Putting Patients in Charge

The Future of Health and Social Care

By Nigel Keohane
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EXECUTIVE SUMMARY

All political parties now acknowledge the importance of more integrated – or person-centred – care. The divisions between health and social care lead to excessive pressure on hospitals and emergency care and too little investment in preventative care or support at home. Patients and their carers are often left confused. These problems are only set to worsen as more people live into old age and experience multiple, complex and chronic conditions.

If the commissioning of care often makes little sense, neither does the funding: while the NHS remains free-at-the-point-of-use, individuals have to cover their own costs of social care, with only those with the highest needs receiving any means-tested support. By 2020, we face a funding shortfall of £12bn across health and social care.

This report looks at ‘how’ to address these challenges and sets out proposals for reform.

MORE PERSON-CENTRED CARE

Part 1 discusses the best ways to deliver integrated care. Integrated care addresses in the round a patient’s health and well-being needs. In doing so, the approach seeks to instil in the system a focus not only on meeting clinical needs as they arise but also on encouraging preventative action to forestall costly care crises developing. Beyond this, it aims to develop a more central role for the patient in care planning, in choices on care and self-management of conditions.

As a first step, we argue that all public money relevant to a patient’s needs should be combined in one place and that the totality of a person’s care needs should be commissioned from one point. This one point should be local, such as the Health and Wellbeing Board. This commissioner will have the flexibility and the incentive to allocate resources to the best intervention – in the hospital, in the community, or in the home – for the patient and to act pre-emptively to avoid more costly and more severe care needs arising later.
But, as the NHS *Five Year Forward Review* implies, how this commissioning is executed also matters fundamentally. Drawing on examples from the UK and overseas, the report analyses different approaches to commissioning care and provides evidence that the market and competition — if used effectively — can be a powerful force for integration. Both state-led integration and the current structure of tariff payments have significant limitations, because they rely on the government retaining control over what aspects of care are delivered thus dampening innovation and flexibility.

The report recommends that the next government should promote the role that the market can play in integrated care through our alternative models of ‘All-out Care’ and ‘Patient First Budgets’. Both offer means to shift to greater prevention of care needs, with the market incentivised to coordinate care around the individual.

- **‘All-out care’**. Under this outcome-based approach, local health and well-being boards and clinical commissioning groups would commission external provider(s) to achieve specified health and well-being outcomes for a population of patients. The provider would bring together a wide range of health, social care and community services to meet these outcomes.

- **‘Patient First Budgets’**. These would complete the evolving concept of personalised budgets by giving the patient public funding to meet all his / her health and social care needs. The patient (guided by their GP and other professionals) would determine what units or packages of care or support to buy. This may be medical treatment, telecare devices, home adaptations or professional care to enable them to remain living at home. Unpaid care provided by family and friends would become eligible for at least partial remuneration.

In moving towards this new vision of integrated care, we propose the following steps:

**Step 1: Pilot new care models** — In the most advanced local areas, NHS England should pilot SMF’s new models of care as part of the NHS Five Year Forward Review. We believe that ‘All-out care’ should be commissioned
for specific patient groups such as older people and for a whole local population, with the risks and responsibilities for health and social care passed over to external providers. Such an approach would be a radical version of NHS England’s ‘Primary and Acute Care Systems’ model of care. In addition, we propose that the next government should make personal budgets an organising principle in a number of localities and enhance the scope of its proposed Integrated Personal Commissioning programme. These budgets should be made available to a wider group of patients, the scope of care that patients can purchase should be expanded, and patients should be allowed to remunerate unpaid carers.

**Step 2: Align incentives for commissioners:** The next government should legally mandate a deadline of 2020 by when local health bodies and councils must have pooled their whole budget. NHS England should also offer financial incentives for local agencies to pool budgets at speed.

**Step 3: Prepare a diverse market:** Local commissioners should ensure that there is a diverse range of bodies positioned to compete for any services including mutual, social sector, private and public sector providers. National regulators should consider how the regulations on providers (such as the rules on ‘Any Qualified Provider’) can function when the care divide is broken down; local commissioners should consider regulating the supply chain when services are commissioned.

**MORE SUSTAINABLE AND FAIRER FUNDING**

Part 2 assesses the range of options for reforming funding of health and social care. By 2020, NHS England has shown that the health service faces a funding shortfall of £8bn (on very optimistic assumptions). Over the same time period, social care services are expected to face a further shortfall of £4.3bn. Any new system needs to be more financially robust to cater for this growing demand.

Beyond this, the current funding arrangement is illogical, iniquitous and inefficient. Currently, an individual’s liabilities for social care costs are unlimited whilst their costs for their health needs are almost all paid for by the state. Even after the provisions of the Care Act 2014 come into force in
2016, those who require social care support will still be liable for costs of up to £72,000. People, therefore, will continue to face markedly differing costs and experiences simply because of the nature of their condition: have a broken leg and be dealt with for free; have dementia and face care costs into the tens of thousands. This is a natural lottery and unfair. We can’t hope to think in the round about someone’s needs with this backdrop.

**We recommend that the starting point should be equal entitlement to health and social care services and a greater emphasis on prevention.**

Analysis by the Personal Social Services Research Unit suggests that the additional cost of providing free social care for those with ‘moderate, substantial or critical’ needs were would be approximately £7bn. The report charts a range of public and private options for achieving this level of funding. These include:

- general taxation
- national insurance contributions
- levies on wealth
- adopting social insurance
- changing the charging structure across health and social care

In terms of raising money publicly to pay for care, there is a strong case – both on grounds of sustainability and of intergenerational fairness – that the burden be spread beyond the working-age population. This makes raising additional money through national insurance contributions or income tax alone problematic. In contrast, others – such as the Barker Commission – have proposed a capital levy imposed when the individual reaches retirement age or on death.

Such approaches have their merits, but the paper argues, in putting social care on an equal footing with health, the individual should be incentivised to prevent health needs and costs arising. Models that rely on the state taking on the entirety of the risks do not accomplish this. While the UK’s current system imposes many costs on the individual, these are spread
very unevenly across different aspects of care (social care, dental care, eye care, prescriptions and some aspects of hospital services). The distribution of costs has little logic, is unfair and cannot hope to encourage preventative action.

*The report puts forward a future funding option that would achieve this blend of funding: a ‘Personal Care Account’.*

This would aim to distribute existing charges more evenly across the care system and for the state to ensure equitable access to care and to protect the individual from catastrophic costs. Under this model, the state would continue to pay for a very large part of the costs of care and would apply the Dilnot ‘capped care cost’ model across all aspects of health and social care. In particular, we propose that:

- The individual would make co-payments set at a small percentage of the actual cost of care.
- Payments would be capped as a per annum charge and as a total lifetime charge, with the state paying for the remaining costs.
- Those on low incomes or with low levels of wealth would be exempt.
- We recommend that this change should be introduced as a cost-neutral reform: in other words that the level of charges in the future system should not exceed the level of charges in the current system. To ensure that those with ‘moderate’ social care eligible for support, this would mean re-distributing £7bn of charging that currently falls solely on social care patients to all health and social care patients.

Such a model would continue Britain’s heritage of predominantly state-funded care services whilst spreading the costs that currently apply in social care more evenly across society. By distributing the costs more widely, it would make the system fairer. By broadening the number of contributors and making the costs more transparent, we envisage this would also boost the sustainability of funding into the future.
INTRODUCTION

WHAT IS INTEGRATED CARE?

Integrated care – or person-centred care – is the attempt to centre all health and social care activities around the needs and well-being of the individual patient, so that the patient’s perspective becomes ‘the organising principle of service delivery’.1 To anyone coming fresh to the debate, this may sound simply like decent care. And, it is. In reality, ‘integration’ is a response to the accumulation of discrete services to meet distinct needs of patients at different points in the history of the health and social care service. If we were starting afresh, we would not be talking about integrated care.

Integrated services should be structured around a person’s health, care and well-being needs, support the person to self-manage their own conditions and make decisions on care, and help the person to live an independent life. All three major parties now accept this premise, whether it is the Coalition Government’s Integrated Care Pioneers, or the Labour Party’s ‘Whole Person Care’ Commission.

EVIDENCE IN FAVOUR OF INTEGRATED CARE

International evidence and case studies from the UK suggest that integration can drive significant improvements. It can promote a greater focus on the wider needs of the patient and care planning, encourage preventative action, enable independent living and improve service quality. Some specific examples include:

- Programmes have led to reduced admissions to hospital and potential for reduction in costs of secondary care.2
- Early evidence from on-going pilots suggests better care planning and involvement of patients in decisions on care, and higher levels of diagnosis.3
- Integrated care approaches in the USA have often out-performed
more traditional forms of fragmented care. Multidisciplinary groups have been shown to provide better quality care to patients at lower costs compared to other methods of care delivery.⁴

- Integrated care programmes for patients with long term conditions have been found to benefit quality of life, functional health, process outcomes and patient satisfaction.⁵

SEPARATE SPHERES: COMMISSIONING AND PROVISION

Currently, health and social care are separately-funded, separately-commissioned and separately-accountable. NHS England is accountable for NHS services through the mandate to the Department of Health which is then accountable to Parliament, whilst local councils are responsible for statutory social care services. In 2012, less than five per cent of the combined NHS and social care budgets was spent through joint arrangements.⁶ Over time, different cultures and different commissioning and regulatory practices have developed across different disciplines.

