DEMOCRATIC GOVERNANCE
Vol. 18, No. 2, 2025, 16-30
Journal homepage: https://d-governance.com.ua/
Received: 12.08.2025; Revised: 05.11.2025; Accepted: 10.12.2025 Published: 05.01.2026

UDC 351.84:364-7:61(100)(477)
DOI: 10.56318/dg/2.2025.16

E-ISSN 2070-4038

Public policy in the field of integration of medical and social services

Olga Fedorchak*
Doctor of Science in Public Administration, Professor
Institute of Public Administration, Governance, and Professional Development of
Lviv Polytechnic National University
79491, 16 Vasyl Sukhomlynskyi Str., Briukhovychi, Ukraine
https://orcid.org/0000-0001-9965-5135

Yurii Shypov
Postgraduate Student
Institute of Public Administration, Governance, and Professional Development of
Lviv Polytechnic National University
79491, 16 Vasyl Sukhomlynskyi Str., Briukhovychi, Ukraine
https://orcid.org/0009-0004-0862-1984

Abstract. In the context of modern warfare and the transformation of healthcare and social protection systems in Ukraine, there is a need to develop a comprehensive model of integrated care that ensures continuity, comprehensiveness, and a person-centred approach. The study aimed to substantiate the feasibility of integrating medical and social services and to identify key directions for developing public policy on the implementation of this type of care, based on an analysis of international experience. The methodological framework was based on a comparative analysis of various integration models, content analysis of Ukrainian regulatory and legal acts, and a systems approach to the interpretation of data on the organisation of medical and social service delivery. As a result of the analysis of international practices, various types of integration presented in the scientific literature were identified: organisational, functional, clinical, professional, regulatory, financial, informational, sectoral, intersectoral, international, horizontal, and vertical integration, as well as service integration and patient-centred integration. It has been demonstrated that medical and social services integration contributes to improved quality and accessibility of care, increased patient satisfaction, more efficient use of resources, strengthened intersectoral interaction, and support for the development of multidisciplinary collaboration. This study systematised contemporary approaches to medical and social services integration, clarified the terminological foundations, and developed criteria for defining medical and social services and their application in the Ukrainian context. The practical significance of the obtained results lies in their potential use for shaping public policy in the field of integrated care, improving government programs, regulatory frameworks, and managerial decisions in the areas of healthcare and social protection

Keywords: public administration; healthcare; social policy; integrated care; intersectoral collaboration; international experience

Introduction

The integration of medical and social services is one of the key directions in the development of modern health care systems worldwide. The need to implement integrated care in Ukraine has become urgent in the context of war, demographic crisis, and population ageing, as well as the increasing prevalence of chronic diseases and declining quality of life. Although a medical reform has been implemented in the country, social services have been

Suggested Citation:
Fedorchak, O., & Shypov, Yu. (2025). Public policy in the field of integration of medical and social services. *Democratic Governance*, 18(2), 16-30. doi: 10.56318/dg/2.2025.16.

*Corresponding author

decentralised, and new institutions regulating the provision of medical and social services have been established, the health care and social protection sectors remain largely disconnected. Such fragmentation reduces the effectiveness of the care system, complicates access to services, and fails to ensure continuity of care for citizens. Therefore, the study of issues related to the integration of medical and social services is timely and holds significant importance for the development of public policy in the fields of health care and social protection in Ukraine.

International experience demonstrates that the medical and social services integration is a complex but necessary process, requiring a systemic approach, intersectoral collaboration, data sharing, and joint financing. In particular, R. Miller *et al.* (2021) analysed the outcomes of the integrated care system reform in the United Kingdom. The authors showed that the establishment of Integrated Care Systems improved care coordination and reduced service duplication; however, issues remain regarding unequal access to services, underfunding of the social sector, and the absence of a unified system for evaluating outcomes. The authors emphasised that integration yields the best results when it is focused on the specific needs of the community and supported by the local government.

M. Collins *et al.* (2023) studied Scotland's experience in integrating health care and social care. In particular, the authors analysed the activities of over 30 Health and Social Care Partnerships and proposed combining clinical, social, and economic criteria when setting funding priorities for medical and social services. They emphasised that effective integration requires not only institutional reforms but also transparent mechanisms for allocating resources between the medical and social sectors.

N. Shuftan *et al.* (2025) analysed the progress, barriers, and prospects of implementing integrated medical and social care in the Baltic countries (Estonia, Latvia, Lithuania) from 2019 to 2024, based on expert surveys and pilot programmes. The authors concluded that, despite political support, the integration of the medical and social sectors is progressing gradually due to challenges related to funding, workforce provision, intersectoral coordination, and data sharing. C. Matos *et al.* (2025) conducted a comparative analysis of European models of integration. The authors emphasised that there is no universal model of integration. Each country develops its own strategy based on its national context. They demonstrated that successful integration requires a national implementation strategy, strengthening of local governance, and a focus on long-term care aimed at promoting the population's well-being, using the example of Portugal.

The topic of integrating medical and social services remains underdeveloped in Ukrainian scholarly thought. In particular, M. Yukalo's (2025) dissertation examines the mechanisms of public administration of the health care system through the lens of an integration approach. The author substantiated the need to move from a fragmented system of health care provision to an integrated, patient-centred model and emphasised that the experience of the United Kingdom may serve as a benchmark for Ukraine.

Another Ukrainian researcher, N. Nazar (2022) conducted a comparative analysis of social work in the health care sectors of Canada and Ukraine. The author noted that social workers are an integral part of medical teams in Canada, whereas such interaction is only beginning to develop in Ukraine. The researcher concluded that the integration of social services into the medical system contributes to improving the quality of care and the efficiency of service provision.

The analysis of scholarly works has shown that leading countries have substantial experience in establishing integrated health care and social protection systems, whereas in Ukraine process is only just beginning. Questions regarding mechanisms of intersectoral interaction at the community level, the evaluation of the effectiveness of pilot integration projects, and the adaptation of international practices to the Ukrainian realities of wartime remain insufficiently studied. The lack of a systematic analysis of the integration of medical and social services in post-socialist countries, particularly in Ukraine, indicates the scientific and practical relevance of further research in this area. The aim of the study was to examine the feasibility of integrating medical and social services and to outline directions for public policy on the implementation of integrated care in Ukraine, taking into account international experience.

Materials and Methods

The research was based on scientific publications, Ukrainian regulatory and legal acts, analytical documents of state authorities and international organisations, as well as dissertations by Ukrainian authors. In particular, the source base included:

- international and Ukrainian scientific publications: articles, reviews, systematic reviews, and conceptual studies on the integration of medical and social services in leading countries, as well as dissertations by Ukrainian authors addressing issues related to the development of social work and integrated models of medical and social service provision in Ukraine;
- Ukrainian regulatory and legal acts: laws and subordinate legislation regulating the health care and social protection systems in Ukraine, including legislation on social services, health care, and state financial guarantees; orders of the Ministry of Health of Ukraine and the Ministry of Social Policy, Family, and Unity of Ukraine, as well as regulatory documents of the State Statistics Service of Ukraine;
- analytical documents and studies of international organisations: materials from the World Health Organization (WHO), the United Nations, and reports from international analytical centres (the UK-based independent charitable analytical centre The King's Fund and the independent UK analytical centre Nuffield Trust), highlighting practices of integrating medical and social services.

The publications primarily cover the period from 1999 to 2025, which allowed for consideration of the development of integration processes over time. The criteria for

selecting sources were: studies and documents directly related to the integration of medical and social services; international and Ukrainian experience in integrating health care and social protection systems; publications in peer-reviewed journals and reputable analytical outlets; and legislative and regulatory acts governing the provision of medical and social services in Ukraine. The exclusion criteria were: sources that lack scientific or analytical value; materials with unverified origin or without a current publication date; and works addressing only one sector – either medical or social care – without considering an integration approach.

