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Conceptualising service integration for inclusive activation: Exploring transferal and translation of models from health care

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Abstract

Conceptual frameworks are important for advancing systematic understanding in a field of research. Many conceptual models have been developed to study service integration, but few have addressed activation. Based on an outline of the literature on the integration of labour market services, we explored two complementary conceptual models from integrated care and assessed whether the models could be transferred to the context of inclusive activation. The transferral of conceptual models is contingent upon whether the significant features of inclusive activation are like those of health care, and whether barriers to integrated labour market services are considered. We argue that the models facilitate a more analytical focus on service integration. Nevertheless, the models must be adjusted to account for the significant position of workplaces and employers, the importance of frontline professionals' knowledge base, the co-production of service provision and the values characterising the service encounters.

KEYWORDS

complex problems, conceptual models, employment, health care, inclusive activation, integrated services

INTRODUCTION

Over the past two decades, European employment policies have increasingly focused on the activation and integration of people with complex problems into the labour market (van Berkel, Caswell, et al., 2017). More recent activation reforms have been characterised by an increased focus on the improvement of the delivery of activation services, including reforms aimed at strengthening the cooperation/integration between service providers (Champion & Bonoli, 2011; Heidenreich & Rice, 2016b; Minas, 2014; Moreira & Lødemel, 2014, pp. 2–3). For people with complex problems, employment services often need to be provided in coordination with a variety of social, educational or health care services (Heidenreich & Aurich-Beerheide, 2014; Heidenreich & Graziano, 2014; Heidenreich & Rice, 2016b). Hence, the issue of service integration must be addressed, and in doing so, conceptual models can be helpful. Conceptual frameworks are important for advancing systematic understanding in a field of research. Nevertheless, in the context of activation, the questions of what service integration means and how service integration can be developed effectively have hardly been addressed. This sharply contrasts with the field of health services research, where many conceptual frameworks for integrated care have

been developed to enhance systematic understanding of the design, delivery, management and evaluation of integrated services (e.g., Amelung et al., 2017; Busetto et al., 2016; Fisher & Elnitsky, 2012; Kodner & Spreeuwenberg, 2002; Minkman, Ahaus, Fabbricotti, et al., 2009; Minkman, Ahaus, & Huijsman, 2009; Valentijn et al., 2013; WHO, 2016).

The expansion of the political goals of labour market participation to include more disadvantaged citizens implies that the support system has to manage problems beyond joblessness, such as health issues, school dropout, homelessness and substance use disorders. Such issues must be addressed within a web of multiple welfare sectors, services and professionals (Heidenreich & Aurich-Beerheide, 2014). Service integration within health care and social services has addressed chronic health conditions, mental illness, disability and problems such as homelessness or substance use disorders (Winters et al., 2016), which are typically also problems experienced by citizens in inclusive activation. The circumstances of these citizens in inclusive activation are very similar those of citizens who seem to benefit most from integrated care. In fact, the addressed populations largely overlap.

Consider the imaginary (but illustrative) case of a young woman, Catherine, aged 18, from a socioeconomically deprived lone-parent family, who left school early without a diploma due to mental health problems. Catherine is at risk of not being in work, education or training, a situation that is commonly referred to as NEET in the policy discourse. Comparative studies have showed that NEET status is strongly related to low educational attainment. Also, the incidence of poor health was much higher among NEETs than among youth in general (Carcillo et al., 2015). In this case, Catherine is not motivated to go back to school, and due to financial strain and crowded housing conditions, her mother insists that Catherine get a job and find her own place to live. However, getting a job has proven difficult due to Catherine's low qualifications. Moreover, the jobs Catherine is qualified for have been hard to keep due to her problems with anxiety and depression, leaving her in a situation of resignation and in need of public benefits to make ends meet. This is a typical case within the employment service system, where multiple services are needed to reengage Catherine back into education or work to prevent the risk of long-term 'scarring' effects (i.e., the permanent reduction of future employment and earnings potential; Carcillo et al., 2015, p. 9).

Given that conceptual frameworks and models could enhance our understanding of what it takes to develop integrated services, a pertinent question was whether conceptual frameworks for integrated care can be transferred and adapted to the field of activation. If such a transferral is possible, the field of activation would benefit from the extensive work of conceptualising integrated care that has been undertaken in health services research. Our assumption was that, at a conceptual level, the underlying elements involved in organising integrated services in inclusive activation were similar to those in the field of health care, especially when considering that the target groups are people with complex and intersecting problems. The ultimate aim of such models, irrespective of the field, is the development of a holistic approach to the whole-life situations of service users or patients.

IMPORTANCE OF UNDERSTANDING THE PROBLEM TO BE APPROACHED

Whether the transferral of conceptual models from one field to another is appropriate is premised on a certain degree of similarity between the two fields. While active labour market policies (ALMPs) have spread throughout OECD countries with the aim of getting citizens off (passive) benefits and into employment, countries vary in the profiles of their ALMPs or activation approaches due to, among other factors, path dependencies or the contingencies of established welfare regimes (Armingeon, 2007; Champion & Bonoli, 2011).

