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# Rapid review of learning and evidence on national systems of social care in Nordic and Scandinavian countries

HEALTH AND SOCIAL CARE

social research

# Rapid review of learning and evidence on national systems of social care in Nordic and Scandinavian countries

Graeme Scobie, Andrew Pulford, Georgia Rendall, Stefania Greci, Emma Riches, Christina Buckton, Grant Donaghy.

Public Health Scotland

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## Key messages for decision makers

This rapid review[i] presents research evidence and learning from Nordic and Scandinavian national systems of social care to inform the development of the Scottish Government's proposed National Care Service for Scotland. Nordic and Scandinavian countries were selected as they have similarities to Scotland's demographics and type of delivery provision in terms of health and social care. The review includes evidence from qualitative research studies with service users and other key informants,[ii] and quantitative research studies reporting population health outcomes.

Although national social care systems varied between countries, we did not find any that could be described as specific "models" of national social care structures in the Nordic and Scandinavian countries. The majority of the identified literature focused on the integration of services between health and social care and how services are delivered at national and local levels. One regional level model - the Norrtaelje[iii] was identified in Sweden, where a single regulatory body was established to deliver care to the regions' population.

Neither did the evidence we reviewed identify any consensus positions around preferred structures of governance and finance of national social care systems. However, the evidence from service users and other key informants suggests a number of key principles that would facilitate the integration of social care services, regardless of the types of finance and governance structures. There was evidence of barriers and enablers to effective implementation relating to person-centred care and user involvement, communication, collaboration and trust between organisations and professionals.

There was limited evidence regarding national care structures and population health outcomes. A number of studies highlighted issues relating to inequalities in access to social care services. Findings were mixed as to whether integrated health and social care resulted in lower demand for services elsewhere in health care. An important evidence gap was the lack of quantitative studies that evaluated the impact of national social care policy implementation within or across countries.

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[i] Definition of a rapid review - "A rapid review is a form of knowledge synthesis that accelerates the process of conducting a traditional systematic review through streamlining or omitting specific methods to produce evidence for stakeholders in a resource-efficient manner" (**Cochrane Rapid Reviews: Interim Guidance from the Cochrane Rapid Reviews Methods Group, 2020**).

[ii] key informants include personnel such as health and social care professionals, care managers, social workers and paid carers.

[iii] The **Norrtaelje model** is a Swedish initiative that transformed the funding and organisation of health and social care in order to better integrate care for older people with complex needs. Norrtaelje is a local authority area situated in the north of Stockholm region, with a population of around 56,000 people, which would be similar to a small Local Authority region in Scotland.

# Summary of findings

## What we did

We undertook a rapid scoping review to identify the key learning, barriers and facilitators from national systems of integrated health and social care from the Nordic and Scandinavian countries. This also included pan-European studies if they included one or more Nordic or Scandinavian countries. We searched six databases of peer-reviewed literature, and the grey literature,[iv] with key search terms from 2010 until January 2022. The key learning from the included research reports was identified and captured under three main research questions: learning from service users, learning from key informants, and the impact of social care at a population health level. Due to the rapid nature of this review, we have not critically appraised the research studies, and present their findings as reported by the study authors rather than as the views of Public Health Scotland.

## What we found

Although national social care systems varied between Nordic and Scandinavian countries, the included studies did not identify any specific national “model” of integrated social care in the countries studied. Social care tended to be delivered in a country specific context, which mainly resulted from integration of organisations and services including how they were governed and funded. How services were controlled (e.g. centrally or locally) and delivered over time, also varied depending on the welfare regime and political views at a given time.

### User experience

A number of studies highlighted the importance of relationships between users of care services, professionals and unpaid carers. This helped to ensure users' needs were being met and that their preferences were being taken into account, as well as facilitating alignment of different parts of the system. There was evidence on the impact of inequalities in systems in terms of access and quality, in particular, for service users with complex needs.

### Learning from other key informants

#### Governance

The evidence reviewed suggests the following principles should be incorporated into governance systems: a clear vision for integrated care and underpinning legislation that is supportive and consistent; only enshrine in law critical elements while leaving room for local flexibility depending on context; the balance of centralisation and decentralisation is less important than being clear about roles and responsibilities and level of funding; and that monitoring systems should include user and process outcomes.

#### Funding

Key informant evidence on the effect on cost, health and service use outcomes is mixed and approaches to achieve integrated funding are variable across the

[iv] As cited by **The Grey Literature Report**, The Fourth International Conference on Grey Literature (GL '99) in Washington, DC, in October 1999 defined grey literature as follows: "That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers."

Scandinavian and Nordic countries. Key facilitators of financial integration include a shared vision among stakeholders, unified structures, coordinated funding and consideration of local circumstances. Difficulties of implementing financial integration were common, with a specific challenge being different payment structures or separate budgets and the transfer of funds between different parts of the system.

Marketisation in the provision of health and social care is increasingly common and approaches varied across countries. While it offers increased choice for care users and could potentially improve quality of care due to competition between providers, it challenges universalism, integrated care provision and equality of access.

### User involvement

Professionals in health and social care see collaboration with users as key for service delivery. However, the practicalities, time, service provision and administrative processes can be barriers especially in developing individual care plans.

Learning from key informant studies emphasised the importance of safeguarding systems across all levels of staff and service providers to ensure vulnerable users are protected and treated appropriately across the care system.

Key informants identified cooperation and trust between different parts of the system and service providers as important. This included the sharing of resources and responsibilities to deliver quality services for different target populations. This went beyond just health and social care integration and could include other sectors such as education and employment. Shared information and communication systems were also viewed as promoting integration, as well as improving service quality and workforce development.

