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Review Article

The Effectiveness and Cost Benefit of Integrated Health and Social Care: A Rapid Review of The Evidence

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Abstract

Background: Integrated care denotes a systematic and coordinated approach to delivering proactive, person-centred services across multiple providers. It is characterised by effective communication and collaboration between two or more care organisations, with the overarching goal of enhancing care quality, improving health outcomes, and enabling individuals to actively manage their own health. This rapid review sought to assess the effectiveness and cost-benefit of integrated health and social care programmes implemented within the UK. **Methods:** A rapid review methodology was employed to expedite the processes typically involved in a conventional systematic review, using streamlined procedures to generate timely and resource-efficient evidence for stakeholders. The review incorporated 15 studies that reported full or partial economic evaluations of integrated health and social care programmes. These evaluations drew on a combination of randomised controlled trials, observational studies, and cohort designs conducted between 2014 and 2024. **Results:** The evidence regarding the effectiveness and economic impact of integrated health and social care initiatives was mixed, with considerable variation in reported costs, positive outcomes, and return on investment associated with integrated care models. The findings were organised around four overarching themes: delivering complex care closer to home; providing home-from-hospital support services; promoting emotional health and well-being; and implementing accommodation-based interventions. **Discussion:** High-quality economic evaluations are essential to enhancing the evidence base for integrated health and social care. Future research should be tailored to the specific policy and funding contexts of the devolved nations within the United Kingdom. Integrated care models play a pivotal role in delivering coordinated, cross-sector services, particularly for individuals with complex needs; therefore, demonstrating their economic effectiveness and return on investment remains crucial. To support informed decision-making, forthcoming evaluations should employ robust economic methodologies, such as Cost-Benefit Analysis, to provide a comprehensive assessment of the financial and societal impacts of integrated care interventions.

Keywords: Integrated health and social care; Patient-centred; Health outcomes; Economic evaluation; Cost-benefit analysis (CBA).

Introduction

Integrated care is an approach to overcome fragmentation in health and social care and may be best suited to people with complex medical needs, but the term extends to the wider definition of promoting health and wellbeing [1]. It involves a structured approach to delivering coordinated, proactive, and person-centred care, and should be understood as a complex adaptive system in which outcomes emerge from interactions between patients, professionals, organisations and communities. Consequently, effectiveness is shaped by context, relationships, collaboration and the capacity of the system to adapt over time [2].

Integrated care is provided by two or more care providers who communicate and collaborate, whether they work within the same organisation or across different organisations. These organisations can be within the healthcare sector or span across health, social, or community care sectors, including informal care providers [3]. Integrated care is illustrated in Figure 1, which was originally presented in a report to support the final report of the evaluation of the social services and well-being (Wales) Act, 2014 [4].

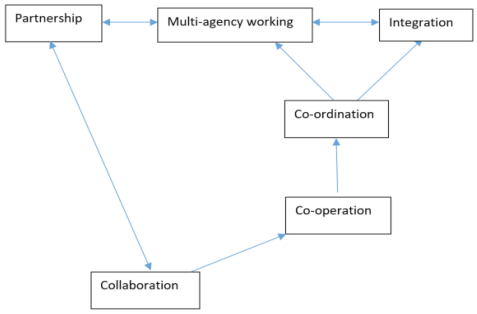


Figure 1: Types of working together and their relationship with one another [4].

Integrated care is a complex intervention, making economic evaluation challenging [5]. Integrated care interventions typically involve multiple organisations, cross-sector collaboration, service redesign, workforce changes, new governance arrangements and digital and information-sharing systems. This complexity means traditional economic evaluation methods often struggle to capture the full costs and benefits as benefits may occur across different sectors (health, social care, community services) and over long time horizons [6].

This review will focus on the United Kingdom (UK). However, healthcare systems and social care systems worldwide are increasingly adopting integrated care models to improve patient/client outcomes and enhance the efficiency of service delivery. Health and care 6 providers are changing how they work with people as partners in care. Countries around the world, including Australia, Canada, New Zealand, and various European nations (e.g., Sweden, The Netherlands, and the UK) have implemented integrated care initiatives to better manage chronic conditions, improve access to services, and enhance the quality of care [7].

The International Foundation for Integrated Care (IFIC) has an annual survey to reflect on the progress of integrated care delivery worldwide. Their annual survey in 2024 showed that health and care providers were more positive about person centred care than the person at the centre of care [8]. In the UK integrated health and social care systems are organised and not all funded in the same way. Different regions of the UK may have specific approaches to integrating health and social care. For example, England, Scotland, Wales, and Northern Ireland have their own health services and policies, which can lead to variations in how integrated care is implemented and funded. In England, Integrated Care Systems (ICSs) are partnerships that bring together National Health Service (NHS) organisations, local authorities, and other stakeholders to plan and deliver services collectively. ICSs aim to improve health outcomes, reduce inequalities, and enhance the efficiency of services. For residents of the UK these services are funded through general taxation. However, members of the public can opt for private health insurance to access private healthcare services, which can offer shorter waiting times and additional services, which are not available on the NHS. The UK Government strives to build strong ICS everywhere.

England is divided into 42 ICSs and these systems bring local health and social care organisations together to improve outcomes for their populations by creating better services [9]. In Wales, the Welsh Government have provided a fund for Health and Social Care integration on a regional basis within Communities of Practice (CoP) to provide integrated care to members of the community [10]. The Health and Social Care RIF in Wales focuses on establishing and mainstreaming six new national models of care (MoC). These models aim to provide seamless and effective services across the country.

The six models of care in Wales are:

- Community-based care - prevention and community coordination.
- Community-based care - complex care closer to home.
- Promoting good emotional health and well-being
- Supporting families to stay together safely, and therapeutic support for care-experienced children.

- Home from hospital services.
- Accommodation based solutions.

These six models of care are part of a broader effort to integrate health and social care services in Wales, ensuring that care is person-centred and delivered as close to home as possible.

To date, models of care have mainly been used for administration and reporting purposes rather than shaping and informing delivery [11]. See overleaf for detailed descriptions of the models of care. In Scotland 'The Integrated Health and Social Care plan for Scotland' (2019) addresses several key issues to ensure that Scotland can provide high-quality, integrated health and social care services [12]. The key issues are workforce integration, mental health services, workforce supply and demand, graining and recruitment, retention and development, and data and intelligence.

