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Funding models in health and social care services focused on culturally and linguistically diverse populations in Sydney, Australia

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Abstract

Purpose – Policies that support joint access to and responsibility for funding increase participation in integrated care. However, knowledge regarding funding systems employed in integrated health and social programs are underreported. We seek to understand the different funding models in health and social care services in the Sydney Metropolitan, Australia.

Design/methodology/approach – Qualitative interviews were designed to map current funding models in integrated health and social care programs aligned with the Wodchis Policy Supports Framework.

Findings – We reviewed 24 local health and social programs. Innovative models of funds for piloting new initiatives at health programs are emerging (e.g. research grants with in-kind contributions). Two health programs had combined funding from social and health funders employing agreements as policy support. Social programs drew more on diverse funding sources than health programs. The health sector supports social care via the commissioning of services through state and federal health agencies.

Practical implications – The landscape of funding models for both health and social care is complex. We demonstrate that systems are adopting pooled funding and entering to agreements to reduce fragmentation. There is an opportunity to build robust systems to expand integrated funding and sharing of control of funds, given the existing collaborations and partnerships highlighted in this study.

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Originality/value – In this paper, we contribute to building a stronger body of knowledge on the different funding models currently used in integrating health and social care services in local systems. We explore the joint control nature of funds and the type of funding systems employed, which is underreported and rarely described in academic literature, evaluations and public reports.

Keywords Funding, Health and social care, Alternative, Joint funds

Paper type Research article

Background

A unified funding system is a critical step in enhancing integrated health and social care in fragmented systems (Amelung *et al*., 2021). It has been demonstrated that policies that support joint access to, and responsibility for, funding increases participation in the integration of health and social care (Wodchis *et al*., 2020).

Historically, funds for health and social care have been managed by different entities and under separate governance funding systems and processes. In Australia, the health system – including primary care, hospitals, mental health and allied health care are funded through mechanisms and payment models distinct from those that fund social care, including welfare, housing and social work. Even within the National Insurance Disability Scheme and various aged care schemes, services provided for social support are separate from those provided under the existing health care system. Small scale initiatives seeking to take an innovative approach to linking health and social care face challenges to fully include integrated funding systems at a small scale due to system-level fragmentation (Wodchis *et al*., 2020).

There is evidence to suggest that there has been little collaboration between the healthcare sector and social service providers beyond ad hoc arrangements in response to immediate service needs (Alderwick *et al*., 2021). Indeed, the lack of integration of funding across sectors is one of the most cited barriers to the integration of health and social care (Amelung *et al*., 2021). In the UK, efforts to achieve local-level integration continue to be impeded by the enduring separation of governance structures and financial responsibilities between NHS organisations and local authorities, a division that complicates coherent strategic planning and the coordinated delivery of services (National Audit Office, 2021).

There is the potential for better health and well-being, better access, and a better experience for patients and service users, their carers, and families, including priority populations, as a result of the integration of budgets across sectors (Mason *et al*., 2015; Nicholls *et al*., 2026).

It is understood that using this approach can reduce unplanned admissions and re-admissions to hospitals and manage increasing demographic and financial pressures (Mason *et al*., 2015). For example, integrated funding can be used to purchase the right mix of community services, helping to prevent deteriorations in health/functioning and/or supporting rehabilitation and recovery following hospitalisation. They can also be used to assemble appropriate care packages to support timely discharge from acute care wards. In recent years, innovative solutions for integrating funding between sectors have been implemented in various international settings (Wodchis *et al*., 2020). New ways of funding for the health and social care sectors in high-income countries have been established. Some systems are opting for *transferring payments*, allowing local authorities to make service revenue or capital contributions to health bodies to support specific additional health services, and vice versa (Mason *et al*., 2015). Some are choosing *aligned budgets*, by identifying their own contributions, but targeted to the same objectives, with joint spend tracking but separate accountability has been adopted and documented by some systems (Mason *et al*., 2015).

