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MOVING INTO ACTION:

The role of governments in the Health and Social Services Alliance

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General Evaluation of the Seminar

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Is an innovation hub in health care and social services. It is focused on the policy implications of the ongoing transformation in these fields.

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01

MOVING INTO ACTION:
The role of governments in the Health and Social Services Alliance

01

Moving into Action
The role of governments in the Health and Social Services Alliance

There is consensus regarding the fact that the social health system is fragmented and that it is the users who suffer the consequences.

There is also **consensus regarding how planning should take shape in this sector: that it should be geared to the needs of individuals as well as the needs of the population in general.**

Furthermore, **consensus exists regarding the importance of providing users with a better coordinated and more integrated health and social services care model.**

In reality, **substantial progress has been made in developing a more coordinated approach at the micro level** delivery level.

However, **faster progress and more experience could be developed** in this direction if there was more committed political leadership. **Other countries and regions are already advancing** as well in relation to furthering a more committed policy intervention favouring integration of health and social services.

"How can conditions be created at the policy level to advance the development of the health and social service system?"

There is no lack of tools – **we have the TECHNOLOGY and SKILLS** to move forward.

The question should be: **HOW CAN WE CREATE THE NECESSARY CONDITIONS AT THE POLICY LEVEL to make a quantum leap from successful local best practices towards an ACTUAL TRANSFORMATION AND DEVELOPMENT OF THE SOCIAL HEALTH SYSTEM?**

On January 21st 2014, a seminar was held on this question in which senior leaders and **senior professionals from both health system and social services of various governments in Spain participated. All the participants have present responsibilities in these areas** as well as implementing the necessary tools to begin exploring its possibilities.

The objective of the workshop sessions focused on:

- **Sharing successful experiences in creating Health and Social Services Alliances aimed at transforming the care model.**
- Identifying **policy and management tools that would encourage and stimulate this 'transformation' of the health and social services** sectors with the intent to ensure patients are cared for in the right way, right place and at the right time
- **Identifying the main barriers** that currently exist in the social and health systems in order to advance in the intended direction and to **reflect on processes to remove such barriers.**

Finally, workshops were held focusing on **several key areas** in order to suggest **proposals for taking action and making progress** in **developing Health and Social Services Alliances.**

Key areas for workshop:
Pending tasks for Governments

1. CONCRETE DECISIONS VS GRAND PLANS
2. IMPLEMENTATION: THE OUTSTANDING TASK
3. GREATER VOICE AND PARTICIPATION FOR PATIENTS
4. WHERE WILL THE RESOURCES COME FROM?
5. ORGANISATIONAL INNOVATION: AN UNDER-EXPLORED KEY ISSUE
6. INFORMATION TECHNOLOGIES
7. FORUMS OF SHARED LEARNING

01 Concrete Decisions vs. Grand Plans

Is there any Autonomous Regional Community today that does NOT have a social healthcare plan or something similar?

The answer is no. Nowadays, all of the system's planning agencies have some sort of plan or strategy for Social and Healthcare.

It can be seen that these plans correspond in part to the political preoccupation about the very real fragmentation felt at various levels and the concern they raise, as well as the need to offer solutions to this situation.

We recognise, therefore, **THAT THERE ARE MANY ROAD MAPS TO GUIDE US BUT THESE PLANS ARE NOT CONVERTED INTO ACTION – AT LEAST, NOT AT THE REQUIRED SPEED.**

"We have many plans but they do not get put into action: they need to be implemented."

Consequently, it is becoming ever more necessary to move forward and to examine the barriers and to decide which management tools are needed to make swifter progress towards the implementation of these collaborative approaches.

At the political level more determination is needed AND GREATER FOCUS ON A SOCIAL SERVICES and HEALTH MODEL THAT IS TRULY CENTRED ON THE NEEDS OF THE PATIENTS.

To place the patient at the **centre implies a radical organisational change and calls into question the entire present system.**

To develop a healthcare model centred on patients requires changing the present itinerary of patient care and also to revise knowledge regarding their needs and social perspective.

"It is essential that political representatives understand and take on board the objective that a development of an integrated Health and Social Services sector signifies. This will involve a change of attitude and tremendous courage."

To develop a healthcare model centred on the patient means enabling them to take a much more active role. Patients are the agents of the process who have the greatest knowledge of their needs and are the true protagonists of their personal situation. In this sense, they – or those close to them – are best placed to know what skills and resources they have available to confront their needs and, therefore, can best explain what type of services and help are needed to complement them. This requires a very radical change to the present organisational model which has been defined in terms of the existing offer and exhibits a strong asymmetry between the capabilities of patients and their empowerment and the care that the system actually offers.

With this **cultural change and greater empowerment of patients** over their health care sweeping improvement can be observed when structured education is directed towards specific groups with respect to their personal involvement and responsibility in such care and maintenance. **Education in self-management and empowerment is an urgent issue.**

"It is essential to promote transparency and assessment."

To achieve the above means that **efforts must be made to make processes and information more flexible in order to move away from an planning process exclusively based on inputs and resources to one that prioritises people.** At times, progress in this direction is hindered by current regulations on data protection; nevertheless, a necessary balance must be sought.

Change in the healthcare model and working methods also means **reducing the level of paternalism and redirecting the model towards providing a response to actual needs. Clear political support** will be needed in order for this commitment to become a reality: **IT IS ESSENTIAL THAT POLITICAL REPRESENTATIVES UNDERSTAND AND TAKE ON BOARD THE OBJECTIVE IMPROVING THE CARE AND COORDINATION ACROSS HEALTH AND SOCIAL SERVICES. THIS WILL INVOLVE A CHANGE OF ATTITUDE AND TREMENDOUS COURAGE**.

"In Spain there is no independent monitoring agency that can provide governments

with Guidelines based on technical criteria and firm evidence to help them develop policies that require mid-term cycles of implementation."

Consequently, **at the political level there is a need to develop greater awareness but even more important would be greater critical spirit and the corresponding drive towards GREATER TRANSPARENCY AND EVALUATION.** In this regard, it should be noted that the economic context of today demands that decisions be made. It is to be hoped **THAT THE SITUATION WILL BE PERCEIVED AS AN OPPORTUNITY AND HELP TO MOVE THE DEVELOPMENT OF POLICY DECISIONS IN THE RIGHT DIRECTION**. This could be a golden opportunity to push forward with some of the proposed formulas and start to make real changes in a sector that is of concern to everyone.

Moreover, **IN SPAIN THERE IS NO INDEPENDENT MONITORING AGENCY THAT CAN PROVIDE GOVERNMENTS WITH GUIDELINES BASED ON TECHNICAL CRITERIA AND REAL EVIDENCE TO HELP THEM DEVELOP POLICIES THAT REQUIRE BROAD CYCLES OF IMPLEMENTATION.** Such technical knowledge could support many of the decisions taken at the policy level by providing alternatives to those which presently operating in the health and social services sector.

"Political cycles must not be allowed to determine these types of long-term changes."

Political cycles must not be allowed to determine these types of long-term changes. There are many people at the micro level of the organisation who have wide knowledge and experience regarding what does and does not work. They are usually ignored by policy makers who, instead, at the beginning of each new mandate mistakenly opt to "wipe the slate clean and start afresh".

In this sense, **THE EUROPEAN UNION'S LAUNCHING OF A STRATEGY WITH A TIME HORIZON OF 2020 SHOULD BE VIEWED AS POSITIVE.**

02
Implementation: the pending issue

One of the handicaps of our system is the asymmetry existing between the accessibility and availability of services within the health sector (that has a universal access model) **and those of the social services sector –** which has a model that, in comparative terms, which is relatively more limited. A priori, the integration of social services without a previous definition of its portfolio of services that differentiates between those that are considered basic and those that are complementary makes any progress enormously difficult in Spain.

"Any process of change demands a corresponding management of the associated economic resources."

"Does this occur in other countries? What is happening in other countries?"