The research strategy aimed to synthesise data from various sources to provide a comprehensive and comparative analysis of the processes of integrating medical and social services. A systematic literature search was conducted using PubMed, MEDLINE, and Google Scholar to identify relevant peer-reviewed articles, government reports, and policy documents. The search included both original research articles and review studies, with no geographic restrictions, in order to ensure broad coverage of international and national experience in integration. The search terms included: "health care and social care," "social and medical integration," "integrated care," and related keywords. In addition, the reference lists of selected articles were manually reviewed to identify additional relevant sources. Data were selected based on their relevance to the study's aim, with priority given to peer-reviewed journal articles and official government documents to ensure academic rigor and reliability.

The article employed a set of scientific methods that ensured a comprehensive analysis of the integration of medical and social services in both international practice and in Ukraine. The comparative method was used to compare Ukrainian and international experience in the integration of health care and social protection systems. A comparison was made of the experiences of the United Kingdom, the United States, and Ukraine. The criteria for comparison were: the existence of a clearly developed public policy on the integration of medical and social services, the presence of legislation in the field of integration, and the availability of institutional support in this area. The application of the comparative method made it possible to develop proposals for amending Ukrainian legislation on the integration of medical and social services, adapted to Ukrainian conditions, including the suggestion of criteria for distinguishing medical and social services from other similar services.

A systems analysis was applied to integrate heterogeneous data from international and Ukrainian sources. The use of a systems approach was driven by the need to develop a comprehensive understanding of the structure, forms, and types of integration of medical and social services. This made it possible to identify: types of integration (organisational, functional, clinical, regulatory, systemic, horizontal, vertical), levels of integration (macro, meso, micro), as well as degrees of integration (full integration, coordination, linkage). The use of this method made it possible to formulate practical recommendations on the priority directions for integrating medical and social services, as well as to develop initial steps for the integration of health care and social protection systems in Ukraine.

A content analysis of Ukrainian regulatory and legal acts was conducted to clarify the meaning of the term "medical and social services" and to determine its use as a key element in the development of public policy in this area. The units of analysis were articles of law, individual provisions, paragraphs, and key terms. The selection of regulatory texts was carried out using the keywords: "integrated services," "medical and social services," and "social and medical care." The material was coded according to thematic categories: medical component and social component. The results obtained made it possible to determine the frequency and prevalence of these categories, compare groups of regulatory documents, and identify patterns in the regulation of the provision of medical and social services. Thus, the combination of the comparative method, systems analysis, and content analysis ensured a comprehensive study of international and Ukrainian experience in the integration of medical and social services, the identification of types, levels, and degrees of integration, and the development of practical recommendations for their implementation.

Results

The concept of integrated care in the international practice of providing medical and social services

Integrated medical care has become an international trend in the healthcare sector, particularly in North America and Europe. It is viewed as a way to create a more efficient healthcare system. However, the term "integrated care" is often used ambiguously: in the United States, it is associated with "managed care," in the United Kingdom with "shared care," and in the Netherlands with "transmural care," as well as other forms of comprehensive care (Kodner, 2009).

The word "integration" comes from the Latin *integer* – "whole," "complete." Integration refers to the unification of previously separate elements to achieve a common goal. Similar to systems theory, healthcare organisations consist of separate but interconnected parts that must work together to perform tasks effectively. Without integration, the quality and accessibility of services, as well as patient satisfaction, deteriorate. Historically, specialisation in medicine has led to fragmented care. The emergence of general and family medicine aims to enhance integration and ensure a comprehensive approach to fully meet patients' needs. Integration is especially important for patients with complex and chronic conditions, individuals with physical and cognitive impairments and developmental disorders, as well as for their families. Such patients require services provided simultaneously or sequentially by multiple providers, including medical, social, and psychological support. The degree of integration depends on

the complexity of patients' needs: the more complex and long-term the conditions, the broader and more structured the approach required (Kodner, 2009).

A review of the literature on integrated care identified approximately 175 definitions and concepts of integrated care (Shaw *et al.*, 2011). At the same time, a key issue remains the lack of consensus on the definitions of basic concepts. As a result, there is a wide range of terms used to describe integrated care, including "coordinated care", "collaborative care", "managed care", "disease management", "case management", "user-centred care in health or social services", "care for chronic conditions", "continuity of care", "seamless care", and others (Nolte & Pitchforth, 2014). Although they may differ conceptually, the boundaries between them often remain blurred.

The concept of integration encompasses organisational, clinical, administrative, and financial aspects and includes the coordination of medical, social, and other related services. Given the multifaceted nature of this concept, integration in healthcare continues to evolve in various directions, resulting in multiple models and approaches for its implementation. Analysis of scientific sources made it possible to identify a wide range of types of integration and to define their characteristics (Table 1).

Table 1. *Types of integration*

№	Type of integration	Description	Authors
1	Patient-centred integration	Building care around the needs of a specific patient, case management, personalised care, and individual care pathways	N. Goodwin (2013)
2	Organisational integration	Formal or informal organisational collaboration: mergers, network creation, joint structures, contractual arrangements, shared budgets, or coordinated planning	N. Curry & C. Ham (2010), S. Shaw *et al.* (2011)
3	Functional integration	Coordination of administrative and support functions: finance, human resource management, strategic planning, IT systems, and the use of shared electronic records	N. Curry & C. Ham (2010), S. Shaw *et al.* (2011), E. Nolte & E. Pitchforth (2014)
4	Service integration	Integration of clinical services through multidisciplinary teams and the comprehensive provision of medical and social care	N. Curry & C. Ham (2010), S. Shaw *et al.* (2011)
5	Clinical integration	Alignment of clinical processes among professionals: use of shared protocols, patient pathways, unified standards, and continuity of care	N. Curry & C. Ham (2010), S. Shaw *et al.* (2011), E. Nolte & E. Pitchforth (2014)
6	Professional integration	Collaboration between medical and social professionals: group practices, joint teams, professional alliances	S. Shaw *et al.* (2011), E. Nolte & E. Pitchforth (2014)
7	Financial integration	Pooling of different funding sources (public, private, donor) to ensure the stability of the service delivery system	D. Yordanov *et al.* (2024), M. Yukalo (2025)
8	Information integration	Shared information systems: electronic medical records, telemedicine, and joint databases	M. Yukalo (2025)
9	Regulatory integration	Shared values, culture, vision, and trust among organisations and professionals; elimination of communication barriers and alignment of professional norms	N. Curry & C. Ham (2010), S. Shaw *et al.* (2011)
10	Systemic integration	Alignment of policies, funding, and regulations at the healthcare system level; unified rules and regulatory approaches	N. Curry & C. Ham (2010), S. Shaw *et al.* (2011), N. Goodwin (2013)
11	Horizontal integration	Integration of organisations at the same level (hospital-to-hospital, service-to-service): shared use of resources, avoidance of duplication	N. Goodwin (2013), E. Nolte & E. Pitchforth (2014), M. Yukalo (2025)
12	Vertical integration	Integration of different levels of care (primary-secondary-tertiary) to ensure continuity of care	N. Goodwin (2013), E. Nolte & E. Pitchforth (2014), M. Yukalo (2025)
13	Sectoral integration	Integration of services within a single sector (healthcare-healthcare or social-social) for comprehensive service delivery	N. Goodwin (2013)
14	Cross-sectoral integration	Interaction of healthcare with education, social services, and the community and volunteer sectors to address complex issues	G. Simpson *et al.* (2023), M. Yukalo (2025)
15	International integration	Collaboration with international organisations and institutions to obtain resources, innovations, technical, and financial assistance	M. Yukalo (2025)

Source*: summarised by the authors*

It is important to note that the scientific literature also distinguishes four categories of integration: integration of medical and social services; integration of primary and inpatient care; integration within a single sector (e.g., mental health); and integration of preventive and curative services (Nolte & Pitchforth, 2014). In addition, some authors, notably N. Curry & C. Ham (2010) and M. Dobbins *et al.* (2016), distinguish the following levels of integration: the macro level, which involves the development of policies on service funding and the regulatory framework; the meso level, which includes the creation of multidisciplinary teams, management of medical service delivery for patients with chronic conditions, and coordination between organisations; and the micro level, which encompasses direct care provision, case management, patient-centred approaches, telemedicine, tele-support, the development of personal budgets, and so on.

