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Integrating Health and Social Care Budgets

A case for debate

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Executive summary

Over the last decade, Britain's public services have faced a number of challenges related to a changing population profile, growing demands from more assertive users, and the need for a more sustainable model of delivery. The UK's huge fiscal deficit will now add the most pressing and complicated challenge of all: cutting expenditure on public services while maintaining quality and user satisfaction.

This paper opens a debate around the prospects for a more innovative, more responsive model of public services for groups of users with complex needs. This model revolves around integrating healthcare and social care budgets. The paper analyses the policy landscape, the key determinants of modern public services and the main financial aspects of integrated budgets. It recognises that there are two different approaches to integrating budgets – an 'individually-centred' approach and a 'system-centred' approach – and argues that the best way to create a more responsive and financially effective service model is to combine the two.

The individually-centred approach to integration promotes enhanced citizenship rights in the planning and delivery of public services and requires frontline expertise to play the leading role. By contrast, the system-centred approach uses various administrative measures to seek greater financial and operational efficiency and is primarily driven by central government. The paper analyses the strengths and weaknesses of each approach and discusses their current uneasy co-existence.

At the moment, attempts at linking health and social care budgets are often fragmented and are planned and implemented without due regard to other similar initiatives happening at either the local or national levels. For integration to find the optimal balance of personalisation, accountability and financial efficiency, central government will need to join forces with local governments, frontline professionals, user groups, and the voluntary and private sectors in order to build synergies between different activity streams. Individually centred and system-centred financial innovations are best used together, with each addressing different segments of public services as appropriate to the context.

It will also be crucial to develop more rigorous analysis of the financial implications of integrating services and their budgets, as there is little evidence yet of the effectiveness and efficiency of doing so. At the same time, it is also important to look at the costs and benefits of increasing the share of preventive services in health and social care, as this should be a way of increasing the financial viability of services. Both these tasks require better quality data and greater engagement from the main stakeholders.

1. Introduction

This paper considers the preconditions and core principles for integrating health and social care budgets in the context of changing needs and significant strains on public finances. Public services in England currently face a number of significant challenges with regard to health and social care:

- Changing demographic patterns, including an ageing population that has growing and more complex care needs
- More assertive service users, who expect more flexibility and control
- A deterioration in some aspects of the public's physical health, particularly the steady growth in obesity
- The drive towards more sustainable ways of living and a 'green' economy
- A shift towards a greater decentralisation of powers from the central government to local authorities

And, above all:

- The prospect of real-term cuts in public spending from 2011 onwards. (Dolphin 2009)

Meeting these challenges will require new approaches to the design and provision of core public services, including healthcare and social care. These new approaches will require financial and organisational innovations, and must precipitate a shift away from reactive health and social care towards a more preventive approach.

The idea of integrating health and social care budgets has been widely discussed at the academic and professional levels, but so far has been explored only tentatively in terms of concrete actions and policy instruments. There is still very limited evidence regarding the effectiveness or otherwise of such an approach, and most initiatives are still at the piloting stage (see discussion in Section 7).

What do we mean by integration?

In this paper, we use integration to refer to the provision of services – originating from different agencies and funded from different financial streams – in a joined-up and coherent way, with single operational and financial systems in place, in order to allow for greater complementarity and less system wastage. Integration usually occurs at the local level, though it is plausible to integrate funding streams at higher levels of governance. For example, the Government recently outlined plans to create single budgets for complex issues that are currently being delivered by multiple departments (for example, climate change, combating obesity) (HM Government 2009, The Times 2009). This will necessitate fundamental changes in administrative procedures, markets and relationships between professionals from different spheres and service users.

There are many significant aspects of integrating health and social care budgets which need to be thoroughly examined. These include:

- The impact and implications of integrated budgets for individuals, professionals, and service managers
- How to adapt administrative and financial systems to manage integrated budgets
- How integrated budgets affect commissioning practices
- The need for new and more robust safeguarding mechanisms and professional training/support of staff
- The need for new governance structures and collaborative instruments at the local and national levels

- Questions about information provision and 'navigating' services for individual users
- Psychological aspects relating to satisfaction with this form of service provision.

It is beyond the scope of this paper to provide a comprehensive analysis of all the issues surrounding the integration of services and funding streams. A number of other research and analytical reports prepared by ippr[1] and other organisations provide useful research and analysis on some of the matters outlined above. This paper focuses on widening the field of debate around two key issues – financial efficiency and the responsiveness of public services to the individual needs of service users. It considers how this can be done, looking at several factors including: financial and administrative innovation; personalisation; enhanced citizenship rights; more preventive care; and changing responsibilities in healthcare and social services.

2. Integrating health and social care budgets: the policy context

The policy landscape in the area of integrated budgets is quite fragmented, with only a few comprehensive policy initiatives regarding integration of health and social care services, for example Staying in Control, Connected Care, and Department of Health Integrated Care pilots (see Section 7 below). There has traditionally been a rift between health and social care services, which were developed and delivered by different agencies and controlled through different tiers of government.