The situation in **Northern Ireland** is similar to our own. The health system is universal and free, with very few direct payments made by patients. Their strategy, "Transforming your care" would entail **a shift of resources from the hospital area to the community in order to reinforce the services that were required at this level** (health centres, paediatric and geriatric care). This economic shift amounted **to 2.4% of the budget.**

There is no doubt that THIS INTERVENTION WAS NOT ONLY PROMPTED WITH THE AIM OF IMPLEMENTING

THEIR STRATEGY BUT ALSO TO SIGNAL THE CHANGES IN THE RESOURCES NEEDED TO ACHIEVE IT AND WHERE THOSE RESOURCES WOULD BE COMING FROM.

It is necessary to prioritise the results of experiences and to breakdown barriers and overcome "policy fear". It is essential to convince the decision-makers to back the shift towards coordination and integration.

Another proposal for achieving this is **to DEVELOP PARTNERSHIPS WITH OTHER AGENTS, for example with broader community organisations.** Nowadays it is well understood that **the widespread fragmentation requires a union of forces with different agents** (community, patients, the public....) **based on an evaluation of the results of the various initiatives.**

And what proposals were suggested to move forward by the participants at the workshop?

- **A systematic review and analysis of international experiences**
- **The promotion of a positive attitude to change among the different interest groups** based on the crisis as an opportunity– parliament, scientific societies, etc...
- **A call to halt to investment programmes and plans that do not contribute to an integrated objective or that are clearly not viable due to lack of economic resources**
- Encouraging **partnerships with the industrial sector** to develop and learn from new integration and healthcare coordination proposals

"Action should not be viewed as something that can wait until tomorrow, it is needed now.""

"It is a basic prerequisite to incorporate the views of the users into the design phases, as well as to gather evidence from each intervention so that it can help to improve the next stage."

03
Greater say and participation on behalf of the users

It is absolutely essential **to count on the participation of the public** in order to carry out some of the interventions concerning the organisation of services mentioned in THE PLANS.

"We need to develop a leadership model that allows for the emergence of local initiatives"

How can this be achieved? How are others managing this?

Experts from Ireland believe that there is no single way of achieving this.

THE ANSWER IS TO WORK AND TALK WITH ALL THOSE INVOLVED, ESPECIALLY WITH THOSE GROUPS THAT HAVE THE ABILITY TO CONTRIBUTE VALUE AND IDEAS TO THE PROCESS AND WHO REPRESENT THE ACTUAL PEOPLE FOR WHOM THE NEW PROCESSES AND SERVICES ARE DESIGNED. There needs to be a great deal of contact with the various groups who can help to build the new health and social services pathways and define the necessary services. **This requires political commitment to the strategy since it demands a great investment in terms of time and effort, and for this to be maintained over time.**

REPRESENTATIVES OF THE EUROPEAN SOCIAL NETWORK (ESN) CONSIDER THAT IT IS NECESSARY TO TAKE INTO ACCOUNT THE VIEWS OF THE USERS FROM THE VERY BEGINNING, INCORPORATING THEIR OPINIONS EVEN AT THE DESIGN PHASES AS WELL AS COLLECTING EVIDENCE FROM EACH INTERVENTION IN ORDER TO IMPROVE THE SUBSEQUENT ONES.

Allowing the consumers a voice in the definition of services means that politicians will not be able to assume that they can plan, define and carry out the multiple necessary connections from above. WE MUST DEVELOP A STYLE OF LEADERSHIP THAT ALLOWS FOR THE EMERGENCE OF THE LOCAL INITIATIVE.

The concept of 'co-production', in which services are designed by both professionals and consumers, is still rare in Spain, although its potential is enormous. In the healthcare sector, the self-management of illness, whereby patients are given greater responsibility for the decisions which concern them and a larger share in the management of their illness, is becoming more common and some of the lessons learnt from this experience can be extended to broader collaborative issues with social services.

As regards how to give the public more of a say in a healthcare system (until now it has based its services on the offer rather than on people's needs), **IT IS SUGGESTED TO CHANGE THE PRESENT FUNDING SYSTEMS TO A MODEL MORE ALIGNED WITH VALUE (CAPITA, BUNDLE PAYMENTS, ETC.) RATHER THAN SIMPLY ON HISTORICAL ACTIVITY.**

Once again we must insist on the need to **reduce the level of paternalism in the system and to raise public consciousness.** To make headway in this direction it will be more necessary than ever **to ENGAGE THE ENTHUSIASM OF THE PUBLIC AND MEDIA WITH RESPECT TO THE INTENDED CHANGE AND TO PROMOTE TRANSPARENCY IN ORDER TO WIN THEIR TRUST.**

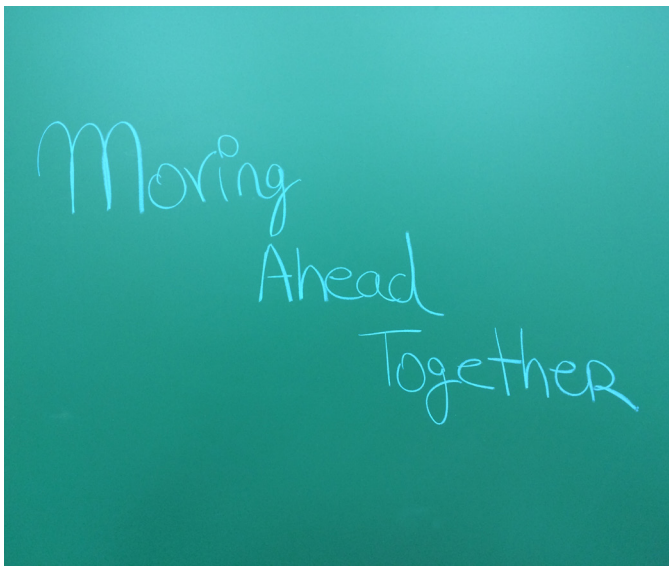
"The concept of 'co-production', whereby services are designed by both professionals and users, is still rare in Spain, although its potential is enormous."

One area of work is **TO RAISE PUBLIC AWARENESS THAT THE DEVELOPMENT OF SOME INTERVENTIONS SHOULD BE VIEWED AS A FAILURE RATHER THAN A SUCCESS. "MORE IS NOT SYNONYMOUS WITH BETTER"**. This idea should be transmitted with the help of the third sector associations.

On this theme, it should be noted that various generations – such as the baby boom – have a greater culture of social participation; in the face of necessity they have the organisational capacity to develop innovative solutions and to demand the changes needed by the new context.

THESE GROUPS UNDERSTAND THAT A FUNDAMENTAL SHIFT FROM A HEALTH MODEL TO A SOCIAL MODEL IS TAKING PLACE DUE TO DEMOGRAPHIC, EPIDEMIOLOGICAL AND SOCIAL CHANGE. "WE MUST SINK OR SWIM". AN ORDERLY CHANGE MUST BE ENCOURAGED TO CONFRONT THE DEGREE OF POLITICAL PARALYSIS THAT EXISTS IN THIS FIELD. THE TIME FOR ACTION HAS COME.

"We must reduce the level of paternalism in the system and increase public consciousness."



04
Where will the resources come from?

THE NEED TO INTEGRATE AND COORDINATE SOCIAL SERVICES AND HEALTH CARE IS NOT EXPECTED TO LEAD TO AN INCREASE IN RESOURCES. In other words, it does not appear that additional resources will be made available in the short-term for the social and health sector. It rather seems that a consolidation will occur through the re-deployment of existing resources and services from their present destination to others which correspond to the new care model and which will be more sustainable in terms of costs and, especially, in terms of being better-adapted and more responsive to the needs of those who require them. As a result, **IT WILL BE NECESSARY TO DEVELOP NEW PLANS BUT AT THE SAME TIME TO THINK ABOUT A REDISTRIBUTION OF RESOURCES WHICH WILL BENEFIT THE CHANGES.**

With a situation of scarce resources, increasing demand and demographic pressure, **SOLUTIONS WILL BE FOUND BY A REORGANISATION OF HUMAN RESOURCES, given that the largest part of the budget in both social and health sectors is devoted to professional salaries.**

"We must engage the enthusiasm of the public and media for the intended change and promote transparency in order to win their trust."

