Summary of Findings

Literature Review of International Models of Social Care: Lessons for Social Care Delivery, Sustainability and Funding in Scotland

A rapid literature review was conducted to compare international social care models. The review found fundamental differences in the way social care is funded, delivered, structured, and governed in high-income countries. It also identified key strengths and limitations associated with each county's social care model, its impact on pollution health outcomes, and challenges to its long-term sustainability.

Australian Model: Social care provision is determined on the basis of need and individual charges are means tested. Financing comes from tax revenue and user charges. State governments are responsible for the provision of health services, but the provision of pensions and funding for welfare services is a federal government responsibility, resulting in a lack of clarity over governance of social care. Increased pressure caused by an ageing population has led to increases in demand and costs to the federal government. However, emphasis on external care provision reduces the need for informal care provision. Needs-based eligibility is also linked to improved health outcomes. Concerns about ongoing financial instability mean that that user contributions will likely need to increase further.

US Model: All social care costs are paid for privately by individuals. Medicaid does not cover social care costs and this is associated with widening health inequalities. Sustainability of the model is dependent on the wider economy.

Alaskan Models: Alaska has its own version of Medicaid, which covers some of the costs associated with home care and is administered by the Alaska Department of Health and Social Services Division of Public Assistance. The Maniilaq and SCFNuka models for Indigenous Alaskans are associated with significant reductions in emergency department visits and hospital admissions, and are also associated with improved diagnosis and treatment of chronic diseases.

Canadian Model: Social care comes entirely under provincial jurisdiction and is considered an extended health service. Each province provides varying levels of social care services under programs that cover part of the costs of institutional care and home care services. The majority of long-term care is provided in residential institutions, and differences in provincial arrangements result in inequalities in care distribution at the national level. Health outcomes in Canada lag behind other high-income countries and inequality remains high. Short political cycles may negatively affect the maximisation of the potential of reforms.

Japanese Model: Japan's social care system is based on a mandatory social insurance scheme. Half of the revenue comes from general taxation, with one-third coming from premiums from people aged 40–64 and one-sixth from people over 65. User co-payments account for the rest. High levels of expectations are still placed on families to provide informal care and formal care services are dominated by medical models of care. However, access to basic social care is standardised and has been linked to improved quality of life for those with complex needs and disabilities. Rapid growth of an aging population means that sustaining the system depends on willingness to expand welfare and insurance schemes.

EU Countries (The Netherlands, Germany and France): These countries have schemes that are also based on mandatory social insurance. In the Netherlands and Germany, these are funded by general taxation at central government level. In France, it is funded by taxation at central government level and at the regional government level. Only basic care is provided, with the rest covered by informal care provision. Contribution-based systems are associated with a reduced need for political bargaining. Concerns are growing over the future sustainability of social insurance-based models, owing to ageing populations. Schemes relying on a single source of funding are more vulnerable to economic fluctuations.

Switzerland: Social care is financed directly by contributions from taxation and a compulsory health insurance system that also provides for social care services. The system ranks well internationally regarding equality of access. However, fragmentation of governance and delivery increases the risk of sub-optimal quality of care provision. Impacts on specific population health outcomes were not ascertainable from the available literature.

Nordic Model (Sweden, Finland, Denmark and Norway): Eligibility for social care services is based on need rather than contributions. The state and local authorities heavily subsidise care services, financed through income and local taxes. Local authorities organise care delivery, but the system is supported by national level legislation to ensure equality of access. However, increased marketisation has been linked to widening health inequalities. The system is based upon the principle of universality, but it is questioned as to whether this will be sustainable in the future given the aging populations of the Nordic countries.

New Zealand Model: Social care services are part of a health board's allocation and are subject to a needs assessment. Integrated care services are better for meeting the care needs of those with complex needs and reducing health inequalities. Integrated systems are dependent on increased community-based spending.

UK Countries (Scotland, England, Wales and Northern Ireland): Each of the four National Health Services are funded primarily from general taxation gathered at a UK level, but funds are distributed to the Scottish, Welsh, and Northern Irish governments through the Barnett formula. Increased integration of care has had a relatively limited effect on reducing health inequalities to date. Care provision in all four countries is experiencing pressure as the population ages and growing rates of health inequality suggest that care demands will likely increase further in the future.

The review identified important lessons learned and recommendations from the international literature for improving the integration of health and social care. The following barriers to integration were identified: uneven geographic distribution of services; existing structural inequalities; different organisational cultures; and a lack of information sharing between sectors. The following were also identified as key enablers of integration: adopting a 'one system, one budget' approach; investment in staff training; legal clarification over provider responsibilities; participatory approaches to care delivery improvement; place-based approaches that include local priorities; and co-development of a standards framework that sets clear expectations and accountabilities. The literature also asserts that quality, not finance, needs to be the driving force behind integration if it is to prove to be successful in practice in improving access to and quality of care.

Recommendations for Decision Makers

The following 10 recommendations have been developed from the findings of the rapid review for decision-makers involved in developing the National Care Service in Scotland:

1. Care services should be provided on a consistent basis across all geographic areas (including remote rural areas).

2. Policy should address existing structural inequalities to enable the care system to achieve its maximum potential.

3. A clear ‘one system, one budget’ approach would reduce complexity.

4. An integrated care service should be substantially publicly funded so that use of privately funded services does not become more unevenly distributed.

5. Eligibility for access to social care services should remain high to prevent rising inequalities, unmet needs and increased dependency on informal care providers.

6. A standardised definition of what ‘personalisation’ of care means should be developed.

7. Mechanisms that address cultural differences between locally accountable social care services and centralised health services should help improve integration.

8. Budgets intended to support integrated care should not be used to offset overspends in acute care.

9. Financial savings should not be viewed an immediate objective of integration.

10. Forward planning and significant investment are required to meet the future care needs of an aging population.