From the perspective of many users, however, health and social care have always been two sides of the same coin. For people with long-term conditions and disabilities in particular, it is often difficult to draw the line between healthcare and social care services, and they expect both systems to work closely together to address their needs and concerns. For these groups of clients, welfare services and housing are also closely related to care, though these are quite distinctive areas of government and thus there is less space for confusion. Nonetheless, there is growing demand for all of these services to be better aligned in order to meet complex health and care needs for some categories of users (the Integrated Care and Connecting Care pilots are designed to test this comprehensive integration of different services).

There is a plethora of regulations, pilots and discussions relating to the areas of integrated care (following the Health Act 1999), self-directed support in social care and healthcare, individual and personal budgets[2], and the new concept of citizenship in public services.

There is also a strand of policy thinking that argues that it is possible to cut the costs of services by joining up and streamlining budgets of different services at the local level. Though such measures are important, they represent only part of the picture and many aspects of integrated health and social care will still require political will and policy rigour if reform is ever to take hold.

The history of integrating health and social care services goes back to the beginning of the New Labour era in 1997. The new government committed itself to destroying 'the Berlin

1. See for example McNeil (2009), Ben-Galim and McNeil (forthcoming), Moullin (2008)
2. Personal budgets are an allocation of funding given to users after an assessment which should be sufficient to meet their assessed needs. Individual budgets differ from personal budgets since they cover a multitude of funding streams, besides adult social care, such as Supporting People, Disabled Facilities Grant, Independent Living Funds, Access to Work and community equipment services (Community Care 2009).

Wall' between social and health care services which had appeared after dramatic reforms to community care in 1974. One of the key steps in this direction was the Health Act of 1999, which allowed voluntary partnerships between local authorities and NHS bodies. Section 31 of the Act provided details about how such partnerships should function. These measures were later integrated into the new Health Act 2006 (Section 75) and remain one of the fundamentals of integrated care in England. There are also several statutory and non-statutory instruments for integrating budgets, for example care trusts, children trusts, grants arrangements, and so on. The integration of funds through pooled and aligned budgets[3] has become especially popular in England over the last 10 years.

The Health Act 1999 enabled the establishment of various inter-sectoral partnerships and initiatives, such as Sure Start, Healthy Living Centres and Health Action Zones. Later assessments of these initiatives demonstrated that the integrated services provided in these centres are effective for the targeted groups of population (for example, children and adults from disadvantaged households with low income and multiple problems). There is also an infrastructure to support joined-up working which was created as a result of policy decentralisation in England. The Local Strategic Partnerships (LSP) and thematic partnerships between Primary Care Trusts (PCTs) and local authorities created for the development and delivery of local strategies are effective forums for designing and delivering integrated services (see Section 4 below).

Across the country, there are hundreds of cases of pooling and aligning budgets in healthcare and social care, especially in areas like mental health, purchase of equipment for disabled people, and care for older people and people with long-term conditions. In such cases, pooling and aligning budgets has proved to be especially effective. The creation of care trusts in 2000, which are delivering both health and social care services, was another incremental step in the process of services integration (Weeks 2005).

However, according to a recent report from the Audit Commission, there is no strong evidence that these types of budget flexibilities (pooling and aligning) have brought substantial economies in administrative or operational costs (Audit Commission 2009). Moreover, a survey of organisations participating in such partnerships conducted by the Audit Commission discovered that local partners had done little to assess the effectiveness of these arrangements in achieving better health and wellbeing outcomes for service users. It also identified multiple problems in integrating budgets which will require further changes to the regulatory frameworks and financial and administrative procedures of core services in order to allow greater flexibility and local initiative.

Self-directed support, which empowers people to make decisions related to their own lives, is perceived as the key instrument for achieving a new level of citizenship in public services. However, the Department of Health has until recently been very critical of utilising this model in the NHS (NHS Confederation 2009), expressing concerns that it might go against the core principle that 'care should be free at the point of use' (Department of Health 2006). However, this attitude has gradually changed since 2007, and in 2008 the NHS Next Stage Review outlined a plan to provide certain NHS services based on self-directed support and personal budgets,[4] in particular for people with complex needs, giving them greater 'choice and voice'. There is, however, a strong understanding that certain services, especially

3. Pooled funds are where each partner makes contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services under the management of a host partner organisation. Aligned funds are where partners align resources (identifying their own contributions) to meet agreed aims for a particular service, with jointly monitored spending and performance but separate management of, and accountability for, NHS and council funding streams (Audit Commission 2009). According to the Audit Commission, pooled funds are preferable as they require and provide greater transparency.
4. Though it should be noted that the Department of Health launched its first pilot programme for Individual Health Budgets in 13 local authorities in 2005.

emergency and acute care, will still be delivered in the conventional form, as greater personalisation will not add value or enhance these services, but might actually damage them.

