care and is administered by the Alaska Department of Health and Social Services Division of Public Assistance. Eligibility is determined by financial need, so applicants must be able to prove that they are at or below a certain income level. It provides funds for in-home care through the Personal Care Services (PCS) program and the Alaskans Living Independently (ALI) waiver. The Alaskans Living Independently (ALI) waiver provides care options and financial assistance for those who would prefer to remain in their own home rather than enter assisted living facilities or nursing homes. Along with assistance paying for personal care and household tasks, the waiver also covers home modification, respite services, adult day care and skilled nursing. However, the waiver is not an entitlement and only a certain number of recipients can receive it at any one time, which means there may be a waiting list. The Alaskan Medicare, like other Medicare systems, does not cover the cost of non-medical home care. However, it may provide some coverage for medical home care, referred to as “Home Healthcare”, for individuals who are homebound and have a referral from their doctor.

Aging in place has many benefits for Alaska seniors, including remaining connected with family and friends and living in a familiar environment. This can be especially important for Indigenous Alaskans who have particularly strong cultural connections to local environments (Lewis 2021). The community is also an important focal point for successful aging amongst Indigenous Alaskans (Lewis 2021). The presence of elders in communities is also important for intergenerational transmission of cultural knowledge (ibid), and thus aging in place is important for both the sustainability of the community and for sustaining important cultural traditions. Alaska seniors can access a wide range of community-based services and programs through Senior and Disability Services. Direct services include case management, congregate meals through the federal Senior Nutrition Program, and health screenings.

In addition, the Alaska Area Indian Health Service (IHS) works in conjunction with Alaska Native Tribes and Tribal Organizations (T/TO) to provide comprehensive health and care services to 163,835 Alaska Natives. Approximately 99% of the Alaska Area budget is allocated to T/TOs who operate under the authority of Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended. The Alaska Area maintains 11 Title I contracts with Alaska tribes and tribal organizations and negotiates one Title V compact with 25 separate tribal funding agreements each year. The Alaska Tribal Health Compact is a comprehensive system of health care that serves all 228 federally recognized tribes in Alaska.

In the 1990s, the Southcentral Foundation in Alaska introduced the SCFNuka model of primary care which has been recognised as being one of the most successful examples of health system redesign in the United States and internationally. Nuka is a multi-speciality primary and community health care provider specific to the Southcentral Alaska region. It developed following consultation with Alaskan Native leaders who found that individual health care was not being met across the population (SCFNuka White Paper Medical Services 2017). Key features of the SCFNuka system include: structural integration across all services, care staff and specialist care in hospitals; horizontal integration with hierarchies removed and team members regarded as peers; a patient-focused approach where customer-owners are considered care team members, and all decision-making regarding how care is provided includes community members in each step of the process (Saskatchewan 2020). While the model is primarily a primary care system, it does provide a greater degree of integration of health with some aspects of social care delivery. However, it remains the case that very little social care is involved except via the Eldercare programme for over 55s, which offers social events aimed at improving quality of life and wellbeing (Scobie et al., 2022b).

The Maniilaq Social Medicine Program (SMP) inaugurated by Northwest Alaska’s regional tribal health organisation in 2017 promotes greater tribal, health and social service integration to help promote the Alaska Native right to health and address stark inequalities between the health outcomes of Indigenous Alaskans and the rest of the population. It aims to deliver equity by building a system of care ground in social medicine theory and practice. The Maniilaq Association is the sole health care and social services provider for 12 circumpolar Inupiat (Alaska Native) villages in the remote Alaskan Arctic and serves a total population of population of 8,391, 83% of whom are Alaska Native (Trout et al., 2018). To fund its early work, SMP has received several federal grants to support care system planning, infrastructure development, and service expansion, including the provision of tribal doctors, chore support and transportation for elders, disability services and other social programmes (Trout et al., 2018).

3.6.2: Benefits and Limitations of the Alaskan Models of Care

Specific strengths identifiable from the literature were:

- Greater recognition of the importance of the need to provide community care and services aimed at aging in place (Lewis 2021).
- The potential of the Maniilaq Social Medicine Program for reducing inequalities in health outcomes (Trout et al., 2018).
- High levels of satisfaction with care delivered under the SCFNuka model (Scobie et al., 2022b).
- Specifically tailored to meet the health care needs of a cultural minority group in the case of the Maniilaq and SCFNuka models, moving from respecting diversity in service delivery towards developing systems based upon diversity and recognition of the specific needs of minority groups (Trout et al., 2018).

However, the following limitations were also identified:

- Lack of similar programs in other regions of Alaska for meeting the needs of Indigenous Alaskans (Trout et al., 2018).

- The focus of these programs is primarily on health care, with little or no funding support available for social care support (Scobie et al., 2022b).
- Lack of funding for social care negatively impacts upon the potential of the Maniilaq program to be able to realise its aims in practice (Trout et al., 2018).
- Funding for social care support remains highly limited for all Alaskans (Lewis 2021).

3.6.3: Impacts of the Alaskan Models on Health Care and Population Health Outcomes

While none of the documents in the sample provided evidence of the impacts of social care delivery for health care systems and population health outcomes amongst all Alaskans, one document provided evidence of the benefits of the Maniilaq and SCFNuka programs for Indigenous Alaskans. Scobie et al. (2022b) explained that SCFNuka resulted in a reduction of 36% in emergency department visits and hospital admissions amongst service users. It also explained that SCFNuka exceeds the 90th percentile in HEDIS4 measures for diabetes annual care testing and control and exceeds the 75th percentile in HEDIS measures in: breast cancer screenings, cervical cancer screenings, and paediatric BMI screening.

3.6.4: Enablers and Barriers to Effective Implementation and Delivery of the Alaskan Models of Care: Lessons Learned and Recommendations for Good Practice

Two of the documents reviewed highlight enablers of effective implementation and delivery of the SCFNuk and Maniilaq models of care. Scobie et al., (2022b) discusses how the holding of a shared vision helped to provide staff with clarity regarding their responsibilities and that change was facilitated by engaging and listening to indigenous care users about they wanted and needed in terms of healthcare and allowing them to participate in decisions about how their needs could be met. They also identified four key areas of structural change that were considered integral to the successful development of the SCFNuka care model. These were changes in medical service provision to provide care to communities in rural and isolated villages, introducing behaviour health professions to provide same day interventions, changes in strategic planning to ensure that plans were transparent and accessible to all that required access, and the redesigning of data management and information sharing systems to increase accessibility of records for all employees. Trout et al., (2018) also identifies important enablers of effective service delivery for the Maniilaq program, including: the creation of health care partnerships to prevent understaffing and problems caused by limited resources for complex care management; creation of a regional hub for learning to train health workers and learn from community experts, and help build relationships between community members, health care providers, tribal government and social services workers; and engagement of community experts to promote the right to health.

3.6.5: Enablers and Barriers to the Long-term Sustainability of the Alaskan Models of Social Care

None of the documents discussed opportunities and challenges to the long-term sustainability of the Alaskan models of care.

3.6.6: Considerations for the Potential Transfer of the Alaskan Models

One of the documents directly discussed the transferability of the SCFNuka model for implementation in Scotland. Scobie et al., (2022b) explain that SCFNuka pilots that have been identified in Scotland include Isle of Eigg (Baird, Kings Fund 2018) and Forfar (Baird, Kings Fund 2018; Audit Scotland 2016). The Scottish Government have also highlighted that Health Boards should be aware of the SCFNuka model especially regarding modernising primary care (Scottish Government 2015, in Scobie et al., 2022b). However, the only evaluation of a Scottish pilot available is the is the Fife “Tayriver” pilot, which was considered unsuccessful after a six-week internal evaluation (Scobie et al., 2022b). This finding suggests that different models of community-led health care may be difficult to transfer across national contexts and demonstrates that prior acceptance of the program by relevant stakeholders is required for effective transfer (Scobie et al., 2022b).

3.7: Nordic Countries (Nordic/Scandinavian Model)

3.7.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

The Nordic (or Scandinavian) Model of Social Care is underpinned by the principle of universalism. Eligibility for social care services is based on need rather than contributions and care services are provided for free so that all citizens who require social care and services can access them. The foundation for children's social services and long-term care services for older people is a public universal service model. Until the 1990s, services were based almost completely on public provision. The state and local authorities heavily subsidise care services, financed through income and local taxes. National legislation guides levels and quality of services. Responsibility for setting policies in practice lies entirely with local authorities who devise needs assessments, entitlements, and specific organisation, regulation, and contents of service delivery. National level legislative frameworks allow locally devised solutions to govern care provision.

Since the 1990s, changes in policy in Sweden, Norway, Finland, and Denmark has transformed the delivery of social care services into a more hybrid public-private approach, with greater involvement of the market in service provision and greater user contribution to the costs of care. The main reforms involved the introduction of contracting practices, where local governments were allowed to contract service provision to private firms and organisations, and the introduction of new organisational models where care users are able to choose between competing providers. The Nordic model is not a single model per se, but rather refers to commonalities between the Norwegian, Swedish, Finnish, and Danish models of social care. While all four care systems are based upon the principle of universalism and are funded and governed in broadly similar ways, subtle differences exist in the structure, delivery, and governance of each of the nations' social care systems.

Sweden
The Swedish Governmental Bill of 1992 separated purchaser and provider functions and allowed local authorities to contract out eldercare provision to private providers, including for-profit firms, through competitive tendering. In Sweden, local authorities are responsible for regulating social care through contractual agreements and for assessing needs to determine eligibility of care. In 2008, the Swedish parliament enacted legislation enabling user choice of provider. However, it is not mandatory for local authorities to implement the reform (SFS 2008, 962). If they chose to do so, the reform stipulates that local authorities must enter into a contract with all providers that meet their essential establishment requirements. The providers are thereafter free to establish themselves in the local eldercare market and are reimbursed by the municipality based on how many users they attract, according to a pre-determined formula. Nearly half of local authorities have introduced user choice in home-based care, with less than 10 per cent offering choice in residential care. Over a quarter of home-care users and nearly a quarter of residential care users receive privately provided care (National Board of Health and Welfare, 2018). Funding of the system remains public and user fees are capped at a maximum as regulated by the Social Service Act. User fees cover approximately only four to five per cent of the eldercare costs. Reforms have also meant that private providers are allowed to supply

additional services to users, which they pay for privately (Governmental Bill, 2008). Fewer than 10 per cent of care recipients currently utilise this opportunity.

Denmark

Denmark operates a similar social care model to that of Sweden. In 2002, the national parliament enacted a law on Free Choice of Provider (Act 399 06/06/2002) which amended the Social Service Act and obliged municipalities to offer a choice of home-care providers (Act 150 16/02/2015). The legislation however, only regulated homecare for older people and the delivery of residential care was not subject to user choice. Local authorities must contract all providers that meet pre-determined local authority requirements. To empower users and increase quality, providers are given the freedom of establishment and are reimbursed based on the number of users they attract (Act 329 18/05/2005). Eligibility for services is determined on the basis of needs and the system is still funded by public funding through income tax. Home-care users do not pay fees, but local authorities can, within predetermined limits, charge a fee for rent and services provided through the residential care (Act 150 6/02/2015). Residential care services are still characterised by public provision, while the role of private provision in home care has increased dramatically since 2002 (Bertelsen and Rostgaard, 2013). Home-care users of private providers can top-up their needs-assessed care by purchasing extra time or more frequent services from their provider (ibid). In 2012, the right to offer additional services was extended to public providers in nine Danish local authorities (Act 550 18/06/2012). Since 2013, local authorities have been able to create choices in home-care provision through the introduction of vouchers, underpinned by national level legislation (Act 326 23/03/2013). Users are able to choose freely between all care companies registered, with agreements being signed directly between users and providers (Act 150 16/02/2015).

Finland

In Finland, since the 1990s, local authorities have been able to contract-out the provision of residential and home-based care to private for-profit providers (Act 23.12.1992/1505). In 2004, the national parliament provided a legal framework for local authorities to utilise service vouchers as a means to increase user choice in the provision of home-care services. In 2009, the Act on Health and Social Service Vouchers, extended the ability of local authorities to use vouchers in all aspects of health and social services (Act 24.7.2009/569). Finnish municipalities are not obliged to implement the act on service vouchers and it has been implemented in just over half of the municipalities. Providers of homecare and residential care must be approved by the local authorities. For a provider to be approved, the quality must be at least the same as for public provision and local authorities can also require higher quality than the minimal levels regulated by law (Governmental Bill, 2009). Eligibility for aged care at home is determined on the basis of need. All needs-assessed care is funded by taxes and income-adjusted user fees. User fees are higher in Finland than other Scandinavian countries and cover up to 20 per cent of the cost. Users are able to use local authority service vouchers to select care provision. The value of the voucher is set by the local authority based on the user’s needs for care and is adjusted for income and, in this sense, the Finnish choice system rests on public funding. There is no regulation of the costs that private providers can charge for their services, which means that costs that exceed the voucher value need to be paid by the user. However, local authorities have the power to exclude providers if they consider their prices to be too high (Governmental Bill, 2009). No contract is entered into between local authorities and the private providers of care. Instead, agreements are made between users and providers. Local authorities are responsible for ensuring quality of care service delivery. If care users do not wish to use the voucher system, local authorities need to ensure they can access care through in-house or contracted provision. Private providers can supply additional services that users can purchase privately (Governmental Bill, 2009).

