Generalitat de Catalunya
Consell Assessor de Salut

GUIDANCE ON THE MODEL OF CARE FOR PEOPLE WITH SOCIAL AND HEALTH CARE NEEDS

Health Advisory Council

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The assignment of the Health Advisory Council

The Council shall make it possible to rethink and redirect the model we want in the future in line with the social, demographic and technological needs and changes of the forthcoming twenty years.

The Council shall enable calm reflection away from the day-to-day running of the Ministry and therefore be a tool which can help us as a country to ensure the future of health is well thought out and planned.

Alba Vergés, Minister of Health

The vision of the Health Advisory Council

Given the large number of assessments made, strategic recommendations and priorities identified and the demonstrative evidence of integrated care, we need to take action based on a country approach. A general framework is needed to foster equity among the territories that are the natural area of operation.

Manel Balcells, Chair of the Health Advisory Council

Contents

1. Situation

Changes in the social, demographic and epidemiological paradigm are leading to a scenario in which more and more people are living in complex long-term situations (1-6). Against this background shaped by financial pressures and the reconceptualisation of health (6), the vast majority of developed countries have chosen to prioritise strategies aimed at improving health and promoting the autonomy of people with health and social care needs (1,4-8).

Planners have directed much of their efforts towards adopting a more holistic vision and achieving people-centred comprehensive and integrated care (5,9). However, there are key aspects which still need to be addressed in order to finally resolve the fragmentation of care which is rooted in approaches based on the disease and not so much on the person (10). In doing so, it is hoped to improve the patient experience of care, improve the health of populations and reduce the per capita cost of health care (*triple aims of healthcare)*; and more recently the goal of improving the work life of health care providers has also been added (6) (in line with the *quadruple aims of healthcare* (11)). Some of these key aspects include having in place a regulatory, financial and assessment framework which encourages integrated care and promotes research, innovation and accountability (12) in this area. Comprehensive and integrated care calls for numerous interventions which require a holistic approach, the availability of roles to coordinate care, aware communities, and a high degree of communication between professionals in both sectors as well as the involvement of various organisations and the commitment of all the stakeholders concerned (10).

The available literature shows a broad consensus, especially about the fact that there is no single successful organisational model or approach (1,2,7,13), that integrated care can be implemented with varying degrees of scale (3,4,13-15) and that the starting point for integration should be a service delivery model with a more preventive approach and early intervention (16) designed to improve care for individuals. However, lack of regulation and fragmented governance structures have often been major stumbling blocks (2,5,9,16-19), which suggests that efforts should be made to clarify and adapt agreements between areas and enhance shared governance (5,20).

1.1. Definition and types of integrated care

There have been ongoing efforts to define integrated care across different settings or levels over the past decades. Some authors point out that conceptual ambiguity remains a challenge in itself and that it makes it difficult to achieve integration (17,21). A review by Armitage et al. in 2009 identified 175 definitions and concepts of integrated care which showed the lack of consensus in its definition

(20,22). Likewise, Bautista et al. identify other terms which have been used in health systems around the world to identify various integrated care experiences such as American 'managed care', British 'shared care' and Dutch 'transmural care', among others (21).

In 2016, in an effort to understand integrated care, Goodwin came up with four widely used definitions of integrated care (3):

1. System vision definition by the World Health Organisation in 2016.

   Integrated health services is health services that are managed and delivered in a way that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites, and according to their needs, throughout their whole life (23).

2. Management vision definition by Contandriapoulos et al. in 2003.

   The process that involves creating and maintaining, over time, a common structure between independent stakeholders (...) for the purpose of coordinating their interdependence in order to enable them to work together on a collective project (24).

3. Social science-based definition adapted from Kodner and Spreeuwenberg, 2002.

   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 the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups can be called 'integrated care' (25).

4. Definition based on person-centred coordinated care by National Voices in 2013.

   I can plan my care, with people who work together to understand me and my carer(s), allow me control and bring together services to help me achieve the outcomes that are important to me (26).

In Catalonia, the *Terminologia de l'atenció integrada* ['Terminology of integrated care'] (TERMCAT) defines integrated care as the *care model based on the joint and supportive actions of social services and health services professionals and organisations which aims to achieve good outcomes in health and wellbeing, proper use of resources and a good care experience, thus ensuring integrated care and person-centred care* (27).

1.2. Integrated care models and governance

Apart from the definition of integrated care, the literature also describes different types that compound the complexity of the concept. In essence, the analysis has been about orientation (whether it is directed at the entire population or at a specific group of people) (3,4,10,28,29), level (organisational, functional, service, clinical, regulatory or systemic) (3,14) and its scale (which can range from integration through informal links to care provided by fully integrated teams or organisations) (3,4,15). It is also important to draw a distinction between integrated healthcare (vertical) and healthcare integrated with other sectors such as social care (horizontal) (1,4).

1.2.1. Integrated care models

In terms of integrated care models, Béland and Hollander differentiated between community-based and large-scale models (28). These authors describe community-based models as *smaller projects that relied on cooperation across care providers, focused on home and community care, and played an active role in health and social care coordination*. By contrast, large-scale models are ones *that could be applied at a national or regional level and had a single administrative authority and a single budget, and included both home/community and residential services* (28). They say that community care-based models are primarily demonstration projects and may need to be formally adopted by governments before they become the standard of care across large geographic areas, while population-based large scale systems may require changes to existing legislation and policy. However, they also stress that the two types of models share a number of important features (Table 1).

The World Health Organisation (WHO) concludes that in order to make changes sustainable over time, integrated care models require action from an organisational, functional, practitioner and service delivery perspective as well as from a systemic perspective (4). Here the Pan American Health Organization (PAHO) defined four domains (model of care, governance and strategy, organisation management and financial allocation and incentives) for the development of integrated health service delivery networks and their relationship with the level of integration achieved (fragmentation, partial integration, integration) (4,30), holding that an integrated health service delivery network requires a unified system of governance for the entire network.

Table 1. Common features of the types of integrated care models

Common features of the types of integrated care models (Béland & Hollander, 2011) (28)
1. Philosophical belief regarding the benefits of a coordinated continuum of care.
2. Care planning and coordination across a range of services.
3. A reasonably wide range of home and community-based services, which are seen to be part of the continuum of care.
4. A single point of entry into the system of care.
5. Independent case management and client classification by case managers/assessors.
6. An integrated information system.
7. System level policies and procedures that spell out how the continuum of care works, particularly with regard to who is eligible for care, how clients can receive multiple services over the same period of time, and how client's transition between types, or sets, of services.

Source: Béland & Hollander, 2011.

1.2.2. **Integrated care governance**

Initiatives designed to find the right fit between public policies in various sectors of a government's activity that are aimed at improving health and wellbeing outcomes call for multi-sector approaches. Gagnon et al. report the need for integrated governance approaches, which they define as *an action initiated and developed by a public agency striving to integrate the actions of other actors around the same problems* (31). In general, a strong governance structure and a strategic framework with broad stakeholder participation and consensus is considered critical to the success of integrated care (2,5,7,17,19,32-34).