A widely used distinction is that between demanding workfare or work-first approaches on the one hand and human capital investment (development) or enabling approaches on the other (Barbier, 2004; Bonoli, 2010; Brodkin & Marston, 2013; Dingeldey, 2007; Lødemel & Moreira, 2014). Broadly speaking, demanding approaches mean imposing job searches, thereby forcing unemployed citizens to take up (any kind of) employment; such approaches are underpinned by incentives (at the level of benefits) and conditionality (where benefits are dependent on activation). In contrast, human capital approaches aim to improve long-term employability through improved education, skills, health and personal development (Lindsay et al., 2007). Such enabling activation approaches mean vocational rehabilitation, skills training and work experience are provided and integrated with social care, education and health services.

The two activation approaches are based on different underlying understandings of the problem to be addressed. Demanding policies imply that the problem is the jobless individuals' lack of motivation to gain employment. Hence, incentives and sanctions are thought to be sufficient, whereas services and service integration are considered irrelevant. In contrast, enabling policies consider the problems to be related to barriers such as low qualifications, housing conditions, childcare, mental health issues or indebtedness, rather than unwillingness

to work (Heidenreich & Aurich-Beerheide, 2014). In enabling policies, multiple interlinked interventions from a variety of services are necessary to remove hindrances and enable citizens with complex problems to (re)enter the labour market. Thus, many types of services are involved. Hence, only for enabling activation approaches is the issue of service integration crucial and indeed relevant at all. Our discussion in this article is therefore only relevant for activation policies that rely mostly on enabling elements, which we, together with Heidenreich and Aurich-Beerheide (2014), term 'inclusive' because they include groups with complex problems, and not only those close to the labour market.

When applied to specific service areas, generic conceptual models (such as the ones investigated here) must be translated and adjusted. One important premise to bear in mind, though, is that conceptual frameworks do not aim to mirror the actual world of services; rather, conceptual models are abstracted, ideal expressions of dimensions or aspects that must be considered by researchers who aim to analytically understand and assess integrated services, as well as the practitioners who aim to develop them.

In the following sections, we first present the relevant literature on the activation and integration of labour market services concerning multiple stakeholders or relationships. We outline three kinds of relationships: that between the sectors and services involved, the relationship to employers and finally, the relationship to service users. Thereafter, we introduce two conceptual frameworks from integrated care. Finally, we explore the models' relevance and transferability. First, we assessed whether the elements of the models were equally relevant to inclusive activation as they are to health care. Second, our discussion centres on whether the significant features of inclusive activation are like those of health care by considering the relevant literature.

RESEARCH ON THE MULTIPLE STAKEHOLDERS INVOLVED IN INCLUSIVE ACTIVATION SERVICES

Heidenreich and Rice (2016b) conceptualised inclusive activation within a governance context in which the need for coordination appears across three dimensions: multi-level (i.e., local, regional, central and even trans-national), multi-dimensional (including services beyond classic employment services and crossing the boundaries of policy sectors) and multi-stakeholder (i.e., public, private and third-sector organisations). To some extent, this complexity can be attributed to policies of marketisation regarding employment services (Bredgaard & Larsen, 2007; van Berkel et al., 2012), resulting in the delivery of activation programmes being contracted out to for-profit and/or non-profit service providers. Heidenreich and Rice (2016a) thus emphasised that multi-stakeholder integration can be challenging because the stakeholders may treat activation services differently based on whether they are viewed as a legal right or obligation (in public services), as an offer to deprived community members (in third-sector organisations), or as a commodity (in private service deliverers).

Sectors and services involved

The implementation of integrated labour market services is conditioned by a range of barriers and enablers. Lindsay et al. (2008) showed that the necessary requirements for partnerships or integration involved a clear strategic focus based on the necessity for interagency cooperation and institutional arrangements (e.g., flexible funding), the commitment of necessary stakeholders, shared ownership, the complementarity of organisational resources and areas of expertise to maximise the benefits. Furthermore, Lindsay et al. (2008) also included trust and mutualism rather than demands of contract agreements, flexibility in resource-sharing and, last but not least, an outcome-oriented focus (p. 720). A barrier to partnership may be overreliance on contractualism and centralised organisational structures that may undermine partnership-based approaches and constrain the ability of partnerships to respond to the needs of the service users and local communities (Lindsay et al., 2008, pp. 728–729). The integration and coordination of labour market services may be challenged by cost-savings and outcome-focused strategies that do not make the service user a source of coordination and leave the coordination of services to purchasers through contracts (Fuertes et al., 2014). McQuaid (2010) pointed to potential problems and barriers of such partnerships, including problems of accountability and organisational difficulties (including differing missions, professional orientations, legal regulations or technological capacities), the external political environment and bureaucratic politics (p. 135). McQuaid (2010) also mentioned a lack of community capacity, differences in the philosophies among the involved actors and issues in handling differences in power relations (pp. 135–136). Also, local conditions may determine how activation-related services are coordinated in practice (Zimmermann et al., 2016). Specific factors tied to local conditions, such as geographical proximity, longstanding coordination structures or policies, regional governance structures, political strategies and conflict, informal relations and individual commitment, may explain inter-country differences in the coordination of policy areas, levels and stakeholders (Zimmermann et al., 2016, p. 259).