Where people can safely access care is an important factor in meeting the needs of users. Provision of home-based care in addition to formal care settings needs to be considered.

### Workforce

A commitment to provide continuous professional development, training and good work conditions with a degree of autonomy across the social care workforce, should be considered in providing efficient social care services.

## Population health outcomes

Much of the population health outcomes evidence identified for social care[v] draws from studies using the Survey of Health Ageing and Retirement in Europe (SHARE). Findings from SHARE studies included inequalities in access to care and unmet need within and across European countries, particularly between users with different socio-economic positions; and the consequences of out-of-pocket costs, which were more likely to affect the poorest and most vulnerable older people. There were several other studies considering the relationship between integrated programmes and demand in other parts of the health system such as emergency department

[v] For consistency, the term "social care" is used throughout this report to replace terms used to describe social care in other countries (such as long-term care).

admissions. The results were mixed as to whether integrated health and social care resulted in lower demand for services elsewhere in health care.

## What this report does not tell us

This rapid scoping review was not designed to provide a systematic, quality-assessed synthesis of evidence. It does not provide a comprehensive analysis of "what works", but rather provides learning on national social care systems from Nordic and Scandinavian countries. Due to the rapid nature of this review, we have not critically appraised the research studies, and the report does not include recommendations but reports findings as published in the included studies rather than as the views of Public Health Scotland. Our review does not include children's services and does not look at community and local programmes of social care services.

The report does not include any detailed analysis of the current health and social care system structures in the included countries. However, further details can be found in the European Social Policy Network's thematic reports on the long-term challenges of social care across European countries (2018).

We did not attempt to look at definitions in terms of consistency of language and meaning across the countries included in this report, and have adopted terms commonly used in Scotland rather than broadly equivalent terms in other countries (e.g. social care rather than long-term care, or unpaid care rather than informal care). However, a glossary of terms used across social care in Europe and other countries is available from the OECD 2011 report "Help Wanted?".

Neither did we find any mention of third sector organisations involved in delivery of care services in Nordic and Scandinavian countries. This may in part be due to how social care is funded and delivered by the public and private sectors in each of the countries.

## Implications for policy and research

No single national “model” of social care was identified, and no consensus was found on optimal governance or funding arrangements. However, the evidence does highlight general key principles that can act as enablers or barriers to the creation of a national social care service depending on national context.

Although we found a large number of studies eligible for inclusion in this review, much of the evidence was largely descriptive. There was little evidence of robust programme evaluations of national social care systems in Nordic or Scandinavian countries.

# 1. Introduction

The Scottish Government announced its intention to establish a National Care Service for Scotland in its 2021-22 Programme for Government. The National Care Service will seek to build on the recommendations of the Independent Review of Adult Social Care in Scotland to create a social care system that is rights-based, person-centred and addresses the challenges in the social care system identified both before and during the pandemic. The Scottish Government issued a consultation on the proposed National Care Service in August 2021. The consultation set out a wide range of suggested approaches for the cultural and system changes required to refocus the social care system to one that delivers consistent and fair access to care and support services across the country and improves outcomes for people. In December 2021, the Scottish Government asked Public Health Scotland to undertake a rapid scoping review of approaches to adult social care delivery and potentially transferable learning for Scotland (taking account of country and system characteristics that will influence comparability such as health care structures, governance and funding).

## 1.1. Aim and objectives

The aim of this report is to review research evidence on learning from selected countries' models of social care, with consideration to the range of themes covered in the National Care Service (NCS) consultation. We set three main research questions to achieve this aim:

1. What qualitative evidence from service users is available on how national models of social care implemented in selected countries relate to key measures of user experience and person-centred outcomes?

2. What qualitative key informant evidence is there on lessons learned from national models of social care implemented in selected countries?

3. What quantitative evidence is available on the impact of national models of social care implemented in selected countries on key public health outcomes at a population level?

# 2. Methods

Due to limited time, a rapid scoping review was undertaken by Public Health Scotland to identify key learning from the three research questions above. The review focused on research studies looking at integrated care where the emphasis was on social care rather than primary care. Countries included in the review were the Nordic and Scandinavian countries as they have similarities to our demographics and type of delivery provision in terms of health and social care. Pan-European studies were included if any of the Nordic and Scandinavian countries were involved.

A steering group was established with representatives from Public Health Scotland, Scottish Government, Healthcare Improvement Scotland and the University of Edinburgh (see Appendix 1 for list of members).

Our search strategy was developed in collaboration with Public Health Scotland's Knowledge Services team. Keywords included (but were not limited to) integrated care; social care, long-term care, person-centred and user experience and linked to various aspects of integrated social care (see Appendix 2 for search strategy). The search was limited to English language from 2010 onwards. Both peer-reviewed and grey literature were included. There were 1,202 references retrieved from six peer-reviewed literature databases (Medline, Embase, Proquest, Scopus, CINAHL and SCIE). An additional 800 references were retrieved from the grey literature using Google. A preliminary first screen of the grey literature was undertaken to remove reports such as blogs and websites resulting in 305 references.

All references were screened in Covidence, a commercial reference manager software tool. Criteria for inclusion/exclusion were based around the PICOS framework - Population, Intervention, Comparison, Outcomes and Study design (see Appendix 2 for inclusion/exclusion criteria). Both title/abstract screening and full text screening were carried out by two independent reviewers. Additional references were obtained from the steering group as well as from limited hand searching of key documents. Due to the limited time, no formal quality assurance process was carried out on the included reports.

