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Ricardo Jorge Correia de Matos

Integration of the Social and Health
Sectors: a Comparative analysis of European models

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comparative analysis of European models

Ricardo Jorge Correia de Matos

Doutoramento em Políticas Públicas

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dezembro, 2025



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“People do not experience care in fragments. Systems do.”

— Adapted from Don Berwick

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Declaration

I declare that this work is entirely my own work, with duly referenced sources and consulted works, as well as clearly identified citations from those works. Therefore, it does not contain any type of plagiarism, whether from published texts, regardless of the medium of publication, including electronic media, or from academic works.

ABSTRACT

Health and social care systems across Europe are under increasing pressure due to population ageing, multimorbidity and widening social inequalities, exposing the limitations of fragmented, silo-based services. In this context, the integration between health and social care has emerged as a strategic priority in public policy, aimed at improving continuity and coordination of care, strengthening person-centred approaches and enhancing system efficiency. This thesis examines how health–social care integration has been conceptualised and implemented internationally, analyses its practical development in Scotland — one of Europe’s most advanced reform contexts — and identifies governance priorities for Portugal.

Drawing on two book chapters and six interrelated scientific articles, the thesis develops a cumulative, multi-method contribution combining narrative and umbrella reviews, comparative policy analysis, an in-depth case study of Scotland and a national Delphi consensus exercise. International evidence identifies recurrent facilitators of integration, including joint governance structures, aligned or pooled budgets, strong primary and community-based care, interoperable digital systems and community-oriented approaches, alongside persistent barriers such as institutional fragmentation and workforce constraints.

The Scottish case demonstrates measurable progress in reducing delayed hospital discharges and strengthening community-based care, while simultaneously revealing the limits of large-scale structural integration, particularly in relation to reducing hospital admissions. In Portugal, the Delphi consensus identified fragmented governance, separated budgets and limited interoperability of information systems as central obstacles, converging on the need for a national integration strategy, interministerial governance mechanisms, shared funding models and sustained investment in digital infrastructure and workforce development.

Overall, the thesis frames health and social care integration as a long-term governance challenge that requires sustained alignment of responsibilities, resources, information flows and accountability mechanisms across sectors.

Key-words: Social Health Care Integration, Integrated Delivery of Health Care, Social Welfare, Health Policy, Government Financing, Primary Health Care

RESUMO

Os sistemas de saúde e de apoio social na Europa enfrentam uma pressão crescente decorrente do envelhecimento demográfico, da multimorbilidade e do agravamento das desigualdades sociais, expondo as limitações de serviços fragmentados e organizados em silos setoriais. Neste contexto, a integração entre os setores da saúde e do social emergiu como uma prioridade estratégica das políticas públicas, orientada para a melhoria da continuidade e coordenação dos cuidados, o reforço da centralidade na pessoa e o aumento da eficiência dos sistemas. Esta tese analisa a forma como a integração saúde–social tem sido conceptualizada e implementada a nível internacional, examina o seu desenvolvimento prático na Escócia — um dos contextos de reforma mais avançados da Europa — e identifica prioridades de governação para o contexto português.

Através de dois capítulos de livro e seis artigos científicos interligados, a tese desenvolve uma contribuição cumulativa e multimétodo, combinando revisões narrativa e umbrella, análise comparativa de políticas, um estudo de caso aprofundado da Escócia e um exercício de consenso Delphi a nível nacional. A evidência internacional identifica facilitadores recorrentes da integração, incluindo estruturas de governação conjunta, orçamentos alinhados ou partilhados, cuidados de saúde primários e comunitários robustos, sistemas digitais interoperáveis e abordagens centradas na comunidade, bem como barreiras persistentes, como a fragmentação institucional e as restrições na força de trabalho.

O caso escocês evidencia progressos mensuráveis na redução dos atrasos na alta hospitalar e no reforço dos cuidados de base comunitária, revelando simultaneamente os limites da integração estrutural em larga escala, particularmente no que respeita à redução das admissões hospitalares. Em Portugal, o consenso Delphi identificou a governação fragmentada, a separação dos orçamentos e a falta de interoperabilidade dos sistemas de informação como obstáculos centrais, convergindo na necessidade de uma estratégia nacional de integração, de mecanismos de governação interministerial, de modelos de financiamento partilhados e de investimento sustentado em infraestruturas digitais e no desenvolvimento da força de trabalho.

De forma global, a tese enquadra a integração entre a saúde e o setor social como um desafio de governação de longo prazo, que exige o alinhamento sustentado de responsabilidades, recursos, fluxos de informação e mecanismos de responsabilização entre setores.

Palavras-chave: Integração Saúde–Social; Prestação Integrada de Cuidados de Saúde; Apoio Social; Política de Saúde; Financiamento Governamental; Cuidados de Saúde Primários.

LONGER ABSTRACT

Health and social care systems across Europe are under increasing pressure from demographic ageing, rising multimorbidity and widening social inequalities. These dynamics have exposed the limitations of fragmented service delivery models organised around sectoral silos rather than the complex, interdependent needs of individuals and communities. In response, the integration of health and social care has become a central priority of public policy, with the aim of improving continuity and coordination of care, strengthening person-centred approaches and enhancing system efficiency.

This thesis examines how health–social care integration has been conceptualised and implemented at the international level, how these processes unfold in practice in one of Europe’s most mature reform contexts — Scotland — and which governance priorities emerge as essential to advance integration in Portugal, where reform remains at a more embryonic stage. The work adopts a cumulative and multi-method approach, bringing together two book chapters and six interconnected scientific papers that combine narrative and umbrella reviews, comparative policy analysis, an in-depth country case study and a national Delphi consensus exercise.

The international component of the thesis establishes the analytical foundations for understanding integration across health and social care systems. A narrative review maps the main national models of integration, highlighting how governance arrangements, financing mechanisms and organisational designs shape integration trajectories across countries. Complementing this, an umbrella review synthesises evidence from systematic reviews, identifying consistent benefits associated with integration — particularly in terms of continuity of care, user satisfaction and reductions in avoidable hospital utilisation — while also underlining the substantial heterogeneity and methodological limitations of the existing evidence base. A comparative analysis of international implementation experiences further identifies recurrent enabling factors, including joint governance structures, aligned or pooled budgets, strong primary and community care, digital interoperability and community-centred approaches, alongside persistent obstacles such as institutional fragmentation, workforce shortages and challenges in sustaining reforms beyond initial pilot phases.

Building on this international perspective, the thesis then focuses on Scotland as a mature case of large-scale integration of health and social care. Two published manuscripts examine the Scottish reform from complementary angles. The first analyses the Public Bodies (Joint Working) (Scotland) Act 2014 through the lenses of public choice theory, institutionalism and functionalism, illustrating how political dynamics, institutional legacies and functional pressures shaped the reform’s design, ambitions and trade-offs. The second assesses the first five years of implementation, documenting

measurable progress in selected indicators — notably reductions in delayed discharges and shifts towards community-based care — while showing that other expectations, particularly substantial reductions in hospital admissions, were only partially achieved. Together, these analyses illustrate both the potential and the inherent limits of large-scale structural integration, even within a favourable policy environment characterised by strong national commitment.

The final empirical component of the thesis turns to Portugal and addresses the transposition of integration principles into national public policy. A national Delphi consensus exercise identifies governance priorities for advancing health–social integration, highlighting expected benefits such as improved autonomy, reduced avoidable hospitalisations and more efficient use of resources. At the same time, experts converge on key structural barriers, including fragmented governance, separated budgets and non-interoperable information systems. The resulting strategic roadmap emphasises the need for a national integration strategy, interministerial governance mechanisms, shared financing models and sustained investment in digital infrastructure and workforce development. A complementary book chapter critically analyses current public policies in Portugal and proposes guidelines for reorganising care around people living with chronic conditions.

Taken together, the publications included in this thesis advance the understanding of health–social care integration as a long-term governance challenge rather than a purely organisational or technical reform. The work highlights the need for sustained alignment of responsibilities, resources, information flows and accountability mechanisms across sectors and levels of the system. By linking international evidence, a mature reform experience and context-specific governance priorities, the thesis offers a coherent analytical framework and a robust foundation for the development of integrated, person-centred and sustainable health and social care systems in Portugal and in other European countries facing similar demographic and organisational challenges.

RESUMO ALARGADO

Os sistemas de saúde e de apoio social em toda a Europa encontram-se sob uma pressão crescente decorrente do envelhecimento demográfico, do aumento da multimorbilidade e do alargamento das desigualdades sociais. Estas dinâmicas têm exposto as limitações dos modelos de prestação de cuidados fragmentados, organizados em silos setoriais, em detrimento das necessidades complexas e interdependentes das pessoas e das comunidades. Em resposta, a integração entre a saúde e o setor social tornou-se uma prioridade central das políticas públicas, com o objetivo de melhorar a continuidade e a coordenação dos cuidados, reforçar abordagens centradas na pessoa e aumentar a eficiência dos sistemas.

Esta tese analisa a forma como a integração entre a saúde e o setor social tem sido conceptualizada e implementada a nível internacional, como estes processos se concretizam na prática num dos contextos de reforma mais maduros da Europa — a Escócia — e quais as prioridades de governação que emergem como essenciais para avançar a integração em Portugal, onde a reforma se encontra ainda numa fase mais embrionária. O trabalho adota uma abordagem cumulativa e multimétodo, reunindo dois capítulos de livro e seis artigos científicos interligados, que combinam revisões narrativa e *umbrella*, análise com-parativa de políticas, um estudo de caso aprofundado a nível nacional e um exercício de consenso Delphi.

A componente internacional da tese estabelece as bases analíticas para compreender a integração entre os sistemas de saúde e de apoio social. Uma revisão narrativa mapeia os principais modelos nacionais de integração, evidenciando como os arranjos de governação, os mecanismos de financiamento e os desenhos organizacionais moldam as trajetórias de integração em diferentes países. Complementarmente, uma revisão *umbrella* sintetiza a evidência proveniente de revisões sistemáticas, identificando benefícios consistentes associados à integração — em particular no que respeita à continuidade dos cuidados, à satisfação dos utilizadores e à redução de utilizações hospitalares evitáveis —, enquanto sublinha a elevada heterogeneidade e as limitações metodológicas da base de evidência existente. Uma análise comparativa de experiências internacionais de implementação identifica ainda facilitadores recorrentes da integração, incluindo estruturas de governação conjunta, orçamentos alinhados ou partilhados, cuidados de saúde primários e comunitários robustos, interoperabilidade digital e abordagens centradas na comunidade, bem como obstáculos persistentes, como a fragmentação institucional, a escassez de profissionais e as dificuldades em sustentar reformas para além das fases iniciais de projetos-piloto.

Com base nesta perspetiva internacional, a tese centra-se, depois, na Escócia enquanto caso maduro de integração em larga escala entre a saúde e o setor social. Dois manuscritos publicados

analisam a reforma escocesa sob perspetivas complementares. O primeiro interpreta o Public Bodies (Joint Working) (Scotland) Act 2014 à luz das teorias da escolha pública, do institucionalismo e do funcionalismo, ilustrando de que forma as dinâmicas políticas, os legados institucionais e as pressões funcionais moldaram o desenho, as ambições e os compromissos da reforma. O segundo avalia os primeiros cinco anos de implementação, documentando progressos mensuráveis em alguns indicadores — nomeadamente a redução dos atrasos na alta hospitalar e o reforço dos cuidados de base comunitária —, enquanto evidencia que outras expectativas, em particular as reduções significativas das admissões hospitalares, foram apenas parcialmente alcançadas. Em conjunto, estas análises ilustram o potencial e os limites inerentes à integração estrutural em larga escala, mesmo num contexto político favorável, caracterizado por um forte compromisso nacional.

A componente empírica final da tese centra-se em Portugal e aborda a transposição dos princípios da integração para as políticas públicas nacionais. Um exercício de consenso Delphi a nível nacional identifica prioridades de governação para o avanço da integração saúde–social, destacando benefícios esperados, como o reforço da autonomia, a redução de hospitalizações evitáveis e a utilização mais eficiente dos recursos. Em paralelo, os especialistas convergem na identificação de barreiras estruturais fundamentais, incluindo a governação fragmentada, a separação de orçamentos e a falta de interoperabilidade entre os sistemas de informação. O roteiro estratégico resultante enfatiza a necessidade de uma estratégia nacional de integração, de mecanismos de governação interministerial, de modelos de financiamento partilhados e sustentados por infraestruturas digitais e pelo desenvolvimento da força de trabalho. Um capítulo de livro complementar procede a uma análise crítica das políticas públicas atuais em Portugal e propõe orientações para a reorganização dos cuidados centrada nas pessoas que vivem com doença crónica.

No conjunto, as publicações incluídas nesta tese aprofundam a compreensão da integração entre a saúde e o setor social como um desafio de governação de longo prazo, e não apenas como uma reforma organizacional ou técnica. O trabalho evidencia a necessidade de um alinhamento sustentado de responsabilidades, recursos, fluxos de informação e mecanismos de responsabilização entre os setores e os níveis do sistema. Ao articular evidências internacionais, a experiência de uma reforma madura e prioridades de governação específicas do contexto nacional, a tese oferece um quadro analítico coerente e uma base robusta para o desenvolvimento de sistemas de saúde e de apoio social integrados, centrados na pessoa e sustentáveis, em Portugal e em outros países europeus que enfrentam desafios demográficos e organizacionais semelhantes.

THESIS OUTLINE

This thesis is presented as a PhD by publications and is formally organised into six sections and eight chapters, bringing together two book chapters (written in Portuguese) and six scientific manuscripts developed during the doctoral programme. Most manuscripts have been published in international peer-reviewed journals or are at advanced stages of revision. Rather than repeating the table of contents, the outline below presents the original part of the thesis through three analytical axes that structure its cumulative argument: (i) international perspectives on health–social care integration; (ii) Scotland as a mature reform case; and (iii) the Portuguese context as an emergent case requiring governance-oriented solutions.

Axis I – International perspectives situate the thesis within the broader international debate on health and social care integration and build its conceptual and empirical foundations. It brings together three published manuscripts: “Integrated care: an insight into the national models and their impact on patients and health systems – a narrative review”, which maps national integration models and links them to governance arrangements, financing mechanisms and organisational designs; “Implementation and impact of integrated health and social care services: an umbrella review”, which synthesises the evidence base and identifies consistent benefits alongside key methodological limitations; and “Health and Social Care Integration: Insights from International Implementation Cases”, which examines concrete implementation experiences across countries, highlighting recurrent enablers (e.g., joint governance, aligned or pooled budgets, interoperable digital infrastructure and community-based care) and persistent constraints (e.g., fragmented accountability, workforce challenges and financial sustainability). Together, these studies clarify why integration has become a policy priority internationally and where the most relevant gaps in knowledge and practice remain.

Axis II – Scotland as a mature integration model provides an in-depth exploration of one of Europe’s most advanced and institutionally structured integration reforms, as identified in the thesis project proposal and thereafter confirmed with the results of our systematic reviews. Scotland was selected because it offers a relatively mature reform trajectory within a tax-funded National Health Service comparable to Portugal’s, and because it addresses similar challenges of fragmentation between health and social sectors. This axis includes two published manuscripts: “The Integration of Social and Health Sectors in Scotland: An Analysis from the Prism of Different Public Policy Models” interprets the Scottish reform through public policy lenses (public choice, institutionalism and functionalism), focusing on the drivers, constraints and trade-offs shaping the reform; “Integration of the Social and Health Sectors in Scotland: Assessment of the First 5 Years (2014–2018)” assesses early implementation outcomes using official data and audit reports, documenting measurable progress in

some areas (notably delayed discharges and shifts towards community-based care), while also showing that other expectations, particularly substantial reductions in hospital admissions, were only partially achieved. Taken together, these manuscripts illustrate both the potential and the limits of large-scale structural integration, even under favourable political and institutional conditions.

Axis III – Health–social care integration in Portugal turns to the Portuguese context, where integration remains at an earlier and more fragmented stage. It is anchored in the manuscript “Health–Social sector’s Integration in Portugal: A Delphi consensus on benefits, barriers and strategic priorities for governance”, which pooled consensus from reputed experts in health, social care, academia, and public administration. The analysis converges on expected gains (e.g., improved continuity and coordination of care, reduced avoidable hospitalisations, better support for ageing populations and more efficient resource use), while highlighting enduring obstacles such as fragmented governance, separated budgets and non-interoperable information systems. It further translates these findings into a context-specific roadmap, centred on a national integration strategy, interministerial governance mechanisms, shared financing models and sustained investment in digital infrastructure and workforce development. This axis is complemented by a book chapter proposing guidelines for reorganising person-centred care for people living with chronic conditions in Portugal, reinforcing the thesis’s focus on governance, stewardship and system alignment.

Across these three analytical axes, the thesis progresses from a synthesis of international evidence to the analysis of a mature reform experience and finally to the formulation of context-adapted governance priorities for an emergent system. In doing so, it advances a central argument: health–social care integration should be understood as a long-term governance challenge requiring sustained alignment of responsibilities, resources, information flows and accountability across sectors and levels of the system.

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Section I

GENERAL INTRODUCTION

General Introduction

Health and social protection systems across Europe are facing structural challenges that cannot be effectively addressed in isolation. Before engaging in detailed policy analysis, it is essential to provide a historical and conceptual framing of health–social care integration, making explicit the demographic, epidemiological and social transformations that underpin it. This general introduction aims to contextualise the research problem, highlighting how different European countries have structured their responses and what distinguishes the Portuguese case, without duplicating the detailed analyses developed in the subsequent chapters.

Over recent decades, health and social needs have undergone a profound transformation. Population ageing, increased life expectancy and the growing prevalence of multimorbidity have significantly expanded the demand for continuing and long-term care (Eurostat, 2020). These trends have shifted the nature of care needs, which increasingly extend beyond clinical provision to encompass social support, housing, mobility, employment and overall well-being (Mercer et al., 2012). Responding effectively to such complexity requires coordinated action across sectors that have traditionally operated separately.

Fragmentation between health and social care systems has well-documented practical consequences, including service duplication, barriers to continuity of care and inefficiencies in resource allocation (Mur-Veeman et al., 2003). International evidence consistently shows that the negative effects of fragmentation are most acutely experienced by vulnerable populations, such as dependent older people, persons with disabilities or mental illness, and families facing social exclusion. These groups are often required to navigate parallel systems that lack effective communication and coordination, exacerbating inequities and undermining care quality (Heenan & Birrell, 2017).

In this context, health and social care integration has emerged as a central pillar of public policy reform. Early conceptualisations defined integration as a set of methods and organisational arrangements designed to promote connectivity, alignment and collaboration across sectors in order to improve the quality and efficiency of care (Kodner & Spreeuwenberg, 2002). Since then, European countries have experimented with a wide range of integration models, including vertical integration across levels of care, horizontal integration between health and social support, and functional, clinical, normative and service-level approaches (WHO, 2006). While these models differ in design and scope, they share a common objective: to overcome fragmentation and better align services with people's needs.

The Portuguese context presents a distinctive configuration. On the one hand, Portugal has a universal, tax-funded National Health Service (Serviço Nacional de Saúde, SNS), historically centred

on hospital care. On the other hand, it has a social sector with strong territorial roots, composed largely of Private Institutions of Social Solidarity (IPSS), Misericórdias and other non-profit organisations that deliver community-based services. Although important integration initiatives have been developed — notably the National Network for Integrated Continuous Care (Rede Nacional de Cuidados Continuados Integrados, RNCCI), established in 2006, and the Local Health Units (Unidades Locais de Saúde, ULS), created in 2008 and reinforced by the Statute of the NHS (Decree-Law no. 52/2022) — coordination between health and social sectors remains constrained by structural barriers. These include ministerial fragmentation, asymmetries in funding arrangements, limited digital interoperability and the absence of shared contracting and accountability mechanisms (Glasby, 2010; República Portuguesa, 2022).

Despite the existence of the RNCCI for almost two decades, avoidable hospital admissions continue to occur due to insufficient social responses, particularly in situations of dependency and chronic illness (Ministério da Saúde, 2021). The lack of interoperable information systems between health and social security further reinforces discontinuities in care, forcing citizens and families to engage with parallel bureaucratic processes that do not communicate effectively. In a context of fiscal constraint and increasing pressure on both the SNS and social protection systems, integration is therefore not only a response to lived experiences but also a potential lever to improve efficiency and equity. Evidence suggests that financial and budgetary integration can reduce duplication, support more rational resource use and strengthen preventive and chronic care strategies, although impacts on overall costs remain context-dependent (Mason et al., 2015; McGuire et al., 2019).

Historically, Portugal has lacked a consistent national strategy for interministerial integration. Although early attempts were made — such as the creation of the Ministry of Social Affairs in 1974, later dissolved in 1983 — health and social security have since been governed through separate institutional frameworks, contributing to persistent fragmentation (República Portuguesa, 2019). More recent reforms, including the Health Basic Law (2019), the Statute of the NHS (2022) and the Health Emergency and Transformation Plan (2024), formally recognise integration as a strategic priority. Nevertheless, translating these commitments into operational governance arrangements remains a significant political and organisational challenge (Pereira & Ferreira, 2024).

From a scientific perspective, this research addresses two key gaps in the literature. First, while numerous systematic reviews examine integrated care, most focus on specific populations or service areas, and there remains a lack of cross-country comparative analyses of national integration models. Second, evidence regarding the economic and financial impacts of integration remains limited and often inconclusive, despite consistent findings related to improvements in user experience, access and care quality (Baxter et al., 2018; Kelly et al., 2020).

International experience suggests that Scotland represents a particularly informative case for countries facing similar challenges. The Public Bodies (Joint Working) (Scotland) Act 2014 established formal integration between health boards and local authorities through joint governance arrangements. Available evaluations indicate improvements in coordination, community-based care and selected service outcomes, while also highlighting ongoing constraints related to funding pressures and workforce capacity (Audit Scotland, 2018). This experience underscores both the potential and the limits of large-scale structural integration. More broadly, the integration of health and social care has become a defining theme of contemporary public policy debates. International organisations such as the World Health Organization and the OECD have consistently framed integration as essential to the sustainability, equity and resilience of health systems. The WHO's Integrated People-Centred Health Services framework emphasises intersectoral coordination, community engagement and person-centred governance as prerequisites for resilient systems capable of responding to complex and evolving needs (WHO, 2016; WHO, 2024). Similarly, the OECD has highlighted that pressures on long-term care systems, workforce shortages and rising demand cannot be addressed without closer integration between health and social services (OECD, 2022; OECD, 2023). At European level, the European Care Strategy and the accompanying Council Recommendation on access to affordable, high-quality long-term care place integration at the core of national reform agendas, linking coordination across sectors to social cohesion and territorial equity (European Commission, 2022). These developments reinforce the view that fragmentation disproportionately affects vulnerable populations and exacerbates regional inequalities.

In light of this context, the general aim of this research is to analyse health–social care integration from a comparative perspective, identify relevant models, and derive governance-oriented recommendations for Portugal. The specific objectives are:

1. To map and analyse integration models in different countries, describing their typologies, implementation processes, barriers and success factors, as well as the main health and social outcomes reported;
2. To examine the Scottish case in depth, combining policy analysis and empirical evidence to assess the effects and limitations of the integration mandated by the Public Bodies (Joint Working) (Scotland) Act 2014;
3. To formulate policy recommendations for Portugal, defining governance principles, financing and contracting mechanisms, monitoring metrics and a phased roadmap for implementation.

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Section II

THE VISION

This section includes 1 published book chapter

Chapter 1

The importance of Multidisciplinary and intersectoral care.

Ricardo Correia de Matos

In Enfermagem em Doenças Reumáticas e Musculoesqueléticas.
Chapter 7. Eds. Andréa Marques & Ricardo Ferreira. Coimbra: APPSReuma. 2021.

7. A IMPORTÂNCIA DO CUIDADO MULTIDISCIPLINAR E INTERSECTORIAL

Ricardo Correia de Matos¹

Dois dos maiores desafios que se colocam atualmente à sustentabilidade e qualidades dos serviços de saúde são a pouca interligação entre diferentes disciplinas que operam na saúde e a fraca interligação entre os setores da saúde e social. Neste capítulo debatem-se estes conceitos, a sua relação com a Liderança e apresenta-se o exemplo da integração dos setores da saúde e social iniciado há 20 anos pelo Governo Escocês, discutindo este assunto em maior pormenor.

Palavras-chave: Interdisciplinaridade, Intersectorial, Saúde, Social, *New Public Managment*

Objetivos de aprendizagem:

- Discutir alguns dos desafios e vantagens do cuidado interdisciplinar
- Identificar os desafios e as vantagens de promover a interoperabilidade entre os setores da saúde e social

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As últimas quatro décadas foram marcadas por importantes mudanças demográficas no Continente Europeu⁽¹⁾, originadas pelos avanços científicos, tecnológicos, sociais e económicos. Se por um lado estes avanços permitiram resolver muitos dos problemas de saúde do passado, por outro, criaram novos problemas, nomeadamente o aumento das necessidades e complexidade dos cuidados de saúde, motivadas pelo aumento da esperança de vida, o envelhecimento progressivo da população, e consequente maior incidência e prevalência de doenças crónicas.^(2,3)

Em Portugal, o processo de envelhecimento demográfico tende a acentuar-se, sendo que o índice de envelhecimento, que compara a população idosa com a população jovem, poderá quase duplicar entre 2019 e 2080. Também o índice de dependência de idosos, que mede o peso dos idosos na população em idade ativa, apresenta esta tendência.⁽⁴⁾

Estas alterações demográficas tornaram evidente que a separação e, muitas vezes, a fragmentação dos Sistemas Sociais e dos Sistemas de Saúde, não permitem responder às necessidades e expectativas da população, que requer cuidados integrados, que ofereçam continuidade na cadeia de valor e proximidade com os profissionais de saúde.⁽⁵⁾

Fazer face aos problemas causados por estas alterações requer reformas de fundo.

Cuidado Interdisciplinar

No campo académico, os conceitos de multidisciplinaridade, interdisciplinaridade e transdisciplinaridade, estão muito bem definidos, estudados e assimilados. A sua transposição para os contextos clínicos exige flexibilidade aos profissionais, assim como um elevado nível de responsabilidade coletiva. Os desafios são intensos e constantes, navegam desde a formação pré-graduada, pós-graduada, investigação, regulação profissional, até à gestão de topo. Todos os intervenientes têm um papel determinante no objetivo final: proporcionar felicidade e elevados padrões de qualidade de vida a todas as pessoas.

A pandemia Covid-19 acelerou a consciencialização do poder da colaboração e da cooperação entre todos os *stakeholders* da sociedade. De todos os sectores que compõem uma sociedade, a Saúde é, indubitavelmente, o mais complexo, competitivo e corporativista. Características que, historicamente, dificultam o desenvolvimento dos Sistemas de Saúde, na sua eficiência e eficácia, assim como uma verdadeira integração dos vários profissionais de saúde, em toda a cadeia de valor.

Aparentemente, o aumento das necessidades em saúde aliadas à inversão, cada vez mais acentuada, da pirâmide demográfica, apontam para a organização das equipas de saúde numa lógica de *skill mix* e numa perspetiva interdisciplinar. O objetivo esperado é otimizar os conhecimentos e as competências individuais de cada profissional, na obtenção do melhor resultado em Saúde.

A este propósito, na tomada de decisão sobre as várias regras do confinamento decorrente da Pandemia Covid-19, percebemos claramente a necessidade de integrar várias áreas do conhecimento, como por exemplo, a enfermagem, medicina, saúde pública, análises clínicas, demografia, economia, sociologia, ciência política, psicologia, epidemiologia, entre outras. Como nos escreve David Tavares (2017)⁽⁶⁾, “o apelo à interdisciplinaridade é maior quando se tem em consideração que os conhecimentos científicos não são rigidamente compartimentáveis e as suas fronteiras relativamente ao mesmo objeto não são facilmente delimitáveis e, muitas vezes, são artificiais.”

Os ganhos em saúde decorrentes do trabalho interdisciplinar são evidentes e documentados cientificamente. Entre estes ganhos, destacam-se os que diretamente envolvem os utentes. Por exemplo, uma revisão sistemática na área oncológica demonstrou em todos os estudos incluídos que equipam multidisciplinares apresentavam melhores *outcomes*, nomeadamente melhores taxas de sobrevivência, maior satisfação e melhor planeamento dos tratamentos.⁽⁷⁾

Mas também na área das doenças reumáticas e músculo-esqueléticas (DRM) existem múltiplas evidências. Por exemplo, Lamper et al.⁽⁸⁾ realizaram uma revisão sistemática da literatura para identificar de que forma o estabelecimento de redes de cooperação (*networks*) interdisciplinares de reabilitação em pessoas com dor crónica músculo-esquelética, melhora os *outcomes*: saúde; custos dos cuidados de saúde; qualidade dos cuidados na perspetiva dos doentes; satisfação profissional dos profissionais de saúde. Para isso consideraram 19 ensaios clínicos randomizados e controlados (RCTs), 12 não randomizados, e 7 estudos qualitativos, que consideravam: a) a cooperação interdisciplinar nos cuidados de saúde primários, entre médicos de família, terapeutas, enfermeiros e outros profissionais de saúde, b) a cooperação entre pelo menos um dos anteriores e centros de reabilitação do setor secundário e/ou terciário, ou c) com cuidados baseados na comunidade (ex. instrutores de fitness), d) ou setor social (ex. terapeutas ocupacionais). Os resultados, de uma forma geral, indicaram que os cuidados centrados no doente e com base interdisciplinar são mais eficazes que os cuidados standard.⁽⁸⁾ Numa outra revisão e meta-análise Cochrane, Kamper et al. (2014)⁽⁹⁾ analisaram a eficácia de modelos biopsicossociais multidisciplinares de reabilitação em pessoas com lombalgia crónica, tendo incluído um total de 41 RCTs. Concluiu-se que as pessoas que receberam estes cuidados multidisciplinares tendiam a apresentar menos dor e menor incapacidade do que os que receberam cuidados

standard, o que se refletiu também na capacidade laboral. Naturalmente que o investimento neste tipo de cuidados é maior, sendo mais custo-efetivo nas pessoas com situações mais complexas (idem).

Mas também em Portugal existem já bons exemplos de como o cuidado interdisciplinar, centrado no doente, é mais efetivo e gerador de múltiplos ganhos. Salienta-se neste âmbito o programa de “Gestão de Caso” da Unidade Local de Saúde do Litoral Alentejano (para saber mais poderá ver um curto vídeo em <https://youtu.be/QTlQaIXtd24>).



Outros ganhos decorrentes da interdisciplinaridade são a redução do número de erros “médicos”, aumentado a segurança dos utentes; e a diminuição dos problemas de *burnout* profissional. Uma razão é que as equipas de saúde multidisciplinares ajudam a quebrar a hierarquia e o poder centralizado das organizações de saúde, dando mais autonomia e capacidade de influência aos profissionais de saúde, conduzindo a um maior nível de trabalho e satisfação no trabalho. Outro fator é a melhoria dos cuidados, realmente centrados no doente, se traduz em maior satisfação para os profissionais.⁽¹⁰⁾

Mas o que se pode fazer, então, para melhorar este panorama no nosso país? Algumas das estratégias para melhorar as competências acima mencionadas são descritas por Hughes (2021)⁽¹⁰⁾, num artigo de fácil leitura, que basicamente implicam treino individual e coletivo. Sugerimos também a leitura do livro “the Cleveland Clinic Way Lessons in Excellence from One of the Worlds Leading Health Care Organizations”, escrito Toby Cosgrove, seu CEO entre 2004 e 2017, com casos clínicos bastante práticos, demonstrativos destes benefícios. Mas importa ainda referir Mayo e Wolley (2016)⁽¹¹⁾, num artigo publicado no *AMA Ethical Journal*, que enfatizam as três competências mais importantes de uma equipa eficaz:

- maximizar a inteligência coletiva – que não se baseia apenas em ter os mais “inteligentes”, mas antes uma equipa inteligente aos mais diversos níveis;
- colaboração inclusiva, o que implica que os elementos da equipa verbalizem o seu conhecimento relevante, para que este possa influenciar a atuação da equipa
- comunicação aberta – o processo anterior requer que exista possibilidade de se comunicar de forma aberta e respeitosa.

