Routledge
Taylor & Francis Group

Journal of Health & Social Policy

ISSN: 0897-7186 (Print) (Online) Journal homepage: http://www.tandfonline.com/loi/wzhs20

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To cite this article: Michael J. Austin PhD & Jonathan Prince MSW, MA (2004) The Implications of Managed Care and Welfare Reform for the Integration of Health and Welfare Services, Journal of Health & Social Policy, 18:2, 1-19, DOI: 10.1300/J045v18n02_01

To link to this article: http://dx.doi.org/10.1300/J045v18n02_01

Published online: 21 Oct 2008.

The Implications of Managed Care and Welfare Reform for the Integration of Health and Welfare Services

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ABSTRACT. In this era of managed care and welfare reform, the two systems of public health and public welfare are increasingly focused on a shared population and the services designed to promote self-sufficiency and good health among low-income individuals, families and communities. The two service systems are often constrained by categorical funding mechanisms that contribute to service fragmentation, discontinuity and redundancy. This paper focuses on the changing nature of health and welfare, the impact of categorical funding mechanisms, the barriers to service integration, the potentials for partnership, and concludes with implications for enhancing service integration and the quality of services.

KEYWORDS. Welfare reform, managed care, service integration

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This exploratory study is based largely on interviews with directors of separate and integrated health and social service departments in Northern California. We wish to thank Maria Martin, MSW, Andrea DuBrow, MSW, MPH, Juliette Kelley, MSW, MPH, and Cheryl L. Walter, MSW, MPH, for their research assistance.

Journal of Health & Social Policy, Vol. 18(2) 2003
http://www.haworthpress.com/web/JHSP

Digital Object Identifier: 10.1300/J045v18n02_01

The history of public health and public welfare programs reflects the categorical funding mandates of federal legislation. Categorical funding of temporary cash assistance to low-income families with children and the public health prevention programs often address the same population. As we enter the 21st century, health and welfare agencies are increasingly serving the same low-income consumers who receive benefits from welfare-to-work programs and Medicaid health care programs. The forces of managed care and welfare reform have helped to shift the focus of health and social service agencies from categorical service delivery programs to collaborative and prevention-oriented services.

Despite the failure of the 1994 federal health care reform legislation, the market forces of managed care have produced a radical restructuring of the U.S. health care sector. Similarly, with the passage of the 1996 federal welfare reform legislation, states and counties are radically restructuring the financing and delivery of social services. Although the two national developments of managed care and welfare reform grew out of a common concern over cost controls and service utilization, they are not generally viewed as related to one another except in the case of health care for the poor (Medicaid). As a result, many health and welfare agencies continue to deliver separate categorical services rather than providing a continuum of integrated services that address multiple consumer needs.

Promoting the employability of low-income service recipients provides an example of the interdependence of health and welfare agencies. For the low-income individuals and families that rely on public benefits, the good health of parents and children is crucial to job placement and the transition off the welfare rolls. The availability of health screening, health education, counseling and clinic services can be critical to successful job retention, especially for former welfare mothers caring for children when they are sick. In some locales, welfare-to-work social service staff are outstationed in public health clinics to provide support services and public health staff are outstationed in social service organizations to provide child immunization services.

This analysis focuses on the growing interrelationship between health and welfare. It begins with the changing nature of health and welfare and the categorical funding mechanisms and barriers to service integration. The shared health and welfare potentials for partnership are explored along with lessons learned from managed care and welfare reform implementation. The paper concludes with a series of recommendations for enhancing service integration and the quality of service for

low-income individuals, families and communities. The primary goal of this analysis is to frame an agenda for organizational collaboration and operations research. While the analysis draws upon the perspectives of county health and social service department directors, it does not report on an empirical study.

THE EVOLUTION OF HEALTH AND WELFARE DEPARTMENTS

In the 1870s, state and local health departments were created to protect and improve public health through sanitary reform. While the initial focus was on infectious diseases, sewage disposal, health education, and recording births and deaths, modern health departments added laboratories to assess water quality, infant care home visiting by public health nurses, chronic disease and injury prevention, health promotion, auto safety violence prevention, environmental health, substance abuse prevention and health care for the elderly. Today it is well-recognized that poverty, unemployment, inadequate housing and social isolation are some of the most important risk factors for disease (Dandoy, 1994).

