Integrated social and health care
Executive summary








CTESC
Consell de Treball Econòmic i Social de Catalunya

STUDIES AND REPORTS No. 51

Studies and Reports. Number 51

INTEGRATED SOCIAL AND HEALTH CARE

REPORT

approved by the Plenary of the Catalan Labour, Economic and Social Affairs Council in the extraordinary session of December 17, 2018.

CTESC
Consell de Treball, Econòmic i Social de Catalunya

Rapporteur

Salvador Guillermo

Director

Xavier Riudor

Coordinator

Diego Herrera

Authors

Diego Herrera
Xavier Riudor
Virgínia Villar

Work Team

Enric Arqués
Juan Cobacho
Carme Martínez
Lluís Viguera

Catalan Labour, Economic and Social Affairs Council

Barcelona, 2018

Catalan Labour, Economic and Social Affairs Council
Diputació, 284
08009 Barcelona
Tel. 93 270 17 80
Web: ctesc.gencat.cat
e-mail: ctesc@gencat.cat

ISBN: 978-84-18199-79-0

Images:
Vector de fondo creat per freepik - www.freepik.es
https://www.freepik.es/foto-gratis/pareja-mayor-en-casa-de-ancianos-mirandose_2272115.htm
oto de personas creada per freepik - www.freepik.es
https://www.freepik.es/fotos-vectores-gratis/personas
https://www.freepik.es/foto-gratis/madre-abrazando-a-su-madre-mayor-sentado-en-el-sofa-en-casa_2698304.htm
Foto de personas creada per freepik - www.freepik.es
https://www.freepik.es/foto-gratis/mujer-adulta-que-cuida-a-la-madre-mayor-mal_1473930.htm
Foto de invierno creada per bearfotos - www.freepik.es
https://www.freepik.es/fotos-vectores-gratis/invierno
https://pixabay.com/es/dependiente-demencia-mujer-edad-441408/
Creative Commons CC0 1.0 Universal
https://www.rawpixel.com/image/427804/group-senior-friends-collaboration
Llicència Creative Commons
https://www.freepik.es/foto-gratis/joven-medico-apoyando-su-paciente_863047.htm#term=doctores%20jovenes&page=1&position=7
Foto de personas creada per pressfoto - www.freepik.es
https://www.freepik.es/foto-gratis/concepto-borroso-de-asilo-de-ancianos_2014481.htm
Foto de personas creada per freepik - www.freepik.es
https://pixabay.com/en/crutches-ill-injured-hospital-538883/
Creative Commons CC0 1.0 Universal

Barcelona, December 2018

This document achieves 2.1 WCAG (Web Content Accessibility Guidelines) Compliance

1. EXECUTIVE SUMMARY

1.1. SYNTHESIS

The report that you have in your hands provides a comprehensive and thorough overview of integrated social and health care in Catalonia and the world. This is not a new concept, although it may seem so to people who are not skilled in the subject. What represents a novelty is the renewed interest in recent years towards its implementation, with more or less political determination, since the publication in Catalonia of the Interdepartmental Plan of Social and Health Care and Interaction (PIAISS) in the year 2014.

The report begins with a chapter of conceptual analysis (3.-What is meant by integrated social and health care) and continues with another one of models description (4.-Integrated social and health care models). Both chapters form the basis on which a story is built from the contributions made by the ten appearing persons to the Catalan model of integrated care (5.-Contributions to the Catalan model of integrated social and health care). Finally, the report ends with a set of considerations and recommendations that the CTESC proposes to the Government (6.-Considerations and recommendations).

Chapter 3 offers a brief historical overview of the origins of integrated care in Catalonia and the world. In 1946, the World Health Organization (WHO) proposed a holistic approach to health in the preamble to its constituent document, and three decades later the Lalonde Report (1974) emphasized the importance of social determinants of health and the preventive promotion of healthy lifestyles. In Catalonia, the Life to Years Program, created in 1986, proposes the planning and coordination of social and health care aimed at the elderly. This pioneer program is followed by a series of actions that pave the way for the Chronicity Prevention and Care Program of Catalonia (PPAC), created in the context of the 2011-2015 Health Plan and the most immediate precedent of the current PIAISS.