Norway
An important difference between Norway and the other Scandinavian countries is that Norway has not enacted any national legislation for user choice. However, all local authorities are free to determine the organisation of the provision of care services, so long as all those in need have access to publicly funded care. Eligibility to care is based on need. Local authorities have the option of introducing user choice models if they wish to do so (Act 2011-06-24-30). In contrast to the other Nordic countries, user choice in Norway does not necessarily involve private providers. Instead citizens can be offered a choice between public and private providers or between different public providers (Vabø & Szebehely 2013). The majority of local authorities have not separated out the functions of purchaser and provider. A small number have allowed private care providers to offer additional services that can be privately purchased.

3.7.2: Benefits and Limitations of the Nordic Model of Social Care

The following benefits and strengths of the Nordic model were identified from the literature in the sample:

- Services are provided to all citizens who require social care (Greve 2022; Moberg 2017).
- The Nordic model, especially the Swedish provision of social care is seen as a ‘best practice’ example by international standards, because of the generosity of its coverage and low user charges (OECD 2013). The Swedish government spends a higher proportion of GDP on social care than any other OECD country except the Netherlands.
- While local authorities have the freedom to organise care delivery, the system is supported by national level legislation which ensures equality of levels of care service provision and the quality of services (Moberg 2017).
- More power of choice was transferred to care users as a result of reform, which allows service users to exercise their agency and decision-making capacities in choosing their own care path if they wish to do so, with appropriate quality controls in place to protect users (Moberg 2017, Scobie et al., 2022a).
- Costs charged by private providers are capped, except in Finland where local authorities instead have the power to exclude providers if the costs they charge are deemed to be too high (Moberg 2017).
- Changes to the system, implemented by the reforms, means that the system is more responsive to the challenges faced by Scandinavian countries as a result of an ageing population (Puthenparambil et al., 2017).
- Coordinated funding can help to align the aims of an integrated resource mechanism (Scobie et al., 2022a).

However, the following challenges and limitations were also identified:

- Difficulties in communication between providers and care professionals can damage care user experience and little evidence is available on how best practice in collaboration and communication can be embedded in the system (Scobie et al., 2022a).
- Fragmentation of care providers for those with the most complex needs can lead to reduced quality of care (Schultz et al., 2019; Scobie et al., 2022a).
- High level framework legislation can be argued to limit local autonomy when used in conjunction with parallel national policies to implement rules and incentives that local social care commissioners and providers are required to follow (Scobie et al., 2022a).
- The introduction of marketisation challenges universalism and paying for additional services challenges the principle of equality of access (Scobie et al., 2022a; Szebehely and Meagher 2018).
- Providing user choice in the form of cash for care can challenge integrated care provision, lead to uncertainties in funding for care providers, and may also lead to fragmentation of service provision (Scobie et al., 2022a).
- Increased competition has increased instability in the market of home care for the elderly and increased costs for local areas (Scobie et al., 2022a).
- Evidence from the pan-European Survey of Health Ageing and Retirement in Europe (SHARE) suggest the reforms have resulted in increasing inequality in access to care, with those on the lowest socio-economic position having lower access to social care and greater levels of unmet need (Scobie et al., 2022a; Greve 2022).
- Those with the highest incomes were more likely to benefit from private care (Scobie et al., 2022a).

3.7.3: Impacts of the Nordic Model on Health Care and Population Health Outcomes

Several articles discuss the impact of recent reform and integrated care provision programs on population health outcomes. The impact of social care integration of the HSC programme in the Norrtaelje area of Sweden was linked to lower emergency department visits for over 65-year-olds, while overall emergency department visits have remained higher than the rest of Stockholm (Scobie et al., 2022a). In Finland, levels of healthcare use decreased after the introduction of integrated care. However, in Norway, medical visits varied little with social care level (Scobie et al., 2022a). Puthenparambil et al.'s (2017) study of the impacts of the increased marketisation of at-home social care services in Finland showed that those whose care involved relied mostly on public service provision, reported poorer health than others and were more likely to be financially poorer, have lower education levels and have unmet care needs than those who relied more heavily on services financed privately. According to the results, the wealthy were also healthier than others. This raises a concern that ability to top-up care with private finances could potentially exacerbate existing health inequalities between the wealthiest and poorest members of society.

3.7.4: Enablers and Barriers to Effective Implementation and Delivery of the Nordic Model of Social Care: Lessons Learned and Recommendations for Good Practice

The following enablers and barriers to the successful reform of social care services were identified in the literature that focused on the impacts of reforms to the Nordic model. While the introduction of marketisation potentially challenges the universality of care, the extent to which the introduction of a market-based approach diminishes the universalistic character of social care systems fundamentally depends on the generosity and quality of the public system. If publicly funded social care services remain so comprehensive that few demands for top-up services are made they will not impair universality. However, if reliance on private topping-up services increases and usage becomes unevenly distributed among groups of users, it risks undermining comprehensive usage, especially if entitlement criteria for public services becomes stricter (Moberg 2017). In addition, universalism can be maintained if attention is given to how the use of additional services is distributed and how this interacts with the political commitment to finance care (ibid).

Research conducted in Denmark found that the introduction of quality control, separation of purchasing and provider functions, customer choice and competitive tendering has resulted in increased standardisation of needs assessments, leaving less room for professional judgement and care workers' flexibility in relation to the needs of the individual service user (Rostgaard 2012). These transformations have led critics to suggest that what is taking place signifies an erosion of the welfare ethos which undermines the occupational agency of the care workers and makes care workers feel unable to provide what they define as good quality care (Tufte 2013). However, it has also meant making social entitlements more visible and the requirement for local authorities to make quality standards public has helped to enhance public knowledge of care options available. Opposition to the reforms in Denmark included concerns about the lack of requirements for formal qualification of workers employed in the private sector (Rostgaard 2012).

A number of policy features were also deemed to limit the success of reforms to the Nordic model in Denmark. One challenge was that the reforms in Denmark were argued to have changed the logics and prioritisations of care towards more physical care and re-ablement approaches, thereby devaluating relational and emotional care work. This has meant that assessment of care needs has been re-focused towards functional ability and has become goal oriented, with care services provided and communicated as a means to an end. This has created new risks of user needs being unmet and introduced a perspective than runs counter to the principle of health prevention initiatives as a policy line. The logic of reablement has also meant that older people are sometimes less likely to seek out care as there are more obligations attached to a system that approaches entitlement via changes in functional ability (Moberg 2017).

3.7.5: Enablers and Barriers to the Long-term Sustainability of the Nordic Model

The review identified a number of key enablers and barriers to the long-term sustainability of the Nordic model. While Nordic social care and service provision are based upon universality, general tax financing, high decommodification, high labour market participation, equality and generosity, a key question is whether achieving these key characteristics is still possible in the future, given an aging population. Population aging is predicted to acutely impact Scandinavian countries over the next few decades, with older people over the age of retirement placing increased pressure on the terms of universal access to health care and fewer numbers of people of working age being able to provide the finances to fund the system through employment taxation (Greve, 2016). The Nordic countries have, to a large degree, already modified their pension systems in anticipation of some of these changes, but planning for the growth of welfare state services has not taken place on the same scale (Greve 2022). In recent decades, income inequality has also risen in Denmark and Sweden, which together with increases in private care services paid for by the user, pose challenges to the principle of equality (ibid). Migration can also be seen as a potential challenge to the sustainability of the Nordic model as international migration can pose challenges to public perceptions of traditional social solidarity. However, Nordic countries still continue to hold some of the most positive views on the contribution of migrants to societal development (Brochmann and Dølvik, 2018). Welfare chauvinism is also less pronounced compared to other European countries (Ejrnæs and Greve, 2019).

While the growth of privately financed services is regarded as an enabler of rising inequality in care receipt and in unequal health outcomes between the wealthiest and the poorest members of society, one study suggests that this could potentially be mediated by re-directing public funding and using tax rebates and vouchers to support the use of private care services. This is because if users of private services have better health than other service users, then public money is not being well allocated towards achieving greater equality in health and wellbeing (Greve 2022).

Nordic welfare states also have relatively decentralised administration and centralised funding. This can be argued to potentially pose new moral risks that threaten the sustainability of the Nordic model in the context of marketisation reform, as the benefits of social insurance can diverge and private actors may be tempted to ‘overutilize’ centrally financed social insurance benefits. However, it has also been suggested that the creation of more co-financing schemes for social insurance in Sweden could considerably reduce existing incentives to overutilize social benefits (Greve 2022).

3.7.6: Considerations for the Potential Transfer of the Nordic Model of Social Care

While the literature itself did not specify any particular considerations, the following issues should be noted when considering the potential of the model for reforming social services and social care in Scotland:

- Social care services and provision in the Nordic countries is traditionally underpinned by the principles of universality and equality (Greve 2022).
- Nordic states operate devolved governance in regulating and organising social care, with overarching national legislation that allows local authorities to exercise flexibility in care delivery arrangements (Greve 2016).

- Scandinavian countries are facing the challenge of an older population that is growing fast. For example, in Finland it has been projected that the population aged 65 and over will rise to 26% by 2030 and 28% by 2060 (ibid).
- Nordic welfare models and social care services and support are underpinned by the principle of gender equality and dual-earner households, and thus less emphasis is placed on informal or familial care to meet the care needs of older residents than in countries like Japan (Moberg 2017).
- Nordic countries score very highly in terms of major welfare and development indicators, with Norway and Denmark ranking first and fifth in the United Nations Human Development Index. Wealth inequality in Nordic states exceed that of Japan but are lower than in France, Germany, the UK, and US.

3.8: EU Countries (Netherlands, France, and Germany)

3.8.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

Social services and social care systems vary across the different EU countries. Given the objectives of this report together with the timeframe of production, the review of the EU countries social care systems was limited to that of the Netherlands, Germany, and France – all of which have systems based on mandatory social insurance schemes.

Netherlands

The Netherlands was the first country to establish a universal social insurance scheme for social care needs in 1968. A universal social insurance scheme called AWBZ pays for the care of older and disabled people. This covers both home care and residential care, including accommodation costs. Social care is also closely integrated with health care and long-term hospitalisations, rehabilitative services and nursing care are also included and funded by the AWBZ insurance scheme. Care provision is determined by a needs assessment. Complex cost-sharing arrangements apply and care users have the option to receive a personal budget to pay for personal care, home nursing, and support with daily activities. Budgets are calculated based on the number of hours of care needed, and users must top up their budget with income-related contributions to buy the level of care they are assessed to need. The budget can be used to pay relatives for providing informal care and carers can also apply for a 'compliment for carers' payment (Robertson et al., 2014). The compulsory social care social insurance scheme is administered by private insurance companies and paid for via an income-related premium deducted from the wages of all citizens aged 16 and over and an employer contribution paid for via payroll taxes (Gleckman 2010). Individuals who use services also have cost-sharing obligations that vary depending on their income level, their family status, and the location of their care. Approximately three-quarters of the programme's costs are paid for by individuals via co-payments or premium contributions, with the rest covered by the general insurance fund (Gleckman 2010). The number of people receiving home care is on the rise, while the numbers in residential and nursing homes has been falling (Schafer et al., 2019).

France

Like the Netherlands, France also has a universal mandatory long-term care insurance scheme called the Allocation Personalisée Autonomie (APA) that was introduced in 2002. It provides a basic level of care assistance to all residents aged over 60 who have care needs above a government determined threshold (Robertson et al., 2014). Needs are categorised on a six-point scale that accounts for capacity to conduct daily activities and mental health status. The needs assessment does not consider the amount of informal or familial care provided when assessing a person's care requirements. The means test is based on taxable income and personal assets. In residential care, individuals pay for their own accommodation costs and personal expenses, however those with low incomes receive a subsidy towards these costs. Nursing care in residential homes is paid for by the state health insurance system, while other personal care is paid for by the individual using their APA benefit and their own contributions (ibid). For home care, the extent of financial support and the type of service provided depends on an individual's level of need, and their financial means. The government covers between 0 and 90 per cent of the cost of a person's care package, up to a maximum which differs by the level of care provided. Above that threshold, individuals must pay the full cost of their care. Although the APA subsidy cannot be used to pay a spouse or partner for providing informal care, it can be used to employ another relative or carer to perform specific tasks that are part of a defined care package (ibid).