GIVEN THE CLIMATE OF AUSTERITY, OTHER NECESSARY AND URGENTLY-NEEDED SOLUTIONS - closely linked to changes in the use of human resources - **WILL LEAD TO ORGANISATIONAL AND TECHNOLOGICAL INNOVATIONS.**

"More is not synonymous with better".

THIS TYPE OF INNOVATION WILL NEED POSITIVE POLICY SUPPORT.

On the other hand, certain improvement can be observed **with respect to funding from governments and various organisations and institutions to develop partnerships and agreements directed towards patient-centred care.** In Europe as well as in Spain it is now thought that money has been badly spent – that investment has been made ignoring the need to prioritise and allowing partnerships and agreements to be signed as mere formalities when in reality they did not respond to improving public need and which, moreover, incurred high administrative costs, etc.. **At the political level, the conditions of these investments should be revised in line with the sought-for objectives. In some cases, the actual process of establishing agreements and developing projects between different agents has been extremely inflexible and cumbersome.**

"The need to integrate and coordinate health and social services is not expected to lead to an increase in resources. "

Another proposal is to study the effect of progressively **giving more policy power to certain agents, for example, local political bodies and similar agents, that operate at the local level and who could act as guarantors of the employment of resources and the achievement of objectives.** This would make the process of advancement more flexible and reinforce the monitoring of results and the use of resources.

A clear way forward from the policy standpoint concerns **funding. Traditionally, incentives have been based on developing activity rather than on achieving results. Tools must be employed that permit resources to be moved to where they will be most effectively employed and where they will best benefit the needs of patients (providing care and improving their health).** Given that we already have the knowledge to do it, there is no reason for delaying. It is merely a question of will and political determination.

"It will be necessary to develop new plans and at the same time to think about redistribution of resources which will benefit new interventions."

05
Organisational innovation: an under-explored key area

The development of a social and health collaborative arrangement requires **THE EMERGENCE OF NEW ORGANISATIONAL MODELS.**

What models are being explored by others?

Catalonia, for example, is evolving from a models centred on the development of the health area to one known as an *integrated response model* in which education, social work and healthcare sectors, among others, contribute in an integrated fashion to provide answers to chronic illness.

To achieve this they are working on changing the determinants and studying the needs of each person, which assets and resources individuals possess to respond to their needs and which remain to be developed by the administrations and the systems to cover for the difference.

This evolution has created the need to develop the local environment – the micro level. This has meant a progressive integration of services at the local level in order to provide a comprehensive response to individual needs. It has also involved raising political awareness, enabling various partnerships to be formed with the third sector. Moreover, some Autonomous Communities have recently approved the Plan of Health and Social Services Integration on the basis of a shared care model that is transversal and common to all.

The idea is to move towards the constitution of a single planning and resource allocation agency that would permit the redistribution of resources in the hope that a future socio-health model will emerge based on the reorganisation of resources rather than on an increase of resources (given that this latter situation appears improbable).

"It is deemed essential to develop a culture of evaluation with proper pilot projects and scientifically-rigorous indicators that permit an evaluation of impact and results in both the social and health sectors."

In the Basque Country since 2009, the health sector has been promoting an emergent form of planning that gives local providers of care more leeway to re-organise their services and this has helped to increase local partnerships. This approach has also created an enabling environment for greater joint assessment of the socio-health sector by the users and has produced more collaborative models. Following this stage of emergence it was then possible to define **structural processes to analyse pilot projects which, in turn, has accelerated mutual learning across sectors.**

There are many pilot projects in many countries where the experience has not been evaluated in terms of impact and results. There are others cases where the evidence for one reason or another is not available to those for whom such knowledge would be valuable and yet more cases where access to evidence is hindered by dispersion etc.

"The solution will be found in a reorganisation of human resources. Given the climate of scarcity, the rest of the necessary and urgent problems will be solved by organisational and technological innovations."

It is deemed essential to develop an evaluative culture with proper pilot projects and scientifically-rigorous indicators that permit an evaluation of impact and results in both the social and health sectors.

"New tools are needed to articulate a type of funding that permits a more efficient transfer and allocation of resources which are better-suited to the needs of the patient."

06 The role of technology

On one hand, if professionals in the social and health sectors are to work together they must share information on the needs, care and treatment of their users. **The current information system that is increasingly connecting primary care and hospitals should be progressively extended to social services.**

Existing and future technologies have the potential to revolutionize where and how social healthcare is delivered. This revolution has already happened in other sectors. By contrast, **the healthcare sector resists entering the digital age.**
Several Autonomous Regions in Spain have made progress in this direction and their common characteristic has been the existence of a firm commitment from the policy arena to ensure new forms of services that employ new means of capture and transmission of information to professionals in the social and health sectors.

"Spain is one of the European countries with the highest acceptance and use of internet, thus creating new conditions for developing these types of services on a larger scale."

07
Forums of shared learning

All the above-mentioned proposals demand a process of learning, the discovery of new ways of doing things. This is especially important in the health sector where, when the need has arisen to do something new or something more, development has been characterized by obtaining increased resources in terms of professionals, structures, technologies and pharmaceuticals. However, this equation has been broken and we have to learn 'to do more with the same'.

THERE ARE NO PERMANENT "LEARNING FORUMS" IN SPAIN WHERE EXPERIENCES CAN BE EXCHANGED WITH THE IDEA OF ADVANCING MORE RAPIDLY TOWARDS AN OBJECTIVE VIA STRUCTURED LEARNING. WE LACK THESE MODELS OF KNOWLEDGE TRANSMISSION. TODAY MORE THAN EVER WE NEED A DYNAMIC FORM OF LEARNING TO KNOW WHAT PROGRESS IS BEING MADE BY OTHERS.

We need to create forums of expertise - free from political bias - that will help to form opinion and on-going social awareness regarding the necessary commitment to the change and transformation of the social and health spheres. **WE LACK SUFFICIENT ACCESS TO MAINSTREAM MEDIA THAT WOULD ENABLE US TO SHARE WITH THE PUBLIC TECHNICAL AND NON-TECHNICAL REFLECTIONS CONCERNING THEIR OWN INTERESTS IN THE ORGANISATION AND SUPPLY OF SOCIAL AND HEALTH SERVICES.**

Thus, we believe it is necessary to develop a strategy for cooperation between the various actors who will participate in the transformation as well as with the mainstream media and to start creating a protected space for technicians and experts to reflect and debate.

THIS INITIATIVE IS WIDE-REACHING AND WITH REGARD TO CONTINUOUS DEVELOPMENT IMPLIES A PROFOUND CULTURAL SHIFT TOWARDS TRANSPARENCY AND TECHNICAL RIGOR.

On the same theme, those responsible for the ESN (European Network of Social services) are asked how far the European Union is acting as a facilitator in the development of networks that favour the generation of knowledge and learning. The reality today is that some countries are very unaccustomed to networking with other organisations and agents from the same sector, such as NGOs.

Collaborative networks and shared working is producing more and more useful evidence about integration and coordination. Indeed, such evidence has prompted the EU itself to make the allocation of funds conditional on the existence of partnerships and collaboration between agents to facilitate the transfer of knowledge. Furthermore, **it can be observed that much of the evidence generated is being incorporated into new stipulations and regulations within Europe.**

"There are no permanent learning forums in Spain where experiences can be exchanged with the idea of advancing more rapidly towards an objective via structured learning."