The tasks of frontline or activation workers differ from country to country, and even within countries. Some undertake long-term follow-up with citizens and their (potential) employers. Others only assess citizens' work capabilities and thereafter refer citizens to activation programmes of varying degrees of standardisation or tailor-made support delivered by external service providers. These differences are due to the variations in policies described above, but also to the governance and management instruments applied by the organisations in which frontline workers are employed (van Berkel & Van Der Aa, 2012).

There is no consensus as to whether activation work should be seen as a professional occupation or as mere policy programme administration with a rule-oriented administrative function (van Berkel & Van Der Aa, 2012). Furthermore, activation workers in different countries have various educational and occupational profiles and backgrounds, and no systematic data are available comparing the types or levels of professional training attained (van Berkel & Knies, 2016). Social workers have, however, played a stronger role in the delivery of activation in the Nordic countries than in, for example, the United Kingdom, Australia or the Netherlands (van Ewijk, 2009). Nothdurfter (2016, p. 426) argued that social work, with its history of dealing with the ambiguities and impositions of social policies and the task of assessing individuals' complex situations and needs, is suitable for activation work. Activation workers, nonetheless, lack many of the criteria of a profession, such as an officially recognised body of knowledge to guide professional decision making, a vocational association, accredited training and education programmes and a code of ethics (Sainsbury, 2008, p. 336; van Berkel et al., 2010). Dutch activation workers, for example, have been characterised as 'professionals without a profession' (van Berkel et al., 2010, p. 447). Still, activation workers are often expected to act in a professional way and have considerable room for discretionary decision making. Accordingly, it has been argued that the lack of institutionalised training can jeopardise the transparency of workers' professional autonomy and discretion (van Berkel & Van Der Aa, 2012, p. 449).

Role of employers

Since the goal of a work inclusion process is employment, success depends on employers' motivation to adjust workplaces and work tasks (and perhaps their perceptions of the ideal employee) to enable the full labour market participation of people with complex needs. Recently, activation policies have shifted from an almost complete focus on supply-side approaches, which are aimed at investment in the human capital of jobless individuals, towards more demand-side approaches involving businesses and employers in actual activation work (Bredgaard, 2018; Ingold, 2018; Van der Aa & van Berkel, 2014; van Gestel et al., 2019). Further, a shift from 'train-place' to 'place-train' models involves a focus on vocational rehabilitation and training after job placement in combination with employment, rather than providing such services in a sequential process (Frøyland et al., 2019). Supported employment approaches imply that employers are actively involved in inclusion work and that workplaces are arenas for improving employability (van Berkel, Ingold, et al., 2017).

Relationships to service users

The provision of an activation service is not a one-way service delivery, but is partly co-produced by the citizen. While there are numerous definitions of co-production, as we understand it here, this concept is an essential and *intrinsic* feature of service provision, which is necessary for users to gain value from those services (Alford, 1998; Osborne & Strokosch, 2013; Radnor et al., 2014; Whitaker, 1980). Co-production in this sense plays a prominent role in human services, where 'delivering' services means helping the individual to make the desired changes (Alford, 2016; Whitaker, 1980). Rather than creating value for the user, service providers can only offer a 'promise' whose realisation depends on the users' willingness and motivation to invest some of their own time and effort (Osborne, 2018; Osborne et al., 2016; Osborne & Strokosch, 2013; Radnor et al., 2014). Inclusive activation entails helping labour market marginalised service users enter employment, for example, through vocational rehabilitation, training, schooling or education, often in combination with physical rehabilitation, mental recovery or addiction treatment; accordingly, such a process requires the active participation (co-production) of the users themselves. Returning to Catherine's case, enabling employment services can provide her with access to activation programmes, skills training and work experience to enhance her 'job readiness', employability and attractiveness to employers. However, the desired outcomes require co-production in the form of active involvement and realisation.

Many studies have demonstrated how employment policy interventions are always enacted in concrete, contingent and negotiated interactions between professionals, unemployed individuals and the contexts in which they are part (Dall & Danneris, 2019). Explorative research has shown the importance of citizens' active agency to achieve job success. However, this agency is

not only about the inner motivations and attitudes of the citizen, but is also co-produced with frontline workers. In this relationship, being given a choice, having influence over the process and co-designing the process with the frontline worker are important factors that determine success (Danneris & Caswell, 2019, p. 623). For the service providers, the job is not only to make Catherine and other citizens in similar situations 'job ready', but to also motivate those who may feel hopelessness and resignation when attempting to engage in the work (re) integration process (Håvold, 2018). Relational work is an important factor in inclusive activation, with frontline workers' responsiveness and respect being core values (Danneris & Caswell, 2019, p. 626; Wright, 2016). Conditionality and sanctions, which may also be coupled with inclusive activation, can interfere in the sensitive relationship between frontline workers and service users.

