Commission on the
Future of **Health** and
Social Care in England

Summary of responses to the second call for evidence

Summary of responses to the second call for evidence

This was the second call for evidence issued by the Commission on the Future of Health and Social Care in England. The first call for evidence was made in June 2013 when the commission was launched, and a summary of responses was published in April 2014 as an appendix to the commission's interim report (www.kingsfund.org.uk/publications/new-settlement-health-and-social-care).

In its interim report the commission set out a range of options that it was considering and asked both organisations and individuals with an interest in health and social care to submit responses to five questions designed to inform their thinking in these areas.

1. Do you agree with our conclusion that a new settlement in health and social care is needed?
2. If so, do you support our proposition for a **single, ring-fenced budget** for health and social care which is **singly commissioned**, and within which **entitlements** to health and social care are **more closely aligned**?
3. Should the aim be to achieve more **equal support for equal need**, regardless of whether that support is currently considered as health or social care?
4. If your answer is yes to question 3, should social care be more closely aligned with health care (that is, making more social care free at the point of use)? Or should health be aligned more closely with social care (that is, reducing the extent to which health care is free at the point of use)?
5. Do you think that adequate funding for health and social care requires:
   - increased charges in the NHS? If so, for what?
   - increased charges for social care? If so, for what?
   - cuts to funds from other areas of public spending, re-allocating it to health and social care? If so, from what?
   - an increase in taxation? If so, which taxes would you favour increasing?
   - none of the above? If you answer yes to this, is it because you think that funding for health and social care is adequate, and that extra demands can be met by using existing resources more efficiently? Or is it for some other reason?

There were 63 responses from a wide range of stakeholders. The commission read the submissions with great interest and is extremely grateful to everyone who took the time to respond. There is a list of respondents at the end of this document.

Key issues from the responses

- There is broad agreement that a new settlement is needed in health and social care.
- Respondents emphasised that any new settlement in health and social care should not involve an extensive reorganisation of the NHS.
- There is little appetite for reducing entitlements to health care in line with social care.

Question 1

Do you agree with our conclusion that a new settlement in health and social care is needed?

There was almost complete consensus on this question, with most respondents agreeing that a new settlement is needed.

> *One of the most powerful moments during the accounts provided by the experts during the launch of the interim report was from Dominic [Stenning], when he described how different bodies spent time and effort arguing about which budget the money for his care would be taken from, rather than focusing upon his need.*
>
> Care England

Some respondents argued that a new settlement would not be a panacea to the challenges faced by the health and social care system. One respondent argued that there is still much that can be done within the existing system, and others felt that the two systems should continue to be commissioned, funded and provided separately but in a more co-ordinated fashion. The system in Northern Ireland was cited as an example where structural integration has not brought the expected benefits.

Other respondents felt that any new settlement should be centred around the patient or service user rather than round a distinction between where health and social services care start and finish. It was also emphasised that public health should not be overlooked.

Question 2

If so, do you support our proposition for a **single, ring-fenced budget** for health and social care that is **singly commissioned**, and within which **entitlements** to health and social care are **more closely aligned**?

This proposal was broadly welcomed. One respondent cited ambiguity in the current guidance about who supplies community equipment, with public bodies in health and social care each thinking the other should provide a hoist for use at home – a ring-fenced budget could reduce the frequency of such incidents.

However, respondents expressed the following reservations:

- some felt that a ring-fence was not required and that democratically legitimate local councils should make their own decisions about how to spend delegated funding
- universal services (eg, transport, leisure and libraries) are very important for prevention and wellbeing and yet would be excluded from a single ring-fenced budget

- it needs to be clear whether the entire adult social care budget would be included in a ring-fenced budget, or just part of the budget relating to specific services (above a new minimum threshold for eligibility)
- there would need to be safeguards so that in a combined system, if a person is deemed ineligible for services in one part of the system (eg, social care), they are not at a disadvantage when accessing another (eg, health care).

There were other suggestions of ways in which health and social care could be aligned without a ring-fenced budget:

- a ring-fenced budget would not necessarily generate the integrated care that is needed – it could be more feasible to align budgets across health and social care with a shared outcomes framework, which is fully transparent
- GPs could commission social care, and 'prescribe' social care visits to those in need
- one respondent expressed the view that the Better Care Fund might provide an important test scheme on the evidence re pooling budgets in support of integration.

Many raised issues about differences between staff in the two sectors and the need for cultural change if a ring-fenced budget were to be implemented. Some raised the disparity of working conditions between the two sectors; one respondent argued that if entitlements for the service user were to be levelled up, then the skills, pay and conditions of those working in social care should similarly be equivalent to those in the NHS. Others felt that the cultural changes still required to ensure that people with multiple long-term conditions were listened to, supported and included should not be underestimated.

Question 3

Should the aim be to achieve more **equal support for equal need**, regardless of whether that support is currently considered as health or social care?

Most respondents agreed that there should be equal support for equal need, arguing that different support for people with the same or similar functional needs makes very little sense. The difference in entitlement to care between those with dementia and those with cancer was frequently cited, and one respondent made the point that people in need of help don't know if their needs fit into health or social care. Respondents emphasised that this division makes very little sense for end-of-life care and that integration would lead to better quality of life at the end of life in particular.

However, some argued that the introduction of equal support for equal need is not as straightforward as it appears, as the current conceptions of need used to allocate health and social care are different. If the budgets were to be aligned then one underlying principle might be to make better use of funds available, in which case alignment of entitlement might not be the best way forward, as it could substitute public for private spending with no benefit in terms of care. There is no way to measure the size of the group that would benefit from such an alignment.

One respondent extended the argument to include independent living in its widest sense as outlined in the United Nations Convention on the rights of people with disabilities (article 19), to include having the opportunity to build a career, to have a family and to have a social and cultural life.