Over the last twenty years significant advances have been achieved in the development of the social health space at the micro level. The role of associations and their representatives has played a key part in a highly monitored care model. **However, it remains necessary to design and organise a model of real participation at the system's macro level.** In the planning sphere the problem of competences has proved extremely difficult to solve. Two completely different disciplinary cultures exist - running along parallel lines – that operate at different levels of competence. As a result of this, **in order to advance we probably need a model with greater functional integration where empowerment processes could be developed. Circuits should be introduced which would empower agents at the micro level to be able to function with a certain degree of autonomy.**

If we examine the results in more detail we would discover which organisational models are the most effective in achieving progress in each particular context. **TO THIS END, WE SHOULD INCLUDE MORE IMPACT EVALUATION VS. PROCESS EVALUATION OF THE CHANGES WE INTRODUCE.**

"We lack sufficient access to mainstream media that would enable us to share with the public technical and non-technical reflections concerning their own interests in the organisation and supply of social and health services."

02

02 THE CONTEXT OF THE SEMINAR

Currently, all of the agents involved in the social healthcare area agree that the challenges we will **face in the future are vast and varied** and that, as a consequence, **it will be necessary to modify the status quo and provide solutions that help to address these challenges.**

The excellent evolution of the principal general health indicators (for example, **the increase in life expectancy**) over the last thirty years is undeniable. This reality presents us with a future scenario where the new demographic and epidemiological circumstances **demand new modalities of care and attention from the social and health systems.**

However, we find that **our healthcare systems are fragmented; a fragmentation** that extends **throughout the continuum of the care that is required** in this new context, **including the availability of social and care provision of services.**

This reality has led us to **explore new ways for the various levels of health and social care to function, seeking a greater integration of the provision of care**. At the same time, **there are increasing arguments in favour of the integration of care**, patient participation and the incorporation of technologies in the definition of new models of care. The evidence for these **arguments points in two directions: improving the quality of care and achieving greater economic efficiency.**

All this means that more and more countries, regions and organisations share the vision to **"transform the present complex system of providing health and social services into another, simpler one that is better adapted to the new needs.** We need a system that can be developed by professionals with less specialised profiles, that is better

coordinated and that can be supplied by new services thanks to technological development. And finally, we need a system that is sustainable over time."

This vision has started to take shape in different countries, regions and organisations through the **creation of various types of locally- integrated organisation.** DBS Health (University of Deusto) is tracking these changes throughout Europe and matching them to similar experiences in the USA and Canada in order to learn together.

Such locally integrated organisations are characterised by the provision and management of care along the whole continuum, **ensuring a supply of services close to peoples' homes and communities through enhanced coordination between the health and social professionals,** and by using more complex health structures only when strictly necessary.

"Our healthcare systems are unintegrated; there is a high degree of fragmentation."

In order to progress we must **create forums and initiate shared planning and work methods between the different health levels** which will enable us to discover new models of work and care-giving which improve our response to peoples' current requirements.

These learning mechanisms are not easy to find. We have no trouble identifying areas of knowledge exchange, such as conferences or symposiums, even though, at best, such forums are limited to an annual meeting. We must also acknowledge that there are other types of spaces where political pressure hinders the advance of calm technical work.

So, we must continue to search together for those instruments and management levers in the macro field that will enable us to advance more rapidly in the desired direction. For example, we need new systems of funding and payment in both sectors, new mechanisms for assessment that will permit us to monitor results in specific areas as well as the experiences of integration, etc.

The great majority of agents with even a minimum experience of working in this area are in agreement about which interventions should be developed – or to put it another way – what needs to be done in order to progress.

However, **most of the barriers and problems involved in moving forward can be found under the heading of 'HOW?'**

It is with this in mind **that DBS Health proposes the development of seminars such as the Social Health Alliance which can establish a stable environment for discussion and reflection – free from the pressure of political ideology – where professionals can be invited to share their experiences of performing management functions in this field, and in this way to push forward with the implementation of the changes that are needed in the social health sphere,** providing the public with a guarantee of improved care at a cost that the system can afford.

In summary, with the setting-up of seminars of this nature we plan to address the following:

- **How to implement change** in the social health field that encourages progress towards improving care in the most efficient way and which can deliver it in the closest possible proximity to the patients.
- **To establish a neutral space**, similar to a university environment, free from ideologies, **that encourages reflection and the production of proposals.**
- **To work with people who are currently performing management roles in the Spanish social health field** and who, therefore, have the competences and abilities to carry out these changes.

To achieve these objectives, we organised a seminar to present two experiences of progress being made in the health system that are taken as references in Spain in terms of the consolidated advance they have made in the improvement of socio-health coordination and integration: Northern Ireland and the Basque Country.

"We must transform the present complex system of the provision of social and health services into a simpler one that is better-adapted to new demands."

01
The public sector perspective

01.1.
THE NORTHERN IRELAND EXPERIENCE

We have chosen the experience in Northern Ireland to contextualise the social health situation in Europe because it has a sufficiently large population (1,800,000 inhabitants) and has carried out a shared development in social and health care.

In 2011, the Minister of Health for Northern Ireland appointed a committee with responsibility for developing a social and health care strategy entitled, **"Transforming your care"**.

The intention hidden within this strategy was **to develop a very radical change: to transform the nature and appearance of the provision of services necessary for maintaining the health, welfare and care of every Northern Irish citizen.**

In carrying out this mandate the committee suggested what changes, policies and interventions were needed in the field of socio-health policy to enable a transformation to take place in the provision of social health services.

The main conclusion was that **it was essential to create a wide consensus in favour of the changes.** To achieve this would require making a huge effort to **create a vision of change,** to explain what "Transforming your care" really meant. Today, everyone in Ireland knows about the "Transforming your care" strategy and the necessary impetus has been created for its development.

Crucial to the creation of this vision was the understanding that, from the policy level, it was impossible to control all the proceedings of the strategy that would take place on the periphery of the system, i.e. at the local level. It was **also important that the politicians understood that their role was to generate the necessary connections to move the integration forward. The transformation demanded that the skills of all the interested agents would have to be integrated.**

In addition, it was agreed that **progressing towards integration implied tolerating flexibility and adjusting interventions to the needs of the user's profile**. For example, if you want to integrate services for the elderly it makes sense to talk about the integration of social and health care; if, however, the aim is to improve care for children then you need to talk about social care and educational services; the most important related services in the case of improvements aimed at the disabled will be those of employment and social services. Finally, according to the Irish experience **of moving towards integration, the need to be community-orientated is another factor that must be taken into account.**

"It was recognised that to create a vision of the change it was necessary to build a broad consensus."

Every day at the community level of Northern Ireland there are very many professionals providing various services: more than 28,000 medical visits; 84,000 prescription; 2,800 new dental treatments; 12,000 interventions of professional nurses in homes and residencies; 8,500 interventions by the home –help services; 2,400 interventions by child care services, more than 2,000 calls on the emergency services; 1,200 visits to professionals, etc. A total of €4,000m is spent annually to attend to a population of 1,800,000 inhabitants.

From the expenditure point of view it should be noted that 10% of the population consumes 50% of the resources with the remaining 90% consuming a mere 20%.

Work has been done developing strategy for different levels of intervention: the political level; the conceptualisation level of the strategy; the level of paying for and financing the service requirements and, finally, the level of provision.

The committee worked closely with the professionals but accepted that they should not interfere politically at the local level. They worked hard at the general political level to gain backing because without it the transformation would be extremely difficult to achieve. However, they soon realised that the political objectives were short-term (5 years) and it was therefore necessary to assume this limited context and learn how to work with it.

This led to the need to create bridge between the political level and specific strategy at the local level. Policy has always had a local dimension and it is essential for politicians to know how to communicate with the general public. In this regard, the majority of their time was spent holding meetings to present and explain the project to the various interest groups.

In these meetings they explained the reasons why it was necessary to adopt the changes outlined in the "Transforming your care" strategy: the aging of the Northern Ireland population, the growth of chronic illnesses, the need to have a system that could give an organised response to the new circumstances as well as to the increased demand for home care rather than hospital care, etc. etc.