This change of mood might also be affected by the positive evaluations given to pilot programmes relating to self-directed services, direct payments and individual budgets in social care and recently in welfare-to-work. These programmes proved to be effective in increasing the level of satisfaction with services and improving the overall health and wellbeing of service users (see for example Glendinning *et al* 2008).

The Government is becoming more interested in the option of integrating different public services, and in rationalising spending on multi-dimensional, cross-departmental issues such as climate change, personalisation of public services and reducing obesity. Recent thinking is moving towards the establishment of single-issue budgets, managed by a lead department which should then coordinate activities across other involved departments (HM Government 2009, The Times 2009). Following the recommendations of the Darzi Review (Department of Health 2008), in early 2009 the Government established a ministerial working group on health and social care integration. This is looking at practical methods for and challenges to joining-up health, social care and housing services, as well as the social care and disability benefit system. At the same time, the Department of Health launched a pilot programme of integrated care in 16 localities across England, which will test different approaches to integrated care for groups of users with complex needs (Department of Health 2009a).

In order to successfully integrate health and social care budgets (and potentially to align them with welfare-to-work and housing streams for certain groups of users) there is a need for the systems to function on the basis of similar principles. Over the last few years, social care has seen a dramatic shift towards an individual-centred approach to care, while healthcare is only just starting to move in that direction. The drive towards personalisation is at different stages in each institution and is moving at different speeds. Thus, different systems are at different stages in terms of adjusting to the new reality of the concept of citizenship in public services. There is a risk that the strong financial pressures facing the public services may result in systems being joined up more hastily than necessary, and sooner than either is ready. Furthermore, the underlining philosophies of the two systems are different – free for all at the point of use for healthcare, means-testing for social care – and it is important to remember that there are some elements of each system that it will never be possible to integrate.

Joining up social care and healthcare budgets is a challenging process at this stage, as discussions are still in progress about how care should be funded (Department of Health 2009d). Given the rising number of people who will need care in the future – 1.7 million more adults than today by 2026 according to the Department of Health – the right balance needs to be struck between the financial role of the state, and contributions from patients and their families. In July 2009, the Department of Health launched a public debate about the creation of a National Care Service (NCS) which would bring together all aspects of social care; it also offered several models of funding in order to meet rising costs. The Government is committed to increase its own spending by introducing wider provision of free personal care to those in greatest need, as announced in the Queen's Speech, 2009.

The difficult financial situation requires not only a greater degree of financial innovations, new governance arrangements and delivery instruments, but also improved assessment frameworks which would make it possible to analyse the effect of financial innovations on the final 'product' – the outcome of improved health and wellbeing. Though there may be no direct savings for the system in the short term, improved health will mean less demand for healthcare and social care services, potentially reducing future costs. The recently introduced Joint Strategic Needs Assessment has the potential to become a comprehensive assessment matrix at the local level, as it requires a complete picture of current and future health and social care needs at the local level (see Section 4 below).

3. Costs and savings

In order to make the policy discussion more practical, it is important to give at least a snapshot analysis of the scale of the challenge in terms of financial value and the number of users. The total healthcare budget in 2008–09 was equal to £101.7 billion, which is twice as much as in 2000–01 (HM Treasury 2009). Due to financial pressures, the Department of Health will need to make efficiency savings of £2.3 billion in 2010–11, on top of the £8.2 billion efficiency savings agreed in the 2008–2011 spending review (King's Fund 2009a).

The total gross cost of adult social care services in 2008–09 was £16.1 billion, a 3 per cent increase year-on-year in real terms (NHS Information Centre 2009). Of this amount, £9.1 billion was spent on people aged over 65. Expenditure on direct payments was £605 million in 2008–09, a 31 per cent increase on the previous year in real terms (ibid), although it still represents only 3.8 per cent of total adult social care spending.

In March 2008 there were 73,500 adults receiving direct payments, a 36 per cent increase on the previous year (Department of Health 2009b). In total, 1.8 million people used adult social care services in 2007–08, of which 1.2 million were aged 65 and over (King's Fund 2009b). According to the Audit Commission, joint expenditure in the 2007–08 financial year represented only 3.4 per cent of overall spending on health and social care in England; by March 2009 the amount had reached £3.9 billion[5] (Audit Commission 2009).

It is difficult to find specific information on how much – if any – money might be saved by integrating budgets. Some specific examples of savings have been made but in most cases there has been no notable difference, as money saved from avoiding duplication and wastage has often been spent on supporting new governance structures and administrative arrangements, such as partnerships and joint posts. A recent report by the Audit Commission found no evidence that public spending had been saved in areas that used pooled and aligned budgets for providing health and social care services. Data quality and availability were identified as one of the key reasons for this problem (Audit Commission 2009). It is thus necessary to initiate a programme that would capture necessary data and would allow policymakers to analyse the real financial effect of such innovations. This will be particularly important in the forthcoming period of funding restraint.

