

Integration of health and social care:

necessary but challenging for all

Faced with ageing populations in which multimorbidity is the norm rather than the exception,¹ governments around the world are seeking to integrate health and social care systems in an attempt to meet the triple aim of improving the individual experience of care, improving the health of populations, and reducing costs.²

In this issue, Dambha-Miller and colleagues undertook a qualitative study exploring the views of key stakeholders on drivers and barriers of integrated primary care and social services, and opportunities for successful implementation.³ Thirty-seven interviews were conducted across England with GPs, nurses, social care staff, commissioners, local government officials, voluntary and private sector workers, patients, and carers. They report that integration is progressing slowly. The drivers and barriers of integration identified were similar to those found in other settings. Drivers included groups of like-minded individuals supported by good leadership, expanded interface roles to bridge gaps between systems, and co-location of services. Barriers included structural and interdisciplinary tension between professions, organisational self-interest, and challenges in record-sharing. They conclude that a systems-wide approach to health and social care integration is required to go beyond local and professional level change, and that such macro policy-level initiatives are necessary to meet the complex and growing needs of an ageing, multimorbid population.

This research is timely, given the new Health and Care Bill 2021–22 recently introduced and debated in the House of Commons.⁴ Under this plan, the whole of England will have local Integrated Care Systems (ICS), statutory Integrated Care Boards (ICBs), and Integrated Care Partnerships (ICP) aiming to bring together health, social care, and public health. The Bill also gives sweeping powers to the health secretary. Concerns have been raised, especially about the new health secretary's powers, and although the bill apparently seeks to roll back privatisation by scrapping

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section 75 of the Health and Social Care Act 2012, it is seen by some groups as a transition to an unregulated private market in health care.^{5–6}

WHAT DO EXISTING APPROACHES SHOW?

Although the call by Dambha-Miller and colleagues³ for a system-wide approach to integration may seem logical, experience suggests that such macro-level approaches involving structural change do not necessarily guarantee success. Northern Ireland has had a structurally integrated system of health and social care since 1973, but has struggled to achieve progress (albeit in the unique context of a complex and changing political settlement). Wales implemented a National Integrated Care Fund in 2014 as part of its vision for a whole system approach to health and social care, yet a recent Audit Wales report concluded that *‘there is little evidence of successful projects yet being mainstreamed and funded as part of public bodies’ core service delivery*.⁷ Scotland integrated health and social care with legislation in 2014, with the resultant launch of over 30 Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (the associated delivery arm) in April 2016. However, Audit Scotland has criticised the slow pace of progress.⁸ Clearly, structural integration of health and social care — although no doubt a necessary pre-requisite for national change — is neither quick nor easy.

DEPRIVATION AND HEALTH INEQUALITIES

An important issue not considered in the study by Dambha-Miller and colleagues³ is

that of deprivation and health inequalities. As the COVID-19 pandemic has clearly demonstrated, the gap in health between affluent and deprived areas remains stark in the UK. Although these inequalities are driven by the wider social determinants of health, health and social care services have an important role to play in reducing or mitigating their effects. It is 50 years since Julian Tudor-Hart described the inverse care law, and its relevance is as great today as it was then.⁹ Although Tudor-Hart wrote about the ‘availability of good medical care’, the challenges of an ageing population make the ‘availability of good integrated health and social care’ increasingly central.

Patients living in deprived areas have more multimorbidity, and this occurs some 10–15 years earlier than in patients in affluent areas,¹ yet receive poorer quality of health care from the NHS than those who are better off.⁹ It is unclear whether a similar inverse care law exists in social care,¹⁰ but it seems likely given the complex funding arrangements and largely private provision. Integration of health and social care is likely to be much harder in socioeconomically-deprived communities with multiple needs (commonly spanning mental, physical, and social problems). Integration policy needs a greater focus on inequalities for our most vulnerable communities and must surely include — once and for all — an end to the corrosive inverse care law.¹¹

CONCLUSION

The pace of change in the health and social care policy landscape shows no sign of slowing, with proposed reforms including structural changes to the NHS in England,⁴ proposed reform of social care funding, and the creation of a National Care Service in Scotland.¹² However, despite the likelihood of future structural changes, there is no clear model of what ‘good’ looks like. Routine collection of data will be pivotal in order to plan, evaluate, and research integration of services but, particularly in the fractured

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social care sector, a framework articulating how data will be collected is absent. We should also avoid the common condition, beloved of health departments across the UK, of 'pilotitis' — characterised by numerous small pilot studies, funded for short periods of time, and with little or no pre-planned evaluation. The 'let a thousand flowers bloom' approach must be replaced with properly funded, rigorous research and evaluation.¹³ We can then learn from and compare given divergence in how different UK countries are approaching integration of health and social care. Rich shared learning may also come from collaboration with other countries facing similar challenges of ageing and care needs, many of which are in a transitional stage between system redesign and model explorations.¹⁴⁻¹⁵

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