# 3. Findings

A total of 1,507 records were identified by our search strategy (1,202 from peer-reviewed databases and 305 from the grey literature). After screening, 86 studies were included in the review - 46 from the peer reviewed literature and 40 from the grey literature.

## 3.1 User Experience

### 3.1.1 User involvement

User involvement in care planning was found to be an important facilitator to positive user experiences as it increases choices and improves the experience for users. Five papers were identified, four of which considered care for older people[1, 2, 3, 4] and one that considered support services for people with severe mental illness in community care.[5] Evidence suggests that user involvement should be facilitated by professionals, to ensure a balance between the preferences of users and professional expertise.[6] Matschek et al (2020) found that for patients with severe mental health issues, developing simple user-led plans with a professional led to improvements and support in daily living.[5] However, three studies considering care for older adults[3, 6, 7] found that in practice it can be difficult for providers to make user preferences a priority when care planning as they may struggle to find a balance between designing care plans based on their own knowledge and considering the preferences of users. Further, systems must ensure that when encouraging empowerment of users in their care planning, attention is paid to individuals who may have limited ability to make decisions about their care or have limited knowledge on options available.[6, 7]

### 3.1.2 Person-Centred

Services which support older people to live the life they choose were found to be important for users' emotional and physical wellbeing.[2, 6] Support services included assisting socialisation and integration into society, support in the home environment and support to deal with unplanned or urgent situations. These were delivered in various ways including through home adaptions, knowledge and information sharing and professional assistance.

One study addressed the transition out of care for young people with learning disabilities.[8] It reported young people do not want services only to consider what professionals think they need but want to be listened to and have the ability to express their needs as well.

### 3.1.3 Joined up

Four papers highlighted that collaboration, respect and communication between care professionals, unpaid carers and users supported a successful system. [1, 6, 9, 10] This joined-up working facilitated the alignment of user preferences and appropriate support for individual need. The evidence also suggested that difficulties in communication between groups was damaging to user experience. This included communication between professionals, unpaid carers and users. There was less evidence on how good collaboration and communication can be embedded in the system. Methods mentioned in the literature included improved support for users and carers to navigate the health and care system (especially when care spans across different providers and sectors),[1] support for the implementation of integration from managers, primary care physicians and frontline staff,[1, 2] reduced fragmentation of the system by using co-location of services and a continuity of care staff,[9] prioritising person-centredness[6] and ensuring there is easy and accessible information sharing.[6] User perspectives should be considered when evaluating and improving services.[2]

Integrated health and social care services provide a broad range of care needs including physical, cognitive, psychological, and social services.[6] This allows care services to support users with more complex needs. It is important that users receive this care with continuity as fragmentation can lead to poorer user experiences.[1, 9]

Roberts et al. (2018)[8] identified that young people transitioning out of care have a range of both personal and professional needs such as relationships, employment, and education. Access to health services, accommodation, and finance, as well as the transition to adult services, are seen as challenging without appropriate support.

### 3.1.4 Equality

Equality in access and quality of older people's care is crucial for a positive user experience.[2, 11] The Danish system focuses on care service provision and high geographical coverage, which aims to reduce inequalities in access to formal care regardless of where a user lives.[12] This is especially important for access to specialised services which can be unequally distributed across an area making them more difficult for individuals in certain geographies to utilise.[11]

One study found inequalities in the continuity of care across patients with chronic care needs.[10] Some users reported a fragmentation of service delivery which

included being examined by multiple healthcare professionals for the same problem; and a high turnover of social workers, making it more difficult for users to navigate the system and develop relationships with professionals.

Schultz et al. (2019)[10] found that service users perceived differing levels of respect from health and social care workers, with some users feeling that there was a lack of understanding and empathy from professionals towards their condition, while others had the opposite experience.

Finally, levels of unmet need were found to vary amongst older adults with disabilities in Europe, suggesting that not all adults have access to services which adequately support them.[13]

## 3.2. Learning from key informants

### 3.2.1. Governance

Eighteen of the papers that considered evidence from key informants specifically discussed the role of high-level governance in the design and implementation of integrated social care. Views were based on experiences from Sweden,[14, 15, 16, 17, 18, 19, 20, 21] Norway,[11, 19, 21, 22, 23, 24] Denmark, [21, 22, 23, 25] Finland,[21, 26, 27] and three multi-country studies.[28, 29, 30] Important themes that arose were the role of legislation, the degree of centralisation and formal organisational integration, and the importance of regulation and monitoring.

#### 3.2.1.1. Legislation

Findings from eleven of these studies highlighted the need for appropriate and consistent national legislation to support the aims of social care services.[15, 16, 17, 18, 19, 20, 21, 23, 24, 25] These discussed the degree to which national legislation can and should dictate standards and means of service provision. For example, in Sweden existing legislation was flexible enough to allow the design and implementation of the integrated Norrtaelje model without the need for new legislation to be enacted. However, the subsequent implementation of the Act on System of Choice in the Public Sector was viewed as presenting challenges to the model, with its emphasis on competition and marketisation, which then had negative effects on integration and the collaboration between health and social care.[15, 16, 18]

The Swedish example also suggests how even high-level framework legislation can limit local autonomy when it is used in conjunction with parallel national policies to implement rules and incentives that local social care commissioners and providers are required to follow.[17] One study, reporting the views of strategic and political stakeholders involved in the care of older people in Sweden, showed that legislation designed to facilitate increased coordination and collaboration could not overcome mistrust between regional and local authorities.[20]

In Norway sectoral reform has been underpinned by legislation that places the responsibility for clinical care, public health and rehabilitation on local municipalities, with the relationships between the organisations involved defined by legislation and monitored service agreements.[19, 24]

Two studies highlight Denmark as an example where national legislation can provide a framework that helps ensure services are user focused. In this example, national legislation defines the right of service users to participate in decision-making about their care.[23, 25]

From the findings of the studies that considered legislation, an important facilitator in the provision of integrated social care is to be clear about the vision for the service and only define in law those elements that are critical, while leaving flexibility for negotiation at the local level.

