What is social care, and how can health services better integrate with it?

May 2014

1.0 Introduction

The ageing population and the current public funding crisis have led many policymakers to give health and social care integration a high priority. Influential institutions such as the King’s Fund and the Nuffield Trust are pursuing projects taking an in-depth look at health and social care integration. The Labour Party commissioned the independent Oldham Review which looked in-depth at health and social care integration, whilst also separately reviewing Labour’s own policy. The coalition have created the better care fund which is made up of £3.8 billion from existing NHS funding which aims to better integrate the two services. The Care Bill, which is currently before Parliament, also addresses the settlement between health and social care.

The BMA aims to contribute to this debate by building a better understanding of doctors’ experiences and perspectives of this kind of integration. This briefing outlines the current state of the social care system and addresses integration between health and social care with the aim of developing members’ understanding and contributing their perspectives to the debate.

2.0 Health and social care integration and current BMA policy

Integration is a nebulous term: there are many varied definitions and they can cover a significant number of differing processes. Integrated care should be defined through the experience of the patient or service user, rather than by the structures, organisations or pathways in place or the way services are commissioned or funded. This is because integration is about individuals and communities having a better experience of care and support, and therefore the individual must be the organising principle for services. Patients and service users should perceive no organisational barriers or bumps while interacting with the various providers of their package of care. We agree with the approach and language used in the recent report from the National Collaboration for Integrated Care and Support headline definition of integration, from the patient’s perspective:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

Given this definition, integration does not necessarily require high-level budgetary or structural integration, rather a refocusing of attention onto how to work together to ensure patients and service users experience as seamless a service as possible as they move through their treatment and care.
It is believed that better integration of health and social care will bring numerous benefits to patients by overcoming structural barriers to care currently experienced between the two systems. The focus is currently centred on the potential cost savings that integration is believed by politicians and some policy makers as being able to bring. The CQC reviewed variance in occupied bed-days for multiple admissions of under 75s, and concluded that better joining up of health and social care across England would save £2billion. The BMA have been sceptical about the cost savings which can be achieved through integration, believing that any potential savings will likely not manifest for many years, if at all. The BMA does not believe full integration of health and social care (structures, budgets and staff) is either necessary or desirable. The current structures should be retained, maintaining separate services, and existing mechanisms to facilitate coordination between health and social care should be used more widely to plan and deliver joined up local services. What matters to patients and their families are not high-level structures but that joined up care is a reality. The BMA believes that coordination is best achieved by creating stability across the NHS and local authorities and allowing integrated care to become a priority, not by further reorganisation.

The BMA believes that professional working relationships between health and social care bodies and professionals should be the basis for any future attempts at closer integration. Mutual understanding of the respective services is a necessary prerequisite for closer professional working.

The BMA is aiming to better understand the role of doctors and their professional relationships with social care bodies and professionals and contribute further to this discussion; initially the BMA is calling for case studies.

### 3.0 Call for case studies on health and social care integration

The BMA is working to gather case studies of health and social care integration from doctors’ perspectives to aid the development of BMA policy on health and social care integration. A discussion paper will be published; this will draw heavily on the case studies provided. We are particularly interested in your personal experiences with this form of integration and any lessons or examples that you can provide us with concerning this. Examples can be diverse; from examples of organisational integration, to organised collaborative working arrangements between doctors and social care professionals, or even just one off examples of successful collaborative working. Below are questions to act as a guide for forming your case study:

- **In general, how often, if at all, do you have contact with social care professionals/providers?**

- **In general, how would you describe your professional relationship with the relevant social care professionals/providers?**

- **In general, how does your professional relationship with the social care professional/provider impact on your work?**

- **Can you provide an example of the impact of your professional working relationships with social care professionals/providers on your work?**

If you would like to contribute to this work please contact James Raymond in the Health Policy & Economic Research Unit via email: info.hperu@bma.org.uk or by phone on 020 7383 6171.

The BMA has previously outlined principles of Social Care reform; these can be viewed in detail [here](#).
4.0 What is social care?

Social care is not simple to define as it covers a great variety of different services, delivered across the country by many differing types of providers who are providing care in often very different circumstances andfashions. The Dilnott Commission defined social care as follows:

“Social care supports people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people to sustain employment in paid or unpaid work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society.”