Conditionality 'enforces' citizens to participate in activation work if they want to be entitled to the benefits upon which they may depend to be able to make ends meet. While studies have found positive effects of the use of sanctions or sanction warnings for some clients (van Berkel & Van Der Aa, 2012), for disadvantaged jobless groups, such as disabled people, sanctions have either no effect or a negative one on employment outcomes and can instead lead to destitution and adversely affect mental health (Dwyer et al., 2020; Geiger, 2017; Williams, 2021).

Behaviour conditionality places service under pressure, overseeing and assessing whether service users meet behavioural standards, and affects vulnerable jobseekers most, but context characteristics impact frontline workers' practices at the street level (van Berkel, 2020). Studies from Scandinavia, where enabling approaches are most prevalent, nonetheless have showed that while the implementation of conditionality may be bureaucratic and primarily concerned with procedures and regulations, it may also be client sensitive, involving interpersonal relational considerations of the clients' responsibility and the potential impact of activity requirements; such implementation may also be justified by professional norms and values (Caswell & Høybye-Mortensen, 2015; Gjersøe et al., 2020; Sadeghi & Terum, 2020; Torsvik et al., 2022). Even in the context of contracted-out welfare-to work programmes with a highly coercive potential, normative judgements on the needs and circumstances of harder-to-place citizens have been found to influence street-level workers' decisions on whether to put pressure on citizens (Kaufman, 2020).

Hence, the controlling dimension related to (the underlying threat) of conditionality and its potential trust-breaching impact depends on the quality of the services delivered and whether the frontline workers' implementation practices are caring or demanding.

In the following section, we introduce two conceptual frameworks from integrated care, followed by an exploration of their relevance and transferability to inclusive activation.

CONCEPTUAL FRAMEWORKS FROM INTEGRATED CARE

When considering the usefulness and transferability of models from integrated care to inclusive activation, we could not assess the excessive number of models in their entirety. We had to select a limited number of models, but no systematic overview existed upon which this selection could be based. Some models are designed to grasp distinctions between different forms and degrees of integration, such as horizontal and vertical integration (Axelsson & Axelsson, 2006), or along a continuum from full segregation to full integration (Ahgren & Axelsson, 2005). Some models focus on specific groups of citizens, such as people with chronic conditions (e.g., the Chronic Care Model; WHO, 2016). Other models concentrate on specific types of integration, such as inter-professional collaboration (Willumsen et al., 2012), and some categorise strategies and types of interventions aimed at developing service integration (Antunes & Moreira, 2011; Kodner & Spreeuwenberg, 2002). Furthermore, some models are aimed at enabling the measurement or evaluation of service integration (Browne et al., 2007; Singer et al., 2011), while others are intended to more broadly describe the totality of the dimensions involved in integrated service development (Busetto et al., 2016; Minkman, 2012; Valentijn et al., 2013).

From this variety of models, in the first step, we selected two based on the following criteria: (a) they had to be generic and not focused on certain diagnoses or user groups; and (b) they had to account for the complexity of service integration, (c) be validated and (d) have been applied in several integrated care practices across country contexts and welfare regimes. The chosen models are the Rainbow Model of Integrated Care (RMIC), initially developed by Valentijn et al. (2013), and the Development Model of Integrated Care (DMIC), which was conceptualised by Minkman and colleagues (Minkman, 2012; Minkman, Ahaus, Fabbricotti, et al., 2009; Minkman et al., 2007, 2011; Minkman, Ahaus, & Huijsman, 2009). The models (Minkman, Ahaus, & Huijsman, 2009; Valentijn et al., 2013) have both been highlighted as formal analytical frameworks that seek to advance the systematic understanding of integrated care (Nolte, 2017, p. 27) and have been internationally recommended and adopted in multiple countries (e.g., Longpré & Dubois, 2015).

TABLE 1 Main features of the RMIC and the DMIC

Conceptual model from integrated care	Significant features
The Rainbow Model of Integrated Care (RMIC)	
Scope	
Person-focused	• Generic
Population-based	• Applicable across contexts
	• Validated
Type	• Accounting for the complexity of service integration
Clinical integration	• Barriers/facilitators to integrated services
Professional integration	• Multilevel and multi-dimensional
Organisational integration	• Degree of integration
System integration	
Enablers	
Functional	
Normative	
The Development Model for Integrated Care (DMIC)	
Nine clusters (with 89 generic elements) following four non-linear dynamic development phases:	
Quality of care	• Generic
Performance management	• Applicable across contexts
Inter-professional teamwork	• Validated
Delivery systems	• Accounting for the complexity of service integration
Roles and tasks	• Quality management tool
Patient- or person-centredness	• Process, concrete activities and phases
Commitment	
Transparent entrepreneurship	
Result-focused learning	

The models each have specific characteristics and advantages that help to provide a more systematic understanding of what service integration means and how it can be developed.