Consideramos que para atingir o almejado nível de proficiência coletiva, é essencial ter lideranças positivas e assertivas. Neste novo paradigma, a gestão de equipas assume um papel absolutamente determinante no sucesso da equipa.

Cuidado Intersectorial

O paradigma da New Public Management (NPM) tornou-se uma tendência internacional nos países da Organização para a Cooperação e Desenvolvimento Económico (OCDE) ao longo dos últimos 30 anos.^(12–15) Esta NPM é uma filosofia implementada por diversos Governos, que se foca na otimização da performance dos serviços públicos e na criação de ganhos reais⁽¹⁶⁾, que assegurem o alcance de metas e objetivos estratégicos do estado e das regiões, bem como ajudem a atender às legítimas expectativas, necessidades e interesses da sociedade.⁽¹⁷⁾

De entre as estratégias envolvidas na NPM muita atenção tem sido colocada na cooperação intersectorial, que preconiza que as práticas do setor privado podem ser transferidas para o setor público, através da inovação e do desenvolvimento da ideologia da integração de processos de administração pública.⁽¹⁷⁾

A integração é um dos eixos modernizadores das políticas públicas, nomeadamente entre o setor da Saúde e Social.⁽¹⁸⁾

Atendendo a esta realidade, com exigências em termos de saúde e sociais cada vez mais complexas, o Governo Escocês iniciou há 20 anos um processo de mudança do modelo de cuidados, mediante a colaboração ativa entre os *stakeholders* do setor Social e da Saúde, com a publicação do relatório *Joint Future Group*, no ano 2000.⁽¹⁹⁾ Este processo de mudança, com implementação regional, envolveu a produção de normas orientadoras que culminaram com a publicação do quadro legislativo (Framework), em Abril de 2014, que suportou a integração dos “Cuidados de Saúde com o Serviços Sociais: “Public Bodies (Joint Working) (Scotland) Act 2014”. Este processo foi estruturado com base em quatro grandes objetivos e em 12 princípios de integração.⁽²⁰⁾

A finalidade maior desta integração é garantir que as pessoas recebam os cuidados de que precisam no momento certo e no ambiente certo, com foco nos cuidados preventivos prestados na comunidade. Estas reformas afetam todos os que recebem, prestam e planeiam serviços e cuidados de saúde na Escócia. A Lei (Act) Escocesa exige que Conselhos de Administração (*Councils* e *NHS Boards*) trabalhem juntos para formar novas parcerias, conhecidas como Autoridades de Integração (IAs). Foram estabelecidas 31 IAs, através de parcerias entre as 14 administrações regionais de saúde (*NHS boards*) e os 32 Conselhos de Administração (*Councils*).⁽²¹⁾

Este processo de integração é auditado anualmente, sendo que no relatório de 2018⁽²¹⁾ se salientam os seguintes resultados (diferenças entre 2014/15 e 2017/18):

- Redução de 4.15 milhões para 3.91 milhões de dias de internamento não planeado por doença aguda;
- Redução de 527,099 para 494,123 dias de altas atrasadas (em adultos).

O último relatório data de 2020, consolidando os resultados positivos e apontando as várias recomendações, nomeadamente para fazer face à Pandemia COVID-19.⁽²²⁾

Em Portugal, as políticas públicas desenvolvidas ao longo dos últimos 30 anos encontram os seus fundamentos na Constituição aprovada em 1976 e nas suas sucessivas revisões, permitindo transformar e modernizar o país.⁽²³⁾ Contudo, exceto o período compreendido entre 1974 e 1983, em que foi criado o Ministério dos Assuntos Sociais, que compreendia as Secretarias de Estado da Saúde e Segurança Social^(24,25) desconhecemos qualquer iniciativa de integração interministerial, nomeadamente entre o Ministério da Saúde e o do Trabalho e da Segurança Social, que desde então, são geridos de forma autónoma e independente.⁽²⁶⁾

A iniciativa Escocesa atraiu já a atenção da Sociedade Portuguesa de Medicina Interna e da Associação Portuguesa de Administradores Hospitalares, que em 2018 organizaram uma conferência sobre o tema “Saúde e Segurança Social – A necessidade de um pensamento global”, que contou com a presença de Anne Hendry, a Diretora da Fundação Internacional para os Cuidados Integrados na Escócia.⁽²⁷⁾ Estamos certos de que este modelo de cuidados merece ser estudado de forma mais profunda, envolvendo as organizações e entidades competentes.

Numa pesquisa preliminar realizada na PubMed identificámos quatro revisões sistemáticas da literatura (RSL) com foco em integração destes sistemas, a nível mundial, que se apresentam de seguida.^(18,28–30)

Baxter et al.⁽²⁸⁾ analisaram 167 estudos realizados em países desenvolvidos, identificando: perceção de melhoria da qualidade dos cuidados, evidência de melhoria na satisfação dos utentes e no acesso aos cuidados. Contudo, a evidência foi classificada como inconsistente ou limitada em termos de outros *outcomes*, incluindo o impacto nos cuidados de saúde primários, cuidados secundários e custos em cuidados de saúde. Os autores não identificaram diferenças significativas entre o modelo adotado pelo Reino Unido e o adotado por outros países, sendo que aqueles com mais estudos produzidos foram, por ordem decrescente: Reino Unido, EUA, Austrália, Canadá, Holanda e Suécia. Esta revisão identifica ainda que os estudos com subpopulações de adultos idosos são claramente os mais prevalentes, seguindo-se depois a área das pessoas com necessidades complexas ou a diabetes. Entre os elementos de inovação nos novos modelos testados, os mais frequentes foram a realização de planos integrados, a implementação de equipas multidisciplinares, ou a introdução de um gestor/coordenador de caso, mas foram identificados um total de 25 elementos testados.

Kelly et al.⁽¹⁸⁾ incluíram 18 estudos sobre medidas adotada para a integração dos serviços de saúde e sociais em pessoas doença crónica, fazendo uma divisão das

medidas em cinco áreas principais: 1) Estrutura - que inclui, por exemplo, o subgrupo “compatibilidade de orçamento e recursos”, “comunicação e partilha de informação”; 2) Processo – referente a “medidas de performance”, ou “perspetivas dos doentes, famílias e cuidadores”; 3) *Outcomes* do sistema, incluindo, por exemplo, “Utilização de serviços”, “acessibilidade”, “admissões e duração de internamento”; 4) *Outcomes* de saúde – com “medidas clínicas” como a mortalidade ou eventos adversos, “função física”; 5) Medidas reportadas pelo doente – por ex. “bem-estar”.

Assim, esta revisão faz um claro mapeamento da imensidão de *outcomes* que se podem avaliar, chamando a atenção para o problema de não existir um grupo de medidas core utilizadas em todos os estudos (ou na sua maioria), dificultando a comparabilidade.⁽¹⁸⁾

Numa revisão mais focada em conhecer os modelos financeiros utilizados, a sua custo-efetividade, e barreiras à implementação, Mason et al.⁽²⁹⁾ analisaram 38 modelos referentes a oito países. Entre os tipos de integração financeira, identificaram: 1) Transferência de pagamentos; 2) Cobrança cruzada; 3) Alinhamento de orçamentos; 4) Liderança do comissionamento; 5) União de fundos; 6) Gestão integrada/ provisão com fundos unificados; 7) Integração estrutural; 8) Liderança de comissionamento com incentivos alinhados.

Em termos de resultados, os autores concluíram existir evidência positiva nos seguintes *outcomes*: acesso aos cuidados, redução de admissões e readmissões (ainda em apenas em alguns subgrupos), cuidados comunitários (saúde e sociais), redução da duração de internamento, experiência do utilizador. Resultados mais inconclusivos foram identificados relativamente a redução total de custos e redução de custos com estruturas residenciais. De uma forma geral, concluem que apesar de se considerar comumente que uma política de integração de fundos é promotora de melhor integração de cuidados e de conduzir a melhores *outcomes* em saúde e a redução de custos, esta relação ainda está pouco demonstrada. Contudo, existe aqui o problema da diversidade de contextos e dos problemas inerentes a fazer conclusões gerais, com análises pouco detalhadas à especificidade de cada modelo e respetivas medidas adotadas.⁽²⁹⁾

Por fim, McGuire et al.⁽³⁰⁾ fizeram quase que uma replicação da análise de Mason et al.,⁽²⁹⁾ agora com 81 modelos testados, numa maior diversidade de países (93% dos quais considerados desenvolvidos), embora tenham analisado a integração com outros setores, como o da educação. Concluíram, uma vez mais, que a diversidade de modelos é tão grande, que é difícil aferir da eficácia geral das medidas.

Considerações finais

A interdisciplinaridade é um conceito muito mencionado quando se debatem questões de saúde, porque todos reconhecem que equipas compostas por diferentes disciplinas, em estreita colaboração, aportam maiores ganhos em saúde aos utentes e trazem também maior satisfação e realização aos profissionais. Contudo, existe um considerável caminho a percorrer no sentido da sua efetiva implementação na prática, importando refletir porquê.

Relativamente à temática da integração dos Setores Social e da Saúde, pouco estudada em Portugal, reconhece-se a necessidade de desenvolver novos modelos de organização em ambos os setores, promotores de otimização de recursos e maior eficácia e eficiência dos processos envolvidos. O modelo escocês pode ser usado como exemplo, possuindo já resultados mensuráveis da sua efetividade.

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Section III

CONCEPTUALIZATION, EVIDENCE AND INTERNATIONAL PERSPECTIVES OF HEALTH–SOCIAL CARE INTEGRATION

This section includes 3 published manuscripts

Chapter 2

Integrated care: an insight into the national models and their impact on patients and health systems – a narrative review.

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Integrated care: an insight into the national models and their impact on patients and health systems – a narrative review

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Abstract

Purpose – Integrated care has emerged as a vital approach to address the growing complexities of healthcare systems worldwide, particularly in managing the increasing prevalence of chronic diseases, aging populations and socioeconomic disparities. Integrated care generally involves the alignment of health and social services to provide patient-centered, coordinated and efficient care, ensuring continuity of care, optimizing resource allocation and improving patient outcomes during crises. Despite these recognized benefits, significant variability exists in how integration is conceptualized and implemented globally. This review aims to explore the diverse definitions, types and implementations of integrated care, comparing international health models and their impacts on patient and system-level outcomes.

Design/methodology/approach – A comprehensive literature review was conducted using PUBMED, MEDLINE, Google Scholar and Science Direct. Eligible studies included original research and reviews without time or regional restrictions. Search terms included “integrated care,” “integrated health and social care” and “integration”. Manual screening of references supplemented data collection. Studies were included based on relevance to the research question, focusing on the definitions, types and national policies regarding integrated care.

Findings – Integrated care models were categorized into vertical, horizontal, functional, clinical and service integration, each with distinct benefits and applications. Integrated care is defined by various authors as collaboration of various pillars of health and social care systems either at administrative, professional or infrastructural levels to obtain optimum health and economic outcomes. Different types of integration have been adopted worldwide depending upon the level of supply chain as well as level of healthcare collaborating with volunteers. Different countries adopted one or more type of integrated care models with some of evidence favoring vertical integration regarding patient outcome. The cost of integrated care in terms of distribution of resources and financial consumption and output may be same or more or less than conventional care model.

Practical implications – Integrated care models enhance patient outcomes, resource efficiency and system-level collaboration. However, barriers such as financial disparities, infrastructural limitations and organizational fragmentation persist. Despite promising examples of integrated care, the evidence on cost benefits remains inconclusive. Recommendations include aligning health and social care budgets, promoting patient-centered care, enhancing inter-professional collaboration and implementing shared electronic health records. Further research is needed to establish cost-effectiveness and refine integrated care policies for better health outcomes and system sustainability.

Originality/value – This is the first review to correlate and compare the national health models of various countries in terms of types of integration of health and social care and to bring out patient and system focused health and financial benefits out of it. Moreover, it gathers almost all the available data on the research question in one review with emphasis on latest approach.

Keywords Integration, Integrated care, Health and social care, Health and social care integration

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Background

Patients with advanced-stage and chronic diseases often experience physical and psychosocial disabilities, along with functional impairments, highlighting the need for support in managing personal, financial and social responsibilities (Gardener *et al.*, 2018). Different studies have highlighted the assistance required by chronic patients, but no existing guideline covers the scope of need and provision of assistance to such patients (Disler *et al.*, 2014). Moreover, the COVID-19 pandemic have emphasized the need to address the socioeconomic and social needs of patients and the social benefit of community volunteering of medical bodies amid pandemic restrictions is reflected in literature which improved patient compliance during treatment and follow-up (Cohen and De Marchis, 2021). Decreased improvement in life expectancy, high mortality during pandemic and increasing burden of chronic illness despite high health expenditures led to the need for development of innovated health care system in UK and Europe while organizational fragmentation was identified as major barrier (Reed *et al.*, 2021). To meet with the rising community, elderly and chronicity induced social demands and to seek better financial and patient outcomes, the health models across the worlds have adopted integrated structure of healthcare and have scaled tools to organize and implement interdependence of health and social care (Gottlieb *et al.*, 2021). An analysis of 167 studies of multiple health models across the world has concluded that multielement integration of health and social can increase patient satisfaction scores, perceived quality of care and increase the access to secondary care resources with variable cost benefit (Baxter *et al.*, 2018). Kaehne argued that integrated care provided services greater than the sum of individual cooperation with additional activation of feedback loop through integration of supply chain thus improving care experience (Kaehne, 2018).

Various cohort studies as well as RCTs have studied the evidence behind integrated care, its elements, effectiveness and various types as well as models integrated across different health systems in USA, Europe and Australia (Alonso and Andrews, 2022; Caldwell and Mays, 2012; Gray *et al.*, 2015; Morciano *et al.*, 2021). Some narrative and systematic reviews have compared the UK health model with Scotland or other international models or have narrated the types, effects or cost and consumer benefits of integrated care (Aujla *et al.*, 2023; Baxter *et al.*, 2018; Heyeres *et al.*, 2016). This review explores the scope of various health models within healthcare systems, analyzing their structures and impacts on patient outcomes, and provides a discussion on the types of integrated care implemented by each model, highlighting their unique characteristics, approaches to integration and contributions to addressing both patient-centered and system-level needs.

Methodology

A comprehensive literature search was conducted using PUBMED, MEDLINE, Google Scholar and Science Direct to identify relevant articles for inclusion in this review. Both original research articles and reviews were considered eligible, with no restrictions on publication date or geographical region. For health models that have been discontinued or replaced, the most recent approaches were included to ensure the analysis reflects current practices. Search terms included MeSH terms such as “integrated care,” “integrated health and social care,” “social care integration,” “integrated model,” “integrated health,” “vertical integration,” “horizontal integration,” and related keywords. Reference lists of both included and pertinent articles were manually reviewed to maximize the breadth of data collection. Study eligibility was determined based on the relevance of evidence to the research question and the robustness of the research design.

Results

Definitions of integration between healthcare and social care

The term “integrated care” lacks a global conceptual meaning and has different regionally recognized definitions and applications. WHO regional office for integrated healthcare

services in Europe works for integration of various levels of health care and home health care with the following take on integrated care in their policy:

Countries should have family health physicians and nurses working at the core of this integrated primary health care service, using multi-professional teams from the health, social and other sectors and involving local communities. (Gröne and Garcia-Barbero, 2001)

Integrated care, according to Kodner *et al.*, is the provision of clinical and human care as single entity and involves logistical and administrative alignment and coordination of key organizational functions such as finance, human resources and information technology across health and social care services for identifying needs, providing adequate service and ensuring continuity within constraints of available resources (Kodner and Spreeuwenberg, 2002). In the same way, Leutz seeks a structural approach which involves organizational merger of existing health and social care entities as well as establishment of new ones to provide a variety of services under a unified organizational administrative system. This kind of collaboration connects healthcare and human service systems to optimize patient care (Leutz, 1999).

Shortell *et al.* describes integrated healthcare according to US model where contrary to organizational collaboration across health and social care, integration is the coordination, within healthcare system, between multidisciplinary shared care teams as well as healthcare providers to comprehensively provide effective evidence-based patient care services (Shortell *et al.*, 1996). A Dutch integrated care development model which divided the 89 elements of integrated care into nine clusters emphasizes the collaboration among various service providers to be patient-centered while focusing on quality of care, team work and financial benefit of implementation (Minkman *et al.*, 2011).

Valentijn *et al.* establishes functional and normative integration between three levels of integrated care where macro level is the vertical integration of primary, secondary and tertiary health care systems and horizontal integration of primary care and public health are needed to provide continuous patient-centered and population-based quality care, meso-level is the broad spectrum professional collaboration among clinical and social organizations for effective governance and accountability and micro level clinical integration that offers person-focused care for multidisciplinary chronic morbidities in a single span (Valentijn *et al.*, 2013).

The nationally adopted model for integrated care in England involves the additional funding to clinical care system for funding delayed discharge and emergency services as well as additional collaboration of local population as well as human service sectors as voluntary care providers within geographical limits (Aujla *et al.*, 2023). The integration model of Scotland defines integrated care as locality-based health care provision integrated with social service provision either by local population or as the responsibility of central Scottish government body (Aujla *et al.*, 2023).

All these definitions tend to aim the provision of continuous quality care to patients but differ in the person-focused or population-based approaches or in the level of integration, i.e. at administrative level, governance level or service delivery system and inter-professional level.

Types of integration

Different types of integration have been recognized across literature and some models of integrated care have more than one type to architecture the optimum care delivery systems.

(1) Vertical integration:

This type of integration involves the collaboration between health and social care across different levels of healthcare, i.e. primary, secondary and tertiary while allowing continuity of care, single accountability and separate organizational budgets is the hallmark benefit of this type of integration (Conrad and Dowling, 1990). Vertical integration of care providers requires shared aims and effective communication between various levels but while it seems

challenging to implement, vertically integrated care systems have been shown to provide better patient outcomes, reduced hospital stays and chronic disease management within the same locality (Suter *et al.*, 2009).

Among examples of vertical integration is Kaiser Permanente in United States which integrates various levels of healthcare with health insurance, i.e. financial element of social care as well as home care and rehabilitation and has been associated with higher patient satisfaction rates (Strandberg-Larsen *et al.*, 2010). Scottish model of integrated care is another example of vertical integration which has improved discharge delays and premature mortality statistics as compared to North England since 2017 emphasizing the comparative superiority of vertically integrated health service delivery systems (Alonso and Andrews, 2022).

(2) Horizontal integration:

Horizontal type of integrated care is limited to merger of similar service delivery systems across single level of healthcare but covers the scope of different geographical locations thus improving access to the specialized health care services as well as increasing shared market (Huckman, 2006). In horizontal integration, organizations either work as autonomous economies, as a subunit of integrated parent company or are merged under unified administration. An analysis conducted in Czech republican hospitals to analyze the effectiveness of horizontal model of integration found the reduced average duration of hospital stay and bed usage in horizontally integrated hospitals as compared to national trend. The horizontally integrated hospitals also provided better treatment at lower per day cost but their overall economic benefit as compared to average national economic output of healthcare organizations is yet debatable (Sarka and Pavla, 2016).

Clinical commissioning groups (CCGs) of integrated primary healthcare in UK integrated care model are an example of this kind of integration but their patient-focused outcome superiority is still controversial (Jager *et al.*, 2023; Morciano *et al.*, 2021).

(3) Functional integration:

Functional integration refers to establishment of a comprehensive infrastructural alignment through coordination of key functional elements and support units including finance, information technology and human resources across health and social care sectors with centralized provision of services within the same geographical and time framework (Kodner and Spreeuwenberg, 2002). Such integration streamlines resource consumption providing quality care at controlled cost and enhances managerial and provider efficiency. Some of the contributory units within system adopt local autonomy under variable local conditions while some systems maintain strict centralized control however harmony and data security among highly variable systems and organizations is highly challenging (Ridgely *et al.*, 2020).

Integrated electronic health records (EHRs) in Denmark are an example of functionally integrated information exchange facility across health care and human service systems (Vest and Gamm, 2010).

(4) Clinical integration:

This type of integration considers patient as centre of care and involves integration of multidisciplinary teams including specialists, physicians, nurses, social worker and allied healthcare providers across settings for the efficient multidomain care delivery to chronic patients at a single place (Tseng *et al.*, 2023). Such collaboration varies with patient needs as well as disease related factors and aims to provide team-based standardized care contrary to traditional physician-controlled care provision (Ridgely *et al.*, 2020). This type of system provides direct benefit to patient through timely cost-effective, continuous and multidisciplinary management of chronic disease within same geographical location and depends on careful planning, strong management and effective communication thus consolidating further service integration (Croushore, 1998).

Texas medication algorithm project and Florida's medipass program for chronic disease care improvement in localities are example of this type of integration (AHA, 2024).

(5) Service integration:

Service integration involves the coordination of service delivery mechanisms, processes and practices across health and social care systems to better address the diverse needs of patients including home care (Glasby and Dickinson, 2014). 29% of the reviews included in a narrative analysis focused on the coordination of various health care services, such as HIV/AIDS services and antiretroviral therapy through integration of maternal, neonatal, child-health, nutrition and family planning services; the integration of care centers and healthcare and the collaboration of general medicine practice with pharmacist services. Integrated services were found to be associated with lower facility costs due to integrated resource utilization as well as cost-effective management of integrated disease programs such as HIV/AIDS. Childhood illnesses, although required greater cost per visit, resulted in significant superiority in case management with integrated services (Heyeres *et al.*, 2016).

The Buurtzorg model in the Netherlands is an example of service integration through which independent self-governed nursing teams work to meet holistic needs of patients across both health and social care and offer home care services as well. This model has been shown to be associated with better patient outcomes and higher satisfaction rates (Gray *et al.*, 2015).

Discussion of various integrated care models

Apart from various types of integration, healthcare systems can be integrated along various levels of supply chain resulting in macro, meso and micro levels of integration (Caldwell and Mays, 2012). Although, the literature highlights various types of integrated healthcare, each offering distinct advantages, however, healthcare models worldwide often incorporate multiple types of integration across different organizational levels to create a comprehensive and effective continuum of care. This review examines diverse global healthcare models and the specific types of integration they employ, as detailed in Table 1.

Scottish healthcare model assumes a vertical type of integrated care where centralized public bodies controlled by government act as integration authorities and manage the partnerships and resources between local councils and community as well as NHS and health boards and thus provide health and social care within the allocated localities (Public Bodies (Joint Working) (Scotland) Act, 2014). The new law now proposes the replacement of integration authorities with community health and social care boards as well as expansion of health care teams for multidisciplinary specialized care approach within same geographical constraints (Aujla *et al.*, 2023). Social boards are independently responsible for budgeting, hiring and care provision in their localities and have shown improved efficiency in emergency and elderly care despite funding constraints (Donaldson *et al.*, 2024). The integrated healthcare model in North England, on the other hand, assumes a horizontal integration approach under NHS where primary level health care organizations are networked and integrated with social services for provision of both clinical and voluntary services (Reed *et al.*, 2021). State-funded Integrated Care Systems (ICSs) in England include integrated care partnerships which are concerned with integrated service delivery system and inter-professional teamwork and integrated care boards which replace the previously employed clinical commissioned groups (CCGs) and are required to assume commissioning responsibilities of CCGs and information exchange (NHS, 2019). The previously limited integrated collaboration by sustainability and transformation partnerships (STPs) in England has been replaced by ICSs each of which is independently responsible for resources expenditure and quality healthcare provision in one of the 44 territories of England of heterogeneous size with greater collaboration with local governments and social organizations. These ICSs are responsible for reduction in discharge delay, improve patient outcomes and enhance emergency care service with additional funding as well as across the

Table 1. Elements, benefits and examples of all types of integrated care

Type of integration	Elements	Benefits	Examples
Vertical integration	1 Organization level collaboration	Patient-focused Greater improvement and satisfaction rates, better access to higher levels and better chronic illness management	Scottish healthcare model Components of US and Australian model
	2 Financial autonomy under same authority	System-focused Better resource and patient load distribution, primary care advancement	
	3 Integration of primary, secondary and tertiary care		
Horizontal integration	1 Professional team level collaboration	Patient-focused: Lower per day cost with improved outcomes	Clinical commissioning groups (CCGs) in England now replaced by Integrated Care Systems (ICSs) and Integrated Care Boards Components of US and Australian health model
	2 Integration of same level of health care	System-focused: benefits individual organizations' service quality and economy more than average national trends with greater geographical coverage	
	3 Financial autonomy may or may not be present		
Functional integration	1 Infrastructural collaboration	Patient-focused Efficient care at controlled costs	Integrated electronic health records (EHRs) in Denmark
	2 Centralized control	System focused Efficient resource consumption with cost control	
	3 Limited local autonomy		
Clinical integration	1 Professional collaboration according to individual patient conditions	Patient-focused Multidisciplinary management of chronic illness under same roof, cost-effective	Texas medication algorithm project and Florida's medipass
	2 Integration of various levels of healthcare	System-focused Streamlines chronic illness management at all healthcare levels rather than haphazard referrals, effective communication	
Service integration	1 Integration of community service delivery mechanisms of various sectors	Patient-focused Community level curative approach as well as home care integration	The Buurtzorg model in the Netherlands
	2 Integration of primary, secondary and tertiary care	System-focused Controls widely spread epidemics and pandemics, Community awareness and mass immunization programs, Lower facility costs	
	3 Integration of maternal and neonatal health, nutrition and family planning and pharmacy services		

Source (s): Authors' own work

system integration with community care providers (Briggs *et al.*, 2020). Welsh regional partnership boards integrate local governments and social services in their localities to provide for needs of elderly and children with chronic illness and are legally entitled to hire staff and consume resources independently for collaborative services. Irish health model formulated

integrated care partnerships with limited social care integration but became entitled in 2021 for collaboration of health and social trusts with representation of carers, service users and social workers in administrative bodies (Reed *et al.*, 2021).

The Dutch integrated care model involves functional and service integration by coordinating financial component through insurance providers while integrating independent self-managed care groups into the health service delivery system which work closely with health and social care providers to ensure provision of patient-specific care as per chronic illness and patient-related factors (Maarse and Jeurissen, 2016). An example of independent care group model in Netherlands is Buurtzorg model in which self-led nursing teams offer multidisciplinary health and social care integrated with home care according to specific needs of patients with improved clinical and satisfaction outcomes (Gray *et al.*, 2015). The Australian health model utilizes an amalgam of horizontal and vertical integration where primary and secondary healthcare is integrated with social care as well as networking of primary health care systems is adopted to deal with emergency care and unplanned admissions with focus on chronic case management within geographical limits (Connor *et al.*, 2016).

Since 2004, Germany started funding morbidity-specific integrated care however multimorbidity cases became point of focus with the development of innovative service integrated care model namely Kinzigtal where multidisciplinary incorporation of care providers including general physicians, specialists, physical and psychotherapists, nurses and rehabilitation/ambulatory care centers was integrated with different sectors such as health and sports clubs, health awareness companies, self-help groups, pharmacies, adult education centers and local governments financed by sickness funds and central allocation pool resulting in reduction in mortality and length of hospital stay for greater number of admissions and providers' cooperation at lower cost (Busse and Stahl, 2014). French incentives of integrated care built around patients' need where implementation of Digital Health Territories started in 2015 on the basis of organizational integration between healthcare centers and social organizations using support teams (PTA) which were contacted by patients and were responsible for allocation of health and social care providers according to patients' needs and choice while the digital arm maintained flow of information for personnel coordination (Gaillard *et al.*, 2022). Spanish health model ensures provision of healthcare in various localities under centralized public organizations with widely adopted clinical integration of various levels of health and virtual consultation between specialists and primary care according to Chronic Care model but incorporation of social organizations is still a challenge (Nuño *et al.*, 2012).

The ICARE4EU program identified the barriers in the provision of patient centered integrated care in 112 European integrated care programs and found that lack of awareness in patients, time constraints of care providers and lack of resources were among the most frequently encountered hurdles. On system level, difficult multidisciplinary cooperation, managerial limitations and decentralized health systems limited expert vision while program recommended steps for greater patient and informal carers involvement as stake holders and better investment and planning of chronic care management for improvement of European integrated care programs (van der Heide *et al.*, 2018). It has been observed that financial inequality of community and infrastructural shortfalls are among the challenges faced by UK model of integrated care and recommendations have been made to direct policies and investments in this regard while alignment of NHS and social care funding is being sought (Anderson *et al.*, 2022). Recommendations for shared electronic health records for joint consultation of multidisciplinary teams, public health campaigns, education of medical students and health professionals on integrated care through curriculum and research funding for interventional trials and determination of cost-effectiveness have also been made for UK model after facing care provision challenges and high mortality amid COVID-19 (van der Feltz-Cornelis *et al.*, 2024).

US health care organizational structures can be categorized into both horizontal and vertical integrated systems. The horizontally integrated systems involve collaboration between solo

practitioners of same specialty as well as related specialties such as between non-invasive and interventional cardiologists and electrophysicians, coordination of independent practice associations with other care providers for infrastructural investments and maintenance of electronic health records, multispecialty group practice where physicians with diverse specializations work as multidisciplinary team to refer patients within the group and share financial and infrastructural benefits, Virtual physicians networks either for rural healthcare access or as Minnesota's Integrated Health Partnership's ACO model which offers market to unaffiliated physicians' network as well as horizontal integration of similar acute healthcare provision centers to streamline resource distribution while reducing competition ([Casalino et al., 2013](#); [Enthoven, 2010](#); [Shortell et al., 2010](#)). The US model is, however, adopting more and more vertical integration even for similar organizational setups. Vertically integrated pillars of US healthcare system include physician hospital organizations, management services organizations, clinically integrated networks, foundation models and integrated delivery systems employing shared care management and information technology resources, administrative integration, clinical integration, corporate sector integration and service providers' collaboration respectively thus providing cost-effectiveness with improved patient care ([Heeringa et al., 2020](#)).

US model has achieved highly integrated health system through direction of health budget into social care, private partnerships of health and insurance stakeholders, screening for social needs in primary care and cross-sectorial data sharing but shortfalls have been determined in terms of rigidity of national policies, lack of cross-border coordination, lack of protocol for assessment of social risks and lack of managerial collaboration which have been recommended to be addressed ([Sandhu et al., 2021](#)).

Cumulative implications and recommendations

Several studies have emphasized superior quality and cost-effectiveness of integrated care in terms of improved patient outcomes, reduced discharge delay and bed usage, lower cost per visit, better resource consumption, specialized diagnoses, emergency care, home care and/or radiology and pharmacy structure but the evidence regarding cost benefit is insufficient in some models ([Alonso and Andrews, 2022](#); [Baxter et al., 2018](#); [Heyeres et al., 2016](#); [Selby et al., 1999](#)). Kaehne argued that integrated care has always been scrutinized at organizational level without any considerable research into patient experience and therefore the integration of perceived benefit of patients and organizations is recommended for correct estimation of outcome improvement ([Kaehne, 2018](#)). Hewitt review identified shortcomings of integrated care and recommended meaningful role of local governments in integrated boards, involvement of patient voices in policy, addressing ethnical clashes of cultures as well as staff shortcomings of education and training for improvement of interprofessional as well as integrated care ([Barr et al., 2024](#)).