The scientific literature also distinguishes "intensity of integration" – a gradation of levels that can range from full integration, where an organisation is responsible for

the complete and continuous delivery of care, to collaboration, in which such care is provided by separate entities, with each organisation retaining its own responsibility for service provision. S. Shaw *et al.* (2011), E. Nolte & E. Pitchforth (2014), and W. Leutz (1999) identified the following levels of integration intensity: "full integration", "coordination", and "linkage". "Full integration" involves the formal unification of resources, enabling the creation of a new organisation, alongside the development of comprehensive services tailored to the needs of specific patient groups. The newly established organisation assumes responsibility for all services, resources, and funding, which can be consolidated into a single management structure or provided through contractual agreements between different organisations. "Coordination" involves operating through existing organisational units to coordinate various medical services, share clinical information, and manage patient transitions between different units. It includes regular information sharing, discharge planning, and the work of case managers to improve coordination of care across sectors. "Linkage" involves interaction between existing organisational units to refer patients to the appropriate unit at the right time and to facilitate communication among the professionals involved, ensuring continuity of care. Linkage operates through separate structures within existing healthcare and social service systems, where organisations retain their own responsibility, funding, selection criteria, and operational rules, with staff duties clearly divided among different teams.

The scientific literature also introduces the concept of an "integration framework", which describes three levels of integration aligned with patient needs to ensure a comprehensive approach to meeting those needs. The relationship between the level of user needs and the level of integration is manifested in various ways. At a low level of need, the focus is on the timely identification of urgent treatment requirements, referral of the patient to the necessary care, and subsequent follow-up. In addition, information is provided upon request, and clarity is ensured regarding who pays for what, corresponding to the basic level of linkage. At a moderate level of need, the primary focus is on coordination, which includes identifying at-risk population groups, planning patient discharges, conducting routine two-way reporting, the work of case managers and liaison staff, as well as determining payment mechanisms. At a high level of need, full integration is established, characterised by the operation of multidisciplinary teams managing all care across key settings; shared documentation is used, along with the pooling of financial resources to procure new services from both sectors (Leutz, 1999; Nolte & Pitchforth, 2014). The literature also describes the relationship between integration and care coordination (Curry & Ham, 2010). Four possible combinations of integration and care coordination levels are identified (Table 2).

Table 2. *Combination of integration and care coordination levels*

		Level of coordination	
		Low	**High**
Level of integration	High	At a high level of integration but low care coordination, there is a single healthcare provider delivering separate medical services that are not connected	At a high level of integration with strong care coordination, there is a single healthcare provider delivering coordinated and interconnected medical services
	Low	At a low level of integration and weak care coordination, there are isolated healthcare providers that are not connected and deliver separate medical services	At a low level of integration with strong care coordination, there are multiple healthcare providers delivering coordinated and interconnected medical services

Source: *developed by the authors based on N. Curry & C. Ham (2010)*

As the analysis has shown, for the patient, it is more important how well the team of professionals works in a coordinated manner and whether they follow shared rules, guidelines, and protocols than the specific organisational structure in which these services are provided. This indicates that high levels of care coordination can be achieved both within a single organisation and among multiple organisations that closely collaborate to provide interconnected medical services. Accordingly, the key managerial priority becomes not the formal consolidation of service providers, but the implementation of effective mechanisms for interprofessional collaboration, joint planning, and continuous information exchange, all focused on the needs of the patient.

W. Leutz (1999) formulated five basic "laws of integration" for medical and social services, emphasising that: "incompatible elements cannot be integrated into a single system"; "integration must encompass multiple components simultaneously"; "integration should address the core of the systems, not just secondary functions or components"; "successful integration requires clear management and control mechanisms"; and "integration should be focused on practical activity". The author viewed integration as a systemic process of aligning medical and social institutions, aimed at improving the quality of care, patient convenience, and the efficiency of resource use.

Some authors, notably M. Minkman *et al.* (2025) have identified nine clusters in the development of integrated care, including: quality orientation, performance management, team collaboration, organisational mechanisms, role distribution, patient-centeredness, commitment, transparent governance, and learning. (1) Quality orientation in the provision of medical and social services includes a focus on patient safety, standards, protocols, and treatment effectiveness. (2) Performance management encompasses the

evaluation of effectiveness, outcome monitoring, the use of quality indicators, and feedback. (3) Teamwork among medical and social workers includes regular meetings, knowledge sharing, and joint decision-making. (4) Organisational mechanisms define the organisational structure, processes, and coordination mechanisms across different levels and sectors. (5) Role distribution encompasses the clear definition of duties, responsibilities, and authority of all participants in the care delivery process. (6) Patient-centeredness ensures an individualised approach for each patient, taking into account their needs, preferences, and involvement in decision-making. (7) Commitment includes the dedication of organisations and staff to integrated care, manifested through motivation, support, and stability. (8) Transparent governance refers to openness in financial and organisational matters, ethical management, and accountability to all stakeholders. (9) Learning promotes the exchange of experience and adaptation based on outcomes and feedback. These elements of integrated care emphasise the importance of proactive, lifelong care, digital health services, and ethical, value-driven collaboration.

Thus, international publications show a clear trend toward understanding the integrated approach, describing its essence, types, and depth, outlining its advantages and disadvantages, as well as practical mechanisms for implementation and assessment of its effectiveness. A comparative analysis of international literature indicates that, regardless of the country, political system, or healthcare financing model, the integration of medical and social services is viewed as a tool to overcome fragmentation resulting from excessive specialisation and the separation of these sectors. There is a general trend toward shifting from isolated, episodic care to continuous, personalised pathways focused on patient needs. In most countries, integration takes on a systemic character and is viewed not as a one-time reform but as a long-term process of synchronising functions, resources, and authority. An important international trend is also the shift from institutional care to community-based support models, which combine primary healthcare, social services, psychological support, and rehabilitation services. The role of multidisciplinary teams, case coordination, and digital tools (shared electronic records, telemedicine, remote monitoring) is also increasing, enabling timely information exchange across sectors.

For Ukraine, the following integration models may be most useful:

1. The W. Leutz (1999) model, divided into "linkage – coordination – full integration", is the most practically applicable to Ukrainian communities, as it reflects the uneven capacities of different regions. It can be used for planning, setting priorities, and making managerial decisions.

2. The three-tier division (macro-meso-micro), proposed by E. Nolte & E. Pitchforth (2014) and N. Curry & C. Ham (2010), is important for Ukraine, where integration processes are uneven: at the macro level, legislation and funding are being reformed, while at the meso level (community level) there is a lack of management mechanisms, and at the micro level (work of doctors, nurses, and social workers) interprofessional collaboration remains underdeveloped.

