

Financial mechanisms for integrating funds across health & social care

Do they enable integrated care?

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4th International Conference on Integrated Care

Brussels April 2-4 2014

The research was funded by a grant from the
English Department of Health to
the Policy Research Unit in the
Economics of Social and Health Care
[ESHCRU]

The views expressed
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- Care for people with chronic and complex needs accounts for a substantial share of health and social care expenditure
- Integrated care is often seen as a panacea
 - Reduce unplanned hospital admissions
 - Improve health outcomes and wellbeing
 - Reduce expenditure
- But high expectations rarely met

■ Financial barriers often blamed...

Fragmented commissioning structures are making it harder to integrate health and care services.... The committee has called for “fundamental changes” if the health system is to meet the needs of patients

12 February, 2014 11:09

Fragmented [commissioning](#) health and care services.

The committee's annual social care has recommended (HWBs) take over commissioning services.

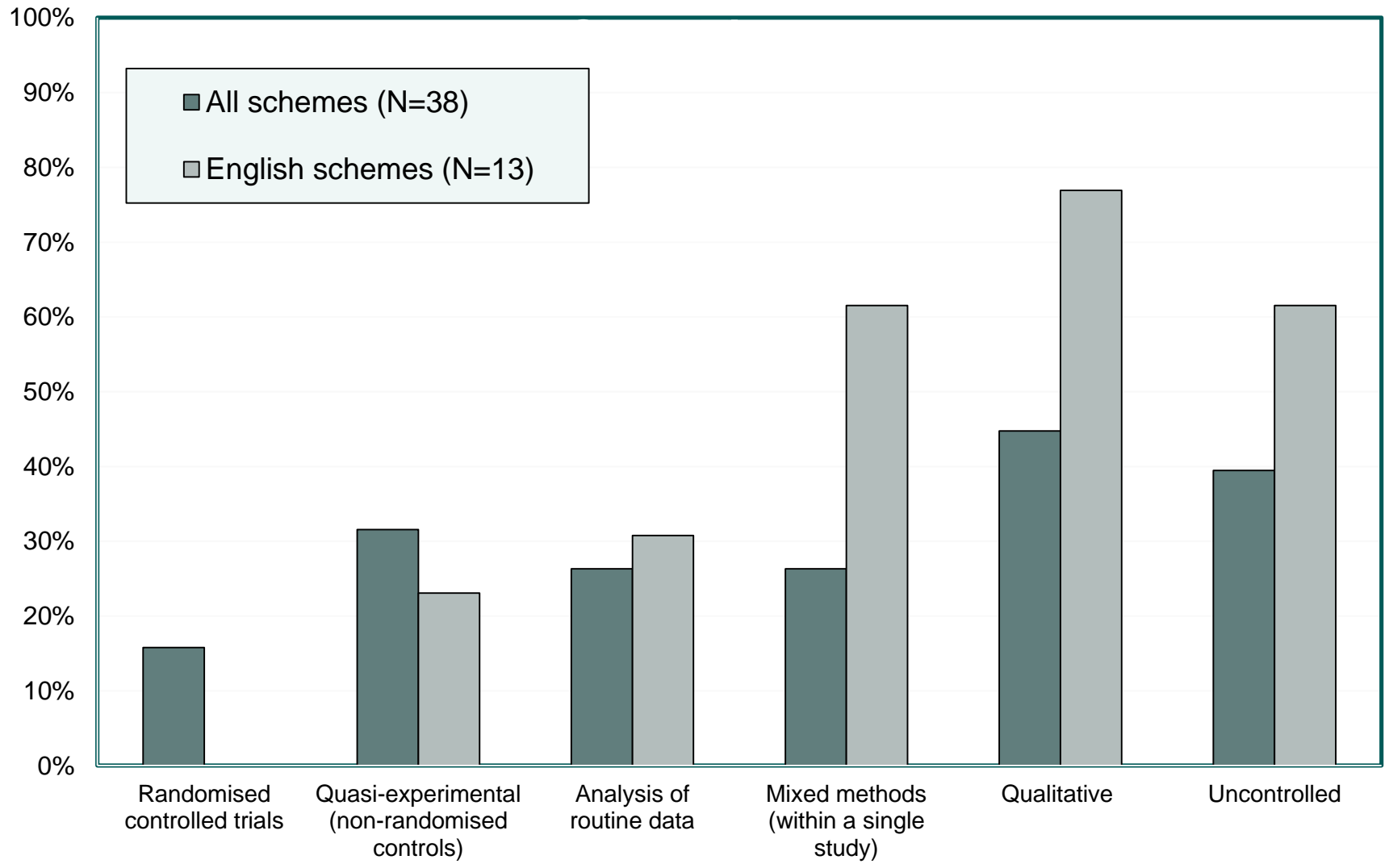
Committee chair Stephen have been established to local health and care ecosystems to become effective services.