Strengths and limitations

This review represents a comprehensive effort to compare national health models across various countries, emphasizing the different types of integration in health and social care systems. By addressing both patient-centered and system-level outcomes, this review provides a nuanced understanding of the clinical, operational, and financial benefits associated with integrated care models. Additionally, it consolidates the available data on the topic, synthesizing evidence from diverse sources to offer insights into the latest advancements and approaches in integrated care.

Despite its strengths, this review has several limitations. First, the reliance on reviews and systematic reviews to provide comparisons of outcomes and structures between health systems may introduce secondary reporting biases, limiting the ability to draw definitive conclusions. Furthermore, studies with weaker methodological rigor were included, which could affect the robustness of the findings. Lastly, heterogeneity in the design,

implementation and outcomes of integrated care models was not explicitly addressed in some comparisons, potentially limiting the generalizability of the findings to specific contexts. Future research should focus on addressing these limitations by including time-bound, high-quality studies and incorporating standardized methodologies to evaluate integrated care outcomes more comprehensively.

Conclusion

Integrated care has emerged as a vital approach to addressing the growing challenges posed by chronic diseases, aging populations and socioeconomic disparities within healthcare systems. The integration of health and social care demonstrated improvements in patient outcomes, resource efficiency and the overall quality of care. This review highlights the diverse definitions, types and applications of integrated care, showcasing its potential to create patient-centered, cost-effective systems that adapt to the complex needs of modern healthcare.

Vertical integration models, such as those seen in Scotland, offer promising clinical outcomes and better chronic disease management, while horizontal and functional integrations provide enhanced access to services and resource optimization. Examples from countries like the US, UK, Netherlands and Germany illustrate the multifaceted approaches to integrating care, each tailored to regional contexts and priorities. However, challenges such as financial disparities, infrastructural limitations and organizational fragmentation persist, indicating that there is no universal solution to achieving optimal integration. While the benefits of integrated care are evident, this review underscores the need for further research to address gaps in evidence, particularly regarding cost-effectiveness and patient experience. Policymakers should focus on aligning funding streams, enhancing cross-sector collaboration and incorporating shared electronic health records to streamline integration.

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Chapter 3

Implementation and impact of integrated health and social care services: an umbrella review.

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Implementation and impact of integrated health and social care services: an umbrella review

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Abstract

Governments in many European countries have been working towards integrating health and social care services to eliminate the fragmentation that leads to poor care coordination for patients. We conducted a systematic review to identify and synthesize knowledge about the integration of health and social care services in Europe. We identified 490 records, in 14 systematic reviews that reported on 1148 primary studies and assessed outcomes of integration of health care and social care. We categorized records according to three purposes: health outcomes, service quality and integration procedures outcomes. Health outcomes include improved clinical outcomes, enhanced quality of life, and positive effects on quality of care. Service quality improvements encompass better access to services, reduced waiting times, and increased patient satisfaction. Integration procedure outcomes involve cost reduction, enhanced collaboration, and improved staff perceptions; however, some findings rely on limited evidence. This umbrella review provides a quality-appraised overview of existing systematic reviews.

Keywords Integration · Integrated care · Social care · Health and social care · Health services · Umbrella review

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Key messages

- Integration of social care and health systems appears to produce moderate improvement in social and health sectors and a wide range of improvements in health outcomes, service quality, and integration procedures outcomes.
- Health and social care integration improves clinical outcomes and quality of care but faces limited, subjective evidence and financial challenges.
- Integration is complex and costly, with potential long-term benefits but limited evidence of immediate cost savings and a focus on efficiency over patient outcomes.

Introduction

Critical demographic changes on the European continent [1] stimulated by scientific, technological, social, and economic advances have helped address many health problems. But they also present new challenges, including demand for more and increasingly complex health services as life expectancy increases, populations age, and prevalence of chronic diseases grows [2, 3].

Demographic changes over recent decades inspired countries adopt a goal: to integrate health and social care [4]. Doing so occupies a central place in the political discussion [5–7], as a key element in modernizing public policies [8]. For the purpose of this review, we define integration as an approach to delivering health care that emphasizes coordination and collaboration among varied health professionals, services, and settings to provide comprehensive and seamless care [9, 10]. An integrated system ensures patients receive well-coordinated and continuous care to meet all their needs, with a focus on quality, improving outcomes, and optimizing use of resources. In a more holistic and patient-centric approach, services include medical, behavioral, and social services [11]. Understanding quality of care, and whether a new approach will improve it, depends on an inclusive measure of patient welfare, after taking into account the balance of expected gains and losses associated with all parts and the entire process of care [12]. According to the World Health Organization (WHO), quality health services should be *effective*, providing evidence-based health care services to those who need them; *safe*, avoiding harm to people for whom the care is intended; *people-centered*: providing care that responds to individual preferences, needs and values. And, to achieve benefits of quality, the services must be timely and equitable, as well as integrated, and efficient [13].

Care of some patients is complex. No single professional can address all the needs, thus responsibility must be shared among patients and varied health and social care professionals who accompany them [6, 14, 15].

European country governments are developing policies to foster the integration of health and social care services [16–18]. These require new structures to enable



sharing assessment and governance between different stakeholders, including healthcare providers, social care organizations, government bodies, and the public, to ensure a coordinated and efficient approach to service delivery [16–20]. Studies have shown resistance to health and social care integration in some countries due to complexities of implementation, resource allocation, and management of organizational changes in the system of care [16, 21, 22]. Some emphasize a need to develop new organizational models in health and social sectors to optimize resources and enhance the effectiveness and efficiency of healthcare and social care processes [9, 17, 20, 23–25].

Several countries, notably Denmark, England, Scotland, and Norway have initiated integration and studied changes intended to ‘humanize’ the care provided—as positive results of integration of [9, 26]. Several systematic literature reviews focus on integration of these systems worldwide [8, 16, 22, 27]. Given the diversity of stakeholders involved and the need for new ways of working, researchers characterize the management and learning involved as challenges. To date, the most successful examples of health and social care integration are small scale and highly localized.

Review question and objectives

The study aimed to synthesize the findings, quality and certainty of the evidence reported in systematic reviews on health and social care integration policies worldwide. It is an umbrella review, meaning a synthesis of existing systematic reviews, which allows findings of reviews relevant to a review question to be compared and contrasted [28]. The research objectives included (1) identifying relevant systematic reviews [28]; and (2) assessing them to provide a comprehensive synthesis of evidence, including key elements or principles associated with better outcomes on models of social and healthcare integration [28]. The SPIDER model, a tool developed for qualitative research, consists of five domains of interest:

- Sample (S): Countries with integration between healthcare and social care sectors
- Phenomena of Interest (PI): Integration of health and social care
- Design (D): All qualitative, quantitative, and mixed methods reviews.
- Evaluation (E): Not applied string due to the nature of the umbrella study
- Research (R): Systematic reviews.

Understanding the impact of specific public health policy interventions will help to establish causality regarding the effects of welfare on population health and health inequalities. We conducted the review to document contextual information on the organization, implementation, and delivery of population-level public health interventions. This information can help to identify effective interventions for reducing health inequalities across and within European countries.



Data and methods

We developed a protocol following the JBI methodology for systematic reviews [29], and the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2020 checklist [30, 31]. We conducted data selection and extraction process from April through July 2022. The umbrella review protocol has been registered on PROSPERO (International Prospective Register of Systematic Reviews—<https://www.crd.york.ac.uk/prospero/>), on 08 May 2022 on the (PROSPERO: CRD42022319432) [32]. The final version of the protocol was uploaded in Open Science Framework (OSF) and it is available in <https://osf.io/nbqvc> and https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42022319432.

Search strategy

On 26 June 2022 we searched electronic bibliographic databases (PubMed, the Cochrane Database of Systematic Reviews and Embase) using combinations of both natural language terms and Medical Subject Headings (MeSH) connected with intervention as “integration”, “social care”, and “health” and terms of study-type-defining such as “systematic review” or “meta-analysis”. After selecting studies for inclusion, we also searched manually their reference lists for potentially relevant papers. We did not limit the search by dates. See the search strategy in Supplementary Material Table S1.

Study selection and eligibility criteria

Two researchers (RCM and CM) performed an initial screening of publications based on titles and abstracts. The same two independently evaluated full texts of studies that met the inclusion criteria. We included systematic reviews, with or without meta-analyses, that focused on integration of social and health care, with focus on patient-centered or service-centered outcomes. We looked for integration implemented in any health and social care setting, including primary, secondary, or community care. We included only reviews published in English, French, Spanish, or Portuguese languages. We excluded grey literature, letters to the editor, abstract or conference posters, and commentaries. We also excluded reviews that did not clearly report or provide sufficient information on the health or social care setting. The reviewers resolved most discrepancies through consensus. Where necessary, they consulted a third reviewer (GN). The screening process was blinded through the use of Covidence® software (<https://www.covidence.org/>) [33].

We identified 490 records, removed duplicates, screened 210 studies, and excluded 164 based on their titles and abstracts. We assessed forty-six full-text articles; 32 did not meet the eligibility criteria. We included the fourteen remaining articles in the analysis. Figure 1 presents the PRISMA flowchart for the selection



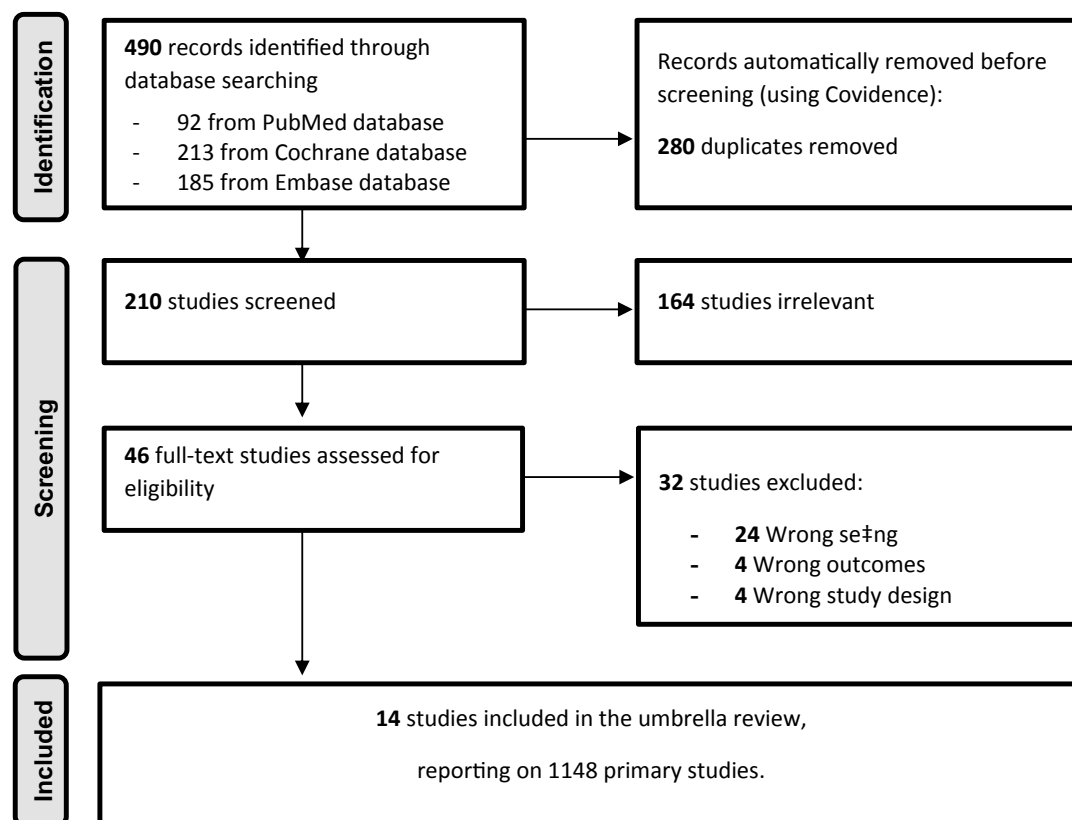


Fig. 1 Flowchart of search results

process and indicates reasons for exclusion. Due to heterogeneity of the reviews included it was not possible to conduct a meta-analysis of quantitative findings, thus we present them in narrative format.

Data extraction and management

One reviewer read the full texts of each article that met the inclusion criteria and extracted data (RCM). To ensure accuracy, a different team member (CM) also checked the data extractions. The information included: author, year, country, study aim, databases searched, number of studies included, and main findings. In Supplementary Material Table S2, ‘main findings’ refers to the outcomes, results, or significant conclusions reported. These reflect key insights, observations, or conclusions about health and social care integration policies.

Assessment of methodological quality of included reviews

Two authors (RCM and CM) critically assessed the methodological quality of each systematic review using two tools: the Assessment of Multiple Systematic Reviews tool (AMSTAR) and the Assessment of Multiple Systematic Reviews 2 tool (AMSTAR-2) [34]. AMSTAR consists of 11 items; its designers intended it to be used for content validity [35]. The updated version, AMSTAR-2, consists of 16 items covering the



entire process: topic selection, design, registration, data extraction, statistical analysis, and discussion of the systematic reviews [36]. The checklist allows ranking according to seven critical and nine non-critical areas. Based on the assessment provided by AMSTAR/AMSTAR-2, we classified the quality of each as “critically low”, “low”, “moderate”, and “high-quality”. Again we resolved disagreements through discussion with a third reviewer (GN) [36]. Of the two scales, AMSTAR-2 is more conservative, and results in very low rankings when some of the critical questions are omitted. This pertained to systematic reviews that did not provide meta-analysis.

Data synthesis and presentation

PRISMA guided our reporting [37]. We present the main results in tabular format with a narrative synthesis. We categorized results according to the three purposes: health outcomes, service quality, and integration procedures outcomes. Substantial heterogeneity among the primary studies in each systematic review, however, prevented pooling of intervention effects across reviews and meta-analyses. We present the synthesized findings according to three distinct phenomena of interest. That of health outcomes is of primary concern. Service quality emerged as a separate category because it encompasses elements that directly affect patient experiences with services and the effectiveness of health and social care delivery; but these are not related to the clinical and health status of the patient. To capture the organizational and structural aspects of integration, we grouped other findings together as integration procedure outcomes. We followed the methodology described by van Tulder et al. to evaluate the level of evidence used for synthesized findings [38].

Outcomes

The primary outcome measure is the extent to which integration of health systems is associated with quality of care, using a variety of metrics. We looked for indications of a change following integration that involved improvement of clinical outcomes, quality of life, or quality of care. We also considered avoidance of hospitalization and mortality indicators, and length of stay.

We evaluated three secondary outcomes: health, service, and economic. Health outcomes include clinical effectiveness such as mortality rates, adverse events, physical functioning, and patient-reported well-being. Service outcomes encompass utilization and accessibility of health services, hospital admissions, and length of patient stays. We examined the economic outcomes associated with health system integration, including cost savings, resource allocation, budget considerations, and performance measures. We included the barriers to effective integration and describe these in the results section.



Results

Summary and methodological quality assessment

The 14 studies reported on 1148 primary studies and review articles published between 2006 and 2021 (Supplementary Material Table S2). The number of articles covered by each review article ranged from 7 [39, 40] to 531 [41]. The majority of reviews included studies from multiple countries, although three reviews focused only on studies in the United Kingdom (UK). One review included only studies conducted in high-income countries.

The average AMSTAR score was 5.4 (range 3–10). This value indicates an average of five “yes” answers to all twelve items, thus, moderate overall quality. Low scores (poor quality) stem from items related to publication status as an inclusion criterion: listing of excluded studies, inclusion of study characteristics, and quality assessment. Most were qualitative reviews, thus there is no statistical analysis could. The AMSTAR-2 rating of overall confidence in the reviews was critically low in eight studies [8, 21, 22, 27, 39, 41–43], low in one [40], moderate in three [16, 44, 45] and high in two [46, 47]. The following domains of methodological quality are those to which all review authors adhered: (a) PICO components in the inclusion criteria and research questions; (b) establishing the methods prior to the conduct of the review; (c) using a comprehensive literature search strategy; (d) describing the included studies in adequate detail; (e) assessing the impact of risk of bias on the results of the meta-analysis; and (f) accounting for the risk of bias when discussing the results. We included only two meta-analyses in the study [46, 47] (see Supplementary Material Table S3 for the AMSTAR-2 assessment).

Below we present findings related to differing levels of evidence related to health outcomes, service quality, Integration procedures, barriers, and requirements for effective integrated health and social care (Table 1).

Health outcomes

Most reviews assessed the impact of integration on health outcomes, revealing consistent findings. We found integration yielded strong evidence of improvement in clinical outcomes [44] and moderate to strong positive impact on quality of life [16, 44–46], quality of care [16, 21, 27, 44, 46], and enhancement of self-management among older individuals with multiple chronic conditions [21, 42, 44–46]. Integration also showed promise in reducing hospitalization rates, with a moderate to strong effect [21, 40, 45, 46]. We found some inconsistent data, specifically regarding mortality rates [44], length of hospital stays [16, 27, 39, 44], unscheduled admissions [16, 27, 40, 47], and readmissions [16, 21, 27, 40, 44, 47]. Thus, the impact of integration on these dimensions remained inconclusive, highlighting need for additional investigation to establish a clearer understanding of the impact of integrated care on them.



Table 1 Summary of evidences in the umbrella review

Phenomena of interest	Synthesized finding	Level of Evidence	References
Health outcomes	Clinical outcomes (improvement)	Strong	[44]
	Quality of life (improvement)	Moderate to strong	[16, 44–46]
	Effect on quality of care (improvement)	Moderate to strong	[16, 21, 27, 44, 46]
	Self-management for older people with multiple chronic conditions (improvement)	Moderate to strong	[21, 42, 44–46]
	Hospitalization (decrease)	Moderate to strong	[21, 40, 45, 46]
	Mortality (decrease)	Inconsistent data. Clarification needed	[44]
	Length of stay (decrease)	Inconsistent data. Clarification needed	[16, 27, 39, 44]
	Unscheduled admission (decrease)	Inconsistent data. Clarification needed	[16, 27, 40, 47]
	Admissions and readmissions (decrease)	Inconsistent data. Clarification needed	[16, 21, 27, 40, 44, 47]
	Access and availability of services (improvement)	Strong	[16, 27, 39, 46]
Service Quality	Effect on patient satisfaction (improvement)	Moderate to strong	[16, 44]
	Waiting times in hospital admission and medical appointments (decrease)	Moderate	[21, 27]
	Health equity (improvement)	Moderate	[21, 43, 45]
	Prescribing rates (improvement)	Limited	[16]
	Time spent in some hospital departments as emergency(decrease)	Limited	[16, 27, 40, 42]
	Clinicians contacts—number of appointments (improvement)	Inconsistent data. Clarification needed	[16]
	Quality of care standards (improvement)	Inconsistent data. Clarification needed	[16]



Table 1 (continued)

Phenomena of interest	Synthesized finding	Level of Evidence	References
Integration procedure outcomes	Staff perceptions (improvement)	Moderate to strong	[16, 27, 40, 45, 46]
	Collaboration between social care and healthcare professionals (improvement)	Moderate	[40]
	Capacity to give ongoing support and training for care home staff (improvement)	Moderate	[40]
	Access to different resources (improvement)	Limited	[16]
	Impact in some settings of clinical care (improvement)	Limited	[16, 27, 39, 40, 42]
	Cost reduction	Inconsistent data. Clarification needed	[16, 22, 27, 39, 41, 43–45]
	Staff working experience (improvement)	Inconsistent data. Clarification needed	[8, 16, 21, 27, 40, 47]



Service quality

Strong and consistent evidence across studies indicates significant improvements in access and availability of services [16, 27, 39, 46]. A moderate to strong level of evidence supports the finding that integration produced overall positive effects on patient satisfaction [16, 44]. A moderate level of evidence supports favorable effects on reducing waiting times for hospital admission and medical appointments [21, 27]. And a moderate level of evidence supports a positive association of integration with health equity outcomes [21, 43, 45]. Only limited evidence supports a finding of favorable impact of integration on certain aspects of service quality, such as improvements in prescribing rates [16], and on reduced time spent in specific hospital departments as emergencies [16, 27, 40, 42]. Data related to the number of clinician contacts and adherence to quality of care standards presented inconsistencies [16], emphasizing the need for further research to clarify these dimensions and strengthen the evidence base.

Integration procedures

The impact of integration extends to integration procedure outcomes. Multiple studies found that Integration demonstrated a moderate to strong positive effect on staff perceptions [16, 27, 40, 45, 46], an important influence on how staff perceive and engage with integrated care initiatives. Integration also demonstrated:

- a moderate positive impact on collaboration between social care staff and health-care professionals, promoting better cooperation and coordination [40].
- a moderate effect in improving capacity for ongoing support and training for care home staff, emphasizing the importance of integrated approaches in enhancing staff capabilities[40].

Evidence of positive impact is limited in other areas, or inconsistent:

- on availability of resources and the impact of integration on access to different resources [16]
- on beneficial effects on some clinical care settings [16, 27, 39, 40, 42].
- on cost reduction [16, 22, 27, 39, 41, 43–45] and staff working experiences [8, 16, 21, 27, 40, 47] some studies pointed to positive, neutral, or negative impact.

Studies on the cost of integration found difficulties in implementation of financial integration, and budget holders' control over access to services remained limited [16]. Many partnerships proved to be costly, hard to manage, and rife with struggle over cultural, organizational, and accountability issues [46]. Integrated care showed significant results in reducing of mean treatment costs [47], but studies often concluded too soon for these benefits to be realized [39]. Although some evidence indicates that co-financing the health and social sectors can lead to improved outcomes



[24], other studies suggested inconsistencies about cost savings from avoided hospitalizations [37] and lack of clarity about reduction in service costs [27]. Integration failed to demonstrate strong evidence in cost reduction in some studies [16, 27]; others suggested that costs could actually increase [16]. A recent meta-analysis of economic evidence on integrated care across different clinical and care areas, and types of integration, found an association between integrated care and lower costs compared to usual care [43]. Most systematic reviews of delivery arrangements lack economic evaluations, thus the value of many of these models is unknown [44, 45].

Barriers

Integration may be hard to measure and overestimated by policymakers [46]. Barriers to successful operation of integration include time consumption for the services and health and social care professionals, failure to acknowledge the expertise of home care staff and high turnover of care home staff, and limited availability of training for professionals in both sectors [40]. Health equity is generally not included in the integration setting and limited evidence suggests lack of access to health care services by some populations, particularly those from marginalized communities, lower socio-economic backgrounds, or rural areas, highlighting a critical need for more inclusive health policies and practices [43, 45, 48]. Other studies report poor service coordination due to the number of professionals involved in caring, or to involvement of multiple jurisdictions and budgets for health and social care [41]. Uptake and use of technology are also major barriers, including financial investment in equipment (to set up and to continue use), licensing, and software required [45]. Despite these barriers, many integration schemes including those that failed to improve health or reduce costs have reported improvements in access to care [27].

Requirements for effective integrated health and social care

A challenge for health care systems is determining how to deliver high-value and effective care while trying to reduce the rate of increase in costs [41]. Optimal resource allocation is fundamental to success for integrated health and social care programs that depend on adequate funding, staffing, and infrastructure. Moreover, to ensure these resources are used effectively, robust economic evaluations of alternative care delivery models are essential. These evaluations inform decisions about funding allocation by comparing the relative value of different models in terms of their effectiveness and efficiency [41]. Effective integrated care requires interprofessional collaboration between health and social care professionals [16], with effective communication and shared decision-making as key elements. Definition of clear roles and responsibilities avoid duplication of efforts and allocation of resources and time ensure effective care [22].

One study identified the length of time it took for teams to become fully operational during the integration and noted that assuring long-term commitment of the organizations is also important [47]. Another study identified need for effective communication between professional groups within teams; for role awareness and



for education about working in partnership, along with professional and personal development of staff [39]. The same study identified a need to reinforce partnerships between higher education institutions and health and social care organizations [39].

Integrated care should address the unique needs and preferences of patients, ‘patient centered care’. Patients and their families should participate actively in decision-making, addressing social determinants of health, such as housing, employment, and access to social services, as well as medical concerns [16]. Integrated care programs require robust monitoring and evaluation mechanisms to assess effectiveness continually, with defined metrics to measure outcomes, including clinical outcomes, patient satisfaction, cost savings, and reductions in health disparities [22]. Intersectoral initiatives need to include a comprehensive equity analysis to identify which populations are positively or negatively affected and the conditions under which such effects occur [43].

Discussion

This study aims to enhance the evidence base for policymakers and inform future interventions by synthesizing and assessing evidence from systematic reviews about health and social care integration policies on a global scale. It identifies relevant systematic reviews and the evidence of outcomes within the integration of health and social care. We categorized evidence by health outcomes, service quality and integration procedure outcomes, and different levels of evidence. Evidence of effectiveness is limited and often subjective. Integration of social and health sectors can lead to greater effectiveness by boosting both sectors, but reduced budgets may lead organizations and professionals to withdraw from integration to protect their own funding [49]

The integration of health and social sectors aims to enhance overall care efficacy, yet financial constraints and reduced budgets could hinder these efforts. Key areas requiring further research include the impact on mortality rates, hospital stays, and patient readmission, as well as the financial implications of integration, especially in systems combining health and social care. There’s a need for improved understanding of integration’s effects on service quality, such as patient and professional satisfaction, and waiting times. While promising in improving clinical outcomes and quality of life, integration in health and social care necessitates further investigation to address uncertainties and adapt effectively to diverse healthcare contexts.

Integration is a complex process requiring high initial investment in time and resources for preparation and planning. Thus, countries sometimes reduced investment in other sectors to ensure sustainability of the integration. Studies have produced inconclusive results on the total cost reduction [27]. Integration may produce new services; these may require time to become stable, and cost savings may become visible only in the long term. Scant evidence supports this claim [50].

Some authors argue that the integration can be driven by the need for cost efficiency, rather than focusing on improving patient outcomes [51]. This review points to more evidence about improvements on health outcomes and service quality than for cost saving through the process. Thus, overall, the evidence supports integration of these two



sectors primarily to improve patient outcomes, not to contain costs. Thus, countries considering integration due to budgetary constraints should reconsider this as a way of dealing with this scarcity of resources. Improvements in patient care may be a beneficial consequence rather than the main motivation [27, 50, 51].

Comparison between countries is difficult due to the great diversity of integration models and national policies, and to the large number of outcomes that can be measured [8]. The literature categorizes the impact of integration in health care into three main areas: health outcomes, service quality, and service efficiency, which includes considerations of costs and the perspectives of healthcare professionals. In terms of health outcomes and service quality, there is clear evidence of improvement following integration, although there are still several aspects that remain unexplained or where the data are either inconsistent or too limited to draw strong conclusions. This grouping helps in systematically assessing the multifaceted effects of integration on healthcare systems. On the first two, evidence from improvement is clear, despite of several outcomes that remain unexplained, or inconsistent, or where data are too scant to support strong conclusions.

Essential to success are cooperation between entities in health and social settings to provide citizens with effective health and social care, and promoting communication between health and social services to identify if care is not being provided. So too is strengthening cooperation between the policymakers, social and health institutions.

Study limitations

One limitation of the umbrella review approach is its inclusion of only articles in systematic reviews. This may exclude the most recent information. Strict criteria for defining a systematic review and inclusion may further reduce study results that may be pertinent to the topic. By limiting our review to the authors' proficiency languages could also have excluded relevant studies published in other languages. We suspect this limitation has a negligible impact on the effect estimates and conclusions.

The diverse models and approaches adopted by different countries and regions [16, 22, 41, 44] may encompass both vertical integration (of different levels of care, services, or functions, with the coordination of primary, secondary and tertiary health care services in a tiered service delivery system), and horizontal integration, (with other organizations that provide the same or similar services) [10, 52, 53]. Although our review encompassed various models, the vertical integration model tends to be more prevalent. This emphasis reflects the nature of the integrated care where coordination and collaboration across levels of health care play important roles in achieving comprehensive and patient-centered care.

Conclusions

This umbrella review provides a quality-appraised overview of existing systematic reviews and allows for a comprehensive review of a vast topic by summarizing the evidence from multiple research syntheses into one systematic review of reviews.



We found that the scientific literature on the integration of social and health care in Europe is relatively limited, with most examples being highly localized and evidence still limited, inconsistent, or unexplored. Overall, integration of social care and health systems appears to produce moderate improvement in social and health sectors and a wide range of improvements in health outcomes, service quality, and integration procedures outcomes. Due to the limited amount of evidence available in most reviews, the current umbrella review's conclusions are weak though instructive if used with caution.

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Chapter 4

Health and Social Care Integration: Insights from International Implementation Cases.

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Perspective

Health and Social Care Integration: Insights from International Implementation Cases

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Abstract: The integration of health and social care is increasingly recognized as essential to address population ageing, the rise in chronic diseases, and persistent health inequities. Across Europe, diverse models have been developed to improve service coordination, resource efficiency, and person-centered care. This paper aims to explore international experiences in integrating health and social care, identify common strategies and challenges, and provide insights to inform policy development in countries where integration remains incipient, with a focus on Portugal. A qualitative comparative approach was employed. A systematic literature review was conducted across PUBMED, MEDLINE, and Google Scholar, including peer-reviewed articles, policy reports, and government documents. Thematic analysis was used to identify integration models, enablers, and barriers across different countries. Different models reveal that joint governance, pooled funding, strong community involvement, and digital innovation are key enablers of integration. However, common challenges persist, including fragmented governance, inconsistent implementation, and financial sustainability. In Portugal, structural separation between the health and social sectors continues to limit strategic alignment. Successful integration depends on political commitment, shared vision, and active stakeholder collaboration. European models offer adaptable lessons for Portugal and similar systems, especially regarding intersectoral coordination and preventive care. Integrating health and social care is vital for building resilient, equitable systems. Portugal must adopt a cohesive national strategy; strengthen local implementation; and embrace person-centered, sustainable solutions to ensure long-term impact. Integrating the health and social sectors is indispensable in navigating the ever-evolving healthcare landscape and promoting holistic well-being.

Keywords: integrated healthcare systems; intersectoral collaboration; patient-centered care; social determinants of health; health policy



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1. Introduction

The integration of the social and health sectors has become increasingly important, reflecting its growing relevance for society and public policy [1]. This integration refers to the collaborative effort to combine and align health and social sectors' activities, resources, and expertise to improve a population's overall health and well-being [2]. In Europe, integrating health and social care is a complex process that continues to evolve in response to political, social, and demographic changes [3,4]. In recent years, there has been a growing recognition of the need to foster collaboration and synergy between these health and social sectors, aiming to enhance healthcare quality and the overall well-being of the population [2,4]. Worldwide, healthcare faces significant challenges, notably population ageing and the escalating burden of chronic diseases [5,6]. By integrating the social and health sectors, it becomes possible to offer more efficient, patient-centered care and address clinical issues and the social determinants of health [7]. The growing recognition of the importance of this integration is mirrored in public policies and ongoing initiatives, which represent an opportunity to optimize existing resources and provide a more holistic and efficient approach to the population's healthcare needs [8].