The symptoms of this fragmentation can be seen clearly. Patients find the current system confusing, fragmented and uncoordinated.⁷ Commissioning and provision are beset with inefficiencies because each small part of the system is responsible for narrow objectives, and providers are typically paid per activity. There is insufficient incentive for organisations to prioritise expenditure on preventative services, because the financial gains are not felt by the organisation making the investment. This misalignment of incentives is costly. For instance, in 2013, the National Audit Office estimated that one in five hospital admissions could be managed effectively in the community.⁸ As the NHS Five Year Forward Review argued, we need a ‘radical upgrade in prevention’.⁹

These problems of disjointed health and social care are set to become more severe over time. First, technological advances – such as in telehealth and telecare – make support in the community more practicable. But, there is little spur to invest in these technologies under the current commissioning and payment regimes.
Second, many conditions formerly considered life-threatening have been converted into long-term conditions due to medical advances. This is obviously good news and contributes to longer average life expectancy. But, such conditions typically have to be managed through a mix of medical and social care. Third, the number of people with three or more long-term conditions is set to increase from 1.9m (2008) to 2.9m (2018). This trend affects both the amount of support and the type of support needed: the amount because a patient with three conditions costs the system treble that of a patient with one condition; the type because care requirements become very complex and clearly require very coordinated social, community, primary and secondary care.

Such changes have important implications not only for the mix of care provided, but also for the role that patients themselves play in making decisions on care and in contributing to health outcomes. The changing nature of illnesses and longevity puts a greater onus on the individual to be involved in care planning, to manage their illnesses and to draw on their capabilities. Evidence also suggests that older people expect increasingly to live independently.

Integrated care must be designed with three principal objectives in mind, as set out below:

**Objective:** To align incentives for commissioners to meet the whole care needs of an individual.

**Objective:** To involve citizens more in their care and promote independence.

**Objective:** To allow commissioners and providers to innovate and adopt new practices rapidly whilst retaining clear accountability.
CHANGES NEEDED TO THE FUNDING OF HEALTH AND SOCIAL CARE

The eligibility and funding discrepancy across the care divide

Across health and social care, there are marked discrepancies in how services are funded and the services to which individuals are entitled. An individual faces huge liabilities for social care costs whilst their costs for their health needs are (almost) entirely paid for by the state. Ultimately, patients are vulnerable to what could be called a ‘boundary penalty’ if they happen to have a condition (such as dementia) typically serviced through social care rather than medical healthcare. A report by the LSE and Alzheimer’s Society has shown that of the £26.3bn expended on caring for dementia patients in the UK, two thirds of the costs are borne privately (£5.8 billion privately funded; £11.6 billion via unpaid care). The figures below tell this story.

The total cost of public and private health and social care is approximately £150bn. The NHS represents roughly three quarters of this. About 1% is raised through charges for NHS services (dentistry, prescriptions and others), equating to between £1bn and £1.5bn. Overall, £9 in every £10 spent on healthcare in England is publicly funded. In contrast, only £6 in every £10 spent on social care is publicly funded. Figure 1 illustrates the modest contributions that individuals make to healthcare, the large private contributions to social care and the huge value of unpaid care. If the state were to publicly fund all ‘moderate, substantial and critical’ social care needs this would cost approximately £7bn – roughly half of the £13bn costs currently borne privately.
A second major axis of difference is that the basket of statutory services provided in health is intended to be sufficient to meet the entire medical needs of the patient whilst in social care the needs that are met extend only to ‘substantial’ or ‘critical’ needs in nine out of ten council areas. This leaves many people reliant on limited services, paying for additional services, overly dependent on unpaid care or going without.

Reforms in the Care Act 2014 – which will cap an individual’s liability at a maximum of £72,000 and will make care available free to all those with assets of less than £118,000 – will serve to lessen the inconsistencies between health and social care funding. But, fundamental discrepancies will remain. Individuals will still face significant costs for their care needs but not their health needs, and the distribution of these costs will remain uneven across society. While there is an incentive for individuals to seek to take action to reduce potential social care costs – such as by adopting healthier lifestyles – there is no such incentive within the confines of healthcare. This wrongly presupposes that individuals are better-placed to manage their social care needs than their health needs.
This is contradictory given that many social care costs stem from the loss of capabilities due to ill-health. It is also potentially harmful, offering incentives for individuals to benefit from state services in health when means-tested (and less generous) social care services might be better suited to meet their care needs; and, incentives for the state to move costs onto self-funders in social care services. The history of NHS Continuing Healthcare is a salutary lesson here where care has been moved into the means-tested sector.¹⁸

Funding shortfalls across health and social care

In addition, resources dedicated to health and social care are facing colossal shortfalls. Since 2010, there has been an effective budget reduction of 26% or £3.5bn in social care services.¹⁹ As a consequence, local authorities have reduced the amount of care provided, are paying less for care (with implications for quality of care and for the workforce) and have imposed stricter eligibility criteria.²⁰

Under optimistic assumptions, by 2020, health and social care together face a funding shortfall of £12bn.²¹ This shortfall comprises £8bn in the NHS (assuming 2-3% annual productivity improvements) and £4.3bn in social care (assuming revenue reductions and rising costs).²² Somewhere between £59bn and £119bn is saved through use of unpaid care.²³ However, by 2017, demand for social care is projected to exceed the supply of available unpaid care from adult children.²⁴

As research by the Health Foundation and the King’s Fund has shown, this funding pressure is not only a medium-term challenge but is forecast to extend into the decades ahead. The graph below illustrates the cost pressures in healthcare using a number of assumptions for productivity with the backdrop of flat real terms funding increases.²⁵
Unless addressed head-on the consequences for care services are likely to be severe: more ad hoc and harsher rationing of services, reductions in the quality of care and a drop-off in investment in preventative care.

These problems and challenges set out above indicate that the reform of the funding of health and social care should be designed with six objectives in mind:

**Objective**: To align incentives by treating an individual’s health and social care needs equally.

**Objective**: To distribute costs in line with principles of social justice both within and across generations.

**Objective**: To give the individual an incentive towards preventative action.

**Objective**: To be sustainable and provide sufficient money now and into the future.
**Objective:** To be practicable within the UK and have some resonance with the existing pattern of funding.

**Objective:** To meet wider efficiency concerns and facilitate equitable access to care.
PART 1: MORE PERSON-CENTRED CARE

1.1 OPTIONS FOR COMMISSIONING INTEGRATED CARE

Successful practice on the ground in the UK and abroad suggests that integrated care can comprise many different features. These can include: co-locating staff and creating multi-disciplinary teams; institutional merger; linking networks of providers virtually; and, data sharing exercises to give professionals easy access to up-to-date patient information.

However, the evidence suggests that no one of these methods is necessarily superior to others, and the job of policymakers and national government should be to create an environment within which commissioners and providers are encouraged and freed to think holistically across health and social care. Below we set out how this can be done in line with our reform objectives:

- **Objective:** To align incentives for commissioners to meet the whole care needs of an individual.
- **Objective:** To involve citizens more in their care and promote independence.
- **Objective:** To allow commissioners and providers to innovate and adopt new practices rapidly whilst retaining clear accountability.

**Putting control in the hands of a single accountable local commissioner**

At the simplest level, integration requires public accountability, funding and commissioning responsibility to rest in one place. Only by doing this will commissioners have the flexibility to decide on the most appropriate care that should be provided to an individual – whether this be in the home, in primary care or in the hospital. This same logic suggests that the commissioner should have a wide range of interventions that it can use: across primary and secondary health, social care, mental health, community services and the home environment (such as intermediate housing).
Beyond this, however, responsibility for commissioning should be reformed. As it stands, statutory accountability for commissioning health services sits nationally. Local government commissioners of social care services, meanwhile, are accountable to locally-elected councillors. Superficially, centralised commissioning has advantages. First, it provides economies of scale in terms of commissioning expertise and greater purchasing power in some aspects of care. This may make it easier to maintain centres of specialism (for instance for stroke treatment). Second, ostensibly at least, it allows standards of healthcare to be even across the whole country thus guarding against a postcode lottery.

However, as Monitor and others have argued, the evidence suggests that integrated care services operate best where there is flexibility at the operational level to respond to demand. For this reason, decentralised commissioning is preferable to national commissioning. Appendix 2 details why this would be the case for whichever type of commissioning was undertaken. The loss of economies of scale is traded off with gains in allocative efficiency through effective personalised services. Meanwhile, even were services to be commissioned locally, commissioners could aggregate demand up to commission specialist services together.

Health and Wellbeing Boards would be the natural organisation to lead this commissioning.

**Recommendation:** The next government should consolidate the vast majority of state expenditure on health and social care and related spending in the hands of one single commissioner at the local level.