However, in many countries there is an insufficient degree of integration into the framework of governance and consequently of delivery. Generally speaking, the health and social fields are organised in different systems with different responsibilities, budgets and professionals (35). A 2014 report comparing 31 European systems which included home care delivery found that 81% had two distinct systems for healthcare and social care respectively, and of these about 50% had responsibility for home care divided between two ministries (32). The report also noted that even where there is one integrated ministry for both health and social home care services, responsibility for financing and regulating home care may still be divided over different levels of governments (state, regional or municipal).

Historically, mergers have been at the heart of the debate. Some researchers argue that larger organisations have more capacity to manage joint budgets and achieve economies of scale, while others point out that the centralisation of decision-making powers detracts from the scope for professional practice (6). However, examination of the effect of institutional mergers (35,36) shows that they are unable to deliver comprehensive and integrated care unless they are widely agreed upon and represent all the stakeholders involved (35,36).

The great challenge lies in the fact that we often find ourselves dealing with systems which differ greatly in terms of competencies, access and funding. In particular, the literature identifies several barriers to the implementation of integrated care that are strongly related to governance: 1) inflexible regulations; 2) social care systems that are often organised locally, with less professional development and different funding; 3) the stakeholders involved resist change often for fear of losing their power and position; and 4) poor funding and/or payment systems that are not aligned with integrated care (2,5,13,19,28,32).

In short, root and branch change is required in the way integrated care for people with complex health and social care needs is funded, managed and delivered (5). Progress will only be made in this direction if the numerous organisations and sectors are brought on board and resulting adjustments are made to enhance shared or integrated governance.

1.3. International initiatives

Socio-economic, epidemiological and demographic changes have impacted the health and social care needs of the population. This has led to the advances in policies and strategies aimed at providing comprehensive and integrated person-centred care around the world. However, it has been noted that the possibilities for integration, and therefore for addressing fragmentation of care, depend on the specific features of organisational contexts, funding and professional cultures (13). It should be borne in mind that although there are an enormous number of integrated care models, approaches and initiatives at the international level, there is no single solution with successful outcomes that can be tailored to diverse realities.

In 2016, the World Health Organisation (WHO) published a comprehensive report on global integrated care models (9). It categorised the models by level of integration, identifying individual models of integrated care, by population groups or specific diseases, and by other population-based models around the world (Table 2). The report of the Catalan Labour, Economic and Social Affairs Council ((CTESC in its Catalan initialism) of December 2018 analyses a selection of international initiatives (13) using the same categorisation as the WHO (9). On this occasion, the CTESC picked out five

initiatives that include examples of vertical (health care) and horizontal (health and social care) integration: the Kaiser Permanente (USA) and the Basque Country Chronicity Care Strategy as population-based models; *Care Chains* (Norrtälje, Sweden) and *Clinical Network Management* (Scotland) as population group or disease-specific models, and the *Te Whiringa Ora* (Eastern Bay of Plenty, New Zealand) as an example of an individual model.

Interest in continuing to work on and extending integrated care is also in evidence in the United States. One example is the report by the National Academies of Sciences, Engineering, and Medicine entitled *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health* (37). This report, which is discussed in the leading journal The Lancet (38), identifies and assesses current and emerging approaches resulting in a number of recommendations aimed at extending integrated care.

Table 2. Types of integrated care models and reference examples, WHO 2016

Types of integrated care models and reference examples (WHO, 2016) (9)
1. Individual models of integrated care ○ Case-management (American Case Management Association) ○ Individual care plans ○ Patient-centred medical care (USA) ○ Personal health budgets (USA, UK, Austria, Germany, the Netherlands and Norway)
2. Group and disease-specific models ○ Chronic care model (USA) ○ Integrated care models for elderly and frail people (PRISMA – Canada; Torbay Care Trust – England; municipalities of Rovereto and Vittorio Veneto – Italy) ○ Disease-specific integrated care models (Chains of Care – Sweden)
3. Population-based models ○ Kaiser Permanente (USA) ○ Veterans Health Administration (USA) ○ Chronicity care strategy (Basque Country)

Source: World Health Organisation, 2016.

The literature also draws attention to the United Kingdom as a benchmark in horizontal integration initiatives, especially in England, Scotland and Northern Ireland (2,18,19):

- In England, Sustainability and Transformation Partnerships (STP) have been chosen which have evolved into Integrated Care Systems (ICS). ICS are advanced local partnerships that take shared responsibility for improving the health of and care for their populations (2). As of June 2019, more than one-third of the country's population was covered by one of these systems (39). In terms of funding, they opted for a model with a single budget for health and social care services known as the Better Care Fund (8,40).

- In Scotland, integrated care governance has been largely organised in Integration Authorities (IA) which run alongside a lead agency model adopted in Highland (41). There are currently 31 IAs created from a partnership between 14 National Health Service (NHS) boards and 32 Scottish councils (41). The Highland lead agency model is one in which a partner or collaborator delegates a particular role and a portion of the resources to another to perform it (19,41-43).
- Northern Ireland has had structural integration of health and social care since 1973 (19). In recent years, Integrated Care Partnerships (ICPs) have been introduced (44). There are currently a total of 17 such collaborative networks of providers which bring together healthcare professionals (including medical, nursing, pharmacy, social work and hospital specialists), the voluntary and association sectors, local council representatives, and service users and their carers to design and coordinate the delivery of local health and social care services (45).

Also in the United Kingdom, the English Local Government Association (LGA) and the Social Care Institute for Excellence (SCIE) published in September 2019 a document with fifteen evidence-based priority actions for integration aimed specifically at local systems (46) (Annex 1).

In general, the results available at the international level on the knowledge and assessment of the different models, approaches and initiatives indicate significant shortcomings, such as the difficulty in extending the outcomes of local initiatives (18) and the lack of assessment of integration policies, plans, programmes and interventions (1,10) which has already become commonplace.

In terms of the analysis of the results of the new models of integrated care in developed countries, solid evidence has been identified only on the improvement of satisfaction of the people served, perceived quality and access to services. However, the results are limited in relation to the impact of the interventions on the real objectives of integrated care (1). Furthermore, there is criticism that when talking about health and social care integration, there are often references to governance, funding, structural reorganisation and improved coordination between professionals from different sectors, but little mention is made of improving people's outcomes in health and autonomy (47).

1.4. The care model for people with health and social care needs in Catalonia

In Catalonia, health and its protection is a right (48,49) which includes the individual dimension, where this means the right to care and clinical treatment, and the collective dimension, which is linked to other social rights and determinants of health and is associated with health strategy in all policies. Autonomy, an individual right to be preserved, became a legal right under the Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons (50), although it was not fully implemented.

In terms of the types of care provided, healthcare refers to care that aims to improve people's health first and foremost through primary and community health care and specialised care services either with or without admission. As for social care, this means support care designed to preserve and promote people's autonomy through basic social services managed by local authorities and advanced social services, which include services such as residential care, day centres, facilities and technical assistance that often have to be paid for by users out of their own pockets.

For more than 30 years, successive governments have striven to advance the model of care for people with health and social care needs by integrating care from both areas. During this time various policies have been implemented in the form of plans and programmes both with and without specific budget allocations. However, in spite of the efforts made, needs continue to grow and are not covered.