The report is committed to a pragmatic and flexible definition of integrated social and health care. It starts from the conviction that the political, institutional and cultural diversity of the contexts in which it has been implemented makes it impossible to adopt a unique definition in this regard. Thus, based on authors such as Leutz (1999) and Kodner and Spreeuwenberg (2002), the procedural dimension of integrated care is emphasized as a will and effort to adapt to the changing needs of individuals, with a triple objective as a common point of reference: the improvement of the results achieved in well-being and health, in the levels of satisfaction (of the users and professionals) and the use of resources. As will be seen in the report, the integration of social and health care can be carried out through different paths (3.1.2.-Elements that promote success and 3.1.3.-Tools for the deployment of integrated care).

Chapter 4 presents systematically five international experiences of integrated care. The selected experiences show the variety of integration models that exist in the world and make aware of the challenges and possibilities in each of the contexts of implementation, evaluation and reformulation of integrated care. The experiences are ordered according to the target population: the whole population, population groups or patients and certain individuals. Thus, Kaiser Permanente (USA) and the Chronicity Care Strategy (Euskadi) are two experiences belonging to the population-based model; the "care chains" (Norrtaelje Region, Sweden) and the "clinical network management" (Scotland) represent the model of population group or specific disease; and the “caring connections” (Eastern Bay of Plenty, New Zealand) are part of an integrated care program for people who, as individuals, meet certain access requirements (individual model).

This chapter also analyzes the main features of the theoretical model of integrated social and health care in Catalonia. Given that a significant part of the model is yet to be transferred to practice, the sources of information used in this section are the official documents that develop, on the one hand, the story about the convenience of transforming the current model and, on the other, the principles of a "person-centered care" and of care for people with "complex needs". As the report will show in detail, the key elements of the Catalan model of integrated care are a) population vocation (although initially it is proposed to prioritize the application to people in a situation of social and health complexity), b) the redefinition of the role

of the subjects of care and their environment, c) the leadership of professionals as the engine of transformation, and d) a territorial vision in the implementation through subsidiarity and shared responsibility.

Chapter 5 presents the conclusions of the appearances organized by the CTESC to think about the following aspects of integrated care: the concept of integrated social and health care, the assessment of the Catalan model of integrated care, the facilitators and barriers to its implementation, the most outstanding experiences in this area and the recommendations for developing integrated care in Catalonia. The concept of integrated social and health care used during the appearances is in line with the theoretical developments in the report and the manifested sense of urgency encourages the transformation of the current, fragmented and inefficient model towards another, integrated one, that puts people and their needs at the center of the system.

Most appearances evaluate positively the advances made in recent years in the conceptualization of the Catalan model of integrated social and health care. At the same time, the worst valued aspects have to do with the difficulties of deploying the model in the territory effectively, which is mainly due to the lack of political impulse. The appearances identify a set of facilitating elements that should encourage the implementation of integrated care in Catalonia, such as the accumulation of experience and knowledge through projects at the local and county level or the willingness to collaborate professionally from the base and the territory. However, the identification of barriers abounds, the most important of which are related to the differences between the social and health sectors and the so-called "false solutions", that is, to all the inertia that deepen into the residual aspect of social services.

The appearing persons value positively various experiences of integrated social and health care. In addition to some of those outlined in Chapter 4, we cite, among others, the Quebec services system for older people who have lost autonomy (SIPA), the Torbay experiences, the ones of the "Pioneers" and of Great Manchester in England, the case of Canterbury in New Zealand, the model of social and health integration of Castile and Leon, the Expert Patient Program Catalonia and the shared clinical and social history of the Barcelona City Council and the Department of Health. Additionally, a note is included with the detailed description of the social and health integration process led by the La Garrotxa Social Action Consortium, one of the most advanced "collaborative projects" in Catalonia.