Further, some systems have opted for *cross-charging*, in the form of mandatory daily penalties, to compensate for delayed discharges in acute care where social services are solely responsible and unable to provide continuation of service (Mason *et al*., 2015). Another form of funding is when a designated partner *leads the commissioning* (holding the budget) of services based on a jointly agreed set of aims. For example, in Australia, the new Health Reform has introduced selective funding for integration between primary and hospital care (Peiris *et al*., 2024). Yet, this is still heavily managed by the health sector (Peiris *et al*., 2024).

A more frequently implemented form of funding is *pool funding* with each partner making contributions to a common fund for spending on agreed projects or services (Mathauer *et al*., 2019). More recently, sectors have also introduced *in-kind contributions*, usually comprising existing staff time allocation to provide services in the integrated health and social care space (Wodchis *et al*., 2020).

Having "joint control of funds" has been cited as a key feature of mature integrated funding, which has been defined as contractually agreed sharing of control of the financial arrangement. However, this is one of the most difficult aspects of implementing financial integration, despite the existence of statutory and regulatory measures to support it (Mason *et al*., 2015). Knowledge regarding the joint control nature of funds and type of funding systems employed is usually scarce, underreported in academic literature, evaluations and public reports, and are rarely described in detail for locally implemented programs (e.g. those servicing locally defined populations or within the jurisdiction of a local system).

This paper contributes to building a stronger body of knowledge on the different funding models currently used in integrating health and social care services by mapping models utilised in local initiatives in Sydney, Australia. Our research questions are (1). What type of funding sources is used in health and social care services in Sydney Metropolitan? And; (2). Is there any evidence of funding innovation in health and social care services in the Sydney Metropolitan?

Method

We reviewed 24 local health and social care initiatives in Sydney, Australia and first distinguished between sources of funding and control of funds within a program of work.

In particular, programs were assessed and explored in depth regarding the degree to which their funding models facilitate and advance integration of health and social care, which is often under-explored in other literature, using the funding section of the Innovative Policy Supports For Integrated Health And Social Care Programs Framework devised by Wodchis *et al*. (2020).

Funding models were described in terms of innovative policies and agreements to support the integration of health and social care funds in programs addressing social and health multimorbidity and other social risk factors targeted at vulnerable groups beyond programs for the elderly (3).

Procedures

Recruitment. The study's research team is based in Sydney and part of a research centre (Centre for Research Excellence in Integrated Health and Social Care) partnering with local health districts and other key stakeholders. This allowed initial contact with health and social care programs throughout the research and services' network. A snowballing method was used to branch further out into other health and social care programs and community leaders and volunteers through common and known participants.

The study was advertised in the health and social care service networks, by sending an expression of interest email (EOI) to several health and social agencies that provide health and social services in the Sydney Metropolitan area. Program representatives were volunteers who contacted the principal investigator (MGU) for enrolment and other information. Program representatives were eligible to participate if they were assisting priority populations, including culturally and linguistically diverse (CALD) communities, or programs that have a role (funding, liaison, advocacy) assisting health and social care programs (e.g. Ministry of Health).

Health and social care staff employed by public, private and non-for-profit health and social care services; as well as volunteers and/or community leaders directly working with culturally and linguistically diverse CALD communities in Sydney, Australia were part of this study.

These included Local Health District (LHD) level services (outpatient and health promotion), Primary Health Networks (PHN), Ministry of Health (MoH), and legal aid, domestic violence service, aged, adult and youth community support programs.

The study was approved by the Ethics Review Committee (RPAH Zone) of the Sydney Local Health District (protocol number X22-0406) and the South Western Sydney Local Health District Human Research Ethics Committee (2023/STE00775). All participants provided written informed consent.

Analysis framework

A thematic analysis of the interviews was performed using NVIVO software. The thematic analysis and coding, against the Wodchis *et al*. (2020) Framework , involved a team of authors, (GU, CHS, MC), who were experts in qualitative technique (GU, CHS), health system financing (CHS) and health economy (MC). Several meetings (GU, CHS) were held to endorse themes, coding strategy and feedback and structure of this work guided by framework. Semi-structured interviews exploring innovative policy supports were conducted by the first author (MGUG) and lasted approximately 45 min each. They were conducted from June 2023 to April 2024. Interpreters were not required as all participants were proficient in English.