The APA is funded by general taxation at central and regional government level. For some people with home care needs below the level covered by the APA, a home help allowance is available called Caisse Nationale d'Assurance Vieillese (CNAV) (Forder and Fernandez 2011). To cover additional costs there is a fairly large private long-term care insurance market, with around 15 per cent of the population aged over 40 holding private plans. Insurance premium payments are not taxable, and are not included in the APA means test. Indemnity policies, whereby individuals receive a predetermined income once they reach a certain level of dependency, are the most popular type of long-term care insurance policy. In recent decades, the government also introduced tax incentives to encourage people to pay privately for their own care and families can deduct 50 per cent of the cost of employing personal and domestic staff at home from their tax contributions, and 25 per cent of residential care costs, up to a maximum set by government. The incentives do not apply to private payments for care covered in part by the APA subsidy (Forder and Fernandez 2011)

Fifty-seven per cent of residential care facilities are publicly owned, 27 per cent are not-for-profit private institutions and 16 per cent are for-profit facilities (Robertson et al., 2014). Intermediary services have also been introduced over the past decade to provide respite care for frail older people who are not in residential homes (ibid). Self-employed physicians and nurses mainly provide home care, with some provision from community nursing services. Community nursing services are mainly private non-profit organisations, although some are publicly owned and this care is paid for by the public health insurance system (ibid).

Germany

A mandatory system of long-term care insurance covers both aged care and care for people with disabilities of working age. Contributions are collected as an income tax which is divided equally between employer and employee. Pensioners also make contributions. The system covers basic needs unlike the German health insurance scheme which covers all healthcare costs. Individuals are expected to contribute private funds, or to apply for means-tested welfare payments to cover at least some of the costs of social care (Robertson et al., 2014). German federal authorities are responsible for providing the infrastructure for social care and nearly all social care is delivered by private providers – either for-profit or non-profit organisations. Care services are administered by health insurers, but the care funds are independent self-governing bodies (Fernandez and Forder, 2012). Individuals can also choose to take out private insurance rather than participate in the government programme, and around nine million people do so. The private social care market is highly regulated and premiums must match those in the public programme and insurers cannot charge higher premiums to those with pre-existing conditions. Eligibility for social care is determined on the basis of assessment by the Statutory Health Insurance Medical Review Board and, if a person meet the threshold for care, they are placed into one of three levels of support, according to their needs (Blümel 2013) and the amount of care provided by informal carers (Fernandez and Forder 2012). People may receive benefits in cash, which they can use to pay family carers or to pay an agency for care, or they can choose to receive in-kind service benefits where care is provided by an agency under contract to the insurance company or choose a combination of both (Robertson et al., 2014). The direct service benefit is financially worth more than the cash payment. Payments are not made until six months after an individual is assessed as needing care. The scheme does not cover the cost of accommodation in residential care and people are advised to buy supplementary private insurance to cover these costs (Blümel 2013). There is a safety net in the form of means-tested social assistance administered by the Lander (federal state), for those who are not able to cover non-insured costs. In 2005 an extra 0.25 per cent premium was imposed on people without children who are less likely to receive informal support from family in old age (Robertson et al., 2014).

3.8.2: Benefits and Limitations of European Social Insurance-Based Models of Social Care

The following limitations of EU social insurance-based models of social care were identified from the literature:

- Because the systems in France, Germany and the Netherlands provide only basic care services, many recipients spend the money provided by the scheme and buy less care than their assessed need (Robertson et al., 2014).
- The German, French and Dutch social care system is premised on the notion that families will be involved in the provision of informal care to older people. Family members are expected to provide care that is not covered by the programme.
- In Germany, childless people are required to pay 0.25 per cent more in insurance contributions than those with children, and benefits in cash (which can be used to pay family carers) are of less value than those given in services (Forder and Fernandez 2011). In Germany there is a legal responsibility to help pay for the care of near relatives.
- In the Netherlands, demand for personal budgets is high and the system has struggled to cover costs resulting in long waiting lists for benefit receipt. Eligibility has been limited to help meet the rising demand for services (van Ginneken et al., 2012).
- Provisions under the French APA schemes are not generous and individuals must have high levels of need to qualify and many need to pay large amounts out of their own pockets or take up private insurance to pay for costs. Similarly, in Germany, benefits are not expected to cover the full costs of care and the scheme does not cover the cost of accommodation in institutional care settings, and so people are advised to buy supplementary private insurance to cover these costs (Blümel 2013).
- The German long-term care fund faces shrinking revenues and increasing expenditures (Robertson et al., 2014).
- The German system does not pay out until someone has required care for six months (Fernandez and Forder 2012).

- One of the potential downsides is that relying solely on a single source of funding may leave long-term care budgets more vulnerable to macroeconomic fluctuations.
  If the labour market is weak for example, revenue from payroll contributions will be reduced and this may lead to budget deficits that need to be addressed by using funds from previous surplus years, taking on debt or drawing funds from general taxation (Cylus et al., 2018).
- If poorly administered, this model of social care could mean that expenditures will fluctuate with the peaks and troughs of the economy rather than smoothing them out (Cylus et al., 2018)
- Having an entitlement system has been argued to potentially lead to moral hazard as individuals could become less concerned about maintaining healthy habits and trying to minimise future reliance on care services, which could make demand more extensive when they do qualify for assistance. Evidence from France indicates a positive correlation between private long-term care plans and obesity levels. However, it appears unlikely that people's behaviour would be significantly influenced by future prospects around entitlement to social care.
- In Germany, private health insurance is seen to undermine the principle of solidarity governing the social insurance system (Cylus et al., 2018).

The following key strengths of the insurance-based social care schemes were also identified from the literature:

- Basic care is provided to all citizens who have contributed to the scheme (Cylus et al., 2018).
- The use of private insurance schemes compliments the public system and in the case of France provides a fixed income to those determined as being dependent that they can then use to pay for expenses not covered by the APA (ibid).
- Indemnity policies help insurers manage financial risk as pay-outs are fixed and not related to the cost of care (Fernandez and Forder2012).
- People insured under the Dutch and German social insurance schemes are able to choose between benefits in cash, in-kind services, or a combination of both (Cylus et al., 2018), which allows the user to have flexibility in choosing their care path.
- Value of benefits of social insurance-funded schemes are dependent on the level of care needed (Cylus et al., 2018)
- One of the main advantages of a statutory long term care insurance system is that the general public are more willing to contribute financially if they are informed about how the revenues are raised and spent. Statutory insurance schemes help overcome distrust of government intentions as they provide reassurance that the money paid will be used for a specific purpose (Cylus et al., 2018).
- Having a contribution-based system reduces the need for political bargaining present in systems that rely predominately on general taxation (Cylus et al., 2018).

3.8.3: Impacts of European Social Insurance-Based Models on Health Care and Population Health Outcomes

None of the articles reviewed provided evidence of the impacts of the social care systems associated with European insurance-based models on health care and population health outcomes.

3.8.4: Enablers and Barriers to Effective Implementation and Delivery of the European Insurance-Based Models of Social Care: Lessons Learned and Recommendations for Good Practice

Eight of the documents provided examples of the enablers and barriers to the effective implementation of the European insurance-based models of social care, with seven of these examining enablers and barriers towards integrated care in the Netherlands, France, and Germany. For example, Hendry et al., (2018) draws on evidence from comparative studies across European countries to suggest that success in the provision of integrated models of care for older people can be enhanced via: a single point of entry in the community (generally in Primary Care); use of simple frailty specific screening tools in all care settings; comprehensive assessment and individualised care plans (including for caregivers); tailored interventions by an interdisciplinary team; case management and coordination of support across the continuum of providers; effective management of transitions between care teams and settings; shared electronic information tools and technology enabled care solutions; and clear policies and procedures for service eligibility and care processes. Lette et al., (2020 draws on evidence from participatory research with care service users in the Netherlands to devise recommendations for improving integrated care for people living at home. Enablers of improvement included interprofessional meetings, focusing on reflection and mutual learning, and improved communication. Different organisational cultures and interests and a lack of ownership and accountability among managers hindered improvement processes. Participatory approaches where care delivery improvements were co-created and tailored to local priorities and needs were also found to be enablers of success (Lette et al., 2020). Looman et al., (2021) also looked at examples from the European context to identify drivers of successful integrated care and recommended a balance between flexibility and formal structures for decision-making, collaborative governance, and leadership distribution.

3.8.5: Enablers and Barriers to the Long-term Sustainability of the New Zealand Social Service and Social Care Model: Recommendations for Best Practice

Growing concerns are evident about the future sustainability of European models of social insurance contribution-based care, especially in relation to funding given the ageing populations in Germany, France, and the Netherlands (Cylus et al., 2018). As a result of women's increasing participation in the labour market and the rise in pensionable age, the pool of informal carers is shrinking (Spasova et al., 2018). This challenges the assumption underpinning the models in these countries that family members will provide at least some level of informal care to those who require it. In addition, the rate of growth in the number of people aged over 80, together with lower numbers of people of working age, mean that national social protection systems face four particular challenges with regard to care for older people. These are: 1) challenges to access and adequacy linked to the underdevelopment of publicly funded formal long-term care services and a lack of complementarity between formal and informal long-term care; 2), challenges to sustaining the quality of care due to the significant increase in demand; 3) challenges to the life opportunities of carers and gender equality; and 4) challenges to the financial sustainability of the system due to population ageing and the need to increase public spending on long-term care (Spasova et al., 2018)

Cost control proposals in the Netherlands have included no longer reimbursing residential costs for those requiring care in nursing or residential settings and merging the programme into the national health insurance scheme (Cylus et al., 2018). In Germany, the role of tax revenue in the in the system changed in 2004 when a tax-funded federal contribution or subsidy was introduced to help cover the care of dependents of insured members. This subsidy was gradually increased to help prevent increases in SHI contribution rates and relieve the labour market of additional costs. This is important for helping to maintain the predictability of revenues in the face of labour market fluctuations. However, it has also been argued that the introduction of tax revenue into the SHI system leads to the risk of the federal ministry of finance gaining greater influence on decisions concerning the allocation of public funds.

3.8.6: Considerations for the Potential Transfer and Implementation of the European Insurance-Based Model

One of the documents reviewed provide several important points for consideration when examining the potential options for funding social care in the UK context, albeit not specifically for the Scottish system. Cylus et al., (2018) warn decision makers that concerns that instigate reform often arise from economic crises or perceived crises and that the ability to generate revenues, whether public or private, from these European schemes is inevitably dependent on the broader economy. They also provide caution that a widely supported principle in one country, such as social solidarity as a basis for care funding, may generate unwillingness to diverge significantly from a longstanding commitment to mandatory insurance-based funding, while in another country, the weight accorded to social solidarity may be perceived as significantly weaker, with consequently greater willingness by policymakers to at least consider other funding options (ibid: 73).

3.9: UK Countries (Scotland, England, Wales, and Northern Ireland)

3.9.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

In the UK, in the context of devolution, health and social care are wholly devolved matters. Each country has, to some extent, different funding and financing systems for health and social care. Each of the four National Health Services is funded primarily from general taxation gathered at a UK level and distributed to the Scottish, Welsh and Northern Irish governments through the Barnett formula, which is based on current and historical population size. The Scottish and Welsh governments also set some devolved taxes such as stamp duty, and have limited powers to raise or lower income tax bands with revenue going to them. This gives them an autonomous ability to increase the size of funds available.

Northern Ireland

As a devolved matter, the Northern Ireland Assembly have adopted their own strategies for governing adult social care. Since 1973 Northern Ireland has operated under an integrated structure of health and social care. This system is one of the most structurally integrated and comprehensive models of health and personal social services in Europe (Chapman 2018). The Department of Health is responsible for adult social care, including the authorising and allocation of government funding. Services are commissioned by a single body, known as the Health and Social Care Board, which is advised by local commissioning groups and delivered by five regional-level trusts (Birrell and Heenan 2014). The trust organises care delivery, which is delivered by a mix of private (for-profit and not-for-profit), public and voluntary providers. The Patient and Client Council provides an independent voice for patients, carers, and communities, covering adult, children and health services, and the Public Health Agency is responsible for improving the health and well-being of the population (Chapman 2018). Legislation for community care operates under the 1990 legislation, People First: Community Care in Northern Ireland (Department of Health, Social Services and Public Safety (DHSSPS), 1990). In 2015, the Northern Ireland Health and Social Care Board devised a new initiative for delivering social care called “self-directed support” (SDS) to offer social care users greater choice in how their care is accessed and delivered (Chapman 2021).

