INTEGRATED DELIVERY OF SOCIAL SERVICES

Payment systems and innovation in social and health services delivery
The What, Why’s and How’s of Service Integration

- Cooperation, collocation to collaboration
- To meet multiple needs, for efficiency goals
- Horizontal and vertical forms of integration
- Common issues in horizontal integration
  - Management: Fragmentation of finances or the ‘wrong pockets’
  - Weak evidence base (person-centred)
  - Balancing intervention and prevention (order)
  - ‘Locked’ public resources
Split Finance Responsibilities across Social Services are common

Source: Frank et al, 2012
Fiscal federalism, and policy transfer

Source: OECD Centre for Tax Policy, 2013.
Complex financing agreements for health and social services

• Multiple financing sources - a major barrier to effective, well-coordinated care
  – Potential negative effects of different payment mechanisms on integrated delivery of services

• Indirect spill-over effects:
  – **Cost-shifting** between providers (fee-for-service)
  – **Overuse of one service** (different funding streams)
  – **Under investment** (multiple financial arrangements)

• Financial and legislative incentives encourage integrated care
Payment reforms and integration – successful examples

• Programme for All-inclusive Care for the Elderly (PACE) in the U.S
  – Integrated provider-model that offers community-care services for frail older people (55+) with high needs
  – *Pooled funding*: through capitation payments from Medicare and Medicaid
    • Total control over all long-term care expenditure, assuming financial risk for its population
• Outcomes: higher satisfaction, decrease of nursing home and ED services, cost-effective
Payment reforms and integration – innovative examples

• **System of Integrated Services for Aged Persons (SIPA)**
  – Demonstration programme introduced to overcome the fragmented nature of Canadian health and social care
  – Case management, multidisciplinary teams and community-care provided in local community centres
  – *Pooling of funds* to overcome disincentives to provide cost-effective, integrated care

• Outcomes: cost-effective, substitution from acute hospital and institutional care to community-care
Payment reforms and integration – innovative examples

• England, Denmark and Sweden
  – *Cross-charging*: a system of mandatory daily penalties made by social care bodies to health bodies to compensate for delayed discharges in acute care (‘bed-blocking’) when the social care body is solely responsible
  – ‘Financial incentive’ to arrange care home placements or home care and support for medically fit patients ready to leave hospital.

• UK Better Care Fund 2015-16
  – Join planning and delivery of 3.8 billion GBP worth of health and social care services at the local level
  – 2 billion GBP of the health budget (saving expected)
  – Integrating clinical commissioning groups (25% of the budget) and local authorities (20% of the budget)
Next steps

• In-depth country studies (PWB 2015-2016)

• Focus on the implementation side
  – administration of cash and tax benefits
  – in-kind services in the broader population
  – best practices in intervention and prevention strategies

• Optimise the use of health and social services
Thank you

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