However, **all change needs to be based on evidence.** It was explained that there were difficulties in covering professional services at week-ends and that there was a need to centralize specialist services. Such situations that occur in our health systems need to be discussed.

Other evidence that the care model could be improved was observed when an analysis was made of the visits of the elderly to their GP (General Practitioner). More knowledge is needed about the behaviour of the elderly and their requirements. This group is more interested in having their needs attended to than in knowing which agent or management level is providing the service. Therefore, it is essential to define the services and their entry points, and that the care pathways address their particular needs.

An increase has been observed in the numbers of elderly patients attending hospitals due to falls or a complication of their health problems. Often the source of the problem is the isolation that patients experience in their environment carrying with it additional problems such as not following medical treatment.

Thus, a necessary step to maintain the momentum towards integration and improve services is to ask users their opinion about services and to analyse the reality. Normally, services

are organised first and questions about their functioning are asked of the users later.

When we talk about the transformation of the care of 1,800,000 people the first thing that must be understood is the actual circumstances of the users. If we listen to **what people are asking for and what they overwhelming use we will clearly concluded that it is community services.**

It was essential for the "Transforming your care" strategy to take note of what the public wanted and put it into practice: that the patient should be placed at the centre of the system. **The centre meant their homes.** In achieving this task great importance was given to **forming alliances with the skills and competences that already existed locally.** This capacity differs from one locality to another, an example of which relates to the integration of local volunteer networks. The first thing they realised was the importance of designing a "portfolio of services or care-giving" that was based on peoples' needs. Sometimes, these services could be enhanced by the help of volunteers, who might, for example, drive people to clubs, community or leisure centres etc, where elderly people could make contact with others. This is made possible in Ireland because there is a deeply-rooted and well-developed culture of voluntary work. However, in some places there is a more powerful network of voluntary workers than in others, which is where attention needs to be reinforced.

Other elements that in their experience facilitate change in **professional leadership and an appropriate use of language** that increasingly talks of welfare rather than illness.

"Transforming your care" is not a perfect experience; it is an on-going transition of implementing a change which is receiving more and more support from the various agents – the public, politicians.....

The most important thing when carrying out such a transformation is the will to maintain the momentum. Change does not happen if no-one fights for it or encourages it; it needs continual backing.

01.2.
THE BASQUE COUNTRY EXPERIENCE

In our own country improvements are being made in the integration and coordination of social healthcare. One such experience is taking place in the Basque region. There are also other similar experiences in other Regions.

In the opinion of the social health coordinator of the Basque Government's Department of Health commitment to advance in the macro field of integration is a necessity. At the care-giving level – the micro level – there is what is known as a 'butterfly effect': small advances that lead to transformation.

First of all a favourable policy narrative for health and social care integration was created via what is known as the Strategy to Manage the Challenge of Chronicity in the Basque region (2009). This strategy implemented a battery of processes which were considered to favour integration. (Risk stratification, ICTs, telecare ..)

At present, there is a two-headed approach in the Basque Country represented by the two coordinators of the social health system: one from the Department of Health and the other from the Department of Social Services. Together they are responsible for **promoting the region's social health strategy.**

Principal characteristics

- To identify the main target groups.
- To integrate emerging models addressing, for example,

accessibility and the consequent need for care to be situated closer to patient's homes.

• To contextualize the strategy within a complex relational system. It is essential that the vision can be understood by planners, clinicians, users, etc.

• The Basque Country's integration strategy has the support of politicians and responsible authorities. It is important that integration is functional, not simply structural (i.e. that it has relational depth).

• Local context: demographic change, increasing dependency care, maintaining the momentum regarding chronic illnesses....

• The strategy proposal is based on values, with an explicit mission and vision of situating the individual at the centre and within a circle of trust afforded by coordination.

• Given the complexity of the environment, it will be necessary to develop various services within the social healthcare system.

• There are 5 strategic lines: one macro level intervention; two intermediate levels; one micro level and a transversal level responsible for carrying out the research and innovation required by the envisioned change.

Strategic line 1: Definition of a portfolio of social healthcare services.

Legal norms at decree level are being sought that would specify the details of the strategy.

Strategic line 2: Introduction of a social healthcare information and communication system.

The aim is to push forward with the idea of relying on health - and other types of useful non-health - information to provide social healthcare services. To achieve this, a closer cultural relationship and a common language between the two spaces (social and health) will be necessary.

This means producing social healthcare case histories by transferring clinical case histories from Osakidetza to the residencies. Additionally, work is being done to create a social healthcare team. In this regard, various relevant experiences have already been tested in different parts of the Basque Country.

To meet this objective it will be necessary to design a strict ethical framework to protect the information generated.

Strategic line 3: Formalising social healthcare partnerships between sectors.

This entails identifying and exploring the many ways of collaboration regarding – amongst others – the flow of funding, protocols, opportunities to produce economies of scale, advances in coordination, etc.

Strategy line 4: Plan of social healthcare development for target groups.

Priority has been given to developing interventions to improve severe mental disorders, dependency and disability with the aim of protecting patients from the risk of social exclusion, and attending to children with special needs. These will take the form of early intervention models or models focusing on groups with rare diseases.

This strategic direction aims to provide a radar system via the use of monitoring indicators to alert us to changes occurring in the community.

Strategic line 5: The promotion of training, research, innovation and knowledge transfer

The constant interaction of different agents enables local solutions to be found for specific problems. We need to encourage this process and facilitate the spread of knowledge. To achieve this we have prioritized the training and use of quantitative and qualitative implementation methodology to collect experiential evidence.

Leadership development is needed as a transforming force. Moreover, although we cannot predict the evolution of such a change, the experience of many tried and tested interventions can provide a useful guide.

"Leadership development is needed as a transforming force".

02 The European context

02.1. THE NEW CONTEXT OF EUROPEAN FINANCING

The experiences described above are part of a new European context in which the institutions are strongly committed to achieving a harmonized development of the social health space.

This commitment is embodied in the definition of the key areas of intervention as well as in the determination of the economic investment which the different member states can choose for setting-up such interventions.

Thus, the European Union, with its investment programme, **Horizon 2020**, has prioritized the following three areas of intervention:

- Excellent in science
- Industry leadership
- Social challenges

The area of social challenges includes the field of "Health, demographic change and welfare" where the task is to address the problems of population aging and the lack of sustainability and inequality of access of the health systems. The aim is to place science at the disposal of the public, support a competitive health system, test new business models and new tools, and to promote active aging.

The budget devoted to health in the EU funding programmes for development and innovation – Horizon 2020 – **is €600m** for 2014, and at this moment those responsible are studying how to meet the funding calls on the issues raised by sundry associates and partners..

Unlike the previous Programme FP7, Horizon 2020 undertakes to carry the whole cost of projects. Furthermore, the European Commission is trying to speeded-up their adjudication of each grant, which should now be made within 8 months of its presentation. The Commission has given itself 5 months to inform participants of the results of their evaluation of the scientific project and then another 3 months for signing the agreement. They intend to fund each project with an amount between €3-6m.

As regards the **Structural Funds in the period 2014-2020, the European Union will invest a total of €336,000m for the whole of the 28 European member states.** Spain will receive the third highest amount of funds, totalling approximately €28,000m.

All the Spanish regions have the possibility to benefit from the Structural Funds 2014-2020. The European Commission has prioritized investment in 11 fields and each region can access these funds with varying conditions of co-finance depending on the level of development in each region and their investment needs in the areas previously prioritized by the European Union:

- Less developed regions: up to a maximum of 85% of the co-financing;
- Transitional regions: up to maximum of 60% of the co-financing;
- More developed regions: up to a maximum of 50% of the co-financing.

The 11 areas prioritized for Structural funds are:

1. Research and Innovation
2. Information and communication technologies (ICT)
3. Competitiveness of small and medium enterprises (SMEs)
4. Low carbon economy
5. Adaptation to climate change
6. Environment
7. Transport
8. Employment and labour mobility
9. Promoting social inclusion and combating poverty and discrimination
10. Education, skills and lifelong learning
11. Improving the institutional capacity and efficiency of public authorities.