In relation to social care, it should be borne in mind that non-formal care, where the family is still the main caregiver, is the paradigm which is mostly maintained in Catalonia and is catching on in the agenda of Scandinavian countries given the benefits for people's health and wellbeing. The great bulk of dependency is found in degrees of moderate dependency. The challenge is how to respond by preventing dependency and maintaining autonomy by promoting local care approaches. Residential care needs to evolve towards intermediate alternatives which are consistent with the discourse of community and local care. Day care has to be rethought, tools must be provided and support must be ensured for the large social service providers who are the families. Currently under consideration is a model of small communities with shared services outside the large residential facilities and nursing homes with different levels of health support which has to be tailored to each geographical area. The emphasis is on considering that the person, whether institutionalised or at home, should have an individual, personal and intimate area of privacy which they own and over which they make decisions. Primary health and social care need to work closely together in an integrated way to deliver a comprehensive response to the needs of these people.

1.4.1. Background and current status of political initiatives

The Life in Years Programme (PVA) was set up in 1986 by the Ministry of Health with the aim of improving care for the elderly who are ill, chronically ill or in an end-of-life situation (51), and has always been considered the starting point for integrated health and social care in Catalonia. This programme launched the health and social care services portfolio which includes long-term care, day hospitals, medium-term convalescence and palliative care, interdisciplinary health and social functional units (UFISS), the Home Care Programme (ATDOM) and support teams (PADES) and multidisciplinary teams for comprehensive outpatient assessment (EAIA) in geriatrics, palliative care and cognitive disorders (13,52). A decade later the Government Decision of 31 May 2005 approved the Programme for the Promotion and Organisation of Personal Autonomy and Care for Dependent Persons (ProDep) (53) and in 2006 (54) the Health and Social Care Master Plan (PDSS). Later on in 2010 came the Integrated Plan for the Care of Persons with Mental Disorders and Addictions (55), and in 2011 (56) the Programme for Prevention of and Care for Chronicity in Catalonia (PPAC), whose work was the basis for progress in the integrated care model promoted by the Interministerial Plan for Health and Social Care and Interaction (PIAISS), approved in 2014 (57).

In lockstep and in the social realm, in 2006 the Spanish Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons was passed (58) and in the following year the Law 12/2007, of 11 October, on Social Services (59).

As for the assessment of these integrated care plans and programmes, in 2015 the Agency for Healthcare Quality and Assessment (AQuAS) published an external assessment of new collaborative health and social care models in Catalonia. The results showed that the nine initiatives were diverse in terms of providers, target population, stages of evolution and professional profiles, which meant that four model profiles could be identified to encompass the whole range of initiatives (60). They also noted that only the oldest initiatives seemed to have reached the consolidation stage. Most initiatives targeted any population at risk of health and social care need. Only two of the models focused exclusively on care for people with chronic conditions. As barriers they identified the resistance of professionals to change and of institutions and providers that had their own objectives and unshared information systems (60). The document closed with a series of recommendations for public policymakers (Annex 2).

The current Government Plan for the 12th Legislature includes ensuring a universal and fair national health system as a priority. Hence there is a commitment to enact and roll out a single strategy for integrated health and social care for the elderly or people with complex needs which promotes personal autonomy and enables these people to stay in their usual

surroundings and be socially included (61). This initiative provides for specific sub-actions already included in the Health Plan for Catalonia 2016-2020 (62) and identified in the roadmap for the Interministerial Plan for Health and Social Care and Interaction (PIAISS) in 2014 (57) which focus on:

- Integrating health and social information systems.
- Deploying integrated home care.
- Approving and implementing the integrated care model for people living in residential facilities for the elderly and people with disabilities.
- Approving and implementing the Plan for the Prevention, Detection and Treatment of Abuse in Children and Adolescents, the Elderly and People with Disabilities.
- Implementing integrated care plans for vulnerable groups: the homeless, child poverty, children at risk of exclusion, unaccompanied minors, immigrants, etc. (61).

In a recent and exhaustive report on the integration of health and social care in Catalonia, Herrera et al. explain the evolution of the PIAISS by concluding that the working methodology during the first stage of deployment fundamentally took a bottom-up approach while in the second stage it was decided to continue with the territorial projects, meaning that interministerial work using a top-down approach was started up in lockstep (13,63).

On 25 June 2019, the Government approved the Integrated Health and Social Care Plan (PAISS) (64) to implement the initiative formulated in the Government Plan for the 12th Legislature (61) which aims to roll out a single strategy for integrated health and social care. The PAISS specifies fresh objectives in order to continue developing tools, strategies and assessment frameworks which are essential for integrated health and social care, and it is also envisaged that the structure of the governing bodies set up for governance should be changed.

On 13 September 2019 the basic document for the Strategic Plan for Social Services 2020-2024 was presented (65). It underscores the *essential integration and horizontal (inter-sector) approach both in shared community and preventive strategies and in tackling complex cases that call for the simultaneous and interrelated intervention of different wellbeing sectors such as health, education, employment, housing, the guarantee, etc.* It includes a new view of social intervention aimed at personal development and enhancing family and community networks framed in the model of person-centred care. In this way social intervention is geared towards needs, the empowerment of people and their active participation in the care process.

1.4.2. The recommendations of the Catalan Labour, Economic and Social Affairs Council, 2018

The recently published report by the Catalan Labour, Economic and Social Affairs Council (CTESC) provides analysis and recommendations about the integration of health and social care in Catalonia (13). The document includes a conceptual analysis of integrated health and social care, a description of existing models, contributions to the Catalan model of integrated care by various experts and a number of considerations and recommendations made by the CTESC to the Government. By means of a review of the existing literature and the outcomes of five international initiatives, the study explains that the integration of health and social care can be accomplished in a number of ways. In relation to the Catalan model, the story is built on the appropriateness of transforming the current model, the principles of person-centred care and care for people with complex needs. It also identifies elements of the Catalan model considered critical: a) the whole population approach; b) the redefinition of the role of the people receiving care and their environment; c) the leadership of professionals as the driving force of the transformation, and d) a territorial vision in implementation through subsidiarity and shared responsibility (13). The paper describes facilitators for and barriers to deployment (Annex 3) and underscores the need to urgently transform the current model, which it describes as fragmented and inefficient, into one with a holistic vision that puts people and their needs at the centre of the system. Finally, it concludes that, as of December 2018, an important part of the model based on the PIAISS has yet to be translated into practice (13) and closes with a series of recommendations (Annex 4).

2. Rationale for the document

In recent years, developed countries have opted for policies and strategies aimed at improving health and promoting autonomy. To this end, they have focused efforts on redirecting health systems towards the development of integrated care and responding to people with health and social care needs.

The growing interest in integrated care has led to progress in this line of research with a plethora of demonstrative projects and pilot tests around the world that have yielded contradictory results. On the one hand, it is argued that integrated care enables a continuum of care, addresses the social determinants of health, and is better able to anticipate problems and avoid potentially unnecessary interventions. On the other, while there is general political consensus that integration of care is crucial, there is no consensus on *how* this is to be achieved. What there is general agreement on so far is that there is no single model or solution, but rather that it should be adapted to the specificities of each geographical area. This has revealed variability in outcomes and problems in extending them to the entire system, which increases inequalities and results in inequities.