The models have supported practices of developing more focused plans for implementation, and the DMIC is being used as a self-evaluation instrument by more than 500 diverse practices/networks; it is also available as a self-evaluation questionnaire. Furthermore, the DMIC is being used for benchmarking between practices, and for monitoring phase-wise development over time. The self-assessments support collaborating partners to set aims, choose interventions and develop in a more focused manner because of the complexity of implementation. The RMIC is also used as a reflective tool and supports the practice of defining developments on a micro and meso level (e.g., Grooten et al., 2019; Huang et al., 2020; Voogdt-Pruis et al., 2021; Zonneveld et al., 2017).

The RMIC model is an analytical instrument for investigating and describing the various dimensions and levels of service integration and has been applied for this purpose (e.g., Angus & Valentijn, 2018; Minas, 2016). The model provides less assistance, however, in improving our understanding and aiding the processual development of integrated care over time. This is the purpose of our second model, the DMIC, which allows for both a conceptual and practical description of the activities relevant to integrating services (van Duijn et al., 2022).

Since the models are different in scope, we assessed them separately in the second step. Our assessment of the RMIC model involved considerations as to whether the conceptual levels were also present in the field of inclusive activation, while our assessment of the DMIC model focused on whether the conceptual domains and activities within it were also relevant to the field of inclusive activation. For instance, we considered whether client-centredness was an issue in both fields. Our assessment of both models involved considerations of important enablers and barriers to integrated labour market services.

The RMIC and the DMIC: the rainbow model and the development model of integrated care

The RMIC model is grounded in the frontline services of the primary care setting (Valentijn et al., 2013, pp. 3–4). The model distinguishes between four dimensions or types of integration: system, organisational, professional and clinical integration, each of which plays an interconnected role across the macro, meso, and micro levels (cf. Table 1). In line with the model's rainbow name, clinical integration in the centre is surrounded by the (half) circles of the professional dimension first, then the organisational dimension and then system integration in the farthest-out position. The two general enablers of functional (technical) and normative (cultural) integration facilitate the linking of different levels (Valentijn et al., 2015, p. 2). The extent of each dimension may be expressed as a continuum, with segregation at one end, linkage and coordination in the middle, and full integration at the other end (Valentijn et al., 2013, p. 7).

At the macro level, system integration entails the alignment of policies, rules, and regulations. More specifically, system integration requires (1) horizontal integration across similar levels and between different sectors, organisations and professionals; and (2) vertical integration across different levels of specialisation (Valentijn et al., 2013, p. 4).

The meso level includes organisational and professional integration. The authors of the model define organisational integration as 'inter-organisational relationships' consisting of 'contracting, strategic alliances, knowledge networks [and] mergers, including common governance mechanisms, to deliver comprehensive services to a defined population' (Valentijn et al., 2013, p. 6). Professional integration is defined as 'interprofessional partnerships based on shared competences, roles, responsibilities and accountability to deliver a comprehensive continuum of care to a defined population' (Valentijn et al., 2013, p. 7). Finally, at the micro level, clinical integration refers to coherence in the delivery of services to individual citizens (Valentijn et al., 2013, p. 7).

The RMIC turns our attention to the many components, areas and levels in which barriers to integrated services can emerge; it also helps with the identification of important enablers facilitating service integration (cf. Table 1).

The DMIC is a quality management model that describes the implementation and development of integrated care through four (non-linear) dynamic development phases: initiative and design, experimentation and execution, expansion and monitoring and consolidation and transformation (Minkman, 2011, p. 18; cf. Table 1). The model contains 89 generic activities grouped into nine clusters that together contribute to the integration of care and services (Minkman, 2011, p. 18).

The cluster 'quality care' includes elements that focus on the design and implementation of multidisciplinary care pathways addressing the needs and preferences of the citizens in accordance with evidence-based guidelines and standardisation. 'Performance management' addresses the measurement and analysis of the care delivered at all levels, as well as the outcomes and feedback received to improve service delivery, while 'inter-professional teamwork' covers interdisciplinary teams for a defined target group in which varying professionals collaborate in multidisciplinary domain-overarching teams across services. The cluster of 'delivery systems' focuses on the service logistics, mechanisms and processes in place to streamline the provision of services to citizens. The cluster of 'roles and tasks' includes collaboration at all levels based on a clear definition of individual expertise, roles and tasks. 'Patient- or person-centredness' addresses integrated care and information flows tailored to individuals and (sub) groups, and the cluster of 'commitment' covers collaborative commitment based on clear goals, along with awareness of interdependencies and domains. 'Transparent entrepreneurship' refers to the capacity for innovation, leadership responsibilities for performance achievements, and financial agreements covering integrated care. Last, the cluster of 'result-focused learning' is indicative of a learning climate encouraging continuous improvement (Minkman, Ahaus, & Huijsman, 2009, pp. 70–72; Van Duijn et al., 2018).

In the next section, we discuss the possibilities and potential usefulness of the transferal of conceptual models from integrated care to inclusive activation. Specifically, we consider whether the significant features of inclusive activation are similar to those of health care and, if not, whether the models can be adjusted to the features of inclusive activation.