Residential and at home care are available to all and contributions are means tested up to a specified limit. Direct payments are now encouraged in Northern Ireland as a means of promoting greater user choice and control over care service delivery. However, uptake amongst older social care users remains the lowest across the UK (McGuigan et al., 2016). Given the means-tested nature of social care, Health and Social Care trusts can choose when to charge for care and support provided in a person’s. home based on a person’s ability to pay. People aged over seventy-five are not charged for care (Chapman 2018). HSC trusts are also responsible for assessing an individual’s finances if they require care home provision through a financial assessment looking at income (state pension, pension credit and interest on savings) and capital (savings, investment, and property).

Scotland

Currently social care services in Scotland cover a wide range of support that enables people to lead a full life and achieve the outcomes that are important to them. Social care support is delivered by a range of partners that includes public, private and third sector organisations (Scottish Government 2022). Social care is provided in people's homes, including through remote care and technology-enabled care in rural areas, in residential accommodation and care homes, or the wider community, and includes advice and support services. Local authorities are responsible for social work and social care support, while local health boards are responsible for health services. They do however work together as integration authorities to assess the needs of their area and plan and commission local community-based health and social care services, using funding contributed by the local authority and health board. The specific services people receive can also vary across the country. Health and social care partnerships (HSCPs) in each local area are responsible for delivering local community-based health and social care services on behalf of the integration authority, including adult social work and adult social care support, primary care, and community health services for adults. Some local areas also have responsibility for children's health, children and families social work and social care, justice social work, and homelessness and housing support. Local authority budgets are derived from a combination of a central grant and local revenue raising such as Council Tax. Local revenue-raising powers are also devolved and Scotland does not allow extra precept increases in the tax rate specifically to pay for care. Means testing is used to determine state-funded access to social care. Anyone with means (income, savings, and property) above the upper threshold is required to meet most of the costs of their care. Those with means between the upper and lower thresholds have their care partly supported by the state, and those with means below the lower threshold can access full funding, depending on level of need. In Scotland, personal and nursing care is free for all people assessed as having an eligible social care need. Some care users with complex, long-term care needs have all the costs of their health and social care needs fully met by NHS Scotland depending on eligibility assessments (Reed et al., 2021).

During the previous two decades, efforts have been made to promote joint working between the Scottish NHS health boards and local authorities. Since 1999, Scotland has taken a ‘Scottish approach’ to integration and policymaking more broadly and has attempted to introduce a single vision across government departments aimed at reducing inequalities in access to health care and an increased emphasis on health prevention. The Community Care and Health (Scotland) Act 2002 maintained separate statutory responsibilities for health boards and local authorities, but conferred power to transfer specific functions between them and the power to create pooled budgets. This was followed by the NHS Reform (Scotland) Act 2004, which required health boards to create community health partnerships in an attempt to further develop integrated primary care, community health, and social care services. The Public Bodies (Joint Working) (Scotland Act) 2014 created 31 statutory health and social care partnerships (integration authorities) to commission health and social care services from health boards and local authorities. Integration authorities hold responsibility over funds for urgent care, mental health care, community services and social care previously held separately by NHS boards and local authorities. They produce strategic integration plans and commission services in line with the plans. The Highland region of Scotland has a different arrangement where the local NHS acts as the lead agency (Reed et al., 2021). It was hoped that integration authorities would deliver efficiency in savings and improve the quality of health and social care in line with the framework of national health and wellbeing outcomes published in 2015.

The National Care Service (Scotland) Bill was introduced to the Scottish Parliament in June 2022. Proposals for a new National Care Service followed recommendations from the Independent Review for Adult Social Care that proposed the integrated joint boards being reformed into commissioning community health and social care boards funded directly by the Scottish government and with statutory responsibility to oversee delivery of all community health and social care services. Community health and social care boards would also replace integration joint boards on community planning partnerships, which would bring together the integration of wider services (including housing and criminal justice) (Scottish Government 2022).

England

In England, local authorities hold a statutory responsibility for social care. Like in Scotland, local authority budgets are derived from a combination of a central grant and local revenue raising such as Council Tax. England spends least per head of the population on health and even less on social care, although it spends the highest proportion of public spending on health. Social care services are subject to care needs and means testing to determine state-funded access to care (Reed et al., 2021). England has maintained separate systems for commissioning and delivering health and social care, with different geographical boundaries, budgets, legal frameworks and cultures across the NHS and local authorities. Unlike in Wales and Scotland, there is also a purchaser/provider split in English health services, meaning that commissioners contract with NHS organisations or independent providers to deliver services rather than run them directly (ibid). Adult social care in England is also more predominantly provided by the private and voluntary sectors than in the other countries, with councils generally purchasing care rather than actually providing it (ibid).

Several national policy initiatives over the past 30 years have aimed to bridge the gap between health and social care and improve coordination. Some initiatives sought to integrate health and social care more closely through a variety of planning bodies, including health and wellbeing boards, sustainability and transformation partnerships and integrated care systems that take the form of area partnerships between NHS commissioners, providers, local government, and other local partners. However, while these bodies have attempted to facilitate greater collaborative working across sectors and join up local services, they have had limited formal powers for doing so (Reed et al., 2021). Since 2012, these bodies have also had to operate in a legislative framework that emphasised competition rather than collaboration between providers (ibid). In 2018, the Health and Care Bill sought to remove competitive tendering requirements to make it easier for the NHS and local partners to agree on local purchasing decisions. This legislation also formalises the powers of integrated care systems, introducing two statutory bodies to directly hold local budgets and oversee health care delivery and changes comprised of NHS organisations responsible for commissioning health care services, representatives of provider trusts, general practitioners (GPs) and councils (Reed et al., 2021). Integrated care partnerships also bring these groups together with local authorities, the NHS, and broader partners to align ambitions and develop a common integrated care strategy for local areas.

Wales

Like in both England and Scotland, local authorities in Wales also have statutory responsibility for social care, with budgets derived from a central grant and local revenue raising. Eligibility for state-funded care is also means tested and subject to a care needs assessment. In Wales however, there is a cap on non-residential care costs, currently set at £100 a week. Since devolution, Wales has emphasised collaboration and moved away from the purchaser/provider split that is more evident in England. Since 2002, legislation has mandated that 22 local health boards work together with local authorities to develop joint health, social care and wellbeing strategies for each local area. Reorganisation of services in 2009 eliminated the purchaser/provider split and consolidated local health boards into seven bodies, which had a legal duty to work collaboratively with local authorities to plan services. The Social Services and Well-being (Wales) Act of 2014 formalised these partnerships into seven regional partnership boards (RPBs) to help accelerate integration across health and social care and enable a pooling of budgets in key service areas. The Act also gave local authorities the ability to delegate a number of social care functions to local health boards, and vice versa. Commissioning responsibilities for health and social care remain split between local health boards and local authorities, but joint and collaborative commissioning arrangements are in place for certain services and are required at a minimum for care for older people and children with complex needs, people with learning disabilities, carers, and family support services. Local health boards and local authorities are also expected to work closely together and with wider public services to improve the wellbeing of communities through public service boards, which are statutory bodies stablished through the Well-being of Future Generations (Wales) Act 2015, and which are tasked with conducting local assessments and setting local plans for how services will come together to support wellbeing, tackle poverty, improve health inequalities and promote sustainability (Reed et al., 2021).

In January 2021, the Welsh government proposed changes to strengthen RPBs and the degree of regional integrated planning by establishing RPBs as legal entities that could directly employ staff, hold budgets, and directly undertake joint commissioning where local partners agree. However, for social care services, local health boards and local authorities would remain the primary commissioning bodies.

3.9.2: Benefits and Limitations of Each UK Country’s Social Care Model

The following strengths and limitations were identified from the sample literature for each of the four UK countries:

Northern Ireland
Northern Ireland has the most structurally integrated system in Europe. However:

- The Donaldson report (DHSSPS, 2015) identified that the current system does not work as effectively as predicted and the system has been described as having has multiple layers, intricate layers of decision-making and unclear lines of accountability (DHSSPS, 2016: 2; Chapman 2018).
- The system suffers from a lack of transparency and there is widespread uncertainty about who is in charge (Chapman 2018)
- The system used to commission domiciliary care services for formal care at home has been described as difficult to understand, and there appears to be high levels of inconsistency in the planning and delivery of services across Northern Ireland (Duffy et al., 2015: 18).
- Commissioning has also been criticised in terms of the lack of integrated approaches and requirements, with the focus mostly being on the procurement of a service (Birrell and Gray 2016).
- Research from the Northern Ireland Life and Times (NILT) survey found respondents were unaware that social care is funded and accessed differently from the NHS and that individuals can be liable to contribute to the cost of care (Gray and Devine 2017)
- Policy developments in Northern Ireland are more limited than in other parts of the UK and there are few strategies dedicated specifically to adult social care. In addition, other than integrated structuring, there have been no major legislative innovations in Northern Ireland. However, given the greater demand of care services, rising expectations about care, and shifting focus towards greater personalised care, it is widely recognised as out of date, unfit for purpose and unable to provide the best standard of care services for older people (Chapman 2021).
- Opponents of personalisation are more likely to suggest that increased personalisation of care is influenced by consumerist principles, while advocates would associate it with empowerment, autonomy, and choice (Chapman 2018).
- An expert advisory panel published in the report “Power to People: Proposals to reboot adult care and support in Northern Ireland” (Department of Health, 2017) identified several concerns about self-directed support, including the level of personal budget, limited brokerage support and perceived administrative burden (Chapman 2021).
- Care user choices can be limited in regard to the time at which services are delivered, who delivers it, and how much support is provided (Chapman 2018)
- Inadequate communication of the system means that participants in receipt of care services are not always able to exercise informed choice as many are unaware of their care options (Chapman 2021).

Scotland

The following limitations were found from the literature focusing on Scotland:

- As a joint organisation between the local authority and the health board, HSCPs budgets are agreed upon and allocated by the NHS Board and the local authority rather than directly funding. This complex arrangement has not always resulted in the quality and well-integrated service that was intended (Scottish Government 2022).
- Success rates vary across Scotland (Scottish Government 2022).

- User satisfaction with care services has declined in Scotland in recent years, particularly in 2019/20 (Reed et al., 2021).
- Differences in pay, terms and conditions, and working practices across staff in health and social care can have an adverse effect on partnership working (Reed et al., 2021).
- Reviews of Self-Directed Support, including by Audit Scotland and the Care Inspectorate, have highlighted inconsistences in implementation across Scotland (Reed et al., 2021).
- There is an inconsistency of advice and information, leading to a lack of understanding and confidence for service users (Leask and Gilmartin 2019).
- The workforce can feel conflicted between focusing on outcome-based assessment and care planning based on what matters to the individual and the existing eligibility criteria (ibid).
- Health has emerged as the dominant partner in integrated boards and is better financed and has greater political capital (Pearson and Watson 2018).

However:

- Overall, people in Scotland are positive about social service provisions. Furthermore, they believe that social services perform a valuable public role (McCulloch and Webb 2020)
- Receiving care from a self-managing, integrated, health and social care team is viewed as acceptable to service users (Leask and Gilmartin 2019).

England

The following limitations were identified in the system used in England:

- Satisfaction with social care has been decreasing in recent years (Reed et al., 2021).
- While real-term spending on health increased, spending on social care has decreased.
- In England, integrated commissioning bodies such as integrated care systems, are not yet statutory organisations even though proposals have been introduced to establish these bodies as legal entities. Without a statutory basis, health and social care partnerships often rely on voluntary commitment, including memoranda of agreement, and lack designated resources to fully deliver integrated ways of working (ibid).
- Pooled budgets only represent a small percentage of overall commissioner spend, which may limit their effectiveness (ibid).

Wales

- One of the biggest weaknesses in Wales's approach to delivering integrated care appears to be a predominant focus upon the strategic, organisational and management perspectives of integrated care rather than addressing the citizen/patient-reported concerns such as accessibility, care quality and coordination (Wales Audit Office 2019)
- Consistency and quality of care varies and moves to deliver integrated care have resulted in little change on user satisfaction with social care (Reed et al., 2021).

- In Wales, legislation only requires RPBs to pool budgets for some services, such as care homes for older people, although areas have the option of expanding pooled funds into other services, and there have been different interpretations of what this means in practice. An evaluation of early experience with pooled budgets showed that they helped facilitate greater data sharing and joint commissioning in some areas, but most RPBs only met the minimum requirements, with very few physically integrating funds and sharing risk between commissioners (ibid).
- While the Welsh Integrated Care Fund has helped support greater partnership working, there is little evidence so far of effective projects being sustained through the core budgets of RPB members. Evaluations suggest this is partly because the scope of the fund has lacked consistency (ibid).