Chapter 5 closes with a list of the recommendations made by the speakers for the effective implementation of integrated social and health care in Catalonia. The recommendations are sorted by field of action, including the need for immediate action, the demand for political commitment and leadership, the development of a balanced governance structure between the social and health sectors, the reform and the strengthening of social services, investment in research, development and innovation (R&D), the characteristics that the Catalan model should have in practice, and the method of financing.

Finally, in Chapter 6, the CTESC elaborates a set of report-based considerations and proposes a series of recommendations to the Government, which are reproduced in full below.

1.2. CONSIDERATIONS AND RECOMMENDATIONS

In this section, the CTESC wants to submit to the Government a set of considerations and recommendations on the integration of social and health care based on the set of contributions contained in the report. As in other reports of this institution, some of the recommendations may require a superior framework of competence than the one currently available to the Generalitat. However, the CTESC values the Government's ability to negotiate with other administrations the possibility of implementing them, as well as to influence the development of initiatives that incorporate their spirit.

The chapter is divided into six sections: a first one referring to what is meant by integrated social and health care; a second section justifying the need for it in Catalonia; the third section identifies the elements that explain the success of integrated care programs and experiences; the fourth section gathers the most important antecedents and political initiatives to advance towards integrated care in Catalonia;

the fifth section details the main facilitators and barriers to the deployment of integrated care; and, finally, we offer a list of the CTESC's recommendations which are linked to promote the deployment of a Catalan model of integrated social and health care.

1.2.1. INTEGRATED SOCIAL AND HEALTH CARE

Social and health integration has become a field of reference for a growing number of governments around the world concerned about how to meet needs from the triple point of view of the well-being achieved, the experiences of the users and the sustainable use of resources.

A pragmatic definition of this type of care is provided by Kodner and Spreeuwenberg (2002: 3), who understand integration as "a set of methods and models of funding, administration, organization, service delivery and clinical care designed to create connectivity, alignment and collaboration within and between the care [social] and the healing [the healthcare] sector". According to these authors, the goal of integrated social and health care is to "improve the quality of care, quality of life, satisfaction of people and the efficiency of the system".

Underlying this approach is the idea that integrated care is not so much about achieving a particular goal but about adapting the care system to become more complete and comprehensive. Leutz (1999, pp. 77-78) also emphasizes this processual dimension of integrated care, defining it as "the quest to connect the health system (i.e., primary, specialized, and acute care) with other human care systems (i.e., long duration, education and training, housing, etc.) with the aim of improving the results (clinical, satisfaction and efficiency). "

Some models of integrated care consider that they should target specific groups or diseases or even individual cases characterized by complex long-term problems that require multiple services, providers and spaces. On the other hand, other models have a population vocation and consider that integrated care must be adapted to the needs profiles of the different population "strata". As stated in the first of Leutz's five "lessons" (1999, p. 83), "you can integrate all services for some people, some services for all people, but you cannot integrate all services for all people."

Integrated care provides three elements that can hardly be efficient in a fragmented social and health approach. On the one hand, this model facilitates the continuum of care and opens the door to developing a person-centered care. On the other hand, it considers the social determinants of health, that is, the links between environment, habits and health status. Finally, it has a greater ability to anticipate problems and avoid potentially unnecessary interventions, especially in the medical field.

Based on these considerations the following clarifications should be added to avoid misunderstandings:

a. There is not a unique or "better" way to integrate (or to achieve the integration objectives), but different paths according to the characteristics and particularities of each territory.

b. Integrated care does not necessarily mean the fusion of all parts or levels of systems, or that it needs to be "complete".

c. The starting point for integration does not have to be an organizational model with a default "top-down" design, but rather a service delivery model designed to improve people's care.