3. The N. Curry & C. Ham (2010) matrix, which combines formal integration and the level of coordination, allows us to determine that for the Ukrainian context, the most realistic model in the near term is "low structural integration + high coordination" (where each service maintains autonomy, but interaction occurs through shared pathways, teams, and information exchange platforms).

Although international approaches to integration are diverse, several significant gaps exist in the theoretical domain. Chief among them is the insufficient development of integration theory under wartime conditions. Most concepts are based on data from stable economies. Theoretical models rarely take into account situations where care must be integrated for military personnel, veterans, internally displaced persons, or contexts of mass trauma and prolonged crises, which is critically important for Ukraine. This area is barely developed in international models, allowing Ukraine to become a country that shapes a new typology of integration for prolonged war contexts. Another limitation lies in the insufficient conceptualisation of the social sector's role. Most models are developed from a medical perspective and only partially consider social services. This leads to an excessive focus on the "medical component of integration", reducing the models' applicability in areas of social support, rehabilitation, caregiving, and long-term follow-up. Strengthening the role of social workers in the provision of integrated services would be particularly beneficial for the Ukrainian context. In most international systems, these professionals provide practical integration – continuous patient support, communication between the patient and physician, case management, and so on. A significant limitation is also the absence of a universal definition of integration and medical-social services. The existence of over 175 terms and concepts indicates that the theory is still in a formative stage. In many cases, different concepts describe the same phenomena, but due to contextual differences, different terms are used, which complicates comparison.

The use of the term "medical-social services" as a key element in developing public policy in this field

Despite the comprehensive coverage of medical and social service integration processes in international literature, there is no clear definition of the concept of "medical-social services" itself, nor are there well-established criteria for distinguishing them from other categories of services. Despite the widespread use of medical-social services abroad, this term is not officially recognised as a separate concept in Ukraine's legal and regulatory acts. It is often used only as part of broader terms or in the context of cross-sectoral assistance. As of December 2025, none of the legal and regulatory acts (including the "Fundamentals of Ukrainian Health Care Legislation") contained an official definition of "medical-social service". Definitions focus on the term

"medical service". Specifically, Article 3 of Law of Ukraine No. 2801-XII (1992) provides definitions for the term "medical care" (as the activities of professionally trained medical personnel aimed at the prevention, diagnosis, and treatment of diseases, injuries, poisoning, and pathological conditions, as well as pregnancy and childbirth) and "medical service" (as a service provided to a patient in a healthcare facility, rehabilitation institution, or by an individual entrepreneur licensed to conduct medical practice). Article 4 of Law of Ukraine No. 2168-VIII (2017) provides a list of medical services covered by the state under the Medical Guarantees Program. These include emergency, primary, specialised, and palliative medical care; healthcare rehabilitation; medical care for children under 16 and for women related to pregnancy and childbirth; as well as services for assessing an individual's daily functioning. However, this law also does not define the term "medical-social service". Analysis of scientific literature on the provision of medical services has allowed for the classification of medical services in Ukraine (Table 3).

Table 3. *Classification of medical services*

Characteristic	Type of service
By medical care profile	Primary medical services – the basic level aimed at prevention, early detection, diagnosis, and treatment of common diseases (family medicine, outpatient care, vaccination)
	Secondary medical services – specialised care provided by physicians with narrow specialties in hospitals or specialised centres (e.g., cardiology, ophthalmology), usually requiring a referral from a primary care physician
	Tertiary medical services – highly specialised care including complex surgeries and treatment of rare or severe diseases (e.g., organ transplantation, oncological surgery), provided in research institutes and high-tech centres
	Quaternary medical services (in international practice – quaternary care) – extremely complex or experimental procedures available only in select centres, involving high-tech, innovative treatments, often within the framework of scientific research
By type of provision	Preventive – aimed at maintaining and strengthening health, and preventing diseases: medical check-ups, vaccination, and health education
	Diagnostic – focused on establishing a diagnosis and detecting pathologies: laboratory and instrumental tests (blood tests, X-rays, ultrasound, MRI)
	Therapeutic – aimed at eliminating or alleviating disease symptoms and restoring health; includes direct treatment of conditions: medication therapy, surgical interventions, restorative procedures, physiotherapy
	Rehabilitative – restoring physical and psychological functions after illnesses, injuries, or surgeries: physical rehabilitation, psychological support, social adaptation, speech therapy
	Palliative – support for patients with incurable diseases, alleviating symptoms and suffering, and improving quality of life: pain management, patient care, and psychological support for the family
By place of delivery	Inpatient – care provided with hospital stay under 24-hour supervision (hospital, medical centre)
	Day hospital – treatment and observation during the day without overnight stay
	Outpatient – care provided without hospitalisation or 24-hour stay in a medical facility (polyclinic, family doctor, medical offices, mobile medical teams)
	Home-based – services provided at the patient's residence (home visits, home care)
	Telemedicine – online consultations and remote monitoring
By form of organisation	Emergency – urgent services are provided immediately to preserve life
	Urgent – requires prompt response, but does not pose an immediate threat to life
	Planned – provided by prior appointment and preparation
By source of funding	"Green package" – free medical services (emergency, primary, and palliative care) fully covered by the state
	"Red package" – services paid for by the patient (non-emergency dentistry, therapeutic consultations without referral, aesthetic procedures)

Source: *compiled based on Law of Ukraine No. 2801-XII (1992) and Law of Ukraine No. 2168-VIII (2017)*

There are also developed classifiers related to medical procedures and services in Ukraine. In particular, these include the State Classification of Products and Services (Section Q – "Human health and social work activities"), which is used for accounting and tax purposes, including the identification of service codes for value-added tax (VAT) calculation and payment. Although it is not a clinical classifier, it is mandatory for financial reporting and contractual arrangements (State Statistics Service of Ukraine, 2010). Another such instrument is the Temporary Sectoral Classifier of Medical Procedures (Services) of the Ministry of Health, developed by the Ministry of Health of Ukraine for internal accounting of medical interventions, procedures, and examinations in healthcare institutions. This classifier is used in medical documentation and for statistical reporting. It has a temporary status until a unified national medical classifier, harmonised with international standards, is introduced (Order of the Ministry of Health of Ukraine No. 67, 2007). If these two classifiers are considered, references to medical and social services appear only in a general form in the State Classification of Products and Services, where groups Q86-Q88 include codes related to healthcare activities combined with social services. However, the concept of "medical and social services" is used only in an economic and administrative sense, rather than a clinical one. Medical and social services are encoded under general categories of social and healthcare assistance (State Statistics Service of Ukraine, 2010).

Thus, although scholars and practitioners in the fields of healthcare and social policy emphasise the importance of integrating medical and social services in

order to improve their effectiveness and ensure equal access, the term "medical and social services" is not used in Ukrainian scientific medical literature or in the relevant regulatory and legal acts. Instead, the concept of "integrated social services" is widely used (Yeremenko, 2025), referring to an approach that combines social and medical components, particularly in the context of rehabilitation, care for persons with disabilities, and related areas. In particular, the term "integrated system of social protection" is used in Law of Ukraine No. 2671-VIII (2019), which provides for comprehensive social services, including services related to medical support, as well as in the Methodological Recommendations for the Implementation of an Integrated System of Social Protection (Order of the Ministry of Social Policy of Ukraine No. 282, 2019), which also address the integrated system of social protection.