This wide-ranging definition captures the activities and policies which can come under the heading of social care. There is often a definitional split between:

- Domiciliary care (for those that receive care in their home);
- Care home care (care for an individual that needs full time institutional support);
- Nursing care (usually provided in a nursing home).

4.1 Health and social care shared ground

Social care has significant crossover with health care, there is an obvious synergy with services such as nursing and care homes, and NHS continuing care often blurs the boundaries between health and social care. There are areas where care crosses over, but is largely provided in the social care setting, the most prominent examples are care for dementia, Parkinsons and end of life care.

The King’s Fund has argued that the current split of care along these institutional lines results in an inequitable financial burden being placed on certain patients; depending upon which condition they have. The King’s Fund compares cancer and dementia; they argue that both conditions have similar burdens on the patient and their families from a healthcare perspective, however financially those suffering from dementia will pay a very large contribution to their care whilst cancer sufferers will not.

There is often contention about whether an individual should be in receipt of health or social care, and consequently, who should fund their care, the NHS or local authorities. Who is ultimately responsible for patient care largely depends on the patient’s condition; there are many examples of disagreement between local authorities and health commissioners about who should be caring for a patient. This puts finance rather than the patient at the centre of care and can cause a great deal of distress to patients and their families, not least due to the potential large sums a patient may be required to pay if their care falls under the remit of social care.

4.2 The privatisation of social care

In recent decades provision of social care has radically shifted from mostly being provided by the public sector, to mostly being provided by the private sector. Social care was never nationalised, but was previously majoritively provided through the public sector. This has dramatically changed since the Thatcher government. In 1979 the proportion of residential and nursing care services provided publicly was 64 per cent, by 2012 this was just 6 per cent. Publicly provided home care services made up the majority of provision as recently as 1993 with the private sector providing only 5 per cent of care, by 2012 private provision had risen to 89 per cent.
4.3 **Who is using social care?**

People can receive social care for a wide range of reasons. The below graph is drawn from data from the Health and Social Care Information Centre and shows the reason behind the need for social care:

![Graph showing the reason for need of social care](image)

This has obvious ties with healthcare as the vast majority of funding recipients (84 per cent) have some form of health care related need as the basis for their requirement for social care.

Community based services make up the majority of users of social care, with roughly 1.1 million users a year out of 1.3 million receiving care in total. The type of support received in the community can vary from for example from home and day care to meals or equipment in the home to enable an individual to cope better. The ageing population in the UK has connected implications for both health and social care, the rise in patients with multiple co-morbidities leads to an increasing amount of complex cases for both health and social care, with care often needing to cross the structural divide between the services.

The majority of users of social care are over 65; spending reflects this as the majority of spending in social care goes on those aged over 65, although proportionally more is spent on those younger than 65. Spending on those aged over 65 has decreased in recent years due to the extent of the cuts within local services. A recent Nuffield Trust report has found that there had been a significant reduction in the amount of older people receiving services, despite increased demand. Compared with 2009/10 levels the report found that there had been a fall of 26 per cent of older adults receiving community based services. Specific social care services were hit particularly hard, for example there was a reduction by 59 per cent of those receiving meals, and a 35 per cent
reduction in day care. The research also shows that funding for older people has been significantly reduced since 2009/10. They find that for older people social care funding has been reduced by 13 per cent for residential care, nursing care by 15 per cent and services in the community by 23 per cent.

4.4 The role of local authorities
Local authorities commission the majority of social care services, although some are provided and paid for through the NHS. Services provided by local authorities are rarely free to the user and almost always necessitate some financial input by the recipient; conversely NHS services are free at the point of use. NHS continuing care is provided for anyone whose needs are predominantly health related. This can be provided in the home, community or in a care home.

Local authorities have a duty of care to pay for social care for those that are eligible, and do not qualify for NHS continuing care. Each local authority currently has the freedom to set their own eligibility criteria to decide who qualifies for social care, there are significant variances between local authorities in social care provision. Under the current system eligibility is assessed along a scale of need ranging from low need to critical need. Due to funding pressures over recent years, many local authorities have been restricting the provision of social care to those who have a substantial or critical need, with many local authorities now not funding services for those with higher or moderate social care needs. The Nuffield Trust has found that, alongside other measures such as increasing fees payable by users and reducing fees paid to providers, tightening the eligibility criteria has been one of the main mechanisms through which local authorities have responded to budgetary cuts.