1.2.2. WHY DO WE NEED SOCIAL AND HEALTH CARE?

There is a high political, academic and professional consensus on the inadequacy of the current care model to the demographic, epidemiological and social reality of the country. In outline, social and health systems have mutual coordination ("horizontal") and internal difficulties ("vertical") and they share an

anachronistic view of users as passive subjects of compensatory care (social services) and of care focused on acute illness (health system). Therefore, integrated social and health care is currently a need driven by change and an opportunity to transform both systems.

There are a number of factors that make the convenience of integrating social and health care in Catalonia more evident than ever:

a. Increased life expectancy, population aging, chronicity, disability, dependence and fragility.

b. Increased social complexity due to the impact of unemployment and the risk of poverty and social exclusion on families and communities.

c. The proven evidence of the importance of social determinants in health and the need to tackle them from a broader social perspective than the healthcare vision.

d. The beginning of the social services transformation towards a model based on the support of personal autonomy and the strengthening of primary family and community relationships.

e. Transformations in the roles of caregivers, families, and community networks in attention and care.

f. Changes in people's expectations regarding social and health care (i.e. more autonomy, participation, decision-making capacity, etc.).

g. Increased healthcare pressure amid a context characterized by budgetary pressures.

h. Increased costs for certain therapies and care practices (i.e., medications, rehabilitation, etc.).

In order to face these challenges, empirical evidence supports the need to urgently develop a model of integrated social and health care, since it improves attention and health outcomes, particularly in the case of people in a situation of social and health complexity. These people represent about 8% of the Catalan population and 40% of the public spending budget on care, with the forecast that these rates will increase over the years (Ledesma, Blay, Contel, *et al*., 2015, pp. 9-10).

More specifically, it is established that there are "benefits derived from integrated care, especially in terms of improving accessibility to services, coordination and continuity of care, experience in care and best collaborative practice among professionals and organizations", as well as an "improvement in health outcomes, the use of institutionalization resources and the crises resulting from the abandonment of a caregiver (Sarquella, Ledesma, Blay et al., 2015, p. 74, from Kodner, 2012).

The risk of not starting up the social and health integration is, on the one hand, of a welfare nature, due to the inadequacy of the answers to the new needs and, on the other, of economic nature, due to the increase in the costs derived of the sharp rise in the utilization of services: urgent hospitalization, avoidable institutionalizations and, in general, care for avoidable or premature complexities caused by the lack of prevention and integrated care.

Indeed, the economic cost of tackling present and future population demands is unacceptable unless the transformation to a person-centered, integrated healthcare model is addressed, taking into account the state of public finances. It should be added that this economic risk causes, in addition, another ones of healthcare nature: first, dissatisfaction of users and worse health results, and also increasing bags of neglect in the form of waiting lists and lack of effective access to services.

Finally, the possible deterioration of the social and political legitimacy of the public protection system in such a scenario is not negligible.

1.2.3. ELEMENTS THAT EXPLAIN THE SUCCESS OF PROGRAMS AND EXPERIENCES OF INTEGRATED SOCIAL AND HEALTH CARE

On the basis of literature on integrated care, expert appearances, and analysis of successful experiences locally and internationally, the following explanatory factors for the success of some programs and initiatives of integrated care in the world can be identified:

a. A common, clear and realistic narrative about the benefits and possibilities of integrated care that motivates parties to overcome current fragmentation and to share power.

b. A visionary political leadership, as well as professional and territorial leadership (within organizations) with the ability to mobilize resources and wills.

c. Realism in setting the goals, timing and expenses for the deployment of integrated social and health care (it takes a long time to change things).

d. Continuous evaluation of progress towards the triple objective of integrated social and health care: improving health outcomes, the experience of care and the use of resources.

e. The balance of powers between the social and healthcare sectors in defining and articulating the model of integrated care and joint cooperative work.