Article 5 of Law of Ukraine No. 966-IV (2003) defined the following forms of social service provision: material assistance and social care services. It was stipulated that material assistance was to be provided to persons in difficult life circumstances in the form of cash or in-kind support, including food, sanitary and personal hygiene products, child care items, clothing, footwear, and other necessities, fuel, as well as technical and assistive rehabilitation devices. Social care services were to be provided in various forms and settings, including at the place of residence of individuals or children in foster families, family-type children's homes, and families of patronage caregivers; as well as in residential institutional facilities, rehabilitation institutions, day-care centres, temporary or permanent residential facilities, territorial centres for the provision of social services, and other social support institutions.

Article 5 of Law of Ukraine No. 966-IV (2003) also defined a broad range of social services, including social and household services, psychological services, social and pedagogical services, social and medical services, social and economic services, legal services, information services, and employment-related services. Social and medical services, psychological services, and social and household services were of primary importance in the context of medical and social support, as they involved the prevention of health impairments, the implementation of therapeutic and rehabilitative measures, psychological support, and the provision of conditions necessary to maintain an individual's functional autonomy. These services were aimed at supporting the physical, mental, and social well-being of recipients, making them fundamental components of integrated medical and social care.

Law of Ukraine No. 966-IV (2003) provided a clear definition of social and medical services, which were understood as "the provision of consultations on the prevention of the occurrence and development of potential organic disorders in an individual, the preservation, support, and protection of their health, the implementation of preventive and therapeutic-wellness measures, and occupational therapy". Social workers carried out these measures at the individual's place of residence, in residential facilities, rehabilitation institutions, day-care centres, temporary or permanent stay facilities, and territorial social service offices. However, as of January 1, 2020, the new Law of Ukraine "On Social Services" came into force, replacing the existing law of the same name adopted in 2003. The new Law of Ukraine No. 2671-VIII (2019) defines social services, presents a comprehensive list of them, and classifies them according to various criteria; however, it no longer makes any reference to medical and social services. According to this law, "social services are actions aimed at preventing difficult life circumstances, overcoming such circumstances, or minimising their negative consequences for individuals and families experiencing them". Article 16 of the aforementioned Law also provides a classification of social services, which distinguishes services by purpose, type, place of provision, and duration of provision (Table 4).

Table 4. *Classification of social services*

Characteristics	**Types of services**
By purpose	Social prevention – preventing the emergence of difficult life circumstances and/or preventing an individual (family) from falling into such circumstances
	Social support – facilitating an individual's (family's) ability to overcome difficult life circumstances
	Social care – minimising the negative consequences of difficult life circumstances for an individual (family), supporting their daily functioning, social status, and inclusion in the community
By type	Simple social services – services consisting of one or several measures necessary for their provision and not involving ongoing or systematic interaction between professionals and the recipient of social services. Simple social services may constitute a component of a comprehensive (complex) service
	Comprehensive (complex) social services – services consisting of a set of measures united by a common objective, within which an individual package of measures is formed depending on the needs of the social service recipient, and which involves continuous and systematic interaction between professionals and the recipient of social services
	Comprehensive specialised social services – services provided to specific categories of social service recipients (people living with HIV, persons with substance dependence, victims of human trafficking, refugees, persons with mental disorders, and others)

Table 4. *Continued*

Characteristics	Types of services
By place of provision	At the recipient's place of residence – at their home
	At the social service provider's facility: ▪ residential (full-time) – with 24-hour stay of the service recipient, including provision of meals and living accommodations; ▪ semi-residential – during a specified period of the day, with facilities for daytime or overnight stay
	At the recipient's location outside their home and the social service provider's premises, including on the street and remotely (online)
By the duration of provision	Emergency (crisis) – provided urgently (within 24 hours) due to circumstances that threaten the life and/or health of the recipient of social services
	Ongoing – provided at least once a month for a period exceeding one year
	Temporary – provided at least once a month for a period of up to one year
	One-time

Source: *developed in accordance with Law of Ukraine No. 2671-VIII (2019)*

Article 16 of Law of Ukraine No. 2671-VIII (2019) defines a list of 18 basic social services, including: home care, day care, supported living, social adaptation, social integration and reintegration, provision of shelter, emergency (crisis) intervention, counselling, social accompaniment, representation of interests, mediation, social prevention, in-kind assistance, physical support, sign language interpretation, care and upbringing of children in family-like settings, support during inclusive education, and mediation. Among the services listed, the most important are home care, day care, supported living, social adaptation and integration, emergency intervention, and mediation. These services combine physical and psychological support, disease prevention, rehabilitative measures, and coordination of access to medical and social resources, forming the foundation for the implementation of integrated care models that provide a comprehensive approach to supporting vulnerable population groups.

Article 16 of the same law also provides for the existence of the Classifier of Social Services of Ukraine, which was developed and approved by Order of the Ministry of Social Policy of Ukraine No. 429 (2020). It supplements the list of the 18 basic social services provided for by the law, offering a brief description of each service, including information on the service recipients, the place of provision, and the duration of service delivery. In particular, the Classifier lists the following social services: information provision, crisis hotline counselling, night shelter, short-term accommodation, transitional supported living, social and labour adaptation, social adaptation for veterans and their families, social accompaniment of families with orphaned children, employment-related social support, residential care, day care for children with disabilities, palliative care, personal assistant services, social rehabilitation for persons with intellectual and mental disorders, socio-psychological rehabilitation, socio-psychological rehabilitation for persons with substance use disorders and gambling disorders, temporary respite for parents of children with disabilities and caregivers of patients or persons with disabilities, transport services, and others. The most important services in the medical and social sector are those that combine physical care, psychological support, and social rehabilitation. These include residential and day care, palliative care, personal assistant services, socio-psychological rehabilitation for various categories of individuals, and crisis support services (crisis hotline counselling, night shelter, short-term and transitional supported living), which provide timely assistance and help prevent social isolation.

The current Classifier primarily groups services by type, although its classification differs from that provided in Article 16 of Law of Ukraine No. 2671-VIII (2019). It also does not refer to medical and social services. In addition, T. Semihina *et al.* (2024) identified a number of other issues inherent in the current Classifier. First, there is duplication in terms of content and categories of recipients: certain social services have similar content and are aimed at the same groups of clients, which complicates their clear differentiation. In particular, practitioners encounter difficulties in differentiating between social reintegration and social adaptation. Furthermore, the structure of the Classifier contains partial duplication, with identical actions being described using different terms across various services. Second, the Classifier is inconvenient for practical use, as access to it is provided only through the relevant order of the Ministry of Social Policy, which complicates the timely work with the document. Third, the logic underlying the structuring of services is unclear and confusing. Even if the developers intended a specific logic, it remains incomprehensible to external users. As a result, the search for a specific service is carried out primarily through contextual search, whereas its position in the classification should be determined logically and intuitively. Thus, the current Classifier of Social Services of Ukraine is characterised by a number of shortcomings that reduce its usability and the effectiveness of its practical application. Based on the analysis of Law of Ukraine No. 2671-VIII (2019) and the Classifier of Social Services (2020), a grouping of social services by service type has been proposed (Table 5).