In contrast to the state and local history of public health programs, the establishment of federal public welfare programs dates from the 1935 Social Security Act. Four major federal means-tested "welfare" programs evolved between 1935 and 1996 to help low-income families with children: Aid to Families with Dependent Children (AFDC: cash assistance for family expenses), Food Stamps (vouchers), Medicaid (health insurance) and Supplemental Security Income (SSI: cash assistance for disability). Other public welfare programs include: (1) federal cash assistance (Social Security) and social services for the elderly, (2) Medicare, or federal health insurance for the elderly, (3) state and local employment services, (4) local General Assistance for indigent individuals not covered by other programs, and (5) federal and state-funded child welfare services for protecting abused and neglected children (Trattner, 1994).

The risk factors for poor health (poverty, unemployment, inadequate housing and social isolation) are also key risk factors for welfare dependency. Similar to the expanding role of public health departments into areas of violence prevention and substance abuse prevention, social service agencies are transforming themselves through the development of neighborhood-based, family-focused services which are coordinated with other community services such as child care, transportation and af-

fordable housing. However, many of these health and welfare departments continue to be constrained by categorical funding mechanisms that can limit the flexible allocation of resources.

THE CONSTRAINTS OF CATEGORICAL SERVICE FUNDING

The separation between health and welfare agencies, and between divisions within agencies, is due in large part to four major categories of funding for health and four different categories for welfare. In California's Contra Costa County, for example, most health funding is for: (1) health care and medical services, (2) public health services, (3) mental health services and (4) substance abuse prevention and treatment services, while most welfare funding is for: (1) aging and children's services, (2) employment and income assistance, (3) food stamps and (4) Medicaid. In the area of health care, federal and state funding in the country covers approximately 90% of the costs of health, mental health and medical services, 80% of the costs of public health services and 50% of the costs of substance abuse prevention and treatment. In contrast, federal and state welfare funding in the county covers 90% of employment services, income assistance and Medicaid, 85% of food stamps and 70% of adult and children's services. Local government funds make up the differences in both health and welfare programs. The two agencies operate on different funding streams but use similar cost-sharing strategies between three levels of government (local, state and federal).

Categorical funding often results in the creation of separate local agencies as well as departments within agencies. Except for some rural counties with limited resources, most health and welfare programs are housed in separate county agencies. As a result, service staff are often isolated and prevented from learning about the work of their counterparts. Similarly, the lack a unified client information data base prevents staff from tracking, identifying and planning for integrated service delivery. Public health and child welfare staff, for example, may both provide services to many of the same families, focusing on similar risk factors but approaching them from different professional perspectives and value systems. Some of the problems that can arise from this separation include (Glisson & James, 1992):

- no single agency follows the consumer to ensure that all service needs are met

- redundancy can result from multiple independent assessments by each agency
- time-consuming or complex communications between agencies arise due to bureaucratic or procedural requirements
- loss of important information can occur when agencies do not communicate effectively
- ineffective collaboration can result due to unresolved tensions between agencies.