In Northern Ireland, the Integrated Care System for Northern Ireland (ICSNI) Framework was established in 2024. ICSNI are working with the Irish Department of Health and Health and Social Care Ireland towards creating a healthier population. The key objectives are population health, community-centred care, integration of services, workforce development, digital transformation and learning from past initiatives [13]. Although the concept and implementation of integrated care is relatively new in terms of policy direction, there are examples of successful implementation. For example, evidence examining the drivers of successful implementation of integrated care for multi-morbidity identified 17 case studies from 8 European countries including Scotland in the UK [14]. The 17 programmes were analysed using implementation theory.

Detailed Descriptions of the Six MoC in Wales:

1. Community-based care - prevention and community coordination MoC is an integrated approach that emphasises prevention and early intervention to improve health and well-being. This model aims to deliver seamless health and social care services within communities, ensuring support is provided as close to home as possible.
2. Community-based care - complex care closer to home MoC is an approach that aims to deliver specialised health and social care services within the community, ensuring that individuals with complex needs receive support as close to home as possible.
3. Promoting good emotional health and well-being MoC - Promoting good emotional health and well-being is part of the broader Welsh Government objectives under the Well-being of Future Generations (Wales) Act 2015 [15]. This involves creating environments and conditions that support individuals to be happy, healthy, and comfortable with their lives. The focus is on improving social, economic, environmental, and cultural well-being through sustainable development principles.
4. Supporting families to stay together safely and therapeutic support for care experienced children MoC Supporting families to stay together safely is providing early intervention and support to families to prevent the need for children to enter care. This involves identifying and addressing issues early, using family strengths and community resources, and ensuring that interventions prevent needs from becoming critical.
5. Home from hospital services MoC - Home from Hospital services is part of the "Home First" approach. This approach emphasises that the best place for recovery after a hospital stay is at home, whether that be a personal residence, a care home, or the home of a friend or family member. The goal is to maintain independence and reduce the risks associated with prolonged hospital stays, such as deconditioning and infections.
6. Accommodation based solutions MoC Accommodation-based solutions is part of the Welsh Government strategy to integrate health and social care services within the community. This approach involves creating and supporting housing options that provide a stable and supportive environment for individuals, particularly those with complex needs. The goal is to ensure that people can live independently with access to the necessary health and social care services.

Ten mechanisms for successful implementation of integrated care were identified including;

- Commonly adopted an incremental growth model rather than a disruptive innovation approach;
- A balance between flexibility and formal structures of integration;
- Collaborative governance;
- Distributed leadership throughout all levels of the system;
- Multi-disciplinary team culture with mutual recognition of each other's roles;
- The development of new roles and competencies for integrated care;
- Secured long-term funding;
- The implementation of Information and Communications Technology (ICT) that was specifically developed to support collaboration;

- Continuous monitoring system; and
- An overarching mechanism for alignment of work across the different components and levels of the health and social care system.

According to the Welsh Government documentation regarding the RIF, regions are encouraged to use outcome measures such as the Warwick Edinburgh Mental Well-being Scale (WEMWBS) and the EQ-5D, for example. However, they also stated that regions may also continue use tools already being used successfully [10] There is no evidence to date to indicate which tools the regions in Wales are using to collect measurement data on the effectiveness of the RIF funding stream.

The Welsh Government has commissioned a research team led from the University of South Wales to provide ongoing review and phased evaluation of the impacts of the RIF [10] Collaborators on the RIF evaluation include partners outside of the University of South Wales, including Brunel University of London and OB3, a research and consultancy firm based in Wales. The evaluation will help to identify the key success factors in developing and embedding the national models of integrated care [11]. This rapid review is aligned to that Welsh national evaluation [11]. The six models of care in Wales are presented in Table 1.

The aim of this rapid review is to determine the evidence regarding the effectiveness and cost benefit of integrated health and care programmes in the UK. The rapid review protocol is published on Prospero [16].

Method

A rapid review methodology was utilised for this review. A rapid review is a form of knowledge synthesis that accelerates the process of conducting a traditional systematic review through streamlining methods to produce evidence for stakeholders in a resource-efficient manner [17-19].

The main review question was: What is the effectiveness and cost benefit of integrated health and social care programmes in the United Kingdom and Ireland? The eligibility criteria for inclusion of papers in this rapid review is described below and existing systematic reviews were included in the rapid review. See table 2.

#	Name of Model of care	Welsh Government Definitions of the Models of Care
1	Community-based care – prevention and community coordination.	Community-based care is an integrated approach that emphasises prevention and early intervention to improve health and well-being. This model aims to deliver seamless health and social care services within communities, ensuring support is provided as close to home as possible.
2	Community-based care – complex care closer to home.	Community-based care – complex care closer to home is an approach that aims to deliver specialised health and social care services within the community, ensuring that individuals with complex needs receive support as close to home as possible.
3	Promoting good emotional health and well-being.	Promoting good emotional health and well-being is part of the broader Welsh Government objectives under the Well-being of Future Generations (Wales) Act 2015. This involves creating environments and conditions that support individuals to be happy, healthy, and comfortable with their lives. The focus is on improving social, economic, environmental, and cultural well-being through sustainable development principles.
4	Supporting families to stay together safely, and therapeutic support for care-experienced children.	Supporting families to stay together safely is providing early intervention and support to families to prevent the need for children to enter care. This involves identifying and addressing issues early, using family strengths and community resources, and ensuring that interventions prevent needs from becoming critical.
5	Home from hospital services.	Home from Hospital services is part of the "Home First" approach. This approach emphasises that the best place for recovery after a hospital stay is at home, whether that be a personal residence, a care home, or the home of a friend or family member. The goal is to maintain independence and reduce the risks associated with prolonged hospital stays, such as deconditioning and infections.
6	Accommodation based solutions.	Accommodation-based solutions is part of the Welsh Government strategy to integrate health and social care services within the community. This approach involves creating and supporting housing options that provide a stable and supportive environment for individuals, particularly those with complex needs. The goal is to ensure that people can live independently with access to the necessary health and social care services.

Table 1: Detailed descriptions of the six models of care in Wales.