Some of the key aspects of this integration include (a) a holistic approach to healthcare, which goes beyond treating diseases and illnesses; (b) patient-centered care, with more personalized and patient-focused healthcare services; (c) efficiency and resource optimization, with a combination of resources from both sectors, reducing efforts, streamline services, and reducing the burden on the healthcare system; (d) preventive healthcare, addressing social determinants of health, such as poverty and education and housing, by tackling the root causes of illness before they develop; (e) equity and inclusivity, seeking to reduce health disparities and promote health equity; (f) community and public health, with integration extending beyond individual patient care to focus on the health of communities and the public as a whole; (g) and, finally, policy and collaboration between government agencies, healthcare providers, and other relevant stakeholders [9,10].

Europe has diverse healthcare systems, each combining public and private resources in different ways. Integrating health and social care is therefore seen as a valuable strategy to meet the population's needs, while dealing with the challenges of a common health policy framework [11], including the complex needs of populations, particularly as they face common challenges such as ageing demographics, rising healthcare costs, and the increasing prevalence of chronic conditions [12]. Integration aims to overcome the traditional separation between healthcare and social services, offering more coordinated, person-centered support that reflects the broader social determinants of health [13].

This process involves creating collaborative frameworks between health institutions, local governments, and social care organizations, often supported by national or regional policy initiatives. These partnerships enable better coordination, more efficient resource allocation, and a more seamless experience for patients and families. However, the implementation of integration varies widely across countries, due to differences in healthcare delivery models, funding mechanisms, and governance structures [14].

Despite these challenges, the integration of health and social care is increasingly seen as essential to improving outcomes and ensuring system sustainability [1,2]. It reflects a broader commitment to patient-centered, holistic care that addresses both medical and social needs [15].

This perspective intends to present different integration examples in health and social care, analyze their implementation across various regions, and provide guidance for countries that are in the early stages of integration. Our objective is to present different integration models in health and social care, analyze their implementation across various regions, and provide guidance for countries that are in the early stages of integration. This

paper also examines the case of Portugal, a country where integration is still emerging, offering insights into challenges and potential strategies for implementation.

2. Methods

The research strategy aimed to synthesize data from multiple sources to ensure a comprehensive and comparative analysis of integration models.

Data Collection and Selection Criteria

A systematic literature search was conducted using PUBMED, MEDLINE, and Google Scholar to identify relevant peer-reviewed articles, government reports, and policy documents. The search included both original research articles and review studies, with no restrictions on publication date or geographical region, to capture the evolution of integration processes over time. Search terms included “integrated care model”, “health and social care”, “implementation”, “social and healthcare integration”, and related keywords. Additionally, reference lists of selected articles were manually reviewed to identify supplementary relevant sources. Data were selected based on their alignment with the study objectives, and prioritization was given to peer-reviewed journal articles and official government documents over grey literature to ensure academic rigor.

To systematically identify challenges and opportunities in health and social care integration, we conducted a comparative thematic analysis across different country models. This process involved reviewing policy documents to extract key implementation barriers and enablers, analyzing research findings on integration outcomes such as cost efficiency, patient-centered care, and intersectoral collaboration, and comparing integration frameworks to identify recurring challenges, including fragmentation, funding constraints, and governance complexity, as well as key opportunities, such as digital health adoption and policy harmonization.

3. General Overview of the Integration Process

The challenge of care integration requires the adequate measurement of policy implementation: the outputs and evidence of the integration have already been synthesized before [16]. Effective integration requires several key strategies, which include the development of interdisciplinary teams, improved coordination and communication between sectorial professionals, and strengthened support and training [17]. Enhancing access to resources and aligning clinical practices through shared guidelines and protocols also contributes to more cohesive service delivery [18]. Furthermore, successful integration depends on strong leadership and governance structures, capable of guiding collaboration across primary care, hospitals, and specialized services [19]. Equally important is the active involvement of patients and carers in the care process, reinforcing a patient-centered approach [20]. Lastly, the implementation of performance measurement systems is essential to monitor integration outcomes and ensure accountability, enabling continuous improvement based on real-world data [9,21,22]—Table 1.

Achieving financial sustainability is a critical component of successful integration, particularly for countries in the early stages of this process [23,24]. It requires strategic use of available resources; avoiding duplication; and promoting efficiency through coordinated service delivery and, where appropriate, consolidation [25]. Aligning financial incentives across sectors is essential to encourage collaboration and shared responsibility among healthcare and social care providers [26–28]. Emerging models such as pay-for-performance and bundled payments offer promising alternatives by focusing on the value and outcomes of care rather than service volume [29–32], which can support better coordination and shared accountability among providers [33,34]. In addition, performance-based budgeting,

informed by data and analytics, can help identify inefficiencies and guide cost-saving decisions. Resource allocation can also benefit from economies of scale, such as joint procurement and streamlined administrative functions, and from strategic purchasing and contracting practices that contribute to the long-term sustainability of integrated systems [35,36].

Table 1. Measures for assessment of health and social care integration.

Measures	Outcomes
Structural	Improved collaboration between social care and healthcare professionals Improved staff perceptions Improved support and training for care home staff Improved access to resources Improved impact in specific clinical care settings
Processes	Improved quality of care standards (inconclusive) Improved prescribing rates (limited) Improved self-management in older people with multiple chronic conditions Improved patient satisfaction Improved staff working experience (inconclusive) Improved integration and coordination of services
System outcomes	Decreased hospitalization Decreased length of stay (inconclusive) Decreased unscheduled admissions (inconclusive) Decreased admissions and readmissions (inconclusive) Increased number of clinician contacts (inconclusive) Improved access and availability of services Decreased waiting times Reduced costs (inconclusive) Decreased time in emergency departments Improved health equity
Health outcomes	Improved clinical outcomes Improved quality of care Decreased mortality (inconclusive) Improved quality of life
Patient and carer reported outcomes	Improved patient satisfaction and wellbeing Improved physical health Improved psychological and social wellbeing Improved perceptions among carers and families

Adapted from Matos et al. [16].

3.1. International Integration Models: Comparative Perspectives

Across Europe, integration has emerged as a key strategy to improve service efficiency, population health outcomes, and the sustainability of healthcare delivery [4]. In other countries, such as the United States, integration efforts have also gained relevance but follow different paths due to distinct funding structures and policy environments [37]. Although countries differ in their approaches based on institutional structures, funding mechanisms, and governance models, many share the common goal of addressing the complex interplay between medical and social needs [9,38]. This section presents a comparative overview of integration efforts in different countries.

The integration of health and social care relies on strong policy coalitions that unite diverse stakeholders, including policymakers, healthcare providers, social workers, and community organizations. Sabatier's Advocacy Coalition Framework (ACF) provides a

valuable perspective on how these coalitions form, evolve, and shape policy decisions over time [39]. According to the author, policy actors with shared beliefs and objectives come together to form advocacy coalitions, working collectively to influence policy changes and implementation [39].

These coalitions typically emerge around key policy goals, such as improving patient-centered care, reducing system fragmentation, and optimizing resource allocation [40,41]. They can operate at multiple levels—national, regional, and local—with their effectiveness depending on factors such as political commitment, shared policy narratives, and institutional support. However, opposition from competing coalitions (e.g., those resistant to structural changes due to financial or ideological concerns) can hinder integration efforts, requiring negotiation, policy adaptation, and long-term advocacy strategies [42,43].

As different countries experiment with integration models, advocacy coalitions must continuously adapt their strategies based on real-world implementation outcomes. For example, successful integration in Scotland and the UK has demonstrated the importance of intersectoral collaboration and shared governance structures, which can serve as guiding principles for other nations. In contrast, in countries where integration efforts face resistance, ACF suggests that coalitions must mobilize resources, build strategic alliances, and actively engage policymakers to overcome barriers and drive sustainable change.

3.1.1. United Kingdom and Scotland

The United Kingdom has made considerable progress in health and social care integration, particularly through the National Health Service (NHS) in England [38,44] and the model implemented in Scotland [24]. Scotland has institutionalized integration through Health and Social Care Partnerships (HSCPs), created under the Public Bodies (Joint Working) (Scotland) Act 2014 [21,45]. These partnerships align health boards and local authorities, sharing governance and financial responsibilities to deliver unified care [24].

The Scottish model emphasizes person-centered care, joint budgeting, and a focus on community-based preventive services. Successes include improved care continuity, reduced hospital admissions, and increased user satisfaction [24]. However, challenges remain in regional implementation disparities, workforce integration, and sustaining long-term funding alignment [16]. Despite these, Scotland is often cited as a leading European model of health and social care integration.

3.1.2. Sweden

Sweden has developed innovative, patient-centered integration models such as the Norrtaelje Model and the Esther Project [46]. The Norrtaelje initiative combines healthcare and municipal social services under a single governance structure and budget, facilitating coordinated service delivery for elderly patients and those with chronic conditions [47]. The Esther Project uses patient narratives to redesign care processes, ensuring that services are aligned with individual experiences and needs [48,49]. These initiatives demonstrate how collaborative governance and localized integration can reduce service fragmentation and improve outcomes. Sweden's emphasis on shared decision-making and community involvement sets a valuable precedent, although implementation can be resource-intensive and dependent on strong local leadership and administrative capacity [46,50].

3.1.3. Germany

Germany's health and social care integration is shaped by a federal and insurance-based system, resulting in significant regional variation. One of the most advanced initiatives is the *Gesundes Kinzigtal* model, a population-based, value-oriented care approach in the Black Forest region [51,52]. It brings together physicians, insurers, and community organizations to promote preventive care and manage chronic diseases more effectively [51,53].

The model has demonstrated improvements in health outcomes and cost savings, particularly through early intervention and integrated care pathways. However, national scalability is limited by decentralized governance and the structural separation of insurance funds. Nonetheless, Germany illustrates how locally tailored, insurer-provider partnerships can drive integration within a pluralistic system [51,52].

3.1.4. Czech Republic

The Czech Republic has achieved universal health coverage with relatively low public health expenditure, yet its integration of health and social services remains underdeveloped [54]. The system is primarily hospital-based, with limited coordination between medical and social care services. Family members provide the majority of elder care, with over 80% of older adults relying on informal caregiving. Integration challenges include insufficient health IT infrastructure, fragmented governance, and inadequate home-based care services. However, there is growing policy interest in transitioning towards more community-oriented care and enhancing support for family caregivers, marking the beginning of a more integrated approach [55].

3.1.5. Denmark

Denmark's health and social care integration is widely regarded as one of the most comprehensive in Europe [3,56]. Services are coordinated at the municipal level, allowing for seamless transitions between hospital, primary, and social care [56]. The country emphasizes preventive health measures, digital infrastructure, and community-based interventions [57]. Health and social services are universally available based on need, regardless of age or income, and are fully financed through general taxation. For older adults, a broad and varied set of integrated services is provided, including home help, home nursing, rehabilitation, and nursing homes, ensuring that care is available without institutionalization, except in the most complex cases. In fact, Denmark has very few institutions outside the hospital system for the frailest elderly, as municipalities are responsible for meeting their needs through community-based, integrated care. This model is underpinned by the principle of self-care, which views individuals as autonomous and capable of making decisions about their own health and life. This emphasis on independence aligns with Denmark's broader ageing policy, which supports dignity, autonomy, and active participation in society [57].

3.1.6. Italy

Italy demonstrates a unique approach to integration through its mental health reform in the city of Trieste, widely recognized as a pioneering model of community-based care [58]. Since the 1970s, Trieste has moved away from institutional psychiatry by closing large mental hospitals and replacing them with open-door services, multidisciplinary teams, and strong community support [58,59]. This model prioritizes patient autonomy and social inclusion, offering personalized care in community settings. Despite ongoing financial and political constraints, Trieste's system continues to deliver effective, rights-based mental healthcare [58,59]. Italy's experience highlights the role of local leadership, civic engagement, and human rights principles in driving integration, particularly in decentralized systems [58,59].

3.1.7. The Netherlands

The Netherlands combines universal social health insurance with innovative, decentralized care delivery models [60]. Buurtzorg Nederland, a nurse-led, self-managed home care organization, exemplifies effective integration at the community level [61]. The model has achieved high levels of patient satisfaction, workforce engagement, and cost-

efficiency [61]. Efforts are ongoing to improve interoperability of digital systems and cross-sector workforce coordination, which are critical for further integration. The Dutch experience illustrates how patient-centered innovation and decentralized governance can coalesce into scalable, sustainable integration models.

3.1.8. United States of America (USA)

The USA healthcare system is largely market-driven, supported by a mix of public and private funding, which presents challenges for achieving effective integration between health and social care. Historically, integration efforts have been limited, with a growing focus in recent years on addressing social determinants of health. Notably, the Medicaid program, established in 1965 and covering around 20% of the population, has become a key vehicle for integration, operating through a joint federal–state funding model with localized administration [37,62]. The Affordable Care Act enabled several states to expand Medicaid, extending access to low-income populations and reinforcing links between social needs and health coverage [63]. Innovative approaches, such as Social Impact Bonds, have also supported integration efforts by funding preventive interventions. Despite this progress, significant barriers remain. The U.S. healthcare system is highly fragmented, and political and ideological divisions continue to hinder cohesive, nationwide integration policies [64].

The comparison between countries reveals fundamental differences in integration models, primarily driven by healthcare financing structures and policy governance [65]—Table 2. While European countries, particularly Scotland and the UK, have embraced publicly funded, government-led integration strategies, the USA remains largely market-driven, with fragmented coordination between healthcare and social services. Scotland’s model, with its centralized governance and shared funding, provides a strong contrast to the USA approach, where financial incentives are often misaligned, and integration depends on state-level initiatives and Medicaid expansion efforts. This comparison underscores the impact of governance structures, funding models, and policy commitment in shaping successful integration efforts.

The UK boasts a publicly funded NHS that offers all-encompassing healthcare services and has a longstanding tradition of integrating health and social services [66]. The NHS is a publicly funded system that provides most healthcare for free. Some services, like emergency treatment, family planning, and care for certain infectious diseases, are free for everyone. However, other services, like dental care, prescriptions, or non-urgent treatments, may have charges, especially for people who do not meet certain exemption rules. Common challenges include patients with disabilities; the closure of public hospitals dedicated to those with physical, mental, and developmental disabilities; escalating costs related to acute and long-term care; the trend toward shorter acute-care stays with an emphasis on community-based care; and the overarching fiscal pressures experienced at both the national and local levels [67].

In a seminal paper, Leutz proffers pivotal recommendations for integrating the social and health sectors [68] regarding the importance of involving service users, carers, and community service providers in planning and oversight processes and the necessity of developing systems that seamlessly integrate, coordinate, and connect services for individuals with disabilities, whilst also clarifying the demarcation between medical and non-medical systems [68]. The UK’s integration of health and social care, led by the NHS and local authorities, reflects strong policy commitment and coordination efforts but faces challenges related to funding pressures and regional disparities in implementation.

Table 2. Comparative table of health and social care integration models.

Country	Integration Model	Key Features	Challenges
United Kingdom and Scotland	Health and Social Care Partnerships (HSCPs) with joint governance and budgeting	Person-centered care, community-based services, and joint budgeting	Regional disparities, funding alignment, and workforce integration
Sweden	Norrtaelje Model and Esther Project—joint structures and patient-centered design	Shared decision-making, local leadership, and patient narratives in design	Resource-intensive, depends on strong local leadership
Germany	Gesundes Kinzigtal—insurer-provider partnerships focused on value-based care	Early intervention, regional tailoring, and outcome-based funding	Scalability due to decentralization and insurer fragmentation
Czech Republic	Mainly hospital-based system with limited integration; informal elder care	Low public spending, reliance on family caregivers, and policy interest in reform	Fragmented governance, lack of home-based services and IT systems
Denmark	Municipal-level coordination; emphasis on preventive and home-based care	Universal access, local delivery, and emphasis on autonomy and self-care	Maintaining equity and consistency across municipalities
Italy	Trieste's community-based mental health model with strong civic engagement	Open-door psychiatric care, multidisciplinary teams, and rights-based approach	Budgetary and political constraints
The Netherlands	Buurtzorg—nurse-led, self-managed home care, and decentralized innovation	High satisfaction and efficiency, strong community presence, and digital efforts	Ensuring digital interoperability and workforce coordination
USA	Medicaid expansion and Social Impact Bonds; limited by system fragmentation	Public-private mix, focus on social determinants, and political/structural barriers	System fragmentation, political resistance to nationwide policies

Scotland has introduced a healthcare integration model that divides responsibilities between health boards and local authorities—a strategy that has shown notable success, as highlighted in a comprehensive study by Bruce and Parry [69]. The core administrative entities in this system are Health and Social Care Partnerships (HSCPs), collaborative arrangements forged between local authorities and health boards, and institutionalized manifestation sanctioned through the Public Bodies (Joint Working) (Scotland) Act 2014 [70]. These HSCPs are tasked with ensuring that healthcare and social services are dispensed in a manner that is not only synchronized but, more crucially, deeply attuned to the singular needs and aspirations of the individuals within their purview [69].

The Scottish model of integration offers several notable strengths but also presents challenges that highlight the complexities of implementing such frameworks [21]. One of its primary advantages is its comprehensive governance structure, with Health and Social Care Partnerships (HSCPs) ensuring close collaboration between health services and local authorities. Additionally, joint budgeting mechanisms have allowed for more efficient resource allocation, reducing duplication and enhancing patient-centered care. Scotland's focus on preventive care and early intervention has also contributed to improved long-term health outcomes [21]. However, despite these strengths, integration in Scotland has faced challenges related to funding sustainability, workforce coordination, and variations in implementation across regions. Some areas struggle with operational inconsistencies, where differences in local governance lead to variability in service effectiveness. Additionally, the integration process requires continuous policy adaptation, as shifting demographic trends and evolving healthcare demands create new pressures on the system. While Scotland's approach remains a leading example of successful integration, ongoing efforts are needed to streamline coordination, address financial constraints, and ensure consistency in service delivery across all regions [21].

Scotland's integration model is grounded in person-centered care, community-based support, and early intervention, aiming to improve quality of life and reduce hospital admissions [71]. It emphasizes preventive strategies and addressing social determinants of health to reduce inequalities. Strong governance, clear health and wellbeing outcomes, community involvement, and the use of digital tools support implementation. Funding is pooled across sectors to ensure flexible and efficient resource use, prioritizing individual needs over institutional boundaries [70,72].

3.2. Integration of Health and Social Sectors in Portugal: A Complex and Vital Endeavor

As the demographic and chronic disease burden grows, the need for integrated care becomes increasingly pressing, and the European models discussed provide both inspiration and guidance for Portugal's next steps.

Portugal operates a National Health Service (SNS) that provides universal coverage, yet health and social care remain structurally separated [73]. Healthcare is centrally governed by the Ministry of Health, whereas social services are managed by municipalities and third-sector organizations—non-profit private entities, mostly associations, including religious institutions and foundations. This division limits strategic alignment and coordination between health and social care sectors. Recent developments include Local Health Units (ULS), which attempt to combine healthcare and some social functions under a shared structure [74], and the Integrated Continuous Care Network (RNCCI), designed to offer long-term, rehabilitative, and palliative care [75].

One of the distinct features of the Portuguese system is its high degree of centralization in healthcare policy alongside strong municipal autonomy in social services, which often leads to mismatched priorities and a lack of shared planning. Furthermore, the strong presence of third-sector organizations, including religious and philanthropic institutions, plays a significant role in long-term and social care, which can create both opportunities for innovation and challenges in accountability.

Portugal could benefit from the experience of successful European models, such as Scotland's joint governance and budgeting frameworks, Sweden's patient-centered coordination strategies, and Germany's efforts toward regional integration. Despite some progress, Portugal continues to struggle with fragmented governance, funding asymmetries, and regional disparities in service provision. To address these issues, Portugal should consider piloting regional pooled budgeting mechanisms between health and social sectors, particularly in areas with ageing populations and high chronic disease burden. These pilots

could be supported by integrated digital case management systems that facilitate data sharing and coordinated care planning across services.

Strengthening intersectoral collaboration, adopting digital health solutions, and developing a unified funding strategy could significantly advance the integration process and promote more patient-centered care. To achieve sustainable progress, a more cohesive and strategic national approach is essential for the full integration of health and social care. Moreover, a national policy framework that incentivizes joint commissioning and formal intersectoral agreements between health institutions and municipalities could strengthen accountability and ensure alignment of goals and resources.

This integration is increasingly recognized as a necessary response to the challenges affecting system sustainability, population well-being, and the broader social determinants of health [76]. However, the process is inherently complex, shaped by intersecting political, economic, demographic, and social factors. National and regional policies aim to support these partnerships, encouraging coordinated action, more efficient resource allocation, and improved service delivery centered on the needs of individuals [77].

Demographic trends such as population ageing, rising healthcare costs, and the increasing burden of chronic diseases reinforce the urgency of integration. Regional and local autonomy adds further complexity, often hindering strategic alignment and effective coordination across sectors [78].

Building on international examples, Portugal could establish regional “integration zones” with dedicated governance teams, shared performance indicators, and budget flexibility to test different coordination mechanisms in real-world settings. To overcome these structural and systemic barriers, Portugal must commit to a long-term vision for integration that includes clear governance frameworks, robust investment in community-based services, and active involvement of all stakeholders—from national authorities to local providers and civil society. Only through a coordinated, person-centered, and sustainable approach can Portugal ensure equitable access, improve outcomes, and build a resilient health and social care system fit for future challenges.

From a theoretical standpoint, the ACF offers useful insights into the Portuguese case. Although there is growing awareness of the need to integrate health and social care, the lack of a cohesive advocacy coalition—bringing together actors from the Ministry of Health, municipalities, third-sector organizations, and civil society—has hindered the emergence of a unified vision. Stakeholders often operate with divergent policy beliefs and priorities, shaped by sectoral silos and institutional inertia. Health sector actors tend to follow a centralized, medicalized logic, while social sector entities emphasize local autonomy and social support. These differing perspectives limit the development of shared narratives and coordinated action. Furthermore, some resistance persists among stakeholders concerned about the redistribution of resources or loss of institutional autonomy.

4. Conclusions

Integrating health and social sectors has emerged as a paramount strategy in the modern healthcare landscape, particularly in the face of demographic change, rising chronic disease burdens, and increasing service demands. This study has explored the multifaceted dynamics of integration across various countries, highlighting the profound interplay between medical care and social determinants of health. International models—such as those from Scotland, Sweden, and Germany—demonstrate that collaborative governance, joint funding, and person-centered approaches can enhance service coordination, reduce inefficiencies, and improve population health outcomes.

In Portugal, despite some promising initiatives like Local Health Units (ULS) and the Integrated Continuous Care Network (RNCCI), structural fragmentation, funding asymme-

tries, and lack of strategic alignment still hinder full integration. The persistence of these barriers underscores the need for a cohesive national strategy that prioritizes intersectoral collaboration, invests in community-based services, and promotes digital innovation.

While the challenges of fragmentation, funding constraints, and political complexity persist, the potential benefits of integration are clear: improved equity, better health outcomes, the more efficient use of resources, and services that are truly centered on people's needs. Achieving this vision requires unwavering collaboration between all stakeholders—from central government to local providers, civil society, and communities—and a firm commitment to addressing the broader determinants of health.

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Section IV

The Scottish Case Study

This section includes 2 published manuscripts

Chapter 5

The Integration of Social and Health Sectors in Scotland: An Analysis from the Prism of Different Public Policy Models.

Correia De Matos, R., Nascimento, G. D., Campos Fernandes, A., & Matos, C.

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Perspective

The Integration of Social and Health Sectors in Scotland: An Analysis from the Prism of Different Public Policy Models

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Abstract: The integration of health and social care has been a key focus in Scotland, driven by demographic changes, rising healthcare costs, and the need for more efficient service delivery. The Public Bodies (Joint Working) (Scotland) Act 2014 sought to formalise this integration by restructuring governance and service provision to improve coordination between health and social care sectors. Despite these efforts, challenges remain in fully achieving the intended outcomes of the integration. This study analysed Scotland's integrated health and social care through the theoretical frameworks of public choice, institutionalism, and functionalism. The objective was to examine policy drivers, structural mechanisms, and governance implications, providing insights into the broader impact of integrated care reforms. A qualitative research approach was employed, synthesising data from peer-reviewed literature, government publications, and policy documents. The findings on integration were systematically examined through the lens of each public policy model, allowing for a nuanced analysis of how Scotland's approach to integration aligns with and diverges from these frameworks. A literature search was performed on PUBMED, Google Scholar, and Scottish government portals. While integration improved coordination and service delivery in some areas, limitations in funding allocation, workforce distribution, and governance autonomy limited its overall success. Scotland's integrated care model demonstrates potential benefits in reducing service fragmentation and improving patient-centred care; however, persistent challenges such as funding constraints, workforce shortages, and governance conflicts indicate that integration alone is not sufficient to resolve systemic healthcare inefficiencies. This study provides a perspective on Scotland's health and social care integration, offering valuable lessons for other European countries facing similar demographic and healthcare challenges.

Keywords: integrated public policy; integrated care; healthcare sector; social sector



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1. Introduction

During the last decade, Scotland underwent major reforms as the government and political parties agreed on the need for new laws, policies, and strategies [1]. With rising healthcare costs and an increasing number of illnesses linked to lifestyle choices, integrated care became a key policy goal [1]. The number of older population in Scotland has also increased, which requires an increase in the budget for healthcare [2,3]. A Joint Working Act was passed in 2014 to integrate Scotland's social and health sectors [1]. This public policy Act changed how health and social care services were planned, developed, and delivered across Scotland [1]. Several studies have examined different aspects of Scotland's health and social care integration, contributing to a deeper understanding of its policy framework, implementation challenges, and long-term impacts. Bruce & Parry (2021) provided an overview of the Public Bodies (Joint Working) (Scotland) Act 2014, detailing its legislative foundation and highlighting the structural framework of newly formed Health and Social Care Partnerships (HSCPs) [4]. The authors emphasised the Act's goal of shifting towards a person-centred approach, ensuring individuals could live longer and healthier lives at home or in familiar environments [4]. Pearson & Watson (2018) investigated the early implementation phase of the Act, revealing structural imbalances, governance challenges, and cultural barriers that hindered its full potential. Their findings suggested that, at that stage, integration was not yet systemically embedded, relying instead on individual innovators or "boundary spanners" to drive change. They argued that despite the rhetoric of partnership working, power remained concentrated within the healthcare sector, limiting the effectiveness of the reform [5]. A more recent critical perspective from Donaldson et al. (2024) assessed whether Scotland's integration reforms have successfully met their objectives and found that despite political and policy enthusiasm, the reforms have not fully delivered their intended outcomes, calling for even more radical changes to Scotland's integrated care model [6]. Similarly, Hendry et al. (2021) examined key enablers and barriers to large-scale integration, emphasising the importance of relational approaches and citizen-led models [7], and highlighted that although local successes were evident, national progress appeared slower, partly due to immature data systems for measuring community-based interventions [7]. Their study advocated for greater emphasis on place-based prevention and early intervention to tackle inequalities and ensure sustainable integration [7]. Beyond Scotland, Reed et al. (2021) provided a comparative analysis of health and social care integration across the four U.K. nations, identifying common goals and policy drivers while also highlighting variations in implementation and effectiveness [8]. Their study reinforced the need for a systematic evaluation of integration outcomes, as evidence regarding its true benefits for patients and communities remains mixed [8]. While these studies offer valuable insights into Scotland's integrated care model, our research extends this body of knowledge by applying a public policy theoretical framework, analysing the driving forces behind policy decisions, and examining how political, economic, and social factors influenced Scotland's approach to integration.

1.1. Theoretical Framework

The demand for effective and efficient healthcare services has risen over the last couple of decades [9]. As resources have always been scarce, the efficiency of the healthcare system has become a significant concern for policymakers around the world [9]. While health and social care integration has been implemented in other U.K. nations, Scotland presents specific characteristics that justify a detailed analysis. The structure of the NHS (The National Health Service) in Scotland is distinct from the rest of the U.K., operating in a more centralised and publicly funded manner, which significantly influenced the design of its reforms [8]. The Scottish legislative framework, particularly the Joint Working

Act of 2014, marked an approach to establishing a fully integrated governance model, distinguishing itself from England's more market-driven and decentralised strategy [1]. The idea of integrating social and healthcare services is not new; it had been implemented in Wales and Northern Ireland way before Scotland. In Wales, major policy reforms took place, and a range of initiatives was introduced to integrate both sectors. Similarly, Northern Ireland has also been using an integrated model since 1973. Since 1999, the Scottish parliament has been devolved the challenge of healthcare administration and the integration of health and social care services has been one of the most prominent changes in Scotland ever since the National Health Services (NHS) was created [10]. Scotland had mostly followed the British health policies of the NHS, and while integration had been the theme of implementation long before, the integration of health and social services became central law in 2014, and several policies variable from the U.K. model have been implemented since 2016 [11].

However, the National Health Services (NHS) is different in Scotland compared to other countries using integrated care structures. The NHS is treated as a separate body in Scotland and is mostly public, unlike other parts of the U.K., with additional key organisational and economic differences.

1.2. Historical, Political, and Socioeconomic Context of Scotland

Considering the historical context, the management of NHS during the post-war period was similar to the structure in the U.K. Though the policies in Scotland were a little different, Scotland had restricted autonomy. In the early 1990s, the previous model of NHS was replaced by a new model called "internal market" that was based on market principles [12]. According to the internal market model, the country's health boards became healthcare buyers for the hospital and the state's citizens. By 1997, broad steps were taken by the U.K. to damage the internal market. As a result, by the year 2000, the NHS had changed its approach and adopted the method of collaboration and integration to provide better healthcare. The government that came into office in 2007 confirmed its commitment towards services that are publicly offered with a focus on mutuality involving patients, healthcare staff, and the general public as partners [13].

The political context of Scotland in 2013 and 2014 reflected the decisions made by the Scottish Executive, also called the Scottish Government, who has been in office since 2007. The U.K. ministers and the secretary of state of Scotland had transferred powers to the new government, and the Scottish Parliament now had the competence of passing legislation. However, some reserved matters for which the decision-making power remained with the U.K. parliament. Among other devolved issues, the management of the health and social care sectors was now in the Scottish parliament's hands [12].

During the time of the Joint Act public policy, which relies on the integration of the health and social care sector, the population of Scotland was 5.2 million [14]. Compared to other states of the U.K., population density has remained low in Scotland. Though the size of the population has been stable, the number of people aged 65 and above has grown gigantically in the last couple of decades. Consequently, it was considered that the healthcare sector's expenses for the coming years would be higher than the current expenses [15].

1.3. Objective

This perspective paper has been constructed by aligning different characteristics of the public policy models. This examination of the reasons behind this law provides valuable insights for European countries facing similar demographic and healthcare challenges, such as Portugal, Spain, and Italy, where aging populations and fragmented social and healthcare

systems present significant obstacles to integration. The authors focused this perspective paper on Europe due to the region's shared policy landscape, governance structures, and legal frameworks, which make Scotland's experience particularly relevant. The structural similarities in public health governance, welfare models, and legislative processes in Europe make the Scottish experience a relevant case study for potential adaptation in these contexts.

From this perspective, the authors present a critical analysis of public policy based on the integration of the social and health sectors in Scotland. The objective was to examine the underlying policy drivers, structural mechanisms, and governance implications, providing insights into the broader impact of integrated care reforms.