Results

Overview

This study included twenty-seven participants from 24 programs (14 health programs; 10 social programs) based in Sydney Metropolitan were part of the study. Interviews were conducted online with clinical directors, health and social service managers, researchers implementing programs, staff specialists (e.g. paediatricians, public health physicians), and community leaders serving CALD clients. The programs' characteristics are presented in Table 1.

In terms of the health care programs, only 2 programs (MoH; PHN) provided support to health systems without service provision.

Funding sources theme

Innovative models of funding for piloting new initiatives at health programs are emerging. Three programs ($n = 3$) were financed by research grants combined with some in-kind contributions from the local health districts (e.g. employed staff providing support). Most programs were funded by New South Wales (NSW) Health (State Government), followed by the Australian Government Department of Health and Age Care (DHAC).

Two health programs had combined (pool) funding from the Department of Community and Justice (DCJ) and NSW Health. Two initiatives were reporting separate funding pathways as the overall funding arrangements (adult program targeting common emergency department presenters; family program for vulnerable children), and thus formed a continuum of approaches to funding and payment in support of innovation and sustainability in the integrated health and social care space. These were from NSW Health and the MoH. Figure 1 describes the type of health programs assessed and the main sources of funds used to support them.

In terms of the social care programs, one provided support without service provision (Legal and Health Enhancement). Funding from social programs was more diverse and broader compared to funding in health programs including philanthropy, State Government (NSW Fair Trading and Legal Aid NSW organisations), and Local Government (City of Sydney Council). These differing funding sources are presented in Figure 2.

The most common funders for social programs were the Department of Social Services (DSS), followed by DCJ. Surprisingly, four interviewees, reported their programs received

Table 1. Programs' description

Label	Service type	Population
Family CALD Program # 1	Health promotion	CALD specific
Family CALD Program # 2	Health promotion	CALD specific
Family Refugee Program # 3	Health screening and referral pathways and coordination	Refugees and asylum seekers specific
Women's Program #1	Healthcare service delivery	Women*
Women's Program # 2	Counselling service delivery	Vulnerable women**
Children Program # 1	Healthcare service delivery and coordination	Rural children with chronic conditions accessing metropolitan services**
Children Program # 2	Healthcare service delivery and coordination	Children and young people with cerebral palsy**
Children Program # 3	Health and social care delivery and coordination	Pregnant women who are Department of Community and Justice clients, including children and babies*
Family Program # 1	Healthcare service delivery and coordination	Women, children and their families experiencing adversity*
Children Program # 4	Health assessment and referral service	Foster care children*
Adult Program # 1	Healthcare service delivery and coordination	Patients with chronic and complex illness*
Children program # 5	Health and social care coordination	Children and their families experiencing adversity*
Primary Health Program # 1	Comprehensive support to clinical practices	No service provision
Ministerial Organisation # 1	Funding and governance support	No service provision
Youth Program # 1	Social care service delivery	Youth experiencing adversity*
Women's Program # 1	Social care service delivery	Women experiencing domestic violence*
Family Program # 1	Social care service delivery, linking services and coordination	Families and school-age children*
Adult Program # 1	Social care service delivery	Individuals experiencing adversity*
Adult CALD Program # 1	Social care service delivery (with health components)	CALD specific
Adult CALD Program # 2	Social care service delivery (with health components)	CALD specific
Adult Program # 2	Social care service delivery	Individuals experiencing adversity**
Legal and Health Enhancement	Policy advocacy, and systems change (legal and health partnerships) for vulnerable groups	No service provision
Adult CALD Program # 3	Social and health care service delivery	CALD specific
Adult Program # 3	Legal and social care and primary care linking	Individuals experiencing adversity*

Note(s): CALD: culturally and linguistically diverse
*High intake of culturally and linguistically diverse clients
** Moderate intake of culturally and linguistically diverse clients

funding for initiatives from NSW Health or the Australian Government DHAC. More broadly, two interviewees reported their programs received funding for initiatives from DCJ and Multicultural NSW to support culturally and linguistically diverse (CALD) communities affected by COVID-19. Only one social program had support from a research fund to undertake COVID-19 related social support.