Legislative barriers include inconsistent and changing legislation that results in power imbalance and national laws that prevent the free flow of information.[21]

#### 3.2.1.2. Centralisation and localism

Another key theme was the extent to which governance and regulation should be centralised in a formal organisation. Eleven studies highlighted the importance of getting the balance right between top-down governance to ensure standardisation and quality of services versus bottom-up flexibility to allow for local context and to meet service user needs. [14, 16, 20, 24, 25, 26, 29, 30]

There are many examples of both approaches with neither one more preferable than the other.[16, 24, 30] One study which examined the historical perspective in Finland, identified a cycle of decentralisation and recentralisation with pros and cons for both models.[26] Recent calls for recentralisation have been driven by the impact of local autonomy on care inequalities at the regional level. A study reporting the views of senior care services stakeholders in Sweden identified opposing stakeholder views: one view supported more centralisation and a single government body responsible for all care of older people; the other placed more emphasis on collaboration based on mutual agreements and networking to ensure services were relevant for the local population.[20] The evidence suggests that decentralisation can be both a barrier and a facilitator to integrated systems. Decentralised systems can lead to fragmentation if there are divisions in health and social care between different institutional levels.[11, 16] However, decentralised governance can be seen as an enabler as is the case in Denmark, where national legislation provides a clear broad framework for service provision within which municipalities retain responsibility for social care policies.[25]

Studies of the Norrtaelje model in Sweden illustrate that a fully integrated model does not necessarily ensure better clinical care coordination.[14, 15, 16] Evidence from a multi-country review suggested that it may be important to focus less on formal organisational structures, and more on relationships with an emphasis on networks rather than hierarchies.[29] In the highly decentralised Danish example, the evidence highlights three key instruments of regulation relating to the content, completion and monitoring of care agreements. In Denmark these are determined by the national government and the regions/municipalities are required to follow them. [23, 25] One study identified that most often bottom-up initiatives were developed by empowering local organisations to work together and be creative, and therefore policy makers should consider a hybrid top-down and bottom-up approach to support integrated care.[30]

An important regulatory facilitator is to have the right balance between formal centralisation and local autonomy. Cultural factors including historical relationships and mistrust can be a key barrier.[20] A facilitator in the Norrtaelje model is the existence of a single decision-making and financing body encouraging agreement with all the providers. This enables delivery of social care, home health care and rehabilitation for the same person in a coordinated manner.[16] Formal governance structures can support systems by providing consistent strategic advice.[30]

#### 3.2.1.3. Regulation

A final theme highlighted the importance of clear regulatory roles and responsibilities to ensure effective regulation and monitoring.

Two studies that examined the systems in Denmark, Norway and Sweden highlighted the fact that central monitoring, standards and control of service provision had the potential to reduce local autonomy with implications for service quality. They noted the importance of having governance structures and national monitoring standards that clearly defined responsibilities and boundaries.[17, 22.]

Evidence from Denmark and Norway also suggests that coordination and monitoring of complex care services is particularly important in a marketised system with both public and private provision.[23] Two studies looking at multiple country examples stressed the fact that marketisation has implications for quality in social care and therefore there needs to be consistent ways of measuring quality[vi] across different care settings to ensure protection of the most vulnerable.[19, 28]

Monitoring systems can facilitate social care integration by including user outcomes, not just process outcomes. One study suggested that policy makers should direct policy development at the individual and local levels, then create mechanisms to support negotiations to achieve the desired outcomes of making care user centred and shifting care from hospital to community settings.[24] Coordination and monitoring barriers include occupational cultures, work boundaries, autonomy, lack of coordination and communication, and data recording.[14]

### 3.2.2. Funding

Approaches to achieve financial integration varied, as highlighted by one study which looked at international literature for integrated resource mechanisms across health and social care; but could include grants, cross charging, aligned budgets, lead commissioning, pooled funds and integrated management with or without pooled funds.[31] Evidence relating to funding of national social care systems has been grouped into the following categories: pan-European learning, horizontal financial integration (e.g. across different parts of a social care system), vertical integration (e.g. between central and local structures) and marketisation.