	Inclusion criteria	Exclusion criteria
Population	People receiving integrated health and social care	People not receiving integrated health and social care
Phenomenon of Interest	Papers directly related to integrated health and social care	Papers not directly related to integrated health and social care
Context/ Comparison	Service delivery of integrated health and social care	Services not relevant to integrated health and social care
Outcome measures	Studies that report on relevant outcomes related to integrated health and social care: e.g. Care closer to home outcomes	Studies unrelated to integrated health and social care.
Study design	Any evidence of effectiveness or economic evidence related to health and social care	Studies not focussed on integrated health and social care
Countries	We will include studies from the United Kingdom and Ireland	Studies outside the United Kingdom and Ireland will be excluded
Language of publication	English or Welsh	All other languages other than English or Welsh.
Other factors	n/a	n/a

Table 2: Eligibility criteria (PICO: Population, Intervention, Comparison and Outcomes).

The following databases were searched for papers of interest:

- EMBASE
- OVID Medline
- EBSCO CINAHL
- EBSCO APA PsycINFO
- SCOPUS

The search strategy was reviewed by an Information Scientist, Royal College of Surgeons in Ireland, University of Medicine and Health Sciences. A table of abbreviations can be found in Supplementary file 1 and the full search strategy for the databases can be found in Supplementary file 2. Common keywords used in all database searches are shown in Table 3.

Population	Outcome	Economic Terms
children	'integrated care'	costs and cost analysis
adults	health	cost-benefit
elderly	social	cost-effectiveness
older people	'emotional health'	Quality Adjusted Life Year (QALY)
families	wellbeing	Social return on investment (SROI).
workforce	well-being	return on investment (ROI)
staff	community-based	cost utility analysis
carers	'supporting families'	
	'home from hospital'	
	'accommodation based solutions'	

Table 3: Common keywords used in all database searches.

The database searches are outlined in the PRISMA diagram in Figure 2 (Page et al., 2021).

Grey literature was also searched and a description of the sources used is contained in Supplementary file 3.

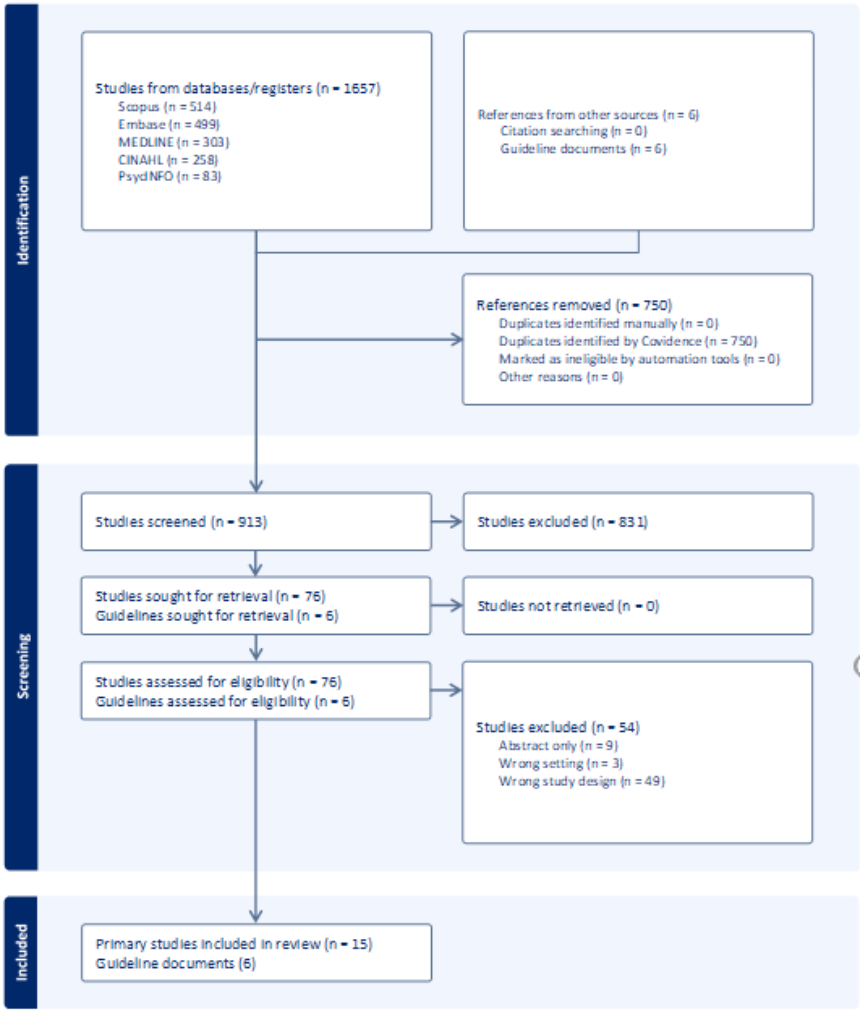


Figure 2: PRISMA diagram of included studies.

Covidence reference management software was used as the main systematic review management tool and to delete duplicates [20]. Mendeley reference manager was used for intext citations [21].

Study selection process, data extraction and assessment of quality

Two reviewers screened 100% of titles and abstracts independently. Following this, the level of agreement was assessed with disagreements settled by discussion and consensus. During independent screening, the lead researchers (LHS & ML) consulted with a third reviewer (DF) to come to an agreement on the final inclusions if there was disagreement. Data extraction was based on the outlined eligibility criteria. The extracted data captured details/characteristics on study region/country, study design, type of intervention, type of economic evaluation, number of participants, relevant costs and outcomes (see eligibility criteria) and study settings. Critical appraisal assessments were conducted on all selected peer reviewed studies using the Joanna Briggs Institute Critical Appraisal Tools [22].

Results

Overview of the evidence base

An evidence map of the literature is presented in Table 4 and guidance documents from the developed nations are presented in Table 5. The database searches are outlined in the PRISMA diagram in Figure 2 [24]. The data extraction table is in Supplementary file 4, and the critical appraisal tables are in Supplementary file 5.