f. Consideration of the lessons learned from the practice of care and the local experiences of integration, as opposed to the deployment, from top to bottom, of a theoretically predetermined model.

g. Willingness and capacity to improve social services and put their access conditions on a level with those in the healthcare system before and/or in parallel with the deployment of integrated care.

h. Flexible sharing of resources (i.e. human, financial, infrastructure, etc.) between sectors and levels of care, and reduction of barriers between different professional cultures.

i. A population stratification model that makes it possible to provide integrated care differently depending on the profile and level of people's needs and objective and shared criteria of eligibility.

j. Access to services based on a person-centered approach to care, rather than the sectoral and/or functional division of services and benefits (for example, a single point of access once needs have been detected).

k. A commitment to integrated home, social and health care as a basic network that avoids neglect and, as a consequence, that people progress through the scale of care resources towards inadequate, more expensive and inefficient levels of care.

l. An information system that allows the registration, exploitation and sharing of social and health data of the users; in its absence, formal or informal spaces for the exchange of information.

m. A unique and holistic social and health needs assessment model that avoids duplicities and disparities between sectors, services and/or professionals.

n. Personalized care plans or tailored to the people's needs, made through the participation of professionals from the social and health sectors.

o. The empowerment and participation of users, as well as informal and family caregivers in the management of health and the elaboration of personalized care plans.

p. The figure of the professionals of reference and the cases managers, who make it possible to guarantee the proximity, the continuum of care and the person-centered attention.

q. The differentiation, on the one hand, between a "central" group of professionals or a multidisciplinary care team that provides close and continuous care (i.e., a home care team, for example) and, on the other, a wider network of providers likely to be activated to guarantee access to other social and health care services.

r. Professionals with well-defined roles within multidisciplinary teams and teamwork between general practitioners and specialists in the social and health fields.

s. A more equitable and efficient balance of resources between services and levels of care: healthcare vs. social care and specialized care vs. primary care.

1.2.4. CATALONIA AND INTEGRATED SOCIAL AND HEALTH CARE

Catalonia's relationship with integrated social and health care is based on the Life to Years Program, created in 1986 by the Autonomous Ministry of Health with the aim of improving the care of elderly people with illness, with chronic illness and in end of life situation. The importance of this program is reflected in the start-up of a social and health services portfolio, which includes long-term care, day hospitals, average stay for convalescence and palliative care, the interdisciplinary social and health functional units (UFISS), the Home Care and Support Teams Program (PADES) and the multidisciplinary teams for comprehensive outpatient evaluation (EAIA) in geriatrics, palliative care, and cognitive disorders.

From here we should also highlight the Program to boost and organize the promotion of personal autonomy and care for people with dependency (ProDep), the Health and Social Master Plan (PDSS), the Comprehensive Plan on Mental Health and Addictions and the Chronicity Prevention and Care Program in Catalonia (PPAC). In fact, the PPAC is the most immediate precedent of the Interdepartmental Plan of Social and Health Interaction (PIAISS), approved in 2014. With PPAC, eight local "collaborative projects" were launched in a local and/or county level that have become the basis of the integrated social and health care model promoted by the PIAISS, together with the experience of more than two decades of the La Garrotxa Social Action Consortium.

The PIAISS is directly dependent on the Presidency Department; it has the participation of the Departments of Health and Labour, Social Affairs and Families, and its main purpose is to promote integrated, person-centered social and health care. According to the PIAISS, the key elements of the Catalan model of integrated care are the population vocation (although initially it intends to prioritize the application to people in a situation of social and health complexity), the redefinition of the role of the subjects of care and their environment, the leadership of professionals as a driver of transformation and a territorial vision in implementation through subsidiarity and shared responsibility (Sarquella *et al*., 2015). Nevertheless, the pace of implementation in recent years, since the birth of the PIAISS, has been insufficient to carry out the proposed changes.