Table 5. *Classification of social services by type*

Type of services	Example of social services
Care services	Home care
	Day care
	Residential care
	Palliative care
	Supported living for persons with disabilities, older persons, and homeless individuals
	Day care for children with disabilities
	Care and upbringing of children in family-like conditions
	Respite care for parents caring for children with disabilities and for caregivers of seriously ill persons
Support services	Social support for individuals in difficult life circumstances
	Social support for orphans
	Support during inclusive education
	Support in employment and at the workplace
	Personal assistant
	Physical accompaniment
	Representation of interests
	Sign language interpretation
Adaptive and rehabilitation services	Social adaptation, including for veterans and their families
	Social and labour adaptation
	Social integration and reintegration
	Socio-psychological rehabilitation (including for individuals with drug or psychoactive substance dependence and gambling addiction)
	Social rehabilitation of individuals with intellectual and mental disabilities
Crisis and protective services	Emergency (crisis) intervention
	Consultative crisis hotline
	Provision of shelter, including overnight accommodation
	Short-term and transitional housing
Consultation and information services	Counselling
	Information provision
	Social prevention
	Mediation and conflict resolution
Material and household services	In-kind assistance
	Transportation services
	Other social services

Source: *compiled in accordance with the Law of Ukraine No. 2671-VIII (2019) and the Order of the Ministry of Social Policy of Ukraine No. 429 (2020)*

As can be seen from the aforementioned list, current Ukrainian legislation does not distinguish a separate category of "medical and social services". Law of Ukraine No. 2671-VIII (2019), which came into force in Ukraine in 2020, defines basic social services without reference to social and medical services. The new law does not separately define medical and social services as it did previously; however, most of the services provided are directly related to healthcare (Nazar, 2022). This is confirmed by the expanded Classifier of Social Services, approved in 2020.

In this regard, by analysing the list of basic and additional social services provided in the current regulatory legal acts, it is possible to identify those services that are of a medical and social nature, i.e., those that combine social and medical support. Thus, the following can be classified as medical and social services:

- all care-related services (excluding the care and upbringing of children in family-like settings if such children do not require specialised medical assistance). Specifically: home care; day care; residential care; palliative care; supported living for persons with disabilities, the elderly, and homeless individuals; day care for children with disabilities; temporary respite for parents caring for children with disabilities and for caregivers of seriously ill individuals;
- partially support services, namely: assistance during inclusive education (if it is related to medical support); personal assistant services; physical support; and sign language interpretation;
- partially adaptation and rehabilitation services, in particular: social adaptation services for veterans and their families; social rehabilitation for individuals with intellectual and mental disorders; and socio-psychological rehabilitation for persons with substance use or gambling disorders (if such rehabilitation requires medical intervention);
- partially crisis services, in particular emergency (crisis) intervention services that involve the provision of urgent medical care;
- services related to temporary accommodation, specifically the provision of temporary shelter, if such services include medical assistance for the affected individuals, and so on.

Other groups of services, such as advisory and informational services (counselling, information provision,

prevention, mediation, and facilitation), as well as material and household services (in particular, in-kind assistance and transport services), do not fall under medical and social services, as they do not involve a medical component. These services are purely social, informational, legal, educational, or material and household in nature, without medical, rehabilitative, psycho-medical intervention, or palliative elements. The criteria for classifying services as medical and social, based on their content and purpose, are presented in Table 6.

Table 6. *Criteria for classifying medical and social services*

Criteria for classification as medical and social services	Criteria for classification exclusively as social services
Presence of a medical component: health status monitoring, assistance with treatment or care, palliative care, home care, and day care for children with disabilities	Exclusively social in nature: assistance not related to treatment, health care, or rehabilitation
Integration of medical and social interventions: health and social integration issues are addressed simultaneously, including social and psychological rehabilitation, and rehabilitation of individuals with addictions	Educational or developmental focus: learning, development, integration without a medical component
Focus on individuals with disabilities due to health conditions: patients, people with disabilities, and individuals with intellectual or mental impairments	Legal or administrative support: counselling, representation, assistance with documentation, and rights protection without medical care
Support in health-related critical situations: provision of emergency assistance in crises	Economic support: financial assistance, help with job search, without medical care
Involvement of healthcare professionals in service provision: doctors, nurses, psychologists, rehabilitation specialists, and others are engaged in the process	Household support: provision of housing, childcare without a medical component, transportation services, and the like

Source: *developed by the authors*

Thus, medical and social services are services in which at least one of the following components is mandatory: a medical component (involvement of healthcare professionals, medical supervision, interaction with the healthcare system); care and health support (medication administration, feeding, adherence to routines, monitoring of health status); a rehabilitation component (rehabilitation equipment, physical, social, psychological, or occupational rehabilitation); palliative and hospice care (pain management, care in terminal conditions, end-of-life care, psychological and spiritual support); psychological support (work with individuals with intellectual or mental disorders, or various types of dependency); or facilitation of access to medical services (accompaniment to a doctor, transportation to healthcare facilities, assistance with medical examinations or check-ups), among others.

Medical and social services are those that lie at the "intersection" of medicine and the social sector: they help not only to treat or provide care, but also to integrate the individual into society and support their daily functioning. Thus, medical and social services combine social support with healthcare, rehabilitation, or psychological assistance, whereas social services are limited to legal, household, educational, or social support without the involvement of medical care. This division of services is rather conditional; other services can also be classified as medical and social, provided that they meet the criteria outlined above.

Therefore, medical and social services should be understood as a set of services aimed at supporting the health and social well-being of individuals who require assistance due to their health status, age, or other life circumstances. They include medical care, social support, and counselling aimed at preserving, restoring, and improving quality of life. These services encompass both a medical component (physician consultations, diagnostics, treatment, rehabilitation, as well as the organisation of medical care and provision of medications) and a social component (assistance with household matters, support in social adaptation, representation of interests, psychological support, social protection counselling, and others). Such services are intended for older adults, persons with disabilities, individuals with chronic illnesses, as well as those facing difficult life circumstances and other vulnerable population groups. Medical and social services can be provided in residential facilities, at the patient's home, as well as in specialised centres.

Discussion

The ideas of implementing integrated care are highly relevant for Ukraine, where the medical and social sectors still operate largely independently. The implementation of an integrated approach to the provision of medical and social services at the level of hospital districts and social service centres can contribute to: the creation of a unified patient pathway ("medical care – social support"); improved coordination between institutions of different types; and a stronger focus of the system on the needs of the individual. The integration of medical and social services will improve the quality and accessibility of service delivery, increase patient satisfaction, and ensure the efficient use of resources through interprofessional collaboration and joint planning. Integrated services ensure quality of care, interprofessional teamwork, patient-centeredness, transparent management, and outcome-based learning (Minkman *et al.*, 2025).

At the same time, there are certain reservations regarding the integration of medical and social services. A report prepared by E. Nolte & E. Pitchforth (2014) showed that although integrated care models generally improve the quality of medical services, treatment outcomes, and patient satisfaction, the evidence of their cost-effectiveness is poor and inconclusive. This indicates the need to review

the definitions of integrated care and the approaches to evaluating these complex strategies. The report emphasises that the lack of high-quality and methodologically sound assessments is the main obstacle to drawing reliable conclusions regarding the economic impact of integrated care. The authors emphasised the need for more comprehensive and long-term studies with clear definitions to provide an adequate basis for policymaking regarding the integration of such services. The same view is reflected in the study by M. Strandberg-Larsen (2011). He examined the provision of integrated medical services in Denmark and compared the results with those in the United States. He noted that integration remains a challenge at the national level in Denmark, and only half or fewer of the patients in need of integrated services actually receive them. The absence of a unified evaluation methodology complicates the monitoring of integration progress at different levels of the healthcare system.