2. Methods

This study employed a qualitative research approach to analyse the integration of health and social care in Scotland through the lens of three different public policy models: public choice, institutionalism, and functionalism. The selection of those models was based on their relevance to policymaking and governance structures. These models offer distinct perspectives on how policies are formulated and implemented:

Roessler and Schmitt (2021) [16] presented that the "public choice model" of public policy is concerned with the use of economic tools to resolve traditional political science issues, like the influence of power in decision-making, roles involved in governance, and political behaviours. It is known that voters' behaviour can influence public officials' behaviour, and the public choice theory results reflect the social choice theory results. One of the possible reasons for deciding on integration could be the influence of public choice theory on the policymakers in Scotland [17]. By offering efficient healthcare interventions, the chances of an increasing bank of voters for the current government were high. Hence, the policymakers agreed to provide integrated services to increase the public's trust in the new government.

The institutionalism theory presents a perspective of policymaking that suggests that individuals are embedded in institutions, and institutional support is essential for public policies [18]. Lastly, the views of functionalism emphasise the idea of offering effective healthcare to support the functional abilities of society.

2.1. Data Collection

The research strategy was adopted to synthesise data from multiple sources to ensure a comprehensive analysis of Scotland's health and social care integration. Data sources included peer-reviewed journal articles retrieved from PUBMED® and Google Scholar® as well as Scottish government publications accessed via official government portals (www.gov.scot) between January 2012 and November 2024.

A structured search strategy was applied to retrieve relevant literature, using a combination of the following keywords: ("integration" OR "integrated care" OR "health and social care" OR "health policy" OR "public bodies" OR "Joint Working Act" OR "integrated joint board")AND ("policy" OR "policy analysis" OR "governance" OR "public choice") AND ("Scotland").

2.2. Data Selection and Inclusion Criteria

Data were selected based on their relevance to the study objectives. Peer-reviewed journal articles and official government documents were prioritised over grey literature. The inclusion criteria for selecting sources were: (a) Publications focused on Scotland's health and social care integration.; (b) Studies discussing the Public Bodies (Joint Working) (Scotland) Act 2014 and its outcomes; and (c) documents analysing the impact of governance structures, funding models, and policy effectiveness.; (d) documents that incor-

porated qualitative or mixed methods approaches to evaluate integration. Only documents published in English were considered.

2.3. Data Analysis

A qualitative research approach was employed to examine Scotland's integration efforts through the lens of public policy models. The analysis began with a comprehensive review of collected documents, ensuring familiarity with the data. Key concepts related to policy implementation, governance structures, and service integration were identified and systematically examined. These concepts were then analysed in relation to the theoretical frameworks of public choice, institutionalism, and functionalism, providing a structured understanding of how Scotland's approach to integration aligns with or diverges from these models. Findings were synthesised to offer a contextualised interpretation of the integration process within the public policy landscape.

3. Results

The findings of this study were structured according to the three public policy theoretical frameworks—public choice, institutionalism, and functionalism—to provide a comprehensive understanding of Scotland's integrated health and social care system. The results section begins by examining the influence of the public choice model, which highlights how political decision-making and economic incentives shaped the integration process. It then explores the institutionalist perspective, emphasising the role of governance structures, regulatory frameworks, and institutional arrangements in shaping the implementation and effectiveness of integrated care. Finally, the results discuss the functionalism framework, which considers how integration contributes to the overall stability and efficiency of the healthcare and social care sectors by addressing the needs of an aging population and enhancing service delivery.

Each section presents key themes identified and supported by relevant literature and policy documents.

3.1. Integration of Health and Social Care Under the Influence of Public Choice

The efficiency of a healthcare system is mainly analysed based on economic and social factors, whereas political influence has always been neglected [19]. However, the Joint Act of 2014 is purely a result of specific reasons examined by politicians. The government of Scotland aimed to improve the performance of the care sector by bringing greater transparency, innovation, and technology together through cooperation [13]. The main characteristic of the public choice model is that it relies on studying the behaviours in the political realm and factors that influence decision-making in politics, with individual/material self-interest guiding economic and political behaviour. The theory deduces to anticipate the way people might respond to a given situation, and the government takes decisions to match people's choices.

The public choice model confirms that results from a political realm reflect the choice of the persons working as agents and officials with the government. As human behaviour is based on factors associated with universal explanations, the public choice model also relies on the idea that circumstances drive human behaviour. Considering the context of Scotland when the general policy was implemented, it is likely that politicians were thinking about ways to reduce health and support care expenses for the ageing population. It was realised that integrated care would help the country's citizens stay healthy and stay in their homes for a longer time [20].

The challenge of inverse care and health inequities was widening socioeconomic barriers among the public while concentrating care provision in already high practice

performance urban regions, raising concerns among rural populations [21]. The public choice of equality motivated the development of GP (General Practitioners) clusters in 2018, which could direct resources as well as staff in practice deprivation regions, thus enhancing public trust in both the quality of care and serving government [4].

The increasing cost of longer hospital stays and rising accidents and emergency burdens, in combination with declining performance, rose public concerns in 2013/14 [6]. By that time, the implementation of integrated care across the world had been beneficial in chronic management and elderly care; therefore, Scotland adopted the newly emerging approach of integrated care to address the public's choice of quality care provision at low costs [22].

Also, efficient health and social care would satisfy residents, who would likely be willing to vote for the same government again shortly. In other words, there were several individualistic benefits associated with the decision of health and social care integration, which had made politicians of that era pass the integrated public policy. The health status largely influences the population's attitudes towards a government.

The choice of public plays a significant role in making and breaking governments, and bringing an integrated approach forward to offer better healthcare was a favourable move. The policy implementation improved the service quality of both social and health care services as integration became a policy priority for the government.

3.2. Relationship of Institutionalism with the Integration of Health and Social Care

The institutionalist model emphasises the idea that the effective implementation of a public policy requires properly structured institutions. Economic instability reduces the spending power of states, and as a result, the budget allotted to the healthcare sector is limited. Due to financial constraints, delivering value-based health and support care services becomes a challenge for state governments [23]. Hence, for most European countries, providing better healthcare has become a challenge because of the limitation of funds and finances.

Conversely, institutional theory offers a conceptual framework through which the government in the office can respond to the external demands of health and social care by utilising the internal resources of organisations. The approach with which an organisation responds to external pressures largely depends on the way institutions manage the overall structure of organisations within a given sector. The way organisations are structured within a society reflects the efficiency of institutions involved in the management of organisations [24].

The creation of a public policy of integration aimed to offer high-quality healthcare so that the early prevention and intervention of disease could be made possible. The politicians of Scotland knew about the country's socio-economic realities and were aware that many people of the country are aged above 50 years. The demographic statistics of Scotland indicated that the elderly population, over 60 years old, is increasing at a 50% rate of the overall population [25]. Furthermore, nearly 40% of the total population of Scotland is aged above 50 years. Subsequently, there was a high chance of aged people needing various care and support services to manage their lives in the next few years. Carey et al. (2014) state that countries with an ageing population must develop policies to strengthen the healthcare system [26]. In doing so, it is essential to consider different social factors related to individuals' health and well-being. Such social factors are income level, education level, adequate housing, and access to health/wellness services. Integration could result in more vital institutions with an improved focus on delivering quality health and social services.

Strong institutions can work towards establishing efficient clinical practices, through which health outcomes for the patients can significantly improve [27]. With a focus on institutional transformation, planning and delivering healthcare/social care services could improve [24]. Considering the same assumption of strengthening institutions, policymakers of Scotland had passed the legislation of integrating health and social sectors. As per this new approach, all of the different units of the health care sector and social sector were legally required to work together to improve the lives of the population residents [28].

3.3. Influence of Functionalism on the Integration of Health and Social Care

The policymakers of Scotland took the theory of functionalism into account before deciding on the public policy for the healthcare sector. Planning and delivering a service are the two most essential functions in promoting superlative health and social care [29]. The theory of functionalism enables that better quality of health and social care can enhance the overall functionality of society. The critical aspects of functionalism are associated with stability, order and consensus within the community. The ideas of functionalism also consider monetary and political contributions as a mode of connecting citizens and the democratic process of the state.

The key concept of functionalism spares the sick person of societal obligations until complete well-being [30]. Scottish policy, under the influence of functionalism, spared chronically ill and elderly patients of constraints of their income and means and, while they are a social and financial dependent component of society, the Scottish government took care of their housing, social interaction, physical activities, free health, and social care as well as the provision of care at the doorstep thus fulfilling their needs and sparing them of worldly chores regardless of income and residential status through the integration of local and health authorities according to new legislations [31]. The issue of limited mobility/disability and resource deprivation has been addressed through remote consultations using telehealth [32].

Functionalism, however, refers mostly to acute sickness, which has been addressed by the Scottish integrated care system through the management of unscheduled calls and visits under NHS boards funded by separate resource allocation [33]. Chronic illness, which has been neglected by functionalism, is the centre of service delivery for the Scottish NHS. Multidisciplinary teams in both primary and secondary care, with the assistance of social care providers, address the physical, mental and social well-being of multiple morbidities within single geographical constraints, reducing the risk of long-term hospital admissions [34].

Considering the same assumption from the theory of functionalism, the integration of health and social care was aimed at improving the functionality of the NHS that is being provided in Scotland. Ever since 1997, every strategic document of the health boards of Scotland has featured integration to enhance the functionality of the healthcare system.

The idea of integration was not only focusing on the external integration of the health and social sector, but it also aimed to create internal integration within the health sector of Scotland. As integration would improve functionality for society, policymakers were willing to take steps to integrate health and social care. Conversely, the main goal of a public policy is to improve the lives of the residents of a country, and the lives can improve when the functionality of society improves. The integration of health and social sectors turned out to enhance society's functionality and improve the health and well-being of the Scottish people [35].

3.4. Integration Model

The model used to integrate Scotland's social and health care sectors is based on partnerships established across the country. These partnerships across Scotland were managed by billions of resources provided by the government body. The Joint Act of 2014 presented an integration scheme jointly prepared by the local authorities and health boards of Scotland. Within the main integration scheme, some subschemas were designed to target different regional areas of the country [36]. The government used a decentralised approach and gave both health boards and local bodies the freedom to distribute significant functions between them, which is called a lead agency arrangement. The policy also allowed health and local authorities to delegate the power of integration to a third body called the Integration Joint Board (IJB) [36].

The implementation of the Joint Act in 2014 took emergence in the form of 14 NHS boards and 32 democratically elected councils, which partnered with non-elected Integration Authorities who were responsible for the locality-based service integration of health and social care while seeking funding from NHS boards and were accountable and supported by both the boards and council [4]. Electoral and administrative clash, manifesting into funding and subsequent outcome restraints, led to the abolishment of Quality and Outcomes Framework (QOF) and development of GMS (General Medical Services) contract whereby general practitioners were controllers of locality-based GP clusters and patient data, and were responsible for patient care decisions and providing social carers access to information [37]. The ongoing challenge of health inequity and the introduction of technology into healthcare was planned to be addressed through remote care provision to rural areas through telecare in light of the Telehealth Act 2016 [38]. With the realisation of the disproportionate demand and supply of healthcare as per inverse care law, the GP contract was remodelled in 2018 to define the role of GPs, who were empowered to hire and relocate multidisciplinary teams to ensure distribution in neglected areas. General practitioners were allocated key care decisions and responsibilities for earlier consultations so as to reduce hospital admissions and emergency visits, and simultaneously, care was directed more multidisciplinary through community-based MDT (multi-disciplinary teams), including specialists, nurses, social carers, pharmacists, etc., for enhancing complex multimorbidity care quality and reducing GP and indoor workload [39]. The 2021 revision of the GP Act adopted further defragmentation of GPs by which preventive services, including vaccinations and pharmacotherapy, were returned to health boards, as well as the inclusion of MDT into primary care. Allocation of additional funds was guaranteed for the burden of services on GPs during the transition period as well as for the recruitment of sufficient MDTs [40]. The introduction of the National Care Service (NCS) 2021 led to the proposition of replacing integration authorities with community health and social care boards and centralising social care while service delivery was emphasised for elders and deprived regions [41].

3.4.1. Financial Reforms

In 2016, the Central government announced the allocation of more funds to primary care. Integration joint boards could spend two-thirds of the NHS and social care budget but with restricted autonomy as they were responsible for reporting to both NHS boards and elected councils, thus limiting the effective utilisation of resources [6]. As the challenge of disproportionate need and supply emerged since 2007, the Scottish government redirected health funds in 2018 as GPs were relieved of their leadership roles and local authorities were empowered to adjust funding for higher-need populations, including elderly and chronic illnesses, and highly deprived regions, including rural and low socioeconomic

regions. Funds were also allocated to cover practice expenses for clinical service delivery and the additional needs of rural practitioners [42].

3.4.2. Health Reforms

Besides chronic illness and elderly care, mental health has been prioritised by Scotland as is evident by the enactment of Mental Health act 2015, mental health strategy 2017, and Mental health and well-being strategy 2022, which defined rights of mentally ill people and formulated principles for indoor and emergency psychological care provision along with strategies for effective implementation, promotion and easy access [31,43]. The challenge of the isolation and integration of community into social care for the elderly was overcome through legislations like Connected Scotland 2018 [44] and Fairer Scotland for Older People 2019. The Strategic Framework for Action on Palliative and End-of-Life Care 2015 involves the integration of families, healthcare and social care professionals for planning and delivering palliative and end-of-life care for the elderly [45].

For sustainable service delivery, the health system focused on the involvement of individuals for the management of their own health and well-being in 2016 when National clinical strategy empowered patients through educational programs and digital tools with the knowledge, skills, and confidence to self-manage their treatment plan, track progress, provide real-time feedback, and consult experts remotely thus reducing complex illness and complications related hospital admissions. Patients have autonomy over personalised care programs for lifestyle modifications, medications, and mental health well-being [46].

Scotland has long anticipated the transformation of healthcare through technology, focusing on key advancements such as remote healthcare delivery for rural communities and elderly, the empowerment of patients in tracking and managing personalised care, and the digitalisation of expert consults and triage in both primary and secondary care. Data sharing among stakeholders, including researchers and industry has been facilitated by legislation such as the National Telehealth 2012 [38], the eHealth Strategy 2017 [47], the Digital Health and Care Strategy 2018, and the revised strategies introduced in 2021 to enhance a Scotland's position in the digital healthcare landscape [48,49].

3.4.3. Public Reforms

Unlike the U.K. model of means-dependent charges of care and upper limit for free care, Scottish policy adopted the universalist approach of free health and social care for elders above 65 years in 2002 and extended this to free care for all people regardless of age, income and residential status in the Community Care Act 2018 [50]. Scottish health model acknowledged and incentivised the role of unpaid carers and directed local authorities to develop the adult carers' support programs as well as assistance for younger carers depending on individual needs in 2013 while Carers act in 2016 required government support for Carers' health and service integration of social carers into health amid requirement for local carer strategies [51].

Age Home and Community, a Strategy for Housing for Scotland's Older People Act 2012–2021 tasked local governments to arrange aging-friendly affordable housing, foster community engagement, and integrate housing providers with health and social carers to provide effective elderly care at the doorstep [52]. Through Active Scotland legislation in 2018, Scottish policymakers implemented the integration of workplace and healthcare to provide a physically active environment at workplaces as well as in the outdoor environment to promote mobility in elders and reduce the healthcare burden through healthy lifestyles in the youth [53].

4. Discussion

This study focuses on Scotland due to its distinct approach to health and social care integration within the U.K.. Unlike other countries, which pursued a commissioning-based and competitive provider model, Scotland introduced substantial reforms with a strong public and centralised focus. The country faced unique challenges, such as a rapidly aging population and increasing care demands in rural areas, which drove innovative policy measures. The findings from the Scottish integration policies offer valuable insights into the potential benefits and challenges of integrated care systems. These results underscore the importance of coordinated efforts between the health and social care sectors to enhance care delivery while navigating systemic barriers. The evidence indicates that integrated care can significantly improve patient outcomes in several dimensions, such as shorter hospital stays and better quality of life.

Despite these positive outcomes, the inability to attract GP and MDTs to deprived areas, even with hiring autonomy, underscores the persistence of the inverse care law. This highlights the need for more innovative and radical policies to ensure the equitable distribution of healthcare resources. The limited autonomy of IJBs in managing funding was another critical issue. The proposed transition to community care and health boards, while addressing these limitations, inadvertently added financial strain due to inadequate accountability mechanisms.

Until 2019, the Scottish integration policies have successfully reduced the duration of hospital stays, but the effect on mortality remains unaltered [54]. Recent research has highlighted the psychological and behavioural benefits of integrated care, particularly in enhancing patient self-efficacy [54,55]. A comparative study by Alonso et al. [54], found that individuals receiving integrated care exhibited significantly improved self-efficacy levels, patient engagement, and adherence to treatment plans. Specifically, the study reported a 7.7% higher self-efficacy score among individuals benefiting from integrated care, suggesting that the coordinated approach to health and social services fosters greater confidence in managing personal health [54]. These findings indicate that integration enhances patient autonomy, reduces uncertainty regarding care pathways, and promotes proactive health behaviours. Additionally, integrated care has been associated with reduced psychological distress, particularly among elderly and chronically ill patients, further underscoring the holistic impact of this model on patient well-being [55,56]. Studies have also found that while integrated carers preferred safety and timely response to unscheduled care seekers, 90% of the people used NHS unscheduled care during the last year of their life and estimated that while NHS managed most of the unscheduled care burden of community, they consumed only 3.9% of unscheduled care budget emphasising cost-effective out-of-hours and end of life integrated care [57].

Literature has, however, observed the failure of GPs to relocate and recruit practitioners and MDTs in deprived areas despite complete autonomy over hiring and distribution of staff, thus requiring radical policies to combat the inverse care law [21]. Donaldson et al. observed that the limited autonomy of integrated joint boards on funding resulted in resource utilisation according to status quo directions especially in the absence of mechanisms of shifting funds and while government tried to address this issue by replacement with community care and health boards, transition process has added to the central financial burden in the absence of appropriate accountability mechanism [6]. The authors suggested that the NHS boards and IJBs could keep functioning under separate funding arrangements with accountability from representatives from health and social care as well as an elected body [6].

This study confirmed that the health and social sectors could improve both institutions and functionality within a society [58]. While integrated care has been positioned as a key

strategy to enhance healthcare delivery, its effectiveness in Scotland remains a subject of debate. Although some evidence suggests that the system has demonstrated resilience despite demographic, workforce, and financial constraints, recent studies indicate that integration in its current form faces significant structural and operational barriers [7]. Donaldson et al. (2024) argue that despite policy enthusiasm, the anticipated improvements in care coordination, efficiency, and patient outcomes have not been fully realised, necessitating more radical reforms [6]. Similarly, Reed et al. (2021) highlight persistent governance challenges and funding limitations that continue to hinder progress [8]. These critiques emphasise that without stronger mechanisms for accountability, sustained investment in workforce capacity, and refined policy execution, integration alone is unlikely to meet its intended objectives.

The findings from Matos et al. further reinforce this perspective by demonstrating that, at the international level, while health and social care integration has yielded improvements in clinical outcomes, quality of life, and service quality, its impact remains inconsistent due to fragmented implementation and variable policy execution. They found that integration efforts have resulted in better access to services, reduced waiting times, and increased patient satisfaction [59]. However, they also noted that improvements in cost efficiency, collaboration, and staff perceptions often rely on limited evidence, underscoring the need for more rigorous assessment of long-term impacts. These insights align with the Scottish experience, where integration has shown potential benefits but remains constrained by financial pressures, workforce shortages, and challenges in governance structures [59].

Moreover, prevention and early intervention are important in reducing healthcare burdens and ensuring long-term sustainability. While localised and equity-driven approaches offer potential benefits, their success depends on clear financial commitments, strategic workforce planning, and the ability to adapt services to evolving population needs. To maximise integration's impact, policymakers must address existing inefficiencies, enhance funding transparency, and reinforce decentralised decision-making processes to empower local health and social care structures.

Strengths and Limitations of the Study

This study provides a comprehensive analysis of Scotland's health and social care integration through the lens of public policy models, offering a unique theoretical perspective that enhances our understanding of policy drivers and outcomes. A key strength is the use of multiple frameworks—public choice, institutionalism, and functionalism—which allow for a multidimensional evaluation of policymaking and implementation. Additionally, the study synthesises evidence from a diverse range of sources, including peer-reviewed literature, government reports, and comparative analyses, ensuring a robust and well-supported discussion.

However, some limitations must be acknowledged. The study relies primarily on secondary data, which may introduce biases related to publication selection and reporting. Another limitation is that the long-term sustainability and effectiveness of Scotland's integration model remain subject to ongoing policy and governance changes, making it difficult to draw definitive conclusions about its success. Finally, while the study applies theoretical models to explain policy choices, the complexity of real-world decision-making means that additional social, cultural, and economic factors may also have played significant roles which were not fully captured within this framework.

5. Conclusions

This study critically analysed the integration of health and social care in Scotland through the lenses of public choice, institutionalism, and functionalism, providing insights

into the policy motivations, structural changes, and broader implications of the 2014 Joint Working Act. The findings suggest that Scotland's approach was shaped by political and economic considerations, institutional capacity, and the functional necessity of improving healthcare access and efficiency. While integration aimed to enhance service coordination and long-term sustainability, its implementation revealed challenges related to governance, funding, and workforce distribution.

This study contributes to a deeper understanding of the decision-making processes behind integrated care and highlights both the potential and the limitations of such reforms. The Scottish experience offers valuable lessons for other European countries facing similar demographic and systemic challenges, emphasising the need for well-structured policies, sustained investment, and adaptable governance frameworks. Moving forward, continued evaluation and refinement of integrated care policies will be essential to ensure equitable and effective healthcare delivery.

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Chapter 6

Integration of the Social and Health Sectors in Scotland: Assessment of the First 5 Years (2014–2018).

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Integration of the Social and Health Sectors in Scotland: Assessment of the First 5 Years (2014–2018)

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Keywords

Integration · Health policy · Healthcare systems · Scotland · Outcomes

Integração dos setores sociais e de saúde na Escócia: avaliação dos primeiros cinco anos (2014–2018)

Palavras Chave

Integração · Políticas de saúde · Sistemas de saúde · Escócia · Outcomes em saúde

Background

In Western societies, the emergent societal challenges require changes in public policies to manage their consequences and to avoid a demise in public sectors. Public health is a coordinated system that engages the government and multiple stakeholders to protect and improve population health through prevention, policy, and community initiatives [1]. Moreover, it requires a clear framework that defines where leadership should be

positioned and at what level it should function [2]. This is essential to develop, implement, and sustain efficient policies and face complex public tasks.

In Scotland, during the last decade, there has been an increase of 25% in people over 75 years, the highest number of health and social care service users ever [3]. In 2011, the Scottish government published a manifesto stating it would deliver a single integrated health and social care system across Scotland [4]. To comply with a national health and social care integration (HASCI), in 2014, the government published the *Health Care with Social Services: Public Bodies (Joint Working) Act 2014*, with guiding norms for regional implementation [5].

HASCI requires health boards and local authorities to partner with the third sector, users, carers, and other key stakeholders. It motivates the creation of a more joined-up care experience for people with health and social care needs. To achieve a more integrated patient experience, health and social care providers often need to integrate at an organizational level [6]. This is critical to sustain the four key areas of HASCI [7], namely, (1) reduce hospital admissions; (2) move toward prevention; (3) promote more personalized health plans; and (4) enable individuals to live more independently [7].

In this sense, the integration of health and social policies is a process that can be achieved through many ways: pooling of funds, strategic planning, functional and organizational consolidations, joint commissioning, service colocation, joint programs, centralized case management and information systems, multidisciplinary teams, shared diagnostic procedures, and patient involvement [8]. Specifically, regarding the healthcare sector, there are four main types of integration: functional, organizational, professional, and clinical, which can occur either horizontally or vertically [9, 10], while most countries have introduced integration schemes to promote professional or clinical collaborations horizontally. This letter examines the integration of the social and health sectors in Scotland, focusing on the first 5 years of implementation following the Health and Social Care Integration policy framework (2014–2018). It specifically analyzes key policy measures and structural changes introduced to facilitate integration, assesses progress based on publicly available outcome data and official reports, identifies challenges and barriers affecting the effectiveness of integration, and discusses future steps to enhance coordination between health and social care services. By examining these early-stage impacts, policymakers, healthcare providers, and stakeholders can make informed decisions about necessary adjustments, ensuring that integration efforts lead to long-term improvements in care delivery. Additionally, understanding initial successes and shortcomings can help refine strategies for future policy development, optimize resource allocation, and enhance the overall effectiveness of integrated health and social care services.

Implementation of HASCI in Scotland

Background and Policy Framework

Scotland has built an integration model for the last decade [5]. In Scotland, the health and social care system is structured around three main administrative bodies: health boards, local authorities, and integration authorities (IAs). Health boards are mainly responsible for delivering healthcare services, including hospitals and primary care, and are funded by the Scottish government. Local authorities oversee social care services, including care homes, home care, and community-based support. *Public Bodies (Joint Working) Act 2014* mandated the creation of IAs to bring these two systems together. Each IA operates through an Integration Joint Board (IJB), which consists of representatives from the health board, local authority, and other stakeholders [5].

IJBs are responsible for strategic planning and allocation of resources for integrated services, aiming to improve coordination and efficiency between health and social care sectors [5]. The relationship between these entities remains crucial to understanding the governance of integration. While health boards and local authorities retain statutory responsibilities, IAs function as decision-making bodies that bridge the two sectors. Health boards and local authorities delegate specific functions and budgets to IAs, which in turn develop strategic plans for service delivery. However, challenges arise due to variations in financial control, accountability structures, and implementation across different regions, impacting the effectiveness of integration efforts [11].

Integration Models and Outcomes (2014–2018)

Starting with the *Public Bodies Act*, it describes two models of integrating health and social care: the Body Corporate model, where there's a delegation of tasks between the health board and local authorities to an IJB, with the responsibility of planning and resourcing services, and the Lead Agency model, where the lead responsibility for planning, resourcing, and delivering care is kept within the health board and local authorities' boundaries. The Body Corporate and Lead Agency models are alternative approaches to HASCI rather than coexisting structures. Each IA in Scotland was required to adopt one of these models based on regional governance preferences. The majority of health boards and local authorities have implemented the Body Corporate model, wherein an IJB oversees planning and resourcing [3]. The Lead Agency model, adopted in fewer regions, retains planning and delivery responsibilities within a single authority. Implementation across Scotland has progressed at varying speeds, with some regions demonstrating more advanced integration than others. The national boards have provided nine health and well-being outcomes for the process of integration [5]:

1. People can look after and improve their health and well-being and live in good health for longer.
2. People, including those with disabilities or long-term conditions or who are frail, can live independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services and have their dignity respected.
4. Health and social care services are centered on helping maintain or improve the quality of life of those who use those services.
5. Health and social care services contribute to reducing health inequalities.

Table 1. Trends in healthcare utilization measures (2014–2018)

Measures	2014/15	2017/18
Acute unplanned bed days	4.15 m	3.91 m
Emergency admissions	574.974	593.531
Accident and emergency admissions – performance	Four-hour A&E waiting time	Time declined since 2014/15
Accident and emergency admissions – attendances	1.64 m	1.65 m
Delayed discharge bed, days	527.099	494.123
End of life spent at home or in the community	86.2%	87.9%
Proportion of over 75s who are living in a community setting	98%	98.2%
Resources for integration	GBP 8.0 billion	GBP 8.3 billion

Adapted from “*Health and social care integration: Update on progress*” [12].

6. People who provide unpaid care are supported to look after their health and well-being, including reducing any negative impact of their caring role on their health and well-being.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they found and are supported to continuously improve the information, support, care, and treatment they provide.
9. Resources are used effectively and efficiently to provide health and social care services.

In 2018, the “*Health and social care integration: Update on progress*” document produced by Audit Scotland provided a synthetic overview of what was happening regarding different measures of the HASCI process in many regions across Scotland (Table 1) [12]. The integration process yielded mostly positive results, with improvements across several key indicators, except for emergency admissions [12]. By the end of the analyzed period (2018), emergency admissions had shown no significant reduction (in 2019 increase of over 1% in emergency admissions) [13], raising concerns about whether integration was effectively alleviating pressure on acute care services, and suggesting that integration was not positively impacting emergency admissions. Meanwhile, other indicators demonstrated a positive trajectory, reinforcing optimism about the integration process. Additionally, challenges remained in supporting unpaid carers, as indicated by the limited improvements in homecare hours across local authorities. In response to these concerns, policies such as *The Carers (Scotland) Act 2016* were introduced to strengthen

support mechanisms and address gaps in social care provision [14].

Moreover, integration implementation was processed at different speed levels across Scotland. Generally, IAs with higher ratio scores regarding integration outcomes have shown statistical correlation with reduced emergency readmission to the hospital within a month of discharge, a higher proportion of the last 6 months spent at home or in a community setting, reduced percentage of health and care resources spent on hospital stays [15].

Although the focus of this letter is the period 2014–2018, subsequent developments are briefly mentioned for contextual understanding only. In the years following the analysis (2019–2020), several indicators showed improvement, including fewer falls, reduced emergency admissions, an increase in people receiving intensive care support at home, and a decline in delayed discharges. The reduction in falls across most IAs suggests that stronger policies and management strategies have been implemented to enhance fall prevention among older adults. However, while these improvements are promising, broader systemic factors continue to shape the integration process. One key factor is the trend in real-term health service spending across the UK. Although spending has increased over the years, growth in Scotland has been the slowest, as reported by Reed et al. [16] (Fig. 1). This financial constraint may limit the sustainability and scalability of integration efforts despite the observed progress.

The Community Care and Health (Scotland) Act 2002 maintained separate statutory responsibilities for health boards and local authorities. Still, it conferred the power to transfer specific functions between them and the power to create pooled budgets [17]. *The NHS Reform*

Fig. 1. UK health and social care system overview. Comparison between UK counties – Adapted from Reed et al. [16] – data from 2019/2020. While the primary analysis focuses on the first 5 years of integration (2014–2018), these data are included solely to provide contextual understanding and to illustrate cost trends beyond the analyzed period.

	England	Wales	Scotland	Northern Ireland
Spending per person on health services, 2019/20, £	2,427	2,546	2,507	2,616
Spending on health services as a share of total public spending	25%	23%	22%	22%
Social care* spending per person, 2019/20, £	318	416	476	521
Spending on social care as a share of total public spending	3.3%	3.8%	4.1%	4.3%

(Scotland) Act 2004 immediately followed, requiring health boards to create community health partnerships to develop integrated primary care, community health, and social care services [16].

This policy is aligned with some pillars to enable the implementation of an integrated care framework [18], like shared values and vision, system-wide governance and leadership, people as partners in care, and workforce capacity and capability. A recent report on health and social care staff experience [19, 20] concluded that the overall experience of the workforce with their engagement with the institutions has improved from 0.1 points to 6.9 between 2018 and 2022 [19, 20]. This is a positive sign for the integration process and an important step for institutional culture and management [12].

Throughout this process, the integration initiative was expected to drive efficiency savings and enhance the quality of health and social care, in line with national frameworks and the evolving focus on well-being outcomes. However, the report by Audit Scotland (2018) and the ministerial progress review uncovered considerable barriers, especially regarding measurement, variation, and financial planning [19, 21], highlighting that the Act 2014 intended to help shift resources away from the acute hospital system toward preventive and community-based services. Still, specific barriers were delaying the integration process, namely, financial pressures impair IAs to make sustainable changes to care delivery, hospital services have not been delegated to IAs in most areas, and there is a need to improve the monitoring and public reporting on the impact of the integration process.