The Care Bill makes significant changes to the eligibility criteria required to receive social care services, these changes will be phased in up to 2017. The Care Bill requires eligibility criteria to be set nationally through regulations. This policy is aimed to counter the severe local variations and differences in outcomes through the social care system. This will be accompanied by national guidance to ensure that social care eligibility is uniform across the country. The BMA supports national eligibility criteria in principle to ensure that care is based on need not postcode. There has, however, been criticism, for example by Age UK, that the eligibility criteria will be set too high, and only be accessible to those needing substantial care leaving many people unable to access funding for their care.
5.0 The funding of social care

Social care makes up a large portion of local authority and government spending. A total of £17 billion was spent in the 2012/2013 financial year, providing support for 1.3 million people. The breakdown of social care spending by means of provision can be seen in the graph below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Care</td>
<td>12%</td>
<td>£2 billion</td>
</tr>
<tr>
<td>Domiciliary Care</td>
<td>43%</td>
<td>£7.5 billion</td>
</tr>
<tr>
<td>Assessment and Care Management</td>
<td>45%</td>
<td>£7.7 billion</td>
</tr>
</tbody>
</table>

There is significant variation in how social care is funded. Around 400,000 people are estimated to be paying for their own care; however data on the exact number is currently poor. A study from Leeds University for Carers UK has estimated that the value of informal carer care in England is the equivalent of £119 billion annually; this is based on the average cost for paid home care in England in 2009/10. If these figures are accepted, this is more than the annual budget for the NHS. There is often little recognition of this form of care, there is little research on the extent of the issue, and there is little support available for those providing such care. The BMA believes that the views of carers and patients’ families should be central to any social care reform.

5.1 Individual contributions to care spending

Currently, local authorities carry out financial assessments on individuals who have been identified as having a social care need to establish the appropriate means of funding their care. The assessment looks at individual’s income, and any assets that they own are taken into account (such as property or investments). The aim is to decide what an individual can afford to pay towards their social care. Broadly speaking, in the current system those with assets of over £23,250 receive no financial support and must fund their own care, until their assets fall to under this threshold. The Dilnot report recommended an increase to £100,000, and the government has decided to raise this figure to £118,000.

In the current system there is also no effective cap on the total amount that an individual may contribute to their care over their lifetime. For a small proportion of individuals their care costs
can run into the hundreds of thousands of pounds, which can result in that individual’s savings and wealth that they have accrued over their entire life being used to fund their care. The Dilnott Commission estimated that currently one in 10 people aged over 65 can expect to spend more than £100,000 on their care costs over their lifetime under the current system.

The government’s proposals in the Care Bill increased the cost cap to £72,000 for people over the retirement age, lower for those of working age (the cap will also be adjusted annually).

There are currently schemes allowing deferred payments but they are not uniformly introduced or widely used, the Care Bill strengthens these schemes. The revised deferred payments scheme will enable individuals who do not wish to sell their home to pay for their care home costs to defer payments until later at which point the cost could be recovered through the individual’s estate. The local authority would pay these costs initially, then recover them, plus interest, at a later date.

After the reforms an individual will still have to pay for many other services that are not included in these figures, for example, an individual will have to pay ‘extra’ care costs if they elect for additional care, they will also pay for any services not covered in their care and support package such as cleaners and gardeners employed by the individual. An individual in a care home will also be responsible for a contribution to reasonable living costs if they can afford it; these are expected to be in the region of £12,000 a year.

It has been shown that the public generally have a low understanding of how social care is funded, with a majority of people falsely believing that any social care that they would potentially need for would be provided for free. The BMA believes that the public should be given a clearer understanding of what they will be expected to pay for and what they can expect to receive free at the point of delivery as part of their healthcare.

6.0 Where next?

The challenges facing social care are very similar to those being experienced by health care. Lack of capacity within social care is increasingly impacting on the provision of healthcare, particularly during times of peak demand, such as winter.

The integration of health and social care to some degree is now vital, it is however imperative that clinicians are at the centre of the debate through any such service reform. If you would like to contribute to this work please contact James Raymond in the Health Policy & Economic Research Unit via email: info.hperu@bma.org.uk or by phone on 0207 383 6171.
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References


