Improving the integration of health & social care: Why prioritised? What effort? What obstacles? What achievement? What opportunity? What promise?

Bleddyn Davies

PSSRU at LSE & universities of Kent & Manchester and Oxofrd Institute of Ageing

b.davies@lse.ac.uk[27]

PSSRU

at the University of Kent at Canterbury, the London School of Economics and the University of Manchester

Paper's argument

- Integration an important policy goal in care of frail older people from time to time in every period postWW2. But the constructions put on the concepts change. The constructions at each stage influence subsequent constructions.
- The investment in pursuit of each of the sequence of constructions has influenced the pattern of outcomes in each phase. The pattern of outcome determined who benefits. Who is to benefit has often been implicitly incorporated into the construction.
- Pressures improving system fairness effectiveness and efficiency have sharpened dilemmas in the definition & prioritisation of constructions: there are bigger resource effects on outcomes & clearer trade-offs between outcomes

The presentation is an historical narrative exploring these propositions around the questions in the sub-title. It illustrates that to draw messages about integration from international comparisons requires understanding of national developmental paths & concept constructions

1. Post-War to Seebohm Report: 1945-68

- Integration not priority. Local residential, nursing and home help not coordinated as required for a strategic policy for care frail older people. NHS/LA divide; also separation within NHS and LAs
- Increasing pressure from local government for financing to help cope diversion of demand from NHS - progressive boundary redefinition.
- Blocking of hospital beds, escalating per diem costs with advances in acute medicine.
- Potential after Powell's visionary water tower speech (1961) but Ten Year Plan little more than minimalist linkage of resource frameworks – policy drift without committed and imaginative political leadership?

1945-68: Paper Questions

Why integration not more prioritised?

- *Preventing cost escalation*– pre-Guillebaud scare, long-run anxiety, so boundaries around free NHS convenient. Narrow policy ambition - *professional laissez-faire within budget and bureaucratic framework* consolidated (Klein)
- Ministry otherwise preoccupied – span of responsibilties, politics of NHS complicated – ministers short tenure
- Small departments with narrow scope & span in small local authorities, MOsH focused elsewhere

Achievements? Some preconditions for development:

- *Ideationally, broader movements laying foundations for reform* : local authorities as outcome-focused policy-making governments not providers of mandated services; greater professionalism of management and service (eg ideas from social work and social work training development).
- Demand-driven growth & budget base & adaptation of services

Phase 2: Seebohm to Griffiths 1968-1987: Report

- Labour administration 1964-. Wilson platform: modernisation. Party concerns: *deprivation & inequality not economic growth*.
- Seebohm Report: a *new 'policy paradigm'*: broad ends & means, focused on incorporating new ideas in US & UK. Integration across newly identified social care central. Hints of leadership of other policy silos around a nascent wellbeing agenda. Family interdependence key. Parallel developments in new public management & las' broad governmental role.
- Specific about integration into *powerful local department*. Vague about meso and micro structures & devices. 'Fabian' influence: top-down command & control with unawareness that markets, state monopoly provision, heavy subsidisation, trust in a dominant profession, paternalism more than rights.
- Coordination with health not especially privileged: social work constituency. Slid in despite contradictions. Fudged distinction between social care & social work, stressing former. Poverty not engaged

2 Seebohm to Griffiths 1968-1987: Evolution

- *Short burst of spending followed by fiscal austerity*: Oil Crisis exacerbated by 'English Disease'. Curtailment of investment in human capital and spending growth to meet demand. Gap between vision and reality. *Intellectual paralysis*: stop-gaps to curtail spending increases, uncoordinated elements of alternative vision emerging reflecting New Right & anticipating 'Reinventing Government' but also filling Seebohm gaps eg bottom-up mechanisms.
- Seebohm's new values & key vision well *embedded in local social services departments* – pace poverty & causation & intervention and later feminist critique.
- *Changes in prioritisation* reflected in decline of social worker influence cf new managers, of social work cf social care
- ***BUT*** *Problems at interface* of health and social care …