Market and administrative challenges

There are significant challenges that need to be addressed in relation to the market of healthcare provision. There is a need to develop new systems of commissioning and infrastructure in order for the new system of support to be effective. There is also a need for the market to absorb two models of services provision – personalised and conventional – at the same time, as some services will not change and some patients prefer conventional services and will not take up the new model of self-directed support. The commissioning process should be adjusted in a way that allows conventional and individual commissioning to co-exist easily and incentivises providers to be flexible enough to meet demand for both models.

Apart from market reconfiguration, there is also a need to reconsider the financial standards of both services in order to understand how they can converge. The NHS, being universally free of charge, has more rigid standards and requirements in terms of efficiency of spending and what money can be spent on. Integrating healthcare and social care into individual budgets might require co-funding of unconventional treatment or services which would not otherwise be funded by the NHS. It is thus up to NICE (the National Institute of Health and Clinical Excellence) to define what services in the new system should or should not be

5. This amount, however, excludes some other statutory instruments of joined-up funding, such as care trusts, children trusts and grants.

funded from the NHS budget. Combining some free and some means-tested services will be a challenge that both systems will need to overcome if they are to co-exist successfully.

Budget planning and resource allocation should also be revised in the light of self-directed support. Similar to discussions already taking place in social care, the NHS will have to consider and approve standards and norms for defining exact budgets and distributing them between users and across the country (the social enterprise In Control calls it a Resource Allocation System – RAS). It is important for people to know exactly how much money they have to meet their needs and that they have guaranteed minimum standards that will be met regardless of costs. The experience of budgeting for individual social care budgets should be taken into account. However, as this was an ongoing experience which gradually developed from a basic to a more sophisticated, outcome-based RAS, it will be difficult to simply replicate it, especially as healthcare services are commissioned in a different way.

4. Decentralisation

The financial crisis and the prospect of freezing if not cutting healthcare and social care costs pose difficult choices for decision-makers at all tiers. On the one hand, central government is concerned with the overall cost of services and efficiency of spending. On the other, it is often the task of local authorities and local commissioners to deal with difficult choices – how to serve an increasing number of (more informed and assertive) clients with less funding. This has been one major driver of discussions in expert and policy circles about decentralisation in healthcare, including funding decisions.

It is argued that local organisations are in a better position to negotiate the best deals from a tight budget in order to meet the needs of the local population (Furness and Gough 2009). They are also in a better position to maintain dialogue with the local population about changes (and possible reductions) to services. It follows that the accountability of local commissioners such as Primary Care Trusts should be increased and that local populations should have a greater say and influence over their decisions and choices.

The decentralisation of healthcare services fits well into a bigger picture whereby various responsibilities are being decentralised from central government to local authorities. In 2000, local authorities gained a new 'power of wellbeing' through the Local Government Act, which means they can do anything they consider likely to promote or improve the economic, social or environmental wellbeing of their area (Department for the Environment, Transport and the Regions 2000). One of the core objectives behind the creation of this power was to encourage local initiative and to enhance collaboration between local authorities and other partners at the local level as a means to achieving a greater quality of life for their community.

More recently, local authorities and their partners (through Local Strategic Partnerships – LSPs), gained new powers and duties in the Local Government and Public Involvement in Health Act 2007 (Communities and Local Government 2007), such as the duty to cooperate in the process of designing new Sustainable Community Strategies (SCS) and implementing them through Local Areas Agreements (LAAs). A range of regulations, such as Creating Strong, Safe and Prosperous Communities (Communities and Local Government 2008), stipulate new frameworks, responsibilities and processes that enable greater collaboration between local authorities and bodies such as Foundation Trusts, Health Trusts, PCTs and others. Local councils play the leading role in LSPs, but the accent is on shared priorities and actions, which strengthens the capacity of local partners in implementing the power of wellbeing.

Among the other innovations in the Local Government and Public Involvement in Health Act are the introduction from 1 April 2008 of the Joint Strategic Needs Assessment (JSNA) and

Local Involvement Networks (LINks). The JSNA is a new mandatory duty for all upper-tier local authorities and PCTs, 'a continuous process that identifies the current and future health and wellbeing needs of a local population, informing the priorities and targets set by LAAs and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities' (Department of Health *et al* 2008). The JSNA is the joint responsibility of the Directors of Public Health, Adult Social Services and Children's Services. It is a crucial instrument for increasing the efficiency of commissioning as it provides an up-to-date picture of the health and wellbeing needs of the local population. The JSNA informs the decisions of the LSP and is an important instrument for integrating healthcare and social care services and their budgets (and other services such as welfare and housing) at the local level.

The Local Involvement Networks (LINks) established in every locality are responsible for involving local population in shaping local social and healthcare services. Since LSPs and their lead local authorities are bound by the 'duty to engage' to work closely with representatives of the third sector, the business community and the general public in defining priorities and implementing specific plans, the LINks will strengthen the accountability of services' providers, be they local authorities or PCTs.