[vi] 'No established set of indicators for measuring integrated care is currently available, and indicators used can be disease and/or non-disease specific. Overall, there is a strong need for international comparable integrated care indicators to highlight where significant variations between countries (or regions) exist, and to consequently call for their explanation and possible filling' (Borgermans).[28]

#### 3.2.2.1. Pan-European learning

Funding of social care is variable across Europe, with it centrally funded in half of the EU states and the other half mostly sharing funding responsibilities between central and regional/local level.[32] To achieve sustainable, high-quality integrated social care requires long-term commitments and investment in social care organisations, alongside robust evaluation.[33] Learning from European health systems suggests improving financing by prioritising the cost-effectiveness of services, better procurement, developing new models of remuneration (giving incentives to provide a balance between quality and amount of services) and adapting financing to prioritise equal service access especially for vulnerable and rural populations where waiting times and workforce shortages can be an issue.[34]

#### 3.2.2.2. Horizontal financial integration

Key facilitators of horizontal financial integration can include all stakeholders having a clear shared vision, financial and non-financial incentives and organisational processes may help to align aims of integrated resource mechanisms (e.g. funding, management and/or provision) with actions among stakeholders, and avoiding a one-size-fits-all approach;[31] as well as pooled resources/unified structure as noted in the Swedish system.[21] Coordinated funding was considered a strength of the Norrtaelje model, and initial difficulties in financial coordination in Sweden were mitigated using local associations.[29] By contrast, multiple sources of funding in Norway were considered to be a weakness.[29]

Implementation of horizontal financial integration is noted as challenging,[15, 21, 35] often despite statutory and regulatory support.[35] Specific challenges were implementing a shared funding system due to differences in payment structures and difficulty transferring cost savings to different parts of the system in the Norrtaelje model,[15] and separate budgets and the flow of funds between municipalities as seen in the Norwegian system.[21, 29]

The effect of financial integration on cost, health and service use outcomes was assessed in three studies.[14, 31, 35] The evidence for cost and service use outcomes was mixed. One international literature review of social care systems from nine countries noted that there was weak evidence that integration resource frameworks could achieve cost savings.[31] In another international review of 38 schemes from eight countries comparing the effects of ‘integrated financing plus integrated care’ relative to usual care, 34 schemes (in studies published in or since 1999) looked at secondary care costs and/or utilisation. This review found approximately a third of schemes had no significant effect on hospital costs or utilisation, three reported a significant reduction in secondary care use versus usual care; in the remaining schemes, the evidence was unclear. This review also noted that integrated care with integrated financing had the potential to enable health and social care to be shifted into the community, reduce admissions for some groups and improve access to care.[35]

The impact of integrated funding on health outcomes was reported to be lacking or not significant in two studies.[31, 35] An analysis of developments in the Norrtaelje model was not able to establish the link with better user- (or cost) outcomes;

however, it did find structural and process changes which increase the likelihood of improved outcomes.[14]

#### 3.2.2.3. Vertical financial integration

Universality of care is a feature of Nordic countries.[14, 22, 25, 36, 37] The literature highlights some challenges: it is expensive to provide,[36] requires a high-level of dedicated funding,[25] and there is potential tension between central government and local government bodies, with the latter concerned that the system is no longer affordable for an ageing population.[17]

Conversely, decentralisation of funding can result in a situation where wealthier local government bodies can choose to invest more in care services,[17] particularly home care service provision.[22] Fragmentation of funding can result in gaps in service provision when budgets are tight and service users can be passed around from one funding body to another.[17]

Austerity and inadequate public resource provision are important cross-cutting funding issues. Although the severity of austerity and consequences of constrained public funding varied among Denmark, England and Norway in one study, austerity measures can result in a gap between what needs to be delivered and what can be, forcing rationing decisions by care workers or local municipalities and potentially reinforcing inequalities in provision based on geographical differences.[22]

#### 3.2.2.4. Marketisation

Marketisation in the provision of health and social care can include a number of approaches, such as competition, private provision and economic incentives. The literature highlights several potential advantages. For example, it may benefit users by offering increased choice.[37, 38]

A case study highlights the implementation of a unique form of public-private partnership in Finland that is a one-stop shop home care service for older users (known as Kotitori); it supports access to private services for those who can pay for it, but also supports access to public services for those that need it and cannot afford it.[38] Positive dynamics of competition and user choice may support integration and drives up quality as well as being a powerful lever for making delivery of services more efficient.[39]

However, a number of shortcomings to marketisation were also reported. It challenges universalism in Nordic and Scandinavian countries, particularly for services for the older users,[22, 37] and paying for additional services may challenge equality of access.[22] Providing user choice in the form of cash for care can challenge integrated care provision, lead to uncertainty of funding for care providers and can also lead to fragmentation of service provision.[40] Increased competition has increased instability in the market of home care for the elderly and increased costs for local areas.

A comparative analysis suggests that in Denmark competition is expensive, has not increased efficiency, and separation between regional and municipal services has led to fragmentation.[39] While new cash-for-care schemes could enable greater choice and control for users, it is unclear whether they are effective in terms of cost

and quality.[41] When considering cash for care options, it is important to be clear about eligibility rules and the mix of paid and unpaid care which can be complicated and a barrier to accessing the funding.[41]

### 3.2.3. Service integration

A large number of papers focused on how services can work together to provide seamless care for those requiring it. Findings tend to be from pan-European or international studies looking at ways to provide better-integrated care. Key themes emerging include person centeredness, mechanisms for integration, collaboration and trust and a shared vision.

#### 3.2.3.1. User involvement

Delivery of services with the person at the centre have been used in Sweden and Norway to involve users, family and carers in developing and providing integrated care for patients with mental health and addiction problems,[42, 43] and for adolescents and young adults with complex mental health issues.[44] Similarly, in a large pan-European[45] and Finnish study[46] looking at integrated care for older adults with multimorbidity, person centred care was seen as a key factor in providing care. Older users were viewed as needing to be seen at the centre of service delivery at a national level (individuality, autonomy, choice) but this needs to be balanced with costs and availability.[47]

Several implementation barriers to involving users have been identified. Social workers and care staff report mixed benefits due to tension between what professionals can provide, and what users want and the unsystematic use of individual care plans across services,[43] administration and bureaucracy, lack of resources, user involvement, time and unclear responsibility.[44]

Facilitators to user involvement mainly focused on leadership style and context, ensuring individual plans were agreed with users, as well as being a supportive manager.[44] Agreement needs to be reached between unpaid carers and service users on what their needs are and how it should be delivered in the home or care setting.[45] In Finland, an integrated and responsive system, service availability and accessibility, guidance, leadership, resources, and the effective use of technology were seen as facilitators.[46]

Professionals delivering services for older users need appropriate training, organisational support and specific competencies.