“Without stronger commissioners and ring-fenced health and care funding, we believe there is a serious risk to both the quality and availability of care services to vulnerable people in the years ahead.”

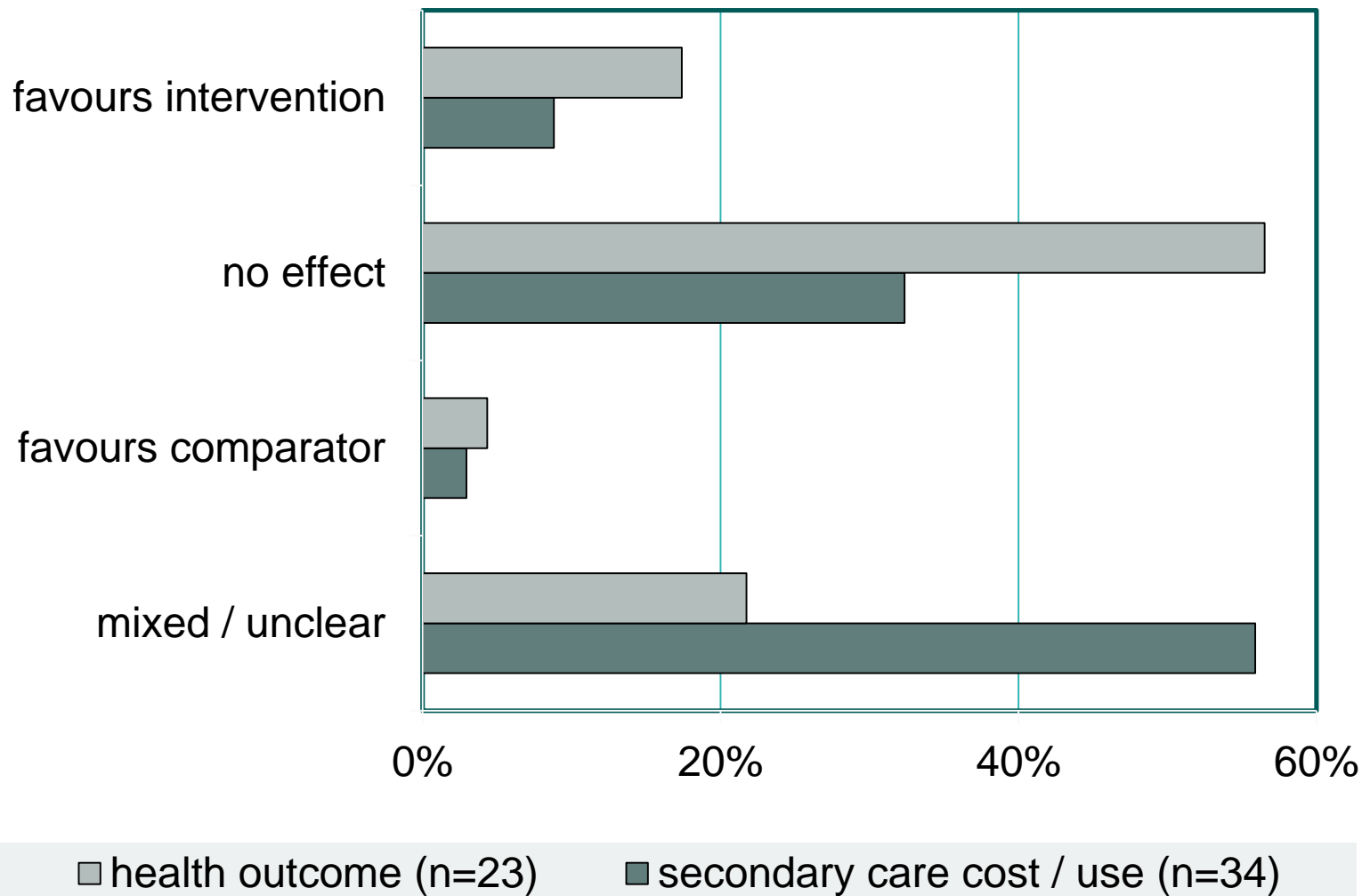
1. What mechanisms are available for integrating resource use across health and social care?
2. What is the evidence that these are effective or cost-effective, and what are the barriers to their use?