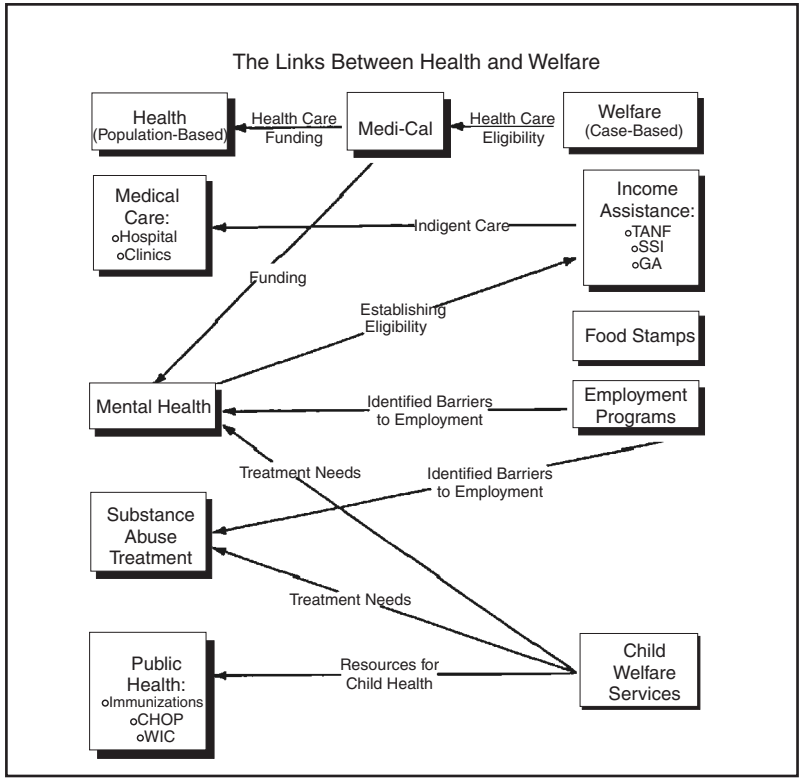
In addition to these system problems, categorical mechanisms tend to reinforce the status quo and therefore: (1) rarely provide adequate funding for prevention, early intervention, and follow up, (2) rarely reward innovation or (3) rarely allow enough flexibility to respond sufficiently to diverse and changing community needs. Furthermore, differing health and welfare regulations and reporting requirements can seriously interfere with service provision. For example, in a northern California county that established a combined mental health and substance abuse treatment site, the state mental health department required that an exit door at the treatment site be located in a certain place, whereas the state department of drug and alcohol abuse services wanted it somewhere else. The two state departments took considerable time to come to an agreement about a local service delivery issue.

SHARED CLIENTS IN HEALTH AND WELFARE SERVICE DELIVERY

Despite categorical barriers to service access and integration, health and welfare programs share a variety of eligibility and funding relationships. As shown in Figure 1, consumers receiving health care services for medical, public health, mental health and substance abuse needs may also receive the welfare supports of income assistance, food stamps, employment programs and child welfare services.

Perhaps the strongest connection between health and welfare is Medicaid and TANF. TANF welfare-to-work families represent the largest proportion of Medicaid beneficiaries (Holian, Wiener & Wallin, 1999). According to Holian and colleagues (1999), medicaid enrollment has not declined as much as TANF participation because: (1) falling Medicaid caseloads cause considerable concern and corrective action while declining welfare rolls are generally seen as positive, (2) individuals leaving TANF receive transitional Medicaid coverage or

FIGURE 1



can qualify for continuing Medicaid coverage, (3) many children who do not receive TANF are eligible for Medicaid, (4) unlike cash assistance to welfare recipients, some large health care provider organizations view Medicaid patients as critical to their financial survival, and (5) many elderly individuals in nursing homes depend on Medicaid, and their families have strong political lobbying power.

The combined impact of welfare reform (e.g., benefit time limits and sanctions) and managed care (e.g., capitated funding) can place low-income individuals at a particularly high risk for reduced service access. Since the beginning of the Medicaid program, eligibility for Medicaid and AFDC was linked, so that every consumer who received AFDC benefits was automatically enrolled in the Medicaid program. Under welfare reform, it is difficult to ensure that children and parents con-

tinue to be eligible for Medicaid even after they have exhausted their welfare benefits, because Medicaid is no longer directly linked automatically to eligibility for TANF and recipients need to be encouraged to reenroll once they have accepted a low-wage job without health insurance. As a result, a substantial number of people across the U.S. are not served by the Medicaid program, despite their eligibility for coverage (Summer et al., 1996). Holian et al. (1999) estimate that the number of uninsured individuals has increased from 35.6 million in 1990 to 43.4 million in 1997, and the California Policy Research Center (1999) estimates that only 60% of families that receive public cash assistance are enrolled in the Medicaid program despite their eligibility for health care.