Few studies looked specifically at social care services for the disabled. One model of social care provision for people with a long-term disability is that established in Stockholm, Sweden.[48] This is based on a cooperative model (collective support) which provides services to allow independent living, providing choice of services and different ways of delivery/funding such as via direct payments. Discussions of barriers to providing disability services through cooperatives[48] focused on understanding how cooperatives function, especially in the social care market, their small size and population coverages, competitiveness and how sustainable long-term funding can be secured.

Inter-organisational co-operation can also be a problem due to welfare agencies having different legislative mandates, budgets, and areas of responsibility. This can result in individuals with a disability being redirected to different organisations without getting the services they need.[49]

#### 3.2.3.2. Organisational integration

There is no one model for integrated care.[50] Analysis of case studies from seven OECD countries identified that integration evolves over time and should be built from the bottom up using a model already designed to improve care. Developing integrated care requires transparency in funding, data management systems, leadership and collaboration, roles and responsibilities, care planning and user involvement.

Key mechanisms for service integration have been identified from several studies including European health systems (e.g. the To-REACH project[51] and the pan-European (SELFIE) project on older people with multi morbidity).[52] These identify the need for person- and population-centeredness and supporting mechanisms to improve efficiency such as the workforce, digital health, measuring and improving quality, financing and governance; as well as integration with other sectors such as education and employment.[51, 53] Implementation of digital health technology is integral to providing joined up care across organisations and improving communication and data collection.[21, 34, 36, 54, 55, 56] A system needs to be designed to enable shared access across different organisations, but still protect patient confidentiality where required.[57]

The key mechanisms to support implementation of integrated care have been reported for frail older people and fall under four main themes: service delivery, leadership and governance, workforce, and financing.[21, 52] Barriers include developing shared information systems, fragmented funding, cultural resistance, and opposing political party views.[52]

Provision of palliative care[58, 59] and rehabilitation[60] varies across Europe and internationally. Palliative care can be regulated at different levels as well as having different funding sources including charitable, public and private sources. Delivery of palliative care needs to ensure early access to health care, health and social care input, be community-based for user access, provide equitable access, and be sustainable.[58, 59] Rehabilitation service requires high-level coordination to provide services[60] as well as equality of services, workforce health and wellbeing, and less provider competition.

Having a clear vision and commitment to deliver an agreed model of care is important, as there is considerable variation across the EU, Norway and Iceland and other countries. How integrated care is defined and delivered in different countries varies considerably.[21, 40, 61] Facilitators of these integrated care initiatives include a commitment to the vision of integrated care, good communication and leadership, trusted and familiar systems providing universal and professional care, a skilled workforce and flexibility and coordination between different levels of service delivery. A commitment to and an understanding of the model of care is important.[62] Barriers

include a lack of cooperation between organisations, teams or professions, organisational culture and separate IT systems.

#### 3.2.3.3. Professional Integration

The majority of studies which focus on working together to provide integrated care report the need for better people skills such as collaboration, communication, cooperation and trust.

People skills, such as communication and cooperation, are key for integration of services amongst different client populations. Personal characteristics of leaders of integrated care such as personality, ability, knowledge, experience on the ground, and person skills are also viewed as important.[45, 57, 63, 64]

This includes collaboration and cooperation both vertically and horizontally between multidisciplinary teams. Integration outcomes rarely focus on health impacts but rather on improving coordination, increasing knowledge and staff and client satisfaction.[64] Health and social care reforms in Finland have required novel ways for cooperation and agreement in establishing service provision[65] including high level ministerial collaboration to overcome functional and cultural boundaries and to reduce hierarchy and create stability.[24, 39]

Trust is important both within multidisciplinary teams as well as across different sectors. This includes the health and social services as well as employment and education.[39, 53] Trust is also required at different political, strategic and inter-professional levels.[20]

Trusting relationships were also found to be a key facilitator[45, 57] including collaboration between care professionals in different parts of the system as well as responsibility and accountability. Successful leaders were important in championing change and promoting integrated services.[57] Power imbalance and breakdown in trust and failed attempts to collaborate and cooperate between agencies were noted as barriers at all levels.[20]

Country and region-specific population factors should also be considered as a one-size fits all approach may not be appropriate.[57] The Norrtaelje system in Sweden found that there was cultural resistance to the model, as consideration was not paid to different cultures in professional groups from different localities – this was partially mitigated by recruiting local health care staff.[29, 57]

### 3.2.4. Workforce

Eight studies considered the impact of work force factors on integrated care systems. Four of these studied integrated health and social care systems for adults,[21, 25, 57, 66] two focused on integrated care for older adults,[64, 67] one compared paid and unpaid care,[68] and one considered multiple areas of care including long term, hospital, primary and mental health.[51]

Evidence from Sweden suggests that staff training and continuous personal development should be considered as part of the integration strategy.[64] In Denmark, education for staff and professionalisation of the role of care providers was found to be an important facilitator for successful teams and systems.[21]

Linked to this is ensuring that there is an appropriate supply of care staff – shortages of social care professionals continues to be an issue in several countries.[25, 66, 67] In Sweden, the availability of a skilled workforce is crucial to the system's success.[68] It is also important that health professionals are trained in a variety of skills and that there is a balance of roles across regions, to ensure access to appropriate care services regardless of location.[34]

In the Norrtaelje model, strong leadership with clear goals and organisational culture supported team collaboration and successful implementation.[15, 62] It developed joint integration activities to encourage managers to get on board.[15] However, this system was set up in a small community and this may be more difficult in larger or more open settings where more time and flexibility is required.