In relation to the Structural Funds it should be emphasised that health as such is not specified as a destination for funds. However, the coordination and integration projects and the search for organisational models and technological support that form part of the strategies for the care of chronic illness are areas that fall within the scope of some of the priority issues.

Therefore, if the various Spanish regions wish to include projects relating to social healthcare coordination in their investment objectives and want them to be co-financed by European funds they will need to develop these initiatives within the boundaries of the Structural Funds' operative development programmes that have been prepared for each region.

At this time, each region is developing its own operational programme. Recently, the Regional Policy Commissioner of the European Commission has indicated a desire to finalise the definition of the Structural Funds Programme for 2014-2020 before the forthcoming European elections.

It is clear that the change required in the European social healthcare sector to meet future challenges will come not only via economic investment and a greater allocation of resources but also from an increase in knowledge and its wider dissemination amongst the various agents within the system.

02.2.
THE EUROPEAN SOCIAL SERVICES NETWORK (ESN)

What is the European Social Network?

It is a network of directors of social, health and education services at national, regional and local levels in Europe. It also includes agencies working on public social services research as well as inspection agencies responsible for establishing quality standards in the geriatric field.

It has over 100 members drawn from 33 European countries.

Method of work

It initiated its activities with a workshop or seminar whose objective was to analyse work concerns in a specific area and define the scope of its work. As a result of the seminar, working groups were formed that included politicians and researchers, with the aim of linking policies at a European level. Finally, they presented the results of their studies to the European Pact.

Main areas of activity

ESN forms an active network for **all policies relating to education, community services and mental health.** Another key area of intervention is **active and healthy aging.**

It also addresses the question of why the collaboration of professionals in the social and health sectors is considered necessary.

The response to the question, particularly in the areas of mental health and aging, is that if you want to put the INDIVIDUAL at the centre of the system it is necessary for professionals from different sectors to work collaboratively to address the needs of these people and offer them a better level of coordinated attention:

- Individualized support for the elderly and their families
- Formal and informal cooperation amongst the work force
- Giving a voice to the service users and their families
- ……

In summary, the shared commitment of everyone is needed in the design and planning of such services.

And what does integration mean in this context?

In 2009, ESN carried out a **bibliographic** review with the aim of finding out **what was meant by social healthcare integration.** The main characteristics of their findings were:

- The provision of shared services (organisational, managerial, supply....) with the goal of improving such services (access, quality, efficiency, user satisfaction....).
- Care networks, integrated services and the provision of social and health services by a single organisation.

Two types of final objectives were defined to provide a guide to the integration of social healthcare services:

- On one hand, what was the **economic motivation** behind an integration that looked to improve the use of services by reconciling the increase in the aging population with a reduction in the budget available for such services.
- On the other hand, **to improve results for the users.** Little is known about the processes that would guide this latter objective.

In each analysis of integration experiences factors were discovered that favoured integration and others that highlighted the difficulties. These factors can be categorised in the following way:

- Organisational factors
- Agents and their relationships
- Financial resources
- The political level
- The possibility of speeding-up interventions of proven worth to the integration process

1. Organisational factors:

• Facilitators of the integration process:

All the following are elements that make a positive contribution to the integration processes: development of a shared culture, the exchange of information, the alignment of processes, resource management, leadership development, firm encouragement for professionals to share physical locations, events and activities to promote team-building.

Conversely, the absence of the above or their development in a contrary direction, represent major barriers to the integration process.

For example, in Denmark, the Department of Psychiatry carried out an integration process after it had decided that the care model for all local services should be the same; they also identified the need to develop a culture of collaboration amongst the services.

One of the barriers detected was the reluctance on the part of local services to share data and analysis. The existence of shared data was seen as a facilitating element of integration. At the same time, the need for convergence between the professionals in the two sectors was recognised and that it should be the professionals themselves who would decide who would lead the process.

2. Agents and their relationships

The development of an integration process depends on people. Thus, the following elements are viewed as facilitators: that all agents share the same vision; sufficient time is dedicated to team-building; positive relations between organisations; professional involvement in the development of services; effective communication channels, and a positive predisposition to change.

The contrary of these elements constitute huge barriers to the introduction of an integration process.

3. Financial resources

The financial area itself can be defined either as a facilitator or a barrier for the implementation of an integration process. It is known that the existence of joint objectives that are to be achieved by means of a common budget is a facilitating factor in an integration process. (However, the main reason for the existence of very marked silos between the social and health field is due, precisely, to budgetary differences.)

By contrast, the great disparity in the existing amount of funding between the health and the social sector is a handicap to the integration process. The uncertainty about funding and cuts in future expenditure is another element that needs to be dealt with when seeking social healthcare integration. And, finally, the idea that integration automatically leads to a reduction in costs should be abandoned. In a crisis context, integration is not a priority concern and normally in such circumstances systems revert to a protectionism that obstructs the integration process.

4. The policy level

The review concluded that the involvement of non-profit organisations in the early stages of the social healthcare integration process was a facilitating factor. Non-involvement was observed to have a de-stabilising effect on the organisation of integration. Moreover, it is considered that regulations or management that place greater weight on organisational performance rather than on "care" and "outcome" improvements represents a obstacle to integration.

And what work is being accomplished in the European context to encourage integration processes?

Principally, Europe is developing a **Social Investment Portfolio** with a long-term investment return. Investment is directed **towards three priority areas:**

- Childhood
- Active inclusion of adults, with special emphasis on mental health reducing disability, and access to the work environment
- Healthy aging: focusing on prevention rather than cure

In this regard, the investment portfolio makes recommendations to member states in areas such as:

- Development of integrated policies, encouraged by the use of Structural Funds
- European Platform against poverty and social exclusion
- Promotion of mental health throughout all policies
- European Innovation Partnership on active and healthy aging
- Promotion of shared learning
- Reduction of school drop-out rate
- Positive action for inclusion in the labour market
- Education and child care
- Youth guarantee

The intention of this portfolio of investment and all the EU recommendations pertaining to it is to identify and analyse examples and good practices whose results can be successfully replicated and scalable in other countries.

Are there HEALTH POLICY experiences at the European level that should be studied, analysed and assessed for their replication?

There are different models of social welfare in Europe that we can learn from regarding the interventions that are being considered here. We have identified four of them to describe in this forum:

1. Continental model: France
2. Anglo-Saxon model: England
3. Mediterranean model: Italy
4. Nordic model: Sweden

1. FRANCE

France has a system that is characterized by the fragmentation of its services, with a growing number of people with chronic conditions. In addition, France is facing an enormous challenge in terms of re-organising its health services.

Fragmentation is present at national and local levels as well as at intermediary levels; there is a ministry dedicated to health, pension insurance, health insurance and social services, institutionalized regional and national funding services and local funding of community services as well as non-profit public services.

Until 2010, services were managed by regional organisations and health insurance companies. In 2010, France carried out a reform which established a single regional agency (ARS) that abolished the decentralisation of regional and departmental management, the regional hospital structures that organised public and private services, as well as the regional providers of health services.

So far there is no evaluation of the French situation that enables us to say whether this intervention of 'services fusion' has improved integration.

"Structural funds for the period 2014-2020: €336,000m for the whole of the 28 member states."

2. ENGLAND

In England reform has been carried out by legislation. There are shared budgets. A single organisation acts as the main contractor on behalf of the two agencies – social and health. England is also seeking to integrate its services.

In 2001 the original law for creating TRUSTS (agencies delegated with the responsibility for health) was drawn up. These trusts serve to finance, plan and provide services for people with mental health problems.

In 2012, a new law relating to social healthcare was passed which was controversial because it created a board for contracting services that was independent of the National Health System and which handled the supply of services, patient selection and sought to reduce administrative costs.

