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Integrating service delivery: why, for who, and how?

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INTEGRATING SERVICE DELIVERY: WHY, FOR WHO, AND HOW?

1. Introduction

1.   In-kind services are increasingly a favoured tool of governments across the OECD. Over the past 20 years, total spending on social services has been steadily increasing, whereas spending on cash transfers has been stable (see Figure 3). Spending on social services is likely to continue to grow in the context of the ongoing Global Recession, as take-up of front-line social services increases. With demand rising as budgets fall, the purpose of this paper is to propose a framework for comparing integrating service delivery policies, and to open the discussion about what can be learned from ongoing examples of the integration of social services for vulnerable groups.

2.   While a complete understanding of service delivery is essential to properly inform social services policy, policymakers are missing important information about the efficiencies and outcomes of service delivery. International debate around service integration, and in particular sharing knowledge about the pros and cons each country faces when delivering social services to the most vulnerable populations, is needed. Given that the goals for supporting these groups are broadly the same for governments across the OECD, all policymakers would benefit from recognising areas for efficiency in service delivery and ways to action them.

3.   One key barrier to informative international debate is the lack of cross-cutting evidence on interventions for vulnerable populations. This barrier exists for two main reasons. First, a standard international definition of who is a member of a vulnerable group is lacking (DELSA, 2009). Second, there is lack of evidence on, and long-term evaluations of, integrated services delivery for vulnerable groups.

4.   Summary evidence from available studies suggests that basic ways to integrate services can 'organically' lead to more complex and fruitful forms of integration. Employing methods such as the collocation of service providers has led to increased collaboration among service providers, cooperation among professionals from different sectors, and efficiency. Available studies also highlight the potential gains from integration, including: the consolidation of social services to save money, improvement in the outcomes of vulnerable populations (often in need of multiple services), and job satisfaction among professionals.

5.   Yet despite consensus on the need to make services more cost efficient, and although the evidence provides positive insights into what makes for efficient service delivery, this has not been translated into an international framework for analysis, information sharing or lesson drawing. To assess the relative merits of service integration cross-nationally, a framework for analysing the effective and efficient practises in social service delivery and the literature on the pros and cons of integrated service delivery, including available policy evaluations, are needed to inform the debate.

6.   The paper is structured as follows: in sections two and three, this paper discusses the various forms of integrating services and introduces a model of integration for comparing international evidence, before providing an overview of trends in social expenditure on in-kind services compared to cash benefits. Section four focuses on vulnerable populations, providing estimates for levels of vulnerabilities across the OECD, and section five, by drawing from the literature and from available evaluations, raises the pros and cons of integrated service delivery. Section six provides policy recommendations based on the evidence raised in the paper. Section seven concludes with proposals for future research.

2. What are integrated services?

7.   In its simplest form, the term 'integrated services' refers to examples of joined-up social services, for the benefit of service users or providers. A more detailed definition can be drawn from the health literature: "integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between [different] sectors" (Kodner and Spreeuwenberg, 2002).

8.   Services can be integrated either horizontally or vertically. *Vertical integration* refers to 'bringing together of different levels in the care hierarchy' (England and Leester, 2005). In health care, for instance, this could mean integrating the hospital, clinical and community-based health services to ensure the continuum of care. The focus of this paper is on *horizontal integration*, which brings together previously separated services, professions and organisations across different sectors to better serve service users with multiple disadvantages and complex needs (Munday, 2007).

9.   Integrated services can be delivered in many forms, depending on the extent of interaction, and the scope of support. Integration of services can happen via cooperation or communication among service providers, collaboration among professionals across different sectors, the physical or virtual collocation of complementary services, or a mix of these.

2.1. Collocation, collaboration and cooperation

10.   The definition of 'integration' used in this paper covers collocation, collaboration, and cooperation. Each defines integration at different levels.

11.   *Collocation* refers to having all agencies in one location such as: legal services, mental health services, health services, housing services, social services or case management services (see Figure 1). Having services in one location can reduce the travel and time costs associated with take-up for service users (Sloper, 2004). Collocation also makes for easier accessibility between agencies that can help to promote collaboration among groups of service providers and professionals.

12.   *Collaboration* entails a higher level of integration than collocation. It refers to agencies working together through information sharing and training, and creating a network of agencies to improve service user experience. Collaboration is a necessary step for reducing the gaps in services for service users. By sharing knowledge, agencies and professionals can improve the referral process to other services offered by the centre (Sloper, 2004). The more knowledge professionals have about the different services, the better 'needs-based' recommendations are available to service users.

13.   The highest degree of integration is achieved through *cooperation*. Cooperation is defined as professionals communicating *and* working together (for example 'within small clinical teams or from multiple agencies') on a service user's case (Rosenheck et al, 2003). Effective cooperation, through good communication, is central to improving service users' outcome. When professionals work well together, costs can be lowered, services are not duplicated, and the identification and response to service users' needs can occur more quickly.

2.2 A model for integrated services

14.   To frame discussion of integrated services in this work, it is necessary to define a model for integrated services and associated terminology.

15.   In developing a model of service integration, and importantly to assess it, it is also necessary to acknowledge the type of goals achieved by integrating services. In this work, the goal for service

integration for vulnerable users is to "enhance quality of [support] and quality of life, service user satisfaction and system efficiency for [service users] with complex, long term problems cutting across multiple services, providers and settings" (Kodner and Spreeuwenberg, 2002).

16.   Figure 1 models an overarching concept of integrated services delivery. The model represents a one-stop centre where service users can access the support they need in one place. The one-stop centre can be physical, or virtual, and can be explicitly defined as 'integrated' or not. In some cases this will include services that the user is eligible for, or in need of, but previously has been unaware of the possibilities of access.

Figure 1: A basic model for integrated services delivery

Service User outcomes

Source: Source: OECD.

17.   The integrated services delivery model includes a number of distinct attributes, which require the following clarifications:

- The purpose of the model is to deliver output in the form of *service user outcomes*. The term 'service user' is used throughout this document to describe the consumer of public services. It is used without prejudice, and refers to an individual or a family unit.

- In this integrated model, it is assumed that a service user has entered the integrated setting following the assessment of their needs from a caseworker (in Case Management Services - CMS), or via one of the service agencies (in cases where CMS is not the entry point, the term 'lead agency' is used to describe the first specialist agency to which the services user presents).

- The various service agencies are all single *service providers*. The five example agencies included in the model are: Legal, Mental Health, Health, Housing, and Social Service agencies. The term 'providers' is used throughout this paper as a catch-all term to describe individual service providers, or a group of integrated service providers. The number and specialism of the agencies may change depending on the circumstances and needs of the services user in question.

- The *outer circle* represents the connection between the service providers. The circle can be used to represent the various forms of integration between service providers. Arrows within the integrated setting, going back and forth to CMS, represent the potential for service providers to share information through and with the CMS.

- At the centre of the model, the *Case Management Services* can take different forms, from an agency or individual, with an 'overview role' of the interventions for the service user, such as a case worker assigned to represent the service user in the delivery process. The CMS, agency or individual, can actively manage the integration (whether it is simple cooperation, collaboration, collocated service, or a mix of all of these). The CMS may also take the form of an information exchange system (i.e. computerized closed-network for data sharing), designed as an information sharing hub at the centre of a service 'network'.

18.   In practise, to meet the defined goals of service integration, this model would have to be adjusted to account for the specific country settings including variations in service demand, public administration and expenditure levels.

2.3 A model for prioritising services and service users

19.   Models of integration provide a framework for understanding how services can be linked to service users, but they do not provide an insight regarding the questions of who should receive the services as a priority, and in what order, and how these two issues might interact. For that reason, theoretical models, outlining the prioritisation of services for different vulnerable groups, are needed to complete the picture.

20.   The OECD's first Expert Consultation on Integrated Service Delivery will focus on people with very high needs, but when comparing these groups *by vulnerability*, it should be appreciated that the prioritisation of services in a schema of necessary services is likely to be different. As an example of how this might work, Figure 2 illustrates differences in four vulnerable populations from the perspective of services required (the numbers 1 to 5 order services by priority). In each case, housing supports may be necessary, but they are positioned in a different order of priority in each context.