Staff needs should be considered when developing an integrated care system. Barriers to integration included issues with employment such as shift patterns, contract types (for example, non-permanent contracts) and hours worked.[21] Berglund et al.[64] found that job satisfaction is an important factor in an integration strategy.

In Sweden, social work has recently undergone reform both in terms of structure and how services are delivered.[69, 70, 71] Professionals' roles were seen as being eroded with less focus on professional management. This included undertaking new duties such as delivering on budgets, securing private services and administrative duties.[69] How services are organised is still under debate. Some professionals see services as specialized (e.g. in depth knowledge of specific areas) whereas others see them as being generic (holistic generalist view).[70, 71]

In addition, there has been an Evidence Based Practice (EBP) approach in Swedish social service practice to succeed the New Public Management (NPM) system.[72] However, little progress has been made over the past 15 years. Reasons for lack of progress include delivery using a top-down approach, difficult and complex to understand, unclear goals and it is not recognised as policy (seen as new methods). The lack of progress is also due to the interpretation of governance and power relations in terms of who has implementation responsibility at national, regional and local level.

### 3.3. Population health outcomes

Much of the population health outcomes evidence identified for social care draws on the pan-European Survey of Health Ageing and Retirement in Europe (SHARE) study. Five SHARE studies looked at inequalities in social care provision in relation to need.[73, 74, 75, 76, 77] These studies highlight inequality issues across selected European countries such as those in greatest need and with lowest socio-economic position having less access to social care. Of these five studies, four made inequality comparisons between countries,[73, 75, 76, 77] including Denmark and Sweden. All studies found inequalities in care, particularly between users with different socio-economic position. The evidence suggested only Denmark and the Netherlands successfully targeted home care services at poorer individuals.[75] Further, Armjios-Bravo[73] suggested that there was an inequitable distribution of use of paid and unpaid home care, with those from higher income households more likely to benefit from paid care. Differences were highlighted between levels of unmet need, with

those from the lowest socio-economic position most likely to have unmet care needs.[76, 77]

An additional SHARE study investigated the consequences of private out-of-pocket expenditure to access social care.[78] Out of pocket costs were found to affect most older people in the included European countries, with a small percentage of older people incurring catastrophic financial costs. These were more likely to be the poorest and most vulnerable older people. The authors suggest action around availability and affordability of social care, increasing equity of financing of social care, and wider strengthening of social protections.

A final SHARE study investigated the impact of home-based social care on the quality of life of care-giving adult children in Sweden and Denmark.[79] The timing of cutbacks to social care provision indicate that social care coverage affects the quality of life of care-giving adult children. This was the only SHARE study that explicitly investigated changes in social care coverage and a health outcome rather than just describing a cross-sectional association.

Evidence from other quantitative research studies on the impact of integrated health and social care on population health outcomes was mixed with regards to access to services and service use outcomes.

### 3.3.1. Access to care services

High target efficiency of social care was found in Sweden, meaning that few people who need public social care services did not receive them.[80] The authors suggested that this could be due to support given to unpaid carers, high geographical coverage of services or appropriate targeting of services. While the perception that many older users in Sweden do not receive the social care they need was not supported by the findings, the authors caution this could change over time and monitoring of key indicators is recommended to ensure that finite resources are matched to need in the most efficient way possible.

A study in two Finnish cities provides information on the reasons for using public or private social care services.[81] It found that while choice can help needs of some users, it may also widen inequalities in access, as choice may not be available to those in greatest need.

A descriptive study looking at social care trends in Sweden between 1993 and 2006 highlights that universalism and localism are inherently in tension and that their relationship may change in complex ways over time.[82] For example, during this period universalism has weakened in terms of social protection but increased in terms of reduced local variation.

### 3.3.2. Service use outcomes

Studies that investigated the impact of social care integration on service use outcomes reported mixed findings. The integrated HSC programme in the Norrtaelje area of Sweden was linked to a fall in emergency department visits for over 65-year-olds while overall emergency department visits have remained higher than the rest of Stockholm.[83] Similarly, in Norway, integrated care may have led to the prevention of unplanned medical admissions amongst the oldest in the population,[85] while a weak

negative association was found between integrated social care provision and days in hospital (though this was neither clinically nor statistically significant).[84] Overall, unplanned medical visits varied very little with levels of social care, suggesting that just providing more social care might not have much impact on unplanned admissions other than for the oldest age groups.[85] After the introduction of integrated care in Finland, levels of healthcare use decreased (after a short-term increase), with the biggest changes being seen in primary health care nurses' appointments.[86]

# 4. Conclusion

We undertook a systematic and comprehensive search of integrated care across the Nordic and Scandinavian countries but also included studies from pan-European and some OECD projects where Scandinavian and Nordic countries were included. We did not restrict any aspects of social care if they related to higher level or national structures such as paid/unpaid care, social services and specific types of care e.g. rehabilitation or palliative care. Although this resulted in a large number of studies, the potential for missing important learning was greatly reduced. This report was limited to a rapid scoping review and did not take the country specific health or social care systems into consideration so any transferability may be difficult.