- Systematic review of international literature
 - 8 databases, websites, bibliographies
- Inclusion criteria
 - H&SC funding streams
 - empirical evaluation
 - English language
 - adults
- Exclusion criteria
 - children
 - studies from low-income countries
 - personal budgets

- 38 schemes in 8 countries
 - integrated funds to support integrated care
 - unclear in some large complex schemes
 - ‘Partnerships for Older People Projects’ (POPP) programme encompassed 146 interventions based in 29 local authorities
- Study designs
 - Randomised evidence from Australia and Canada
 - Quasi experimental studies
 - Regression analyses of routine/trial data
 - Qualitative studies
- Comparators
 - Most compared with “usual care”, which was rarely described
 - “added effect” of integrated funds not assessed



Type of integration	Definition
1: Transfer Payments	Also known as Grant Transfer. Allow local authorities to make service revenue or capital contributions to health bodies to support specific additional health services, and vice versa.
2: Cross charging	Mandatory daily penalties. Compensate for delayed discharges in acute care where social services are solely responsible and unable to provide continuation service.
3: Aligned budgets	Partners align resources, identifying own contributions but targeted to the same objectives. Joint monitoring of spend and performance. Management and accountability for health and social services funding streams remain separate.
4: Lead commissioning	One partner leads commissioning of services based on jointly agreed set of aims
5: Pooled funds	Each partner makes contributions to a common fund for spending on agreed projects or services
6: Integrated management /provision without pooled funds	One partner delegates duties to another to jointly manage service provision
7: Integrated management / provision with pooled funds	Partners pool resources, staff, and management structures. One partner acts as host to undertake the other's functions. Includes (but is not synonymous with) 'joint commissioning' across health and social care.
8: Structural integration	Health and social care responsibilities combined within a health body under single management. Finances and resources integrated using the Health Act flexibilities.



Potential Impact	What does evidence show?
Improve access to care	Largely positive. But provider autonomy and eligibility policies can undermine budget-holders' ability to facilitate access.
Reduce unplanned re/admissions	Positive for some groups; negative in others (i.e., increased admissions).
Increase community care (health and social care)	Evidence is positive to some degree for community services
Reduce total costs	Mostly neutral
Improve outcomes	Neutral or positive
Improve the quality of care	Few studies measured the quality of care, and they employed different measures of quality, with mixed results.
Reduce length of stay	Cross charging and pooled funding may reduce delayed discharges in the short term
Reduce residential care	Equivocal: relatively few studies assessed this outcome, and findings were very mixed
Improve patient and user experience of care	Positive largely although some negatives. There was no standardised measurement across schemes

- 2 year RCT
- 50+ with chronic and complex conditions
 - Cardiovascular, musculoskeletal, endocrine / metabolic, psychological, respiratory
- N=2720 [1774 / 946]
- Integrated management with pooled funds
 - GP care coordinator + service coordinator
 - Pool: AUS\$21.5m
 - \$8,333 per person
 - \$2.6m for care coordination
 - Risk-based capitation budget \approx cost of usual care

- Intervention participants
 - significantly better general health, less depression and better HRQoL
 - significantly higher total costs, but some service substitution achieved - less inpatient care, more primary care
- “Had the trial progressed for longer, evidence suggests that it would have been at least cost neutral in achieving these outcomes, even after incorporating the cost of care coordination..”

- GPs solely responsible for service substitution, but had no control over admissions or discharges
- GPs did not receive information on pooled expenditure and were not liable for overspend
- Some services identified in the written care plan were accessible only if clients met pre-existing eligibility criteria ...so money did not follow the patient...

- GPs agreed that unless the financial reimbursement system was simplified and co-ordinator support was continued, care planning ...would be unlikely to occur in future
- “While flexible funding arrangements were pursued by all trials neither of the mainstream trials achieved a true pooling of funds...”