Just as in the countries at the forefront of integrated care development, the integrated health and social care models tested in Catalonia have shown great capacity for running pilot projects and innovating based on professional leadership. However, it is essential to improve performance and make progress in extending the results to the rest of the system under standards of equity, quality and efficiency. To this end, targeted funding and the provision of the tools needed to train professionals in the health and social fields for change need to be ensured.

3. Purpose of the document

The purpose of this document is to provide guidance on a specific formula for the development (governance and management) of public policies for the care of people with health and social care needs which guarantees equity, quality and efficiency based on a local care model to improve people's health and wellbeing.

4. Methodology

Face-to-face and virtual work and discussion meetings between the members of the Health Advisory Council including using collaborative work tools and reviewing reports and relevant literature.

5. The discussion process

Starting point of the Health Advisory Council

The Health Advisory Council was set up as a forum for calm reflection in order to act as a hub for thinking and lay the foundations on which to structure the future of the healthcare model. Prior to the debate and following the procedure established at the beginning of the HAC's meetings, it was decided to extend the discussion beyond the current regulatory framework.

Health Advisory Council

The first discussion sessions of the members of the Health Advisory Council (HAC) focused on key aspects of the Catalan health system. From the outset, the opportunity presented by the current consensus on the need to integrate the health and social care settings in order to meet the growing demand for care from people with complex needs was identified.

The HAC's discussions, which formed the basis for the preparation of this document, were anchored in a review of the state of affairs in relation to the care of people with health and social care needs. The extensive literature published on integrated care[1] (intra-health and socio-health) and the compilation of recommendations made by expert organisations allowed the identification of relevant and priority issues established from a cross-cutting and global vision of the system.

Reorientation of care systems to achieve a higher degree of integration has traditionally taken into account structures, models and processes. The idea that structural changes are a good starting point for directing the comprehensive improvement of care processes has been widely shared. However, the organisational changes which have been attempted in many places have not been consolidated

[1] The Health Advisory Council adopts the definition of integrated care from the Terminology of Integrated Care (TERMCAT), which defines it as 'the care model based on the joint and supportive actions of social services and health services professionals and organisations which aims to achieve good outcomes in health and wellbeing, proper use of resources and a good care experience, thus ensuring integrated care and person-centred care' (27).

and nor have they come up to expectations. Consequently, in order to mitigate this effect, the response of the most advanced countries in integrated care has been to conduct demonstration projects and test micro-governances and alliances between providers to focus care on people's needs (i.e. person-centred care) rather than on services.

Today the challenge lies in extending the results of these integration initiatives to a whole region based on standards of equity, quality and efficiency. However, there is still no agreement on what the formula should be for continuing to move forward in the development (governance and management) of public policies for the care of people with health and social care needs while ensuring equity, quality and efficiency in a local care model.

The conclusion is that a lot of work has been done and that there are recent documents making strategic recommendations which have been extensively explored by experts in care for people with health and social care needs.

The HAC seeks to go beyond the recommendation stage to action. It envisages the development of a formula, instrument or body that will take on board the recommendations and the design, planning, implementation and assessment of the actions that have already been described in order to make them effective, irrespective of the debate on whether or not to merge ministerial structures. It should be a formula which can channel the strategies and actions already outlined in public policies targeting the care of people with health and social care needs under standards of equity, quality and efficiency.

6. The way forward: a public body for the development of policies for the care of people with health and social care needs in Catalonia

6.1. Rationale for setting up a public body to develop policies for the care of people with health and social care needs in Catalonia

6.1.1. Sole responsible

There are several ways to achieve integrated care for people with health and social care needs. Regardless of which model is adopted, some of the key factors to consider are the effective coordination of different types of care services and the coordination of care provider organisations to ensure continuity of care. In this context, professionals often say there should be a structure in place to take responsibility and provide solutions when they have to resolve day-to-day problems. They often look up the chain and fail to get an answer to the question "*Is anyone there?*" Likewise, the literature and evidence do not provide a clear answer as to who should be there and what the answer should be. Governance and accountability have become increasingly complex and attempts at rationalisation and simplification have not been effective. These attempts have failed to sufficiently manage the diversity of local organisations and their lack of connection to the Catalan Government's structures.

People should be attended to on the basis of the perception of a single service that resolves their problems and without needing to know whether it is one or another type of service. Professionals must be able to perform their professional practice with the conviction and confidence that they have the backing of a body which helps to resolve everyday situations based on standards of equity, quality and efficiency.

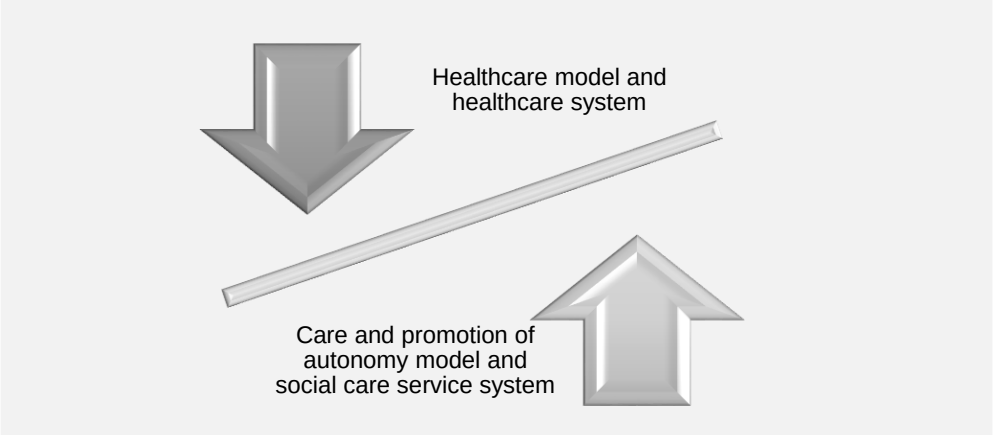
6.1.2. Balance of power

The numerous daily cases which are difficult to fit into pre-established profiles call for urgent *ad hoc* solutions. The fact that these solutions are not available has led to suffering of people and professionals, causes tension between the two systems, overloads the health system and leads to dysfunctions, duplications, inequities and inefficiency in both (health and social care) networks.

In this situation there is no body that can govern by making strategic decisions which are binding and replicable across the territory. This body should ensure equity in access and quality of care by integrating health and social services to deliver integrated care.

Examination of the various governance formulas shows that where health systems have been dominant in relation to social systems, the problems of the social aspect take on a more health-related dimension. By contrast, where health systems have evolved less intensively, social systems have taken over in order to reach both the general public and more vulnerable people. This imbalance between powers and systems puts them at opposite ends of an axis. It illustrates a situation which calls for efforts to balance powers in order to ensure an equitable, quality and efficient model of care for the health and social care needs of people while respecting their preferences and expressed wills (Figure 1).

Figure 1. Imbalance of powers between health and social care models



Source: Authors' own compilation.

Achieving a balance of power between the two systems is a unique challenge that calls for a shared vision and a long-term agreed strategy. In order to do this without hindering the roles of each of the existing structures (health and social care) while at the same time meeting people's health and social care needs at the local level, it is proposed to set up and implement a mechanism or instrument which goes beyond the stage of local initiatives. The culmination of these initiatives is the scaling up of innovation resulting from a first and prolonged pilot project stage. However, it should be borne in mind that it will be difficult to speed up this process of integration across the territory without strong organisation, adequate funding and training professionals to implement change.