Figure 1. Health Care Programs. Abbreviations in Figure 1: CALD: culturally and linguistically diverse; NHMRC: National Health Medical Research Council; NSW: New South Wales; SESLHD: South Eastern Sydney Local Health District; SLHD: Sydney Local Health District; TGRS: Translational Grant Research Scheme. Source: Authors' own work

Funding innovation theme: joint control of funds

This study elucidated emerging funding arrangements. There were two health programs that reported a contractual agreement via a Memorandum of Understanding with the Australian Government Social Department. It was established that a pool fund was to be created to cover a social worker and a project coordinator role. However, the ability to use the funds more autonomously was not established contractually.

Conclusions

This paper aimed to identify and describe funding models, and other characteristics inherent to integrated funding as well as what policy and packaging innovation are used to increase integration of health and social care in Sydney Metropolitan with a CALD focus. Overall, this study demonstrated the fragmented nature of funding models in health and social care and the existing significant differences on how health and social care are funded.

Specifically, this study elucidated that the main funding model was *pooled funding* and in-kind support mainly presented at health programs (South Western Sydney Local Health District, 2024; NSW Health, 2023b). More sophisticated integrated models like transferring payments, cross-charging, aligned funds, and commissioning were not found. Importantly, joint control of funds, even when using pooled funding with a contractual agreement between parties, was virtually non-existent. This phenomenon has been cited elsewhere as one of the main barriers of integrating funds for health and social care (Mason *et al*., 2015).

Historically, health programs in NSW (outpatient services and health promotion services) have been funded primarily by the State Government (Australian Institute of Health Welfare,

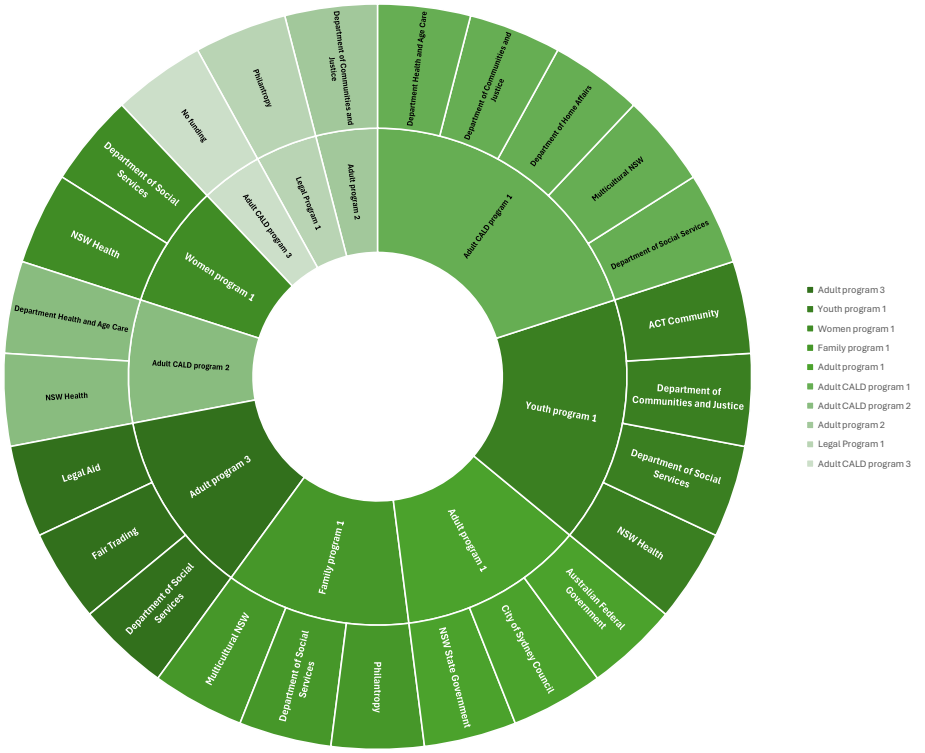

Figure 2. Social Programs. Abbreviations in Figure 2: ACT: Australian Capital Territory; CALD: culturally and linguistically diverse; NSW: New South Wales. Source: Authors' own work

2023a; Australian Institute of Health Welfare, 2016). Encouragingly, our study found that new models of funds have emerged with new initiatives addressing the health and social needs of priority populations at local levels, including the use of research and implementation funding in combination with in-kind contribution (staff allocation, governance support), which is often deployed but less reported (Hall *et al*., 2022; Ostojic *et al*., 2023; Lingam *et al*., 2023).