In order to better understand the Medicaid enrollment barriers, the Institute for Health Policy Solutions (2001) interviewed families with a child who had stopped receiving benefits despite continuing eligibility. Parents reported that they did not pursue reenrollment because: (1) the application paperwork was too lengthy and complicated, (2) they could not afford the family's share of costs, (3) they reported having never received a notice warning of benefit termination, (4) the office hours or locations were inconvenient, (5) various ethnic groups faced language barriers in completing the application or speaking with workers, or (6) they experienced difficulty contacting county workers, found them to be unhelpful or unfriendly, or were transferred too frequently between them. The researchers also interviewed the county workers. Tellingly, they agreed that the Medicaid application is too complicated, that family cost-sharing is too high, and that notices warning of benefit termination may not be received by parents because of frequent relocation or because the letters are discarded as "junk mail." Interestingly, whereas the parents sometimes found the workers to be inaccessible, the workers came to the opposite conclusion, reporting that the parents are busy and difficult to reach, or that the parents fail to follow the procedures necessary to keep their child enrolled in Medicaid. In addition, the workers reported that efforts to follow-up with families (in order to help them maintain their eligibility) are not made with enough regularity, perhaps because staff are overworked or under-trained.

Even though public health and welfare services share many of the same clients and have a similar array of eligibility, service and funding relationships, low-income individuals continue to experience reduced access to public health and welfare service. The means for addressing this predicament can be found in the common objectives of welfare re-

form and managed care noted in Figure 2. They include the following similarities:

- controlling costs by reducing service fragmentation and redundancy (e.g., through a centralized intake process)
- increasing consumer involvement and outreach (e.g., through the use of peer support groups and job clubs)
- advocating for the value of prevention (e.g., through family maintenance services in child welfare and prenatal services in managed health care)
- increasing the continuity of care over time (e.g., by assigning to all service recipients a case manager or primary care provider)
- developing management and information systems (MIS) to monitor the flow of consumers through systems (e.g., to track child foster care placements and immunizations).

In contrast to shared objectives, there are several key differences between managed care and welfare reform, including:

- managed care strives to increase service access (e.g., health care outreach) while welfare reform strives to decrease access (e.g., benefit time limits)
- managed care is based on a private sector, medical model (e.g., treatment of illness by an independent health care provider) while welfare reform is based on a public sector, strengths-based model (e.g., universally available one-stop employment centers)
- managed care has few legal constraints (e.g., the service provider assumes risk for most clinical and fiscal outcomes) while welfare reform has many legal constraints (e.g., well-established eligibility criteria).

As these policy objectives reflect, managed care has placed the medically indigent in a particularly vulnerable position. With the increased interest of private providers in serving the medically indigent in the highly competitive managed care environment, public hospitals in California have lost a significant number of Medicaid patients and a third of their Medicaid dollars. Meanwhile, the proportion of uninsured patients in local hospitals rose as the proportion of Medicaid patients fell (Friedman, 1997), and matching funds for hospitals have decreased with the Balanced Budget Act of 1997 (Holian et al., 1999). These developments have threatened public hospitals because they have depended on

FIGURE 2. Comparison of Managed Care to Welfare Reform

MANAGED CARE	WELFARE REFORM
I. PURPOSES	
Similarities	
Cost Containment (reduced services)	Cost Containment (reduced benefits)
Increased Consumer Involvement	Increased Consumer Involvement
Prevention & Health Promotion	Prevention and Diversion
Differences	
Increased Access	Reduced Access
Increased Quality of Care	Increased Self-Sufficiency (work)
Service System Responsiveness	Service System Integration
II. PRINCIPLES	
Similarities	
Blended Funding	Blended Funding Streams
Gatekeeping (primary physician)	Gatekeeping (case managers)
Managing Cases	Managing Cases
Differences	
Medical Model	Bio-Physical-Behavioral Model
Network Development (providers)	Network Development (public/private)
Utilization Review/Management	Outcome Goals & Evaluation
Private Sector Marketplace Model	Public Sector Safety Net Model
III. MANAGEMENT PROCESSES	
Similarities	
Information Systems – Essential	Information Systems – Essential
Performance Outcome Measures	Performance Outcome Measures
Practice Guidelines	Service Protocols
Provider Profiling & Monitoring	Provider Profiling & Monitoring
Expanding Consumer Involvement	Expanding Consumer Involvement
Differences	
Limited Public Policy Impact	Extensive Public Policy Impact
Risk Sharing (providers)	Responsibility Sharing (community)
Capitation & Rate Setting	Eligibility & Benefit Capitation
Service Preauthorization	Prescreening for Employability
Rapid Marketplace Implementation	Legislatively Defined Implementation
Few Legal Constraints	Many Legal Constraints