It is important to bear in mind that any calls for greater decentralisation and localism in public services delivery are likely to have a second – negative – side. Public opinion is such that despite the fact that local innovations and flexibility are considered as a positive thing, any divergence in services provision from locality to locality is often thought to be unacceptable and referred to as an unfair 'postcode lottery'. Hence, any policy thinking behind changing the levels of responsibility and accountability between central and local tiers should seriously consider models of local engagement with the public and ways of representing local divergence so that it has a more positive than negative character.

5. Prevention

Prevention is becoming an especially crucial element of the UK's health system due to the challenges identified above: changing demography; a growing number of more assertive service users; the rising costs of healthcare and social care; and squeezed public funding. Traditionally, there are two types of preventive measures:

- *Primary*, for those who have had no previous history of a disease but have some risk of acquiring it in the future
- *Secondary*, for people who have already suffered from an instance of the disease and require further advice and intervention to prevent them from further problems.

It has been noted that there is not always enough coordination between primary and secondary preventive care, which has a negative impact on final health outcomes (National Audit Office 2009).

There is a question as to whether integrating budgets from different services will enable stronger prevention measures that would target a wider group of people. Risk assessment and screening is believed to be a crucial element of preventive measures. However, quite often these procedures are made for a single disease, such as cardio-vascular diseases or cancer. Experts argue for a more holistic and complex approach whereby lifetime risk is assessed in terms of a range of diseases (Furness 2008). There is also a question as to whether interventions should follow immediately after initial lifestyle and health risks are identified (especially for mental health). Currently, there are only 'light' services offered to people with potential health problems in the form of literature and advice on how to change their lifestyle. This may not be enough, and some experts argue that more 'invasive' primary

interventions are required (ibid). This demands a greater integration of primary care providers with other areas of healthcare.

Coordination is also required to bring people with 'manageable' health conditions back to work. There are already specific programmes run by the Department for Work and Pensions that have this aim. However, not all primary healthcare institutions direct their patients towards these programmes (National Audit Office 2009). There are some pilots, like the Right to Control programme initiated by the Department for Work and Pensions in eight localities, which are looking to test the effectiveness of integrating social care and welfare-to-work services and funding for people with disabilities (Ben-Galim and McNeill 2009). The possibility of integrating healthcare services into these pilots should be explored to see whether this might make an even greater contribution to the final health and wellbeing outcomes of people with disabilities.

Primary care institutions (PCTs and GP surgeries) are believed to be the best place for identifying people at risk and offering first interventions. However, there is some evidence that for some illnesses, GPs are not always qualified enough to identify the problem and refer the patient to specialist care at earlier stages of the disease (National Audit Office 2009), which ultimately results in higher healthcare costs.[6] There is also a challenge posed by people who have a greater risk of certain illnesses due to their lifestyle but who rarely or never ask for medical help. In these cases, welfare and social services might help, as they have access to a wider network of people who are vulnerable and are in greater danger of becoming ill. It is thus not enough to integrate healthcare and social care services in order to increase the efficiency of preventive measures, as these services mostly deal with people who are already aware of their problems. Only secondary preventive measures will be more efficient in these cases. The roles of welfare and social service agencies are crucial in enhancing primary preventative measures among disadvantaged groups of the population that are difficult to target.

Preventive care is at the heart of the proposed National Care Service (NCS). Both Government and experts are arguing that shifting shrinking funding towards prevention will offer substantial savings for both the NHS and NCS in the longer term. For example, in the recently published Green Paper on Social Care (Department of Health 2009d) there is a greater emphasis on prevention than on treatment for all groups of clients, especially for people with long-term conditions and disabilities and for older people, which potentially could save money for both systems at later stages of care. New approaches to care like self-direction and personalisation are also contributing to preventive care. The evidence from the Department of Health suggests that improving self-care could decrease the length of stay in hospitals for mental health patients, reduce A&E visits for asthma patients and halve the number of sick days for people with arthritis, which would all contribute to bringing down the cost of the healthcare system.

Nonetheless, many questions remain in relation to assessing the costs and benefits of specific preventive measures, especially in social care. NICE is already assessing the effectiveness of preventive measures for the NHS, and the Government argues that there is a need for a similar body to be created in the social care sector.

6. For example, modelling by the National Audit Office suggests that if the share of patients diagnosed with rheumatoid arthritis within the first three months of the disease increased from 10 to 20 per cent the treatment costs would rise by £11 million in the first five years but the overall productivity saving for the economy would be £31 million (National Audit Office 2009)

6. The rationale for integrating budgets

It is important to underline that integrating services and budgets is not always appropriate. Integration can bring benefits for health and social care – and indeed for welfare-to-work and housing services – when it is carefully designed and appropriate to the context. It should not, however, be touted as the answer to everything and rolled out without thought. Different systems and services are based on different principles, and it will not always be possible to integrate systems without compromising the fundamental rights of users and/or the quality of services. Furthermore, even where services have many similarities, they may still serve different population groups (some are universal, others are very selective). Hence, while crucial in many aspects of public services planning and delivery, users' voice and choice are not always pre-determinants of success. Some components of healthcare, welfare-to-work and (less so) social care must continue to function as stand-alone services to ensure the best outcomes and value for money.