The itinerary carried out by integrated social and health care in Catalonia allows us to affirm that there is sufficient pilot evidence and experience, soundness in the story and sufficient professional predisposition to be able to take a more ambitious leap towards the implementation of this paradigm. In addition, there

is a solid (albeit stressful) primary care available, which should make possible to develop integrated care in parallel with the strengthening of social services.

1.2.5. FACILITATORS AND BARRIERS FOR THE DEVELOPMENT OF SOCIAL AND HEALTH CARE IN CATALONIA

In relation to the Catalan background, there are aspects of a contextual or structural nature that can act as facilitators of the development of integrated social and health care. According to the point of view of the appearing persons and starting from the consideration of the pilot tests and the successful experiences in the local and county level, the following facilitators can be identified:

a. Social, demographic and epidemiological change, in the sense that it poses new challenges for social and health care that require immediate and disruptive responses.

b. The accumulation of experience in social and health integration through pilot tests and experimental programs (some of them highly consolidated) at the local and/or county level.

c. The preparation of the PIAISS, which has served to visualize, mobilize and put into contact different wills in favour of integration.

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

e. A health information system practically common throughout the territory that allows to stratify population, to make needs forecasts and to develop instruments such as the shared medical history in Catalonia (HC3).

f. A solid, direct access system of primary health care with public funding and universal character.

In contrast, the main barriers to the development of social and health care in Catalonia are:

a. Lack of leadership, both territorially and professionally (*i.e.*, in organizations) and, above all, in politics.

b. The concentration of the integration processes in pilot tests that expand over time, without being evaluated or scaled throughout the territory.

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

d. The mutual trust deficits that occur occasionally between the social and health fields, between primary and specialized care and between the Public Administration 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 goals.

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

g. The differences between the professional cultures of the social and health fields.

h. An initial and lifelong learning system that does not prepare professionals for integrated, person-centered care.

i. A large number of users by professional and lack of time for the coordination that involves integrated care.

j. Lack of social valuation of everything that is related to caring for people, compared to that received by the healthcare system.

k. An unbalanced distribution of resources between primary and specialized social care, and lack of coordination between these two levels of care.

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

m. And, definitely, systems that are still excessively bureaucratic and rigid.

At the same time, it is worth pointing out specifically the adjustment difficulties between the social and health systems as one of the most important barriers to the care integration in Catalonia, for several reasons:

a. The social care system is less developed and weaker than the health care system, and its sectoral perimeter is not well defined (*i.e.*, it functions as a "broom truck" instead of dealing with people's links and autonomy).

b. The healthcare system is universal while most social services have a conditioned access.

c. Health services are financed from public budgets, while most social services are co-financed with the participation of users.

d. The healthcare system is centralized and has unique access criteria, while social services are decentralized and access to basic benefits may vary locally.

e. Social services are geared towards long-term care while the healthcare system has shorter stay times.

f. The workers' labour conditions in the social and health sectors are different.

g. The health system provides services to people, while social services often provide economic benefits.

h. The territorial divisions of the health care and social services systems do not coincide, which hinders the coordination between devices and between professionals.

i. The healthcare field has a practically unique information system throughout the territory, while in the case of social services it is highly fragmented and unevenly developed.

j. There is an imbalance between the two systems in terms of the volume of scientific knowledge, the accumulation of empirical evidence, with a very significant lack of predictive social models that allow for careful planning.

k. Unlike what happens in the healthcare system, the social sphere does not have standardized devices to know how users value the care they receive.

1.2.6. HOW TO PROMOTE THE INTEGRATION OF SOCIAL AND HEALTH CARE IN CATALONIA

Given the current situation of social and health care in Catalonia, and starting from the base of the identification of facilitators and barriers to implement integration, the CTESC makes the following recommendations:

Concerning **the need and opportunity** of integrated social and health care:

1. Accelerate the process of integration of social and health care throughout Catalonia on the basis of a realistic calendar.