Figure 1: The role of housing services in integrated services for vulnerable populations

Source: OECD.

21.   This model highlights the need for a distinction to be drawn between the order of service delivery and the desired outcomes for different service users. Using the example of vulnerable families, and the

services they require, it might be the case that the ultimate goal for the user is to achieve self-sufficiency through employment. To achieve this might mean delivering housing, health and education services, in an integrated way and in advance of employment supports.

22.   For the purpose of this work, and to help interpret the differences in service delivery and access *by stages of need,* a distinction needs to be drawn between services delivery for the same vulnerable groups in terms of services for prevention and services for treatment.

23.   When service users present for their first service, providers first become aware of the extent of their needs. In the case of the most vulnerable populations, this first service is often a service designed for emergency treatment – to help the service user meet basic needs (health, housing, or basic material goods such as food). The emergency services are likely to be the most costly, insofar as they will require treatment of acute need, delivered first as a matter of priority. Following the emergency service, providers may want to help the user access further services in support of self-sufficiency or dependency. These second stage interventions can be interpreted as preventative interventions, designed to avoid repeat visits to emergency treatment services (such as hospitalisation, prison, or emergency shelter), or in early-diagnosis, or early-intervention, designed to prevent emergency service use altogether.

24.   In further discussion, *priority services* will refer to those which are deemed necessary to meet basic needs, and provided immediately. *Supportive services* will refer to those delivered as a secondary priority for the service users, and as self-sufficiency focused, in order to prevent repeat demand for priority services.

**3. Developments in service spending and integrated services delivery**

25.   Although the discussion of service integration itself is new at the international-level, there is evidence to show that the use of in-kind services across OECD countries has been steadily increasing over three decades. Moreover, the integration of social welfare policies is not new. From integrated employment and welfare services for the unemployed across many countries, to health and welfare services for young families (birth grants in Hungary and previously in the United Kingdom, and immunisation allowances in Australia [OECD, 2011]), cash and service combinations may offer some good examples for integrating multiple services. Below, following a brief look at public spending trends, working examples of integrated social services policies are introduced.

3.1 Trends in social expenditure - in-kind and cash benefits

26.   Figure 3 below provides an overview of trends in social expenditure on in-kind and cash benefits between 1980 and 2007. Within the last three decades, there has been a clear increase in total public spending on in-kind services in comparison to cash benefits, and in particular as regards to spending on families where there is a clear convergence across OECD countries. Housing spending overall has been increasing, whereas spending on drug and alcohol rehabilitation services – for the ten countries with data – has fallen.

Figure 3: Trends shows increases and convergence in service spending on families, the elderly and in total

Trends in average public spending, by cash (dashed line) and in-kind (solid line) with standard deviations (shaded area), 1980-2007
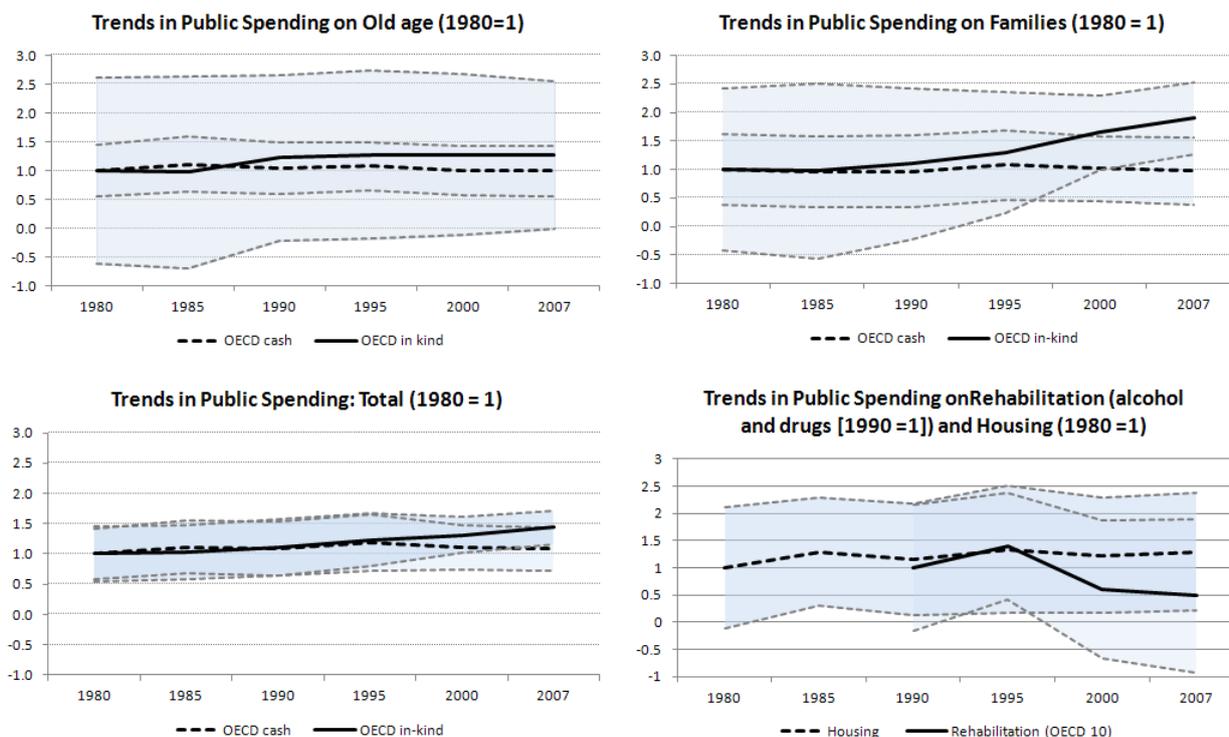
Note: Public spending standardized in relation to 1980 levels. Shaded area represent +/- 1 standard deviation relative to spending in that year. Since 1997, and fuller access to education spending data, there is a fuller inclusion of pre-school / childcare spending data. Data on housing does not include Chile, Korea, Japan and the United States. Data on rehabilitation of alcohol and drugs abusers is available for 10 countries: Austria, Belgium, Czech Republic, Finland, Greece, Hungary, Iceland, Slovenia, Spain, Sweden and the UK.

Source: OECD Social Expenditure database, 2012.

3.2 Policy initiatives to integrate health and welfare services

27.   As a consequence of the increase in spending on in-kind services, growing focus has been placed on effective, and integrated, service delivery by governments within recent years: integrated approaches to the delivery of services have already been implemented in several OECD member states.

28.   *Community Links* in New Zealand, delivered by the Ministry of Social Development, offers income support and employment assistance to disadvantaged job seekers (New Zealand Ministry of Social Development, 2012). The Community Links model relies on collocation of social services such as housing, health, financial assistance or legal and family services, which are provided by governmental and non-governmental organisations. Community Links operate as 'one-stop centres', which aim to provide client-centred integrated services by providing shared resources for the community, and common staff areas to enhance joint working in providing support for clients (Work and Income, 2012). According to an evaluation carried out by the Centre for Social Research and Evaluation, Community Link has led to improvements in efficiency and coordination in service delivery, and based on these positive outcomes, the

Ministry of Social Development has committed to widening access to these integrated services by establishing more Community Link centres (New Zealand Ministry of Social Development, 2010).