There are two drivers for integrating health and social care budgets in the current model of services provision (see Figure 1), which we summarise below.

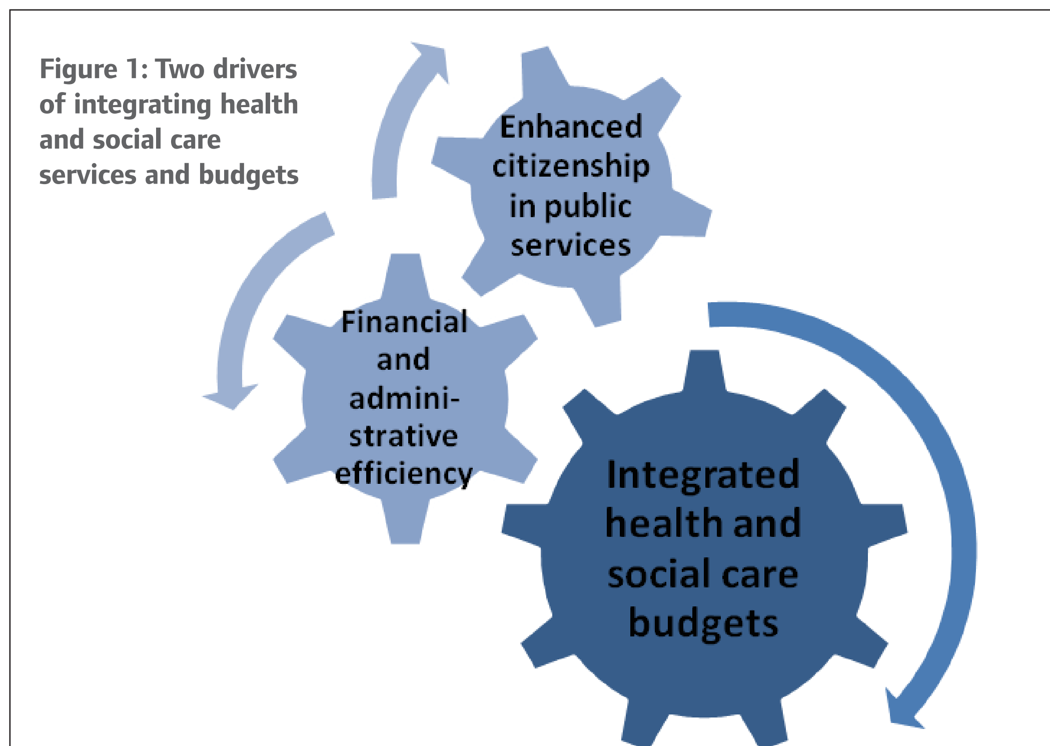

Figure 1: Two drivers of integrating health and social care services and budgets

Enhanced citizenship

Enhanced citizenship in public services means that citizens, as well as frontline professionals, are empowered in planning and delivering individually-tailored public services. This is via a combination of self-direction, personalisation, co-production and the new citizenship model in public services. The aim is to achieve better outcomes by strengthening the commitment of each of us to each other and to the whole community (Duffy *et al* 2009).

In practice, this means extending the principles of self-directed support from social care to some areas of healthcare, housing and welfare-to-work, leaving out those areas that are impossible to personalise without undermining their impact or outcomes (for example, emergency and invasive treatment in healthcare). It will involve integrating service provision and funding (through individual budgets, which combine several funding streams of different services for the benefit of the user), as well as integrating operational and administrative systems.

Again, it is important to underline that not all services are fit for integration and/or personalisation, and that it is not acceptable simply to directly translate self-direction from one sphere to another. While the general principles may be more universally applicable, each sector will require its own instruments, standards and budgeting for self-directed support.

Financial and administrative efficiency

The second driver is financial and administrative efficiency, which in the last few years has became even more important due to budgetary constraints and the pressure for savings. There is a widespread understanding that the 'financial bonanza' period in the public services is over and that austerity will be the watchword for some time. There is thus a growing number of policy provisions (such as single issue budgets) and practical steps for pooling or at least aligning the budgets of different services providers, which all aim to provide better quality services with less money. Another benefit of this innovation is that it makes services less confusing and more centred on specific client groups.

Combining individual- and system-centred integration

These two drivers have their own distinctive natures and objectives. Enhanced citizenship is centred on the individual, their needs and aspirations. Efficiency is centred on the system of services provision. We suggest that the best way to integrate budgets is to combine these two innovation streams – individual-centred and system-centred integration. Individual-centred integration requires frontline expertise to play a leading role while engaging higher tiers of governance in order to ensure the systemic change in delivery. In system-centred integration central government needs to play a key role but engage local institutions and frontline professionals as partners in all stages.