Medicaid dollars to subsidize indigent care. Although individual consumers may receive as good or better health care from private as they do from public providers, the increased flow of patients to private providers, the rising numbers of uninsured individuals, and decreased federal support for hospitals threaten to destroy the public hospital system and the major health care safety net for low-income individuals.

Providers, state governments and local authorities, however, have refused to allow the collapse of the safety net system and have created mechanisms that: (1) increase private insurance or Medicaid coverage to low-income individuals, (2) link health insurance with General Assistance and (3) create a separate state-subsidized health insurance system to serve individuals ineligible for Medicaid (Holian et al., 1999). Nevertheless, these solutions place most of the financial responsibility on local and state government. As a result, there is a growing interest among health and welfare administrators to find ways to develop a more holistic approach to the needs of individuals, families, and communities through neighborhood-based integrated services.

In addition to the impact of managed care, welfare reform has placed many low-income individuals in a particularly vulnerable position. Before the 1996 enactment of the federal TANF legislation, many individuals with personal and family barriers to employability were exempted from work requirements. As increasing numbers of recipients find work, people with barriers to employment (sometimes referred to as the *hard-to-place*) remain on the rolls due to a variety of personal and family challenges that are *disabling* and *interfere* with finding or maintaining employment (Danziger, Corcoran, Danziger, Heflin, Kalil, Levine, Rosen, Seefeldt, Siefert & Tolman, 1999; Kramer, 1998; Olson & Pavetti, 1996; Pavetti, 1996; Pavetti, Olson, Nightingale, Duke & Isaacs, 1997). These challenges include low basic work skills, mental health problems, chemical dependency, learning disabilities, medical problems, housing instability, domestic violence issues, criminal records, low self-esteem and little understanding of workplace norms or behaviors.

Estimates of the total number of TANF recipients with one or more barriers to employment range from 16% to over 50% of the entire caseload (Kramer, 1998; Olson & Pavetti, 1996; Pavetti et al., 1997; Urban Institute, 1999). Furthermore, between 11 and 21% of children on welfare are estimated to have some level of limitation or disability, requiring parents to balance employment with attending to a variety of medical, school, mental health or child care needs (Olson & Pavetti, 1996). Staff are now forced to identify alternative strategies to help dis-

abled recipients find employment, including: (1) providing specific job training, (2) subsidizing continuing general education, (3) providing assistance with job-seeking and retention skills, (4) working directly with employers, (5) offering mental health and substance abuse treatment and (6) reducing caseloads for welfare staff that work with the hard-to-place (Pavetti et al., 1997).

The combined impact of welfare reform and managed care has placed many low-income individuals at a high risk for poor health and welfare outcomes. However, despite categorical barriers to service access and integration, public health and social service programs are improving strategies for assisting indigent clients who are eligible for both forms of assistance.

STRATEGIES FOR ENHANCING THE INTEGRATION OF HEALTH AND WELFARE SERVICES

Health and welfare service partnerships vary along a continuum, with collaboration on one end and integration on the other. While collaborative partnerships between county health and welfare departments are based on separate health and welfare programs, integrated partnerships are found in "umbrella" human service organizations that include public health and social services inside the same agency. Integration at the public policy level (county and/or state) does not necessarily guarantee collaboration at the service delivery level. Using integrated approaches, staff are able to make "in-house" referrals to services internal to the program and provide the information necessary to successfully access all other needed services. In addition, health staff working in integrated or collaborative environments to improve services can: (1) ensure that all eligible consumers are enrolled in Medicaid, (2) provide health and welfare services to uninsured or undocumented consumers to prevent costly emergency assistance, (3) represent the cultural and linguistic diversity of the consumers they serve, and (4) enhance service delivery in the home and in the community to prevent hospitalization (Chapin & Nelson, 1993; Henley & Clifford, 1993; Ingram et al., 1993; Mason & Kahn, 1991; Medi-Cal Community Assistance Project, 1997; Stollman, 1994).