6.2. The instrument

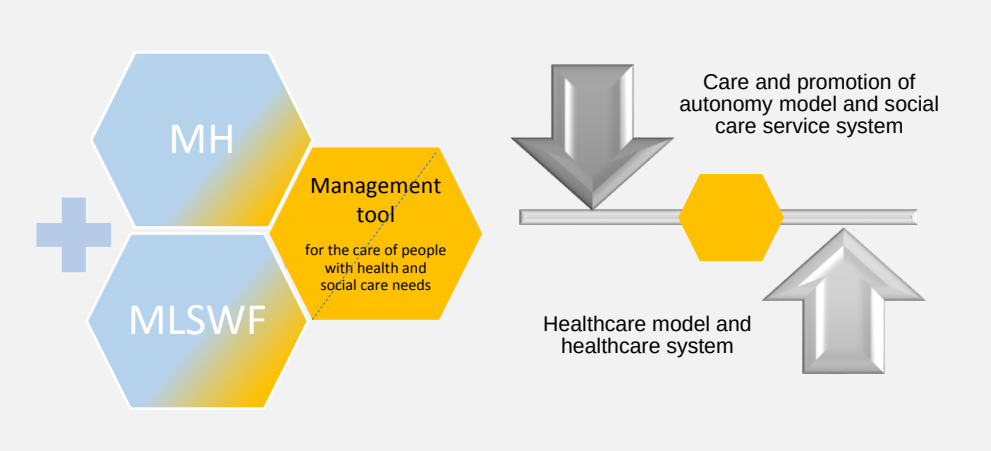
In line with the basis of the definition of the Catalan model of integrated care and the report of the Catalan Labour, Economy and Social Affairs Council, the HAC stresses that there is a consensus on the delimitation of the rights and duties of the parties involved. Based on this consensus, an instrument with the capacity for innovation should be put in place to transform the relationship between the various levels of intervention and engage all the stakeholders. The idea is to set up a body that will implement public policies for the integrated care of people with health and social care needs in Catalonia. This instrument must enable responsibility to be taken for planning strategies and services for improving health and promoting autonomy and it must also ensure coverage in conditions of equity and quality of the services provided. This body meets the need for an instrument that exercises health and social authority by making inter-sector and inter-governmental coordination effective in a way that is dependent on but differentiated from the current structure of government administration. This will make it possible to deliver effective, agile and flexible solutions to the needs and challenges posed by people with health and social problems.

Efforts must be made to ensure that this instrument is perceived by the public as the body that coordinates the various tiers of government; by professionals as the body that generates knowledge and innovation, provides them with tools and drives training to prepare them for change; and by service managers as the body that leads knowledge and innovation, clarifies and arranges the supply of services and allocates the resources available in the system.

In the field of network management, this organisation could be set up as an autonomous administrative body attached to the ministries responsible for health and social affairs and its governance body would be made up of these ministries and local authorities. It should provide the strategic leadership to operationalise the actions required to fulfil the mandate of both ministries in care for people with health and social care needs and assesses the results (Figure 2). This body will be the reference point for the regions and therefore must be capable of coordinating the decentralisation and territorialisation of its actions.

The territorial structures should operate under the guidelines of the central body ensuring the integration of the various health and social care services. This integration will be carried out through executive, agile and flexible organisations with the capacity to deploy local, supra-local and governmental health and social care resources at the same time. A single point of entry to the integrated health and social care system is needed to coordinate access to all public coverage services from a local perspective, incorporating and improving shared information, case management, a common assessment tool and an individualised care plan.

Figure 2. Management tool and balance of power between health and social care models



Source: Authors' own compilation.
MH: Ministry of Health; MLSWF: Ministry of Labour, Social Welfare and Family

Consequently, this body should have a specific budget, the capacity to determine service procurement or, failing that, health and social care resource allocation, and be responsible for accountability to ensure fair, quality and efficient health and social care.

6.2.1. **Principles and values in care for people with health and social care needs**

The planning and execution of actions in care for people with health and social care needs has to embrace its principles and values. The vision will be truly shared if it is rooted in common principles and values based on respect for the personal autonomy and dignity of the person. These principles and values are described below in alphabetical order.

1. Agility, flexibility and transparency. An agile and flexible executive organisation with the capacity to deploy local, supra-local and governmental health and social care resources at the same time.
2. Empathy and respect for diversity. An inclusive organisation that ensures personalised and accessible care taking into account each person's wills, preferences and experiences.
3. Equity. Equity and overcoming social, gender and regional inequalities.

4. Knowledge, research and innovation. To bring together, generate and distribute innovation knowledge and capacity in relation to the care of people with health and social care needs.
5. Nearness and decentralisation. The requirement to meet people's needs as closely as possible to their own setting through an organisation which can operate in a decentralised way.
6. Participation. Effective participation, both individually and collectively to give people a voice and to draw attention to their needs from a global perspective.
7. Proactive approach. A proactive attitude in addressing the care of people with health and social care needs based on promoting health and autonomy, preventing illness and dependency and caring for people.
8. Quality and sustainability. Rationalisation, efficacy, effectiveness, efficiency and sustainability in the organisation, promoting and improving quality and safety, assessing actions and taking the best available evidence into account.
9. Shared governance. Governance based on a comprehensive, integrated and inter-sector concept to achieve better care rooted in people's preferences and with an impact on their health and degree of autonomy.
10. Universalisation. Universalising and guaranteeing benefits for the care of people with health and social care needs as an individual and social right.

6.2.2. **The instrument's roles**

The instrument's roles in relation to governance and decision-making:

a) Leading the strategy for integrated care for people with health and social care needs in Catalonia in the inter-sector and inter-governmental framework.
b) Implementing public policies for integrated care of people with health and social care needs in Catalonia: planning (promotion, prevention and care), managing and evaluating. This means the actions to fulfil the mandate of both ministries in terms of care for people with these needs are made operational; activities are decentralised and localised and outcomes are assessed.
c) Generating knowledge and innovation, clarifying and organising the services range.
d) Procuring or, failing that, allocating the local, supra-local and governmental health and social care resources available in the system.

7. Proposals and aspects to be considered

People with health and social care needs and the professionals who should provide them, with comprehensive and integrated care, have been waiting for a long time to have points of reference that provide the guidelines and tools to do so. Besides mapping out the strategies, and in the knowledge that some have already been mapped out, agreed upon and accepted, it is intended that somebody will be responsible for leading, implementing and directing them in order to contribute to improved health and greater autonomy under standards of equity, quality and efficiency.

The foundations have to be laid for what is to be the public body for the development (governance and management) of policies for caring for people with health and social care needs in Catalonia. Realistic deadlines need to be set for its approval, yet nevertheless as soon as possible. At the same time, the priority actions agreed by both ministries over the last few years should be implemented. They have already been accepted as essential for moving forward in developing the model and should come together with the actions the new body is to take in the future, which are described below and summarised in Table 4.