Table 1 summarises the main features of the two models.

DISCUSSION

The RMIC and the DMIC translated into inclusive activation

The RMIC turns our attention to the many components, areas and levels in which barriers to integrated services can emerge; it also helps with the identification of important enablers facilitating service integration (cf. Table 1).

When translated into the domain of inclusive activation, the system level of the RMIC model implies, for instance,

that labour market policies for youth could be (more) aligned with education policies as part of the national implementation of the reinforced Youth Guarantee (Andersson & Minas, 2021). Organisational integration could be translated such that organisations providing labour market services could make formal agreements regarding access to health services, such as psychiatric centres, or form knowledge networks with the police, schools and the criminal justice system in case of prevalent youth delinquency in a particular area. They could even merge various employment services with the benefit system and other municipal services in one-stop shops. At the street (clinical) level, organisational and professional types of integration of the RMIC model would imply that professionals across health care, employment, housing, education and social services could coordinate the assistance they provide to ensure that all the important needs of each citizen are met in a 'single process across time, place and discipline' (Kodner & Spreeuwenberg, 2002, p. 11).

In the case of Catherine, she could be referred to a youth team within the local one-stop shop, where the objective of the interdisciplinary team would be to provide individually adapted services tailored to her needs. The interdisciplinary teams could comprise collaboration between services and professionals within the one-stop shop, such as that between employment and social services, as well as interagency collaboration and interprofessional partnerships with local health services and educational services outside the one-stop shop. To be successful, however, the literature outlined above points to important barriers and enablers, such as clarifying the specific aims and goals of interagency collaboration, the commitment of necessary stakeholders and accountability, shared ownership and the complementarity of organisational resources and areas of expertise, as well as strategic leadership and support (Lindsay et al., 2008; McQuaid, 2010).

The functional dimension of the model implies that the services must be adequately financed to ensure that the caseload of the professionals is sufficiently small to allow for the coordination of meetings and tasks (Heidenreich & Rice, 2016b). The functional dimension also entails that legal regulations (such as data protection legislation) should not prohibit the sharing of information across services or sectors. This is in line with the literature outlined earlier, which highlights legal regulations and technological capacity as potential barriers to collaboration and partnerships (Lindsay et al., 2008; McQuaid, 2010).

Furthermore, the normative dimension implies that different professionals must (learn to) share common goals and values. If professional members of the youth team in Catherine's case have high caseloads, this would inhibit close individual follow-up. Moreover, if health professionals and others in charge of employment services cannot share information about Catherine, individual-adapted services will be difficult to achieve. Whether teams can deliver integrated services depends on whether they are able to agree on problem formulation, joint and specific goals and direction; have an outcome-oriented focus; and are capable of collaborating across services and sectors, despite their differing logics and service mandates (Lindsay et al., 2008; McQuaid, 2010).

Turning to the DMIC, the strength of the model is its relation of the extent of integration to a broad number of identified activities (Van Duijn et al., 2018, p. 2), which could be equally relevant in the context of inclusive activation. The flexible adjustment of integrated services corresponding to individual citizens' needs, results-focused learning, the establishment of clear roles and tasks and attention to commitment are all activities applicable to inclusive activation, although we could add to this the importance of mutualism and trust (Lindsay et al., 2008; McQuaid, 2010). Elements such as signing collaboration agreements among the partners, holding structural meetings at the higher levels of the organisational hierarchies, establishing dependencies, sharing knowledge among the partners and using collaborative education programmes are all relevant to all forms of cross-sectoral collaboration as (partially) discussed in relation to the RMIC model. Such elements have also been highlighted in research on inter-organisational collaboration, network governance and joined-up government (Bryson et al., 2015; Pollitt, 2003).

An important precondition to the delivery of integrated services relevant to a case such as Catherine's could be the signing of collaboration agreements between the local one-stop shop and high schools, with the aim of preventing young people from leaving school early or facilitating a return to school for early leavers. Another example would be collaboration agreements between mental health services, schools, social services and employment service organisations to establish dependencies between partners and reach agreements on the joint responsibilities for youth with complex problems, such as Catherine. In the context of the DMIC, these collaborative agreements are activities that form part of the initiative and design phase (Minkman, Ahaus, & Huijsman, 2009). This collaboration could be organised in the form of a multidisciplinary youth team in the one-stop shop, where part of the experimental and execution phase would involve agreeing on the specific aims and content of the team and coordinating the chain of services needed. Clarifying areas of expertise and the commitment of the involved stakeholders, as well as shared ownership, would be important enablers in this phase, and these factors are also highlighted in the literature on the integration of labour market services (Lindsay et al., 2008).

The expansion and monitoring phase of the youth team would involve close attention to evaluation and results-focused learning, as well as innovation in youth services. Lastly, the consolidation and transformation phase would encompass continuous improvement that draws upon successful results, perhaps by exploring options to collaborate with other external service partners and stakeholders (Minkman, Ahaus, & Huijsman, 2009), such as the child service system or even local employers.