In order to ensure that all eligible consumers are enrolled in Medicaid, the Institute for Health Policy Solutions (2001) offers several recommendations. First, the application paperwork can be simplified by removing unnecessary questions, by pre-completing new applications

based on information from the previous year so that families will only have to enter the new data, and by offering alternate application forms in various languages. Second, communication can be improved by issuing several discontinuance warnings in the mail and on the telephone, calling families multiple times in the evening if necessary. Explanations of Medicaid coverage should be straightforward and in the consumer's primary language, and consumers should be reminded to inform the county office of relocation. Third, county offices can be made more accessible by extending office hours into the evenings and weekends, and by enabling the consumer to either keep the same county worker or switch to a new one if they are dissatisfied. Fourth, county workers can be assisted by additional training that is consumer-oriented, by rewarding workers according to their ability to retain eligible families, and by expanding the number of staff while reducing caseload size. Fourth, family share of costs can be determined by taking cost of living into account, reducing the share for families in high-cost areas, and, if necessary, by referring families to health programs with lower out-of-pocket expenses (e.g., Health Families or Healthy Kids programs).

Restructuring Health and Human Service Organizations. Successful service partnerships require a favorable political and economic climate, as well as considerable collaboration of staff at all levels. For example, in 1993 the Public Health Department and the Human Services Agency in Napa county, California merged to reduce costs, streamline their organizational structure, and increase consumer access to services (Corsello, Brandt & Murtaza, 1999). Although the two agencies had shared the same building for 15 years, there was little communication between them, and they had vastly different missions, styles of governance and communication channels which led to "culture shock" after the reorganization. Nevertheless, integration was made possible through collaboration between the County Administrator's Office, the Board of Supervisors, affiliated advisory boards, community-based organizations and consumer populations. Senior managers created the momentum to overcome barriers to change by providing staff with opportunities to learn how service integration offers a better and more cost-effective way to serve consumers (Corsello, Brandt & Murtaza, 1999).

Blended Funding. A second strategy for enhancing service integration involves blended funding which often involves drawing down matching state and federal dollars to the fullest extent possible. Creative examples of blended funding include using: (1) Child Protective Services (CPS) funding in social service agencies to purchase mental health treatment in health agencies that can, in turn, obtain federal matching funds for

these services thereby doubling the initial CPS investment, (2) Temporary Assistance to Needy Families (TANF) funds in welfare agencies to train workers in the Women with Indigent Children program about facilitating the self-sufficiency of TANF recipients, (3) funding for programs for severely emotionally disturbed children to cover some aspects of child welfare workers' activities, (4) Medicaid funds to pay for public health nurses to provide certain types of in-home supportive services to child welfare consumers, (5) Child Welfare (Title IV-E) training dollars for health and social service staff training, also: (6) addressing the "cross-over" needs of clients being assisted in both child welfare and welfare-to-work programs by using TANF funding for employment-related child welfare services (e.g., health care, child care), and (7) notification of the availability of continued Medicaid funding for low-income workers after leaving the TANF program.

While blended funding can significantly increase the amount of funds available for integrated services, these funds need to be allocated flexibly to meet the diverse needs of health and welfare consumers. Incremental modifications can be made within existing categorical funding structures to support integrated services. Examples of cross-categorical claiming include: (1) using non-health personnel to provide Early Periodic Screening, Diagnosis, and Treatment services, (2) eliminating duplicative activities, particularly by streamlining the intake process, and (3) exploring opportunities for agencies to share funds for the development of MIS systems (Goldman, 1995).