3.9.3: Impacts of the Devolved Nations' Model on Health Care and Population Health Outcomes

One of the goals of integration policies has been on improving population health by preventing health problems escalating, reducing the time spent living with illnesses, narrowing health inequalities, and supporting people with long-term health conditions and complex needs. Existing research examining the four UK countries has identified three measures related to this goal. These measures will be impacted by wider social and economic factors which are determinants of health. These three measures are: mortality from treatable conditions, healthy life expectancy at age 65; inequalities in healthy life expectancy at age 65; and access to employment for people with a long-term health conditions (Reed et al., 2021). Across all countries, mortality largely followed the same trend with little change in the last decade, suggesting that reformed approaches to enhance integration have had little effect on outcomes. Inequalities in healthy life expectancy at age 65 remain high between the most deprived and least deprived areas of England, Wales, and Scotland. However, although only under a half of people with long-term health conditions were in employment at the end of 2010, this proportion had steadily improved from 2013/14 for Scotland, Wales, and England (ibid). The rate in Northern Ireland was much lower than the other UK countries. Length of stay in hospital declined over the decade in all countries of the UK, but the drop was larger and more consistent in England and Scotland. Delayed transfers of care from hospital were higher in England and Scotland in 2019 than in 2012, but they were at a similar rate in Wales. Rates in England increased rapidly in 2015 and 2016 and although they had fallen by 2019, they were still higher compared to the other nations (ibid). Overall, this suggests that the impact of changes to the social care system has had a relatively limited effect on population health outcomes.

3.9.4: Enablers and Barriers to Effective Implementation and Delivery of the Different Models of Social Care in the Four UK Countries: Lessons Learned and Recommendations for Good Practice

The following specific enablers and barriers to the implementation of integrated models of care were identified for each of the four countries.

Northern Ireland

The Donaldson report (DHSSPS 2015) recommended that the commissioning system should be redesigned to make it simpler and more capable of reshaping services for the future (Chapman 2018). Problems also arose from a lack of clear definition as to what personalisation of care would mean in practice, beyond greater support for a system of care that promotes care closer to home and provides users with greater choice. The Donaldson report (DHSSPS 2015) and Bengoa report (DHSSPS 2016) found that service users felt that it was not being implemented, and nor was it properly planned or funded (DHSSPS 2015: 14). The report also noted that commissioning needed strengthening to make the system simpler. In addition, while the Bengoa report acknowledged that care should be personalised, preventative, participative and predictive, none of those objectives have been easy to achieve in the present fragmented system (Chapman 2018). Policy developments have also been deemed inadequate for supporting increased integration (Chapman 2018). In addition, several studies found that a paternalistic approach exists amongst care users who consider professionals to know better than them about which care options may be most suitable (Chapman 2021). This means that increased user choice could result in increased anxiety and confusion amongst service users (ibid).

Scotland

One of the most important barriers to increasing the integration of health and social care services in Scotland is that development of integrated care bodies does not necessarily lead to effective partnership working or collaboration. However, formalising health and social care partnerships can help resolve other challenges. For example, if statutory integrated care bodies are better able to control resources and hire dedicated staff, it means they may be less reliant on stretching existing capacity to accelerate progress. It is crucial however that the right balance of voice and influence is given to different perspectives from across local authorities, the NHS and third sector organisations, and that processes are in place to avoid any one sector's priorities taking precedence over other equally valid goals (Reed et al., 2021). Structural reorganisations also take time, lead to delays, and make assessing change over time difficult. Underlying challenges, such as social care being more financially overstretched than health relative to the level of need, cultural differences between locally accountable social care services and centralised health services, and variability in leadership capacity are also not fundamentally addressed by joint arrangements (Pearson and Watson 2018; Hendry et al., 2018). Integrating finances effectively also requires reliable information sharing across health and social care, joint assessments that account for differences in the workforce between the two sectors, and a financial framework that can adequately share risks and benefits across different commissioners. Integrated finances have also been shown to be unlikely to make much difference until underlying funding pressures are addressed, with budgets intended to be allocated to integrated care boards to support integration ending up offsetting overspends in acute care (Reed et al., 2021). Multidisciplinary service models have also been difficult to establish when the sharing of staff across organisations follow different approaches to pay, holidays and pensions (Pearson and Watson 2018). Information technology and data-sharing barriers have also impeded progress. Differences in organisational units and ill-defined goals have also made tracking integration a challenge.

Wales

A parliamentary review board in 2018 found that Welsh health and social care services struggled in delivering collaborative, seamless care and lacked a clarity of vision of what care needed to look like to meet the needs of the population. Howson et al., (2021) drew on insights from an integrated care study, A Healthier West Wales: Proactive Technology-Enabled Care, which was an ambitious transformation project that sought to radically change health and social care in the region over the coming years. Driven by the West Wales Care Partnership (WWCP), the approach leveraged insight from the work undertaken by two separate but linked Bevan Exemplar projects - one which looked at the provision of holistic care for people living with dementia and another which focused on developing and testing an integrated health and social care support worker role. The project sought to explore how integrated care systems could be transformed by developing proactive and preventative services facilitated by new technologies. Howson et al., (ibid) argue that fast-tracked, consistent integration that provides a multi-agency crisis response service to support people in crisis and link them with local support can help avoid entry into the acute health system. In addition, proactive, technology-enabled care can help enable people to stay at home but be quickly connected with wrap-around, responsive support within their community. Another lesson that can be drawn from experiences of applying integrated care in practice in the Welsh context, is the need to adopt a place-based approach to ensure that health and social care services respond directly to the needs of people in the local area (Willson and Davies 2021). Another lesson learned is that transformational change requires a radical shift in thinking to ensure care is delivered by community-based teams and inter-professional working (ibid). In addition there also needs to be a clear co-created vision for change and clear communication of the aims and purpose of new innovations to all stakeholders (Howson et al., 2021). Wales has also had very limited success to date with pooled budgets owing to diverse levels of needs across localities, which make subsidising the costs of services across local authority boundaries more likely. Even though sharing and redistributing resources is a key aim of pooled budgets, existing legal frameworks in Wales when coupled with budget pressures make this kind of cross subsidisation difficult (Reed et al., 2021).

England

The shift towards integrated care systems in England comes with a new system-by-default approach to financial planning, which moves away from an organisation-based judgement of financial performance to one that focuses on integrated care systems as a whole, and introduces system-wide control totals or caps. This is seen as beneficial for removing incentives that undermine collaboration. However, organisational and cultural challenges to combining finances still exist. For integration efforts to be successful, proportionate, and appropriate governance arrangements will be needed to support transparency and ensure that power is balanced across partners. In addition, while integrated finance arrangements can help lead to improvements in collaborative working, these will not necessarily lead to financial savings, especially in the short term. This implies that delivering savings should not be viewed as an immediate core outcome or objective of integration, especially as improvements in service delivery can also identify unmet need, and because demand for care is also rising (Reed et al., 2021). Pooled budgets will have a limited impact if they do not override any individual organisation's statutory responsibilities or lines of accountability or if they only represent a small share of the overall commissioning budget. Pooled budgets have also shown to be unsuccessful in shifting finances away from acute services towards primary, community and social care (ibid).

3.9.5: Enablers and Barriers to the Long-term Sustainability of the Devolved Nations' Social Service and Social Care Models: Recommendations for Best Practice

Social care across all four countries of the UK is experiencing severe pressures and instabilities as a result of an aging population and ever-declining funding. Growing rates of health inequality between the wealthiest and poorest social groups in each country and falling birth rates suggest that demands for long-term care will likely increase further in the future (Howson et al., 2021). Increasing levels of chronic health conditions have added to the burden of illness in the UK, and result in more complex health and care needs, which integrated services must meet (Hendry et al.. 2018). Living with long-term conditions has a significant impact on individuals' lives, and their wider social circumstances also impact on the support they need from health and social care services. The gap between resources and demand for care will likely rise further, potentially leading to deteriorating performance on measures of quality (Hendry et al., 2018). Fluctuations in the wider economic conditions will affect both the labour market and the market for care services.

The sustainability of recent efforts to enhance integration may also be threatened by poor management (Reed et al., 2021). Improving quality, efficiency, and population health have all been aims of integration, but are rooted in complex problems heavily constrained by broader government policies that influence the distribution of resources across health and social care, and ability for people to lead independent, healthy lives. Without significant changes to the broader context in terms of system incentives and the distribution of resources, the latest reforms are unlikely to yield more favourable results in the longer term (ibid). Another common challenge is the tendency for successive governments to establish new integrated partnerships without regard for existing relationships and structures and how different bodies will connect or evolve from what preceded it. This makes it difficult for partnerships to fully embed and support change over the long-term (Howson et al., 2021).

3.9.6: Considerations for the Potential Transfer of the English, Welsh, or Northern Irish Model to Scotland

Although none of the documents reviewed presented evidence from cross-national transfers or trials or specify any particular considerations if different aspects of the English, Wales or Northern Irish models were to be implemented in the Scottish context, several key issues were highlighted that have relevance when considering the feasibility of these models for the Scottish context. These were that:

- Important differences exist in population size between the four countries, with the population sizes being just over 3.1 million in Wales, 5.4 million in Scotland, 1.8 million in Northern Ireland, and 55.98 million in England (Reed et al., 2021).

- The four countries also differ in terms of wealth, with Wales now considered the poorest of the four countries (determined by Gross Value Added (GVA) per head of population) (ibid).
- Inequalities in population health between the wealthiest and poorest social groups are evident in all four nations and this gap is predicted to continue to grow (Hendry et al., 2018; Reed et al., 2021).
- All four countries have an ageing population, however life expectancy for both men and women in Wales declined for the first time in recorded history in 2018 (Reed et al., 2021).
- While all three of the devolved countries have legislative responsibility for health and social care, differences exist in terms of legislative powers across other policy areas.
- England has a healthier population than the other countries indicated by higher life expectancy (Reed et al., 2021).
- More than a quarter of adults in all four countries experience more than one long-term health condition, with this proportion set to double by 2035 (Hendry et al., 2018).

3.10: Canada

3.3.1: Structure, Delivery, Funding, and Governance of Social Services and Social Care

In Canada, social care, including long-term care, comes under the jurisdiction of provinces and territories (Norris 2020). In addition, while the Canada Health Act specifies a set of criteria in which health care services deemed medically necessary must be covered by provincial health-insurance programs, this excludes long term and other social care services. Instead, social care is considered an extended service that can be provided at the discretion of the provinces and territories (Section 92(13) and (16)). However, each province provides social care services under provincial programs that cover part of the costs of institutional care and home care services, including for older people.

Each provincial program varies in extent of the amount of benefits offered and the cost to services users for the benefits provided, but these are relatively similar across all provinces (Norris 2020). For home care, public programs cover the care portion up to a maximum limit, but services for personal assistance are not covered and the costs must be covered by the service users themselves. In practice, this means that home-care services such as nursing care and rehabilitation services are covered subject to a needs assessment, while services such as meal preparation assistance, eating, dressing and toileting are not usually covered. For residential care, service users are responsible for the cost of rent, laundry and cleaning. Most provinces and territories offer means tested subsidies to residents. Care that is covered under these programs is provided by regulated licensed professionals, while social care services that are not finically covered are provided by personal support workers and informal care givers (Mery et al., 2016). Nursing homes are tightly regulated and monitored regularly. All must obtain a license to operate from the provincial governments. Services are delivered by a range of providers. In 2021, 46% of nursing homes are publicly owned, 29% are private for-profit, 23% are private not-for-profit (CIHI 2021). However, the extent of private for-profit participation varies significantly across the provinces, being highest in Ontario (57%) and lowest in Newfoundland and Labrador (2%) (CIHI 2021).

Canada devotes 2% of its GDP to long-term social care, which includes both institutional and home care. About 78.4% of funding for social care services for aged care comes from governments, 3.3% from private insurers, and 18.3% from out-of-pocket spending by individuals (OECD, 2021). Take up of insurance is low. The Federal Parliament relies on its spending power inferred from sections 91(1A), 91(3) and 106 of the Canada Health Act to provide the Canada Health Transfer to the provinces under the Federal-Provincial Fiscal Arrangements Act and to set national standards and conditions under the Canada Health Act. From this, the federal government ensures that all provinces and territories provide assistance to those in need. In addition, it also means that each jurisdiction has a procedure in place to appeal decisions made by welfare officials and that provinces and territories do not impose a residency requirement on conditions of eligibility. Regulation of health and social care itself however falls under provincial jurisdiction and legislation regulating the delivery of all services has been implemented in all provinces and territories. Québec is the only province which integrates health and welfare services; all others maintain separate health and welfare services in different ministries. Some provinces, especially Québec and BC have assumed wide control over private agencies, while others, especially Ontario, support private agencies. Most of the jurisdictions have established some form of decentralization of responsibility for the actual administration of services, while maintaining central government control of policy and financing. Québec, for example, has established regional bodies, community-service centres, and local neighbourhood organizations called local community service centres. Alberta and Québec have established regional offices and local area offices for their provincial social and welfare services. Newfoundland's more regionalized service reflects its geography and the number of isolated communities.