An amendment to the law was passed whose aim was to encourage competition among suppliers in order to reduce costs and thus increase integration. However, some have viewed it as an attempt to increase the authority of the Board and blame it for increasing the fragmentation of the system.

Currently, the law has evolved to increase the Board's authority and to promote more joint projects with the private sector.

This intervention has not been evaluated as to whether such a regulatory intervention contributes, or not, to the integration of the social healthcare system.

3. ITALY

Italy has a national health system which is financed by taxes. The State determines the level of care. Local health units and hospitals control the services at the local level.

In 1999, a reform was enacted to promote integration and enable the local health units to be incorporated into the municipalities. Integration exists in terms of management and professional employment.

In 2003, a study was conducted that demonstrated that since the reform hospital stays and the number of hospital beds have decreased.

However, it was found that the development of community services at the local level was very uneven.

4. SWEDEN

Sweden has a national health system that is funded from various sources.

The organisation is divided into three levels: national, regional and local. Sweden has 21 counties and 300 municipalities.

Over the last few years initiatives have been taken to achieve social healthcare integration. Specifically, Sweden has transferred the responsibility for the elderly, the disabled and those with long-term illness to municipalities.

At the local level, the municipalities have developed alternative care pathways. Since 2005, specific pathways

have been developed according to patients' conditions. These have been introduced with the aim of facilitating collaboration between professional health care workers and social care workers; the pathways cover the whole of local health and social care.

This social healthcare integration has favoured collaboration between professionals and community development in terms of addressing the needs of each individual. It has also increased cost effectiveness and a reduction in hospital beds.

There is no single care model.

And is it possible to identify SPECIFIC INTERVENTIONS in the European context that can be analysed and evaluated to assess their ability to be replicated in other contexts?

The following briefly describes some specific interventions that have been successful in integrating social healthcare. We will describe one intervention carried out in each of the countries whose overall policy has been mentioned above.

1. FRANCE

- **MAIA**: Integrated care for Alzheimer patients

Between 2008 and 2012 a plan was developed to introduce 'case management' for this group of patients. Its aim was to promote the coordination amongst professionals, with a single point of entry, multidimensional assessment and the development of a shared information system. It addressed the provision of personalised services with a central focus on home-care.

2. ENGLAND

- **TORBAY**: Integrated care for the elderly

This English intervention addressed the integration of health and social teams with shared budgets that supplied home-based services to the elderly with the aim of avoiding hospital admissions. The population consisted of 25,000-40,000 inhabitants. Teams were coordinated to facilitate the various social health home-care services required by people.

In 2012, an evaluation of this intervention showed a reduction in emergency room visits and a reduction in hospital admissions amongst the target population. It also demonstrated a reduced use of residential services and a consequent increase in home-care services.

3. ITALY

- **VENETO**: Integrated care for mental health problems

In Veneto the health sector has regional authority and the social sector has local authority. A decision was taken to introduce a department for mental health in each local authority. This department is responsible for responding to all social healthcare needs. To achieve this, professionals work together in integrated teams which include psychologists, social workers, etc. The intervention has had a varying degree of success depending on which specific local area is studied.

4.SWEDEN

- **NORTALIJE**: Integrated social & healthcare

An organisation was created to administer shared budgets for the social and health sectors. It has responsibility for planning, financing and organising care for three different age groups: 0- 18 years, 19-64 years and the over 65s.

In 2010, an evaluation was conducted into the performance of this organisation which found that the cultural predisposition in favour of such a change was a key factor to its success. It also demonstrated that work cultures represented a barrier according to their greater or lesser disposition to the change and also that there were few incentives for developing coordinated care.

What are the main conclusions to be drawn from this?

1. **There is growing evidence of the benefits of the integration and coordination of health and social services at the local level, particularly with respect to:**

- Children and young people with complex needs
- People with mental health problems
- People with chronic illnesses
- The elderly

2. **There are still few examples of large-scale structural integration in Europe.**

3. In order to **replicate and access the scalability** of the experiences analysed it is **essential to evaluate:**

- The **local development context** of each intervention;
- **Willingness to change existing conditions;**
- The **individual and organisational relationships** in each environment;

4. **Different care structures currently co-exist in Europe;**

5. **The greater the scope of the intervention, the greater probability there is for success.**

As a general conclusion we would **highlight the convincing evidence that has been generated by all these experiences.** It seems that every country wants to bring about change using a r**easoned analysis of results** and **the generation of evidence as a method of advance.**

In this sense, The European Union is participating in this reasoned method of work and is encouraging the accumulation of evidence from more and more initiatives in order to produce a sufficient volume to provoke the necessary radical structural changes. This support is not simply theoretical but is backed by a significant economic budget to ensure its viability.

Given these circumstances, if we analyse the situation in Spain we should conclude that, judging by the type of activities carried out jointly by the social and health systems – or rather the omission of these types of interventions -, the results that we obtained would come as no surprise: room for great improvement and a long road to travel to achieve it.

Finally, and with respect to the **difficulties of scalability** of interventions: it is unclear whether the lack of replication is caused by the definition, planning and development of **very localised interventions** whose posterior scalability is made more difficult in terms of costs and results; or whether, on the contrary, it is caused by the fact that when evaluating different interventions insufficient notice is taken of the generation of knowledge which would allow an assessment of the capacity to successfully replicate the same intervention **in a very different context.**

"The change required in the social healthcare sector in Europe to meet future challenges will not only come via economic investment and greater resource allocation but also from an increase in knowledge and the speed at which it is disseminated and multiplied among the different agents throughout the system."

03

The private sector perspective and public/private partnerships

Given the progress that has occurred in Europe with the prioritising of the social healthcare sector and the clear signals from the EU regarding the amount of financial resources that will be invested over the coming years, more and more health workers (public and private) are interested in aligning their local health strategies with other partners who have experience of new advances.

To achieve real change and transformation it has become increasingly important to initiate different experiences that can be evaluated and replicated in other contexts; to do this a critical mass must be reached in order to make such interventions viable.

"The high income countries that are undergoing a transformation are committed to realising this change via a reasoned analysis of the results and the generation of evidence."

Many agents in Europe are increasing the pressure for more coordination and integration projects in social healthcare. The ideas and resources already exist. **It will be necessary to discover what new models of collaboration and financing have to be introduced to carry out the interventions demanded by our social healthcare environments.**

And why are more and more private health services companies deciding to increase their investment in the health sector? The reason is because they are aware of the challenges facing health systems today in providing care for an aging population and a growing number of patients with chronic disease. The direct costs of care in Europe for chronic conditions such as diabetes and heart disease are unaffordable in the long-term unless new models of care are discovered.

This requires investment in innovative technology; but on its own this is not enough. **It will take the united energy of all the stakeholders to discover new organisational models that incorporate the new technologies for improving the care model at an affordable cost.** The commitment to this demands a very profound change in the present care model which must come from all the agents involved: patients, social healthcare professionals, policy makers, universities, R&D centres, industry, etc.

For example, **Philips** is a company that has a **mission, "to improve people's health"**. A proposal has been made to improve the lives of three billion people by 2025.

This objective will **involve three sectors:** healthcare, lighting, consumerism, and lifestyle. In concrete terms, the fulfilment of this goal in the health sector will be accomplished by reinforcing innovations that place the patient at the centre of the care process.

Some of the strategies that are being employed to achieve this are:

- Seeking the highest quality health system at the lowest possible cost;
- Helping people to live healthy, active lives and the elderly to maintain their independence;
- Developing health-related innovations at home: 15% of health expenditure is concentrated in home-care.

Thus, Philips has prioritised five areas to reinforce innovation:

- Hospital to Home
- Image-guided Intervention and Therapy
- Clinical Information Technology
- Value segment
- Consulting Services

Philips undertook to increase their investment in these areas from €679m in 2009 to €803m in 2012 in order to develop their strategy "Transforming health together".

This signifies that more and more private companies who traditionally focused their activity in investing in and developing technologies are currently participating in innovative European projects. These projects are aimed at advancing the search for new care processes and organisational models that will be able to incorporate their technologies and thus provide better and more affordable services.