Review or systematic review	Cross-sectional study - economic evaluation	Cross-sectional study - Cost study	Randomised Controlled Trials	Total
Hill et al (2017)	Garner et al (2017)	Exley et al (2019)	Evans et al (2021)	
Sandhu et al (2022)	Stokes et al (2019)	Tian et al (2014)	Heslin et al (2017)	
Thomson and Chatterjee (2023)	Stokes et al (2021)	Ware (2019)	Jones et al (2016)	
	Visram et al (2020)	Wilberforce et al (2016)		
	Yu et al (2017)			
n = 3	n = 5	n = 4	n = 3	n = 15

Table 4: Evidence map of the included studies according to study design.

Guidance document	Country	Year	Key elements of the guidance documents
A healthier Wales: Long term plan for health and social care (Welsh Government, 2021)	**Wales**	2021	In Wales, the 'Healthier Wales' policy is designed to create a more integrated, efficient, and patient-centred health and social care system. The key areas are: • Prevention and early intervention • Seamless integration of local health and social care • Digital and data • Sustainable funding • Workforce development • National leadership and direction
Regional Integration Fund (RIF) (Welsh Government, 2022)	**Wales**	**2022**	The RIF fund in Wales is designed to support the integration of health and social care services. Key elements are: 1. Focus on prevention and early intervention 2. Six national models of integrated care ➢ Community based care ➢ Complex care closer to home ➢ Promoting emotional health and well-being ➢ Supporting families ➢ Home from hospital services ➢ Accommodation based solutions 3. Sustainable long-term resourcing 4. Communities Of Practice (COP) 5. Pooled Fund Arrangements 6. Regional planning and partnership infrastructure. These elements aim to create a more integrated, efficient, and patient-centred health and social care system in Wales.

Guidance document	Country	Year	Key elements of the guidance documents
Building strong integrated systems everywhere: ICS implementation guidance on working with people and communities (NHS England, 2021)	**England**	**2021**	NHS England has a policy which provides comprehensive guidance on how Integrated Care Systems (ICSs) can effectively engage with local communities. Some of the key elements are: 1. Principles of working with people and communities 2. Core requirements and good practices 3. Involving people in governance 4. Tackling health inequalities 5. Co-producing 6. Collaboration with health watch and the voluntary sector
Scotland **An Integrated Health and Social Care Workforce Plan for Scotland (Scottish Government, 2019a)**	**Scotland**	**2019**	The Integrated Health and Social Care plan for Scotland addresses several key issues to ensure that Scotland can provide high-quality, integrated health and social care services. The key issues are: 1. Workforce integration 2. Mental health services 3. Workforce supply and demand 4. Training and recruitment 5. Retention and development 6. Data and intelligence
Northern Ireland The Integrated Care System for Northern Ireland (ICS NI) Framework document (Integrated Care System Northern Ireland, 2024)	**Northern Ireland**	**2024**	Integrated Care System in Northern Ireland are working with the Irish Department of Health and Health and Social Care Ireland towards creating a healthier population. The key objectives are: 1. Population Health 2. Community-centred care 3. Integration of services 4. Workforce development 5. Digital transformation 6. Learning from past initiatives

Table 5: Guidance documents for the integration of health and social care in the UK.

The included papers from the database searches (n=15) were mapped on to four of the models of care in Wales (Table 6): Complex care closer to home; Home from hospital services; Promoting emotional health and well-being; and Accommodation based solutions. None of the included papers provided economic evidence for the 'Supporting families' model of care.

#	Author and date	Type of integrated care intervention	Type of intervention translated to Regional Integrated Fund (RIF) Model of Care (MoC)
1	Wilberforce et al (2016) (Wilberforce et al., 2016)	Older people community mental health and institutional settings	Accommodation based solutions
2	Evans et al (2021) (Evans et al., 2021)	Palliative care	Community based care: Complex care closer to home
3	Garner et al (2017) (Garner et al., 2017)	COPD service	Community based care: Complex care closer to home
4	Heslin et al (2017) (Heslin et al., 2017)	Psychosis and health promotion	Community based care: Complex care closer to home
5	Jones et al (2016) (Jones et al., 2016)	Stroke self-management programme	Community based care: Complex care closer to home
6	Stokes et al (2019) (Stokes et al., 2019)	Pooling of health and social care budgets	Community based care: Complex care closer to home
7	Stokes et al (2021) (Stokes et al., 2021)	Evaluation of two new care models in England.	Community based care: Complex care closer to home
8	Thomson and Chatterjee (2023) (Thomson & Chatterjee, 2023)	Integrated care in the UK - Review	Community based care: Complex care closer to home
9	Visram et al (2020) (Visram et al., 2020)	Integrated health and wellbeing service in the UK	Community based care: Complex care closer to home
10	Yu et al (2017) (Yu et al., 2017)	Diabetes integrated care	Community based care: Complex care closer to home
11	Exley et al (2019) (Exley et al., 2019)	Older people's programme	Home from hospital services
12	Tian et al (2014) (Tian et al., 2014)	Pathway for older people in England	Home from hospital services
13	Ware (2019) (Ware, 2019)	Supported discharge service	Home from hospital services
14	Hill et al (2017) (Hill et al., 2017)	Alcohol prevention	Promoting emotional health and well-being
15	Sandhu et al (2022) (Sandhu et al., 2022)	Social prescribing programs in England and the United States.	Promoting emotional health and well-being

Table 6: Included paper according to model of care.

See supplementary file 5 for the critical appraisal tables. Please note that there are a different number of critical appraisal questions for each type of study, therefore the maximum score ranges from 11 to 13. The studies ranged in quality from low quality to high quality (n = 8 high quality studies; n = 5 moderate quality studies and n = 2 low quality studies).

Community Based Care: Complex Care Closer to Home

Nine of the included studies focused on complex care closer to home [24-32] See Table 7 for the main cost findings from the complex care closer to home included studies.

The economic evidence from the identified studies focusing on care closer to home were mixed. Whilst, Evans et al [24] Garner et al [25] and Visram et al [31] provided positive evidence for beneficial integrated health and social care, Jones et al [27] and Thomson and Chatterjee [30] provided mixed evidence, and Heslin et al [26], Yu et al [32], and Stokes [28,29] found no economic evidence in favour of integrated health and social care.

Evidence from an observational study aimed to examine data from the Acute Chronic Obstructive Pulmonary Disease (COPD), Early Response Service (ACERS) intervention [25]. Pre-ACERS and post-ACERS datasets were analysed. The intervention sample size was 69 COPD patients. A multi-disciplinary team made up of COPD Specialist Nurses, Respiratory Physiotherapists, Nurse Consultant (team leader), Respiratory Consultant (who provided medical advice and leadership) delivered the intervention.