However, the element 'defining performance indicators to evaluate the results of the integrated care delivered' must be reconceptualised as 'defining indicators related to inter-organisational and inter-sector collaboration'. To enhance the outcome objectives of cross-sectoral collaboration, incentives and rewards for success in the cross-cutting of work are important (Pollitt, 2003). If only applied to frontline practice, too strict or narrow performance indicators may 'squeeze out' the discretion essential in frontline workers' responsiveness to citizens' needs, as has been shown in management and governance studies (Brodkin, 2012, p. 945).

In summary, both the RMIC and DMIC contain elements that are equally relevant in inclusive activation as they are in healthcare, and the implementation of both models is conditioned on the consideration of important barriers and enablers of integration. In the next section, we discuss whether significant features of inclusive activation are like those of health care, considering the relevant literature on integration of labour market services.

Are the similarities sufficient to transfer the models?

As we emphasised in the introduction, our discussion in this article is only relevant for activation policies that rely mostly on enabling elements, although even inclusive activation is combined with forms of benefit conditionality (Heidenreich & Aurich-Beerheide, 2014). Nevertheless, the concept of 'inclusive activation' brings social policy closer to other research streams and policy areas engaged in the enabling (re)integration of citizens marginalised in the labour market. In the research on disability, recovery and vocational rehabilitation, employment is perceived as part of the ordinary life courses to be enabled by supportive services (Andreassen et al., 2020). With its goal of supporting people with multiple problems, inclusive activation, far more than demanding activation policies, resembles the cure, care and rehabilitation goals of health care.

Like inclusive activation, the health care system has a multi-level, multi-dimensional and multi-stakeholder character. Governance challenges derived from a mix of public, private, and third-sector service deliverers in tackling complex problems are highly present (Greer et al., 2015). Therefore, like those involved in inclusive activation, the various health care actors may represent different logics that define the relevant service differently.

However, the discretion involved in frontline workers' inclusive activation practices differs from the professional discretion of occupations within the field of health care. In health care, professional actions are based on the best available evidence combined with clinical expertise and consideration of the rights, preferences and values of the patient (Greenhalgh et al., 2014; Sackett et al., 1996). Although the idea of evidence-based medicine has been subject to fierce criticism, it is fair to say that the research-based knowledge of medicine extends far beyond that of activation. Furthermore, frontline workers, especially medical professionals, are expected to carry out their work based on certified knowledge and skills, which in turn give patients and collaborating partners clarity in terms of what to expect from them, as well as good reasons to trust their professional expertise.

When assessing the transferability of models from health care, we must consider the lack of an officially recognised body of knowledge in activation work. In both integrated care and inclusive activation, post-educational training and staff development have been identified as critical factors in building service integration (Heidenreich & Rice, 2016b; Kaehne, 2016). The models implicitly seem to presume that knowledge bases exist for professionals to base their practices on. For instance, in the DMIC model, the cluster of 'roles and tasks' involves a clear definition of individual expertise. Specifying roles and tasks can be difficult if the knowledge base that the professionals involved have adopted is unclear or even unknown. Therefore, the specific professional knowledge base held by the activation workers in a specific context needs to be accounted for as part of this cluster to inform collaborating partners and citizens about what to expect. In the RMIC model, the same specification should be added to the dimension of professional integration to ensure that the involved professionals across service areas represents complementary of resources and areas of expertise.

While the RMIC model directly incorporates the complex multi-level and multi-dimensional characteristics of integrated service delivery, neither model includes collaboration with actors and organisations beyond those that have, as their purpose, some form of service provision to disadvantaged groups. Since the goal of a work inclusion process is employment, success depends on employers' motivations to adjust workplaces and work tasks (and perhaps their perceptions of the ideal employee) to enable the full labour market participation of people with complex

needs. From the perspective of enabling employment for citizens with complex needs, involving employers is essential. The involvement of employers means expanding the types of stakeholders involved; it also implies the involvement of a stakeholder for which the main purpose is not service delivery to citizens but the production of goods and services. Motivating these actors to be (or become) involved in integrated endeavours must be considered a task of its own.

Hence, the significant role of employers and workplaces is an important characteristic that distinguishes inclusive activation from integrated care. However, we assume that employers could be added as part of the RMIC's professional/organisational integration and as part of clinical integration, with a focus on employers and citizens. In the DMIC model, the role of the employer could be specified as part of the cluster of 'roles and tasks' and/or the cluster of 'commitment'.

As emphasised above, co-production, in the sense of an essential and intrinsic feature of service provision that is necessary for users to gain value from those services, plays a prominent role in human services such as those of activation, where 'delivering' services means helping the individual to make desired changes (Alford, 2016; Osborne, 2018; Whitaker, 1980). The employment goal of an activation process cannot be achieved without users' willingness and motivation to invest some time and effort. Furthermore, health care service delivery often requires the citizen to exhibit some form of compliance, cooperation and work. For instance, patients must take prescribed medication, perform training during rehabilitation or work on their recovery through other means. In the context of inclusive activation and the case of Catherine, she must first agree on seeking help to treat her mental health problems, and second, she must actively engage in therapeutic work with mental health professionals.