2. Achieve a political commitment with a strong leadership of the whole Government, making integrated care a national priority.

3. Establish political and also professional leadership to face the challenges of integrating health and social care as an innovative transformation of structural scope.

4. Strengthen and disseminate the social aspect of the narrative about the benefits and possibilities of integrated care, with the participation and adherence of civil society.

5. Establish a Strategic Agreement and an Action Plan for the development of integrated social and health care in Catalonia between the different levels of the Public Administration and with the participation of business and union organizations, the entities of the Third Sector, the professional colleges, etc. The Strategic Agreement must define the person-centered model of integrated social and health care and the lines to be developed by the action plan. This plan should be ambitious and realistic, have a reasonable time horizon and have solid instruments (calendar, governance system, evaluation and indicators, economic memory, etc.).

Concerning **the Catalan model** of integrated social and health care:

6. Endow the model with a universal vocation, although in the first phase it may be appropriate to prioritize the attention to certain profiles of needs throughout the territory.

7. Not to assume that integration must necessarily be structural, but it must be at least functional, that is, it must be effective in the people's care field and in the allocation of economic resources.

8. Promote a model that considers primary and community care as a guarantee to meet social and health needs in an appropriate and efficient way.

9. Substantially expand home care services and assign a central role to them (*i.e.*, home help services and/or support and care technology services), both in the social and health care field, focused on the person and their family. The efficiency of home care services requires a significant reduction in waiting lists beforehand.

10. Implement support services for families and carers: financial benefits, training activities, opportunities for rest, etc.

11. Strengthen the role of civil society, volunteering and the neighbourhood in detecting needs and look for an integrated solution.

12. Make citizen participation effective in defining, implementing and evaluating the model.

13. To empower users in the decision-making process regarding the management of their health and the characteristics of the care, treatment or intervention received.

14. Promote prevention, understood as the active participation of people in their health, through awareness of the determinants of health and the promotion of healthy lifestyles and habits.

15. Enhance personal capacity and autonomy.

16. Expand the concept of palliative care and go to a model where global early care is provided, with specific care programs for the needs of people close to the end of life. This action must be adapted to the population structure, the longevity forecasts and the increase of people in end of life situations.

17. Prepare a study on the costs and benefits of the gradual approach of the working conditions of professionals in both sectors.

18. Prevent the deployment of integration from being based on a single intervention, since experience shows that concerted, coordinated, and synchronized actions (i.e., "multi-lever models") are those that have proven effective.

19. Encourage collaborative practice between professionals and different healthcare fields, and recognize that this is an essential organizational factor or "input" in order to articulate healthcare responses.

20. Provide an integrated framework for continuous assessment of the deployment and functioning of integrated care.

21. Update the 2010 social services portfolio and develop a specific catalog of integrated social and health services, although they may initially be shared and complementary.

As for **the governance** of integrated social and health care:

22. To create a governance structure with a balance of power between the social and health sectors and with capacity to make decisions.

23. To define in the organization chart of the Government a people care services commissioner that depends on the Presidency Department, with the aim of coordinating the integration of social and health care.

24. To design a flexible governance model that sets specific, shared and measurable

goals whose achievement can be determined in the territory according to its characteristics and specificities. In this sense, it is advisable to provide local-level territorial governance with a group of instruments (or "toolbox") without need that all territories end up implementing the same territorial mix of policies.

25. To explore the creation of partnerships or similar figures between the involved fields under a program contract. In this process, the emergence of local leadership that has the necessary management resources to carry out integration should be promoted.

26. To design a proposal for citizen participation that envisages an overall view of spending, access and use of services, with the aim of achieving the highest possible levels of efficiency in the use of resources and of strengthening social cohesion and equity in funding our welfare state.

27. To unify the territorial areas of the basic social and health areas.

28. To promote regulatory reforms to facilitate the development of social and health integration.

29. To provide person care services through a common and integrated instrumental organization of financing, planning, accreditation, contracting and information and evaluation systems that interact with suppliers.