**Options for future care commissioning**

How these services are commissioned also matters. Typically, market structures – if properly designed – offer a framework within which providers have strong incentives to respond to demand and to innovate. Over time, this innovation leads to more efficient services and practices and successful innovations are replicated by other providers. Given the scope for innovative techniques to improve care, the raw case for involving the market is compelling.
However, the potential role of the market remains under-explored, under-developed and one dimensional. For instance, in January 2015, the Shadow Health Secretary Andy Burnham said: ‘If we allow market forces to continue to take hold, they will eventually break the NHS apart. Our destination is integration. Markets deliver fragmentation.’

The debate has been dominated by the volume of NHS care competed and provided by independent providers. This is a diversion for two reasons – first because the volume has only marginally and gradually increased. Indeed, the growth of outsourcing has slowed rather than increased in recent years. Second, and more important, because the type of competition is as important as whether or not it is present. As Figure 3 shows, there is a spectrum between pure individual choice, through to contracting services for outcomes from providers through to wholesale state provision. As discussed below, each of these has different attributes which provide different opportunities to promote integrated care. A crucial dimension across which these models differ is their ability to retain clear lines of accountability whilst enabling operational flexibility and innovation on the frontline.

**Figure 3: Commissioning options**

1. Monopoly state provision
   - State provision
   - State determines and delivers the activities

2. Commissioning for outputs
   - Payment by results tariffs
   - State determines the outputs may be delivered by the state or independently

3. Commissioning for outcomes
   - Accountable lead provider
   - Alliance contracting
   - State determines the outcomes delivered independently

4. Patient-led commissioning
   - Direct payments
   - Personal budgets
   - Individual determines the outcomes
1. Monopoly state-led integration

Government and arms-length providers / commissioners could lead the integration and provide themselves. This could be done by broadening the role of the District General Hospital to encompass primary care; or, as set out in the NHS *Five Year Forward Review*, the proposal of ‘Multi-speciality Community Providers’ that could draw in other forms of provision over time (such as local community hospitals) and eventually take responsibility for delegated multi-year budgets to manage defined populations. It might also be facilitated by removing GPs’ independent contractor status so that GPs are formally employees of the state.

**Future care scenario: ‘National Health and Social Care Service’ (NHSCS)**

An ‘NHSCS’ could mirror many attributes of the current NHS, with a more generous basket of social care services provided universally. Each patient could be allocated an ‘Integrated Care Coordinator’ who could be responsible for advising the patient, coordinating the care from different parts of the system and ensuring that services joined up for the patient. Care planning could take place through discussion with a multi-disciplinary team located in a primary care or community care setting. This could be modelled on the ‘House of Care’ approach, which emphasises ‘the active involvement of patients in developing their own care plans through a shared decision-making process with clinicians’.

Entitlements could be set centrally with some flexibility over how the service is delivered locally. CCGs could be instructed to promote new integrated care pathways for patients, which they could do by commissioning packages of care from primary, secondary and community care or by forming Multi-speciality Community Providers.
Ultimately, if trying to keep services in-house, the government typically faces an accountability dilemma, adopting one of three responses, each with its own flaws:

- Trust professional judgement to make the best choices on care services. But, successive governments have failed to fulfil this ambition and services are vulnerable to producer capture.
- Rely on mandated targets to persuade the frontline to do certain activities. But, such proscription denies the providers the flexibility necessary to deliver the right mix of care (see commissioning for outputs below).
- Delegate risk and responsibility to NHS providers via the internal market. However, the passing of risks onto NHS providers is currently often illusory with those providers that fail being bailed out.\(^{33}\)

2. Commissioning for outputs

Here, the commissioner pays tariffs for specific outputs, units of care or activities that it wishes the providers to execute. In UK health services, this is often called ‘Payment by Results’. Currently, much of the health service is subject to output specifications via the Quality Outcome Framework, the NHS Outcomes Framework and the Quality, Innovation, Productivity and Performance initiatives. Outputs commissioned include paying GPs to keep a register of patients with dementia. As reports by Sir John Oldham, the Nuffield Trust and others note, this approach mandates certain responses by providers and limits severely the scope of providers to intervene effectively to support the patient and to innovate.\(^{34}\)

Outputs can be defined narrowly or broadly. Broader outputs clearly offer greater scope for flexibility. These could include paying for a bundle of activities associated with an episode of care. For instance, when a patient is due for a hip replacement, the bundle of care could include a range of different measures along the pathway such as care planning, the operation itself, and post-procedure care (such as rehabilitation in the home). This is preferable to paying each provider for specific aspects of
the care separately and can work in simple, linear processes. However, it will always offer less scope for flexibility and innovation compared to outcome-based commissioning.\textsuperscript{35}

3. Outcome-based commissioning

Under Outcome-based commissioning, the commissioner calculates the total predicted cost of the individual’s needs across designated aspects of care for a given period of time (often called a ‘capitated budget’). This sum is then made available to the provider to achieve specified health and well-being outcomes in the way it thinks best. Such approaches incentivise providers to innovate and to find the best value methods for sustaining and improving the health and well-being of the patient group and for preventing costly care crises. The responsible provider is unlikely to deliver the services themselves but instead rely on a range of public, private and third sector providers. NHS England recognises that such a concept could be a variant – albeit a radical version – of one of the models it hopes to pursue post-2015: what it calls the ‘Primary and Acute Care System’.\textsuperscript{36} Commissioners should co-design these outcomes with patients and their carers.

This approach is already taken in parts of Spain, the USA and in limited forms in the UK:

- The Massachusetts Alternative Quality Contract has achieved quality improvements of 3.7\% and cost reductions of 2.8\% compared to a control group in only one to two years.\textsuperscript{37}

- Geisinger Health System in Pennsylvania receives capitated payments and carries out coordinated care for patients, resulting in a reduction in readmissions to hospital of 53\%. It offers performance-related bonuses to clinicians that relate to the quality of care thus incentivising them to promote the right intervention for the patient, whilst offering to share with them the savings from preventing acute readmissions.\textsuperscript{38}

- The Veteran’s Health Administration receives a capitated budget from the federal government to run services for a specific demographic
of the population who have high care needs, including high levels of mental health conditions. The provider has moved towards a series of regionally-based integrated service networks. Outpatient visits have increased by 42%; inpatient admissions have been reduced by 32%.

- In Valencia, the government pays the provider a sum for all healthcare associated with the patient group. The provider is responsible for looking after 250,000 residents. Average hospital stays are lower than in other parts of Spain; referrals to hospital have been reduced by bringing consultant physicians into primary healthcare centres; and, costs are significantly lower as compared to other geographies.

- In the USA, Kaiser Permanente receives global payments that encompass virtually all of their members’ healthcare needs. Professionals are divided into multi-speciality groups. Patients have access to specialists in primary care through telehealth and telecare services.

- In more limited forms this approach has also been adopted in a number of CCG areas in England, including Milton Keynes (for maternity services) and Kent (as part of the Year of Care project), Staffordshire, Bedfordshire, Salford, Lambeth and Cambridgeshire.

**Future care scenario: ‘All-Out Care’**

The total predicted cost of the individual’s needs across all aspects of care for a given period of time would be passed over to the provider who then has total discretion as to how respond. Under this model, overall strategic commissioning responsibility would sit with a local commissioner such as the Health and Wellbeing Board (HWB) within each locality.

The risk of success or failure is put onto the provider. The provider would act as the integrator using sub-contractors (and potentially its in-house delivery function) to provide public health, primary care, community care, acute services, mental health services and social care services.
The provider would be incentivised to provide an integrated care package and to seek to prevent high costs in the acute sector by helping individuals live successfully as independent individuals at home, through prevention strategies and by improving the quality of care. If the contract was based in part on patient outcomes, quality of care and patient satisfaction, the provider would have an incentive to achieve the balance between patient preferences for certain treatments or services, quality of care and cost reduction.

4. Patient-led commissioning

If the market is orientated to meet the needs of a patient’s wider needs it has an incentive to coordinate its activities accordingly. Simon Stevens has applied this logic in announcing the Integrated Personal Commissioning (IPC) programme, which will ‘blend comprehensive health and social care funding for individuals, and allow them to direct how it is used’. Patients who will receive this budget include: people with long term conditions; children with complex needs; people with learning disabilities; and, people with severe and enduring mental health problems.42

Successive governments have promoted personal budgets (PBs) in social care, health and across both services.43 PBs are intended to have both instrumental benefits (by driving competition for services and thus driving quality up and costs down) and intrinsic gains (by empowering the individual and allowing them to choose which services best match their needs). They can be considered particularly important in integrated care: because self-management and independent living sit at the heart of how older people and those with long-term conditions can be supported.

While personal budgets in social care have received mixed reviews regarding their efficacy, the minority who have received direct payments (i.e. cash payments) have reaped the most positive outcomes.44 Meanwhile, the major evaluation of Personal Budgets in Health in England found that there was a statistically-significant improvement in the care-
related quality of life and psychological well-being of patients whilst
health outcomes were maintained. The report also concluded that PBs
could be an enabler of greater integration.