29.   The *Stronger Families and Communities Strategy* in Australia is an initiative that facilitates and encourages collaboration between service providers, community members, non-government organisations, businesses and all levels of government to enable communities to tackle their own issues at a local level. The idea behind the initiative is, that providing funds to help coordinate effort in local communities across community services, education, health and other sectors and across various government initiatives, will strengthen both families and communities (Australian Government, 2009). The Communities for Children initiative is funded under the Stronger Families and Communities Strategy and is a place-based response to programme management and service delivery that focuses on children up to five years old and their families, with a particular focus on prevention and early intervention. Service providers are brought together under a lead non-government agency that oversees wide community consultation with the aim of developing solutions to address locally identified needs (e.g. parenting, family relationships, education, health, crime, problems with gambling and suicide prevention) (Lewis and Taylor, 2005). Evidence from a short-term evaluation of Communities for Children suggests that the initiative has had some beneficial effects, albeit to a limited extent. Positive outcomes included fewer children in jobless households, parents feeling more effective in their roles and having better parenting practices. Moreover, there were positive impacts among the most vulnerable, such as improvements in 'children's early receptive vocabulary and verbal activity', decreased unemployment rates and mothers' increased community involvement (Australian government, 2009).

30.   The *Co-location Fund* in the United Kingdom is a cross-government initiative that provides funding for capital projects to enable the collocation of two or more services for children, young people and families. The fund enables an integrated delivery of services that contribute to improving outcomes for local children, young people and families (including reducing inequalities) (Atkinson, 2009), as well as improve access for service users and assist integrated working between professionals. The co-location fund supports projects on sites where universal services are already located, such as schools and primary health care services, which enable simple and direct access to services for children and families (UK Department for Education, 2012c).

31.   *Sure Start* in the United Kingdom is a government initiative providing a wide range of services to pre-school children and their families from disadvantaged neighbourhoods. The purpose is to improve early education, childcare, health and family support by developing outreach and community services for families with children from pregnancy up to age of fourteen, or sixteen for children with disabilities (integrated services for young children and families include advice on health care and child development, play schemes, parenting classes, family outreach support and adult education and advice). Sure start Children Centres are funded through the Early Intervention Grant (non ring-fenced grant that aims to support services for children, young people and families) (UK Department for Education, 2012a). A national evaluation (assessing child and family functioning when children were 7 years old as well as the change in functioning from age 3 to 7) found that the Sure Start Children's Centres have had some positive impacts on maternal well-being and family functioning, regardless of the level of family deprivation. These beneficial effects appeared to apply to all SSCC areas (UK Department for Education, 2012b).

32.   The *Head Start* programme in the United States targets low-income children and their families from birth to age five. It is a federal programme that offers services including health, nutrition, education and parent involvement services, designed to promote the school readiness of low-income children 'by enhancing their cognitive, social, and emotional development and supports children's growth in several domains' (language and literacy; cognition and general knowledge; physical development and health; social and emotional development; and approaches to learning) (the Office of Head Start, 2012). Many Head Start programmes also provide Early Head Start, which is a community-based programme targeting

newborns, pregnant women and their families whose income is below the federal poverty level. Agencies that are granted funding by the Office for Head Start must provide the services as described in the Head Start Performance Standards and in accordance with the Head Start Act of 2007. The Head Start programmes reach over a million children every year across the United States. Nearly 30 million disadvantaged children and families have received these comprehensive services since 1965 (the Office of Head Start, 2012). According to a national research project, access to Head Start has resulted in positive outcomes in parenting, health and cognitive domains for 3 and 4 year-old children. By first grade, however, there is little evidence on the beneficial effects of access to Head Start for the programme population as a whole (U.S Department of Health and Human Services, 2010).

33.   *Best Start* in Australia, initiated by the Victorian government, targets children ages birth to eight and aims 'to improve the health, development, learning, and wellbeing of all children' by supporting communities, parents and service provider to meet the local needs and to improve universal early years services (Victorian Department of Education and Early Childhood Development, 2012). Best Start has a strong emphasis on prevention and early intervention, is designed to enhance access to child and family support as well as to health services and early education, and should result in 'improvements in parents' capacity, confidence and enjoyment of family life and communities that are more 'child and family friendly' (Victorian Department of Education and Early Childhood Development, 2012). Developing strong cross-sectoral local partnerships, and integrating existing services, are central to achieving these goals. As reported in a state-wide evaluation, Best Start sites have been shown to be successful in enhancing community engagement through partnership arrangements, and have been recommended for extension into other vulnerable communities (Victorian Department of Education and Early Childhood Development, 2006).

34.   *Dream Start* in Korea offers services for the growth and development of low-income children (up to 12 years of age) and their families. Dream Start centres focus provision to areas where the proportion of vulnerable families and children is high. They aim to adopt a local, 'whole family' approach instead of only concentrating on children's needs by providing case-by-case integrated care management. Integrated services provided include health care, social development, family support and education (Korean Ministry of Health and Welfare, 2012). In 2010, there were 100 Dream Start centres providing these services in Korea (Dream Start, 2012).

35.   The Finnish Social Insurance Institution (SII) provides *Maternity Grants* in the form of a maternity package (contains child care items) or as cash benefits (140 Euros tax free in 2012) to expecting mothers, and in doing so integrate health and welfare services. Expecting mothers (who need to be residents in Finland and be covered by the Finnish Social Insurance System) may obtain the Maternity Grant after at least 154 days of pregnancy and after undergoing a medical examination at a maternal welfare clinic or a doctor's office before the end of the fourth month of pregnancy (Finnish Social Insurance Institution, 2012).

4. Vulnerable populations

36.   Although integrated service delivery can be applied in any welfare settings with multiple or complementary needs (see section 3.2), the people who are most likely to benefit from integrated service delivery are those with multiple disadvantages and complex needs. With the purpose of identifying the potential demand for integrated services, now and in the future, this section focuses on vulnerable populations, providing estimates on the level of vulnerabilities across the OECD.

37.   The term 'vulnerable populations' refers to people or households who live in poverty, or who are confronted with life situations that increase the likelihood of extreme forms of poverty (DELSA, 2009).

These populations often face multiple risks and can require a range of services, from low-cost interventions such as food parcels, to more costly interventions such as housing, or mental or physical health care.

38.   To tackle vulnerability, services focused on the vulnerable populations should strive to reduce the living standard gaps between the average population and the services users; this can be done via prevention or treatment. In regards to priorities for improving living standards of vulnerable populations, stability in housing, health, material conditions and food security are likely to be amongst immediate goals. As stated in the UN Universal Declaration of Human Rights, under article 25.1, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." For the most vulnerable in society, there is inevitably a two-stage process in meeting needs. Once the basic needs are satisfied, service providers can focus on supporting the service user to become self-reliant and develop independency.

*4.1 Estimates of homelessness, and housing and food insecurity*

39.   The homeless population is clearly a vulnerable population that would benefit from multiple interventions, and therefore integrated services. A review of the Social Policy Working party (DELSA, 2009) attempted to compare recent estimates of homeless populations across OECD, and clearly showed that definitions and surveying techniques (street counts or administration data; by city, region or country) made these data broadly incomparable.

40.   Nevertheless, despite cross-country comparison being impossible, recent evidence from different OECD countries has shown that comparison across time in different settings is possible, and this shows an increase in homelessness. Evidence from Seoul in Korea, England and the United Kingdom, and New York in the United States, has shown that the period spanning the financial crisis has seen large increases in the homeless population. The homeless population in Seoul, for instance, has increased as much as 67% within the last two years[1] (Chosun, 2012) compared to a rise of 24% of children in homeless shelters in New York since July 2011 (Gabbatt, 2012). The number of rough sleepers in England, on the other hand, has risen by 23% in past year (Ramesh, 2012a), whilst the number of homeless families in temporary B&B accommodation increased by 44% in the UK as a whole (Ramesh, 2012b). There is evidence in England that this increase in homelessness is being discussed by groups providing health and mental health services for the homeless, and not simply seen as an issue for housing providers.