3.10.2: Strengths and Limitations of the Canadian System of Social Care

The following limitations of social care in Canada were identified in the literature focusing on the Canadian system:

- The lack of consistency and common definition of long-term care across the provinces means that services covered as part of extended health care vary across the country (Labrie 2021).
- The system lacks the funding capacity to cope with Canada’s aging population needs (Labrie 2021).
- Unlike in other countries, across Canada the vast majority of long-term social care is still provided in residential institutions, despite the fact that most older people consider institutional care a last resort and would prefer to receive care services at home if these were accessible to them (Labrie 2021; Béland and Marier 2020).
- For those requiring social care support at home, waiting lists can be long. One in 10 Canadians accessing this support have had to wait more than 35 days to obtain these services. Waiting times are especially long in Alberta and BC (CIHI 2021).
- As a result, many older people fail to get the care they need in their own homes and have to be admitted to long-term care facilities prematurely. In 2018/19, about one in nine (11%) newly admitted residents in a long-term care institution had low or moderate health conditions and could have been better cared for at home (Labrie 2021; Béland and Marier 2020).
- Take up of private insurance to cover the portion of costs users are required to meet themselves remains low and evidence from older people suggests they have high expectations that the cost of long-term aged care should be met by the government (Boyer et al., 2020).
- Evidence about the ownership status (public, private for profit or private not for profit) on standards of delivery is mixed but recently for-profit provision has been heavily criticised in the context of the Covid-19 pandemic for worse outcomes (Labrie 2021).
- It can be difficult to qualify for access to publicly funded residential homes due to the number of places available. In Ontario, only 40% of residents obtained this first choice of residence and waiting times to secure a place can be long, with half of older people having had to wait 145 days or more in 2019/20 (Labrie 2021). The situation is even worse in Quebec, where seniors in need

of a place in a public nursing facility (CHSLD) had to wait 300 days on average during this same year (Sullivan-Taylor et al., 2022).
- Provider revenues do not depend on quality of service provided (Labrie 2021).
- Distribution of services varies across the country. Almost half (45.7%) of home-care providers in Canada are now located in Ontario, but this is proportionally more than its demographic weight in the country as a whole (ibid).
- The rise in the number of people with neurocognitive disorders associating with ageing in recent decades has not been taken into consideration in government planning and spending on social care (Manuel et al., 2016).
- Lack of integration (except in Quebec) in governance and delivery of the health and social care systems create difficulties in meeting the needs of those with complex care needs and disabilities (Sullivan-Taylor et al., 2022).
- Provincial management of health and social care, often through multiple ministries, creates a complex governance system (Sullivan-Taylor et al., 2022).
- Despite national and international commitment to increasingly move towards implementing integrated delivery systems, there is an absence of national standards that support evidence-based design, implementation, and monitoring for improvement (Sullivan-Taylor et al., 2022).
- It is argued that the Canadian system will require significant reform and increased funding to be able to cope with its aging population over the next few decades (Labrie 2021).
- The current system for providing long-term care for older people comes under that of ‘extended health’ care services, rather than social care per se. This results in the dominance of a health-focused approach to care and fails to cover the needs of those requiring assistance with day-to-day tasks that do not come under the more medicalised remit (Béland and Marier 2020, Giosa et al., 2022). One in six individuals who needed home care or assistance do not get it (Sullivan-Taylor et al., 2022).
- Inequalities in accessing care services are prevalent. Those with lower incomes, immigrants, refugees, or non-permanent residents were more likely to have unmet care needs (Sullivan-Taylor et al., 2022).

However, the following strengths were also associated with the Canadian social care system:

- Efforts made to integrate health and social care more closely over the past few decades have led to efforts to improve the coordination of long term care services (Sullivan-Taylor et al., 2022).
- Provincial and local control potentially allows care services to be more specifically tailored to the needs of local geographic areas (Breton et al., 2019).
- Studies have found that in Canada, owing to the strict regulations that are put in place for licensing of residential homes and accreditation of professionals, private-for-profit providers perform as well as private not-for-profit providers and better than public providers in meeting care delivery standards (Wilkinson et al., 2019).

3.10.3: Impacts of the Canadian model on Health Care and Population Health Outcomes

In 2019, Canada spent 4.7% of GDP on curative care and 0.7% on preventative care (Sullivan-Taylor et al., 2022). Canada spends less on long-term continuing care and services overall than most OECD countries. However, Canada's population health outcomes are lagging and inequality is high, especially amongst lower earners and indigenous people. Eight OECD countries had lower health spending and higher life expectancy at birth than Canada (Sullivan-Taylor et al., 2022). Canada ranked worst among 11 OECD countries for adults with lower incomes to access after-hours care without going to hospital (64% in Canada compared to 35% in the Netherlands (ibid). With lengthy waiting lists for residential care, a high number of people occupy beds in hospitals during the time they wait for a place in a residential care facility. During this time they occupy beds and mobilise staff time and other medical resources, which them more expansive to care for relative to the cost of caring for them in a residential facility and also prevent other patients from gaining access to hospital treatment in a more timely manner (Sullivan-Taylor et al., 2022). However, evidence also shows that nursing homes attached to hospitals reduce rates of hospitalisation (Labrie 2021). The impacts of programs to try to integrate health and social care more closely on population health outcomes cannot be ascertained from the literature and evidence to date alone (Sullivan-Taylor et al., 2022).

3.10.4: Enablers and Barriers to Effective Implementation and Delivery of the Canadian Model of Social Care: Lessons Learned and Recommendations for Good Practice

A number of articles within the sample provided evidence from research examining recent efforts to try to better align health and social care delivery in Canada of the enablers and barriers of enhancing integration.

Sullivan-Taylor et al., (2022) used evidence from care users and families, policymakers and subject-matter experts (academics and advisors) to provide a set of recommendations for enhancing the quality of care. Recommendations from care users and families were that an integrated system should: mobilise care user voice and empower users as equal partners in care; consider diversity factors (e.g., rurality, indigeneity, LGBTQ+; provide care tailored to communities and the social determinants of health; and use clear terminology. Recommendations from policymakers included: the need for a comprehensive framework to be developed to enhance integration and guidance on how to operationalise it; the need for quality, not finance, to be the driving force behind integrating health and social care; and the need to consider cultural awareness in planning and implementing new programs. Recommendations from subject experts were that integration takes times and one should not expect rapid results in terms of impact in the short term, and that integration must be based on the people's needs that it intends to service (Sullivan-Taylor et al., 2022). They also provide evidence from previous stakeholder consultations focusing on integration to argue that efforts to derive frameworks to date have been too theoretical and too high-level to support integrated design and implementation (ibid).

Sullivan-Taylor et al., (2022) also examine system-level policy changes implemented in BC, Saskatchewan, Ontario, Quebec and Nova Scotia to attempt to enhance integration through various programs in recent years. They explore how the First Nations Health Authority (FNHA) in BC designed and managed the delivery of First Nations health and service programmes run on behalf of 203 diverse First Nation communities helped to embed the BC First Nation perspective on health and wellness into the health system, shifting the focus from a medicalised-treatment model into a wellness model. They also explored how the Saskatchewan's Ministry of Health implementation of the Patient-and Family-Centred Care (PFCC) Framework helped to put care users and their families at the centre of care plans. Saskatchewan's transition to combine its 12 Regional Health Authorities into a single provincial health authority in 2017 also helped focus on meeting patient/user needs by enhancing the connectivity of care delivery (ibid). The 2015 Nova Scotia government's design to amalgamate its district health authorities into a single health authority helped to increase access to care and enhance the quality of care, which helped to reduce waiting times and deliver integrated forms of care to specific populations (ibid). Lessons that can be learnt from Ontario's effort to transition towards a more bottom-up approach to care delivery are that the introduction of 24 Health Teams within the province helped to provide more connected care coordination and base care delivery on local population needs (ibid). Legislation introduced in 2015 in Quebec helped to consolidate governance to centralise decision-making and achieve more community-oriented integrated care. This is because it helped make it easier to assure the continuity of care for care users requiring multiple points of care. However, Sullivan-Taylor et al.'s (2022) research also noted that this has not solved persistent inequalities of access for the most vulnerable. Simiarly, Wankah et al., (2018) also examined the impact of consolidation of governance in Quebec and found that the merger did not sufficiently achieve all it intended to achieve and argued that for improvements to be made the mechanisms through which centralised systems will achieve community-oriented integrated care need to be properly understood in order to improve outcomes (ibid).

From the findings of their research, Sullivan-Taylor et al., (2022) devised a set of principles for guiding integration that help to guide policy makers and system partners on what to do and how to engage with care users and their communities. These are that frameworks and standards for integration should: 1) be co-designed in partnership with a range of diverse stakeholders to create a standard that has utility and is accepted by diverse user groups; 2) be people-centric to ensure that the populations served are at the centre of all integration activities; 3) be co-designed through an ongoing consultation process with several rounds of multi-stakeholder feedback; 4) set clear expectations and accountabilities for policy makers that reinforces that integrated care implementation requires strong partnerships; 5) be flexible to accommodate local content in strategic planning and funding decisions; and 6) help to evaluate and advance efforts (ibid).

Breton et al., (2019) looked at evidence from interviews with older care users in Quebec to identify their concerns and hopes associated with enhanced integration, as well as from interviews with other stakeholders (policy-makers providers, managers, professionals) to see where their concerns converged and diverged. They found that care users were mostly concerned by unmet needs, while policy-makers, providers and professionals were more concerned by structural barriers to integrating care. These findings show that it is important to consult a variety of stakeholders early on in planning processes regarding integration so as to be able to consider the needs of all stakeholders when designing interventions.

3.10.5: Enablers and Barriers to the Long-term Sustainability of the Canadian Model: Recommendations for Best Practice

Four of the documents reviewed discuss the barriers to the long-term sustainability of the current Canadian model of social care (Giosa et al., 2018; Sullivan-Taylor et al., 2022; Breton et al., 2019; and Labrie 2021). All four documents explain that the key challenge to the sustainability of the Canadian model is the aging population. The population of Canada is aging at a rapid pace. In 2000, 12.6% of Canadians were aged 65 years and older, but by 2020 there were 6.8 million seniors in Canada, representing 18% of the overall population (Labrie 2021). This proportion is expected to rise to one fourth by 2040 (ibid). The number of people aged 80 and over is also expected to steadily keep increasing and the number of people aged 80 and over is expected to almost triple between 2018 and 2045, from 1.6 million to 4.4 million people (ibid). It is also estimated that the prevalence of problems associated with chronic disease will increase as the population ages as at present nearly three quarters of older people in Canada suffer from a chronic disease and half of those aged 85 or over have multimorbidity (ibid). These health problems limit the activities of a growing proportion of the elderly population and will contribute to an increase in costs associated with the use of health-care services and the provision of long-term care. Last year it was estimated that the number of older people requiring long-term residential care will increase by 60% by 2031 and the number of people who will need care and support at home is expected to increase by a third during the next decade (ibid). It is argued that Canada’s current system is not prepared for the funding challenges associated with these demographic changes (Giosa et al., 2018).

The literature also identified one challenge to the sustainability of recent efforts made through various municipal programs to increase integration between health and social care. Sullivan-Taylor et al., (2022) note that the political cycle typically limits program planning and implementation to a short window of two to four years before another election may stall, sustain, or reverse any progress.

3.10.6: Considerations for the Potential Transfer of the Canadian Social Care Model

- Canada has a total population of just under 38.5 million people (Labrie 2021)
- The geography of Canada is diverse and includes many very remote and inaccessible areas (ibid).
- However, more than half of Canadians live in just two provinces: Ontario, where one in three Canadians live, and Quebec where almost a quarter of Canadians live. The combined population of Canada's three territories (Northwest, Yukon and Nunavut) is less than the population of Canada's smallest province (Prince Edward Island) (ibid).
- While the population of Canada is aging rapidly, the total population is growing at a steady pace and, based on current projections will surpass 50 million by 2070. Canada has one of the fastest growth rates of any G7 nation, growing faster than many other industrialized countries. While Canada’s

fertility rate is 1.53 births per woman, below the population replacement rate, the population continues to grow as migration plays an increasing role in the population. Canada’s net migration rate is 6.375 per 1,000 people, the eighth-highest in the world (Statistics Canada 2020).
- Health inequalities are prevalent and result from social, political, and economic disadvantages, with inequalities especially pronounced between indigenous and non-indigenous people (Giosa et al., 2022).
- In Canada the provinces and territories have the responsibility for health and social care governance rather than the federal government (Labrie 2021).