**Future care scenario: ‘Patient First Budget’**

Under a ‘Patient First Budget’, the patient would receive a
comprehensive budget to meet the costs of their health and social care
needs. He / she would use this – following advice from professionals
– to purchase the mix of health and social care services to meet their
needs from a market of public, private and third sector providers.
Patients would be informed through care planning, through access
to their own data and records and through access to information on
available care and the quality and cost of care.

Patients would be able to use the money in their ‘Patient First Budget’
not only to make specific purchases of services and products but also
to purchase broader packages of care. This is likely to be particularly
important in specialist care where coordinated networks are needed
to provide quality outcomes. We imagine therefore that demand would
steer providers to form into collaborations to provide care pathways
for a patient.

The individual could have significant freedom over how they spend
this budget, including remunerating family carers.
To conclude, the current structure that encourages providers to compete on specific activities is one of the root causes of the disjunctures within care. Two alternative options are far more amenable to pursuing integrated care. Tendering the health and well-being outcomes of a patient group to

<table>
<thead>
<tr>
<th>Objective: To align incentives for commissioners to meet the whole care needs of an individual.</th>
<th>Monopoly state-led integration</th>
<th>Commissioning for outputs</th>
<th>Commissioning for outcomes</th>
<th>Patient-led commissioning</th>
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<tbody>
<tr>
<td>Possible, but only at the cost of weaker accountability and commissioner must be ready to have very loose control over provision.</td>
<td>Impossible. Less worse with bundled payments.</td>
<td>Possible.</td>
<td>Possible.</td>
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<table>
<thead>
<tr>
<th>Objective: To involve citizens more in their care and promote independence.</th>
<th>Monopoly state-led integration</th>
<th>Commissioning for outputs</th>
<th>Commissioning for outcomes</th>
<th>Patient-led commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult to retain accountability whilst allowing flexibility to providers to respond to individual needs. Limited scope for choice.</td>
<td>Limited as outputs are predetermined.</td>
<td>Possible. Could be encouraged by setting patient satisfaction as an important condition for receipt of outcome payments.</td>
<td>Yes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective: To allow commissioners and providers to innovate and adopt new practices rapidly whilst retaining clear accountability.</th>
<th>Monopoly state-led integration</th>
<th>Commissioning for outputs</th>
<th>Commissioning for outcomes</th>
<th>Patient-led commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited as no market incentive to innovate and take risks, and accountability likely to be weakened if providers are free to innovate.</td>
<td>Limited as outputs are predetermined thus dictating provider activity.</td>
<td>Yes. Targeting broad outcomes gives the provider the flexibility to adopt new practices.</td>
<td>Yes. Accountability is to the patient directly.</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Forms of commissioning and whether they meet reform objectives.
an external provider is one. The other – perhaps more ambitious still – is to give control to the patient and give an incentive to the market to respond to individual needs. Both allow for operational innovation whilst retaining accountability.

Recommendation: Future governments should promote the role that the market can play in integrated care through models such as ‘All-out Care’ and ‘Patient First Budgets’.

Summary of recommendations for future commissioning

- The next government should consolidate the vast majority of state expenditure on health and social care and related spending in the hands of one single commissioner at the local level.
- Future governments should promote the role that the market can play in integrated care through ‘All-out Care’ and ‘Patient First Budgets’.

1.2 PUTTING COMMISSIONING INTEGRATED CARE INTO PRACTICE

The section above set out recommendations for the future direction of health and social care services. It argued in favour of a single local commissioner and a greater role for the market as a driver of integration. This section sets out a range of steps that should be taken during the course of the next parliament to get us there. In discussing next steps, our analysis draws on the distinction made by NHS England between what can be expected in the most advanced local health economies as compared to the rest.

Step 1: Pilot new care models

As part of its programme to prototype new models of care with the most advanced health economies, the next government should encourage a number of areas to pilot ‘All-out care’ and ‘Patient First Budgets’. 
Piloting ‘All-out care’

In taking the idea forward, initiatives must:

- Ensure that there is clarity on the risks being transferred and that the provider can be held fully to account. A situation must be avoided where the state bails out failing providers. For instance, NHS Trusts and Foundation Trusts that found themselves in financial difficulty in 2013-14 received additional subsidy from the government totalling £511m.\(^{47}\)

- Cover a wide population base. Developing disease-based contracts risks replicating a partitioned care service; in contrast, the wider the client base the more likely the provider will enjoy economies of scale or scope.\(^{48}\) Therefore, at least one of the pilots should contract out the outcomes for all people over the age of 65 in an area. The government should also work with a local area to commission outcomes for a whole local population.

- Ensure that the provider has sufficient control over the outcomes.\(^{49}\) Contract length will need to be reasonably long to encourage providers to invest and innovate.

- Consider payment terms to ensure that the risk is distributed efficiently. Payment contracts can include either entirely outcome-based payments or part outcome-based payments or can be graduated over time.\(^{50}\) The commissioner can share the risks with the provider: contracts can include a sharing of the upside risk (such as in Alzira, Valencia). Equally, commissioners should consider clauses which limit the downside risks to providers to ensure that the market is ready to participate. Such models are used in other regulated and public service markets such as rail franchises.

- Consider straightforward prime contractor models (where one provider takes the risk) or alliance contracting / consortia. Borrowed from the world of construction, alliance contracting sees providers form networks where they share the risks and rewards associated with the contract.\(^{51}\) Such an approach is heavily reliant on trust and is at risk of an accountability deficit.
• Evidence from other public service markets suggest that where the prime contractor also provides there may be a danger of this organisation deliberately selecting the easy clients to work with whilst passing the more difficult clients onto sub-contractors.

• Specified outcomes are better being very broad – such as well-being, survival and patient satisfaction measures – rather than particular types of activities.

Piloting the ‘Patient First Budget’

Beyond its initiative on Integrated Personal Commissioning programme, NHS England should work with a number of local areas to pilot ‘Patient First Budgets’. In doing so, we propose:

• Giving the personal budgets to a wide range of demographic groups so as to assess the benefits of an integrated care budget for a wider range of patients. These could include all older people in an area.

• Varying the package of care to be included in the budget. For instance, NHS England currently envisages that patients will still have free access to their GP and to hospital care. As part of the pilots, the government should test the patient outcomes and choices when the full package of care is included in the personal budget.

• Expanding the scope of the budget to allow patients to remunerate their informal carers.

In moving to personal budgets, commissioners should exploit existing processes and infrastructure in social care services, such as referrals, care planning, budget setting, monitoring and sign off of personal budgets can be utilised to facilitate integrated care. This would allow patients to make decisions in parallel on health and social care without adding significantly to the costs, such as has happened in the Greenwich Integrated Care Pioneer.52
Step 2: Align incentives for commissioners to focus on patient needs

As part of its attempt to help all areas adopt new models of care, the next government should:

• Mandate a deadline of 2020 by when local health bodies and councils must have pooled their whole budget.
• Offer financial incentives for local agencies to pool budgets at speed.
• Provide generous subsidies for commissioners to reduce the costs of capital and make SIBs an attractive proposition for commissioners.
• Direct a portion of its new £200m Transformation Fund to help investments in innovative technologies in non-hospital settings.
• Encourage all areas to adopt practices such as care planning.

Pooling budgets

Many of the most innovative integrated care initiatives in the UK incorporate pooled budgets. The process can enable: commissioners to align provider activity against a common set of outcomes for their population; flexibility on resourcing; greater scope for innovative practices; and capitation to look after whole population groups and focus on outcomes.53

Pooled budgets in practice

Sheffield City Council and Sheffield CCG have pooled £278m with the aim of developing an entirely shared budget in the future. The joint plans for 2015-16 comprise £187m from the CCG and £91m from the council.54 This will allow the council / CCG to develop an ‘outcome-based specification’ for services that support people to keep well at home and for intermediate care services that can provide alternatives to hospital and support to those leaving hospital.55
As part of its move towards integrated care in Torbay, the local NHS and council came together pooling £95m of its total expenditure of £285m. The flexibilities created by the pooled fund facilitated integrated care teams organised around zones of over 30,000 people with single points of access and assessment. Intermediate care services are now available within each zone via the single point of access. Since 2003, emergency bed day use has fallen by 24%.

**NHS Somerset and Somerset CCG** agreed a pooled budget in 2012 which allows joined-up provision of learning disability services and integrated community equipment services. In 2011/12, NHS Somerset contributed some £14.6m and Somerset CC £40m. Including income from charges, the total pooled budget was £60m.57

The Better Care Fund was established to incentivise local health and social care commissioners to make better use of funding and to allow a shift of resources from spending on acute services to spending on social and preventative care. Therefore, the government established an allocation of £3.8bn that local commissioners were to spend as pooled budgets held jointly by local health and social care commissioners; and an incentive pot of £1bn, drawn from expected savings, was to be paid out to those local areas that succeeded best in reducing pressure on acute health services. However, the Government was over-optimistic about the amount of money the initiative could save and unambitious about the level of pooled funding it wanted to see. It is time for a more straightforward policy. Building on the proposal of Care Minister Norman Lamb, the next government should set a legal deadline for when local health bodies and local authorities should have moved to fully pooled budgets. The incentives should also be clearer, such as a match-fund scheme whereby for each £1 pooled by the different health partners at a local level, the government contributes a specified sum of money.