Furthermore, several studies indicate that integration does not always yield immediate or expected results. In particular, S. Mercer *et al.* (2021) summarise the findings of a study conducted in England, which included interviews with key stakeholders (general practitioners, nurses, social workers, government representatives, charity organisations, patients, and caregivers) regarding the facilitators and barriers to the integration of primary medical care and social support. The authors concluded that although the healthcare and social services integration is necessary to meet the growing needs of the population, its implementation in practice faces numerous obstacles – ranging from structural and legal to staffing and technological challenges. The authors emphasised that even countries that have long implemented structural integration (Northern Ireland, Wales, Scotland) experience slow progress, demonstrating that structural changes alone do not guarantee success. They paid particular attention to the socio-economic inequality of communities – the poorer the community, the worse their access to medical and social care, and the integration of services in such regions is especially challenging. The researchers also warned about the risks of a "pilot approach", that is, implementing numerous short-term projects without proper evaluation of their outcomes. They emphasised the need for a scientifically grounded, large-scale approach to integration, which would allow the adaptation of the best international practices to national conditions. Integration policy should be based on a systemic approach, the collection of reliable data, careful evaluation of program effectiveness, and international cooperation. Only a comprehensive, systemic approach, rather than isolated local initiatives, can truly facilitate the implementation of integration reform.

R. Miller *et al.* (2021) examined the outcomes of a decade of development in the integrated health and social care system in England following the major reforms of the 2010s. The authors analysed how the idea of integrating the resources of the healthcare system and local social services has evolved from a political concept into a real practice of public health management. Alongside the positive changes, the authors identified key challenges of integration, including differences in funding and regulatory frameworks between the healthcare and social care sectors; difficulties in measuring integration outcomes due to the absence of a unified evaluation system; a lack of shared digital patient record systems; and inequalities in access to services across regions, among others. It was also observed that government attention was largely focused on the healthcare sector, while social services, particularly care homes for older people, faced shortages of funding, protective equipment, and highly qualified staff, among other needs. The lack of funding in the social sector resulted in social services remaining institutionally weaker compared to the National Health Service. As a result, the authors concluded that integration delivers the best outcomes when it is focused on specific problems and guided by clear objectives and measurable results. England experienced varying levels of success across regions. The most effective integration occurred where there were strong local leaders, active local authorities, and good coordination of actions.

L. Thomson & H. Chatterjee (2024), examining the provision of integrated services in the United Kingdom, noted that Integrated Care Systems were formally given a legislative basis in April 2022, although the idea of integrated care itself had been actively promoted for more than sixty years. Over more than a decade, the National Health Service in England implemented three national pilot programmes of integrated care. Although these pilot projects achieved some successes, they had little impact on reducing hospital admissions. As a result of the study, the authors identified the following barriers to integration: a weak evidence base, non-standardised evaluation methods, limited evidence of cost-effectiveness, and uncertainty regarding the impact on reducing hospital admissions. Although integrated care has significant potential to increase patient satisfaction, improve access to services, and strengthen a person-centred orientation of the system, evidence of cost reduction and the achievement of systemic effects remains limited.

In view of this, it is advisable in Ukraine to allow communities the flexibility to adapt integration models to their own conditions, taking into account local infrastructure, workforce capacity, and the specific needs of the community's population. It is also unrealistic to expect rapid changes across the entire country. Integration reforms require time, resources, training, and the establishment of new managerial and legal structures. It is also important to avoid overloading reforms with too many initiatives at once, so as not to create confusion or a disconnect from practice. The experience of foreign countries is valuable for Ukraine's health care and social protection reforms. In the context of decentralisation, Ukraine can adapt this experience by establishing unified centres for the provision of health and social services within communities, developing joint financing and management across sectors, building digital systems for intersectoral data exchange, and orienting policies toward the comprehensive needs of individuals rather than those of specific agencies. The success of

integration depends not only on laws and structures but above all on a shared vision and partnership among all system participants: healthcare professionals, social workers, administrators, and the citizens themselves.

Conclusions

The integration of health and social services is a global trend in healthcare and social protection, aimed at improving the efficiency of service delivery, ensuring continuity of care, and addressing patients' needs comprehensively, particularly for those with chronic illnesses, disabilities, or complex health and social care requirements. The literature review revealed the multifaceted nature of integration approaches, including organisational, clinical, functional, financial, informational, and intersectoral integration. At the same time, different countries employ specific models of integrated care, such as "managed care" in the United States, "shared care" in the United Kingdom, and "transmural care" in the Netherlands.

The concept of "health and social services" is not officially defined in legal and regulatory acts in Ukrainian practice. Instead, the term "integrated social services" is used, which combines social and medical components, particularly in the context of rehabilitation and support for people with disabilities. An analysis of Ukraine's legal and regulatory acts revealed the absence of a clear definition for "health and social service" and the limited use of this term in legislation, which complicates the development of state programs and policies for the provision of integrated services.

Criteria have been proposed to distinguish health and social services from other service categories, which will enable a systematic approach to their planning, financing, and coordination. Specifically, the criteria for classifying services as health and social services include: the presence of a medical component in their provision (such as health monitoring, assistance with treatment or care, palliative care, home care, or daytime care for children with disabilities); the combination of medical and social interventions, addressing both health issues and social integration (including social, psychological, and rehabilitative support, as well as assistance for individuals with addictions); a focus on people with limited capabilities due to health conditions (patients, persons with disabilities, or those with intellectual or mental impairments); provision of support in critical health-related situations (emergency assistance in crises); and the involvement of medical professionals in service delivery (doctors, nurses, psychologists, rehabilitation specialists, etc.).

International experience confirms that the integration of health and social services improves the quality of care, service accessibility, patient satisfaction, and the efficiency of resource use. At the same time, its implementation requires overcoming structural, workforce, technological, and financial barriers. Taking international experience into account and adapting it to Ukrainian conditions lays the groundwork for creating a comprehensive system of health and social services that is user-centred and aimed at providing integrated care, fostering intersectoral collaboration, and ensuring the sustainable development of the healthcare and social protection system.

Future research prospects in the field of health and social service integration in Ukraine may focus on developing comprehensive approaches to the legal and regulatory framework, including the clear definition of terminology and service categories. It is necessary to study models of institutional support for the provision of health and social services that ensure effective coordination between healthcare authorities, social protection agencies, and the civil sector. Furthermore, an important direction is the development of a strategic document or national strategy for the provision of health and social services, which would define priorities, quality standards, financing mechanisms, and criteria for evaluating the effectiveness of integrated care. Such research will provide a scientifically grounded basis for the implementation of a health and social services system in Ukraine, ensure the sustainable development of intersectoral collaboration, and improve the quality, accessibility, and comprehensiveness of care for patients with diverse health and social needs.

Acknowledgements

None.

Funding

The study was not funded.

Conflict of Interest

None.

References

[1] Collins, M., Mazzei, M., Baker, R., Morton, A., Frith, L., Syrett, K., Leak, P., & Donaldson, C. (2023). Developing a combined framework for priority setting in integrated health and social care systems. *BMC Health Services Research*, 23(1), article number 901. doi: 10.1186/s12913-023-09866-x.

[2] Curry, N., & Ham, C. (2010). *Clinical and service integration: The route to improved outcomes*. London: The King's Fund.

[3] Dobbins, M.I., Thomas, S.A., Melton, S.L., & Lee, S. (2016). Integrated care and the evolution of the multidisciplinary team. *Primary Care*, 43(2), 177-190. doi: 10.1016/j.pop.2016.01.003.

[4] Goodwin, N. (2013). Understanding integrated care: A complex process, a fundamental principle. *International Journal of Integrated Care*, 13, article number e011. doi: 10.5334/ijic.1144.

[5] Kodner, D.L. (2009). All together now: A conceptual exploration of integrated care. *Healthcare Quarterly*, 13, 6-15. doi: 10.12927/hcq.2009.21091.