4. Concluding Discussion

This review of international models of social care and services has demonstrated that the ways in which social care and service systems are funded, delivered, structured, and governed varies between different high-income countries. It also highlights important lessons and recommendations for improving, sustaining and, in many cases, enhancing the quality of care provision in countries facing challenges to sustaining their existing social care models resulting from ageing population. In particular, the review highlights important enablers and barriers to the sustainability of existing social care models, including the financing of these models, and for improving the integration of health and social care services.

4.1: Differences in Social Care Funding, Delivery, Structure and Governance

The Australian social care sector predominantly focuses on the most vulnerable people, with the greatest and most complex needs and includes child and family services, child protection, mental health, and aged care. The system is not universal and government assistance focuses on those with low incomes. Services provision is determined on the basis of need and charges to the individual are means tested. The financing of social care comes from tax revenue and user charges, which means the wealthiest people have to pay all or the majority of their care costs themselves up to a specified government defined limit. It can be difficult to obtain private forms of insurance to cover these costs. In Australia, while the provision of health services falls to State governments, the provision of pensions and funding for welfare services is a federal government responsibility. The clear division of health care services and social care evident in Australia is shared by the United States. However, unlike in Australia, in the US all social care costs are paid for privately by individuals. The US Medicaid programme is a publicly funded system which provides a safety net by covering the costs of health care services for those with low incomes, but it does not cover social care costs. However, the delivery, structure, and governance of social care services in Alaska differs slightly from that of the other US states as Alaska has its own particular arrangements regarding the coordination and provision of care for Indigenous Alaskans. Alaska also has its own version of Medicaid, which covers some of the costs associated with home care and is administered by the Alaska Department of Health and Social Services Division of Public Assistance. Eligibility is determined by financial need, so applicants must be able to prove that they are at or below a certain income level to qualify.

The Canadian social care system most notably differs from other models in the extent of power held by municipal (regional) governments for social care governance and funding. In Canada, social care (including long-term care), comes entirely under the jurisdiction of provinces and territories. While the Canada Health Act specifies a set of criteria in which health care services deemed medically necessary must be covered by provincial health-insurance programs, municipal governments have the freedom to plan their own particular arrangements. In addition, the Canada Health Act also excludes long term and other social care services. Instead, social care is considered an extended health service that can be provided at the discretion of the provinces and territories. In practice however, each province provides varying levels of social care services under provincial programs that cover part of the costs of institutional care and home care services, including for older people.

Japan, the Netherlands, Germany and France all have social care systems that are based on mandatory social insurance schemes separate from mandatory health insurance schemes. In the Netherlands and Germany, these schemes are funded by general taxation at central government level. In France, it is funded both by taxation at central government level and at the regional government level. In Japan however, half of the revenue for the long-term care insurance scheme comes from general taxation, with one-third coming from insurance premiums from people aged between 40–64 (at a rate of 1 per cent of income) and one-sixth from people over 65 (according to a fixed tariff of premium rates). User co-payments account for the rest (Forder and Fernandez 2011). Municipalities operate the public long-term care insurance system and have the responsibility for planning long-term care in their jurisdictions and developing infrastructure for care services. For people in employment, individuals' contributions are shared with employers and premiums are determined and collected nationally and redistributed to municipalities according to need. Benefits in Japan are much more generous than in the Netherlands, Germany and France and are designed to cover the costs of a wider range of care services, with less than a 10 per cent co-payment required from individuals, which is further reduced on a means-tested basis for people on lower incomes.

Social care in Switzerland is also financed directly by contributions from taxation and a compulsory health insurance system that also provides for social care service provision. However, under the Swiss system, people on lower incomes are eligible for subsidies and those with the lowest incomes who receive welfare aid, have their premium paid for by the government. However, all earners earning above a certain income level all have to pay the same premia.

Nordic models of social care differ to others in that they underpinned by the principle of universalism, which means that eligibility for all social care services is based on need rather than contributions so that all citizens who require long term social care and services can access them. Until the 1990s, services were based almost completely on public provision. The state and local authorities heavily subsidise care services, financed through income and local taxes. Since the 1990s, changes in politics and policy in Sweden, Norway, Finland, and Denmark have transformed the delivery of social care services into a more hybrid public-private approach, with greater involvement of the market in service provision and greater user contribution to the costs of care.

New Zealand differs from the other countries in its approach to the funding, governance, and delivery of social care in that social care and services are part of a health board's allocation. Care service provision is subject to a needs assessment and the health ministry funds and purchases care for people with disabilities under the age of 65. New Zealand has a larger range of private sector care and service provision than in the UK countries and primary health organisations contract with district health boards to provide a range of primary and community services. In the UK context of devolution, health and social care are wholly devolved matters, with Scotland, Northern Ireland and Wales having subtle differences in funding and financing social care from that of England. Each of the four National Health Services are funded primarily from general taxation gathered at a UK level, but distributed to the Scottish, Welsh, and Northern Irish governments through the 'Barnett formula,' based on current and historical population size. The Scottish and Welsh governments also set some devolved taxes such as stamp duty, and have limited powers to raise or lower income tax bands with revenue going to them. Since 1973 Northern Ireland has operated under an integrated structure of health and social care. Scotland, England, and Wales are gradually moving towards increasing integration of their health and social care systems.

4.2: Key Strengths and Weaknesses of the Different Social Care Models

Under the Australian scheme, increased pressure caused by an ageing population has led to increases in demand and costs to the federal government under the current system for age-related care. While increasing the opening up of care provision to private service providers and market forces has been identified as a way to reduce the fiscal demand on the federal government, concerns have also arisen about increasing inequalities in care provision and in the standards of care provided as a result of increased private sector involvement in care provision, problems associated with increasing deregulation of care services, and power imbalances in leadership and service delivery. Lack of integration between health and social care providers also negatively impacts the delivery of care for users with complex care needs. However, the Australian emphasis on external care provision reduces the need for informal care provision and associated impacts, including lower workforce participation of working adults and negative impacts on wellbeing of informal care providers.

While the Australian model emphasises care user choice in determining care providers, social care policy in Japan is paternalistic and involves medical expertise in assessing eligibility to disability services and leaves little scope for individuals to express their agency, choice, and decision-making capacities. Again, unlike in Australia, Japan places a high level of expectation on families to provide high levels of informal care. This creates challenges in an increasingly aging society where increasingly older people will bear the brunt of caring for the oldest members of society. Informal care provision is also a gender equality issue, with the majority of informal care being carried out by women and which results in lowering employment opportunities and quality of life for women. Social care services are dominated by medical models of care at the expense of general wellbeing and quality of life. However, access to care is standardised. The Canadian system of social care also, for the most part, remains dominated by a health and medical approach to care with social care coming under ‘extended health care services, and unlike in other countries, across Canada the vast majority of long-term social care is still provided in residential institutions, despite the fact that most older people consider institutional care a last resort and would prefer to receive care services at home if these were accessible to them. For those requiring social care support at home, waiting lists can be long. Differences in provincial arrangements for care provision has also resulted in inequalities in the distribution of care services between the different provinces. Consequently, many older people fail to get the care they need in their own homes and have to be admitted to long-term care facilities prematurely. However, efforts made to more closely integrate health and social care in Canada over the past few decades have helped to improve the provision and coordination of long-term services while retaining provincial control to allow services to be more specifically tailored to the needs of local geographic areas. Importantly, research conducted in

Canada has shown that when strict regulations are put in place for the licensing of residential homes and accreditation of professionals, private-for-profit providers can perform as well as private not-for-profit providers and public providers in meeting care delivery standards.

In contrast to the medicalised model of social care in Japan, the integration of health and social care services in New Zealand is more adapted for addressing the care needs of those with complex needs and addressing overall wellbeing, including for older people, children, young people, and people with disabilities. Integrated care provision embedded upon an ethos of respect for socio-cultural diversity has also enabled positive steps to be made towards addressing health and social inequalities between Indigenous people and other New Zealand citizens that result from the history and legacy of colonialism. In contrast, the US model of social care delivery is associated with exacerbating socio-economic and racial health and quality of life inequalities. Internationally, the Swiss system ranks well regarding quality of care, access, efficiency, equity, and promotion of healthy lives, however fragmentation of social care governance and delivery, with responsibilities divided between the federal, cantonal, and local levels is associated with increases in the risk of sub-optimal quality of care.

The main strength of Nordic models of care is that care services are provided to all citizens who require social care regardless of personal ability to pay. The Swedish provision of social care is seen as a ‘best practice’ example by international standards, because of the generosity of its coverage and low user charges. Under the Nordic models local authorities have the freedom to organise care delivery, but the system is supported by national level legislation which ensures equality of levels of care service provision and the quality of services. However, the introduction of marketisation in the 1990s has challenged the principle of universalism in care provision, particularly in services for older care users and the introduction of the option to pay for additional services challenges the principle of equality of access. Unlike in the Scandinavian countries where a full range of services are provided to all citizens, the insurance-based systems in The Netherlands, Germany and France provide for basic care only, with the rest expected to be covered by informal care provision. One of the potential downsides of insurance-based systems like these that rely on a single source of funding is that they may leave long-term care budgets more vulnerable to macroeconomic fluctuations. If the labour market is weak, for example, revenue from payroll contributions will be reduced and this may lead to budget deficits that need to be addressed by using funds from previous surplus years, taking on debt or drawing funds from general taxation. However, having a contribution-based system is associated with a reduced need for political bargaining, present in systems that rely predominately on general taxation.

While increased integration of health and social care in Wales, Scotland and England is associated with the potential to provide a more holistic approach to care, the system in Northern Ireland has come under criticism for not working as effectively as predicted and having multiple layers of decision-making and unclear lines of accountability which complicate the system. Similarly, the complex arrangement between the local authority and health board in Scotland resulting from attempts to integrate care services further have not always resulted in the quality and well-integrated service that was intended, with health emerging as the dominant partner in integrated boards and being better financed. However, receiving care from a self-managing, integrated, health and social care team is generally viewed as acceptable to service users in Scotland. The lack of statutory basis in England, however, means that England's health and social care partnerships often rely on voluntary commitment and lack designated resources to fully deliver integrated ways of working.

4.3: Impacts of the Different Social Care Models on Population Health Outcomes

Under the Australian system, the provision of basic social care services based on need is linked to improved health outcomes. However, the US poor efforts to integrate health and social care compared to other high-income countries, contributes significantly to growing health inequalities. In contrast, the New Zealand integrated system is associated with improved health and quality of life outcomes, particularly in relation to mental health and wellbeing. In the four UK countries however, the evidence to date suggests that the impact of changes to the social care system, including the increased integration of health and social care, has had a relatively limited effect on population health outcomes and in reducing existing health inequalities.

In Canada, the impacts of programs to try to integrate health and social care more closely on population health outcomes cannot yet be ascertained from the literature and evidence to date alone. However, health outcomes in Canada continue to lag behind those of other high-income countries and health inequality remains high, with lower earners and indigenous people having the poorest health outcomes. In addition, the health dominated approach to social care provision and greater amounts of care being delivered within residential settings, has a negative impact on health care services as lengthy waiting lists for residential care, mean a high number of people occupy beds in hospitals during the time they wait for a place in a residential care facility.

The existing research literature suggests that the impacts of the increased marketisation of at-home social care services in Finland and the other Scandinavian countries show that marketisation is linked to the potential of widening health inequalities between the wealthiest and poorest members of society, with whose care involving rely mostly on public service provision, reporting poorer health than others and unmet care needs than others who have the financial ability to rely more heavily on services financed privately.

From the available literature, it is not possible to ascertain the impacts of the French, German, Dutch and Swiss models of social care on population health impacts. However, in the case of Japan, while the long-term impacts of major social care reform are not yet known, the model has been linked to improving quality of life amongst people with disabilities. This is young people with disabilities receive services from infancy to adulthood, which helps improve consistency in care and service provision. While the literature did not specify evidence of the impacts of its model of social care for population health outcomes amongst all Alaskans, both the Maniilaq and SCFNuka programs for Indigenous Alaskans are associated with significant reductions in emergency department visits and hospital admissions and are also associated with improving diagnosis and treatment of chronic diseases.

4.4: Barriers and Enablers of the Success of Different Models of Social Care: Lessons Learned from the International Examples

The review of the international literature highlighted important lessons learned and recommendations for sustaining and improving the quality of care provision, including for improving the integration of health and social care services.