Scotland's integrated care model demonstrates potential benefits in reducing service fragmentation and

improving patient-centered care; however, persistent challenges such as funding constraints, workforce shortages, and governance conflicts indicate that integration alone is not sufficient to resolve systemic healthcare inefficiencies [22]. These challenges are not unique to Scotland. A comparative analysis by Reed et al. [16] found that across the UK, integration efforts have struggled to deliver the expected reductions in hospital admissions and delayed discharges. Similarly, Donaldson et al. [23] argued that while Scotland's HASCI has been widely promoted as a progressive reform, the actual outcomes remain far from the ambitions set by policymakers. Their analysis suggests that institutional inertia, persistent funding constraints, and operational silos between health and social care services continue to hinder the realization of a truly integrated system [23]. Without greater accountability mechanisms and a shift toward outcome-driven integration, Scotland risks maintaining the rhetoric of integration without delivering the expected substantial improvements in service delivery and patient experience [23]. Despite promising examples of integrated care, the evidence on cost benefits remains inconclusive [9]. The mismatch between policy expectations and real-world implementation remains a key issue, with integration models often failing to address underlying structural and operational challenges. Additionally, the absence of standardized evaluation metrics has made it difficult to assess progress effectively, leading to overestimated expectations from policymakers and inconsistent reporting across different regions. Recent evidence further supports these concerns, showing that integration policies often face structural and financial limitations that hinder their effectiveness. De Matos et al. [11] found that while integration can

improve collaboration, service access, and patient satisfaction, the financial sustainability of these models remains uncertain. Many integration schemes have not demonstrated significant cost savings, and in some cases, financial constraints have led to delays in implementation and inconsistencies in service delivery.

Given these findings, there is an urgent need for more robust, long-term evaluation frameworks that move beyond structural integration and assess the real impact on patient outcomes, service efficiency, and financial sustainability. Scotland's experience highlights that simply establishing governance structures is insufficient; successful integration requires ongoing investment, adaptive policy responses, and a commitment to cultural and operational change. Future integration efforts should prioritize outcome-based performance monitoring and ensure that financial models are aligned with long-term sustainability goals, rather than short-term restructuring measures.

Future Steps

Building on the initial results observed between 2014 and 2018, future strategies must address existing gaps and ensure that integration leads to tangible improvements in outcomes, resource use, and patient experiences. The integration of health and social care in Scotland between 2014 and 2018 showed positive trends in some areas, such as reductions in delayed discharges and increased home-based end-of-life care, but also revealed persistent challenges, particularly regarding emergency admissions and financial constraints. These mixed results highlight the need for further efforts to strengthen and sustain integration. Many studies have suggested the need to integrate these two sectors, but few address the effectiveness of that integration, either vertically or horizontally implemented. New studies and

projects should cultivate and raise awareness within public institutions and advocacy bodies to cover areas like engagement and involvement, empowerment, collaboration and coordination, innovation and improvement, reflection, and learning [18, 24].

Statement of Ethics

No study approval statement or consent to participate was needed for the development of this manuscript.

Conflict of Interest Statement

The authors have no conflicts of interest to declare. The authors declare that no experiments were performed on humans or animals for this investigation. The authors declare that no patient data appear in this article.

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Data Availability Statement

Detailed data are available upon reasonable request to the corresponding author.

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Section V

Governance Priorities for Portugal

This section includes 1 submitted manuscript and 1 book chapter in prelo

Chapter 7

**Health–Social sector’s Integration in Portugal: A Delphi
consensus on benefits, barriers and strategic priorities for
Governance.**

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Health–Social sector’s Integration in Portugal: A Delphi consensus on benefits, barriers and strategic priorities for Governance

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Abstract

The integration between health and social sectors has become a central policy challenge in European health systems. Fragmented governance, separate financing, and demographic ageing have exposed the limitations of siloed service delivery. In Portugal, despite a long-standing political commitment to improve coordination between the National Health System (*Serviço Nacional de Saúde* -SNS) and the Social Security, integration remains limited and inconsistent. This study aimed to identify and prioritize key advantages, barriers and obstacles, and strategic initiatives for implementing effective health-social integration in Portugal. A two-round Delphi study was conducted using the Welphi® online platform between July and October 2025. A purposive panel of 105 experts from health, social care, academia, and public administration were invited to participate. In Round 1, 36 participants provided open-ended responses on the perceived advantages, barriers, and strategies for integration. Qualitative analysis produced a consolidated list of items for quantitative rating in Round 2 using a 9-point Likert scale. Descriptive statistics (median, interquartile range, and percentage agreement) were calculated for each item. Consensus was defined as $IQR \leq 2$ and $\geq 70\%$ of responses ≥ 7 points. Experts achieved consensus on 21 advantages, 22 obstacles, and 23 strategic measures. The highest agreement ($\geq 90\%$) was observed for benefits related to autonomy, healthy ageing, and reduced hospital admissions. Key barriers included institutional fragmentation, separate budgets, and lack of interoperable information systems ($\geq 80\%$). Priority measures included the creation of an interministerial coordination entity, a national integration strategy with measurable targets, interoperable digital systems, joint financing models, and interprofessional education programs. This Delphi study represents the first national consensus framework on health and social care integration in Portugal. The findings provide an actionable roadmap for policymakers, emphasizing digital interoperability, shared governance, and results-based financing as foundational elements to advance coordinated, person-centered care and social cohesion.

INTRODUCTION

The integration between the Health and Social sectors has emerged as one of the most critical and complex policy challenges in contemporary health systems [1,2]. Across Europe, demographic ageing, multimorbidity, and the growing social determinants of health have placed unprecedented pressure on fragmented care structures [3,4]. Traditional health and social protection systems, historically designed as parallel domains with distinct governance, financing, and accountability mechanisms, have struggled to provide coordinated responses to populations with multidimensional needs [5]. As a result, countries have increasingly sought to develop integrated care models that emphasize continuity, coordination, and person-centeredness as foundations for sustainability and equity [6,7].

International experience illustrates both the promise and complexity of integration [8]. The Scottish Public Bodies (Joint Working) (Scotland) Act 2014 stand as a notable example of a systemic reform that operationalized joint governance between the National Health Service (NHS) and local authorities [9–11]. Evaluations of the Scottish model have shown measurable progress in reducing delayed discharges, strengthening community-based care, and promoting shared accountability between sectors. However, challenges persist in ensuring consistency of implementation, data interoperability, and professional alignment [10,12]. Similar findings have been observed in other European contexts where integration efforts have often been hindered by administrative fragmentation, distinct budgetary frameworks, and sectoral cultures resistant to change [6].

Portugal shares many of these systemic limitations [13]. The country's health system, organized around the Serviço Nacional de Saúde (SNS), and its social protection network, centered on the Social Security and/or Private Institutions of Social Solidarity (IPSS), operate under separate ministries, legislation, and financing streams [13]. Although strategic documents have long advocated for intersectoral cooperation—such as the National Health Plan (PNS) and the National Strategy for Active and Healthy Ageing, the practical implementation of integration remains limited to isolated local projects and pilot programs [7,14,15]. Empirical analyses of the integrated systems highlight recurrent structural barriers, including the lack of interoperable information systems, rigid financing rules, and insufficient coordination mechanisms between ministries [6,8]. Moreover, human resource shortages, workforce demotivation, and limited interprofessional training exacerbate fragmentation and impede a shared vision for integrated service delivery [8].

To address these multidimensional challenges, a coordinated governance model that aligns objectives, resources, and accountability across sectors is urgently required. This study aimed to achieve

expert consensus on the key advantages, obstacles, and strategic measures necessary to implement effective integration between the Health and Social sectors in Portugal. The research sought to (1) identify shared priorities among experts from different institutional backgrounds, (2) quantify the level of agreement around structural and operational determinants of integration, and (3) generate a validated framework to inform the formulation of a national strategy for Health–Social coordination and governance.

METHODS

Study Design

A Delphi study was conducted to achieve expert consensus on the integration between the Health and Social sectors in Portugal. This approach was selected due to its appropriateness for exploring complex, multidisciplinary issues where empirical evidence is limited and consensus among stakeholders is essential.

Participants and Recruitment

A purposive panel of experts was assembled to ensure comprehensive representation of sectors relevant to Health–Social integration. Members were selected based on objective criteria, including current or past leadership roles in healthcare or social sectors — such as chairs of boards of health institutions, directors of departments, heads of institutes, or representatives of ministries and professional bodies — and on their recognized expertise in health policy, social care, health management, or service integration. Participants included professionals from public administration, healthcare institutions, and social sector organizations, reflecting expertise across the National Health Service and Local Health Units (SNS/ULS), Social Security and private social solidarity institutions (IPSS), and private providers. Invitations were distributed via email, outlining the study’s objectives, voluntary nature, and confidentiality assurances. In total, 105 experts were invited to participate in the Delphi process. Participation in the first round was considered as implied consent. Thirty-six experts completed the first round, and 35 participated in the second round, ensuring continuity and sectoral diversity (15 personalities, 12 representatives from Local Health Units, and 7 from professional bodies).

Round 1 – Exploration and Item Generation

The first round of the Delphi, was designed to capture the collective knowledge, experience, and policy insight of participants across different domains of practice and governance. Participants were invited to complete a short, written questionnaire, which included three open-ended questions, developed based on prior literature, previous conceptual frameworks from earlier phases of this project[6,8,16], and international policy guidance from the WHO and OECD on integrated care. The guiding questions were:

1. *What are the main advantages of closer integration between the Health and Social sectors in Portugal?*
2. *What are the main obstacles or barriers that currently hinder such integration?*
3. *What strategic measures or actions should be implemented to promote effective Health–Social integration?*

To ensure conceptual clarity and encourage comprehensive input, each question was accompanied by a brief explanatory note clarifying the scope of the inquiry. Participants were instructed to reflect on policy and governance dimensions but also on operational, professional, and community-level aspects of integration. They were encouraged to provide as many contributions as they deemed relevant, supported by their experience, institutional knowledge, or empirical evidence, when applicable. Responses were collected over a four-week period, during which reminder emails were sent to optimize participation. All submissions were exported verbatim and analyzed using qualitative content analysis. A deductive coding was guided by the three predefined thematic dimensions (*advantages, obstacles, and strategic measures*).

Similar or redundant statements were merged, while conceptually distinct ideas were retained to preserve the diversity of perspectives. Each response was independently reviewed by two researchers, and discrepancies were resolved through discussion and consensus. The resulting items were then consolidated into a structured list, which served as the basis for Round 2, where participants rated the importance of each item using a 9-point Likert scale.

Round 2 - Consensus Formation

The second round of the Delphi process focused on achieving consensus among experts that participated in Round 1, regarding the items identified in Round 1. This stage was conducted through the Welphi® online platform (Lisbon, Portugal) between September and October 2025. The consolidated list of items derived from the first round was presented back to the expert panel for structured evaluation. Each

participant was asked to rate the importance of every item using a 9-point Likert scale (1 = “not important at all”, 9 = “extremely important”).

The survey interface provided clear instructions and ensured full anonymity, minimizing group influence and promoting independent reflection. Items were displayed in randomized order within each thematic dimension to reduce response bias. Participants were encouraged to draw on their professional expertise, institutional experience, and knowledge of the Portuguese health and social systems when assigning ratings.

The data collected in this round formed the basis for quantitative analysis of consensus levels. Items meeting the predefined statistical criteria—an interquartile range (IQR) ≤ 2 and $\geq 70\%$ of ratings within the 7–9 range—were classified as having achieved consensus and retained as priority issues or strategic measures. Items not meeting these thresholds were considered to have no consensus and were either excluded from interpretation or flagged for potential inclusion in future rounds or qualitative discussion.

Data Analysis

Descriptive statistics, including the median, interquartile range (IQR), and percentage of ratings within the 7–9 range, were calculated for each item. Consensus was defined a priori, and items meeting these criteria were considered to have achieved consensus and were retained as priority advantages, obstacles, or strategic measures. Items that did not meet the consensus threshold were either excluded from subsequent interpretation or, if deemed conceptually relevant, considered for possible inclusion in a third Delphi round. Measures with persistently low consensus were removed from the final list to ensure the robustness and clarity of the agreed priorities.

RESULTS

Advantages of Health–Social Integration

Experts identified a broad set of benefits expected from closer coordination between the Health and Social sectors in Portugal. The items in Table 1 present the advantages rated as highly important (scores 7–9) by the expert panel. The highest levels of agreement were reached for advantages directly linked to the promotion of dignity, autonomy, and healthy ageing (97%), the reduction of avoidable hospital admissions and difficult discharges (92%), and the more efficient use of public resources (92%). High consensus was also observed for measures that strengthen community-based responses, home-care services, and interprofessional collaboration—reflecting the experts’ shared view that integration must extend beyond institutional coordination to encompass territorial and workforce dimensions.

Table 1. Advantages of Health–Social Integration according to experts (n=35)

Code	Suggested Advantage	Median (IQR)	Rating ≥7 (%)
V01	Improvement in overall quality of life and well-being	8 (2)	88%
V02	Promotion of dignity, autonomy, and healthy ageing	8 (2)	97%
V03	Greater equity in access and social inclusion	8 (2)	<u>81%</u>
V04	Person-centered and individualized responses	8 (2)	83%
V05	Prevention of premature institutionalization and support for home permanence	8 (1)	91%
V06	Structured support for families and informal caregivers	8 (2)	91%
V07	Reduction of avoidable hospital admissions and difficult discharges	8 (1.5)	92%
V08	Decrease in hospital readmissions	8 (2)	83%
V09	Improved patient flow in hospital beds and emergency services	8 (1.5)	92%
V10	Continuity of care throughout the life course	8 (2)	83%
V11	Greater efficiency and sustainability of the NHS through reduction of duplications	8 (2)	83%
V13	Increased territorial proximity and community-based response	8 (2)	83%
V14	Expansion and qualification of home-care services	8 (2)	91%
V15	Valorization and motivation of multidisciplinary teams	8 (1)	<u>77%</u>
V16	Strengthening of new skills and interprofessional collaboration	8 (1.5)	84%
V17	Greater satisfaction and fulfilment among health and social professionals	8 (2)	<u>81%</u>
V18	Improvement of intersectoral governance and strategic planning	8 (2)	86%
V19	Promotion of collaborative contracting based on results	8 (2)	91%
V20	Reduction of waste and better use of public resources	8 (2)	92%
V21	Strengthening of social cohesion and community development	8 (1.5)	86%
V22	Promotion of health literacy and citizen co-responsibility	8 (2)	<u>78%</u>

Obstacles to Health–Social Integration

The Delphi panel identified structural, financial, legal, and cultural barriers that hinder effective integration between the Health and Social sectors in Portugal. The highest levels of agreement were observed for obstacles related to institutional fragmentation, separate budgets, and the lack of interoperable information systems, each reflecting deep systemic divisions between ministries and service networks. Conversely, items such as deficits in interprofessional competencies and differing

professional cultures received comparatively lower levels of agreement, though still signalled as significant constraints.

Table 2. Obstacles to Health–Social Integration according to experts (n=35)

Code	Perceived Obstacle	Median (IQR)	Rating ≥7 (%)
O01	Historical and institutional fragmentation between the Health and Social sectors	8 (2)	80%
O02	Lack of effective inter-ministerial coordination	8 (2)	82%
O03	Organizational silos with distinct structures and priorities	8 (2)	83%
O04	Absence of a common vision and joint strategies	8 (2)	85%
O05	Separate budgets between health and social security	8 (2)	86%
O06	Lack of integrated and sustainable funding for joint projects	8 (1)	86%
O07	Budget rigidity preventing co-financing	7 (1)	77%
O08	Misaligned and insufficient contracting models	8 (1)	80%
O09	Non-existent interoperable information systems	9 (1.5)	88%
O10	Difficulties in sharing clinical and social data	8 (2)	83%
O11	Excessive legal and bureaucratic barriers to information sharing	7 (1.5)	74%
O12	Absence of unified citizen-centered records	8 (2)	79%
O13	Shortage of human resources in both sectors	7 (1.5)	83%
O14	Chronic professional demotivation and overload	7 (1)	83%
O16	Absence of stable multidisciplinary teams	7 (2)	<u>71%</u>
O17	Organizational and professional resistance to change	8 (1.5)	74%
O18	Corporate and sectoral interests blocking cooperation	8 (2)	74%
O20	Lack of consistent and sustained political will	8 (2)	<u>72%</u>
O21	Governmental and leadership instability	8 (1)	83%
O22	Absence of a clear national strategy for integration	8 (2)	82%
O23	Deficit of integrated planning and evaluation	8 (1)	85%
O24	Territorial inequality in service availability and coverage	8 (2)	<u>71%</u>

Measures and Strategic Actions for Health–Social Integration

Experts proposed structural, technological, and organizational measures to strengthen integration between the Health and Social sectors in Portugal. The items in Table 3 summarize the strategic actions rated as highly important (scores 7–9) by the expert panel of the Delphi process. The highest levels of agreement were observed for the development of secure digital platforms for clinical and social data sharing (97%), the creation of integrated service portfolios with joint contracting (94%), and the implementation of interoperable information systems (93%).

Table 3. Measures and Strategic Actions for Health–Social Integration according to experts (n=35)

Code	Measure / Strategic Action	Median (IQR)	Rating ≥7 (%)
M01	Creation of an interministerial Health–Social coordination entity	8 (2)	77%
M02	Definition of a national integration strategy with targets and timelines	8 (2)	92%
M04	Establishment of integrated service portfolios with joint contracting	8 (2)	94%
M05	Development of integrated Health–Social financing models	9 (1)	89%
M06	Creation of joint integration funds managed intersectorally	8 (1)	77%
M07	Implementation of results-based contracting in health and well-being	8 (2)	86%
M08	Creation of interoperable information systems between health and social sectors	9 (1)	93%
M09	Implementation of a person-centered unified record	9 (1)	91%
M10	Development of secure digital platforms for sharing clinical and social data	8 (1)	97%
M11	Establishment of integrated multidisciplinary teams across territories	8 (2)	89%
M12	Generalization of the case manager role	7 (1.5)	77%
M13	Joint and continuous training of health and social professionals	7 (1)	78%
M14	Inclusion of Health–Social integration topics in academic curricula	8 (1.5)	<u>75%</u>
M15	Capacity building for middle management in integrated governance	8 (1)	85%
M16	Structured support for informal caregivers	8 (2)	85%
M17	Implementation of local pilot integration projects with rigorous evaluation	8 (2)	83%
M18	Expansion of Local Health Systems as models of integrated governance	8 (1)	77%
M19	Establishment of common impact indicators for health and social inclusion	8 (2)	91%
M20	Strengthening the role of municipalities in local coordination of responses	8 (2)	78%
M21	Creation of local integrated support centers for coordinated service access	7 (2)	<u>72%</u>
M22	Promotion of health literacy and social inclusion	8 (1)	83%
M23	Development of integrated care pathways for chronic diseases and mental health	8 (2)	85%
M24	Adaptation of international best practices in integration to the Portuguese context	7 (1)	77%

DISCUSSION

This Delphi study provides the first structured national consensus among Portuguese experts on the integration between the Health and Social sectors. It offers a comprehensive overview of perceived advantages, main obstacles, and strategic priorities required to advance toward an integrated system of care and demonstrates a shared recognition of the urgent need for reform and alignment between the two sectors, which historically have operated in isolation [7,14,15].

The results reveal a prioritization of person-centered care, system efficiency, and digital integration as the foundations for successful Health–Social coordination. The strongest consensus emerged around measures related to information interoperability and data-sharing infrastructures, as well as the joint contracting and financing of integrated services. This reflects the experts’ understanding that technical and financial integration are prerequisites for any sustainable governance reform. The creation of secure digital platforms and a person-centered unified record, both rated above 90% agreement, signal a collective demand for technological solutions that enable real-time coordination across services.

In parallel, potential advantages such as the promotion of autonomy and healthy ageing, reduction of waste, and decrease in preventable hospitalizations, underscore the perceived societal and economic value of integration. These align closely with evidence from other European contexts, where integrated care initiatives have been associated with improved quality of life, cost containment, and reduced institutional dependence among older adults [8].

The obstacles identified exposed persistent structural and institutional fragmentation that continues to limit integration in Portugal. The lack of interministerial coordination, separate budgets, and non-interoperable information systems were all rated above 80% agreement, indicating deep systemic misalignment. These barriers are not unique to Portugal; similar issues have been reported in other countries and previously highlighted by the authors, in countries where health and social sectors evolved under distinct administrative and funding regimes [8]. The perceived deficit of interprofessional skills and resistance to change suggests that, beyond structural reform, integration also demands cultural transformation and leadership development across organizations. In this regard, the relatively high support for capacity building among middle management (85%) and joint professional training (78%) in the measure’s domain confirms a growing awareness that workforce readiness is as critical as institutional alignment.

From a policy perspective, the consensus around a national strategy for integration (92%) and results-based contracting models (86%) points to a demand for stronger national coordination mechanisms and

performance accountability. The proposed creation of an interministerial coordination entity and joint integration funds could serve as structural anchors to institutionalize cross-sector governance. These findings echo international recommendations—such as those by the WHO and the European Observatory on Health Systems and Policies—advocating for whole-of-government approaches to integrated care[17].

Moreover, experts highlighted the importance of municipal engagement and community-based governance, recognizing the territorial dimension of integration. Strengthening the role of municipalities and local partnerships aligns with the principle of subsidiarity, ensuring that responses are adapted to the specific needs of local populations. However, the moderate consensus around territorial councils and local support centers suggests that operational models must still be clarified and piloted.

Strengths and Limitations

A major strength of this study is its multisectoral and multidisciplinary panel, which included decision-makers, stakeholders and experts from social sector, which ensure a balanced representation of viewpoints. The use of the Welphi® platform enabled a fully anonymous process, reducing social desirability bias and group pressure. Additionally, the two-round design ensured the consolidation of both qualitative and quantitative consensus; however, several limitations should be acknowledged. First, the sample size, while appropriate for Delphi methodology limits generalizability beyond expert perceptions. Second, as participation was voluntary, selection bias toward professionals more engaged in integration policy cannot be excluded. Third, despite strong consensus in several areas, some items with moderate agreement may still reflect conceptual ambiguity or varying local realities. Finally, the study focused on expert consensus rather than empirical implementation outcomes; future research should validate these priorities through pilot programs and evaluation studies.

Future Directions

The findings outline an actionable roadmap for policymakers seeking to operationalize Health–Social integration in Portugal. In the short term, a critical step involves the formulation of a national integration strategy with clearly defined targets, timelines, and accountability mechanisms. Such a strategy should articulate a shared vision across ministries and levels of government, ensuring that health and social policies are planned and financed in a coordinated manner. Parallel to this, the development of interoperable digital systems and unified, person-centered records must become a national priority, enabling data-driven decision-making and seamless coordination between services. These digital

infrastructures should be designed with strict adherence to data protection standards, ensuring trust and transparency for both professionals and citizens.

Equally important is the creation of joint financing mechanisms and results-based contracting models that link funding to measurable outcomes in health and social well-being. This shift from activity-based to value-based financing can foster innovation, efficiency, and accountability, aligning incentives across sectors. Alongside structural and financial reforms, investment in interprofessional education and leadership capacity is essential to sustain integration efforts over time. Developing a workforce capable of collaborating across professional boundaries requires continuous training, shared competencies, and the empowerment of mid-level leaders who can operationalize integration locally.

Finally, the reinforcement of municipal and community-level governance structures will be key to translating national strategy into tangible outcomes. Municipalities, by virtue of their proximity to citizens and local networks, are uniquely positioned to coordinate integrated responses adapted to regional needs. Strengthening their capacity, resources, and political mandate can ensure that integration is not merely a national ambition but a lived reality across territories.

Future research should continue to build on this consensus by combining Delphi rounds with mixed-method and implementation studies that examine the real-world feasibility and impact of these measures. Comparative analyses across regions and pilot programs could identify scalable models and best practices, supporting the gradual construction of a cohesive, equitable, and sustainable Health–Social system in Portugal.

CONCLUSION

This Delphi study provides the first national consensus among Portuguese experts on the priorities, barriers, and enablers of integration between the Health and Social sectors. The findings reveal strong agreement on the transformative potential of integration to improve system efficiency, enhance population well-being, and strengthen social cohesion. Experts converged on the need for a unified national strategy, interoperable digital infrastructures, and joint financing mechanisms as the essential building blocks of reform.

Beyond structural alignment, the study highlights the importance of developing interprofessional competencies, local governance capacity, and results-based accountability to sustain integration efforts over time. By articulating a clear, evidence-informed framework, this work offers policymakers and institutional leaders a roadmap for advancing coordinated, person-centered care in Portugal.

Implementing these priorities will require political commitment, long-term investment, and cross-sector collaboration to translate consensus into lasting systemic transformation.

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Chapter 8

Health policies and reorganization of person-centred care in chronic diseases: challenges and paths for a sustainable system.

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In “Enfermagem Avançada no Cuidado à Pessoa em Situação
Crónica”

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“Políticas de saúde e reorganização dos cuidados centrados na pessoa com doença crónica: desafios e caminhos para um sistema sustentável”

Ricardo Correia de Matos

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Resumo

A crescente prevalência de doenças crónicas, resultante do envelhecimento populacional e do aumento da multimorbilidade, constitui um dos principais desafios à sustentabilidade dos sistemas de saúde. Em Portugal, a resposta organizacional continua fragmentada, com um predomínio de modelos assistenciais episódicos e hospitalocêntricos, pouco adequados à complexidade e continuidade exigidas pelas condições crónicas. Este capítulo procura analisar de forma crítica as políticas públicas em vigor e propõe orientações para a reorganização dos cuidados centrados na pessoa com doença crónica, reforçando a necessidade de eficiência técnica e económica, da valorização e otimização das equipas de saúde, da contratualização por resultados e da promoção da complementaridade entre os setores público, privado e social. Apresenta-se ainda o potencial estratégico da constituição de uma nova especialidade de enfermagem dedicada à pessoa em situação crónica por forma a reconfigurar o modelo assistencial, promover uma abordagem centrada no valor em saúde e garantir cuidados mais integrados, eficazes e humanizados.

Palavras-chave: doença crónica, políticas de saúde, reorganização dos cuidados, skill mix, task shifting, eficiência em saúde, contratualização por resultados.

Abstract

The growing prevalence of chronic diseases, driven by demographic ageing and an increase in multimorbidity, represents one of the main challenges to the sustainability of health systems. In Portugal, the organizational response remains fragmented, with a predominance of episodic and hospital-centered care models that are ill-suited to the complexity and continuity required by chronic conditions. This chapter seeks to critically analyze current public policies and proposes guidelines for the reorganization of care centered on people with chronic diseases, reinforcing the need for technical and economic efficiency, the enhancement and optimization of healthcare teams, performance-based contracting, and the promotion of complementarity between the public, private, and social sectors. It also presents the strategic potential of establishing a new nursing specialty dedicated to people with chronic conditions in order to reconfigure the care model, promote a value-based approach to health, and ensure more integrated, effective, and humanized care.

Keywords: chronic disease, health policy, care reorganization, skill mix, task shifting, healthcare efficiency, results-based contracting.

1. Introdução

Nas últimas décadas, o panorama global da saúde tem sofrido uma profunda transformação decorrente do envelhecimento populacional e consequente transição epidemiológica. Por transição epidemiológica entende-se uma inversão nos padrões de doenças e causas de morbilidade e morte, caracterizada por um declínio de doenças transmissíveis e um aumento exponencial de doenças crónicas não transmissíveis (Osareme et al., 2024) e multimorbilidade, especialmente em grupos populacionais mais velhos.

Esta mudança nos padrões demográficos e de saúde tem imposto desafios sistémicos às organizações e sistemas de saúde, exigindo reformas estruturais não só em termos assistenciais (com a promoção de abordagens mais holísticas, proativas e centradas na pessoa; Organização Mundial de Saúde [WHO], 2020) como também ao nível das políticas públicas de saúde, dos modelos de financiamento em saúde e da alocação e gestão de recursos (Osareme et al., 2024).

Este capítulo propõe uma análise crítica das atuais políticas públicas em relação à doença crónica, discute os principais desafios organizacionais e apresenta propostas de reestruturação baseadas em evidência científica e orientadas para a sustentabilidade, qualidade e a humanização dos cuidados em saúde.

2. Enquadramento do problema

A evolução demográfica e epidemiológica das últimas décadas colocou a cronicidade no centro das preocupações das políticas de saúde. O aumento da esperança de vida, o envelhecimento acentuado da população e a prevalência crescente de doenças crónicas não transmissíveis (DCNT) transformaram de forma profunda o perfil das necessidades em saúde e, consequentemente, a organização dos sistemas de cuidados. Estes fenómenos, muitas vezes interdependentes e cumulativos, implicam uma maior complexidade clínica, maior utilização dos recursos, e exigem um planeamento mais integrado e orientado para a sustentabilidade.

Este subcapítulo propõe-se analisar, de forma estruturada, os principais fatores que enquadram o desafio contemporâneo da doença crónica. Inicia-se por caracterizar o impacto do envelhecimento populacional e das mudanças demográficas na Europa e em Portugal, evidenciando o seu peso na carga de doença e na pressão sobre os sistemas de proteção social. Segue-se uma análise da multimorbilidade e da carga global das DCNTs, com especial foco no contexto nacional, onde os indicadores são particularmente expressivos. Por fim, apresenta-se uma reflexão sobre o impacto socioeconómico da cronicidade, com destaque para os custos diretos e indiretos, as desigualdades no acesso, e a necessidade de uma reorganização estratégica dos investimentos em saúde.

2.1. Envelhecimento populacional e transição demográfica

O envelhecimento populacional representa um dos fenómenos demográficos mais marcantes do século XXI, constituindo-se como um problema de saúde pública (Coelho et al., 2019) com implicações diretas na estrutura e sustentabilidade dos sistemas de saúde. Estima-se que, em 2050, o número de pessoas com mais de 60 anos atinja 2 biliões, o dobro do registado em 2015 (Nações Unidas, 2019). Na Europa, prevê-se um crescimento de 10% no número de pessoas com 65 ou mais anos entre 2015 e 2050 (Eurostat, 2020). Em Portugal, 25% da população tinha 64.5 ou mais anos em 2024, sendo o segundo país mais envelhecido da Europa, com um índice de envelhecimento de 192.4 — quase dois idosos por cada jovem — apenas ultrapassado pela Itália (Instituto Nacional de Estatística [INE], 2024; Pordata, 2024). Prevê-se que esta tendência de crescimento acelerado da população idosa se mantenha ao longo do tempo: até 2050, cerca de um terço da população portuguesa terá 65 ou mais anos (INE, 2004), e a proporção de pessoas com 80 ou mais anos deverá mais do que duplicar até 2100 (Eurostat, 2020). As projeções estimam que o índice de envelhecimento possa atingir os 459.2 em 2080 (INE, 2020).