The financial efficiency of either of these streams of integration is still under question. There is no strong evidence that self-directed support in social care and welfare policy (via individual and personal budgets and direct payments) saves a great deal of money, though there are cases of savings for specific groups of clients (see for example Glendinning *et al* 2008 or Duffy *et al* 2009). One of the key arguments is that it is a relatively new policy initiative, affecting a relatively small number of service users and involving a small share of total service costs. Thus there is no sufficient dataset to measure the financial gains effectively. On the other hand, there is already some evidence that integration does not cost any more money and that it leads to people expressing more satisfaction with the services they receive, thanks to increased engagement and the right to control. Also, self-directed support often has a strongly preventive nature.

As with most preventive measures, it is a challenge to attribute any changes directly to the original intervention, which makes it difficult to measure the direct effect on the short-term costs of either healthcare or social care systems. Over the longer term, however, the effect is more defined, as demonstrated above (for example, the Department of Health registered a reduction in the number of hospital admissions and in A&E usage among people who use self-directed services and the National Audit Office calculated productivity gains for the economy through better diagnosis and preventive measures in treating rheumatoid arthritis).

Pooled and aligned budgets are more 'administrative' than 'human' in nature, and these types of financial innovation in health and social care services are easier to implement and then assess in terms of their effectiveness in saving public money. A recent report from the Audit Commission questions the link between pooling/aligning budgets and reduced costs of services, and notes that there is so far very little data regarding the impact of such practices on final health outcomes (Audit Commission 2009). However, we believe that this approach has more potential for cutting costs, as it deals with 'group needs' rather than individual needs. Group needs are easier to make more rational and cost-effective through improved commissioning and by shifting the emphasis from treatment to preventive measures.

Democratic control, which is essential in the new model of public services delivery, is less clear in system-centred integration than in individual-centred integration. Pooling and aligning funding streams for services with different degrees of accountability could be managed by 'non-democratic' institutions (such as PCTs) which could limit citizens' control over the design and implementation of services, which are usually the responsibility of local councils. There is thus a need for new strengthened models of accountability (through supervisory boards or networks similar to LINks) and for the safeguarding of new integrated services which will not only be efficient in terms of using public funding, but will also be transparent and understandable for the general public. There are already several practical steps in this direction offered by the 2008 NHS review and the Local Government and Public Involvement in Health Act 2007 (see Section 4 above).

There is also a tension between the personalisation agenda (introducing individual budgets) and pooling/aligning budgets. Frontline staff in the pilots of individual budgets for social care noticed that in many cases this innovation is counter-productive (Glasby 2008). As individual budgets are often offered to people with complex health and social care needs, which are often provided by PCTs and on the basis of inter-agency collaboration, separating the social care segment from the overall package in order to 'wrap' it into the individual budget caused confusion and difficulties. People do not understand why they cannot receive an integrated individual budget for the entire package and why they should change already established practices and existing providers.

Bearing in mind these limitations of the two approaches to integrating services – person-centred and system-centred – and some challenges of their co-existence, we believe that the best way forward is to combine the two. The most rational approach would be to use individual-centred instruments in the areas that are possible to personalise in order to respond to the complex needs of specific groups of users that stretch across the silos of healthcare, social care, welfare-to-work and housing (for example, people with disabilities and older people). This approach has already been employed by the Government in its various pilot projects.

Integration of back-office services, procurement and other operational elements needs to be guided by institutional expediency and value for money where it is impossible to use a personalised approach. However, there is a need to coordinate different partners that are delivering similar services or working in the geographical proximity. Another challenge is to ensure that future attempts at integration begin with a realistic measurement of the current situation and an estimation of the projected costs and impacts (particularly on the health and wellbeing of the local population), against which it will be possible to monitor and evaluate success in greater detail.

In this model, different segments of services and their markets will be affected either by person-centred or system-centred financial innovations, which should combine to bring improved overall outcomes. In this case it will be possible to reduce costs, as the financial climate dictates, and at the same time to enhance personal satisfaction by giving citizens a stronger role in the planning and provision of services that improve their health and enhance their wellbeing. However, in order to achieve success, there needs to be understanding and practical support for this process from the highest levels of government. Otherwise, there is a risk that combining local initiatives with pilots and instruments designed at the national level could become counter-productive and users and frontline professionals could be discouraged from implementing such models out of fear of the many problems and confusion that might lie ahead.

7. Relevant practices and pilots

There are few practical examples of integrating healthcare and social care budgets and services. There are many examples of administrative measures like pooling and aligning budgets, but they do not go as deep in joining up services and their funding as integration implies. Below are some examples of integrated care pilots, and also pilots related to self-directed and personalised support in social care and welfare-to-work, which might be relevant for our debate.

