Table 2: Comparison of Key Features of Different Models of Social Care and Associated Population Health Outcomes

Model	Delivery	Governance	Linked Health Outcomes
Australian Model	Emphasis is on external care provision and reducing the need for informal care provision. Services are provided by a mix of public, private for-profit and private not-for-profit services. Care user choice is emphasised for determining care provision.	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. This results in a lack of specific clarity over social care governance.	Lack of integration between health and social care providers negatively impacts delivery of care for users with complex care needs.
US Model	The majority of residential nursing homes in the United States are for-profit, one-third are run by non-profit providers, and a small number are government-run facilities.	Adopts a decentralized approach to social care governance where governments provide incentives and flexibility private actors and community-based organizations.	The US model is associated with widening health inequalities..
Alaskan Models	Eligibility is determined by financial need. Care delivery promotes 'aging in place.' Special programs are designed to provide social care to Indigenous Alaskans.	Alaska's version of Medicaid is administered by the Alaska Department of Health and Social Services Division of Public Assistance.	Social care programs for Indigenous Alaskans are associated with reductions in hospital visits and improved prevention and treatment of chronic disease.
Canadian Model	The majority of long-term care is provided in residential institutions, by a mix of public, private for-profit and private not-for-profit providers.	Social care comes entirely under provincial jurisdiction and is considered an extended health service, provided at provincial discretion. Each province provides varying levels of social care services.	Differences in provincial arrangements result in unequal care distribution at national level. Health outcomes lag behind other high-income countries.
Japanese Model	Provides a basic level of universal care, with high levels of expectations still placed on informal carers. Services are dominated by medical models of care.	Municipalities operate the public long-term care insurance system and are responsibility for planning long-term care in each jurisdiction.	Linked to improving quality of life outcomes for those with complex needs and disabilities.
EU Countries (Netherlands,	In Germany, most formal social care is delivered by	Federal authorities are responsible for providing	Demand for personal budgets is high and

Germany, and France)	private providers. In France, fifty-seven per cent of residential care facilities are publicly owned. People insured under the Dutch scheme are able to choose between benefits in cash & in-kind services. High levels of care are also provided by informal carers.	the infrastructure for social care in Germany. Care services are administered by health insurers, but the care funds are independent self-governing bodies.	the system has struggled to cover costs resulting in long waiting lists and unmet care needs.
Swiss Model	Professional care is delivered by a range of providers.	Governance is fragmented with responsibilities divided between the federal, cantonal, and local levels.	Internationally, the Swiss system ranks well regarding quality of care, access, efficiency, equity, and promotion of healthy lives.
Nordic Models	Since the 1990s, changes in policy have transformed service delivery into a more hybrid public-private approach.	Local authorities have the freedom to organise care delivery, but the system is supported by national level legislation.	Increased marketisation of care is linked to widening health inequalities.
New Zealand Model	Care service provision is subject to a needs assessment and the health ministry funds and purchases care. A wide range of services are delivered by private sector organisations. Primary health organisations contract with district health boards to provide a range of primary and community services	From 1 July 2022, Te Whatu Ora - Health New Zealand has taken over responsibility for planning and commissioning hospital, primary and community health services.	Integration is associated with improved mental health and quality of life for those with complex needs. Integrated care provision has helped address health inequalities between Indigenous people and other New Zealand citizens.
UK Countries (Scotland, England, Wales, and Northern Ireland)	Since 1973, Northern Ireland has operated an integrated structure of health and social care. Scotland, England, and Wales are gradually moving towards increasing integration in their health and social care systems. Adult social care in England has greater private and voluntary sectors provision than in Scotland and Wales. Northern Ireland's services are commissioned by the	Local authorities in Scotland, England and Wales are responsible for social care support, while local health boards are responsible for health services. They also work together as integration authorities to assess the needs of their area and plan and commission local community-based health and social care services using funds contributed by the local authority and	Increased integration of health and social care is associated with more holistic approaches to care. However, this has had a relatively limited effect on reducing existing health inequalities to date.

	Health and Social Care Board.	health board. The Department of Health in Northern Ireland is responsible for adult social care, including the authorising and allocation of government funding.	