The types of costs measured were cost of ACERS team, length of stay, bed days saved, and cost of death outside of hospital. There was evidence that the integrated COPD team improved the quality-of-care provision, reduced the number of bed days and length of stay in hospital. The bed days saving was £400,000 per year. The model also calculated the rise in patients dying outside of hospital, leading to a £252,000 saving per year. The overall finding was that the implementation of the ACERS integrated care service was cost neutral, whilst improving the quality of care [25]. This study was rated as high quality (10/13).

A randomised control trial (RCT) study was conducted to investigate the cost-effectiveness of a health promotion intervention used to improve physical health while decreasing substance use among people living with a psychotic disorder [26]. The RCT examined the 'Improve health and reduce substance use in established psychosis' - IMPaCT intervention, which was an integrated health promotion intervention designed to improve physical health and reduce substance use in individuals with established psychosis.

The IMPaCT intervention included health promotion sessions, individual support, training and supervision. Data and analysis included 104 care coordinators along with 446 patients. Research findings indicated that there is no difference in health and social care or societal costs between those individuals with a diagnosis of psychosis receiving the integrated health promotion intervention or not receiving the intervention. In addition, there was no improvements in quality-of-life outcomes or cost-effectiveness [26]. This study was rated as high quality (10/13).

An economic evaluation of The Wellbeing for Life (WFL) intervention [33]. Included 3179 clients who received services from Health trainers (lay individuals who had been trained up). The interventions varied, with one-to-one behaviour change clients receiving up to eight sessions with a health trainer, or twelve sessions for those in the 'high need' intervention. Group-based activities typically lasted for at least four sessions. The WFL service had a total delivery cost of £3,528,894.25. The main findings were that the total health gain from the WFL service (287.7 QALYs) implies an estimated cost saving to the NHS of £1,477,911, not including £300,000 for costs offset from asset mapping and £498,800 from signposting and events.

The results indicate an additional cost saving to social care of £126,326 (linked to the reduction in adverse health outcomes) and to criminal justice of £3883 (from reduced alcohol and substance abuse by clients). Therefore, the total public sector cost saving attributed to the WFL service was £2,406,920. Being able to demonstrate value for money like this is crucial for the sustainability of interventions such as WFL, especially given the broader context of austerity and reductions in public health funding [31]. This study was rated as moderate quality (7/11).

A RCT investigating the impact of the short-term integrated palliative and supportive care intervention for older people living with chronic noncancer conditions was conducted in four NHS general practices in England between January 2019 and December 2020. Multidisciplinary teams including community nurses and GPs provided in-person palliative care [24]. The cost-effectiveness analysis showed that the ICER was: £12,000 per QALY gained, which would be considered cost effective according to guidelines in the UK context [34]. The findings remained robust after sensitivity analysis was conducted. It showed that the cost-effectiveness of the community-based short-term integrated palliative and supportive care intervention remained consistent even when key assumptions and parameters, such as costs and discount rates, were varied [34]. This study was rated as high quality (10/13).

Mixed evidence for the benefit of integrated health and social care was found in a feasibility study to investigate the effectiveness of a self-management programme integrated into stroke rehabilitation service in England [27]. The study included 78 patients with a diagnosis of stroke over a 14-month period during 2014-2015. Rehabilitation clinicians were trained to integrate defined self-management principles into scheduled rehabilitation sessions, supported by a patient-held workbook. Cost utilisation data was collected at baseline, 6 weeks, and 12 weeks from 2014-2015. Healthcare costs included staff costs, training costs and healthcare utilisation costs. Costs collected were those associated with the use of healthcare services, such as hospital readmissions and outpatient visits. The main cost finding from the feasibility study was that costs varied by site. This variation was likely due to differences in how the self-management programme was integrated into existing community rehabilitation services.

Total rehabilitation inputs were similar in the two control sites (24 therapy hours per patient). However, a difference was found between the two intervention sites (20.1 vs 50.7 therapy hours). Intervention sites reported a proportionately higher use of therapy assistants than control site. Costs of patient-facing time ranged from £600 in the low resource use intervention site to £1667 in the high resource use intervention site. The costs of the two control sites were similar (£754 and £763). Total costs for control sites (mean of two sites) ranged from £930 to £1459, depending on the

assumptions made about the ratios of patient-facing to patient-related non-face-to-face costs. The equivalent range for the low resource use intervention site was £721–£1103, and for the high resource use intervention site it was £1987–£3012 [27]. This study was rated as high quality (10/13).

There was also mixed evidence of the benefit of integrated health and social care in a rapid review [30]. The aim of the rapid review was to determine the barriers and enablers of integrating health and social care and community resources in the UK, and to ascertain the extent of this evidence. A variety of interventions were included in the review. All were aimed at improving the coordination and delivery of health and social care services. These interventions encompassed both medical (clinical and diagnostic) and non-medical (public health services and community-based or person-centred care) strategies. The rapid evidence included 34 review articles, and 21 grey literature reports published between 2018 and 2022. The review highlighted the paucity of robust research to evaluate integrated health and social care interventions and lack of standardised methodology to assess cost effectiveness. This study was rated as moderate quality (5/11).

A further three of the included papers found no evidence for the benefit of integrated health and social care [28,29,32]. The Diabetes Integrated Care Initiative was evaluated in England [32]. The study included a sample size of 2,700 patients with Type 2 diabetes in the Cambridgeshire intervention area. The intervention was delivered by specialist nurses, dietitians, podiatrists and medical professionals. The length of follow-up was 3 years, and the types of costs measured were inpatient care costs, community service costs, and expenses related to the enhanced community diabetes services, including specialist nursing, dietetic, podiatry, and medical support. The approach involved comparing the area under the curve (AUC) of inpatient payments at baseline and follow-up periods.

This method allowed the researchers to estimate the effect of the integrated care intervention on commissioner payments by analysing the distribution of inpatient payments over time. The Diabetes Integrated Care intervention did not lead to cost savings for the healthcare commissioners. However, there were reductions in inpatient payments for certain age groups. Specifically, the study observed a reduction in inpatient payments for 3.2% of patients aged under 70 years and 4.1% of patients aged 70 years and older in one of the two adjacent areas. This suggests that the impact of the Diabetes Integrated Care Initiative varied across different age groups [32]. This study was rated as high quality (9/11).