A recent review of the evidence found that pooled budgets do not necessarily lead to significant improvements in care or reduced costs,
citing barriers such as disjointed strategic objectives and priorities across health and social care. It argued that ‘it will be important not to underestimate the efforts required to forge and to maintain the relationships that underpin the financial mechanisms’. Therefore, local commissioners should explore how leadership and strategy can complement pooled budgets.

Promoting alternative finance

Moving towards integrated care often requires dual (or double) funding for the initial period. Expenditure on preventative and community services should mean that fewer resources have to be dedicated to acute care in the longer-term. However, expenditure on acute services is unlikely to reduce quickly enough to offset investment in services in the community and in preventative initiatives in the short term. In such instances, there is a strong case to seek private finance to allow investment in alternative services in the shorter term.

At the local level, Social Impact Bonds (SIBs) provide one route for commissioning integrated care. Under a SIB, a private investor finances a range of interventions (such as preventative services) and gets paid a return if these interventions achieve pre-determined outcomes (typically to do with reduced incidence of high cost support such as unplanned acute care). SIBs can be used to finance early diagnosis of illnesses such as dementia; they are being developed to reduce loneliness amongst old people so as to boost well-being and reduce costs to health and social care in Worcestershire; and, to help train those with long-term conditions in how to self-manage their illnesses. Through its work in Cornwall with older people with long-term conditions, Age UK is seeking to build an evidence base of cashable savings that would provide a case for a social impact bond. The approach includes a personalised care plan that includes physical and mental health needs including falls prevention support, exercise groups, social care and social clubs.

As the SMF has argued elsewhere, SIBs can be difficult to get off the ground, in part because the risks inherent in the schemes push up the costs of capital and there is a strong case for central government to subsidise some of the costs.
Subsidising investments in technology

Technological innovations have significant potential to promote better care and a better use of resources across the health and social care divide, including:

• Smartphone apps can help supported living. For instance, one smartphone app uses a wearable garment with wireless health sensors and a GPS to communicate conditions to professionals monitoring patient progress remotely.

• Telehealth and telecare devices can help people live independently at home, including early pull chords and specialist sensors.

• Equipment can allow rapid and remote diagnosis of conditions, thus enabling, for instance, more efficient treatment of Stroke.

Currently, there is insufficient incentive for commissioners to invest in technological adaptations for community services because the returns are not immediate. The costs of technology to facilitate integrated care records are also significant. The Government has already announced a bidding fund of £500m called the ‘Integrated Digital Care Technology Fund’. This aims to provide funds for NHS Trusts to support progression from paper-based clinical record-keeping to integrated digital care records.

In the Autumn Statement 2014, the Government announced that £200m is to go a transformation fund to help establish new models of care. We argue that a part of this fund should be set aside to stimulate investment and technological innovation in telehealth and telecare services.

Adopt personal care planning

The methods set out above should all drive a more holistic approach to commissioning. However, at the same time we should encourage the system to plan for the total needs of the patient. The ‘House of Care’ model developed as part of the ‘Year of Care’ provides a template for this. This model was a primary care-level intervention for patients with long-term needs piloted in Tower Hamlets, Calderdale and Kirklees PCTs and NHS North of Tyne. The approach encouraged the active involvement...
of patients in developing, alongside clinicians, their own care plans. It includes all aspects of health and social care.

**Step 3: Develop and manage the market**

*As part of its programme to evolve new models of care, NHS England and local commissioners should work proactively in all localities to ensure that there is a diverse range of bodies positioned to compete for any services including mutual, social sector and public and private sector providers.*

Developing the market and encouraging collaboration for integration

If the market can be a facilitator of effective integration, this is dependent not only on the form of commissioning adopted (as discussed above) but also the market of providers and how they interact. Diversity and plurality of providers is a necessary condition for effective competition, and hence for desired innovation, good quality care and productivity improvements. Plurality ensures that there are sufficient organisations to compete for business, guards against consolidation of the market, guarantees that there is back-up in case of provider failure and increases the chances of innovation.

Indeed, diversity is particularly important in health and social care services. First, no single organisation is likely to be able (or indeed willing) to seek to meet the whole needs of a patient let alone a large group of patients. Second, for-profit organisations are better-able to make capital investments in innovative practice, whilst charities may be more mission-driven and able to subsidise their activities with voluntary donations of time and money. Mutuals, such as some Foundation Trusts and other co-operative organisations, may be considered to be ‘people businesses’ suited to the provision of care. A brief glance at the range of providers of healthcare in England shows a significant under-representation of mutuals compared to other countries. In France, a fifth of health services are provided by the mutual sector; in Germany, over a third of hospital beds are provided by not-for-profit organisations. Third, there is a vibrant third sector providing and funding health and social care services: it would be counterproductive not to seek their involvement in care services.
Managing the market for outcome based contracts

Under outcome-based commissioning, there will be an important role for commissioners to stimulate the market, to encourage collaboration and, if necessary, to regulate.

- Commissioners can help build alliances and understanding between providers, especially across the private and third sector by matching and building awareness.
- Previous SMF research suggests that the government must consider carefully the types of providers that are likely to bid for contracts and the distribution of risk within the supply chain and the outcome risks to which smaller providers and especially charities are exposed.\(^{71}\)
- National regulators should also be alert to the potential problem of any one provider being ‘too big to fail’ and assess contingencies that can be put in place so that there is continuity of service.

Patient-led markets

In choice-led markets, regulators and commissioners will have to develop and regulate the market such that there is a sufficient range of suppliers for choice to be meaningful and to overcome any information barriers. Important steps are likely to include:

- Ensuring that consumers (and their agents) have the requisite information on quality as well as costs of services so that they can make informed decisions.
- Considering the role for social sector organisations not only as providers but as advocates and brokers acting on behalf of patients.
- Broadening the range and type of providers in the market.\(^{72}\)
- Helping current providers – many of whom will be accustomed to traditional block contracts – adapt and respond to patient demand.\(^{73}\)
- Lowering barriers to entry to allow new providers to enter the market.
• National regulators should assess the extent to which the regulation on ‘Any Qualified Provider’ will operate as choices are made across the care divide.

Summary of recommendations for next steps

Recommendation: As part of its programme to prototype new models of care with the most advanced health economies, the next government should encourage a number of areas to pilot ‘All-out care’ and ‘Patient First Budgets’.

Recommendation: As part of its attempt to help all areas adopt new models of care, the next government should:

• Mandate a deadline of 2020 by when local health bodies and councils must have pooled their whole budget.
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• Provide generous subsidies for commissioners to reduce the costs of capital and make SIBs an attractive proposition for commissioners.
• Direct a portion of its new £200m Transformation Fund to help investments in innovative technologies in non-hospital settings.
• Encourage all areas to adopt practise such as care planning.

Recommendation: As part of its programme to evolve new models of care, NHS England and local commissioners should work proactively in all areas to ensure that there is a diverse range of bodies positioned to compete for any services including mutual, social sector and private sector providers.
PART 2: THE FUTURE OF FUNDING

Part 1 discussed the future direction of health and care services. Part 2 explores the funding reforms that should accompany it. As noted in the Introduction, the future funding arrangement must meet a number of core objectives:

• **Objective:** To align incentives by treating an individual’s health and social care needs equally.

• **Objective:** To distribute costs in line with principles of social justice both within and across generations.

• **Objective:** To give the individual an incentive towards preventative action.

• **Objective:** To be sustainable and provide sufficient money now and into the future.

• **Objective:** To be practicable within the UK and have some resonance with the existing pattern of funding.

• **Objective:** To meet wider efficiency concerns and to facilitate equitable access to care.

Below, we discuss the range of options for reforming future funding and test them against these core objectives.

**What level of care to fund**

There is little logic in treating health and social care needs differently. Health and social care services should be put on an even footing and made available to patients on the same terms either by charging for both or making both free-at-the-point-of-use. A study by the ‘Personal Social Services Research Unit’ for the King’s Fund estimated that it would cost an additional £3bn to cover ‘critical and substantial’ needs and £7bn to cover ‘moderate’ needs as well.74

These steps need to be seen in the wider context of growing funding pressures over time associated with budget cuts in local government,
an ageing population and the costs of medical advances. Even assuming annual productivity improvements in health of 2-3% a year, this still leaves a shortfall of £12bn. Integration itself is not the answer to this funding shortfall. There is little evidence that integration can do more than reduce the upward trend in demand in the long term. In the immediate term, integration may mean running services in parallel.

The funding options

By one means or another, the public has to pay for care costs. But, there are a wide range of methods for reforming funding. Here we ignore options that redistribute public expenditure from outside of health and social care (e.g. by reducing pension tax relief or abolishing Winter Fuel Allowance) or revolve around simply rationing existing services to reduce costs. The principal options we consider are:

- General taxation – including altering income tax thresholds.
- Raising more from national insurance contributions.
- Levying a wealth tax on people whilst alive or on death.
- Moving wholesale to a social insurance system funded by employee contributions.
- Raising more money in the NHS by asking individuals to contribute privately.