41.   Cross-country comparisons are however possible for estimates of housing insecurity and food insecurity, taken from the Gallup World Poll. Figure 4 below provides an estimation of the level of vulnerability in OECD countries by looking at people's ability to meet two basic needs, food and shelter, within the past year. On average, 10% of people reported having troubles affording shelter, whilst the corresponding share for food was 13% across the OECD. These proportions vary widely across the member countries: for instance, in 2012, over 25% of people reported having had difficulties affording shelter in Turkey, Korea, Estonia and Mexico, compared to only 3% in Denmark, Germany, Sweden and Luxembourg. The share of people not having enough money for food, on the other hand, was as high as 39% in Mexico the same year. When looking at variations in these figures between 2006 and 2012, some countries have seen significant increases in the number of people not being able to afford food or shelter since 2006, whilst in others these shares have decreased. Notably, for Greece the rates of vulnerability on food measures have doubled, and for housing vulnerability have tripled. Finally, despite sharp, and contradictory results for New Zealand and Poland, overall correlations between the waves of data are strong: the Pearson R^2 for shelter (2006 to 2012) = 0.59; and for food (2006 to 2012) = 0.79.

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[1]It must be noted that more surveyors were used in Seoul to conduct a more comprehensive investigation.

Figure 4: People not having enough money for food or shelter in the past year, 2012 and 2006 (or latest available year)
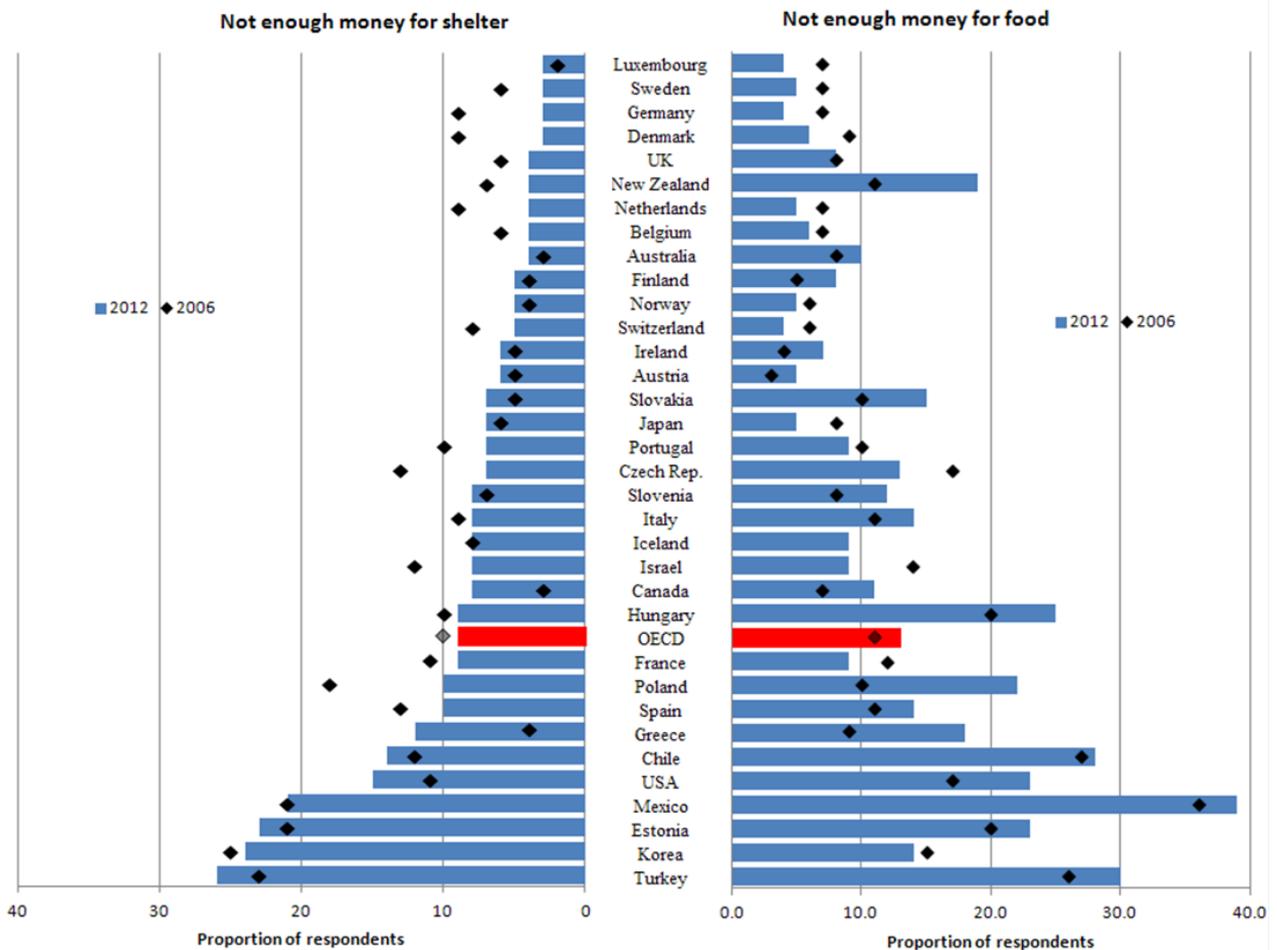

Source: Note: The Gallup World Poll was conducted by telephone in approximately 140 countries in total, and all OECD countries, using a common questionnaire translated into the main national languages. Samples are nationally representative of the resident population aged 15 and over in the entire country, including rural areas in most cases. Sample sizes are limited to around 1 000 persons in most countries (exceptions include Iceland and Luxembourg [c. 500]; Japan and New Zealand [c. 750]). Data for Germany and Japan are the average of four quarterly samples. Latest data for Norway and Iceland available from 2008. For Iceland, no data available for 2006.

Source: Gallup World Poll, 2012

4.2 Estimates of mental health and old-age related dependency

42.   Although estimating the true proportion of persons with mental health disorders across countries is a difficult task (DELSA, 2009), it is possible to look at changes across time within countries. Using data on disability benefit receipt, evidence shows that spending on people with mental disorders in a number of OECD countries has increased in recent years (OECD, 2012). Moreover, since the mid-1990s, the proportion of disability benefits granted for people with a mental health conditions has increased (Figure 4).

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Figure 5: Newly granted disability benefits for people with a mental health condition* as a proportion of all disability benefit grants in selected OECD countries, mid-1990s and latest available year
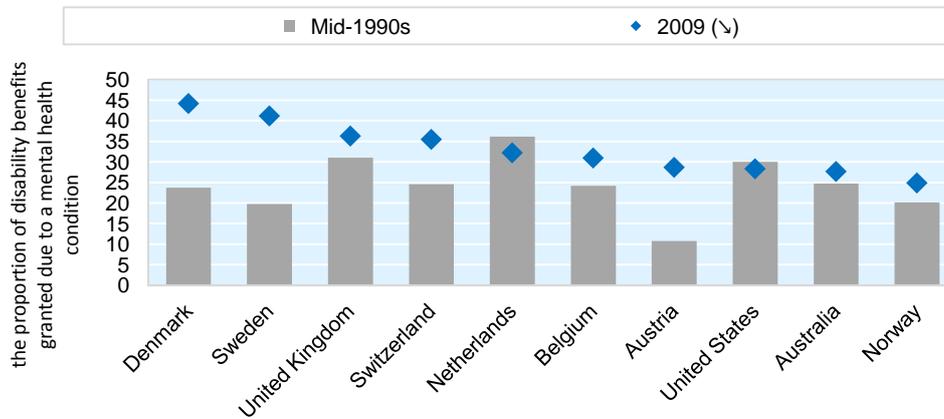

Source: Note: Data on mental health conditions include mental retardation/intellectual disability, organic mental disorders and unspecified mental disorders for: Austria, Belgium, Sweden and the United States (of which mental retardation/intellectual disability, accounts for 4.6% of the total inflow in 2006). Data for Australia include organic disorders and Switzerland mental retardation

Source: OECD (2012), Sick on the Job? Myths and Realities about Mental Health and Work, Mental Health and Work, OECD Publishing.

43.   Findings from a recent OECD study indicate that the rise in the share of disability benefit claims due to mental disorders may be largely explained by two factors. First, it appears that people with co-morbid conditions increasingly take mental disorder as 'the primary cause for incapacity'. And second, given that mental illnesses are more often viewed as disabling, claimants with mental disorders are more often granted a full benefit, their claims are less frequently denied, and they are less likely to move off benefits than those with somatic conditions. Because members of this group tend to be less likely to re-enter the labour market at the time of the claim (for further details, see OECD, 2012 Chapter 4), the co-ordination of services across different sectors is central to bringing down the spending on disability benefits and to providing effective support for people suffering from mental health disorders. For example, there is evidence that integrated clinical and vocational services lead to better employment outcomes (OECD, 2012).