In 2009, as part of its 2020 strategy, the European Union launched an initiative for innovative collaboration: **"European Innovation Partnership on Active Healthy Aging."**

The ultimate goal of this initiative was to prolong life expectancy by two years by 2020.

"It will be necessary to discover new models of collaboration and funding."

The development of a direct collaborative initiative between regional and local communities was proposed to attain this goal. The initiative aims to speed-up innovation via the sharing of experiences and resources that can be evaluated and subsequently elevated to the policy level, generating scalability and thus helping to accelerate the transformation process demanded by the European social healthcare sector.

This EU initiative found a private sector ally in Philips whose mission includes a commitment to push beyond the development of pilot projects and put large-scale projects into action that will improve access to innovative healthcare solutions for the greatest number of people.

'Integrated care' was designated as a specific area of work within the European collaboration initiative with the objective of reducing the number of hospital admissions of elderly patients with chronic illnesses, thus, helping to improve the efficiency of health systems.

This specific group is now working collaboratively to develop and test more pro-active and integrated healthcare models.

One of their concrete targets for 2015 is to put into operation programmes to manage patients with chronic illness in more than 50 European regions, covering 10% of the population. Once they have tested the results of these development projects with the integrated care groups, the task they have set for 2015-2020 is to replicate the projects in over 20 European regions in 15 member states.

Currently, in Europe, Philips is coordinating the **"Advancing Care Coordination & Tele-health"** project which seeks to identify best practices of coordinated organisation processes that support the integration and introduction of tele-health solutions for patients suffering from chronic disease.

Five regions in four European countries are participating in the project which involves healthcare experts and professionals and almost 3,000 patients. In Spain, the participating authorities are the Basque Country, Catalonia, Valencia and Galicia. The estimated time for the project is 36 months (2013-2015) and it has a budget of €1.8m.

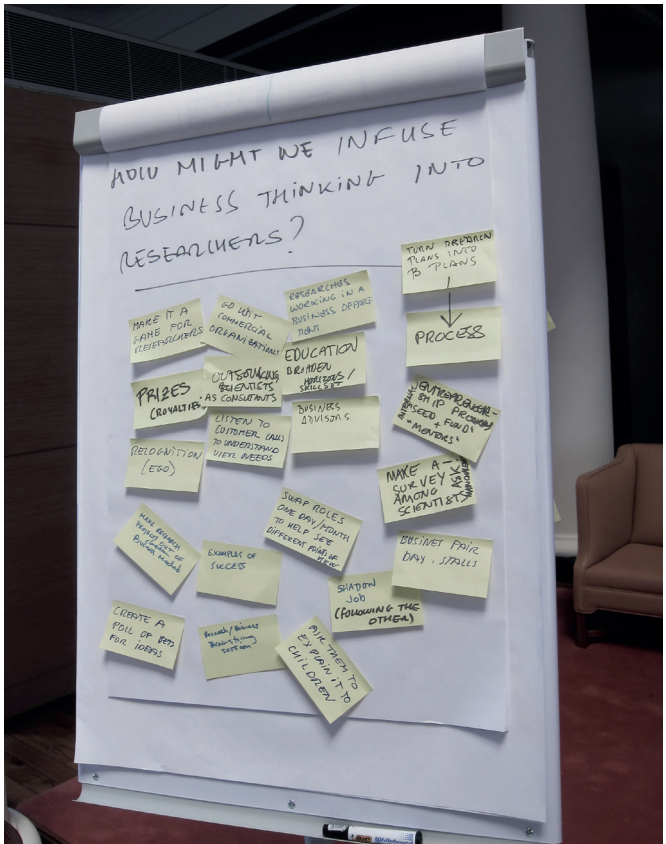
Additionally, Philips has participated in two other European projects of similar scope:

- **MyHeart:** Focused on sensors; 30 European partners; budget €30m, duration 72 months; (2004-2010)
- **HeartCycle:** Focused on the use of sensors to maintain the stability of patients outside of hospitals; 21 European partners; budget €22m; duration 48 months (2008-2012).

It can be seen, therefore, that the private sector has at its disposal innovative technology, knowledge and the experience of participating in diverse projects and is well-qualified to be considered as a collaborative partner with the rest of the social healthcare agents who are involved in transforming the sector.

Consequently, **it is seen as essential to move forward with public/private partnerships to develop new initiatives that will allow us to reorganise the current healthcare sector in the shortest possible time and to reduce its present fragmentation. We need to offer the optimum care from the point of view of users and their needs; moreover, thanks to the development of technology, these services can be provided in a sustainable and timely manner.**

"It will take the united energy of all of the stakeholders to discover new organisational models that incorporate new technologies for improving the care model at an affordable cost."



04
The methodology of the workshop

During the seminar **three workshops were formed with a maximum of ten participants in each.**

Each group discussed the following key issues:

1. How to create conditions at the policy level to facilitate more rapid progress towards the integration and coordination of healthcare. How to make the quickest advance from the policy level to implementation of integrated and coordinated healthcare.

2. How to create a more participatory culture amongst the public. How to give a voice to people regarding the development of these services.

Each group was supported by a DBS- Health member acting as a **facilitator**. This person was responsible for **encouraging and moderating** each workshop and **ensuring that the two designated areas were covered in the available time**. They were also responsible for **summarising the conclusions and presenting them to all the participants at the plenary session**.

03

General evaluation of the seminar

03 GENERAL EVALUATION OF THE SEMINAR

At the end of the seminar participants were asked to give An overall assessment of the day. The main comments were as follows:

- The tone of the presentations received a positive rating. No interest was shown in demonstrating how good any particular experience was but rather in sharing learning and building bridges for joint work.

- The above created a favourable climate for exchange and critical reflection: a climate of openness and calm.

- The format of the seminar was propitious for listening and learning about the integration and coordination of social healthcare.

  - Concrete experiences of coordination and integration of social healthcare were shared. Furthermore, global perspectives of the European context were discussed.

  - They reviewed experiences that sought similar ends but via different means; for example, Northern Ireland's approach highlighted the ability to combine political support and leadership with the development of local services, how can bring healthcare policy be brought to the local level and how can the process be made more dynamic.

- Participants were able to share different realities in a flexible format such that representatives of organisations operating in more global spaces were given the

opportunity to hear about different realities in specific locations, different terminologies, different routes being developed to bring about change in the health environment, etc. Learning diversity was valued very positively.

• On the other hand, participants from more specialised levels of provision valued the chance to learn about the different strategies being developed at the macro level, especially in Europe. They also positively rated the opportunity to identify other agents – in this case industry, represented by Philips – as potential allies for undertaking new initiatives and collaborative projects.

• Participants greatly appreciated the giant step forward gained by sharing experiences and a space for reflection with different agents working in the various fields of healthcare development: public administration, service suppliers, industry, NGOs, etc.

• The development of a space to put the individual at the centre was welcomed, as was the shared discussion about what this meant. There was a broad consensus among the participants regarding today's necessity to change the current care model and evolve towards a different one centred on people's real needs.

According to Chris Stewart, Director of Health Modernisation at the Department of Health, Social Services and Public Safety in Northern Ireland, the previous Northern Ireland plan failed for two basic reasons: **lack of political leadership and lack of dialogue with the public.**

He believed that technologies are the key for helping people to connect. However, he considered that for the public to assume and understand much of the information provided by technology there has to be a friendly face to explain it: a need for an organisational model that was human. **In his view, Spain is moving in the right direction for developing care that is orientated towards the individual; the proof of this is that previously his references for sharing successful experiences came from England and Scotland. He now has increasing contact about shared experiences with Spanish regions from which he has learnt, and he greatly appreciated the opportunity afforded by the seminar to continue to do so.**

Finally, it was proposed that **this forum should be constituted into a space for the transfer of social healthcare knowledge as well as a reference for learning about European policies and the accessibility to their funds.**

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