An economic evaluation of The Better Care Fund (BCF) assessed the effects of BCF on secondary care utilisation and costs using a dataset recording all secondary care use in England [28]. The study analysed data from a cohort of 14.4 million patients, focusing on the short (1 year) and intermediate-term (up to 2 years) effects. There were various health and social care interventions funded by the BCF and the types of costs which were measured were, hospital inpatient admissions, emergency department visit costs, outpatient appointment costs and cost of bed days. The evaluation found no significant reduction in hospital use or costs in the short to intermediate term. For patients with multimorbidity, the use of bed days increased by 0.164 bed days per patient per year, which is approximately a 4.9% increase in the short term. Stokes et al [28] acknowledge that while pooling budgets has potential benefits, it is not a guaranteed solution for reducing hospital use and costs. Successful integrated care requires careful implementation and realistic expectations [28]. This study was rated as moderate quality (5/11).

Another large evaluation study aimed to examine the effectiveness of two integrated care models in Salford and South Somerset in England in relation to patient experience, health outcomes and costs of care [29]. Data was collected three years following the introduction of the new integrated care models which aimed to enhance inter-organisational support for chronic condition management, improve coordination between primary and secondary care services, and proactively manage patients with complex needs to prevent hospital admissions. The sample included 1.2 million patients, and the intervention deliverers were healthcare professionals including General Practitioners (GPs), nurses, specialists, community health workers, and social care providers. Costs of secondary care were measured, including all hospital-related expenses along with cost per user of secondary care, and avoidable emergency admissions. Both intervention sites showed an increase in total costs of secondary care (approximately £74 per registered patient per year in Salford, £45 in South Somerset) and cost per user of secondary care (£130–138 per person per year). Additionally, there were no statistically significant effects on health status or patient experience of care [29]. This study was rated as high quality (10/11).

Author and date	Country	Integrated service	Main cost finding	Was there evidence of a benefit of integrated care?	Critical appraisal score
Evans et al (2021)	England	Integrated palliative and supportive care intervention for older people living with chronic non-cancer conditions.	The cost-effectiveness analysis showed that the Incremental Cost Effectiveness Ratio (ICER) was: £12,000 per Quality Adjusted Life Year (QALY) gained.	Yes	High quality (10/13)
Garner et al (2017)	England	The Acute COPD Early Response Service (ACERS).	The bed days saving was £400,000 per year. Setting up the integrated COPD service was cost neutral.	Yes	High quality (10/13)
Heslin et al (2017)	England	The IMPaCT intervention, was an integrated health promotion intervention designed to improve physical health and reduce substance use in individuals with established psychosis.	Evidence indicated that there is no variance in health and social care or societal costs between those individuals with a diagnosis of psychosis receiving the integrated health promotion intervention or not receiving the intervention. In addition, there was no improvements in quality-of-life outcomes or cost-effectiveness.	No	High quality (10/13)
Jones et al (2016)	England	Community based stroke rehabilitation teams in London. Clinicians were trained to integrate defined self-management principles into scheduled rehabilitation sessions, supported by a patient-held workbook.	The costs of implementing the programme varied significantly across different sites. This was attributed to differences in how each site integrated the programme into their existing community rehabilitation services.	There was no sufficient evidence to answer this question.	High quality (10/13)
Stokes et al (2019)	England	Pooled budgets for integrated health and social care	There was no significant reduction in hospital use or costs in the short to intermediate term. For patients with multimorbidity, the use of bed days increased by 0.164 bed days per patient per year, which is approximately a 4.9% increase in the short term.	No	Moderate quality (5/11)
Stokes et al (2021)	England	Two new models of care including: Two new models of care including: • Enhanced inter-organisational support for chronic condition management. • Improved coordination between primary and secondary care services. • Proactive management of patients with complex needs to prevent hospital admissions	Both intervention sites (Salford and South Somerset) showed an increase in total costs of secondary care (approximately £74 per registered patient per year in Salford, £45 in South Somerset) and cost per user of secondary care (£130–138 per person per year).	No	High quality (10/11)

Thomson and Chatterjee (2023)	England	A variety of interventions were included in the review. All were aimed at improving the coordination and delivery of health and social care services.	The evidence showed that there is a paucity of robust research to evaluate integrated health and social care interventions and lack of standardised methodology to assess cost effectiveness.	Mixed findings	High quality (11/11)
Visram et al (2020)	England	Wellbeing for Life Service (WBL)	There was an estimated cost saving to the NHS of £1,477,911, not including £300,000 for costs offset from asset mapping and £498,800 from signposting and events. The results indicate an additional cost saving to social care of £126,326 (linked to the reduction in adverse health outcomes) and to criminal justice of £3883 (from reduced alcohol and substance abuse by clients). The total public sector cost saving attributed to the WFL service was £2,406,920	Yes	Moderate quality (7/11)
Yu et al (2017)	England	Integrated Type 2 diabetes service.	The Diabetes Integrated Care intervention did not lead to cost savings for the healthcare commissioners.	No	High quality (9/11)

Table 7: Economic evidence from the complex care closer to home services studies.

Promoting Emotional Health and Wellbeing

Of the included papers, (n=2) were focused on promoting emotional health and wellbeing [35,36] See Table 8 for the main economic evidence relating to promoting emotional health and well-being.

Author and date	Country	Integrated service	Main cost finding	Was there evidence of a benefit of integrated care?	Critical appraisal score
Hill et al 2017	England	Studies regarding excess consumption of alcohol.	There is insufficient use of rigorous economic methods such as Cost Benefit Analysis (CBA) and Cost Consequence Analysis (CCA) which are advised as economic theoretically suitable approaches applied in public health intervention evaluation.	No	High quality (11/11)
Sandhu et al 2022	England and USA	Financing of social prescribing initiatives in England and the USA.	Dedicated funding for social prescribing activities is crucial but insufficient on its own as the sustainability and effectiveness of these programs also depend on adequate investment in community-based organisations and broader public services to which patients are referred.	No.	Low quality (1/11)

Table 8: Economic evidence from the promoting emotional health and wellbeing service.