The RMIC model presents only a vague indication of the involvement of the patients, citizens, or jobless persons themselves, which in the RMIC is only implicit at the level of 'clinical integration'. The model seems to place citizens in the position of being receivers rather than co-producers of care (services or assistance). The DMIC model, in contrast, emphasises citizen-centredness and the adjustment to individual needs and includes citizen judgement and satisfaction as part of performance management, meaning that 'the voice' of the citizen (Winters et al., 2016, p. 16) is not left out. Thus, the position of the concerned citizen is more prominent in the DMIC model, which incorporates aspects such as self-management and shared decision making. Nevertheless, the DMIC could have paid even more attention to co-production.

Within the field of integrated care, there has been the development of more focus on shared decision making, self-care and community care, emphasising the needed co-production between professionals and citizens (Glimmerveen et al., 2020; van Duijn et al., 2022). This applies in particular to people with chronic illnesses in need of service integration. Hence, in the field of health care as well as for the employment of disadvantaged citizens, it is important that the conceptual models include the co-production aspect of service provision, and, not least, that they allow for citizens to influence their goals and interventions in the process. As we see it, in the DMIC model, values characterising the service encounter at the individual level could be added to the cluster of 'quality of care'. Similarly, values could be added as part of the RMIC's clinical integration dimension.

When discussing the transferability of service integration models from health care to inclusive activation, an important question concerns the position of citizens and their opportunities to have a voice in the activation process. In this respect, activation policies represent some challenges, especially for the most disadvantaged, unemployed citizens (Andersen et al., 2017; van Berkel, Caswell, et al., 2017). Of crucial importance is the potential trust-breaching impact of conditionality and sanctions.

However, also in health care, service may be conditioned and dependent on negotiations about credibility and deservingness, which sometimes involve perceptions of health problems as signs of moral failure, poor lifestyles or a lack of discipline (e.g., Knutsen et al., 2013; Mik-Meyer & Obling, 2012). Furthermore, medical certification of work incapacity and disability serves as an important mechanism for entitlements to benefits (Stone, 1984), and compulsory treatment is an opportunity in cases where patients are at risk to themselves and others. Hence, in health care as well as activation services, a trusting relationship with the concerned citizens can be jeopardised by forms of social control that may violate personal freedom and agency (Bothfeld & Betzelt, 2013, p. 261; Møller, 2013), and such control may influence the relations of mutual trust between frontline workers and citizens.

CONCLUSION

In this paper, we have explored whether and to what extent models from integrated care can be used within or transferred to the field of securing employment for disadvantaged citizens, drawing on an assessment of the literature on the activation and integration of labour market services concerning multiple stakeholders or relationships. An important lesson to draw from the field of

integrated care is that the multi-dimensional characteristics of service integration must be accounted for. This characteristic has also been recognised within the field of inclusive activation by authors such as Heidenreich and Rice (2016b). We have shown the complex characteristics and interlinked problems faced by citizens in inclusive activation, illustrated by the case of Catherine, and the suggested implications for a conceptual model are like those in the field of health care.

As we see it, given that conceptual models can be used analytically to enhance our understanding of service integration, models from health care could be further developed for use in the field of inclusive activation. The RMIC model grasps the varying types of service integration involved at different levels and the factors that enable integration. Both models allow for the identification of areas where barriers to service integration can occur and those that must be attended to in seeking to enable coordination. Many of these barriers and enablers have been highlighted in research on the implementation of integrated labour market services (e.g., Lindsay et al., 2008; McQuaid, 2010). The DMIC model also provides guidance for specific activities and processes that may enable cross-sector service provision, while also showing the various phases involved.

However, from the perspective of inclusive activation, we need to translate the models to address the extended complexity, especially the important position of workplaces and employers. Moreover, analytical models for inclusive activation should consider the lack of a common knowledge base among frontline professionals. Finally, our assessment of the models has shown that the values characterising the service encounter are not sufficiently addressed, and although 'the voice' of the citizens is not left out of these models, their role in the co-production and co-creation of services is less visible, at least in the RMIC model, and requires more attention.

Given that conceptual models could guide our further research and development of service integration in the context of inclusive activation, we suggest that future research should develop models of service integration that incorporate the significant characteristics of inclusive activation, but at the same time use the rich experience from health care models of integration, including their mechanisms and ingredients. We realise that models of service integration are idealised, as they envision those features to be addressed if comprehensive and coordinated services to citizens with complex needs could be developed. Nevertheless, when transferred from integrated care to inclusive activation, conceptual models point to more failures in activation services than just a lack of coordination, such as less professional knowledge and skills, low-quality activation programmes, and the potential trust-breaching impact of conditionality and sanctions. We therefore hope that introducing models from health care into an activation context can also help direct the attention of policymakers and practitioners to addressing the complexity of these citizens' circumstances and the many barriers to be removed if the goal of employment is to be realised. In the end, only a domain-overarching vision and approach and the organisation of support will help citizens with complex problems, like Catherine, move forward.

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CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during this study.

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