44.   Finally, there are future challenges for service delivery in terms of the growing elderly population, that is likely to bring with it increases in chronic conditions and health expenditure, as widely acknowledged by governments in OECD member states. Indeed, by 2050, the dependency ratio is projected to increase in all OECD countries (Figure 4). In the majority of OECD countries, the share of dependent population is likely to rise over 40%, and almost as high as 50% in Japan, Korea and Italy.

Figure 2: Share of dependent population as a percentage of the total population
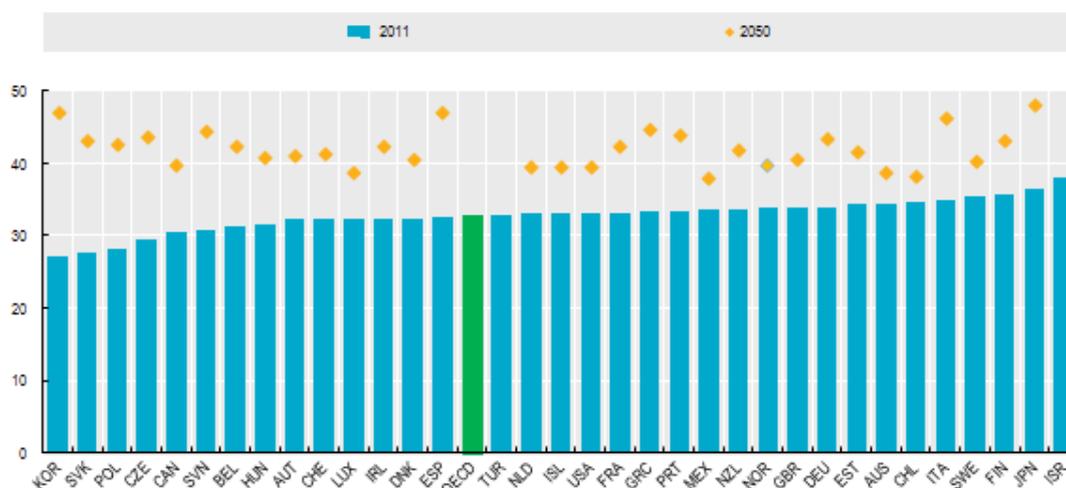
45.   As illustrated above, a significant proportion of the population across the OECD experience some type of vulnerability, and in each case there is evidence of growth in these populations (homelessness, mental health, and the elderly) which calls for a profound reflection on innovative and integrated care delivery solutions to efficiently address their needs.

5. Arguments for Integrated Services Delivery

46.   Drawing on evidence from the available literature, this section looks at the main benefits of integrating services, such as cost-effectiveness, accessibility and quality of services for both service users and providers.

5.1 Cost-effectiveness and cost savings for services

47.   Cost-effectiveness of services is one of the main reasons for integrating services. Through an integrated approach, service users can save money by accessing multiple services in one place, or by reducing other transaction costs (telephone calls, other communications, time, and working hours). Moreover, the overall expenditure on services can also be brought down by reducing hospitalisation and duplication of services.

5.1.1. Savings for service users

48.   Whilst the needs of the vast majority of the population can be effectively met via more traditional forms of service delivery, integration of services is cost-effective for the populations that have multiple needs and utilise the most services: visits to different services and other transaction costs are reduced. For example, in the context of ageing populations, the use of health care is expected to increase as elderly people are more likely to suffer from chronic diseases (such as diabetes or arthritis) or other health problems (Hardy et al, 1999). Evidence from the literature suggests that if people that utilise the most health care, such as the elderly population and those with mental health disorders, can access the multiple services in one place, the actual cost of health expenditure can be reduced. Facilitators, or case service managers, can further reduce costs as over-use of health services by these populations can also be avoided by effective coordination of care by a gatekeeper (Reich et al, 2012; Grone and Garcia-Barbero, 2001).

49.   Not only are additional services effective in reducing costs at the point of intervention, but additional services provided at the first point of intervention can act as preventative measures and reduce later service use, and so costs. Effective discharge plans – including a range of complementary follow-up services - for instance, reduce the likelihood of hospital readmissions (Rosenheck, 2000; Stewart et al, 2012). Reducing the number of interventions required by the service user through effective prevention, or effective management of priority services, will save time and money for the service users, and may improve take-up.

5.1.2. Savings for providers

50.   Integrated services can help service users navigate through the system and get the services they need. With regard to mental health services, for instance, there has been a shift from hospital-based to coordinated community care approach in a number of OECD countries (e.g. Australia, the Nordic countries, or the United Kingdom) in recent years. Coordinated mental health care and integrated treatment (such as assertive community treatment) have led to improved service delivery and better clinical outcomes. Moreover, fewer readmissions and reduced use of intensive care services and contact with 'community crisis teams' have resulted in cost savings (Stewart et al, 2012; Rosenheck et al, 2003; Woods and McCollam, 2002). Spending on disability benefits for people with mental health condition could also be brought down by a more integrated approach to care (see section 4.2).

51.   The integration of services, through effective collaboration in particular, will have the dual benefits of reducing gaps in priority services, and avoiding duplication of generic services from different agencies. Vulnerable populations may already be at a greater risk of being unaware or misinformed about the systems and services available to them, which can result in them enrolling in similar services with different agencies (Rosenheck et al, 2003), or missing out on necessary services altogether. With an integrated approach, the likelihood of over or under consumption of services can be significantly reduced.

5.2 Accessibility

52.   An important consideration for the efficiency of integrated services is the question of accessibility. Accessibility refers to the ease, and the extent, of access service users have to the services to which they are eligible. This section looks at accessibility issues from the perspective of the service user – who depending on their needs or vulnerabilities, may have unique or augmented barriers to service access – before going on to view the issues from the side of the provider, who may facilitate accessibility through various methods.

5.2.1 Service users and accessibility

53.   Service users with multiple needs tend to have difficulty navigating through the system, which may result in them missing out on services they are eligible for (OECD, 2012). With vulnerable groups in need of priority services, the longer they are without access to these services, the more severe their needs may become (Rosenheck et al, 2003). Integrated service models, particularly those with case management, are central to helping vulnerable service users navigate the system for reasons of time as well as accessibility: collocated services, for example, enable access to multiple services, which in turn is conducive to receiving full assessment of needs, and a faster delivery of appropriate services (Maslin-Prothero and Bennion, 2010). Case management is also important for non-vulnerable groups, as this is likely to reduce the personal and public cost burden of multiple application and multiple record collections across administrations.

54.   Certain service users may find it difficult to be physically present where services are delivered, and as such their accessibility is limited. For instance, service users with severe disabilities, chronic

illnesses or mobility problems (e.g. the elderly population) will have a harder time in accessing centre-based services. This in turn may result in increased use of emergency and inpatient services and hence increases in costs (Vedel et al, 2011). Without an appropriate system that links these vulnerable groups to the services they need, integrated services, no matter how well organised, will not optimise coverage, and in some populations will not reduce the need for repeat access to priority services.

55. Families that utilise social services (e.g. families in temporary social accommodation) are often likely to suffer from low incomes or unemployment (OECD, 2011) and tend to have multiple needs for services across different sectors (such as health, education and social services) (Sloper, 2004). Families with insecure employment, or parents who are working more than one job, may have difficulties attending appointments due to time constraints or employment obligations. There are costs related to accessing services (transport to the service centre) and to taking time off work (especially when not salaried), which make accessing services more difficult.