7.1. Setting up the public body to develop public policies for the care of people with health and social care needs in Catalonia

7.1.1. Agreeing on a medium and long-term strategy

Moving towards true person-centred care enables people to have utmost control over the decisions affecting them. To do this, a culture of collaborative work involving both people and professionals needs to be built. Emphasis should be placed on people's wills, experiences and preferences, the capacity for interdisciplinary, multidisciplinary and transdisciplinary professional work and the delivery of comprehensive and integrated care.

As progress is made in understanding people's needs, there is evidence of an exponential increase in the need for care which far exceeds the need for diagnosis.

It is essential to stress promoting and maintaining autonomy as a starting point to avoid an even more unsustainable situation in view of the challenges faced by vulnerable groups and an ageing population with high health and social dependency. In this respect the debate on the limits of the effort to maintain life cannot be ignored, especially in the final stage when comfort and quality of life is uncertain.

Table 4. Drawing up the foundations of the public body, areas for action and activities

Drawing up the foundations of the public body, areas for action and activities
1. Setting up the public body for the development (governance and management) of care for people with health and social care needs in Catalonia
1.1. Agreeing on a medium and long-term strategy
1.2. Defining the features of the body
1.3. Drawing up and approving the rules for setting up and regulating the body
2. The body's areas of action
2.1. Primary and community healthcare and basic social services primary health care
2.2. Home setting
2.3. Day-care centres
2.4. Long-term care
2.5. Assisted living facilities
2.6. Information systems
2.7. Early childhood with disabilities, mental disorders and rare diseases
2.8. Vulnerable women
2.9. Promoting personal autonomy and preventing institutionalisation
2.10. Mental health and addictions
3. Operational actions to be prioritised
3.1. Setting up venues for public and professional participation
3.2. Promoting social networks and volunteering
3.3. Providing the public and professionals with the tools for shared decision-making
3.4. Redefining professional roles in the health and social care realms
3.5. Starting up a conversation between government, institutions, workers' representatives and professionals from both sectors in order to explore possibilities for joint perspectives, starting with working conditions
3.6. Enhancing research and innovation to transform care for people and improve the accessibility, quality and efficiency of the health and social care system
3.7. Assessing the impact of actions designed to improve the health and autonomy of people with health and social care needs
3.8. Testing different payment systems and procurement and accountability mechanisms
3.9. Standardising the geographical scope of the basic social services and healthcare areas

Source: Authors' own compilation.

7.1.2. **Defining the features of the body**

The legal status, objective, tasks, management forms, organisational and territorial structure, legal system, human resources, financial and property system, budget and mechanisms for transparency and accountability must be specified in order to define the body's scope of action, purpose and role.

7.1.3. Drawing up and approving the rules for setting up and regulating the body

It is essential to work out the regulatory foundation for the establishment and operation of the body to empower, stabilise and acknowledge this instrument so as to build the model of care for people with health and social care needs. There should be no fear from the regulatory standpoint about introducing innovative features which will make the current rigidities hindering cross-cutting and inter-sector work more flexible.

7.2. The body's areas of action

In line with the public policies agreed in the Integrated Health and Social Care Plan (PAISS, 2019), long-term, variable and diverse care in the residential sector and family breaks need to be redefined and restructured, as this has been delayed too long, while also continuing with all other priority actions geared towards:

7.2.1. Interaction between primary and community healthcare and basic social services primary health care.

7.2.2. Integrated health and social care in the home setting.

7.2.3. Integrated health and social care in day-care centres.

7.2.4. Integrated long-term health, social and mental healthcare in Catalonia.

7.2.5. Integrated healthcare in assisted living facilities for the elderly, the disabled and people with mental disorders.

7.2.6. Integrated health and social care information systems model.

7.2.7. Integrated model of health and social care for early childhood with disabilities, mental disorders and rare diseases.

7.2.8. Integrated model of health and social care for vulnerable women: with disabilities, gender violence, pregnancy and motherhood with social exclusion.

7.2.9. Integrated model for promoting personal autonomy and preventing the institutionalisation of elderly people and people with mental disorders.

7.2.10. Integrated plan for mental health and addictions in the deployment of the community care model in mental health and addictions.

7.3. Operational actions to be prioritised

In order to deliver an integrated response with shared solutions in areas such as information systems, the community care model, home care and residential care, the Health Advisory Council also proposes priority actions:

7.3.1. Setting up spaces for public and professional participation

Draw up a proposal for forums and instruments so that the general public and professionals can take part in the process of defining the public body. These venues should allow for improved transparency and quality.

7.3.2. Promoting social networks and volunteering

Social networks and volunteering bring added value to enhance the care received by people with health and social care needs, especially people who are most dependent on services such as ones with multiple long-term conditions or mental health problems.

7.3.3. Providing the public and professionals with the tools for shared decision-making

Promoting self-care, health literacy and empowerment is critical. Health literacy is a concept that has been worked on and developed over recent years. Further effort is needed in this area and it should be extended to social and socio-health care because of its impact on the experience and outcomes of people with health and social care needs, their caregivers and professionals in using services and in expenditure. Advance decision planning should also be promoted, developed and mainstreamed as a support tool for the public and professionals.

7.3.4. Starting up a conversation between government, institutions, workers' representatives and professionals from both sectors in order to explore possibilities for joint perspectives, starting with working conditions

The difficulty of integrating two work systems with such different cultures and employment conditions is a major challenge and brings with its considerable resistance (including governance and management). This cannot continue to be allowed to hold back progress.

7.3.5. Redefining professional roles in the health and social care realms

Professionals from various sectors need to work together united by a common goal: improving the health and wellbeing of the individual. It has been noted that the stakeholders involved are often resistant to change for fear of losing their power and position. The roles, competencies and needs of institutions and professionals have to be adjusted.

7.3.6. Enhancing research and innovation to transform care for people and improve the accessibility, quality and efficiency of the health and social care system

Encourage and promote specific research on health and social care to find out how the various stakeholders interpret and measure integrated care based on their experience and on health and autonomy outcomes. The advantages of technology and innovation must also be leveraged in the search for solutions to situations which generate health and social care needs, especially at home.

7.3.7. Assessing the impact of actions designed to improve the health and autonomy of people with health and social care needs

Integration can take the form of structural reorganisation, better governance, improved teamwork between professionals from different sectors, various forms of funding, etc. In all these interventions, the capacity to deploy all health and social care service providers and professionals involved should be monitored and assessed. This means progress is needed in a cross-cutting assessment framework to identify measures to improve care for people.

7.3.8. Testing different payment systems and procurement and accountability mechanisms

The application of different criteria or protocols by professionals depending on the organisation that hires them leads to duplication and variability. This demonstrates the need for joint accountability and outcome assessment regardless of where the professionals come from. Accountability mechanisms need to be put in place featuring joint health and social care indicators.

Professionalisation of care, quality of care outcomes and payment for outcomes need to be considered. Likewise, the needs of family caregivers must be addressed by rolling out payment systems that ensure their health and wellbeing.

7.3.9. Standardising the geographical scope of the basic social services and healthcare areas

The spatial organisation of the health and social care systems does not match. This impacts any joint work whether by organisations or professionals.

Spatial boundaries should be the same for all and integrated comprehensive care should be delivered to people with health and social care needs.