2 Seebohm to Griffiths: Interface of health & social care

- Diminished incentives for types of health/social joint field initiatives earlier praised by CMO of Ministry of Health.
- Diminished capacity for local strategies for epidemiologically inspired system-focused interventions.
- Parallel reforms to health system structures made those agencies increasingly self-absorbed too
- Changing function of hospitals, demand diverted to social care, cost-shifting, local government protests, later distrust of local government reflected in penal cost in local taxes of additions to local expenditure and spending caps.
- Responses: local joint planning mechanisms & joint finance (only 0.05% of NHS spend - pattern: limited marginal undiffused innovations incapable of system transformation); Social security system funding of residential care for poor (£1985 = 46x£1979)

2 Seebohm to Griffiths: Answers summarised

- Why not prioritised?
  - Path-determined institutional structures & political formations led to *prioritising construction of a social care paradigm*. Enduring influence of social care paradigm compared with other countries; cf CSCI in new qa consultation
  - DHSS priority for integration, psychiatric hospital closures. Las seen in lead in care of frail older people
- What achievement, promise, opportunity cost?
  - *Developments of institutional infrastructure* capturing resource commitment at local level & with some national influence capable of slipping under the radar of powerful competitors.
  - *Lacunae*: top-down, no coordination of fragmented services at field level, weak field policy & management, too influenced by cost containment
  - At field level, *'ships passing in the night'*: the obvious losses of low integration for some; for others compensated by holism of social care paradigm

3 From Griffiths to Modernising: Griffiths Logic

Political context

- Reflects forerunners of Reinventing Government and Ridley's 'enabling authority. Distrust of local government;
- Audit Commission: unsustainable growth in social security payments for care homes, distorted incentives because of fragmented systems

- Griffiths logic: new vision about structural framework
  - *Problems* At centre: gap between rhetoric of community care policy & reality because of fragmented responsibility accountability authority over policy-making financing and commissioning. In field, lack of coordination – care management 'the keystone' of proposals. *Solution*: consolidation and integration from top to field in context of enabling authority with infrastructural preconditions for market to work.
  - Acknowledged *integration issue*. Disruptive & costly structural change would be irresponsible without first testing adequacy of outcomes if removed roadblocks (restore financing of care home use to ssds; performance management in resources framework