O crescente envelhecimento populacional a par com o aumento da longevidade terá, inevitavelmente, impacto sobre o próprio desenvolvimento sustentável. De facto, o índice de sustentabilidade potencial, isto é, a relação entre a população em idade ativa e a população idosa, deverá decrescer de 263 pessoas em idade ativa por cada 100 idosos em 2024 para 124 pessoas em 2080 (INE, 2020). Ambos os fenómenos demográficos irão contribuir igualmente para um aumento da carga global de doença na população, refletida através de um incremento e coocorrência de doenças crónicas não transmissíveis (DCNT) associadas à idade e à exposição cumulativa a múltiplos fatores de risco (e.g., obesidade, sedentarismo, padrões de consumos problemáticos; WHO, 2024a) e do aumento dos anos de vida perdidos devido a morte prematura, doença e incapacidade. Em 2019, registaram-se 292.891 anos de vida potencialmente perdidos antes dos 70 anos (Direção-Geral da Saúde [DGS], 2021). Em 2022, a esperança de vida saudável à nascença em Portugal — número médio de anos vividos sem incapacidade funcional ou deficiência — era de 58 anos para as mulheres e 60 anos para os homens (INE, 2022), valores inferiores à média europeia ($M = 62.6$; Eurostat, 2025). Para mulheres e homens com idade igual ou superior a 65 anos, a esperança de viver sem incapacidade funcional ou deficiência era de 7.3 e 8.6 anos, respetivamente (INE, 2022).

2.2. Multimorbilidade e carga da doença crónica

A multimorbilidade — definida como a coexistência de duas ou mais condições crónicas num mesmo indivíduo — constitui um desafio crescente para os sistemas de saúde (Skou et al., 2022). Esta está tipicamente associada a piores resultados clínicos, incluindo maior risco de morte prematura, hospitalizações evitáveis, internamentos prolongados, polifarmácia e pior saúde mental. Além disso, está ligada à redução da funcionalidade, maior dependência e fragilidade, menor qualidade de vida, bem como a custos socioeconómicos acrescidos (Skou et al., 2022).

Em 2024, 42.3% da população residente com 16 ou mais anos referiu ter uma doença crónica ou problema de saúde prolongado (por oposição aos 35% registados na EU em 2023), colocando Portugal como o terceiro país europeu com maior prevalência de doenças crónicas (INE, 2024b). Os resultados referem ainda que Portugal está bastante acima da média europeia (~ 40%) no que concerne a multimorbilidade em idades superiores a 65 anos, com 68% das pessoas a referirem a presença de múltiplas doenças crónicas (Federação Europeia das Indústrias e Associações Farmacêuticas [EPFIA], 2025). Por sua vez, dados de um relatório de avaliação do sistema de saúde português coordenado pelo Gabinete Regional para a Europa da OMS e pelo Observatório Europeu dos Sistemas e Políticas de Saúde (WHO, 2018), indicaram que 41% dos utilizadores do Serviço Nacional de Saúde têm multimorbilidade. Os resultados do Primeiro Inquérito Nacional de Saúde com exame físico realizado em Portugal apontaram para uma multimorbilidade de 38.3%, com prevalências superiores em mulheres e grupos etários mais velhos e de estatuto socioeconómico mais baixo (Quinaz Romana et al., 2019). A este respeito, é de salientar o potencial efeito sindémico, ou seja, a interação patológica entre múltiplos problemas de saúde e fatores socioeconómicos.

Embora exista variabilidade na sua prevalência em função do grau de desenvolvimento dos países, nível socioeconómico e políticas de saúde implementadas, as DCNTs são responsáveis pela maior carga global de saúde à escala mundial. As DCNTs figuram entre as principais causas de mortalidade (WHO, 2022) e de anos de vida ajustados por incapacidade (DALYs) globalmente, os quais têm vindo a aumentar progressivamente na última década (Brauer, 2024). A nível europeu, a mortalidade associada a DCNTs atingiu os 90% (e cerca de 2,5 milhões de mortes prematuras) enquanto a percentagem de anos vividos com incapacidade ou deficiência devido a estas condições foi de 85% (WHO, 2025).

Em Portugal, 86% dos DALYs estão associados a doenças crónicas, muitas delas potencialmente evitáveis (Simões et al., 2017). As principais causas de DALYs no país são semelhantes às observadas a nível europeu e mundial, com as doenças cardiovasculares, o cancro, a diabetes, as doenças neurológicas,

as doenças respiratórias, as doenças musculoesqueléticas e as doenças mentais a ocuparem um lugar de destaque (Simões et al., 2017; WHO, 2024b).

Esta realidade exige abordagens terapêuticas complexas, monitorização contínua e modelos de cuidados integrados e longitudinais, em contraste com a abordagem tradicional, centrada em doenças isoladas, que tende a gerar cuidados fragmentados, a favorecer erros e potenciais efeitos adversos e a aumentar a sobrecarga associada ao tratamento (Skou et al., 2022).

2.3. Impacto socioeconómico da cronicidade

Para além do impacto individual e familiar, as DCNTs e multimorbilidade acarretam elevados custos socioeconómicos, representando uma parte significativa das despesas públicas em saúde (Comissão Europeia [CE], 2022). Estas despesas incluem não só custos diretos associados a uma maior utilização dos serviços de saúde (regimes de diagnóstico e tratamento mais intensivos, número crescente de consultas e internamentos, polimedicação e cuidados continuados a longo-prazo) mas também custos indiretos com o aumento da incapacidade e mortalidade prematuras, perda de produtividade, absentismo laboral, diminuição do rendimento familiar e/ou perda de poupanças, e a necessidade de assistência informal (Nikolic et al., 2011; Wheatley, 2024). De facto, a informalidade dos cuidados, embora essencial, carece frequentemente de apoio formal (sendo que apenas recentemente foi criado o estatuto do cuidador informal; Lei n.º 100/2019, 2019), expondo as famílias a cargas físicas, emocionais e financeiras que nem sempre são reconhecidas.

Em média, as despesas com saúde representaram 8.3% do Produto Interno Bruto (PIB) europeu em 2019, aumentando para 9.1% em 2020 (Organização para a Cooperação e Desenvolvimento Económico [OECD] Data Explorer), com as DCNTs a representarem 25% das despesas totais com cuidados de saúde (OCDE, 2016), um impacto económico estimado em 2% do PIB (Vandenberghe & Albrecht, 2020). As principais DCNTs – doenças cardiovasculares, cancro, doenças respiratórias crónicas, diabetes e doenças mentais – incorreram num ónus de 530 mil milhões de euros à EU em 2023, o correspondente a 3.13% do PIB anual combinado, dos quais 60.5% foram custos diretos (EPFIA, 2025). Por sua vez, estima-se que o custo anual em perda de produtividade devido às DCNTs seja superior a 115 mil milhões de euros (EPFIA, 2025). Estes valores colocam a Europa entre as regiões com os custos mais elevados associados às DCNTs a nível global (WHO, 2025). Prevê-se que, até 2050, a incidência e mortalidade decorrente de DCNTs registem um aumento substancial (EPFIA, 2025) gerando custos acumulados de 37 biliões de dólares (WHO, 2025) e perdas económicas adicionais estimadas em 47 biliões de dólares até 2030 (Bloom et al., 2011). Os encargos associados a mortes prematuras pelas principais DCNTs equivalem a 0.8% do PIB da

União Europeia (OCDE, 2016), sendo que 1,8 milhões de mortes anuais são evitáveis. Na Europa, onde a mortalidade evitável representa perdas de 514,5 mil milhões de dólares em produtividade, mais de metade das mortes poderiam ser prevenidas da redução da exposição a fatores de risco modificáveis e intervenções de saúde pública, enquanto as restantes poderiam ser evitadas através do acesso atempado a cuidados de saúde adequados (WHO, 2025). Esta observação é particularmente relevante atendendo a que apenas 3% das despesas totais em saúde na UE são destinadas à promoção da saúde e prevenção de doenças, embora a literatura indique que este tipo de políticas públicas de saúde possa reduzir em até 70% no número total de casos de DCNTs (CE, 2022).

Portugal tem apresentado, de forma consistente, níveis de despesa total em saúde, incluindo prevenção e cuidados continuados, inferiores à média da União Europeia, quer em percentagem do Produto Interno Bruto (PIB) quer *per capita*. O desinvestimento continuado tem impactado negativamente a satisfação da população com os cuidados de saúde (DGS, 2021; OECD, 2023).

3. Avaliação crítica das políticas públicas atuais

Face à crescente pressão das doenças crónicas sobre os sistemas de saúde, têm sido delineadas e implementadas, nos últimos anos, diversas estratégias a nível nacional e internacional com o objetivo de melhorar a gestão da cronicidade. Estas políticas, geralmente assentes na promoção da integração de cuidados, na valorização da prevenção e na reorganização da prestação, revelam um avanço significativo face aos modelos centrados na doença aguda. No entanto, persistem fragilidades relevantes na sua operacionalização, particularmente quando aplicadas em contextos públicos marcados por constrangimentos estruturais, como é o caso de Portugal.

Este subcapítulo propõe uma análise crítica das políticas públicas direcionadas para a resposta às doenças crónicas. Na primeira secção (3.1), é feita uma síntese das principais estratégias e programas atualmente em curso, destacando boas práticas nacionais e internacionais, bem como os respetivos fundamentos conceptuais. Na segunda secção (3.2), são identificadas as principais limitações que comprometem a efetiva implementação destas políticas no contexto português, com especial atenção às disfunções no planeamento, financiamento, articulação interinstitucional e valorização dos profissionais de saúde.

3.1. Estratégias nacionais e internacionais em curso

A resposta organizacional ao desafio das DCNTs tem sido objeto de diversas iniciativas políticas e estratégicas, tanto a nível internacional como nacional.

Nas últimas décadas, tem-se verificado, em diversos contextos nacionais e regionais, a implementação progressiva de modelos integrados de cuidados de saúde centrados na continuidade assistencial e apoiados em evidência científica (Barros, 2024). Estas abordagens partilham um ou mais elementos orientados para cuidados integrados de saúde, nomeadamente um ênfase na prevenção, na individualização dos planos de tratamento, no empoderamento e promoção da autonomia dos indivíduos com DCNTs, bem como na coordenação interprofissional, na introdução de mecanismos de compensação baseados no desempenho, na incorporação de inovações tecnológicas e na estratificação do cuidado em função do grau de risco clínico (Barros, 2024).

Exemplos incluem iniciativas como o *‘España Salud’* na Andaluzia, o *‘Chronicity Prevention and Care Programme’* e o *‘Catalan Expert Patient Program’* na Catalunha, a *‘Strategy to Tackle the Challenge of Chronicity’* no País Basco, o programa francês *‘Amélioration de la qualité de vie des personnes atteintes de maladies chroniques’*, e o modelo da Kaiser Permanente nos Estados Unidos da América (Barros, 2024; Cooke, 2024). Tais modelos têm demonstrado eficácia tanto na melhoria de resultados clínicos de interesse quanto na otimização da eficiência técnica e económica dos sistemas de saúde (Bodenheimer et al., 2002).

À escala europeia, o programa *‘Healthier Together – EU Non-Communicable Diseases Initiative’*, promovido pela Comissão Europeia para o quinquénio 2022-2027, centra-se na promoção da saúde e na prevenção e mitigação do impacto das principais DCNTs. A iniciativa tem como pilares a partilha de boas práticas e recomendações, o financiamento de ações inovadoras com elevado potencial de impacto, o reforço da capacitação técnica e a cooperação internacional (CE, 2022).

No caso particular de Portugal, o desenvolvimento do Plano Nacional de Saúde 2021–2030 (DGS, 2021), um quadro estratégico colaborativo alinhado com as metas da Agenda 2030 para o Desenvolvimento Sustentável (Organização das Nações Unidas [ONU], 2015), centrado no cidadão e com participação pública, constitui um avanço no sentido da integração dos cuidados. Sob o mote “saúde sustentável: de todos para todos”, a iniciativa visa simplificar procedimentos administrativos e eliminar redundâncias e tem como principais eixos estratégicos a promoção da saúde (programas educativos), a prevenção da doença (vacinação, diagnóstico precoce) e a gestão integrada das condições crónicas (reabilitação, cuidados paliativos; DGS, 2021).

Embora estes modelos demonstrem potencial e resultados promissores, a evidência atual não permite determinar de forma conclusiva e inequívoca a sua real custo-eficácia ou custo-benefício (Barros, 2024). Além disso, a replicação destes modelos em contextos de sistemas públicos, como o português,

exige uma análise preliminar e possível adaptação às especificidades organizacionais e financeiras dos sistemas em que irão ser implementadas (Barros, 2024).

3.2. Limitações na operacionalização em Portugal

Apesar das orientações estratégicas e da retórica centrada na integração de cuidados, a realidade portuguesa ainda revela profundas fragilidades na resposta à cronicidade. As causas destas fragilidades são múltiplas (Ferreira & Fonseca, 2023; Oliveira et al., 2022; Porter, 2010) e incluem, entre outros fatores, a:

- Inexistência de práticas consolidadas de planeamento e avaliação de políticas de saúde e a existência de desigualdades ao nível assistencial, de acesso e de alocação de recursos;
- Falta de investimento generalizado em estruturas e recursos decorrente do subfinanciamento reiterado;
- Fragmentação e/ou dificuldades de articulação entre os diferentes sectores e níveis de cuidados de saúde;
- Desvalorização dos cuidados de proximidade;
- Fraca interoperabilidade dos sistemas de informação;
- Modelos de financiamento focados na quantidade (volume de atos ou produção hospitalar) ao invés da qualidade (orientados para resultados efetivos relacionados com a prevenção e gestão da doença e melhoria da qualidade de vida) promovendo a hospitalocentria e o uso excessivo dos serviços de urgência;

Escassez e insatisfação dos recursos humanos decorrentes da baixa remuneração, ausência de incentivos, alocação e gestão desadequada de recursos bem como a desvalorização de competências diferenciadas (por exemplo, os enfermeiros especialistas em pessoa em situação crónica). A este respeito, os dados mostram que o número de enfermeiros em Portugal é substancialmente inferior à média europeia (OECD, 2023).

4. Reorganização do sistema de saúde centrada na pessoa com doença crónica

A crescente complexidade associada às doenças crónicas exige uma transformação profunda do modelo assistencial, que ultrapasse a resposta fragmentada e reativa que tem caracterizado os sistemas de saúde. Em vez de estruturas centradas no episódio agudo e na prestação hospitalar, torna-se necessário adotar

abordagens integradas, coordenadas e centradas na pessoa ao longo do seu percurso de vida e de cuidados.

Este subcapítulo apresenta quatro eixos fundamentais para essa reorganização: os modelos conceptuais de cuidados integrados centrados na pessoa (4.1), a valorização de equipas multiprofissionais e do *skill mix* como estratégia organizacional (4.2), a implementação de Centros de Responsabilidade Integrados e de modelos de gestão por resultados (4.3), e, por fim, o papel estratégico do enfermeiro especialista em enfermagem à pessoa em situação crónica (4.4). Estes pilares interligam-se e sustentam uma proposta de sistema mais humanizado, eficiente, adaptado à realidade demográfica e epidemiológica atual e orientado para a melhoria dos resultados em saúde e da experiência dos utentes.

4.1. Modelos de cuidados integrados e centrados na pessoa

Para superar as limitações dos modelos tradicionais de cuidados, foram desenvolvidos novos modelos conceptuais de cuidados integrados que oferecem linhas orientadoras para práticas mais eficazes e humanizadas.

O Modelo de Cuidados para Doenças Crónicas (Chronic Care Model, CCM) de Wagner e cols (1996) assenta em seis pilares fundamentais: 1) organização e articulação entre diferentes níveis de cuidados de saúde; 2) utilização de ferramentas ou sistemas de apoio à decisão clínica, que deve ser informada e partilhada, baseada em evidência e alinhada com as preferências individuais de cada pessoa; 3) sistemas de informação clínica que permitam a partilha de dados, monitorização da condição e coordenação dos cuidados de saúde; 4) desenvolvimento de processos de cuidado proativos e individualizados, por exemplo através da criação de fluxos específicos de cuidados; e 6) capitalização de potenciais de redes de apoio social e comunitário. A literatura aponta que a adoção deste modelo contribui para a melhoria do controlo sintomático, a redução das hospitalizações evitáveis e o aumento da satisfação dos utentes (Bodenheimer et al., 2002; Coleman et al., 2009; Gover & Joshi, 2014).

Em 2006, Wielawski propõe uma extensão ao Modelo de Cuidados na Doença Crónica que vem adicionar a segurança do utente, a sensibilidade às necessidades culturais e linguísticas dos utilizadores dos serviços de saúde e a gestão de casos complexos como elementos importantes.

Por fim, o Quadro de Referência de Cuidados Inovadores para Condições crónicas (Innovative Care for the Chronic Conditions- ICCC; WHO, 2002), o qual assenta nos seguintes princípios-chave: integração e articulação intersectorial e multinível da prevenção e prestação de cuidados com vista à melhoria da qualidade e eficiência; foco na prevenção, através da deteção precoce e da modificação dos comportamentos de risco comuns às várias doenças crónicas (tabagismo, sedentarismo, obesidade);

melhorias na alocação e gestão dos profissionais de saúde; flexibilidade/adaptabilidade das políticas e dos sistemas de saúde (Gover & Joshi, 2014).

Apesar da necessidade de mais estudos dirigidos à custo-eficácia da adoção de modelos de cuidados integrados, a evidência existente parece apontar para o potencial destas abordagens na transformação dos sistemas de saúde e dos cuidados prestados (Nuño et al., 2012).

4.2. Organização em torno de equipas multiprofissionais e skill mix

Um sistema de saúde centrado na pessoa requer equipas multiprofissionais que conjuguem competências técnicas, relacionais e organizacionais. O conceito de *skill mix* — ou mistura de competências — refere-se à composição e distribuição de profissionais com diferentes formações, experiências e funções, atuando em sinergia para alcançar melhores resultados em saúde (Buchan & Dal Poz, 2002). O *skill mix* pode assumir diferentes formas tais como a diversificação e desenvolvimento de competências técnicas ou de comunicação avançadas, a existência de diferentes graus de senioridade num mesmo grupo profissional, a composição plural da equipa (com múltiplos perfis e categorias profissionais) e a inovação nos papéis desempenhados, com a modificação ou introdução de novas funções profissionais (Buchan & Calman, 2005; Sibbald et al., 2004).

O *skill mix* apresenta-se como uma solução estratégica para responder aos desafios sistemáticos e a necessidades específicas tal como a escassez de determinadas categoriais profissionais, a prestação de cuidados de excelência, maximização do impacto dos cuidados em saúde, desigualdade em termos da distribuição ou qualificação dos profissionais, otimização da relação custo-benefício na prestação de cuidados manuseamento de equipamento/técnicas, e a necessidade de inovação em determinados serviços (Buchan & Dal Poz, 2002; WHO, 2008). A literatura indica que a qualidade do cuidado prestado por enfermeiros especialistas em diferentes contextos (cuidados primários, urgências, primários) e relativamente a determinados resultados de saúde (feridas ligeiras, controlo glicémico, a adesão terapêutica à medicação) é análogo ou superior ao prestado por médicos, com maiores índices de satisfação mas em alguns casos com custos superiores (Buchan & Calman, 2005; Holloway et al. 2023; Renders et al, 2001).

No caso específico da ampliação de funções, como é o caso da delegação ou substituição de tarefas (*task-shifting*), esta permite que profissionais não médicos, como enfermeiros ou farmacêuticos, assumam responsabilidades em áreas como o acompanhamento de doenças crónicas, a titulação de fármacos e a monitorização de sinais de alerta, constituindo-se como uma estratégia particularmente útil em contextos de escassez de recursos ou falta de cobertura da rede de cuidados (van Schalkwyk et al.,

2020; WHO, 2008). Quando bem estruturada, com profissionais formados, supervisão contínua e protocolos definidos, esta abordagem é segura e bem recebida pelos utilizadores (Laurant et al., 2018). Além disso, a ampliação de funções tem mostrado resultados interessantes ao nível dos cuidados de proximidade, ao acesso aos cuidados de saúde, na adesão a rastreios ou em intervenções de promoção da saúde (educação e aconselhamento relativamente à alimentação, cessação tabágica e promoção da atividade física; Maier et al., 2023). No contexto da doença crónica, os enfermeiros especialistas desempenham um papel estratégico na coordenação dos cuidados, educação terapêutica, vigilância clínica, planeamento da alta e gestão de casos complexos.

Apesar da importância do *skill mix* e da reconfiguração das funções clínicas, em Portugal, a implementação de competências avançadas em enfermagem ainda enfrenta barreiras regulamentares, culturais e organizacionais que precisam ser superadas para responder às necessidades reais da população e garantir a sustentabilidade do sistema de saúde.

4.3. Centros de Responsabilidade Integrados e gestão por resultados

A reorganização dos cuidados crónicos deve também passar pela reforma dos modelos de gestão e governação clínica, com a instituição, por exemplo, de Centros de Responsabilidade Integrada (CRI) que permitem que equipas multiprofissionais assumam a responsabilidade e autonomia organizativa, operacional, técnica e financeira de uma determinada área de cuidados, de forma descentralizada e numa lógica de contratualização interna por objetivos (com acesso a mecanismos de compensação contingentes ao desempenho; Decreto-Lei n.º 374/99, 1999). A literatura demonstra que a gestão por resultados, quando combinada com indicadores bem definidos (qualidade clínica, impacto funcional, satisfação, otimização de recursos) e ajustados à complexidade dos doentes, pode melhorar significativamente o desempenho organizacional (Carvalho & Fernandes, 2024; Porter & Kaplan, 2016).

A experiência portuguesa com alguns CRI — nomeadamente nas áreas de medicina interna e cirurgia — é positiva, mas limitada, com diversos desafios à sua implementação efetiva (Freire, 2014). Atendendo à melhoria do desempenho demonstrada pelos CRI já existentes e no sentido de alavancar a implementação deste modelo organizativo, foi recentemente aprovado um novo regime jurídico, o qual identifica como áreas prioritárias para a criação de novos CRI os serviços de urgência, a saúde mental, a medicina interna, a pediatria, a dermatovenereologia, a gastroenterologia e a hospitalização domiciliária (Decreto-Lei n.º 118/2023, 2023). A constituição de equipas dedicadas no contexto da doença crónica (e.g., insuficiência cardíaca, cuidados respiratórios, diabetes) assume-se como igualmente relevante e

deve ser incentivada, com definição clara de metas, incentivos por desempenho e reforço da governação clínica participativa.

4.4. O papel estratégico do enfermeiro especialista em enfermagem à pessoa em situação crónica

A criação da nova especialidade de enfermagem à pessoa em situação crónica (Regulamento n.º 429/2018, 2018) representa um marco na evolução da profissão em Portugal e uma oportunidade estratégica para reformar o modelo assistencial, tornando-o mais centrado na pessoa, mais eficiente e mais sustentável. A resposta à doença crónica exige competências específicas na gestão de condições prolongadas, na articulação entre níveis de cuidados e na capacitação das pessoas e famílias. Este é precisamente o domínio de intervenção do novo enfermeiro especialista.

O enfermeiro especialista em enfermagem à pessoa em situação crónica atua como agente central no acompanhamento longitudinal, na prevenção de descompensações clínicas, na educação terapêutica, na gestão da transição de cuidados e na coordenação com outros profissionais e setores (Griffin, 2017). A sua ação é particularmente relevante em contextos como:

- a gestão da multimorbilidade no domicílio;
- a monitorização clínica de condições como diabetes, insuficiência cardíaca, hipertensão ou DPOC;
- a articulação com os cuidadores informais e os serviços sociais;
- a promoção da literacia em saúde e da tomada de decisão partilhada.

A evidência internacional tem vindo a demonstrar que enfermeiros com competências avançadas contribuem significativamente para melhorar os resultados em saúde em populações com doença crónica (Laurant et al., 2018 Martinez-González et al. 2014a). Adicionalmente, o enfermeiro especialista encontra-se particularmente bem posicionado para liderar intervenções de natureza preventiva, antecipar agudizações, e integrar tecnologias digitais na monitorização contínua da condição clínica. A sua proximidade à comunidade, o conhecimento contextual das trajetórias de saúde dos utentes e a capacidade de comunicação terapêutica fazem dele uma figura-chave num modelo centrado na pessoa e na gestão proativa da doença .

Para que este potencial se concretize, é essencial assegurar:

- o reconhecimento formal do domínio de atuação da nova especialidade;
- a sua integração em equipas multiprofissionais com funções clínicas, organizacionais e de governação;

- a criação de cargos de liderança de enfermagem nos domínios da gestão da cronicidade, especialmente em unidades de cuidados de saúde primários, hospitais de retaguarda, cuidados continuados e estruturas comunitárias;
- a contratualização de resultados específicos associados à atuação destes profissionais, com métricas clínicas, funcionais e de experiência do utente.

A reorganização do sistema de saúde em torno da pessoa em situação crónica será tanto mais eficaz e sustentável quanto maior for a valorização do enfermeiro especialista como pilar da intervenção clínica e da transformação organizacional.

5. Eficiência técnica e económica na reorganização dos cuidados

A sustentabilidade dos sistemas de saúde, particularmente num contexto de crescimento exponencial da cronicidade, exige uma gestão rigorosa dos recursos disponíveis e uma orientação clara para a obtenção de valor em saúde. Este valor, entendido como a relação entre os ganhos efetivos em saúde para a pessoa e os custos para os alcançar (Porter, 2010), depende de forma decisiva da eficiência com que os recursos humanos, financeiros e tecnológicos são mobilizados.

Segundo o *World Health Report* de 2010, entre 20% a 40% da despesa em saúde global pode ser considerada desperdício evitável, resultante de ineficiências na organização dos serviços, duplicações, erros clínicos, uso inadequado de tecnologias ou subutilização de competências profissionais (WHO, 2010). Neste contexto, os conceitos de **eficiência técnica** — fazer melhor com os recursos disponíveis — e **eficiência económica** — fazer o mesmo ou melhor ao menor custo — assumem centralidade estratégica na reorganização dos cuidados.

A presente secção decompõe este desafio em dois domínios fundamentais. No primeiro (5.1), discute-se a eficiência técnica, com enfoque na reorganização dos processos de prestação de cuidados, no papel das clínicas lideradas por enfermeiros e na utilização inteligente da tecnologia e dos recursos humanos. No segundo (5.2), aborda-se a eficiência económica, refletindo sobre os modelos de financiamento baseados no valor, a contratualização por resultados, e os mecanismos para reduzir desperdícios sem comprometer a qualidade assistencial.

5.1. Eficiência técnica: fazer melhor com os recursos disponíveis

A eficiência técnica refere-se à capacidade de um sistema produzir os melhores resultados clínicos e funcionais possíveis a partir de um determinado conjunto de recursos financeiros e humanos, evitando

desperdícios e redundâncias (WHO, 2006). No caso da cronicidade, isso implica garantir uma alocação otimizada de recursos entre setores e que os profissionais mais capacitados para determinadas tarefas as desempenham de forma segura, eficaz e custo-efetiva.

As nurse-led clinics — clínicas lideradas por enfermeiros, caracterizadas pela autonomia protocolada e responsabilidade na promoção da saúde, educação do paciente e gestão de casos complexos — têm-se consolidado como uma estratégia crescente em diversos países, especialmente em contextos de sobrecarga dos sistemas de saúde e necessidade de otimização dos recursos disponíveis (Sibbald et al., 2006; Terry et al., 2024). A literatura tem apresentado resultados inconsistentes no que concerne a eficácia deste tipo de metodologia nos indicadores clínicos e socioeconômicos. Alguns estudos indicam que, em comparação com os cuidados médicos tradicionais, essas clínicas apresentam resultados comparáveis ou superiores ao nível do controlo da doença, número de hospitalizações e readmissões, mortalidade, adesão ao tratamento e a comportamentos saudáveis, qualidade de vida e satisfação dos pacientes em diversos contextos (cuidados de saúde primários e especializados) e populações (Davis et al., 2021; Deschodt et al., 2024; Htay & Whitehead, 2021; Laurant et al., 2018; Martínez-González et al., 2014^a, 2014^b; Randall et al., 2017). Por outro lado, revisões da literatura em populações e contextos específicos (e.g., artrite reumatoide; transição de cuidados) têm mostrado resultados inconclusivos em relação à melhoria de resultados clínicos e funcionais e custo-eficácia desta metodologia (em parte devido à baixa qualidade metodológica dos estudos analisados; Donald et al., 2015; Laurant et al., 2018; Ndosì et al., 2011).

Para que esta realidade se concretize em Portugal, é necessário ajustar o quadro regulamentar, dotar os profissionais de formação específica, implementar sistemas de supervisão e apoio à decisão, investir em serviços de saúde domiciliar e cuidados residenciais e promover uma vigilância contínua e intervenções mais atempadas através da utilização de novas tecnologias (Bashi et al., 2017).

5.2. Eficiência económica: fazer o mesmo (ou melhor) ao menor custo

A eficiência económica refere-se à produção de valor clínico e social com o menor custo possível, otimizando a utilização dos recursos financeiros e evitando gastos desnecessários ou de baixo retorno. No caso da gestão da cronicidade, esta lógica implica que os sistemas de saúde não apenas procurem melhores resultados, mas também façam escolhas estratégicas sobre onde, como e com quem investir os seus recursos.

O modelo de *Value-Based Healthcare* (VBHC), proposto por Porter (2010), tem sido progressivamente adotado como orientação estratégica por sistemas e instituições de saúde e parte do princípio de que o

valor em saúde resulta da relação entre ganhos efectivos em *outcomes* relevantes para o doente (e.g., qualidade de vida, autonomia, controlo da doença) e os custos para os alcançar. Neste modelo, a eficiência económica não é apenas uma função de contenção de custos, mas sim de investimento seletivo em práticas, tecnologias e profissionais que gerem valor efetivo (Porter, 2010).

A operacionalização deste paradigma exige três condições:

- Seleção e medição sistemática de múltiplos *outcomes* clínicos e funcionais de curto e longo-prazo e ajustados ao risco clínico que sejam relevantes para o doente (e.g., por exemplo com base nos sets desenvolvidos pelo International Consortium for Health Outcomes Measurement);
- Transparência nos custos reais por ciclo de cuidados.
- Autonomia das equipas para organizarem os cuidados da forma mais eficiente, dentro de um quadro de responsabilização.

Em Portugal, o potencial de adoção do VBHC é elevado, sobretudo através da contratualização com Centros de Responsabilidade Integrados (CRI), da monitorização de indicadores de desempenho clínico e da utilização de sistemas de registo eletrónico interoperáveis. Contudo, a implementação prática ainda se encontra limitada pela fragmentação institucional, ausência de mecanismos de compensação eficazes e cultura organizacional demasiado orientada para o volume de atos (Porter, 2010).

O relatório da OCDE ‘Tackling Wasteful Spending on Health’ (2017) estima que entre 20% a 25% da despesa em saúde nos países membros corresponde a desperdícios evitáveis relacionados com falhas na prestação de cuidados (erros clínicos, eventos adversos evitáveis, tratamentos ineficazes, redundância de exames), operacionais (eliminação de medicamentos ou dispositivos médicos não utilizados, uso excessivo de medicamentos de marca, deslocações às urgência ou hospitalizações evitáveis, ausência de cuidados pós-alta adequados) e governativos (subaproveitamento de competências profissionais, elevada burocratização e fraude/abuso/corrupção).

Uma das principais estratégias para aumentar a eficiência económica do sistema de saúde é redesenhar os modelos de financiamento, abandonando o pagamento por volume de atos (*fee-for-service*) e adotando modelos baseados no valor gerado. Modelos como os *bundled payments* (pagamentos por pacote de cuidados), *pay-for-performance* (pagamentos em função dos resultados clínicos e funcionais) e pagamento por capitação (valor fixo por pessoa para um período definido) têm sido aplicados com sucesso em países como os Países Baixos, Suécia e Reino Unido (Barros, 2024; OECD, 2021, 2016; Porter & Kaplan, 2016). A escolha dos métodos de pagamento deve ser feita em função do

contexto e das metas específicas que se pretendem atingir: modelos de capitação parecem ser particularmente eficazes, desde que devidamente monitorizados para a promoção da prevenção; por sua vez, caso se queiram alcançar resultados clínicos específicos, o modelo pay-for-performance poderá ser uma opção mais adequada, embora o sucesso desta estratégia esteja aquém do esperado devido à ausência de resposta efetiva e à imprevisibilidade de efeitos secundários. O pagamento por episódio poderá ser uma opção viável na gestão de doenças crónicas na medida em que promove a colaboração entre profissionais e níveis de cuidado apresentando, contudo, um desempenho inferior na prevenção de episódios de descompensação (Barros, 2024).