■ *Integrated Health & Social Services Boards*

Despite three decades of structural integration, ‘perennial tensions’ between the medical and social models of care persisted, as did professional rivalries. Social care services were more vulnerable to cuts than health care, and the study found several examples where significant sums of money (>£1m) had been diverted from community budgets into the acute sector

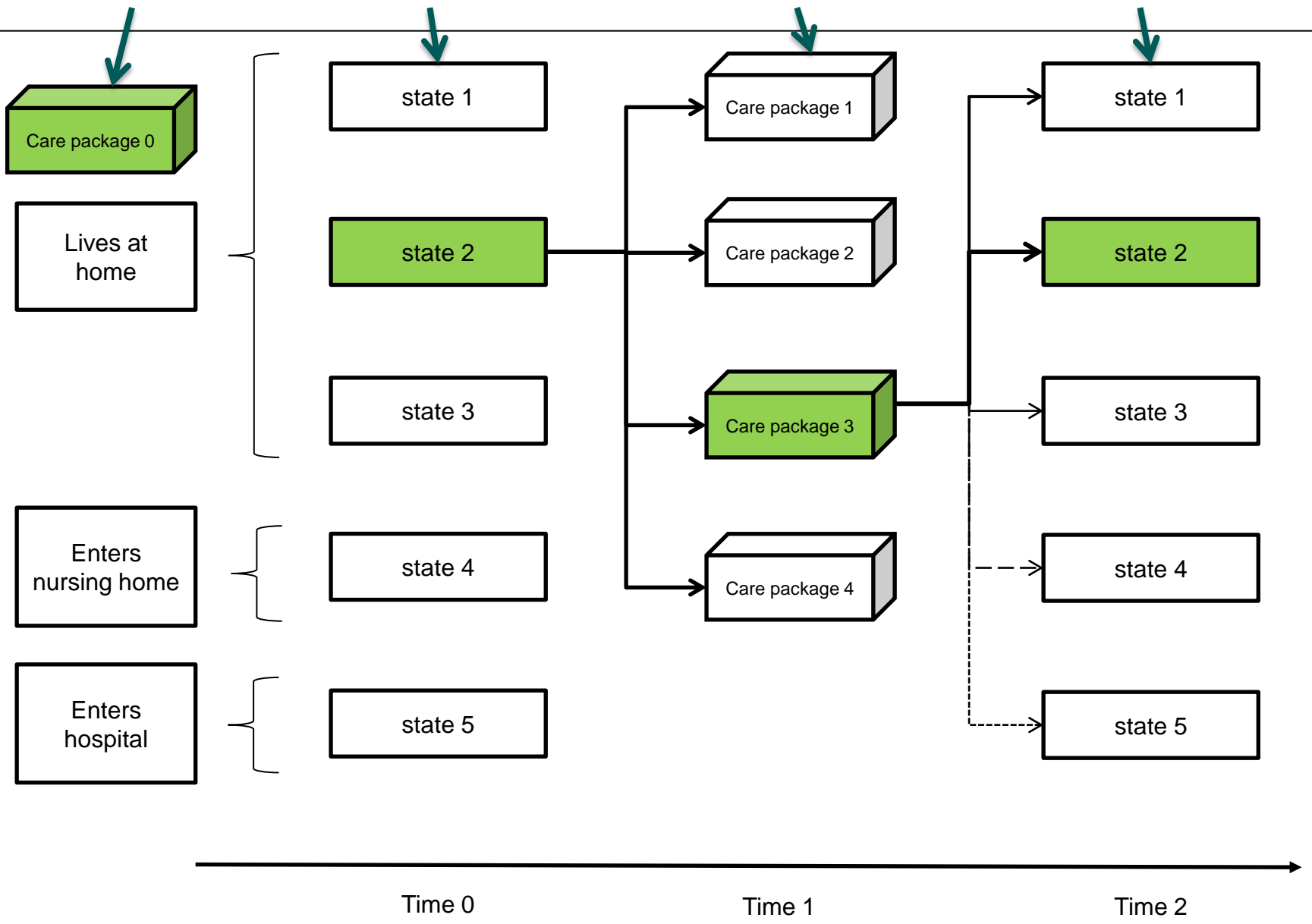
- Care Trusts: “statutory responsibilities and accountabilities of individual organisations ... are not removed by entering into arrangements for integrated governance, whether of the Care Trust form or other kinds of partnership”
- Pooled budgets: different accounting and audit requirements, tax regimens... budgets were effectively ‘ring fenced’, reducing partners’ capacity to manage deficits in other parts of the system

Baseline care uncertain

Needs uncertain

Access uncertain

Effects uncertain



- Very few schemes improved health outcomes or achieved cost savings, but some succeeded in shifting care into the community
- Implementing integrated funding streams is not straight forward and requires legal, institutional and cultural mechanisms in place to facilitate integration
- Policy makers should be aware that if existing levels of unmet need are high, overall costs are likely to rise
- Given the complexity of integrated systems, robust evaluations are needed to systematically assess benefits, costs and harms
- Expectations should be realistic

- CHE Research Paper 97
<http://www.york.ac.uk/che/>



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- Any questions