As can be seen from the list above, health and social care funding can be pushed in one of two principal directions. First, expanding public funding would make social care services more akin to the current NHS – with broad coverage of services available and with the state carrying the risks. The Care Act 2014 has nudged social care in this direction. Alternatively, costs of health care could be shifted onto individuals so as to mirror the market for self-funded social care services, with the individual bearing some or all of the risks.

The decision on which way to move is likely to be the outcome of the trade-off between two over-riding objectives in any health and social care system. The first objective is to prevent as far as possible health needs
and costs arising. In an ideal world, there would be a strong incentive on the individual to prevent health needs occurring – because individuals are best-placed to make judgements as to what action to take, for instance, in improving their lifestyle. The second objective is to ensure equitable access to care and support if and when the needs materialise. This goal may favour forms of pooled risk (either via the state or via insurance markets) and means-testing. This complicated trade-off – on the one hand incentivising the individual to seek to prevent needs arising versus protecting them from excessive costs when needs do arise – encapsulates much of the inherent tension between public and private funding.

1.1 PUBLICLY FUNDED OPTIONS

Publicly-funded care could be paid for by levies on:

- The working age population, such as via income tax or workers via National Insurance contributions (see for instance Funding Scenario 1 below).
- Wealth – via a capital levy on a person at a specific age or on death (see for instance Funding Scenario 2 below)

In deciding how any money is raised publicly a number of factors should be considered, especially whether the costs should be levied solely on the working-age population. First, the dependency ratio is declining, meaning that each working-age person will have to fund services for a growing number of older people. This means that any tax that falls wholly or predominantly on the working-age population is likely to have to be increased over time as the proportion of the population that can be taxed dwindles and the proportion that need care and support grows. Some countries that have introduced mandatory insurance funded by levies on workers’ wages – such as the Netherlands – have been unable to sustain generous social care entitlements.\textsuperscript{77} Simply raising income tax (as set out in Funding Scenario 1) would therefore be problematic. This may also make social insurance unattractive (see Funding Scenario 3).
Second, working-age taxpayers already bear the longevity risks of the older population through the state pension. It is highly questionable whether younger cohorts should also have to bear all the longevity risk for preceding generations for health and social care costs. It may be more sustainable to distribute the risks more widely across society.

Third, there are equity concerns about the distribution of wealth and assets across generations. For instance, the older generation holds a greater proportion of housing wealth than did previous generations. Therefore, there may be logic in making each generation pay for its own care. For instance, in Canada, the concept of ‘prefunding’ is being debated, in which working-age people pay upfront towards the costs of their own care in old age, so that each cohort bears its own costs. Finally, older people would be significant beneficiaries of a public-funded health and social care service and could therefore be expected to contribute something towards its costs (as would also be expected of younger generations).

Funding Scenario 1: Income tax-funded ‘National Health and Social Care Service’

The current funding regime for healthcare services could be expanded to encompass social care services, thus creating a universal, free-at-the-point-of-use care service in which there is no means-testing. Were such an approach to be adopted, it would be logical to expand the basket of social care services available free of charge to include ‘moderate needs’ so as equalise them and ensure that individuals can get by adequately on state support. This would cost approximately £7bn.

Adopting the current NHS funding model would mean a heavy reliance on taxpayer funding. This would follow the recommendation for a publicly-funded social care system made by the Royal Commission in 1999. To boost the political sustainability of the funding, the money could be clearly hypothecated to care services for instance by creating a specific element of income tax that funded the service.
This may boost the political salience of spending on care services. As an order of magnitude, to raise sufficient funds to state-fund social care at ‘moderate’ levels, the government could raise the basic rate of income tax by 2p or the higher rate by 7.5p.\textsuperscript{81} This would cover the immediate shortfall.

While the social care costs of patients would be met, individuals would still be responsible for the costs of board and lodging.\textsuperscript{82}

In addressing the dilemmas set out above, wealth taxes are likely to have some attractions. As the Mirlees Review of taxation and the Barker Commission for the King’s Fund pointed out, taxation of property and wealth is more efficient than taxing income. It might also address concerns about the intergenerational distribution of wealth and assets as well as ensuring that older people – as the primary beneficiaries of more heavily subsidised care – contribute.

**Funding Scenario 2: ‘Care levy’ for social care costs**

Under this option, each individual would be liable to make a lump sum contribution to a ‘Health and Social Care Fund’. The amount would be calculated each year for those reaching State Pension Age. The sum could be paid immediately or deferred so as to make a call on the estate at the point of death. This would be simpler to administer than an inheritance tax given the latter is open to gaming. Assuming that a wealth threshold continued as present, it would be no more progressive than the current funding arrangement but it would reduce the lottery element of care funding (which cannot be adequately dealt with through insurance).

This would have the advantage of internalising the cost for each cohort. However, the cost imposed on each generation would be the predicted costs of care estimated when they retired and would therefore be liable to alter were periods of morbidity to vary unexpectedly or costs of care to change.
All three major parties have shown their readiness to use levies and charges on estates to pay for care. Prior to the last general election, the Labour Government proposed imposing a levy of about £20,000 on every 65 year old. They argued that this would enable state-funded social care. The Coalition Government is subjecting more people to inheritance tax in order to pay for part of the capped care cost reforms to be introduced in England in 2016.

As a transition measure and so that people do not have to pay twice (for care they have already received and for a levy), the government could phase this in so that only a partial charge is levied on the existing retired population.

As described in Table 2 below in more detail, different public funding options achieve different objectives. While some options are able to achieve social justice objectives, where all public funding options fall down is that they do not put an incentive on the individual to take preventative action. Therefore, it is questionable whether it is advantageous to aim to socialise all the risks. As discussed below in Funding Scenario 3, social insurance faces a similar problem, as well as posing particular dilemmas of its own.

**Funding scenario 3: Social insurance in the UK?**

A number of commentators have proposed that the UK should move to a social insurance system. Social insurance is the most common form of health financing on the continent, although it is adopted and utilised in many different forms. It is characterised by compulsory contributions made typically by working-age individuals to insure against their health needs; these funds are administered by a quasi-independent public body; typically the premiums paid are risk-blind (i.e. the insurers cannot price in the health risks of an individual into the premium they charge); often regulators prohibit insurers from turning clients away (to guard against creaming).
The SMF has previously considered the merits of social insurance for health services. Social insurance has significant potential advantages, which include: scope for choice (sometimes between insurance companies, and at times once insured between providers of care); transparency of costs and of care and a clear link to the services subsequently available. It also resolves problems such as selection, individuals’ myopia and creaming that beset private health insurance.

However, four major arguments can be made against it. First, many (though not all) of its attributes can be replicated in a predominantly tax-payer funded care service: choice can be given to the patient; in outcome-based contracts, providers have the same incentive as the insurer for preventative action to reduce the downstream costs where possible; and, there may be other ways of providing transparency. Second, insurance markets typically struggle more than state-financed models to contain costs. This is because of the moral hazard facing individuals and the fact that it is easier for the state to ration care than it is for insurers to do so. Third, there remain significant questions (as set out in Table 2) over the problems with imposing the costs predominantly on the working age population. Fourth, regulation imposed to ensure coverage (such as not allowing insurers to charge different premiums) serves to reduce the effectiveness of market forces that would otherwise exist and to constrain choice.

2.2 PRIVATELY FUNDED OPTIONS

When proponents talk about charging and self-funding they almost always mean the sharing of costs or hybrid funding. As shown in the box below, most countries have a mix of publicly-funded and privately-funded social care. The UK currently has a hybrid model of public and private funding across health and social care. But, it is not well-designed because it locks in existing discontinuities across health and social care. If this is resolved, there is no reason why a hybrid model should not be adopted whereby the patient and the state share risks and the costs.
Mix of private and public funding in other countries

Research by the OECD shows that nearly all countries have a mix of privately-funded and publicly-funded social care services – even if the balance varies markedly.87 The OECD has identified three broad types:

a) Universal coverage: funded either by tax (Scandinavia); social insurance (Germany, Japan); or provided through the health service (Belgium). Most countries that have social insurance schemes for social care also have an element of social insurance in health and there is, thus, some complementarity.

b) Mixed systems: may include care benefits distributed to all but larger benefits given to those with less means.

c) Means-tested safety net: where most costs and risks are borne privately except for those with the lowest financial means and the highest care needs.

Most comparator countries also have a much wider range of charged-for services across health services than the UK: many charge for primary care visits; a large number for inpatients.88 This applies both in largely taxpayer-funded models (such as Norway) and social insurance models (such as France and Germany).

Charging raises significant questions of efficiency (administrative costs associated with charging and means-testing); and social justice (whether equitable access can be maintained or whether patients may forego care and treatment to reduce the costs). If these can be addressed, a number of factors suggest that a reformed cost-sharing model would be a logical way to fund a health and social care service for the future.
A hybrid funding model for health and social care would have a number of distinct advantages:

1. A privately-funded element would put more responsibility on individuals because it is they that bear more directly the costs of treatment and can be expected to take reasonable steps to reduce the risks of this occurring. By making the costs transparent it would reduce moral hazard.