We found limited evidence from across the included countries and pan-European programmes of care to support any one model of integrated care. How integrated care is delivered differed considerably in terms of governance, structure, funding and flexibility, both at a national and local level. We also found that how care is delivered varies within countries and over time – changing from central control to local control and then back depending on specific county welfare regimes and political climate at a particular time.

Evidence on how different integrated care structures impact on changes in health at a population level was also limited, but a consistent theme was inequality of access to services especially for those who require it most. Countries also vary in where they deliver care – most are mixed in terms of formal care establishments and in the users own home although there is a drive towards home care as being preferred by users.

What is more consistent is the need for better integration between organisations and professionals. Better collaboration, communication and trust is important in working together with a clear vision and understanding of what is required at all levels of staff. Although few studies focused on the workforce, better professional development, skills training, autonomy and working conditions were identified.

Identified gaps in the literature point towards a need for robust programme evaluations of national care systems, although these are difficult to do in practice.

## Appendix 1: Steering group members

Alix Rosenberg (Scottish Government)

Laura Martin (Scottish Government)

Anna Kynaston (Scottish Government)

Carol Brown (Scottish Government)

Ingrid Roberts (Scottish Government)

Karen Macpherson (Healthcare Improvement Scotland)

David Henderson (Edinburgh University)

Andrew Pulford (Public Health Scotland)

Georgia Rendall (Public Health Scotland)

Stefania Greci (Public Health Scotland)

Graeme Scobie (Public Health Scotland)

Lorna Renwick (Public Health Scotland)

Richmond Davies (Public Health Scotland)

# Appendix 2: Search strategy

Database search terms

1 Denmark or Danish or Finland or Finnish or Norway or Norwegian or Sweden or Swedish or Scandinavia* or Nordic or Iceland* or Europe*) adj5 ("social care" or "social service*" or "social care service*" or "long-term care" or "adult care" or "care program*" or "model* of care" or "integrated care" or "joint working")).ti,ab.

2 (governance or funding or interface* or delivery or system* or experien* or barrier* or facilitator* or integrat* or structure* or "population outcome*" or "health care quality indicator*" or qualitative or "policy change*" or "hospital admission*" or discharge or readmission* or "health system* performance*" or inequal* or inequit* or "human rights" or access* or "user outcome*" or "person* outcome*" or "person-centred").ti,ab.

3 1 and 2

4 limit 3 to (english language and yr="2010 -25 January 2022")

Databases searched:

Medline, Embase, Proquest, Scopus and CINAHL. An additional amended search was undertaken in the Social Care Institute for Excellence (SCIE) database

| Database | References retrieved |
|---|---|
| Medline | 198 |
| Embase | 259 |
| Proquest Public Health Database | 86 |
| SCOPUS | 489 |
| CINAHL | 272 |
| Social care Institute for Excellence (SCIE) | First 500 references |
| Total | 1804 |
| Total (after Covidence deduplication) | 1202 |

Grey literature (Google search):

The first 100 hits from Google for the following searches were retrieved and added to Sciwheel reference manager for an initial screen before being added to Covidence:

(Denmark | Danish) (“social care” | “social service” | “social care service” | “long-term care” “integrated care”)

(Finland | Finnish) (“social care” | “social service” | “social care service” | “long-term care” “integrated care”)

(Norway | Norwegian) (“social care” | “social service” | “social care service” | “long-term care” “integrated care”)

(Sweden | Swedish) (“social care” | “social service” | “social care service” | “long-term care” “integrated care”)

(Iceland) (“social care” | “social service” | “social care service” | “long-term care” “integrated care”)

(Nordic | Scandinavian | Europe) (“social care” | “social service” | “social care service” | “long-term care” “integrated care”)

(“social care” | “social service” | “social care service” | “long-term care” “integrated care”) site: who.int

(“social care” | “social service” | “social care service” | “long-term care” “integrated care”) site: eurohealthnet.eu

Inclusion/exclusion (PICOS table):

| Criteria | Include | Exclude |
|---|---|---|
| Population | Adults<br>Selected countries (Scandinavian and Nordic, including pan European<br>Cross-country studies that include findings for selected countries | Children<br>Other countries<br>Dates – pre 2010 |
| Intervention | National social care structures including:<br>Legislation<br>Commissioning<br>Regulation<br>Improvement<br>Access<br>Care planning<br>Workforce development | Individual-level interventions<br>Community-level interventions<br>No link to national care structures in title or abstract (or aims/objectives)<br>Informal carers/unpaid carers/home care unless a national level focus |

| | | |
|---|---|---|
| | Users experience if national level or linked to overarching care strategy.<br><br>Experts' views on national systems (opinions?)<br><br>Quantitative outcomes e.g. LTC and hospital admissions<br><br>Primary health care (if clear link with social care)<br><br>Findings from large care networks (Pan EU) (check with steering group if in scope)<br><br>Inequity of access to services (or different types of care services eg by SES) | |
| Comparison | n/a | n/a |
| Outcomes | | No outcome (population or person-centred)<br><br>No quantitative analysis (e.g. hospital admission/discharge) |
| Study design | As per RQs<br><br>Studies of national policies (policy analysis)<br><br>Scoping reviews (but new ones could be useful – include if methods, check references) | No methods described<br><br>Editorial/opinion piece<br><br>Conference paper<br><br>Protocols<br><br>Methods papers (e.g. validation of tools)<br><br>Descriptive trends |

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