3 From Griffiths to Modernising: What implemented

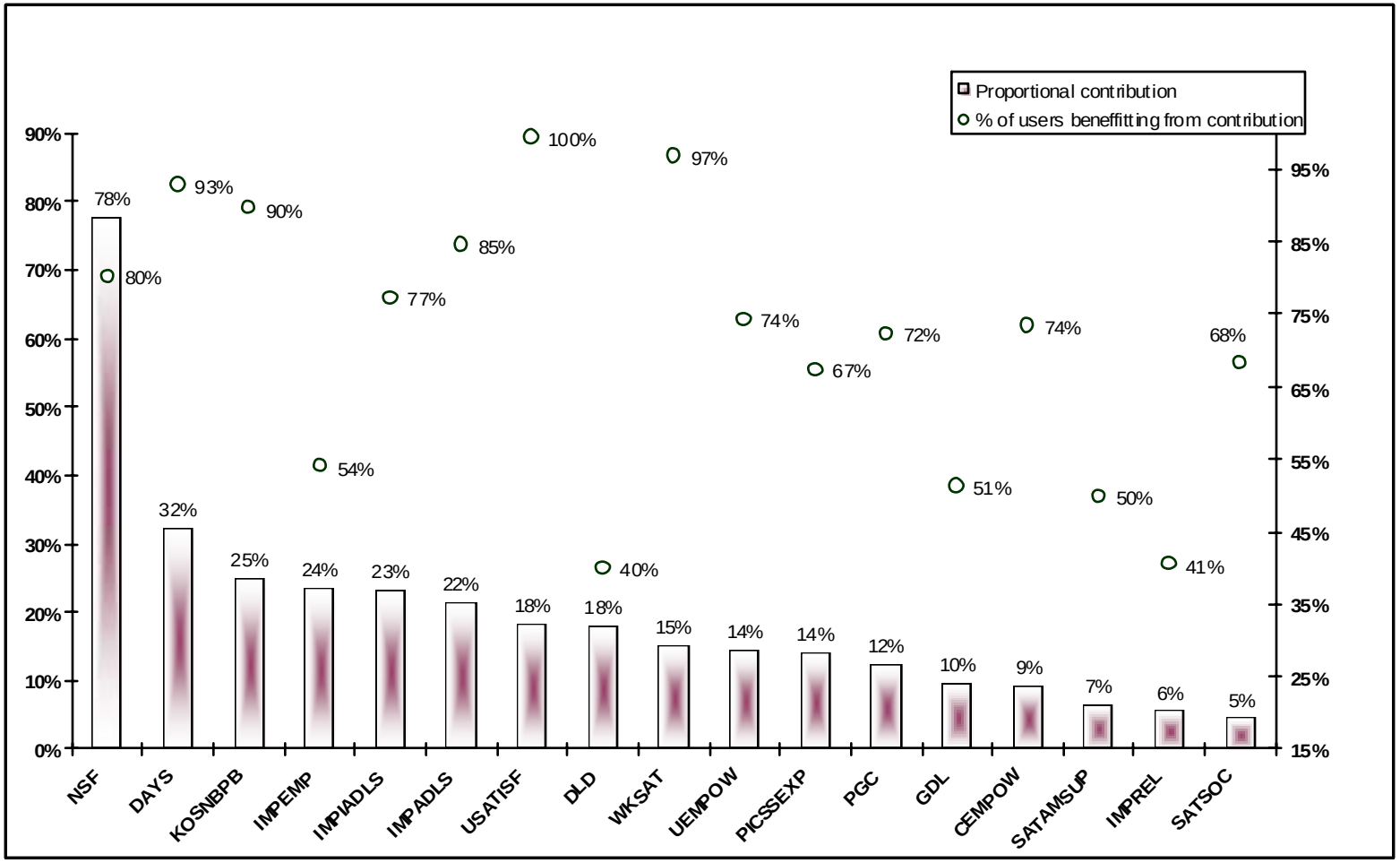
- *Consolidation of financing* but not ring-fenced grant; not budgeting from top to bottom conditional on collaboration built into community care plans
- *Care management:* DH pressed KCCP-style budget devolved cm, but las reluctant, so opportunity costs of alternatives given total budget could not be balanced by field team
- Throughout, *low growth in spending cf demands* – NHS cost-shifting (bed reductions, contraction of 'continuing care' & community nursing)', 'capping' and tax price of additional spending. Worsening health/social care relations. Pressure such that 'cms with $s in their eyes', allocation & performance management tied more to core business tasks, concentration based on narrow concepts of needs & risks
- Shift to primary care-led NHS – gp views narrower, patient-centred, not broad and community-focused.

3 From Griffiths to Modernising: Answers summarised

- *Main integrative effects within social care system* – 'This focus on individual cm focussed towards helping more people to live in their own homes was the key change to the system' (Modernising SC white paper 1998).
- *Achieved major benefits* – created system with predictable & substantial marginal productivities & rates of substitution, evidence of efficiency in producing goals most prioritised in 1989 white paper. (See ROPPs slide & targeting). Diversion from acute care
- BUT *low rate of improvement in integration* interpreted in context of political panic about consequences of waiting lists etc in NHS. (Pilot integrative field schemes in some better authorities, including Warner's Kent)

% predicted loss due to risk factors offset (ROPPs)

Source: Davies & Fernandez: Equity and Efficiency Policy …



3 From Griffiths to Modernising: Answers summarised

- *Main integrative effects within social care system* – 'This focus on individual cm focussed towards helping more people to live in their own homes was the key change to the system' (Modernising SC white paper 1998).
- *Achieved major benefits* – created system with predictable & substantial marginal productivities & rates of substitution, evidence of efficiency in producing goals most prioritised in 1989 white paper. (See ROPPs slide & targeting). Diversion from acute care
- BUT *low rate of improvement in integration.* Interpreted in context of political panic about consequences of waiting lists etc in NHS. (Pilot integrative field schemes in some better authorities, including Warner's Kent)

4. From Modernising … to present: 1998-: Logic

Weaknesses

- *Widening gap between ambitions and reality in 90s*: belief that low cost packages preventive, dilemmas of purposive allocation given scarcity more visible (& comprehendible) than achievement of improved ROPPs & COPPs, temporary support of 'carer blindness' (temporary loss of DH social care expertise & internal voice during a key period acknowledged); some groups neglected
- Post-Griffiths performance management had not achieved sufficient reduction of pressure on acute beds. Growing concern about Alzheimer's