Atualmente, o financiamento estabelecido para as Unidades Locais de Saúde (ULS) baseia-se num modelo de capitação ajustado ao risco clínico, e no recurso a acordos de cooperação, incentivos institucionais e prémios de desempenho dependentes do cumprimento, na totalidade, das metas previamente contratualizadas (ACSS, 2025).

6. Complementaridade entre os setores público, privado e social

A resposta à complexidade da doença crónica exige mais do que soluções intrassetoriais. Enfrentar os desafios clínicos, funcionais, sociais e económicos associados à cronicidade implica uma abordagem sistémica e colaborativa, que valorize a complementaridade estratégica entre os diferentes segmentos do sistema de saúde. Nenhum setor — público, privado ou social — detém, isoladamente, os meios, a flexibilidade e a capilaridade necessários para dar uma resposta integrada, eficaz e sustentável à diversidade de necessidades das pessoas com doença crónica.

Esta secção propõe-se analisar o contributo específico de cada um destes setores na organização de cuidados centrados na pessoa, destacando os seus papéis, potencialidades e limitações. O ponto 6.1 explora a responsabilidade estruturante do setor público, nomeadamente do Serviço Nacional de Saúde (SNS), enquanto garante do acesso universal e da coordenação dos cuidados. O ponto 6.2 aprofunda o papel do setor social, sublinhando a sua capacidade de proximidade, humanização e apoio comunitário. O ponto 6.3 reflete sobre o setor privado como parceiro estratégico na inovação, cobertura e flexibilidade assistencial. Por fim, o ponto 6.4 discute a necessidade de construção de modelos colaborativos e de contratualização por missão, baseados na confiança, transparência e corresponsabilização por resultados em saúde.

6.1. Papel do setor público: coordenação, universalidade e garantia de acesso

O Serviço Nacional de Saúde (SNS) mantém um papel estruturante na resposta à cronicidade, como garante da universalidade, generalidade e continuidade de cuidados. Os cuidados de saúde primários (CSP), os cuidados hospitalares e os cuidados continuados integrados constituem a espinha dorsal da rede assistencial (Decreto-Lei n.º 52/2022, 2022). Dentro dos CSP existem ainda unidades funcionais em rede com autonomia técnica e administrativa que prestam cuidados focadas em áreas específicas, nomeadamente unidades de saúde familiar (USF), unidades de cuidados de saúde personalizados (UCSP), unidades de cuidados na comunidade (UCC), unidades de recursos assistenciais partilhados (URAP) e unidades de saúde pública (USP; Decreto-Lei n.º 52/2022, 2022). Principal ponto de acesso ao sistema, os CSP enfrentam desafios consideráveis relacionados com a falta de profissionais, tempo de consulta reduzido, escassa integração de tecnologias e baixa flexibilidade organizacional. Tais dificuldades contribuem, em parte, para o uso indevido do serviço de urgências – detetado em cerca 30% dos casos – em situações passíveis de gestão em níveis de cuidados menos diferenciados (WHO, 2018). Para além disso, a compartimentalização entre níveis de cuidados e a ausência de um verdadeiro modelo de governação integrada gera deficiências na comunicação e colaboração, descontinuidades no cuidado e barreiras à concretização das metas estratégicas, limitando a resposta coordenada à pessoa com doença crónica.

6.2. Contributo do setor social: proximidade, humanização e apoio comunitário

As Instituições Particulares de Solidariedade Social (IPSS), as Misericórdias e outras organizações do setor social desempenham um papel vital na prestação de cuidados de proximidade e promoção da inclusão social (Decreto-Lei n.º 101/2006, 2006), sendo responsáveis por mais de 70% da capacidade instalada na Rede Nacional de Cuidados Continuados Integrados (RNCCI) em Portugal (ACSS, 2021).

Estas instituições têm demonstrado uma elevada capacidade de resposta em contextos de fragilidade social, isolamento e dependência, com um modelo de intervenção centrado na comunidade e próximo das famílias. No entanto, enfrentam constrangimentos relevantes: subfinanciamento crónico, saturação da rede, longos tempos de espera, referenciação inadequada (não cumprimento de critérios e sub-referenciação pelos CSP), necessidades crescentes de cuidados (a rede responde a apenas 50% das necessidades identificadas), falta de recursos e necessidade formação contínua dos mesmos, ausência de partilha de sistemas de informação (Conselho Nacional dos Cuidados Continuados da Ordem dos Médicos, 2016).

6.3. Contributo do setor privado: inovação, flexibilidade e complementaridade técnica

O setor privado de saúde em Portugal tem apresentado um crescimento consistente, com uma taxa média anual de crescimento de 4% no quinquénio pré-COVID, representando, atualmente, cerca de 40% da despesa total em saúde — o dobro da média europeia — sobretudo através de pagamentos diretos (out-of-pocket) e, em menor escala, de seguros e planos privados de saúde (OECD, 2023).

O setor privado configura-se como um parceiro estratégico para suprir lacunas ao nível da cobertura e acesso a cuidados de saúde, da capacidade e rapidez de resposta do setor público em determinadas áreas (Sistema Integrado de Gestão de Inscritos para Cirurgia, programa cheque dentista) e na construção de soluções para a cronicidade, através de diferentes mecanismos de cooperação como programas de combate às listas de espera cirúrgicas (SIGIC) e de promoção da saúde (cheque-dentista) e parcerias e contratos público-privados. Esta cooperação entre os dois sectores pretende melhorar a eficiência e a qualidade dos cuidados de saúde, através da inovação e capitalização dos recursos humanos e técnicos (e.g. meios de diagnóstico e de terapêutica (Fernandes & Nunes, 2016). Nos cuidados à doença crónica, o setor privado é particularmente relevante no contexto do acesso a clínicas de especialidade, serviços de monitorização digital, apoio domiciliário e centros de reabilitação.

Apesar da complementaridade que o sector privado oferece, é importante que os mecanismos de cooperação sejam devidamente regulados, para garantir o cumprimento dos princípios orientadores do SNS, nomeadamente o acesso universal, geral e equitativo a cuidados continuados ou complexos.

6.4. Modelos colaborativos e contratualização por missão

A integração real entre os três setores exige mais do que convenções administrativas. Requer uma contratualização por missão, orientada para resultados em saúde, que reconheça o valor acrescentado de cada parceiro e promova a articulação funcional entre os diferentes níveis e contextos de cuidados. A *contratualização relacional* — proposta por diversos autores como alternativa aos contratos transacionais — pressupõe confiança mútua, partilha de objetivos, transparência na informação e mecanismos de coavaliação do desempenho (Hughes et al., 2024; Palmer et al., 2000). Esta abordagem é particularmente relevante no contexto da doença crónica, onde os resultados dependem de fatores multidimensionais e da continuidade da relação terapêutica (Porter et al., 2013). As *redes locais de cuidados* — constituídas por unidades do SNS, IPSS e privados — podem assumir a responsabilidade conjunta pela gestão de uma população com determinadas características (ex.: idosos com multimorbilidade), com base em planos regionais de saúde, financiamento capitado ajustado ao risco e indicadores partilhados.

7. Considerações finais e recomendações

A progressiva transição epidemiológica e demográfica observada nas últimas décadas exige uma reformulação profunda dos sistemas de saúde. A doença crónica impõe desafios estruturais, organizacionais e financeiros que não podem ser enfrentados com os modelos de prestação convencionais. Pelo contrário, exige uma abordagem centrada na pessoa, longitudinal, interdisciplinar e baseada na continuidade e proximidade dos cuidados.

Ao longo deste capítulo, analisámos os principais desafios associados à cronicidade em Portugal — desde o envelhecimento populacional e a multimorbilidade até ao impacto económico e à fragmentação dos serviços. Demonstrámos, com base na evidência nacional e internacional, que a reorganização dos cuidados é não só desejável, como imprescindível para garantir a sustentabilidade do sistema e a qualidade dos cuidados prestados.

A resposta à doença crónica não pode continuar a ser episódica, hospitalocêntrica ou centrada exclusivamente em profissionais médicos. Requer um novo paradigma organizacional, em que os enfermeiros especialistas em enfermagem na pessoa em situação crónica assumem um papel central na coordenação do cuidado, na capacitação do utente e na articulação entre níveis assistenciais. Para tal, são necessários investimentos claros na definição de competências, na autonomia profissional e na criação de contextos organizacionais facilitadores.

Neste enquadramento, propomos um conjunto de recomendações estratégicas baseadas na literatura (Osareme et al., 2024; Wheatley, 2024; WHO, 2017), agrupadas em cinco eixos prioritários

a) Reorganizar os cuidados em torno da pessoa e da continuidade assistencial

- Promover a adoção de modelos de cuidados integrados (e.g., Chronic Care Model) e redes locais de cuidados;
- Implementar planos personalizados de gestão da doença crónica, baseados em evidência científica e com participação activa do cidadão e da sua rede de suporte;
- Promover estratégias de *case management*, sobretudo para pessoas com elevada complexidade clínica e social;
- Expandir a oferta de cuidados preventivos (e.g., exames de saúde regulares, programas de vacinação) e de cuidados domiciliários, incluindo monitorização remota e visitas multidisciplinares programadas;

- Aumentar a deteção precoce e a cobertura de cuidados de saúde, priorizando intervenções de alto impacto e com elevada rentabilidade orientadas para a promoção da saúde e prevenção da doença;
- Desenvolver e implementar uma política de cuidados paliativos, incluindo o acesso a analgésicos opióides para o alívio da dor, juntamente com a formação de profissionais de saúde;
- Estabelecimento de canais de comunicação sólidos entre os diferentes níveis de cuidados;
- Promover a literacia da população, visando uma maior capacitação na gestão da sua saúde e a procura e utilização apropriada dos serviços de saúde;
- Fomentar a utilização de recursos comunitários com foco na promoção da autonomia;
- Monitorização e avaliação da qualidade dos serviços e resultados;
- Expandir o acesso e uso de tecnologias digitais (telemedicina, monitorização remota e domótica) e medicamentos essenciais.

b) Otimizar o uso das competências dos profissionais de saúde

- Reconhecer e regulamentar o papel dos enfermeiros especialistas na gestão de condições crónicas, educação terapêutica, vigilância clínica e planeamento da alta;
- Implementar consultas lideradas por enfermeiros em contextos definidos (ex.: diabetes, DPOC, hipertensão), com autonomia protocolada;
- Investir na formação avançada de profissionais de saúde para o exercício de funções expandidas, especialmente em contextos de escassez médica;
- Garantir supervisão clínica, protocolos claros e articulação com médicos e outros profissionais para assegurar segurança e eficácia.

c) Promover eficiência técnica e económica através de novos modelos organizacionais e de financiamento

- Definição de um orçamento plurianual centrado em objectivos de saúde, incluindo a promoção da saúde e prevenção da doença;
- Medir de forma sistemática os *outcomes* relevantes para o doente (ex.: qualidade de vida, funcionalidade, autonomia);
- Monitorizar o uso de recursos e os custos reais por ciclo de cuidados, para fundamentar decisões de investimento;

- Explorar mecanismos viáveis de financiamento da saúde e ferramentas económicas inovadoras apoiadas por evidências;
- Generalizar a criação de Centros de Responsabilidade Integrados (CRI) dedicados à gestão de doenças crónicas;
- Alinhar o financiamento com os resultados em saúde através de modelos como *pay-for-performance*, *capitação ajustada ao risco* e pagamentos por pacotes de cuidados;
- Explorar modelos de seguro de saúde e outros mecanismos de proteção financeira inovadores que levem em consideração as necessidades de cuidados continuados prolongados específicas dos utentes;
- Implementação de sistemas integrados de comunicação e informação que melhorem a acessibilidade e eficiência dos cuidados de saúde.

d) Valorizar a complementaridade entre os setores público, privado e social

- Colaboração mais estreita com as ONG e a sociedade civil para implementar planos de saúde pública, criando oportunidades mais amplas para a participação pública;
- Integração vertical e horizontal eficaz com base em contratualização por missão e objetivos comuns;
- Incentivar as autarquias a desenvolver *Estratégias Municipais de Saúde* focadas na cronicidade, em articulação com os serviços de saúde e os recursos comunitários.

e) Fortalecer a governação clínica e a contratualização por resultados

- Promover uma cultura organizacional orientada para o valor, a responsabilidade partilhada e a melhoria contínua;
- Desenvolver metas e indicadores nacionais para a prevenção e controlo das DNTs que envolvam a colaboração dos diferentes sectores e parceiros;
- Utilização mais ampla da avaliação do impacto na saúde para orientar e monitorizar as ações de saúde pública;
- Definir metas claras e mensuráveis para as equipas de cuidados crónicos, em parceria com as mesmas, com monitorização regular e feedback contínuo.

Conclusão

Portugal tem hoje as condições técnicas, humanas e políticas para dar um salto qualitativo na forma como organiza a resposta à doença crónica. A criação de uma nova especialidade de enfermagem centrada na pessoa em situação crónica constitui uma oportunidade única para promover esta mudança, não apenas no plano técnico, mas também simbólico: é o reconhecimento de que cuidar da cronicidade exige competências próprias, trabalho colaborativo e inovação organizacional.

O sucesso desta transformação dependerá da capacidade de mobilizar todos os setores, alinhar incentivos com objetivos de saúde pública e, sobretudo, colocar a pessoa no centro do sistema de saúde. Fazer diferente é possível. E fazer melhor é uma obrigação moral, política e profissional para com todos os que vivem com doença crónica em Portugal.

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Section VI

Overview and future Prospects

Overview and future prospects

The work presented in this thesis is dedicated to understanding how health and social care can be more effectively integrated, and how different governance models, policy choices and institutional arrangements shape that integration in practice. Drawing on six interconnected scientific articles, framed by two book chapters written in Portuguese, the thesis follows a deliberate and progressive trajectory.

It begins with the synthesis of international evidence and the analysis of national integration models, through which Scotland emerged as one of the most advanced and relevant examples of health–social care reform. It then moves to an in-depth examination of the Scottish experience, before concluding with the development of a consensual roadmap to support the governance of health–social integration in Portugal.

Taken together, these studies progress from an understanding of “what is known” at the international level and which models appear most promising, to “what happens” within a concrete and mature reform process, and ultimately to “what could or should be done” in the Portuguese context.

The international perspective

This thesis makes several contributions to the international debate on health and social care integration. First, the narrative review of national integration models offers a structured perspective on how different countries have sought to institutionalise health–social integration at system level. It identifies and characterises the main “families” of integration models — such as regional responsibility for both health and social care, contractual integration supported by pooled budgets, and locally based partnership arrangements — and links these approaches to specific governance structures, financing strategies and accountability mechanisms.

By placing these models side by side, the analysis demonstrates that while high-level objectives, particularly person-centred and coordinated care, are widely shared, the pathways chosen to achieve them are deeply shaped by welfare state traditions, administrative configurations and political choices.

Complementing this analysis, the umbrella review provides one of the most comprehensive syntheses to date of the implementation and impact of integrated health and social care services, with a particular focus on the European context. The findings clarify that the term “integration” encompasses a wide range of interventions and organisational forms. Benefits are most consistently observed in service-related outcomes, including improved continuity and coordination of care, higher user satisfaction and, in many

settings, reductions in avoidable hospital use. At the same time, the review highlights the substantial heterogeneity and methodological limitations of the existing evidence, particularly regarding long-term costs, equity outcomes and system-wide effects.

Finally, the analysis of international implementation cases brings the discussion closer to real-world practice. Examining concrete integration initiatives across several countries, it identifies a recurrent set of enabling factors — notably joint governance arrangements, pooled or aligned funding mechanisms, strong community-based and primary care systems, and effective digital and information infrastructures. These enablers coexist with persistent challenges, including institutional fragmentation, workforce shortages and the difficulty of sustaining integration beyond time-limited pilot funding. Taken together, these findings reinforce the understanding of integration not as a single reform event, but as a long-term process that requires sustained alignment between governance structures, organisational culture and professional practice.

Scotland – a mature example of health–social integration

Among European countries that have pursued large-scale health and social care integration, Scotland stands out as one of the most advanced and institutionally structured examples. Over the last decade, the country has implemented major reforms, most notably through the Public Bodies (Joint Working) (Scotland) Act 2014, which established Health and Social Care Partnerships (HSCPs). These partnerships brought together NHS boards and local authorities under joint governance arrangements and pooled budgets, covering a wide range of health and social care functions. The reforms were developed in response to rising healthcare costs, demographic ageing and the growing prevalence of chronic, often lifestyle-related conditions.

The Scottish case studies included in this thesis provide an in-depth examination of what happens when integration is formalised through robust legislation and institutional design. The descriptive assessment of the first five years of implementation shows tangible, though uneven, improvements in selected indicators, particularly reductions in delayed discharges and an increased emphasis on care at home. However, other expectations associated with the reform, such as substantial reductions in hospital admissions, were only partially achieved, and significant regional variation persisted.

A complementary policy analysis, drawing on different public policy lenses, sheds light on the underlying drivers, constraints and trade-offs of the Scottish reform. Using perspectives from public choice theory, institutionalism and functionalism, the analysis illustrates how political dynamics,

institutional legacies and functional pressures interact to shape both the ambitions and the limits of integration. While Scotland has developed a sophisticated governance framework and successfully institutionalised joint working through HSCPs, the reform has remained constrained by persistent funding pressures, workforce challenges and ongoing tensions between national strategic direction and local autonomy.

Overall, the Scottish experience suggests that integration has contributed to improved coordination, reduced service fragmentation and a stronger orientation towards community-based, person-centred care. At the same time, it highlights the limits of large-scale structural reform in a high-income welfare system. Integration has, in many respects, reallocated responsibilities and redesigned organisational arrangements without fully resolving structural inefficiencies or delivering clear system-wide cost-effectiveness gains. Taken together, these case studies underline both the potential and the limits of integration, and caution against assuming that institutional reorganisation alone is sufficient to achieve transformative change.

Transposition to Portuguese public policies

The Delphi consensus on health–social sector integration in Portugal provides the first systematically developed national roadmap for governance in this field. By bringing together experts from health care, social care, academia and public administration, and structuring their contributions across multiple iterative rounds, the study identifies and prioritises the perceived benefits of integration, the main obstacles to its implementation and the strategic measures considered essential to move forward.

The consensus highlights improved autonomy and healthy ageing, reductions in avoidable hospitalisations, enhanced coordination and more efficient use of resources as core expected benefits. At the same time, it converges on a set of persistent barriers, including fragmented governance arrangements, separate funding streams, limited interoperability of information systems and insufficient strategic alignment across sectors. In response to these challenges, the experts prioritised a number of strategic actions, notably the creation of interministerial governance structures, the development of a national integration strategy, the implementation of shared or pooled financing models, and sustained investment in digital infrastructure and workforce development.

Beyond these empirical findings, the thesis advances an integrative conceptual contribution by framing health–social integration primarily as a challenge of governance and stewardship rather than solely as a clinical or organisational issue. The analysis shows that meaningful integration depends not

only on local initiatives or new organisational arrangements, but on the alignment of responsibilities, resources, information flows and accountability mechanisms across sectors and levels of the system. It also underscores the importance of co-producing national strategies with those responsible for implementation and those directly affected by integration efforts.

The thesis is strengthened by its methodological breadth. It combines umbrella and narrative reviews, comparative case analysis, descriptive policy evaluation and Delphi consensus building to examine the same phenomenon from multiple angles. It spans different levels of analysis — from macro-level policy and governance, through meso-level organisational models, to the perspectives and priorities of key system actors — and covers diverse contexts, ranging from mature integration environments to an emergent case such as Portugal. This triangulation across methods, levels and contexts enhances the robustness of the findings, while also making explicit where conclusions remain context-dependent.

Important limitations must nevertheless be acknowledged. The evidence synthesised in the reviews largely reflects high-income settings and is influenced by publication bias, heterogeneous definitions of “integration” and relatively short follow-up periods. The Scottish case study represents a single national trajectory and cannot be directly extrapolated to other institutional contexts. The Delphi study captures the views of a selected group of experts and does not replace the perspectives of patients, informal caregivers or front-line professionals, which remain under-represented in the empirical material. Moreover, the thesis adopts a predominantly governance and policy perspective; detailed micro-level analyses of clinical practice, team dynamics and patient pathways fall outside its scope.

Despite these limitations, the body of work provides a coherent and useful platform for further debate and policy development. The convergence between international evidence, lessons from the Scottish experience and expert consensus in Portugal suggests that, while institutional arrangements vary, the fundamental challenges of health–social integration are widely shared. The thesis also demonstrates that broad normative aspirations — such as person-centred and integrated care — can be translated into concrete strategic priorities and governance options at national level.

Future research and prospects

This thesis points to several important directions for future research and policy development. One key line of inquiry concerns the implementation and impact of governance reforms. While the Delphi exercise identifies priority governance measures for health–social integration in Portugal, the next challenge lies in understanding how such measures can be designed, sequenced and implemented in practice.

Longitudinal evaluations of forthcoming reforms, combining quantitative performance indicators with qualitative implementation research, will be essential to assess not only whether change occurs, but how and why it unfolds.

A second line of inquiry relates to measurement and outcomes. This work demonstrates that existing evaluations of integration continue to rely heavily on hospital utilisation and a limited set of service indicators. There is a clear need to develop and apply outcome frameworks that better capture what matters in integrated health and social care, including functional trajectories, autonomy, social participation, caregiver burden, equity and user experience over time. Further research is also required to connect these outcome frameworks to data architectures and information systems designed to support integration, rather than reinforcing sectoral silos.

Closely linked to this agenda is the role of digital and data infrastructure. Many of the barriers identified in both the international literature and the Portuguese Delphi study are rooted in non-interoperable information systems and the absence of shared, person-centred records. Future research should explore how different models of data governance, digital platforms and shared analytics can facilitate integration while respecting privacy, security and ethical requirements. It should also examine how these tools can support joint decision-making at clinical, organisational and policy levels.

The thesis also highlights the importance of professional cultures, workforce models and multiprofessional collaboration. Although the primary focus of this work lies on governance structures and policy frameworks, it is evident that integration will not succeed without sustained attention to training, professional roles, incentives and working conditions. Empirical studies examining integrated teams, boundary-spanning roles and emerging professional profiles — such as care coordinators or community link workers — within the Portuguese context would complement the governance-level perspective developed here and help translate strategic priorities into everyday practice.

Greater emphasis should also be placed on the perspectives of service users, families and communities in both the design and evaluation of integration reforms. The present thesis primarily captures expert and system-level views; future research would benefit from participatory approaches, the systematic use of patient-reported outcome and experience measures, and community-based methodologies. Such work is essential to ensure that integration is not only administratively coherent, but also meaningful and acceptable to those it is intended to serve.

Finally, the comparative dimension opened by this thesis offers a further avenue for investigation. The combination of international reviews, the Scottish case study and the Portuguese consensus points to a rich agenda for cross-country learning. Future studies could explore how different welfare and health

system regimes operationalise similar integration principles in divergent ways, and under what conditions lessons from one context — such as Scotland — can be transferred to another, such as Portugal, without neglecting institutional and cultural specificities.

Taken together, the work presented in this thesis reinforces the understanding that health and social care integration is both necessary and inherently complex. It is not a purely technical exercise, but a long-term governance project that depends on political commitment, institutional capacity and continuous learning. By clarifying what is currently known, by making explicit the choices and trade-offs involved, and by outlining a consensual starting point for reform, this thesis contributes to advancing the debate on health–social integration in Portugal and in other health systems facing similar demographic, social and organisational challenges.

Personal growth and prospects

This doctoral journey has been both an academic process and a sustained path of personal and professional development. Over the course of the programme, learning extended well beyond the production of scientific outputs, profoundly shaping the way I understand governance, public policy and leadership in complex health and social systems. The knowledge developed through research has continuously interacted with professional practice, allowing theory and experience to inform and challenge one another.

The completion of this thesis coincided with a period of intense public and institutional engagement, offering privileged contexts in which to apply, test and refine the competencies developed throughout the PhD. Participation in local, national and international governance arenas deepened my understanding of how health and social policies are shaped through negotiation, institutional constraints and political trade-offs. These experiences reinforced the importance of strategic thinking, evidence-informed decision-making and sensitivity to the perspectives of diverse stakeholders.

Engagement in intersectoral policy processes, particularly within national reform initiatives, provided direct exposure to the challenges of system-wide governance and cross-sectoral coordination. Contributing to the design of structural policy measures strengthened my capacity to translate scientific knowledge into concrete public policy instruments, while also highlighting the limits of technocratic solutions in the absence of political alignment and institutional capacity.

At the international level, participation in global professional governance structures broadened my perspective on health systems and integrated care. This experience fostered competencies in institutional

representation, intercultural communication and diplomatic engagement, and underscored the relevance of shared global challenges — such as sustainability, workforce development and integration — across very different health system contexts.

At the local and organisational levels, leadership roles within professional and social sector organisations offered an opportunity to operationalise and critically reflect on the core theme of this thesis: the integration of health and social care. Managing organisations at the interface between health services, social responses and community needs made visible the practical implications of fragmented governance, as well as the potential gains of coordinated action. These experiences reinforced the conviction that integration is not an abstract policy objective, but a necessary condition for addressing contemporary demographic, social and organisational challenges.

Overall, the doctoral process contributed to the consolidation of a set of competencies that now underpin my academic and professional activity. These include the ability to analyse complex public policies critically, to design and implement governance-oriented integration strategies, to exercise collaborative leadership in interprofessional contexts, and to communicate scientific evidence within national and international policy networks. Most importantly, the PhD reshaped the way I approach decision-making and leadership. Research strengthened analytical rigour; professional practice tested the applicability of theory. The dialogue between these two dimensions has become the central axis of my development.

Looking ahead, this work provides a foundation to further apply and expand the knowledge generated through this thesis, particularly by contributing to the implementation and evaluation of the governance measures identified through the Delphi consensus. The ultimate objective is to support more integrated, equitable and responsive health and social care systems, capable of bringing institutions closer to the communities they serve and of addressing complex needs in a coherent and sustainable manner.

Final comments

Integration between health and social care is not primarily an organisational exercise. It is a political, institutional and ethical response to how people actually live their lives. Individuals do not experience illness, vulnerability or dependency through administrative sectors or policy silos; they experience them through families, communities and daily routines. When systems remain fragmented, the consequences are not abstract: they materialise as avoidable suffering, inefficiency and unequal access to care.

Against the backdrop of population ageing, multimorbidity and growing social complexity, the ambition of reform cannot be limited to better coordination. What is required is meaningful continuity — continuity that protects dignity, supports autonomy and sustains trust over time. This thesis was developed with that guiding principle in mind and seeks to demonstrate that integration becomes feasible only when it is treated as a matter of governance rather than structure alone. Clear responsibilities, aligned financing mechanisms, shared information and collective accountability are not technical details; they are the conditions under which integration can move from aspiration to practice.

The evidence reviewed and generated throughout this work suggests that successful integration does not emerge from universal templates. It develops through institutional learning, political commitment and sustained collaboration across professional and organisational boundaries. Comparative experiences, such as the Scottish case, show that progress is possible, but also that integration is a continuous process rather than a final state. For Portugal, this implies moving beyond isolated pilot projects towards a coherent policy framework that translates broad aspirations into concrete priorities and supports long-term, adaptive implementation.

Ultimately, the future of integrated care will be shaped by choices. Choices about how responsibilities are shared, how resources are allocated and how success is defined. Choosing integration means building bridges: between health and social care, between policy and practice, between evidence and decision-making, and, above all, between institutions and the people they serve. It is a demanding path, but one that holds the potential to deliver more coherent, humane and sustainable responses to the needs of populations. It is to this path — and to the informed choices it requires — that this thesis aims to contribute.

Curriculum Vitae

Ricardo Correia de Matos is a Mental Health and Psychiatric Nurse Specialist, a Certified Accountant, and a PhD candidate in Public Policy at ISCTE – University Institute of Lisbon. His academic and professional trajectory is marked by a strong orientation toward the analysis, formulation, and implementation of health public policies, with particular emphasis on the integration of health and social care, health system governance, and the organizational sustainability of public services. He complements his background with a postgraduate programme in Management for Health Professionals (ISCTE Executive Education), strengthening his competencies in leadership, organization, financing, and service transformation.

Over the past two decades, he has held institutional leadership and governance roles at different levels of the health system and the social sector. These include serving as President of the Centre Regional Section of the Portuguese Nursing Council (SRC-OE), President of the Águeda Branch of the Portuguese Red Cross (CVP Águeda), and Director of the Neurointervention Complex (CNI-CVP) in Gaia. In these roles, he assumed strategic responsibilities in governance, planning, workforce management, and institutional representation, gaining an in-depth understanding of professional regulation mechanisms, public decision-making processes, and integrated care delivery.

At the national public policy level, he has participated in governmental working groups responsible for the design, implementation, and monitoring of structural reforms in the health sector, namely through his involvement in the task force that developed the Health Emergency and Transformation Plan (PETS), as well as in its monitoring committee. This engagement provided direct exposure to policy formulation, negotiation, and execution processes, reinforcing a critical understanding of institutional constraints, political trade-offs, and operational challenges associated with health system transformation.

At the international level, he is a Board Member of the International Council of Nurses (ICN), contributing to strategic discussions and global advocacy on health public policies, health workforce planning, professional governance, and the sustainability of care systems, thereby reinforcing the comparative and international dimension of his research. He was also a member of the Municipal Health Council of the Municipality of Coimbra, actively contributing to the development of the Municipal Health Strategy, and served as a consultant in the design of municipal health strategies for the municipalities of Santa Maria da Feira, Oliveira de Azeméis, Vale de Cambra, and São João da Madeira.

In parallel, he has developed a consistent academic and scientific activity. He teaches in higher education in the areas of health public policy, health economics, management, and organization of care. He is a member of the Research and Development Unit of the Red Cross Health School of Norte (ESSNorteCVP), participating in a couple of funded projects. He is the author of scientific articles and

book chapters, including “Magnet Hospitals: Patient outcomes, staffing trends, organizational and economic characteristics – A narrative review”, published in the Portuguese Journal of Management & Health. He regularly serves on the scientific and organizing committees of the Portuguese Nursing Council’s congresses and is a consultative member of Fórum Saúde XXI, where he acts as a moderator and speaker. Internationally, he was the coordinator and moderator of the session dedicated to the development and retention of health professionals at the Cascais International Health Forum 2025, organized by Fórum Saúde XXI, and participated, in 2022, in a round table entitled “Complexity of care in RMD: intersection between health and social care” at the EULAR Annual Congress in Copenhagen. He was also awarded the People’s Choice Award at the World Hospital Congress, organized by the International Hospital Federation, for the poster “Systematizing care at distance: Expert recommendations to remote nursing consultations in Portugal”, which was also published as a scientific manuscript. Throughout his career, he has served as moderator and invited speaker at dozens of national and international scientific and institutional events focused on governance, organization of care, and health public policy.