A review was conducted to examine the economic methods applied to evaluate interventions used in the prevention of excess consumption of alcohol to assist public health decision makers. The review focused on cost benefit analysis (CBA) and cost-effectiveness analysis as guided by National Institute for Health and Care Excellence [34] with twenty-seven studies included in the review. The main cost finding was that dedicated funding for social prescribing activities is crucial but insufficient on its own as the sustainability and effectiveness of these programs depend on adequate investment in community-based organisations and broader public services to which patients are referred. There was no sufficient evidence as to the benefit of integrated care. The review identified that there was a deficiency of focus on the methodological challenges connected with evaluating public health interventions and insufficient use of rigorous economic methods such as cost-benefit analysis and cost-consequence analysis which are advised as economic theoretically suitable approaches applied in public health intervention evaluation [35]. This study was rated as high quality (11/11).

Another review aimed to describe the public-financing approaches in England and USA to support social prescribing to advance uptake of this non- clinical approach [36]. The purpose of the review was to examine English and USA governmental approaches to financing of social prescribing to understand from a policy perspective what financial supports are required to advance the implementation of social prescribing in both countries as well as globally. The types of costs measured were, health care costs, social care costs, program implementation costs and community-based organisation costs. There are differences in health and social care financing in England and USA. In England, primary healthcare is free at the point of contact from birth to death and in the USA, there is a market-based health care system with mixed public and private insurance.

Both countries apply flexible funding models pooling of funds (England) value-based payment, incentivised models (USA). Direct financing is also different in England the USA. In England, there is funding for link workers through primary care. In the USA direct financing is through models such as Medicare Accountable Health Communities. In both England and the USA, greater consideration should be given to the financial provisions required for the nonmedical interventions in social prescribing schemes. The current financing models in England and USA mainly focus on evaluating social needs and/or connecting with relevant social services. Consideration should be given to supporting the capacity of voluntary and community sectors in both countries to increase resilience and sustainability for social prescribing provision [36]. This study was rated as low quality (1/11).

Home from Hospital Services

Three of the included papers in this review focussed on interventions which align with the theme of 'home from hospital' services, and all were from England [37-39].One study was a cohort study, one was an observational study, and one was a cost-analysis study (Table 9) for the economic evidence for the home from hospital services).

Author and date	Country	Intervention	Main cost finding	Evidence for the benefit of integrated care?	Critical appraisal score
Tian et al (2014)	England	Integrated care pathways for older people who have experienced falls.	The cost of hospital, community, and social care services for each patient who fell was almost four times higher in the 12 months following the fall compared to the cost of the fall itself. Specifically, costs increased by: · 160% for community health care · 37% for social care · 35% for acute hospital care	Inconclusive – but authors in support of integrated care.	Moderate quality (5/11)
Exley et al (2019)	England	Southwark and Lambeth Integrated Care Older People's Programme	The programme did not achieve cost savings and resulted in a net increase in health service expenditure of £64 per resident aged 65 and above.	No	Moderate quality (5/11)

Ware (2019)	England	Supported Discharge Service (SDS) within the Harrogate and District NHS Foundation National Health Trust in Ripon, UK	An average of 2.3 bed days were saved per patient.	Yes	Low quality (3/11)

Table 9: Economic evidence from the home from hospital services.

A retrospective cohort cost study aimed to explore the whole system cost of the care pathway for older people (aged 65 and over) who were admitted to hospitals following a fall in southwest England [38]. The study aimed to track and analyse the costs of hospital, community, and social care services for patients before and after a fall. The intervention was delivered by a coordinated team of healthcare professionals, including community health workers, social care providers and hospital staff over a two-year period. For each patient who fell, costs were almost four times higher in the 12 months following the fall compared to the cost of the fall itself. Specifically, costs increased by 160% for community health care; 37% for social care; and 35% for acute hospital care. There was also evidence of under-coding of co-morbidities for falls patients, particularly for dementia [38]. This study was rated as moderate quality (5/11).

An observational study including a controlled time series analysis and a cost consequence analysis evaluated the Southwark and Lambeth Integrated Care Older People's Programme [37]. The main aim was to improve the care and health outcomes for older people at risk of avoidable hospitalisation. Specifically, the programme sought to reduce hospital utilisation by decreasing Accident and Emergency (A&E) attendances, outpatient visits, and both elective and emergency admissions. The programme also aimed to enhance integrated care through holistic assessments and integrated care management to address unmet needs; and manage costs by potentially reducing overall health service expenditure through more efficient care delivery. The costs of the Programme were £149 per resident aged 65 and above but savings in hospital costs were only £86 per resident aged 65 and above, equivalent to a net increase in health service expenditure of £64 per resident though the Programme was nearly cost neutral if set-up costs were excluded. By the end of the fourth year, there were reductions in A&E attendances, outpatient visits, and elective admissions, but there was no significant reduction in emergency admissions [37] This study was rated as moderate quality (5/11).

A cost analysis study was conducted in England and evaluated the Supported Discharge Service (SDS) [39]. The service was introduced to improve patient flow and bed management by supporting patients over the age of 65 years in returning to their normal place of residence as soon as they were medically fit. Patient Satisfaction Questionnaires and Therapy Outcome Measures (TOM) were collected over a two-week period in February 2018. Direct healthcare costs, operational costs and productivity costs were measured. Significant improvements in patient health and recovery were observed. Patient satisfaction levels were high and increased productivity and efficiency led to notable financial savings. There was also evidence that the service demonstrated enhanced operational efficiency, reducing hospital readmissions [39]. This was rated as a low quality study (3/11).

Accommodation Based Solutions

Only one of the included studies in this review focused on accommodation-based solutions Click or tap here to enter text. This cost study evaluated the association between the degree of community mental health team (CMHT) integration and **(1)** the service costs of community mental health and social care provision, and **(2)** rates of admission to institutional settings (mental health inpatient wards and care homes). Results found patients supported by high integration teams received services costing an estimated 44% more than those supported by low integration teams. After controlling for case mix, there were no significant differences in the likelihood of admission to mental health inpatient wards or care homes between the two types of CMHT teams [40]. This was rated as a moderate quality study (score of 8/11).