So Modernising white papers

- *Integration*: a/the central priority, statutory duties to work in partnership: elaborate performance management with health policy priorities, tough sanctions
- *'Third Way'*: [a] partnerships, care trusts, Health Act flexibilities: & [b] Wellbeing Agenda with preventive intent – growing importance: green paper 2005BGOP & POPPs more bottom-up
- *Parallel NHS-run Intermediate Care* absorbing social care inputs

4. Contemporary instruments for integration

- ***Performance management***: reduction of hospital use highest priority targets for social care – waiting list: challenge to Blair in election campaign, then doubling of NHS spend. Targetry – but crude & unintended consequences & attaches responsibility for failure on centre. So reduction in number of targets and devolution
- ***Management structure, process & policy framework.*** Align performance of duties: Health Improvement Plans, Joint Investment Plans, Local Strategic Partnerships, Health Act 1999 'flexibilities' allowing 'care trusts', 'pooled budgets', delegated commissioning. Intense open & covert central pressure. Local level structures & processes affected. Targeted bespoke schemes. Costs & user outcomes mixed. Unclear re integration *level* in what circumstances
- ***Blair accountability web & integration in more directions*.** Public Service Agreements & Local Area agreements working through Local Service Partnerships. Older people bloc, some communautarian, in Wellbeing Strategy. Conflict between silo-specific accountability & local flexibility. Question may become 'whether NHS coordinated with local area strategies'.

Conclusions

Narrative broadly in line with summary of process

- Radically different constructions of integration between phases, and within (in response to stochastic events and learning)
- Creation by mid-late90s of big effects of substantial productivities for prioritised outcomes with clear tradeoffs between outcomes preceded the biggest effort to integrate better with health
- Reflected in system's achievements in the production of welfare – who benefited to what degree in what way at what costs to whom with what efficiency. Influence of social care paradigm strong on values and goals better matching ltc user & carer philosophies than some powerful health care paradigms
- But not full structural integration of, eg, care trusts: own inflexibilities

Examples of begged questions

Was Griffiths wrong to recommend first trying weaker measures to integrate health & social care, in effect prioritising integration within the social care system?

- Implicit in some argument of the time and since

But reforms

- Extended social care paradigm introduced in Seebohm
- Reforms established the technologically determinate care economy with high productivities, clear service-outcome relations, big valued outcomes
- More balanced basis for extending integration

Examples of begged questions

- ***Difference made by integration already to basic pattern of productivities, outcomes, who benefits, variations in efficiency between area & groups?***
- ***Increasing concentration reduced carer benefits compared with a decade ago?***
- ***Could pressure on care management have reduced its productivity?***
- ***Could diversion of social care budgets to intermediate care on balance have reduced outcomes for other high need cases?***

Evidence weak. Not all positive: cf (ignored) results of English 'Evercare' projects with the big impacts of social care on acute bed use, & mixed results from some other IC evaluations.)

Periodic replicated definitive system-wide collections vital, though complex

Examples of begged questions (con)

- *Will the power structure of integrated organisation give the good features of the social care paradigm requisite influence to best balance who will benefit in what way & produce most wellbeing for the bucks?* Social care paradigm better fits many of highest priority ltc cases. *Their access & benefits otherwise reduced?*
  - CSR07: NHS 4%, social care 1%. Wanless 20% & > under-funding of social care cf NHS.
  - Incentives to conform to central pressures &/or quit
  - 40% of social workers with adults question whether their jobs will still exist a decade hence.

Examples of begged questions (con)

Will [a] sequencing & [b] differentiation by target group – logics of 80s forgotten in 1990s apparently emerging from the bottom – prove to in the longer run to be means of side-stepping Leutz' First Law of Integration?

'Don't try to integrate everything' 2005 paraphrase of 'You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people

- Sequence of integration at different allocative levels, over different boundaries, at different levels of integration, increasingly simultaneously
- But targeting of integrative effort & level vital – bottom-up logics lead to variety & health/social in context