30. To coordinate integrated health and social care with other areas of activity such as housing, training, leisure or work.

As for **the transformation of social services** in Catalonia:

31. Carry out the transformation of social services in parallel with the integration process.

32. Transform social services in order to bring the rights of access and quality of services closer to the standards of the healthcare system.

33. Foster a new structuring of basic social services so that they can become a universal pillar in the promotion of autonomy, the reinforcement of primary relations and the development of community relations, surpassing the model exclusively focused on social assistance for disadvantaged groups and in emergencies.

34. Develop the Social Services Law normatively, taking into account the model of integrated care and with a preventive and predictive look.

35. Guarantee a social services portfolio that ensures territorial equity.

36. Update the social services information system to move towards the unification, simplification and streamlining of data collection and to enable their exploitation and interoperability in an integrated care system.

37. Develop predictive models of social needs at a population level as an essential planning tool.

38. Develop high social complexity detection models. In this sense, the development by the Generalitat of a "self-sufficiency scale", which emphasizes the identification of

people's abilities, is positively evaluated as an approach tool.

39. Establish a social single window and give consistency to the processes to prevent users from having to take multiple steps before the different administrations and entities.

40. Reinforce community social care in the face of the growing phenomenon of unwanted loneliness.

Regarding integrated care **management**:

41. Respond to the growing healthcare pressure with better staffing ratios, both in the social and healthcare spheres, in order to guarantee equity and efficiency of care.

42. Move towards initial and continuous cross-cutting vocational training in accordance with the principles of person-centered integrated care, which will reduce the differences between the professional cultures of the social and healthcare sectors.

43. Continue advancing in the interoperability and unification of health and social information systems based on the evaluation of existing pilot experiences.

44. Make careful quality management and process certification.

45. Unify the evaluation processes to avoid duplication through the creation of interdisciplinary teams that take into account people's social and health needs.

46. Work on the development of integrated scales for the detection of social and health needs.

47. As indicated by the AQuAS, to establish the figure of a project director with capacity for solving problems in the processes of social and health integration in the territory. This function can be performed by an external professional or by a person appointed by consensus, with the consequent legitimacy, with the aim of facilitating the reception and involvement in the project.

48. Promote case management or attention management, which aims to coordinate the supply and demand of services for people in complex situations. The case managers do not necessarily have to be professionals in the field of health, but must be determined by the profile of the needs of the users and by the bonds they have with their social and health ascendants.

49. Establish the figure of the professional of reference, who knows the person and the environment and is in charge of directing the attention plan, together with the person and, if applicable, the family. As with the case manager, the professional of reference should not necessary belong to the health area.

50. Enable the activation of services and benefits at any time of the year in order to respond to urgent social and health needs.

In relation to **the financing** of the social and health care integration:

51. Increase economic resources to deploy integrated social and health care. This increase in resources will mean, in the medium and long term, an improvement in the financial sustainability of the system over the option of not completing the integration process.

52. Rebalance funding between the social and healthcare systems in order to put rights on the same level, based on a careful study of costs and sources of funding.

53. Introduce shared budget scenarios ("pooling budget") to fund integrated social and health care, as reflected in the report from international experiences.

54. Provide greater coherence, balance and transparency to the common portfolio of social and health services regarding the possible expenses that users have to bear, so that similar non-healthcare expenses get the same treatment in all services, in order to achieve more equity and social cohesion.

55. Especially strengthen the human, material and financial resources of primary, social and home attention. It will be helpful to take advantage of the overall joint budget increases to carry out this prioritization, until reaching a better balance in the relative funding received by the aforementioned sectors of activity.

56. Modify the measures of financial participation in the field of social attention, making them progressive, so that the users' personal and financial autonomy is guaranteed.

57. Solve the distortions arising from different financial participation between the social and health fields with regard to certain cases, such as those related to mental health and disabilities.