As an alternative to incremental modification, funding streams can be fundamentally restructured by integrating federal, state, and county funds. Creating a consolidated budget to support the integration of health and welfare services could involve the development of a capitated rate system, or it could occur through a shift to a block grant system in which lump-sum payment is assigned to cover the service needs of a particular community.

Collaboration. A third strategy to promote health and welfare service integration relates to collaborative program planning, staff training and service delivery. When consumer-identified health and welfare needs are assessed and incorporated into program design, such program planning can greatly enhance the effectiveness of outreach and referral services. Similarly, joint planning for decentralized, neighborhood-based programs can more easily respond to the specific needs of local consumers. The cross-training of staff can lead to the development of common languages and service approaches as well as educate all staff about funding streams and program mandates in health (for welfare profes-

sionals) and welfare (for health professionals). One new service approach involves the release of confidential consumer information to health and welfare staff through the creation of a "health passport" or "children's passport" to document all services received and track patterns of service utilization through a shared management and information system. Collaboration can also lead to shared appointment systems that schedule services to meet multiple consumer needs in a one-stop service center.

States may also reexamine their systems for enrolling children and families in services. Like TANF block grants in welfare reform, managed health care allows flexibility in how the Medicaid program will be administered, and states have the opportunity to align their health and welfare program policies and procedures so that a single set of standards determines eligibility for both programs. The more closely the eligibility rules for both programs are aligned, the easier it will be for states to coordinate program enrollment. For example, a single application form could be used to determine eligibility for both programs, and a single agency could make the eligibility determination. Keeping welfare and Medicaid rules consistent may also minimize state administrative costs and maximize federal reimbursement because, whereas states can claim federal Medicaid administrative matching funds to cover the cost of determining Medicaid eligibility, states do not receive additional federal funds for TANF administration. If the eligibility processes for the two programs are closely linked, the administrative tasks required to determine eligibility for aid under TANF could be significantly simplified (Sumner et al., 1996).

LESSONS FROM ABROAD

As we struggle to find new ways to deliver health and social services in a way that meets the changing needs of clients in the U.S., it is helpful to find ways to learn from others. The issue of linking health and social services has been a major topic in Great Britain as they seek to find ways to modernize government, reduce service fragmentation, and free-up direct service staff and family caregivers to organize client services that are relevant, efficient and effective. Here are some lessons from abroad.

In the process of identifying new ways for public social service and health organizations to collaborate, the policy staff of the British Department of Health developed a framework for addressing the need to

collaborate and reduce service fragmentation (Department of Health, 1998). They describe collaboration as "joint working" at three levels (strategic planning, service commissioning and service planning) in order to improve services, eliminate duplication and service gaps, and ensure the effective and efficient use of public funds.

They also identify the need to remove barriers to "joint working" through the use of new administrative directives which have legislative support. The three new directives receiving the most attention and having the most relevance for county and state government in the U.S. are:

1. Pooled Budgets–bringing health and social service budgets together into a joint budget accessible to those authorized to use the funds to create comprehensive, integrated services, and allowing for the allocating of funds from different sectors to local health and social service authorities as well as local voluntary organizations.
2. Lead Commissioners–creating one authority to oversee and manage the pooled budgets and those responsible for integrating health and social services.
3. Integrated Provision–authorizing health services staff to provide or gain access to social services and social service staff to provide or gain access to health services, as well as integrating some health and social services into a single provider or "one stop center" of co-located services.

In order to link the National Service Frameworks with planning by the Local Authority (county government), new Joint Investment Plans are designed to be implemented through a process of Joint Commissioning which involves a partnership between local health services, social services, housing services, and voluntary non-profit community agencies. This group focuses heavily on needs assessment as a cross-agency collaboration in local service planning by:

1. Acting as a coordinating body with the authority to extend the purview of health to include the impact of crime, poverty, unemployment, and housing.
2. Identifying key issues in the development of social service community care plans.
3. Proposing priorities that emerge from local joint planning groups for dealing with drugs and alcohol, learning (developmental) disabilities, mental health, and aging.