56. Due to the limited education that some of the vulnerable populations have, services have to be easy to access. Imperfect information, or misinformation about the services, their conditions or compulsions, may play into this reluctance to engage (OECD, 2012; Maslin-Prothero and Bennion, 2010). Clear, direct and comprehensive information for service users, perhaps delivered by a known case worker, is likely to be conducive to full engagement with all available and appropriate services (reducing under or over consumption of services, optimising coverage, and increasing efficiency).

5.2.2 Providers and accessibility

57. Collocation of different providers facilitates information sharing, which can in turn improve knowledge for agencies, promote communication among the different providers, and reduce the time professionals take when assisting service users access the right services (single or multiple services) (England and Lester, 2005; Sloper, 2004). In recent years, countries across the OECD have recognised the 'five cars in the drive' problem, where the same service user is accessing multiple services at home without coordination. When contact with service users is coordinated by agencies, or via a case-worker, the possibility that schedules of treatment will conflict are minimised, and efficiencies are made.

5.3 Quality of services and Improved Outcomes

58. Integrated service delivery improves the quality of services for service users and leads to better outcomes: it can, for example, reduce homelessness more effectively than emergency shelter options (Pleace, 2012). Moreover, integration of services enhances the quality of work for providers.

5.3.1 Service user's outcomes improve through integration of services

59. When professionals collaborate and cooperate with each other, service users get better outcomes. For instance, it has been shown that children experiencing mental health problems benefit from the integration of mental health services with education institutions (OECD, 2012). On many occasions, and particularly for the most vulnerable priority service users, professionals speaking on behalf of the user, in interaction with other professionals, can be more effective than service users advocating for themselves – issues of objectivity, urgency and priority all come into play. Across a range of services, professionals are more likely to have the skill sets to communicate effectively with other professionals, as well as having working knowledge (and examples of precedence) in dealing with a variety of cases.

5.3.1.1 Case workers and case management

60. Case management services (CMS) makes it easier for service users to navigate through the system, and through CMS, service users' needs can be identified from a professional standpoint. For

services to be most efficient, the human interaction aspect of the delivery needs to facilitate full disclosure of both circumstances and needs, and honest interpretation of progress. Ultimately, through efficient case management, misinformation and stigma and associated system failure can be avoided.

61.   Sharing certain information, such as present address, employment status, family status or earnings (their own or their family members), may be perceived by service users as a risk to their housing, benefits, or other services they receive (OECD, 2011). Moreover, when multiple services are required, and the service user does not have full information, preconceptions regarding which benefits or services are available in tandem, may result in additional supports not being taken-up. Having a caseworker that can clarify their situation and advise before decisions are made is crucial to successful interventions.

62.   Integrated services that have case management services seem to produce higher quality of care for families. Much of the literature shows that integrated services for families and children are effective when one worker acts as an access point for all the other professionals that the service users need to engage with (Sloper, 2004). Via the case worker, families can communicate with the school counsellor, the therapist, special education teachers, and other professionals, on the most effective schedule, without having the pressure of organising and deciding the schedule. This is likely to have efficiency gains for both the service users and providers. Moreover, the case worker and other professionals can meet and discuss relevant issues in the services users' absence.

63.   Quality of services can be enhanced when care is delivered through a medical home. Findings from a recent Commonwealth Fund survey (2011) indicate that whilst coordination problems in health care were an important concern in all the participating countries, patient experiences were consistently more positive when care was coordinated through a medical home (see Box 1).

Box 1. Health care coordination can be facilitated by medical homes, but effective, well-coordinated care remains a challenge

The 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults investigated care of over 18 000 adults who were in fair or poor health, had surgery or had been hospitalised in the past two years or who received care for serious or chronic illness, injury or disability in the past year. The average age of survey responders was 57 years, whilst 38 per cent had two or more chronic conditions. Eleven OECD countries participated in the survey (conducted by telephone), including Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. The survey focused on areas such as affordability and access, care coordination, patient-centred care, management of chronic conditions and medical homes.

Whereas patients with complex care needs in the U.K and Switzerland stood out in the survey as generally reporting more positive experiences compared to other countries, most problems were often encountered by sicker adults in the U.S, especially in terms of cost of and access to care. The share of patients having problems or being unable to pay medical bills in the past year, for instance, was as high as 27% in the U.S, compared to the U.K with only 1% or the Netherlands with 14%, reporting the second highest share.

Findings from the survey highlight the need for improvement in care coordination in all the participating countries from the perception of the patients. For example, providers failing to share important information with each other appeared to be a problem especially in Sweden, Norway, Germany and the U.S. The problem of specialists not having information about patients' medical history and/or regular doctor not informed about specialist care, on the other hand, was particularly pertinent in France and Germany (figure 1.).

Box Figure 1. Coordination problems in the past two years
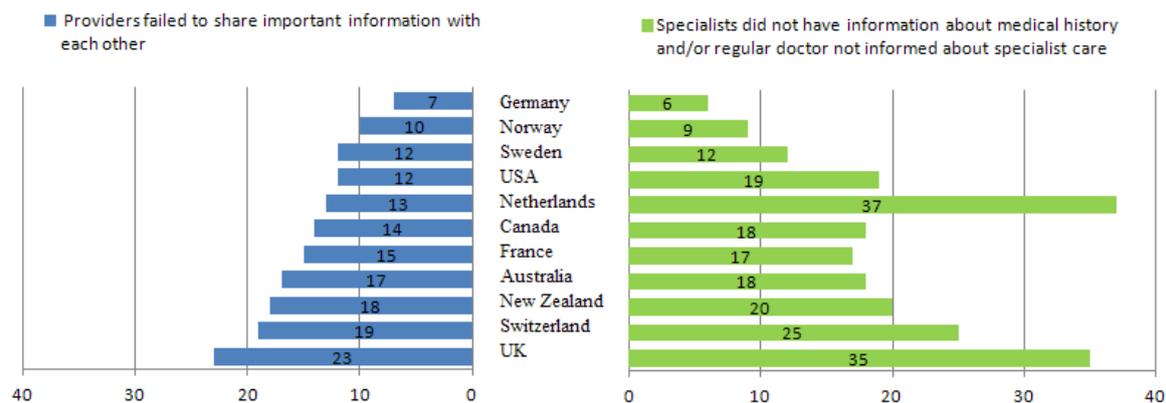
Source: The Commonwealth Fund International Health Policy Survey 2011 of Sicker Adults in Eleven Countries
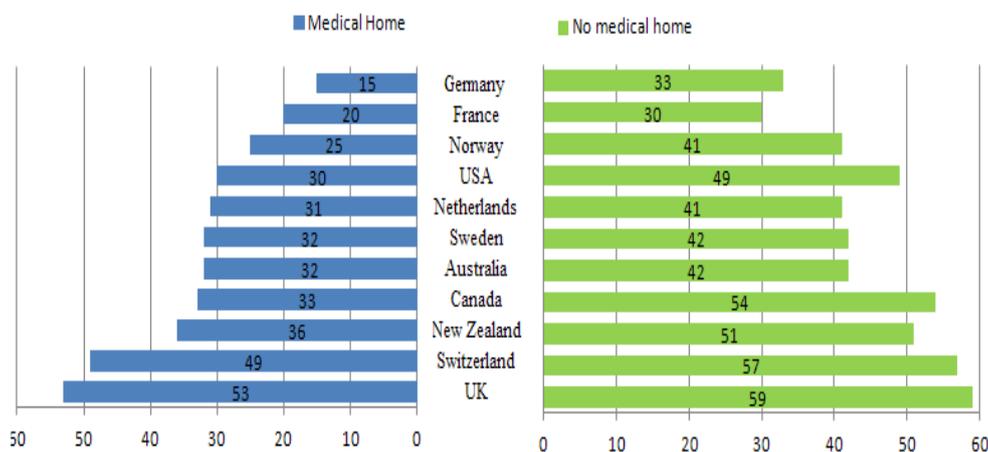
Moreover, the proportion of patients encountering difficulties in getting after-hours care without having to go to the emergency room was relatively high in all countries, ranging from 21% in the U.K and 26% in Switzerland to Sweden, France, the U.S, Australia and Canada all reporting shares over 50%. There were also significant gaps in hospital or surgery discharge in some countries: the proportion of patients not receiving a written plan for care after discharge was as high as 46% in Sweden and 44% in Norway and the Netherlands, in comparison with 7% in the U.S. In addition, almost half (47%) of the patients in Germany and France did not have arrangements made for follow-up visits, compared to only 12% in the U.K.