It is important to look for inspiration and lessons not only in other sectors of public services, but also in the UK's devolved administrations. Devolution of powers to the governments of Scotland, Wales and Northern Ireland created opportunities for different approaches to planning and delivery of the same range of services. Potentially, this could ease the process of learning the effects of different models and could also offer opportunities for cross-fertilisation of approaches and practices. Both positive and negative experiences are important in this regard.

Examples

Connected Care: a pilot programme for integrating health, social care and housing services in the most deprived communities. Community-led, it will test new ways of community engagement and commissioning led by the community. It is currently in the first stage, an audit of local needs and aspirations; the second stage will design integrated services corresponding to the community's needs. The Turning Point: Connected Care Centre of Excellence champions the delivery of Connected Care in England and Wales.

Right to Control: a pilot programme designed by the Department for Work and Pensions for eight local authorities in order to test the possibilities of integrating social care and welfare-to-work services for people with disabilities. It was launched in 2008 and it is too early for any conclusions regarding its efficiency.

In Control: launched in 2003, this was the first programme to develop the concept of self-directed support in social care. It has already led to some concrete results, mostly positive, as highlighted in an evaluation by York University. In Control is now a national charity which extends self-direction into other public services, such as healthcare and welfare-to-work.

Staying in Control: a pilot jointly launched in spring 2009 by the Department of Health, CSIP (Care Services Improvement Partnership) and In Control to extend self-direction and personalisation practices from social care to healthcare. It is being tested in 34 local authorities and the first results are not expected until 2010.

Programme of Integrated Care Pilots: a two-year initiative launched by the Department of Health in 16 local localities in 2009. It is testing models of integrating different care elements in order to achieve seamless and effective services provision for different groups of users with multiple needs (for example, elderly, disabled, people with diabetes, substance abusers).

Personal Health Budgets: pilots by the Department of Health in 13 localities in 2005–2007 to see whether it is possible to extend this model of services provision from social care to healthcare. The results of these pilots were positive and the Department of Health has since launched more widespread pilots of individual budgets (see below).

Individual Health Budgets: pilots launched by the Department of Health in September 2009 in 20 localities (out of 70 that declared their initial interest to participate in the pilot). This is a two-year programme which aims to develop models and instruments for defining and implementing individual health budgets for people with long-term disabilities.

Independent Living Fund (ILF): the first 'cash for care' scheme, introduced in 1988, providing money for the care of seriously disabled people living at home. Currently there are

some challenges of integrating this funding stream with other streams for disabled people (for example welfare-to-work) and the Department of Health is considering how ILF fits with the individual budget model (Henwood and Hudson 2007).

8. Conclusions

The modern, individualistic world requires more personal public services. At the same time, the economic crisis means that less public (and private) funding is available for more sophisticated, technology-intensive services. As public spending will be facing severe constraints in the coming years, it must develop and implement innovative policy and financial instruments which can cut costs but at the same time provide high-quality services to all those who need them.

Our brief analysis here demonstrates that integrating different services and funding streams might be the way to address this double-faced challenge. However, decision-makers should not choose between individual-centred and system-centred integration. Neither should they run these two types of financial and organisational innovations in parallel without due regard to their overlapping and sometimes counter-productive impact on each other. Understanding the nature of local service integration innovations at the central level is a pre-condition for their successful implementation and sustainability after other national-driven reforms related to either financial efficiency or personalisation come into force. We argue that a thorough combination of individual-centred and system-centred integration will be the best way to tackle the lack of resources and the need to respond to more individual and complex needs.

There are still many questions in terms of the financial efficiency of integration. There are very few evaluations of this matter, and those that do exist have not demonstrated that integration brings any significant savings for either healthcare or social care (see for example Audit Commission 2009). On the other hand, there is also no indication that it increases costs. The lack of a proper data system was identified by many experts and policymakers as one of the core obstacles to any proper assessment of financial impact, and if this is addressed in the near future we believe it will be possible to demonstrate the positive effect of integration on public spending. Bearing in mind the needs for savings in the near future, making mechanical cuts across all public services (for example 10 per cent) might be dangerous as it is does not take into account the respective significance of particular streams. It might well be possible that cutting funding in one area by only 5 per cent or not at all, but changing its way of use (for example funding more preventive measures), might save 10 or even 20 per cent of spending in another element of the system. This is an important issue for further analysis.

As a cornerstone of modern healthcare and social care systems, prevention is a crucial element for addressing problems at earlier stages. It might lead to a short-term increase in NHS or social care budgets, but it will bring greater long-term gains for the national economy, for example through a healthier and more productive workforce.

There is a significant opportunity for further discussion among practitioners and policymakers, bringing together several issues that are already occurring in separate parts of the system. Further research into the financial implications of integrating services and increasing the share of preventive care in NHS is crucial in defining the success of the current path of reforms – towards personalisation and greater efficiency of public services.

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