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Letter

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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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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].

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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*

	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%

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.

(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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