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9. Annexes

9.1. Annex 1. Fifteen best practice actions addressed to local organisations for achieving integrated care. LGA – SCIE, 2019

Fifteen best practice actions addressed to local organisations for achieving integrated care. LGA – SCIE, 2019 (46)

- ✓ Realising person-centred coordinated care
    1. Risk stratification
    2. Access to information
    3. Multidisciplinary team (MDT) training
    4. Personalised care plan
    5. Rapid response
- ✓ Building place-based care and support systems
    6. Operational framework
    7. Integrated commissioning
    8. Shared records
    9. Community capacity
    10. Partnership with voluntary, community and social associations (VCSE) sector
- ✓ Leading for integration
    11. Common purpose
    12. Collaborative culture
    13. Resource allocation
    14. Accountability
    15. Workforce planning

Source: Local Government Association, Social Care Institute for Excellence. Achieving integrated care: 15 best practice actions. London; 2019. Available from: https://www.local.gov.uk/sites/default/files/documents/25.141%20Achieving%20integrated%20care_05.pdf

9.2. Annex 2. Recommendations. External assessment of new collaborative models of health and social care in Catalonia. AQuAS, 2015

Recommendations. External assessment of new collaborative models of health and social care in Catalonia, AQuAS, 2015 (60)

- ✓ **Institutional support with communication resources and feedback**
- ✓ The Interministerial Plan must be an enabler of integrated care and provide resources and structures to carry it out
- ✓ A shift towards a care model centred on the real person is needed
- ✓ The Interministerial Plan is essential for setting clear guidelines for all models
- ✓ Resources need to be provided (and given institutional status) and professionals need to be motivated (extend the project) in order to ensure follow-through
- ✓ In the long term, consideration should be given to creating a third system (a joint health and social "production" system)
- ✓ Shared information systems must be prioritised
- ✓ Involvement (institutional linkage) between health, wellbeing and local councils
- ✓ Change mentoring: these are changes in competencies, in the model and in work methodologies, and all this generates significant resistance
- ✓ The role of primary health care must be rethought and given tools and resources. Primary health care should be one of the cornerstones
- ✓ Collaborative work must be legitimised: encouraging, appreciating and acknowledging collaborative work; hours and work invested
- ✓ **The legitimacy and (health and social) positioning of the ministries is needed to establish common objectives envisaged in the programme contracts, the regions or the cooperation mechanisms (what there is at the moment is not enough)**
- ✓ The political commitment must be crystal clear
- ✓ Professionals must be familiar with each other in order to work together
- ✓ On degree courses (especially in healthcare) it would be useful to explain that the bond with the patient is not the only important thing; the relationship and knowledge of their surroundings and integrated teamwork are also crucial

Source: Serra-Sutton V, Montané C, Pons JMV, Espallargues M. Avaluació externa de nou models col·laboratius d'atenció social i sanitària a Catalunya. Barcelona; 2015. Available from: http://aquas.gencat.cat

9.3. Annex 3. Facilitators for and barriers to deployment of integrated health and social care. CTESC, 2018

Facilitators for and barriers to deployment of integrated health and social care. CTESC, 2018 (13)

✓ Facilitators for the deployment of health and social care integration

a. Social, demographic and epidemiological change, inasmuch as it poses new health and social care challenges that call for immediate and disruptive responses

b. The build-up of experience in health and social integration through pilot tests and experimental programmes (some of which are well established) at the local and/or county level

c. The drafting of the PIAISS, which has displayed, mobilised and brought together various parties supporting integration

d. The interest of health and social care professionals in delivering a more appropriate response to the needs of users

e. A health information system that is practically the same throughout the region, making it possible to stratify the population, forecast needs and develop instruments such as the Integrated Electronic Clinical Record of Catalonia (HCCC)

f. A robust primary healthcare system featuring direct access, public funding and universal coverage

✓ Barriers to the deployment of health and social care integration

a. The lack of regional, professional and most of all political leadership

b. Restricting integration processes to pilot tests that are lengthy and not assessed or scaled to the whole region

c. The existence of corporate interests (professionals, suppliers, etc.) which, in practice, translate into resistance to change

d. Occasional lack of mutual trust between the health and social fields, between primary and specialised care and between government and providers

e. **The differences between the acute care and long-term care paradigms** (**i.e.** chronic social and/or health needs) in terms of their procedures and objectives

f. Lack of coordination between the social care system and the healthcare system in relation to integrated car

g. Differences between health and social care professional cultures

h. A basic and continuous training system which does not prepare professionals for integrated person-centred care

i. A high number of users per professional and lack of time for coordination involving integrated care

j. The lack of social recognition of all aspects of people care compared to appreciation for the health system

k. A lop-sided distribution of resources between primary social care and specialised social care and a lack of coordination between these two levels of care

l. Lack of experience in horizontal coordination between different services: social services, health, housing, work, education, etc.

m. And, in short, systems that are still overly bureaucratic and rigid

n. Challenges in dovetailing the health and social systems as one of the most important barriers to integration of care in Catalonia for a number of reasons:

a) The social care system is less developed and weaker than the health system and its sector scope is not well defined

b) The health system is universal while most social services have conditional access

Facilitators for and barriers to deployment of integrated health and social care. CTESC, 2018 (13)

c) Health services are funded from public budgets, while most social services are co-funded with user charges

d) The health system is centralised and has uniform access criteria, while social services are decentralised and access to basic benefits may vary depending on the local setting

e) Social services are geared towards long-term care, while the health system has shorter length of use times

f) The working conditions of staff in the health and social sectors are different

g) The health system provides services to individuals while social services often provide cash benefits

h) The geographical divisions of the health and social services system do not match and this makes coordination between mechanisms and professionals difficult

i) The health sector has a practically uniform information system throughout the region while it is highly fragmented and unequally deployed in social services

j) There is an imbalance between the two systems in terms of the volume of scientific knowledge and build-up of empirical evidence, with a very significant lack of predictive models in the social field that would enable meticulous planning

k) Unlike the health system, the social field does not have standardised mechanisms for learning how users rate the care received

Source: Herrera D, Riudor X, Villar V. Integració de l'atenció social i sanitària. Col·lecció Estudis i Informes. Barcelona; 2018. No. 51. Available from: http://ctesc.gencat.cat/doc/doc_16249881_1.pdf

9.4. Annex 4. Recommendations. Integration of health and social care

Recommendations. Integration of health and social care, CTESC, 2018 (13)

✓ **Concerning the need and opportunity for integrated health and social care**

1. The process of integrating health and social care in Catalonia must be expedited and planned on the basis of a realistic timetable
2. A political commitment with strong leadership from the entire Government to make integrated care a national priority must be achieved
3. Political and also professional leadership must be put in place to meet the challenges of health and social care integration as an innovative and structural transformation
4. The social side of the story about the benefits and possibilities of integrated care must be enhanced and publicised with the participation and engagement of civil society
5. A strategic agreement and an action plan for the development of integrated health and social care in Catalonia has to be drawn up between the various tiers of government and with the participation of business and trade union organisations, third-sector organisations, professional associations, etc. This strategic agreement will define the model of person-centred integrated health and social care as well as the strands to be implemented by the action plan. This plan should be ambitious yet realistic and have a reasonable time horizon along with robust instruments (timetable, system of governance, assessment and indicators, financial report, etc.)