2. Our current system contains a mix of state and individual responsibilities for meeting the costs of care. Aspects of standard healthcare treatments (prescriptions, dental treatment, some hospital costs and optometry) are already borne privately, with exemptions for those deemed less able to afford to pay; many individuals bear all the costs of social care services themselves with only the poorest receiving means-tested support.

The problem is that these costs are complex, poorly-understood and haphazard. There is a strong argument to equalise entitlements and costs across health and social care. This would remove the anomaly whereby patients pay for certain treatments (prescriptions), certain aspects of care (dementia care) and certain parts of their anatomy (eyes and teeth) and not others. Such a funding regime could be phased in over time.

Such a policy would promote greater equity in terms of the distribution of the costs by spreading the costs of social care more evenly across the population. It might also be noted that the distribution of health and social care costs have different patterns across the population. For instance, only 1 in 4 people over the age of 65 have social care needs and under a quarter of people aged over 75 die in nursing or other residential care; meanwhile, nearly 60% of people aged over 75 die in hospital. Data from South Somerset’s Symphony Project indicates this effect with consumption of publicly-funded healthcare services spread more broadly across the population than consumption of publicly-funded social care services alone (see Appendix).
3. As Kate Barker’s review for the King’s Fund argued, ‘the NHS is unique in its low level of cost sharing’ compared to other countries. Most other health systems charge users fees. Given the widespread existing range of charges within health and social care, the opportunities through new data sharing, the information on unit charging that exists through the internal market and developments in electronic payments, we believe that the administrative changes would be manageable.

4. If designed sensitively it should be possible to use charges as a check on unnecessary consumption of care, whilst ensuring that any detrimental effect on access is minimised. Funding Scenario 4, the ‘Personal Care Account’ is based on a partnership model of funding between the state and the individual. By placing an element of risk on the individual, this would put downward pressure on demand and give the individual an incentive for preventative action, whilst the publicly-funded element would protect individuals from major costs. Charges could be capped as annual and lifetime maximums.

5. A combination of individual and state funding would be a good means of ensuring sustainability of funding for healthcare by ensuring a wide base of contributors.

6. Charges could be means-tested both on the basis of wealth as well as income to overcome equity concerns and to ensure that costs are borne by groups that have the resources to pay for care. Once introduced, Universal Credit would be one relatively straightforward option for carrying out this means-testing.

7. The move to greater public support for social care would be an opportunity to reconsider the issue of unpaid carers and whether they receive the requisite support or reimbursement currently. The proportion of individuals providing unpaid care is higher in the UK than in almost any other country. The strain on many is very heavy and inefficiencies arise where caring duties undermine other responsibilities at work or in the family. However, in the UK, social care is means tested not only on the basis of the wealth of the individual but
also on the basis of availability of unpaid care. Conversely, many other countries have systems that take a more generous view of unpaid care support. For instance, Hungary, Slovakia and the Czech Republic have set up ‘cash-for-care schemes’ under which individuals receive a budget with which they can remunerate their family carers. There are a range of support mechanisms in place for carers such as Carers Allowance.

Funding scenario 4: A ‘Personal Care Account’

The ‘Personal Care Account’ would be designed to allow the individual and the state to contribute to the costs of health and social care. These charges across health and social care would be set at a low level percentage of the cost of care and capped as a per annum charge and a total lifetime charge. As with the Dilnot principle in social care, the state would bear the catastrophic costs of care. These charges could be means-tested so that only those with sufficient income or wealth were subject to charging. We propose that there should be both an income threshold and a capital threshold. The latter could be raised to target the asset-rich.

As a default, provision could be made – or financial products developed – to allow individuals to defer payment of their charges until death. Introducing charging and capping the costs would allow other innovations to emerge. For instance, individuals could potentially be allowed to build up credits by providing unpaid care support to others. These ‘credits’ could, for example, serve to reduce the lifetime cap from its starting position. This would mirror other countries such as the Netherlands, Australia and France where patients can use their personal budgets to remunerate carers (although at a lower rate than would be paid to formal carers).

Such a funding model would work well where the individual has significant choice over the care that they receive and less well where there is a monopoly provider.
<table>
<thead>
<tr>
<th>Objective: To align incentives by treating an individual’s health and social care needs equally.</th>
<th>Income tax</th>
<th>Workers, e.g. national insurance</th>
<th>Levy on cohorts at specific age or on death</th>
<th>Social insurance</th>
<th>SMF’s Personal Care Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public or private?</td>
<td>Public</td>
<td>Public</td>
<td>Public</td>
<td>Depends on design.</td>
<td>Hybrid.</td>
</tr>
<tr>
<td>Objective: To distribute costs in line with principles of social justice both within and across generations.</td>
<td>As progressive as tax regime. Likely to advantage older generation over working age population.</td>
<td>Advantages older generation over working age population, unless current older population can be levied in an alternative way (see King’s Fund report). Less progressive than income tax (threshold for paying is lower and contributions are not levied on income above £42,500).</td>
<td>Possible. Threshold determined by wealth rather than income, thus replicating inheritance tax and its distributional effects.</td>
<td>Arguably advantages older generation over working age population.</td>
<td>Possible, assuming an income and wealth means-test.</td>
</tr>
<tr>
<td>Objective: To give the individual an incentive towards preventative action.</td>
<td>No because individual bears no risk.</td>
<td>No because individual bears no risk.</td>
<td>No because individual bears no risk.</td>
<td>No, assuming all the risks are pooled and insurers can’t price the risk.</td>
<td>Yes (to the extent of the charge).</td>
</tr>
</tbody>
</table>

Table 2: Funding options and how they perform against the objectives
<table>
<thead>
<tr>
<th>Income tax</th>
<th>Workers, e.g. national insurance</th>
<th>Levy on cohorts at specific age or on death</th>
<th>Social insurance</th>
<th>SMF’s Personal Care Account</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective: To be sustainable and provide sufficient money now and into the future.</strong></td>
<td>Questionable, as the population is growing older and the proportion of the working population paying is shrinking proportionate to the proportion receiving care.</td>
<td>Yes, although danger that estimated costs of care may be much lower than actual costs of care.</td>
<td>Questionable, as social insurance may provide a weaker method of controlling costs than state or individual funding.</td>
<td>Yes. Broadens base of funders.</td>
</tr>
<tr>
<td></td>
<td>Closest to current funding arrangement.</td>
<td>Builds on history of national insurance and replicates some European comparators.</td>
<td>Capital means-test has some similarities to current social care funding model.</td>
<td>Introduces no more charges than are present currently.</td>
</tr>
<tr>
<td></td>
<td>Builds on history of national insurance and replicates some European comparators.</td>
<td>Increases made previously (1% in 2001) to pay for NHS services. Probably popular though policymakers would have to overcome distrust of national insurance and its opaqueness in national accounts.</td>
<td>Totally new model of funding without any basis in post-war care services.</td>
<td>Rhetorically different from status quo. But, this model has similarities to practicalities of current arrangements.</td>
</tr>
<tr>
<td><strong>Objective: To be practicable within the UK and have some resonance with the existing pattern of funding.</strong></td>
<td>Disincentive effect on earnings from work. No access trade-offs.</td>
<td>Disincentive effect on earnings from work. No access trade-offs.</td>
<td>Disincentive effect on saving. No access trade-offs.</td>
<td>Access trade-offs can be managed via exemptions for those with fewer resources. Disincentive effect via means-test.</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
Recommendation: The SMF’s preferred method for reforming would be a ‘Personal Care Account’. Under this, the state would continue to pay for a very large part of the costs of care. At the same time, the social care costs that currently fall on the individual would be redistributed so that they fall more fairly across the population and act as an incentive for individuals to take preventative action. Under a ‘Personal Care Account’:

- The individual would make co-payments set at a small percentage of the actual cost of care.
- Payments would be capped as a per annum charge and as a total lifetime charge, with the state paying for the remaining costs.
- Those on low incomes or with low levels of wealth would be exempt.
- We recommend that this change should be introduced as a cost-neutral reform: in other words that the level of charges in the future system should not exceed the level of charges in the current system. To ensure that those with ‘moderate’ social care needs are eligible for support, this would mean re-distributing £7bn of charging that currently falls solely on social care patients to all health and social care patients.

The aim of this policy is to preserve the same level of state funding of health and social care as exists currently in aggregate and retain a predominantly state-backed and taxpayer funded system. Where costs are borne by the individual they would be spread more evenly across the population and reduce the huge anomalies across care.
Summary of recommendations for future funding

• Any future funding regime should offer equal entitlement to health and social care services.

