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INTEGRATING HEALTH AND SOCIAL CARE

State or Market?

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Summary

- Medical and nursing care have been separated from social care by deliberate design since the creation of the NHS. This is true with regard to the institutional and policy frameworks and also with regard to how care is provided in practice.
- This divide, even if once justified, is now entirely artificial. People spend far less time in hospital than used to be the case and four million people over the age of 65 have a life-limiting illness. In such circumstances, medical, nursing and personal care should be combined in different ways in a range of institutional settings.
- Technology is also changing medical and nursing care. Smartphones, for example, can be used to monitor medical conditions whilst assessment takes place remotely. Phones can be used to monitor glucose levels in diabetics and to control insulin uptake more precisely. This is also contributing to the breakdown in the divide between medical, nursing and personal care and the institutional settings in which they take place.
- There have been growing calls for the greater integration of health and social care. Such proposals invariably involve a significant role for the state in integration, ranging from the current government's policy of bringing the functions under one ministry to Labour Party proposals for a National Care Service.
- The National Health Service is already the fifth largest employer in the world with 1.4 million people and the third largest employer in the world that is not an army. The social care sector employs 1.6 million people. An integrated national health and care service would be the largest employer in the world. Bringing social care within the orbit of government planning and finance would lead to the creation of a centrally planned service without precedent in the Western world.

- Dis-satisfaction with the current regime arises partly because of the totally different policy frameworks for health and social care established at the creation of the NHS. On the one hand, healthcare is largely centrally planned and delivered. On the other hand, social care, personal care and some nursing care is delivered and organised by a huge range of organisations including local authorities, hospital trusts, profit-making companies, social enterprises, non-profit-making companies, voluntary organisations and religious groups. It is very difficult to achieve integration of health and social care in these circumstances.
- Competition and markets are the best way to discover how to integrate health and social care. Such integration could be expected to happen in different ways in different contexts and through different providers. In order to achieve meaningful integration, we should make the health sector more like the social care sector so that there is more pluralism in provision and financing. This would also move health provision closer to the models that exist in continental Europe. Providers could then compete on the basis of how they integrated different aspects of care.
- Competition and markets are also necessary to facilitate pluralism in the health and social care sectors. Different people have different preferences for different types of delivery (for example, whether home or hospital based, whether to focus on care or medical treatment, the extent to which technology is desired, and so on). Also, ethical views on the provision of care differ. Given that medical, nursing, social and personal care will be such an important part of the lives of a large proportion of people, it is vital that people are able to make active choices about how different forms of care are provided and combined.

Introduction

The relationship between health and social care has been at the forefront of the government's agenda for a number of years. In a cabinet reshuffle in January 2018, then Secretary of State for Health Jeremy Hunt had his responsibilities widened to include social care. In a speech following his re-appointment, Jeremy Hunt laid out the principles that should underlie the provision of social care. This included welcoming the introduction of technology and more person-centred and holistic approaches that gave those being cared for more choices. His speech also proposed the further integration of health and social care. Hunt's successor, Matt Hancock, retained the same, widened, responsibilities. The NHS Long-Term Plan (NHS 2019) echoed these messages both in relation to the adoption of technology and also with regard to the integration of health and social care.

It would be difficult for anybody to doubt the desire to integrate health and social care provision or, for that matter, the wider adoption of technology. Indeed, the two issues are related as will be discussed below. The question for public policy, however, is whether integration arises from top-down planning by government or through large numbers of organisations responding to need, preferences, costs and dispersed information. These organisations would include charities, social enterprises and profit-making organisations.

There are, at the moment, significant differences between how healthcare and social care are provided. When it comes to the provision of social care, at a micro-level there is an apparent mixed economy of provision. Families, charities, churches and other religious groups, profit-making companies, non-profit making organisations, local government and central government all play a role in social care provision. There is, though, significant state control of some of the more important issues, such as access and finance.

On the other hand, market mechanisms and civil society organisations were more or less totally absent from healthcare provision for most of the NHS's history. This has changed somewhat over the past fifteen years or so (see Niemietz 2016: 71-85), but relative to other developed countries, the UK remains a laggard in the use of market mechanisms and the involvement of independent sector organisations in healthcare (Niemietz 2016: 54-59). This means that the interface of health and social care brings together a nationalised near-monopoly with a mixed economy made up of myriad organisations with significant local government control of finance and access. The transaction costs of integration can be significant and the very nature of the different approaches to providing health and social care can prevent meaningful and efficient integration.

So far, the government has not shown any clarity about how it will achieve greater integration of health and social care. A common response to the perceived problems, though, is to propose the development of a single organisation for the provision of health and social care run along the same lines as the National Health Service – a National Care Service. This is the route proposed by the opposition Labour Party. In its 2017 election manifesto, it stated:

> The National Care Service will be built alongside the NHS, with a shared requirement for single commissioning, partnership arrangements, pooled budgets and joint working arrangements. We will build capacity to move quickly towards a joined-up service that will signpost users to all the appropriate services at the gateway through which they arrive.