[6] Law of Ukraine No. 2168-VIII "On State Financial Guarantees of Medical Services to the Population". (2017, October). Retrieved from https://zakon.rada.gov.ua/laws/show/2168-19#Text.
[7] Law of Ukraine No. 2671-VIII "On Social Services." (2019, January). Retrieved from https://zakon.rada.gov.ua/laws/show/2671-19#Text.
[8] Law of Ukraine No. 2801-XII "Fundamentals of the Legislation of Ukraine on Health Care". (1992, November). Retrieved from https://zakon.rada.gov.ua/laws/show/2801-12#Text.
[9] Law of Ukraine No. 966-IV "On Social Services." (2003, June). Retrieved from https://zakon.rada.gov.ua/laws/show/966-15#Text.
[10] Leutz, W.N. (1999). Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom. *Milbank Quarterly*, 77(1), 77-110. doi: 10.1111/1468-0009.00125.
[11] Matos, C.R., Nascimento, G., Fernandes, C.A., & Matos, C. (2025). Health and social care integration: Insights from international implementation cases. *Journal of Market Access and Health Policy*, 13, article number 28. doi: 10.3390/jmahp13020028.
[12] Mercer, S., Henderson, D., Huang, H., Donaghy, E., Stewart, E., Guthrie, B., & Wang, H. (2021). Integration of health and social care: Necessary but challenging for all. *British Journal of General Practice*, 71(711), 442-443. doi: 10.3399/bjgp21x717101.
[13] Miller, R., Glasby, J., & Dickinson, H. (2021). Integrated health and social care in England: Ten years on. *International Journal of Integrated Care*, 21(S2), article number 6.
[14] Minkman, M.M.N., Zonneveld, N., Hulsebos, K., van der Spoel, M., & Ettema, R. (2025). The renewed development model for integrated care: A systematic review and model update. *BMC Health Services Research*, 25(1), article number 434. doi: 10.1186/s12913-025-12610-2.
[15] Nazar, N.I. (2022). *Development of social work in the field of health in Canada and Ukraine: A comparative analysis*. (Doctoral thesis, Lviv Polytechnic National University, Lviv, Ukraine).
[16] Nolte, E., & Pitchforth, E. (2014). *What is the evidence on the economic impacts of integrated care?* Copenhagen: World Health Organization.
[17] Order of the Ministry of Health of Ukraine No. 67 "Temporary Sectoral Classifier of Medical Procedures (Services) and Surgical Operations". (2007, February). Retrieved from https://www.dec.gov.ua/wp-content/uploads/2019/12/2007_67_klasifikator_mp_xo.pdf.
[18] Order of the Ministry of Social Policy of Ukraine No. 282 "On Approval of the Methodological Recommendations for the Implementation of the Integrated Social Protection System". (2019, February). Retrieved from https://old.msp.gov.ua/files/deinst/metod/282.pdf.
[19] Order of the Ministry of Social Policy of Ukraine No. 429 "On the Approval of the Classifier of Social Services" (2020, June). Retrieved from https://zakon.rada.gov.ua/laws/show/z0643-20#Text.
[20] Semihina, T., Slozanska, H., & Stolyaryk, O. (2024). *Classification and standardization of social services: International and Ukrainian experience*. Kyiv: UNDP.
[21] Shaw, S., Rosen, R., & Rumbold, B. (2011). *What is integrated care? Research report*. London: Nuffield Trust.
[22] Shuftan, N., Scarpetti, G., Polin, K., Kasekamp, K., Behmane, D., Murauskiene, L., & Struckmann, V. (2025). Integrated care in the Baltic countries over a five-year period: An expert-informed cross-country analysis of progress, challenges, and future directions. *Health Policy*. doi: 10.1016/j.healthpol.2025.105526.
[23] Simpson, G., Entwistle, C., Short, A.D., Morciano, M., & Stokes, J. (2023). A typology of integrated care policies in the care home sector: A policy document analysis. *Frontiers in Public Health*, 11, article number 943351. doi: 10.3389/fpubh.2023.943351.
[24] State Statistics Service of Ukraine. (2010). *Classification of types of economic activity (KVED-2010)*. Retrieved from https://kved.ukrstat.gov.ua/KVED2010/SECT/KVED10_Q.html.
[25] Strandberg-Larsen, M. (2011). Measuring integrated care. *Danish Medical Bulletin*, 58(2), article number B4245.
[26] Thomson, L.J.M., & Chatterjee, H.J. (2024). Barriers and enablers of integrated care in the UK: A rapid evidence review of review articles and grey literature 2018-2022. *Frontiers in Public Health*, 11, article number 1286479. doi: 10.3389/fpubh.2023.1286479.
[27] Yeremenko, I. (2025). *Modern approaches to the implementation of integrated social services at the community level*. Retrieved from https://www.unicef.org/ukraine/media/36691/file/Unicef Integrated%20social%20services.pdf.
[28] Yordanov, D., Oxholm, A.S., Prætorius, T., & Kristensen, S.R. (2024). Financial incentives for integrated care: A scoping review and lessons for evidence-based design. *Health Policy,* 141, article number 104995. doi: 10.1016/j.healthpol.2024.104995.
[29] Yukalo, M.V. (2025). *Development of mechanisms of public administration of healthcare services for the population of Ukraine on the basis of an integration approach*. (Doctoral thesis, Lviv Polytechnic National University, Lviv, Ukraine).

Публічна політика в сфері інтеграції медичних та соціальних послуг

Ольга Федорчак
Доктор наук з державного управління, професор
Інститут адміністрування, державного управління та професійного розвитку
Національного університету «Львівська політехніка»
79491, вул. Василя Сухомлинського, 16, м. Брюховичі, Україна
https://orcid.org/0000-0001-9965-5135
Юрій Шипов
Аспірант
Інститут адміністрування, державного управління та професійного розвитку
Національного університету «Львівська політехніка»
79491, вул. Василя Сухомлинського, 16, м. Брюховичі, Україна
https://orcid.org/0009-0004-0862-1984

Анотація. В умовах сучасної війни та трансформації систем охорони здоров'я та соціального захисту в Україні постає необхідність формування цілісної моделі інтегрованої допомоги, яка забезпечує безперервність, комплексність та орієнтованість на потреби людини. Метою дослідження було обґрунтувати доцільність інтеграції медичних і соціальних послуг та визначити ключові напрями формування публічної політики щодо впровадження такого виду допомоги на основі аналізу міжнародного досвіду. Методологічну основу становили порівняльний аналіз різних моделей інтеграції, контент-аналіз українських нормативно-правових актів, системний підхід до інтерпретації даних щодо організації надання медико-соціальних послуг. У результаті аналізу міжнародних практик виокремлено різні види інтеграції, представлені в науковій літературі: організаційну, функціональну, клінічну, професійну, нормативну, фінансову, інформаційну, секторальну, міжсекторальну, міжнародну, горизонтальну та вертикальну, а також інтеграцію послуг й інтеграцію, орієнтовану на пацієнта. Доведено, що інтеграція медичних і соціальних послуг сприяє підвищенню якості та доступності допомоги, задоволеності пацієнтів, забезпечує ефективніше використання ресурсів, посилює взаємодію між секторами та підтримує розвиток мультидисциплінарної співпраці. У цьому дослідженні було систематизовано сучасні підходи до інтеграції медичних і соціальних послуг, уточненні термінологічні засади, а також розроблені критерії визначення медико-соціальних послуг та їх застосування в українському контексті. Практичне значення отриманих результатів полягає у можливості їх використання для формування публічної політики у сфері інтегрованої допомоги, удосконалення державних програм, нормативного забезпечення й управлінських рішень у сферах охорони здоров'я та соціального захисту

Ключові слова: державне управління; охорона здоров'я; соціальна політика; інтегрована допомога; міжсекторальна співпраця; міжнародний досвід