✓ In relation to the Catalan model of integrated health and social care

6. The model should have a universal scope, although initially it may be appropriate to prioritise care for certain profiles of needs throughout the region
7. It should not be assumed that integration must necessarily be structural, but it must at least be functional, i.e. it must be effective in care for people and the allocation of financial resources
8. A model that views primary and community health care as a means of appropriately and efficiently addressing health and social needs must be promoted
9. Home care services (i.e. home help services and/or assistive technology and care services) in both the health and social fields should be substantially expanded and given a central role, centred on the individual and their family. Efficiency of home care services involves cutting waiting lists considerably beforehand
10. Support services for families and carers need to be deployed: financial benefits, training actions, opportunities for rest, etc.
11. The role of civil society, volunteering and the community in identifying needs and addressing them in an integrated manner must be enhanced
12. The public's participation in designing, implementing and assessing the model must be ensured
13. The user must be empowered in the decision-making process about managing their health and the features of the care, treatment or intervention received
14. Prevention, where this means the active participation of people in their health, must be promoted through awareness of the underlying factors of health and by encouraging healthy lifestyles and habits
15. Personal abilities and autonomy must be enhanced
16. The concept of palliative care must be broadened and a shift made towards a model in which global care is delivered earlier, including specific programmes to meet the needs of people nearing the end of life. This action must be tailored to the population structure, to longevity forecasts and to the increase in the number of people in an end-of-life situation
17. The costs and benefits of gradually making the working conditions of professionals in both sectors more comparable should be studied
18. The deployment of integration should not be merged into a single intervention, as experience shows that concerted, coordinated and synchronised actions (e.g. multi-lever strategy models) have proven to be the most effective

Recommendations. Integration of health and social care, CTESC, 2018 (13)

19. Collaborative practice between different practitioners and care settings must be encouraged and it must be acknowledged that this is an essential organisational factor or input for the organisation of care responses
20. An integrated framework for the continuous assessment of the deployment and performance of integrated care is needed
21. The 2010 social services portfolio needs to be updated and a specific catalogue of integrated health and social **services needs to be developed, although initially they may be shared and complementary**

✓ In **terms of integrated health and social care governance:**

22. A governance structure with a balance of powers between the health and social sectors and with decision-making capacity must be set up
23. A commissioner for people care services under the Ministry of the Presidency should be established in the Government's organisation chart with the purpose of coordinating the integration of health and social care
24. A flexible governance model must be designed to set concrete, shared and measurable targets to be achieved in the local area based on its characteristics and special features. Along these lines, it is recommended that local-based territorial governance be provided with a set of instruments (or "toolbox") without all territories necessarily ending up implementing the same policy mix
25. Setting up partnerships or similar structures between the areas involved, subject to a programme contract, should be explored. As part of this process, local leaderships need to emerge that have the management resources required to carry out the integration
26. A proposal for public participation must be designed that includes a global vision of expenditure, access and use of services, with the objectives of achieving the greatest possible degree of efficiency in the use of resources and enhancing social cohesion and equity in the funding of our welfare state
27. The geographical scope of the basic social services and health areas must be standardised
28. Regulatory reforms should be undertaken to promote the development of health and social integration
29. Care services need to be provided through a common and integrated funding, planning, accreditation, contracting, and information and assessment systems organisation that interacts with providers
30. Integrated health and social care must be coordinated with other areas of action such as housing, training, leisure and employment

✓ Concerning the transformation of social services in Catalonia

31. Social services must be transformed in lockstep with the integration process
32. Social services must be transformed in order to align access rights and the quality of benefits with system standards
33. A new basic social services structure is needed so that they become a universal mainstay in fostering autonomy, enhancing primary relations and developing community relations, thus moving beyond the model exclusively focused on social care for disadvantaged groups and in emergencies
34. The Social Services Law must be implemented in regulatory terms, bearing in mind the integrated care model and taking a preventive and predictive approach
35. A social services portfolio must be provided that ensures territorial equity
36. The social services information system needs to be upgraded in order to move towards data collection standardisation, simplification and streamlining and enable use and interoperability in an integrated care system
37. Predictive social needs models should be drawn up at the population level as an essential planning tool
38. Models for identifying high social complexity need to be developed. In this respect, the development by the Government of Catalonia of a self-sufficiency scale which emphasises identifying people's capabilities is welcomed as an approach tool

Recommendations. Integration of health and social care, CTESC, 2018 (13)

39. A social one-stop shop has to be set up and processes made consistent to avoid users having to make multiple arrangements with different authorities and associations
40. Community social care must be improved in view of the growing problem of unwanted loneliness

✓ Regarding integrated care management

41. Growing user/patient loads must be addressed with more appropriate staff ratios in both the health and social fields so as to ensure equity and efficiency in care
42. Progress must be made towards cross-cutting initial and continuing vocational training founded on the principles of person-centred integrated care which will make it possible to lessen the differences between professional cultures in the health and social sectors
43. Further progress is needed on the interoperability and standardisation of health and social information systems based on the assessment of existing pilots
44. Process quality and certification must be carefully managed
45. Evaluation processes should be standardised to avoid duplication by setting up interdisciplinary teams that take into account people's health and social needs
46. Integrated scales for identifying health and social needs should be drawn up
47. As noted by AQuAS, the position of a project director with problem-solving capacity in health and social integration processes in the territory will be established. This role can be performed by an external professional or a person appointed by agreement, with the resultant legitimacy, in order to foster acceptance of and involvement in the project
48. Case management, or care management, should be promoted with the aim of coordinating the supply of and demand for services for people in complex situations. Case managers do not necessarily have to be healthcare professionals, but they do have to be determined by the profile of the users' needs and by the ties they have with their upstream health and social care managers
49. The position of the key professional should be established, someone who knows the person and their background and will be responsible for directing the care plan together with the person and, where appropriate, their family. As with the case manager, the key professional does not necessarily have to be from the health field
50. It must be possible to activate services and benefits at any time of the year in order to meet urgent health and social needs

✓ Concerning funding for health and social care integration

51. Funding resources must be stepped up to deploy integrated health and social care. In the medium and long term, this increase in resources will enhance the financial sustainability of the system compared to the option of not implementing the integration process
52. Funding needs to be rebalanced between the health and social systems to equalise rights based on careful consideration of costs and funding sources
53. Pooling budget scenarios should be introduced to fund integrated health and social care as outlined in the report based on international initiatives
54. The shared health and social services portfolio needs to be made more consistent, balanced and transparent in terms of any costs borne by users, so that similar non-care costs are handled in the same way in all services with the aim of achieving greater equity and social cohesion
55. Human, material and financial resources for primary, social and home-based care must be enhanced in particular. It will be useful to leverage the overall joint budget increases to implement this priority until more appropriate balances are achieved in the relative funding received by the abovementioned activity sectors
56. Financial contribution measures in social care should be reworked to make them progressive so that the personal and financial autonomy of users is ensured
57. The distortions arising from the different financial contributions between the health and social areas must be resolved in certain cases such as mental health and disability

Source: Herrera D, Riudor X, Villar V. Integració de l'atenció social i sanitària. Col·lecció Estudis i Informes. Barcelona; 2018. No. 51. Available from: http://ctesc.gencat.cat/doc/doc_16249881_1.pdf

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