Sicker adults with medical homes[2] were found to be more satisfied with their care and reported fewer care coordination problems than those without one in all countries as illustrated in figure 2. Patients were most likely to have access to medical homes in the U.K and Switzerland, where three quarters of patients reported having a regular doctor or a place that helps to coordinate care. In other countries, the share was slightly lower at around 60%, with the exception

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[2]   Medical home refers to an accessible primary care practice that knows their medical history and helps coordinate care
       (Schoen et al, 2011)

of Sweden (42%). In addition, patients with medical homes also reported more positive experiences with regards to engaging themselves in care management for chronic condition in all countries.

Box figure 2. Experienced Coordination Gaps[3]

■ Medical Home   ■ No medical home

	Medical Home	No medical home
Germany	15	33
France	20	30
Norway	25	41
USA	30	49
Netherlands	31	41
Sweden	32	42
Australia	32	42
Canada	33	54
New Zealand	36	51
Switzerland	49	57
UK	53	59

Source: The Commonwealth Fund International Health Policy Survey 2011 of Sicker Adults in Eleven Countries

As the findings of the survey illustrate, medical homes contribute to more positive patient experiences and fewer problems with care coordination. Nonetheless, all countries face problems in providing effective, well coordinated care to patients with complex needs. In order to provide more effective care to sicker adults (both in terms of quality and costs), measures need to be taken to address issues such as coordination problems, gaps in hospital or surgery discharge or patient engagement in chronic care management.

5.3.2 Provider's outcomes

64. When professionals are working together directly, rather than relying on the service user having to go from one agency to another, providers save time through direct contact and professional clarity (Maslin-Prothero and Bennion, 2010).

65. Some studies suggest that cooperation itself evolves and becomes more efficient over time. For instance, when professionals are aware of the kind of work other professionals are doing, the communication becomes easier and benefits each other (Maslin-Prothero and Bennion, 2010). Services that are integrated can improve communications and collaboration among service providers, which strengthen over time, and provide increasing returns on the initial investment. As agencies learn more about each other, the important process of referral becomes more efficient.

6. Barriers to Integrated Services Delivery

66. As outlined above, integration of services represents many advantages to both service users and providers. Nonetheless, there are also a number of arguments for maintaining services separated, including uncertainty in outcomes; administration of social services and fiscal consolidation; data sharing problems or problems around joint working.

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[3] Test results/records not available at time of appointment, doctors ordered test that had already been done, providers failed to share important information with each other, specialists did not have information about medical history, and/or regular doctor not informed about specialist care.

6.1 Uncertainty in outcomes

67.　　The benefits of integrated service delivery tend to be long-term and evidence of the efficacy of an integrated service delivery model is not immediate (Hardy et al, 1999). Hence, there might be barriers to investment, such as short term competing interests and political will (Vondeling, 2004). As integrating services entail large capital costs and fundamental changes to the way services are delivered, policy makers and stakeholders need to be reassured about the efficacy of this kind of public investment.

68.　　To support long-term financing of integrated service delivery, there is a need for further economic evaluation of these systems (Vondeling, 2004). The planning and implementation of these types of care delivery is also made more challenging due to the lack of high-quality empirical evidence on the impact of integration and standardised tools for measurement and comparison (Armitage, 2009).

69.　　While the costs of integrated services for vulnerable populations with complex, multiple needs are likely to be high, better outcomes are not always guaranteed. Homeless people, who are new to services require multiple services (e.g. housing assistance, health care), a combination which is usually associated with increased costs but not necessarily improved outcomes (Rosenheck, 2000).

70.　　A review of the literature suggests that integrated service delivery might only be effective for certain populations. For people with chronic diseases, evidence on improved outcomes is easier to obtain, as the less these people use hospital services, the lower their medical costs (Reich et al, 2012). With regard to vulnerable populations, on the other hand, the results are much slower to see since these populations require stable housing and income and health services, rather than more direct chronic disease management in the community. Hence, some policymakers might be reluctant to provide long-term funding for comprehensive integrated service programmes targeted to these vulnerable population groups (Rosenheck, 2000).

71.　　 A final potential downside to integrated services is that quick and comprehensive treatment may be costly and inefficient in the case of misdiagnosis of a service user's needs. This is more of a risk when a single case worker, or gate keeper, has made the misdiagnosis, and in turn may result in an increase in the vulnerabilities experienced by the service user.

6.2 Obstacles to administering integrated social services

72.　　As with the introduction of any other type of social service, integrated social services are likely to require a large fixed capital cost. In times of fiscal consolidation there will be a certain reluctance to invest large sums on new social policies. Running costs are also an issue: sustainable streams of public investment are necessary for optimal service delivery. This is particularly important for integrated services: if a public body withdraws funding from an agency in an integrated setting, there is the obvious potential for a 'domino-effect' in belt-tightening or closure. If the funding for an integrated service comes from several different Ministries, for instance, then the potential for this 'domino effect' is multiplied due to a set of unrelated risks and competing interests in each sector (Vondeling raises this issue, 2004).

73.　　Sustainable, and unique funding streams, are not only a main factor in securing the long term ambitions of integrated service delivery. This is also the issue – in the shorter-term – for pilots. Many of the pilot programs are run over restricted time periods because of limited funding (Vondeling, 2004). Funding, and the security of funding, plays directly on the plans and decisions of the services providers and managers. (Mur-Veeman et al, 1999).

74.　　Successful joint working also requires a careful balance of the financial input. Commitment to integrated working by professionals and allocation of their time is likely to depend on the amount of funding each agency receives for the same project. Moreover, the short-term nature of and limited funding

for integrated service programs may prevent long-term contracts and limit opportunities for promotion for the staff. Hence, service providers may be less inclined to fully invest in integrated working (Maslin-Prothero and Bennion, 2010).

75.   In addition to financial investment, integration of services also entails significant structural and organisational changes to the often complex administration and management of the service system. In a number of OECD countries, the responsibility of providing and delivering care has been decentralised to regional or local authorities. Hence, establishing an integrated service model in a decentralised system would require adapting it to different local or regional circumstances. Whilst decentralised structures may facilitate collaboration across the social and health sectors at a local level (Woods and McCollam, 2002), available evidence from the literature suggests that the effectiveness and outcomes of service integration depend greatly on the local context (Mur-Veeman et al, 2008; Williams and Sullivan, 2009).

76.   Full integration of services can be very difficult to achieve when services are provided not only by the public sector but also by non-profit organisations and private providers, due to the multitude of actors and different administrations (Munday, 2007). Moreover, managing both competition and collaboration among care providers can also be great challenge in some countries. Policies introduced to increase competition in the health or social sector, such as free choice of provider (e.g. in Sweden) or increased involvement of the private sector, tend to lead to further fragmentation of care and hinder efforts made to integrate these services (Ahgren and Axelsson, 2011).

6.2.1 Challenges of joint working between professionals

77.   Despite the advantages that collaboration and cooperation between professionals represent, the divide between different professions may remain a significant barrier to integrated working. Differences in culture, training or attitudes between professionals can, for example, impede joint working (Maslin-Prothero and Bennion, 2010). In addition, there is a risk that service integration leads to a dominance of one or more professions and marginalisation of others. This is a particular concern affecting the health and social care sectors - traditionally, health care providers (doctors in particular) have been seen as holding a higher status than employees in the social service sector (Munday, 2007). There is, however, some evidence that cross-agency working can be facilitated, for example through joint training (Maslin-Prothero and Bennion, 2010) or strong management (Sloper, 2004).