• The SMF’s preferred method for reforming would be for the state to continue to pay for a very large part of the costs of care and to redistribute the costs that currently fall on the individual so that they fall more fairly across the population and act as an incentive for individuals to take preventative action. Under a ‘Personal Care Account’, the individual would make small co-payments for each aspect of their care. These would constitute only a small proportion of the costs of care and would be capped as annual and lifetime sums, and subject to means-tests. We recommend that this change should be introduced as a cost-neutral reform: in other words that the level of charges in the future system does not exceed the level of charges in the current system.
APPENDIX 1: HEALTH AND SOCIAL CARE COSTS

Figure 4: Estimated total costs of health and social care in England

<table>
<thead>
<tr>
<th>Total healthcare expenditure</th>
<th>£120bn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total social care expenditure</td>
<td>£30bn</td>
</tr>
<tr>
<td>Total private expenditure</td>
<td>£27bn</td>
</tr>
<tr>
<td>Total public expenditure</td>
<td>£123bn</td>
</tr>
</tbody>
</table>

HEALTHCARE SPENDING:


- Private spending: £7.2bn was spent on dentistry in the UK in 2009/10. Of this, £4bn was private dental expenditure, £2.1bn of which was dental treatment. Of the private expenditure on dental treatment, £1.8bn was spent in England. The remainder of the private dental expenditure was spent on cosmetic dentistry. Of this £1.9bn, £1.6bn was spent in England (obtained by applying an England-UK population ratio of 0.84). Rounded to the nearest integer, some £3bn was spent on private dentistry in England in 2009/10. King’s Fund – *A new settlement for health and social care: interim report* (2014)


• Self-pay, private medical insurance and NHS purchases/private patients amounted to £6.7bn in 2013/14. The figure relates solely to the private market for screening and acute medical care. An estimated £1bn was NHS purchase of non-emergency operations and £0.4bn NHS private patient payments. The remainder was estimated as the total private spending in this sector (The King’s Fund). It is made up of private acute hospital sector spending, specialist fees, private screening, and pregnancy terminations. King’s Fund, *The UK private health market* (2014); King’s Fund – *A new settlement for health and social care: interim report* (2014). http://www.laingbuisson.co.uk/MediaCentre/PressReleases/LaingBuissonHealthcareMarketReview20132014.aspx

SOCIAL CARE SPENDING:


## APPENDIX 2: ACCOUNTABILITY AND COMMISSIONING

Table 3: How the accountability question plays out across different commissioning approaches

<table>
<thead>
<tr>
<th>Form of commissioning</th>
<th>Why local accountability would be preferable to national accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>State provision</td>
<td>Local accountability preferable so that commissioners are closer to providers. It is hard to see how a system can stipulate meaningful patient entitlements at a national level (which are adhered to) whilst allowing genuine flexibility at the local level.</td>
</tr>
<tr>
<td>Commissioning for outputs</td>
<td>If activities are stipulated and standardised nationally, even less scope for effective integration than were activities to be stipulated locally.</td>
</tr>
<tr>
<td>Commissioning for outcomes</td>
<td>Theoretically, a national commissioner could commission outcomes for all people in the country via one provider, but local commissioning more desirable:</td>
</tr>
<tr>
<td></td>
<td>• National commissioning would be problematic because this would limit the number of prime contractors in the country, which would reduce the benefits of competition at bidding points. The existence of only one provider would also increase the risks of service discontinuity in an instance of provider failure.</td>
</tr>
<tr>
<td></td>
<td>• If national contracts are split by different types of condition this helps increase the number of providers, but this would lock-in the discontinuities across different parts of health and social care.</td>
</tr>
<tr>
<td></td>
<td>• A local commissioner would be better placed to adapt the commissioning strategy to specific needs of the population.</td>
</tr>
<tr>
<td>Patient choice</td>
<td>Local commissioners are likely better-placed to manage the market of providers and to seek to ensure that the patient has sufficient information and advice to make informed decisions on care.</td>
</tr>
</tbody>
</table>
ENDNOTES

12. Sarah Gregory, *Attitudes to health and social care: review of existing research* (King’s Fund, 2014)
24. This is driven principally by rapid growth in the number of older people with disabilities and much slower growth in the number of adult children providing care. Linda Pickard, ‘A growing care gap? The supply of unpaid care for older people by their adult children in England to 2032’, *Ageing and Society*, August 2013
25. Anita Charlesworth, *NHS Finances – The challenge all political parties need to face* (Health Foundation, 2015)
29. Albeit at some cost to certainty of demand.
30. http://andyburnhammp.blogspot.co.uk/2015/01/andy-burnham-speech-on-labours-10-year.html
34. Chris Ham, Judith Smith and Elizabeth Eastmure, *Commissioning integrated care in a liberated NHS* (Nuffield Trust, 2011)
35. For a detailed discussion about the spectrum between output-based contracts and outcome-based contracts, see Chris Ham, Judith Smith and Elizabeth Eastmure, *Commissioning integrated care in a liberated NHS* (Nuffield Trust, 2011)
46. It should be noted here: there are always likely to be many elements of care (such as highly specialised care) where state monopoly provision may be the most efficient option.
48. Sir John Oldham et al, *One person, one team, one system* (2014)
50. For instance, the provider delivering Knowsley’s integrated cardiovascular service was eligible to up to performance payments of 20 per cent of the value of the contract in the first year, rising up to 40 per cent in the third year.
53. Social Care Institute for Excellence, *Factors that promote and hinder joint and integrated working between health and social care services* (2012)
54. Dave West, ‘Sheffield aims for single health and care budget’, *HSJ*, 20 June 2014
55. *Sheffield’s Plans for Integrated Commissioning of Health and Social Care Information Document May 2014*
57. Somerset Partnership NHS Foundation Trust Performance Report (July 2013)
64. SMF, *Risky Business?* (2013)
69. For instance, NHS Scotland established in 2011 a £10m fund for investment in telecare and telehealth. The aim of the fund is to facilitate the treatment of patients at home. Technologies such as tablet computers and smartphones can allow remote monitoring in real-time of conditions. http://news.scotland.gov.uk/News/Digital-future-for-the-NHS-a0a.aspx
70. See Health Foundation website: http://www.health.org.uk/areas-of-work/
PUTTING PATIENTS IN CHARGE

programmes/year-of-care/; Angela Coulter, Sue Roberts and Anna Dixon, Delivering better services for people with long-term conditions Building the house of care (King’s Fund, 2013); Year of Care Report of findings from the pilot programme (2011)

71. See for instance Nigel Keohane, Breaking Bad Habits: Reforming rehabilitation services (2014)
73. Claudia Wood, Tailor made (Demos, 2011i)
74. Barker Commission, A new settlement for health and social care Final report (King’s Fund, 2014)
75. This is based on the NHS projection of £8bn in the NHS plus £4.3bn in social care as projected by the LGA and ADASS.
76. There does not seem to be a sound rationale for removing these allowances specifically to fund care even if some may argue that they should be altered in any case.
77. Ruth Robertson, Sarah Gregory and Joni Jabbal, The social care and health systems of nine countries (King’s Fund, 2014)
78. See for instance Intergenerational Foundation, Hoarding of Housing (2011)
79. OECD, Health Reform: Meeting the Challenge of Ageing and Multiple Morbidities (2011)
80. See House of Lords debate, 1 March 1999 vol 597 cc1392-406
81. HMRC, Direct effects of illustrative tax changes (2014)
82. The vast majority of countries charge individuals for board and lodging when they are in residential care.
83. HMG, Shaping the Future of Care Together (2009)
84. James Lloyd, Options for funding care (2014)
86. Lord Warner and Jack O’Sullivan, Solving the NHS care and cash crisis: Routes to health and care renewal (Reform, 2014)
87. OECD, Help Wanted? Providing and Paying for Long-Term Care (2011)
88. Thomas Cawston and Cathy Corrie, The cost of our health: the role of charging in healthcare (Reform, 2013)
90. Centre for Health Economics, The importance of Multimorbidity in Explaining Utilisation and Costs Across Health and Social Care Settings: Evidence from South Somerset’s Symphony Project (2014)
91. Ruth Robertson, Sarah Gregory and Joni Jabbal, The social care and health systems of nine countries (King’s Fund, 2014)
92. Sarah Gregory, ‘What can we learn from how other countries fund health and social care?’ King’s Fund, 26 March 2014
93. OECD, Help Wanted? Providing and Paying for Long-Term Care (2011)
94. Ruth Robertson, Sarah Gregory and Joni Jabbal, The social care and health systems of nine countries (King’s Fund, 2014)
All political parties now acknowledge the importance of more integrated – or person-centred – care. The challenge is how to pursue this during the next parliament.

Due to the divides across health and social care, current provision is characterised by huge inefficiency, poorly coordinated support and underinvestment in preventative care. In response, the paper advocates a single local commissioner, a greater role for a diverse market of providers and a future where patients can be given much greater control of spending across both health and social care. It sets out steps to get us there by 2020.

The second part of the report addresses the inequity, unsustainability and illogicality of funding: while the NHS remains free-at-the-point-of-use, many individuals have to cover their own costs of social care. In addition, we face a care funding shortfall of £12bn by 2020. The paper recommends that eligibility for social care services should be the same as for health, and it advocates redistributing the costs borne privately in social care across the whole of health and social care services. By spreading the costs more widely, it would make the system fairer; by broadening the base of contributors and giving individuals an incentive to prevent care costs, this would boost sustainability.