Question 4

If your answer is yes to question 3, should social care be more closely aligned with health care (that is, making more social care free at the point of use)? Or should health be aligned more closely with social care (that is, reducing the extent to which health care is free at the point of use)?

A minority argued that access to social care should be aligned with health care, ie, universal and free at the point of use, but this view was not widely held. One respondent said, 'I simply do not think it is affordable or inter-generationally fair to align social care with health care.'

However, there was very clear opposition to reducing the extent to which health care is free at the point of use to align it with current entitlements to social care. The most frequently cited argument was that increased charging would deter those in need of medical attention from seeking care, particularly those who could least afford charges.

One respondent raised a concern that provision of integrated care should be nationally consistent so that people have equal access to equal standards of care throughout the country. Other solutions that were posed included simplifying the process by replacing NHS Continuing Healthcare with a system based on the current accepted model that a certain level of daily living support is means-tested but nursing and medical interventions are free. Another suggestion was that social care could be granted additional funding, which would introduce a lower level of eligibility for support, but would stop short of equivalence with the NHS.

Question 5

Do you think that adequate funding for health and social care requires any of the following?

Increased charges in the NHS? If so, for what?

A minority favoured increased NHS charges, with suggestions that hospital stays could be means-tested, and that people could be fined for non-attendance at hospital appointments.

The arguments against increased charges in the NHS were:

- a heavy burden would fall on people with long-term conditions (unless they were exempt) and would also have detrimental consequences for informal carers
- charging for the length of a hospital stay would be partly dependent on hospital quality, with well-run specialist services having reduced length of stay – it would arguably be unfair if people were paying more for worse care
- possible negative consequences with regard to A&E attendances if charges were imposed on GPs but not on emergency departments
- the creation of a barrier to seeking care for people on low incomes.

Increased charges for social care? If so, for what?

There was no support for increased charges for social care. Respondents argued that older people already make substantial contributions to their care, and that they will be unwilling to pay more while the quality of social care is perceived as uneven. One

respondent felt that charging for care at the point of delivery requires people to make financial decisions at a time of great emotional distress.

Cuts to funds from other areas of public spending, re-allocating it to health and social care? If so, from what?

There was only one suggestion here from a respondent who queried overseas funding and spending on the National Programme for IT.

There was little support for means-testing universal benefits. It was argued that means-testing does not necessarily mean that benefits are better targeted and it can prevent people in need from claiming benefits to which they are entitled, but who might be confused by the rules. It can therefore lead to poor health and wellbeing outcomes for vulnerable older people.

One related idea was that benefit payments for Attendance Allowance, Disability Living Allowance, Employment Support Allowance and the new Personal Independence Payment could be viewed as part of the funding pool for the health and social care system. If people were supported in how to spend that money to improve their care and their quality of life, the health and social care system could draw more value from those benefits.

An increase in taxation? If so, which taxes would you favour increasing?

Many respondents thought that both health and social care should be funded through increases in general taxation.

In terms of specific taxes, one suggestion was that higher rate taxes should be charged to companies manufacturing or selling products that are known to be potentially harmful to consumers, such as high-sugar drinks and alcohol.

Some respondents argued for hypothecated taxation to increase the pool of funding from which allocations are made.

A small increase in National Insurance, to be ringfenced for spending on health and social care, was suggested more than once.

One respondent supported taxes collected after death (although no detailed suggestions were made).

None of the above? If you answer yes to this, is it because you think that funding for health and social care is adequate and that extra demands can be met by using existing resources more efficiently? Or is it for some other reason?

A couple of respondents favour social insurance as an option, even though it had been ruled out in the commission's interim report, arguing that the benefits that social insurance affords, such as risk pooling and a consistent national offer for all, might be worth re-visiting. Japan was cited as a positive example of a social insurance system.

A significant minority of respondents said they had no strong position on where funds should be raised, or that they believed funding is a political issue that falls outside their remit.

Other comments

As in submissions to the first call for evidence, several respondents argued that the commission should not overlook the opportunities that greater integration of housing with health and social care will bring in allowing people to stay supported in their homes for longer.

Another comment was that more consideration could be given to the flexibility of a future health and social care system so that people can access services and support when they need them and stop using them when they don't.

List of respondents

Age UK
Ros Altmann
Association of Directors of Adult Social Services in conjuction with the Local Government Association
Nick Bosanquet
British Geriatrics Society
British Healthcare Trades Association
British Medical Association
Julian Budd
BUPA
Change Through Partnership
Care England
Clive Bowman
College of Emergency Medicine
College of Occupational Therapists
The College of Social Work
Gerald Davies
Denplan
Diabetes UK
E J Dunstan
Ed Dyson
Essex County Council
Jane Finnerty
Howard Glennester
Colin Godber
Hurley Group
Inclusion London
Intergenerational Foundation
Geoff Inwood
Paul Jenkins
Sue Johnson
Joseph Rowntree Foundation
Leeds City Council
George Magnus
Marie Curie
Medical Defence Union
Motor Neurone Disease Association
National Association of Primary Care
National Health Action Party
National Housing Federation

National Pensioners Convention
Nuffield Health
Parkinsons UK
Prescription Charges Coalition
Real Life Options
Mike Redwood
Royal College of Anaesthetists
Royal College of Nursing
Royal College of Ophthalmologists
Royal College of Psychiatrists
Royal Pharmaceutical Society
Royal Society for Public Health
Scope
Shaping Our Lives
Shared Lives Plus
Society of Local Authority Chief Executives
Terrence Higgins Trust
Tri Borough Coalition, Westminster, Chelsea
Trades Union Congress
Turning Point
United for All Ages
United Kingdom Homecare Association
Lord Norman Warner
Michael Whalley
Gerald Wistow, London School of Economics