78.   Some evidence from the existing literature suggests that collaboration and communication between service providers is effective in the short-term but might not contribute to any significant change or improvement in the long-term. While outcomes of inter-organisational working may be promising at first, it appears that trust and respect between professionals and agencies, joint planning, or other practises to encourage integrated service delivery might decline or 'level off' in the later course of the project (Greenberg and Rosenheck, 2010).

79.   An overarching concern for social service integration is the effect integration may have in terms of changing workloads, and any potential realignment of public budgets going to specialist agencies within a team. The public policy literature on power and resource dependency in policy delivery would suggest that an imbalance in resource management can impact on dependency, and in turn affect interests, motivations and behaviours in different agencies to different degrees (Parsons, 1999). Differences in interests, motivations and behaviours at the provider-level allows for the potential inefficiencies, or failures, in service delivery.

6.2.2 Data sharing problems

80.   Data and information sharing for effective integration of services is complicated, and can lead to legal challenges. Information sharing for integrated services can be complicated by legal issues relating to service user's information and privacy (Maslin-Prothero and Bennion, 2010). In the most complex cases, each agency may have to get legal advice prior to sharing information because violations could result in liabilities. Where advice is regularly sought, cost barriers to integrated service delivery may result.

81.   Another factor relating to data sharing includes the costs, and in some cases the potential for start-up problems, associated with setting up a sufficiently comprehensive data-sharing tool. This may involve a computer system, which means not only having the hardware and technical assistance costs, but also the training of staff.

6.3 Stigma

82.   Stigma associated with the take-up of services, or having experienced system failure, may lead service users to avoid repeat visits to services they are in need of (OECD, 2011). This may mean that sometimes people with the most acute need for services may refuse to use them.

83.   Stigma may not only lead to a complete withdrawal from services, but a selected withdrawal. Some service users would prefer to choose an agency outside the network of integrated services to avoid stigma. Having all agencies in one location, therefore, does not necessarily mean that the service user will pick the agency at the location. In order to feel comfortable, some might prefer an agency further away from their home. This might make managing the service user's case more challenging for the case worker, who would have to liaise with an agency located separately.

7. Policy recommendations

84.   There is a need for a policy shift from separation to integration of services in order to tackle the complex social problems experienced by vulnerable populations. An integrated approach would better serve these populations (e.g. the homeless), who tend to stay below the poverty line due to limited educational attainment and job insecurities (Rosenheck et al, 2003). In order to enable these people to maintain stability and encourage independency and employment, access to stable services that suit their complex needs must be ensured (England and Lester, 2005). Consequently, governments can save on social expenditures, as fewer people will have to rely on government services.

85.   Moreover, the growing share of the elderly population, which is more likely to suffer from chronic diseases and have dual or multiple diagnoses, will also increase health expenditure (Vondeling, 2004). In order to prevent the costs of health care increasing in the future, more integrated care delivery solutions are needed to better meet the complex needs of the elderly.

86.   Despite the lack of overwhelming evidence for the integration of social services, the subject is worthy of further attention from policy makers and is justifiable in terms of the potential effective integrations has for long-term cost efficiencies, agency collaboration and overall improvements in service users' satisfaction and outcomes alone.

87.   The following recommendations stand out:

- *More work is required to evaluate the cost efficiencies of services. There is a role for research and practitioner communities and policymakers in enabling this.* Although available evidence from pilot programs of service integration shows that it reduces costs and can improve outcomes,

there is a lack of evidence overall – and in particular in the long-run. Specific evidence on the effectiveness of collaboration is needed, as are examples of how to manage integration.

- *Efforts should be made to facilitate and increase Agency Collaboration.* Aside from the potential cost savings of integrated services, these services may improve the culture of the professional environment. Agencies collaborating have the opportunity to build a trusting relationship and share their working cultures, their priorities and ideas, and reduce the reproduction of the services for same service users (Maslin-Prothero and Bennion, 2010). Agencies interacting with one another have the opportunity to provide educational training for staff from different agencies, which enables a more profound understanding of other agencies' working cultures. Moreover, organised and informed team working is likely to reduce overall costs.

- *Policymakers could reduce the costs of service delivery by facilitating early and easy access to gate keepers of the integrated services, by the vulnerable populations.* When services are easier for the most vulnerable service users to attend to and manage, the cost of acute service delivery can be reduced. When vulnerable populations focus on meeting their basic needs (whether it be housing, health care, or food) appointments for health, social services, or to seek therapy can be missed, and the underlying drivers of their problems can persist.

- *Targets for integrated services should be set that reflect the outcomes of collaboration.* To encourage collaboration between agencies, the targets set within each services should be dependent, at least in part, on the achievements of other services that are amenable to collaboration. Goal-setting is commonly used to monitor and improve public services; integrated goal-setting is one way of encouraging fuller collaboration.

- *Service user's satisfaction should be included in the list of monitored outcomes.* When policy encourages the establishment of integrated models of service delivery, it enhances the quality of services and in turn the satisfaction among service users.

- *Standard practises are needed, and auditing or overview is required.* For instance, standard good practise between providers requires agency staff to record relevant information to ensure that information is received and acted on. It is also needed to ensure that all providers, despite the speciality, can be confident that they are accessing full information.

- *Secure, efficient and ethical data sharing platforms for providers are needed.* For professionals, when documented work is more accessible, and interventions can move at a faster pace. Integrated services delivery has the potential to change the work culture, reduce the burden on service users to engage with complex systems, and in turn improve experiences of the service users.

- *Effective preventative and future service planning through the 'discharge plan' is of use in all services settings.* If an exit plan is outlined for users of priority services (those designed to meet extreme need) it can provide comprehensive, timely, and even tapered support to help service users to become self-reliant, independent, and less likely to return to priority services.

8. Summary

88. To respond to fiscal consolidation, and demographic changes and the rising costs and needs associated to them, there is a strong demand for innovative service delivery solutions. When looking for innovative service delivery that responds to such demands, integrated services is clearly one promising

route for exploration. However, whilst available evidence shows the potential of integrated services, comparative empirical analysis of different approaches to integration remains limited.

89.   As this work has sought to illustrate, the integration of services can be beneficial to both service users and providers, especially for vulnerable populations with multiple disadvantages. First, integrated services are likely to reduce the cost burden of delivering support and care, as multiple visits, duplication of services, and costly interventions like hospitalisation are reduced. Moreover, integration improves accessibility to services, which is of particular importance to vulnerable people in need of priority services, such as the homeless. With regards to providers, integrated services also facilitate information and knowledge sharing between professionals. Finally, evidence from the literature also highlights that more integrated models of service delivery increase cooperation and collaboration between providers and agencies and leads to improvements in service quality as well as better outcomes and thus increases satisfaction amongst service users and providers.

90.   The limited empirical evidence-base for, and the absence of tools for, measurement and comparison of integrated services remain a significant barrier for the evaluation and implementation of these policies. There is a need for policy discussion and comparative analysis on integrated services at an international level to assist stakeholders and policymakers to prepare for future challenges.

91.   Nonetheless, several factors hinder the implementation of integrated models of service delivery. Indeed, the added-value of service integration, in terms of cost savings and improved outcomes, remain uncertain despite the logical expectation of a win-win scenario, especially in the long-run. As evidence from available literature underlines, implementing an integrated service system requires significant financial input and the undertaking of organisational and structural changes in financing, management and practice. Given that available evidence shows that the returns on integration tend to be long-term, there might be reluctance amongst policymakers to make such commitments. In addition, integrated service delivery is not immune to issues of stigma, and has additional challenges of effective data sharing, new training, and problems of joint-working across different sectors.

92.   There seems to be a relatively broad consensus across countries that integrating services has the potential to reduce the increasing health and social expenditure in the future. Hence, governments need to commit to longer-term investments to achieve (and appropriately evaluate) real outcomes. Multiple needs and multiple interventions are a fact of life for many vulnerable groups, and therefore to enhance the capacity of systems to respond to the complex social and health problems, policies need to focus more on integrated service solutions instead of traditionally separated services.

8.1 Proposals for future work

93.   Proposals are to be completed following the consultation on the 8th and 9th of November.

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