In particular, the Australian literature reveals that limitations in access to services in certain geographic areas (including rural areas) can hamper efforts to achieve more holistic approaches to integrated care provision. Case studies also warn that attempts to increase user choice need to be responsive to existing structural inequalities, because if they fail to do so, they risk increasing social inequalities. Case studies also show that more government policy is required to address existing structural inequalities to enable an integrated health and social care system to be able to achieve its maximum potential.

A series of recommendations were also identified in the Australian literature for helping to reduce issued posed by the use of private providers of social care services. In particular, target populations need to be carefully defined to ensure an appropriate nexus exists between a person’s right to make their own decisions and society’s protective responsibilities. In addition, a functionally independent agency must be empowered to investigate, both on its own and following a complaint or notification, any situation of concern. A “supportive intervention” approach by the agency that enables it to identify and, where necessary, coordinate support services (e.g., aged care, disability, mental health, family violence support services) is also central to controlling its effectiveness, and appropriate safeguarding mechanisms must be put in place. Access to personal data should be regulated and information sharing laws need to enable relevant agencies to communicate necessary information.

Lessons learned from the success of the New Zealand Canterbury model of integrated social and health care provision demonstrates that having a clear vision of a ‘one system, one budget’ approach, investment in staff through training and skills development, and development of new models of service contracting and integrated working is important for achieving positive outcomes. In Switzerland, the 2017-2020 Promotion of Interprofessional Collaboration in Healthcare helped to identify good practice in fostering the coordination of care and interprofessional collaborations and highlighted the need for quality indicators and greater legal clarification about the responsibilities of non-medical care providers for the development of a more integrated system. Different organisational cultures and interests and a lack of ownership and accountability among managers hindered improvement processes. Participatory approaches were care delivery improvements were co-created and tailored to local priorities and needs were also found to be enablers of success. Literature focusing on Germany, the Netherlands and France revealed that enablers of improvement in greater integrated care included interprofessional meetings and improved communication.

The literature focusing on Canada is particularly strong in identifying the importance of governance in enabling improved integration of health and social care and moving away from a medicalised approach to care provision towards a wellness model. Using case studies from several provinces, the research shows how provincial amalgamation of district health authorities into a single provincial health authority helped to increase access to care, provide greater coordination of care for those with complex care needs, enhance the quality of care delivered, and improve targeting towards population care needs. However, it is important to note that this has not solved persistent inequalities of access for the most vulnerable. The Canadian literature also specifies how frameworks and standards for integration may help to facilitate successful integration if they are co-designed in partnership with a range of diverse stakeholders, people-centric, set clear expectations and accountabilities for policy makers that reinforce strong partnerships, and are flexible in accommodating local content in strategic planning and funding decisions. This body of literature also asserts that quality, not finance, needs to be the driving force behind integration if it is to prove to be successful in practice in improving access and quality of care.

The experience of the SCFNuka system in Alaska demonstrated the need for structural integration across all services, care staff and specialist care in hospitals, horizontal integration with teams members all regarded as peers, and improved decision making that includes community members in deciding how care should be provided as key to success of the initiative. Similarly, the Maniilaq Social Medicine Program (SMP) inaugurated by Northwest Alaska’s regional tribal health organisation in 2017 provides another example of a system whereby tribal, health and social service have been integrated to help promote address the social determinants of health that are associated with health inequalities between Indigenous and other Alaskans. However, the Alaskan models are primarily primary care systems and it remains the case that very little social care is integrated.

Under the US model, the ability of reforms to improve outcomes and generate reserves – whether public or private – is dependent on the broader economic situation. However, the development of the Japanese model also shows the important of the need to be flexible as a result of fluctuations in demands for care services and to adjust eligibility criteria accordingly to control expenditure. The literature also demonstrates that while the introduction of marketisation potentially challenges the universality of care in Sweden, Denmark, Finland and Norway, the extent to which it diminishes the universalistic character of social care systems, fundamentally depends on the generosity and quality of the public system. If publicly funded social care services remain so comprehensive that few demands for top-up services are made, they will not impair universality. However, if reliance on private topping-up services increases and usage becomes unevenly distributed among groups of users, it risks undermine the dimension of comprehensive usage, especially if entitlement criteria for public becomes stricter. In addition, universalism can be maintained if focus is given to how the use of additional services are distributed and how this interacts with the political commitment to finance care and citizen willingness to pay taxes.

Important lessons can also be learned from the case of Northern Ireland, where commissioning systems make it difficult to reshape service provision for the future. In relation to the issue of increasing user choice, problems have arisen in Northern

Ireland from a lack of clear definition as to what 'personalisation' of care means in practice, beyond greater support for a system of care that promotes care closer to home and provides users with greater choice. Literature focusing on Scottish efforts to integrate health and social care have shown that one of the most significant barriers to the increasing integration of health and social care services is that development of integrated care bodies does not necessarily lead to more effective partnership working or collaboration. Underlying challenges, such as social care being more financially overstretched than health relative to the level of need, cultural differences between locally accountable social care services and centralised health services, and variability in leadership capacity also remain unaddressed by joint arrangements. Integrating finances effectively requires reliable information sharing across health and social care, joint assessments that account for differences in workforce between the two sectors, and a financial framework that can adequately share risks and benefits across different commissioners. Integrated finances have also been shown to be unlikely to make much difference until underlying funding pressures are addressed, with budgets intended to be allocated to integrated care boards to support integration ending up offsetting overspends in acute care. Lessons learnt from efforts to increase integration in Wales have revealed the need to adopt a place-based approach to ensure that health and social care services respond directly to the needs of people in local contexts and the need to devise a clear co-created vision for integrated care. In England, it has been shown that while integrated finance arrangements can help lead to improvements in collaborative working, these will not necessarily lead to financial savings, especially in the short term. This suggests that delivering savings should not be adopted as an immediate core outcome or objective of integration, especially as improvements in service delivery can also identify unmet need and because demand for care is rising.

4.5: Challenges to the Sustainability of Existing Social Care Models and Identifying Potential Solutions to these Challenges

The review also highlights important enablers and barriers to the sustainability of existing social care models, including the financial sustainability. All the countries in the sample are experiencing severe pressures and instabilities as a result of an aging population and declining funding for welfare and service provision. The present gaps between resources and demand for care in all countries will likely rise further, potentially leading to deteriorating performance on measures of quality. Fluctuations in the wider economic conditions will affect both the labour market and the market for care services.

The literature focusing on the EU countries (Germany, Netherlands and France) provides more specific details about the challenges that an aging population may pose to the sustainability of the social insurance model of social care, revealing that the key challenges to the long-term sustainability of this model are: challenges to access linked to the underdevelopment of publicly funded formal long term care services, challenges to sustaining quality of care due to significant increases in demand, challenges to the life opportunities of carers and gender equality resulting from increased informal care being required to plug the gaps in care access, and challenges of financial sustainability due to a need to increase public spending on social care.

The Australian literature identified several barriers to the long-term sustainability of the Australian social care model, including a lack of forward planning and significant investment as well as the need to increase government funding costs for sustaining future care provision. Concerns about ongoing financial instability mean that that user contributions will likely need to increase further. In addition, changing patterns of care provision with more people accessing care at home rather than permanent residential care means that individuals will be required to pay more for their care in the future because under this model individuals with incomes higher than the full state pension pay more towards their care.

The sustainability of the US and Alaskan models is highly dependent on changes in the wider economy with the direction of reforms being underpinned by debate regarding ideas of fairness and responsibility.

In Japan, the huge growth of the aging population means that sustaining the system depends on willingness to expand welfare and insurance schemes for the provision of longer-term care. Sustaining the care workforce also presents a huge challenge to the long-term sustainability of the current system. Growing concerns are also evident about the future sustainability of European models of social insurance contribution-based care, especially in relation to funding given the ageing population in Germany, France, and the Netherlands.

Although Nordic social care and service provision are based upon universality, general tax financing, high decommodification, high labour market participation, equality and generosity, a key question now remains as to whether achieving these key characteristics is still possible given an aging population. In Switzerland, at present the personal contributions of those in need of care account for a high proportion of total financing compared with other countries (30%, while the average internationally is only 13.5%). However, if this is maintained, the financial burden on those in need of care and on the municipals will reach the limits of feasibility in the near future.

While integrated health and social care systems, like in the case of the Canterbury model in New Zealand, may help to reduce spending on costly emergency hospital care and medical services, it is dependent on increased spending on community-based services. Funding provision for these systems through the current system of taxation may also be difficult to sustain in the future owing to the aging population. Research focusing on Canada shows how the political cycle may limit the long-term sustainability of recent efforts made through various municipal programs to increase integration between health and social care, as a short timeframe of two to four years between elections may stall, sustain, or reverse progress.

In the UK countries, social care across all four countries is experiencing pressure as the population ages. Growing rates of health inequality between the wealthiest and poorest social groups in each country and falling birth rates suggest that demands for long-term care will likely increase further in the future. Increasing levels of chronic health conditions have added to the burden of illness in the UK, and result in more complex health and care needs, which integrated services must meet. The gap between resources and demand for care will likely rise further, potentially leading to deteriorating performance on measures of quality. In the case of integrated care, without significant changes to the broader context in terms of system incentives and the distribution of resources, the current system is unlikely to yield more favourable results in the longer term.

4.6: Factors to Consider when Thinking About Transferring Social Care Models to A Different Context

The sample literature focusing on the EU and Alaskan models of social care provide examples of factors that need to be considered when considering transferring one model of social care from one context to another. The literature focusing on the Alaskan SCFNuka model provides an important consideration based on an unsuccessful trial to implement this model in various locations in Scotland (Isle of Eigg, Forfar and Fife), which is that prior acceptance of the program amongst relevant stakeholders is fundamental for effective transfer. This unsuccessful attempt also cautions how, in practice, it can be difficult to transfer one model from one socio-cultural, economic, legislative and regulatory context to another. Literature focusing on the EU also provides a cautionary note for transferring models across contexts, explaining how the abilities of each model to succeed and generate revenues (public or private) is inevitably dependent on the wider economy. In addition, it also shows the need to consider fundamental principles and values that underpin a country's model of social care when thinking about its transferability, as a widely supported principle in one country as a basis for care provision (e.g., universalism, equality, responsibility and freedom), may not be as strongly upheld in another country.

In addition, while the literature focusing on the other countries do not explicitly specify factors that should be considered in relation to the transferability of one model to another context, the literature focusing on all countries specifies important demographic information and considerations related to the potential sustainability of its model that can be used to infer whether the model might succeed or face similar future challenges if it were implemented another context. Important factors to consider when assessing the suitability of each model for transfer are: the rate of population ageing in both countries, the geographic location of the population, future life expectancy, projected levels of health and income inequality, structures of governance, population diversity and ability of the care system to meet the needs of diverse groups, socio-cultural values and expectations about responsibility over care provision, and public willingness for public spending to be increased to improve social care. In this way, answers to questions about the country whose model is being considered can be compared to answers to these same questions about the country of potential implementation to help aid judgement and decision-making about the suitability of a model for transfer to a specific context. For example, if the very high rate of population aging in Japan is associated with challenges to the future sustainability of the model, such a model is likely to face similar challenges in the future if it were to be implemented in another country with similar demographic projections. However, the current model in Japan may be more suitable for implementation in a country where the projected rise in the aging population is not as high as that predicted for Japan. Similarly, in the case of the potential transfer of the Nordic model, it may be more likely that support for its implementation would be higher in a country where there is strong public support for the principles of universalism and equality in service provision, in contrast to a country that places greater value on individual responsibility. Likewise, the municipal governance system of the Canadian model may be better suited for transfer to a country characterised by high levels of diversity in the spatial, social and cultural geography of its regional populations than for a country where population geography and diversity are similar across all regions.

5. Recommendations for Decision Makers

The following 10 recommendations have been developed from the findings of the rapid review for decision-makers involved in developing the National Care Service in Scotland:

1. Care services should be provided on a consistent basis across all geographic areas (including remote rural areas).

2. Policy should address existing structural inequalities to enable the care system to achieve its maximum potential.

3. A clear ‘one system, one budget’ approach would reduce complexity.

4. An integrated care service should be substantially publicly funded so that use of privately funded services does not become more unevenly distributed.

5. Eligibility for access to social care services should remain high to prevent rising inequalities, unmet needs and increased dependency on informal care providers.

6. A standardised definition of what ‘personalisation’ of care means should be developed.

7. Mechanisms that address cultural differences between locally accountable social care services and centralised health services should help improve integration.

8. Budgets intended to support integrated care should not be used to offset overspends in acute care.

9. Financial savings should **not** be viewed an immediate objective of integration.

10. Forward planning and significant investment are required to meet the future care needs of an aging population.

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