Our study also proved that separate funds for integrated care initiatives to address the needs of priority populations have been brought forward by the State Government (Eastwood *et al*., 2020; NSW Health, 2023a).

Cited in the Australian literature, State and Australian Government health agencies are experimenting with c*ollaborative commissioning* schemes which are aimed at addressing regional fragmented systems, namely primary and secondary health sectors to enhance value-based care in NSW (Koff *et al*., 2021). However social care services are not explicitly or consistently incorporated.

There are important differences between existing health and social care funding models that may explain differences in the articulation of how services are funded. Health care is funded by a combination of sources, including the Australian Government (44%), State (29%) and others (individuals, private insurance) (Australian Institute of Health Welfare, 2023a). In contrast, the Australian Government funds nearly 90% of social care support with the remaining funded by State and Territory governments (Australian Institute of Health Welfare, 2023b). Social care, by comparison is heavily funded by the Australian Government budget.

They receive support from LHDs, NSW Health, and the Australian Government that enables social programs. In addition, social programs are funded beyond traditional sources of

funding (e.g. Fair Trading NSW, Legal Aid NSW) and even more so when addressing the needs of CALD communities. For example, Department of Home affairs (Australian Government) and Multicultural NSW (State Government) have special portfolios aiming at providing social support, including settlement, mentorship, and a cultural community cohesion agenda (Australian Government Department of Home Affairs, 2024a, b; NSW Government, 2022; Multicultural NSW, 2024). This creates a much more vertically concentrated funding model than health care.

The current landscape—and the funding models underpinning both health and social care—are complex and fragmented, mirroring the broader system itself. However, the move toward new approaches, such as pooled funding, has emerged in response to this fragmentation and reflects a growing need to better integrate services and more effectively support priority populations. It can meaningfully support and create genuine shared governance and joint decision making unlike other alternatives, such as "lead commissioning" (often medical-dominant, not social-care-inclusive) or "cross charging" (penalises collaborative behaviour) (Australian Healthcare and Hospitals Association, 2018).

Implications

The evidence of this article calls for urgent policy attention. There is an opportunity to build more robust funding systems, sustainable systems across sectors. In particular, the findings highlight the potential for joint control of funds and the expansion of integrated funding schemes, leveraging the existing collaborations and partnerships between health and social sectors identified in this research.

While implementing an integrated health and social care funding model alone will not achieve full system integration (Wodchis *et al*., 2020), it represents a critical enabling step. Integrated funding can reduce duplication of services (e.g. double-spending, fragmented reporting), improve tracking of expenditure, and reduce counterproductive competition for resources. This, in turn, can alleviate dissonance created by differing performance indicators and funding requirements across the health and social service systems.

Strengthening policy development around well-defined, jointly (polled or commissioned using existing partnership) governed integrated funding models is therefore essential. Such models must be embedded within the broader integrated care agenda to support coherent, coordinated, and equitable service delivery.

Authors' contributions

MGUG, CHS, JG, JE conceived and designed the study. MGUG was responsible for gathering data. CHS. and MC conducted the analysis and interpreted the data. MGUG, MC, VG drafted the manuscript. All authors made critical revisions, read, and approved the final manuscript.

Research ethics approval and consent to participate

The study was approved by the Ethics Review Committee (XXX Zone) of the XXX (protocol number X22-0406) and the XXX Human Research Ethics Committee (2023/STE00775). All participants provided written informed consent.

Consent for publication

All participants included in this study provided written informed consent.

Availability of data and materials

Materials used during the present study are available upon reasonable request from the corresponding author. We would like to acknowledge that data from each participant from this study cannot be shared to comply with the Ethics Review Committee (XXX Zone) of the XXX and the XXX Human Research Ethics policy.

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