Discussion

This rapid review is novel in that it focuses on the economic evaluation of integrated health and social care initiatives, and this has not been the focus of a previous review, which solely focused only on alcohol prevention interventions, [35].

In this review, 15 studies were included from the database searches, and were selected on the basis that these peer reviewed articles provided economic evidence related to integrated health and social care related services. The 15 studies included were mapped onto the national 'Models of Care' as described within the Welsh Government's guidance on the Regional Integration

Fund. There was a degree of overlap with four of these, namely, Community based care: complex care closer to home; Home from hospital services; Promoting good emotional health and well-being; and Accommodation based solutions Welsh Government 2022. However, there were no studies to include under the heading of 'Supporting families to stay safely together'.

Overall, the nine studies included under complex care closer to home, showed that the economic evidence for integrated health and social care is mixed, with some studies demonstrating positive outcomes and others highlighting no significant economic benefits. The WFL intervention demonstrated substantial cost savings across various sectors [31]. Two studies focused on promoting emotional health and wellbeing, with evidence from the ACERS intervention for COPD patients, demonstrating improved care quality and was cost-neutral, saving significant costs [25]. However, findings from the IMPaCT intervention for psychosis reported no cost-effectiveness or quality-of-life improvements [26]. Evidence indicates that that there is a lack of application of rigorous economic methods in evaluating prevention interventions [35]. In addition, evidence reviewing public-financing approaches in England and the USA for social prescribing, emphasising the need for financial support to implement these non-clinical interventions [36].

Two of the three home from hospital included papers demonstrated that interventions in England aimed at reducing secondary care costs did not achieve cost savings [37,38]. Only one of the included studies (from England) provided evidence of reduced hospital admissions due to the Support Discharge Service (SDS) [39].

The economic evidence-base regarding accommodation-based solutions related only to one paper indicating that more economic evidence is needed in this area. The authors found that costs increased with a higher level of CMHT integrated care. There is therefore a clear need for a more rigorous evidence base to inform accommodation-based solutions in relation to integrated health and social care.

All 15 papers included in this review were from England with one paper comparing financing across England and USA, therefore evidence regarding effectiveness and economic evaluations regarding integrated care from other devolved nations in the UK were not captured in this rapid review. This may be because the area of integrated health and social care is relatively new, and the research community have not published this work yet [12,13,41]

Similar evidence as found in this review identified a lack of focus on the methodological challenges associated with evaluating public health interventions Click or tap here to enter text. insufficient use of rigorous economic methods such as CBA and CCA. These methods are recommended as theoretically suitable approaches for evaluating public health interventions [35].

Although integrated care initiatives have been implemented for several decades, significant challenges remain in translating the growing evidence base into practical implementation strategies. Goodwin [42] argues that integrated care science has "mapped out the ocean on which integrated care must sail and provided knowledge on the nature of the ship and its crew that will set out on its journey, but it hasn't provided enough practical guidance and knowledge on how to navigate the seas ahead" (p. 2). [42]. This observation highlights a persistent gap between understanding what integrated care is and knowing how to implement, sustain and adapt integrated care interventions in complex real-world settings. The challenge is particularly important given that integrated care operates within dynamic systems where outcomes emerge through relationships, collaboration, adaptation and local context rather than through linear implementation processes [2].

Implementation science could offer a valuable lens through which to understand the economic dimensions of integrated care. While economic evaluation has traditionally focused on assessing the costs and outcomes of integrated care interventions, implementation science highlights the importance of examining the resources required to achieve adoption, delivery and sustainability. Integrated care interventions are complex, context-dependent programmes whose success depends not only on effectiveness but also on the costs and value of the implementation strategies used. Consequently, there is growing recognition that economic and implementation evaluations should be conducted in tandem to support decision-making regarding the scale-up and long-term sustainability of integrated care initiatives [43-45].

Conclusion

This review has highlighted that the economic evaluation of integrated health and social care is a developing area. To date, there is limited information, data and analysis available regarding integrated health and social care interventions in the UK. The existing studies and data on the economic impact of integrated health and social care programmes are sparse, with mixed evidence about the economic benefit of integrated care, therefore inconclusive. This lack of comprehensive economic analysis highlights the need for further research to better understand the cost-effectiveness and broader financial implications of integrated health and social care programmes. Future evaluations should incorporate implementation science approaches alongside economic evaluation to capture the full range of implementation costs, resource requirements, contextual influences, and long-term economic consequences associated with integrated care interventions.

Limitations

The quality of the included studies varied. Some of the included reviews were not systematic reviews, and only three RCTs were included. No studies were excluded based on quality. The included papers were not all about the same approach to integration or with a similar range of interventions, and this has implications for what was compared in this review. Only studies from the UK were considered for this rapid review, a global net would have resulted in an increased number of studies relevant to answering the research question.

Guidance Based on the Evidence Presented

Based on the analysis that has been undertaken, the authors suggest that: There is a need for joint strategies across organisations which includes strong leadership to support integrated care. It is important to consider variations in population demographics, healthcare infrastructure, and local policies. Policymakers should implement mechanisms for continuous monitoring and evaluation of integrated care models to identify areas for improvement and ensure that integration efforts are meeting their intended health and social care goals. Future health and social care integrated services or programme evaluations should include an economic component such as cost-benefit analysis, cost consequence analyses, social return on investment analyses (SROI) or where possible, cost-effectiveness analysis.

Conflict of Interest

The authors report no conflicts of interest.

Author Contributions

The study concept and design was conceived by Professor Deb Fitzsimmons (DF), Professor Mary Lynch (MLynch), Professor Mark Llewellyn (MLlewellyn), Professor Carolyn Wallace (CW) and Dr Llinos Haf Spencer (LHS). The funding was secured by Professor MLlewellyn on behalf of the RIF evaluation team. All authors provided edits and critiqued the manuscript. All authors have read and agreed to the published version of the manuscript.

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Data Availability Statement

No new data were created or analysed in this study. Data sharing is not applicable to this article.

Ethics Statement

This study did not require ethical approval as it involved a rapid review of existing literature rather than the collection or analysis of primary data from human participants. All sources used were publicly available, and no identifiable personal or sensitive information was accessed or processed.

Artificial Intelligence Statement

Artificial intelligence (AI) was used solely to review and improve grammar and sentence structure.

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