4. Identifying funding sources to be committed to jointly-planned services, by area of service, and including the use of special funds alongside mainstream social services and health service funds.
5. Ensuring that integrated and more efficient services are focused on the needs of individual service users by:

    a. allocating care (case) managers drawn from social services and health (community nurses) as appropriate to individual care needs
    b. clarifying the different responsibilities of care managers (direct service providers) and service managers (program managers)
    c. involving local physicians in community care developments
    d. seeking agreements with housing authorities on areas calling for collaboration.

All of these strategies to enhance "joint working" require a substantial commitment to staff training and education. These efforts are seen as crucial to the support and development of improvements in the ways that health and social services work together. Providing opportunities for staff to learn together, locally and regionally, is a central feature of both initial and continuing professional development.

CONCLUSION

Today the two systems of public health and public welfare overlap considerably. In addition to sharing a similar consumer population, where most of the same low-income individuals receive benefits from welfare-to-work programs and Medicaid health care programs, both systems seek to promote self-sufficiency. In addition, both systems collaboratively intervene early in the lives of low-income family members to prevent the development of welfare dependency and poor health caused by poverty, unemployment, inadequate housing and social isolation which are key risk factors for both of these conditions. Through the use of partnerships and prevention strategies, health and social service agencies are increasingly moving towards a social investment strategy to enhance the capacity of needy individuals, families and communities to achieve self-sufficiency. The strategies involve neighborhood-based, family-focused services that provide access to such community assets as child care, elder care, affordable housing, transportation, employment services, health care and family well-being. Currently, however,

the health and welfare partnership is constrained by categorical funding mechanisms that do not provide enough flexible funding for prevention, early intervention and follow-up, and the reduction of service fragmentation, discontinuity and redundancy.

Categorical funding has also compelled most health and welfare agencies to respond separately to several common welfare reform and managed care objectives. These shared objectives include: (1) controlling costs and increasing service efficiency and effectiveness, (2) increasing consumer involvement and outreach, (3) advocating for prevention, (4) increasing the continuity of care over time and (5) developing management and information systems (MIS) to monitor the flow of consumers through systems. The categorical distinction between health and welfare is reinforced by several central differences between managed care and welfare reform. Managed care strives to increase service access, focuses on the private sector, and adheres to a medical model with few legal constraints, while welfare reform strives to decrease access, focuses on the public sector, and adheres to a strengths-based model with many legal constraints.

The combined impact of managed care and welfare reform has placed low-income individuals in a particularly vulnerable position. Welfare reform ended the automatic linking of Medicaid enrollment with welfare recipiency and, as a result, a substantial number of people in every state are uninsured despite their eligibility for Medicaid coverage. Furthermore, under managed care, the increased flow of patients to private providers, the increasing number of uninsured individuals and decreased federal support for hospitals threatens to undermine the public hospital system which has been the major health safety net for low-income individuals. Taken together, the recent changes in health care and welfare have reduced low-income access to an array of human services.

These new realities have prompted the more visionary health and welfare professionals to develop a more holistic approach to integrating both functions within one comprehensive human service organization or collaborating through special health and welfare programs. Successful service partnership requires a favorable political and economic climate, as well as considerable staff dedication at all levels to address multiple consumer-identified needs by blending funding streams to draw down matching state and federal funds to the fullest extent possible. While blended funding can increase significantly the amount of revenue available to integrated programs, these funds need to be allocated flexibly by modifying existing categorical funding structures or

by creating a consolidated health and welfare budget composed of integrated federal, state and county funds.

In this era of managed care and welfare reform several operations research questions are worth pursuing regarding the integration of health and welfare services. First, what are the best ways for welfare professionals to develop partnerships with public health providers in order to address the barriers that interfere with gaining and sustaining employment? Second, given the high number of shared clients in health and welfare service delivery, which partnership strategies best address the constraints of categorical service funding? Third, what are the best ways for health and welfare professionals to overcome the service access barriers caused by managed care and welfare reform? Fourth, how can health and welfare professionals best utilize blended funding to increase the amount of resources available for integrated services? Finally, how could a single set of health and welfare eligibility standards be used to help consumers address multiple needs in a single one-stop service center? Answers to these questions could facilitate the access of low-income consumers to resources that have been impacted by managed care and welfare reform.

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