The National Health Service is already the fifth largest employer in the world with 1.4 million people and the third largest employer in the world that is not an army. The social care sector employs 1.6 million people. If such a proposal involved the creation of a single organisation to provide health and social care, it would be the largest employer in the world (even taking into account the US Department of Defence and the Chinese army). And to include the provision of social care within the orbit of government finance and provision in an integrated, centrally planned service would be without precedent in the Western world. It might be the case that there would be some mixed economy of provision within the integrated services (the details are not clear), but the essence of the proposal is for the full government planning of health and social care.

The creation of a National Health and Care Service would involve rejecting the most important mechanism for ensuring the efficient use of resources and determining how health and social care should be provided and integrated. Indeed, it is notable that few other countries have rejected the price mechanism and market and civil society institutions for the provision of healthcare as comprehensively as Britain.

The question of the integration of health and social care is even more important given developments in technology. These may change the settings in which health care is provided and change how diagnoses are made – health care may become more like social care in terms of where it is best delivered. Technology will also change the boundary between health and social care. An artificial distinction between the institutions that provide health care and those that provide social care and the rejection of market discovery processes to find the best approach to integration will become even more problematic. It is therefore understandable that a single integrated service might be proposed, but it is argued below that this is not the best approach.

Social care and health care – a seamless web?

The barriers between health and social care were erected at the time the National Health Service was created. The Beveridge Report (Beveridge 1942) recommended that healthcare should be provided and financed by the state and that such care should include rehabilitation. However, health care was not to include long-term care for the elderly. Furthermore, Beveridge was clear that his plans were designed to provide a basic level of care on which people could build using institutions which already played a role in the finance of healthcare. Beveridge also emphasised that he did not wish to undermine the family: indeed, he wished to strengthen it. Certainly, the implication of his whole report was that the national insurance system should be providing for insurable risks and not personal care.

The resulting National Health Service Act 1946 clearly made the distinction between medical care and rehabilitation on the one hand and after-care and nursing in the home on the other hand. The latter categories, according to the Act, could be subject to charges and be provided outside the National Health Service.

Thus, from the origins of the NHS, the categories of healthcare and long-term care have been separated with nursing care being a grey area in the middle.

If such a distinction was ever apt, it is not so now. The availability of medical treatments is such that life can be prolonged for people with complex conditions which might be partially disabling and which might require some nursing care. Individuals also now spend much shorter times in hospital

than in the past and this trend may well continue (see Table 1[1]). After discharge, patients often still need some form of care. As such, a situation in which somebody in hospital should receive all medical care, nursing care, personal care, food and board free and then move into a different institution (or the home) and pay for many of these things just because of where the bed happens to be seems unjust and provides incentives to keep people in need of care in the wrong places. Interestingly, this problem was, in fact, noted by Beveridge (1942: paragraph 434).

Table 1: Average number of days per year spent in hospital (men)[2]

Age range	1972	1997	2015
25-64	1.0	0.7	0.5
65-74	3.3	1.9	1.3
75+	8.2	4.3	3.7

Lengthier stays in hospital are not only expensive, but they can lead to patients being more likely to suffer from an infection which will then delay their recovery. The Carter Report estimated that there was huge scope for discharging patients from hospital who no longer needed to be there (Carter 2016: 26-28). It is generally estimated that a hospital bed costs £400 per day which is significantly more expensive than even the costliest nursing home or out-of-hospital monitoring and care.

Despite the incentives for people to stay in hospital, large numbers of people do, of course, receive medical treatment and nursing care outside hospital as well as receiving personal care. There are 4,000,000 people over the age of 65 who have a life-limiting illness and 416,000 people who live in care homes. In 2015, nearly 400,000 people received an average of 12.2 hours a week of care funded by local authorities and health service commissioning groups at a total cost of £3.9 billion. Data on self-funders is sparse, but the same survey suggested that 279,000 people purchased nearly 79 million hours of care at a total cost of £742 million. In addition,

1 The data in the table do not show average stays after specific procedures which might illustrate the point more clearly. However, Charlesworth and Johnson (2018) do note the huge reduction in times spent in hospitals after heart attacks and treatments and this is not untypical.

2 Data from Charlesworth and Johnson (2018).

a great deal of care (though probably not nursing care) is provided by family and friends.

Illness is often associated with the presence of complex combinations of conditions, especially in older people who may need hospital treatment or social care. One major study has suggested that patients with multi-morbidity (that is, suffering from more than one condition) accounted for 52.9 per cent of general practice doctor consultations, 78.7 per cent of prescriptions and 56.1 per cent of hospital admissions (Cassell et al. 2018). The idea that people have symptoms, go to the doctor and are either treated or referred to hospital into which they may be admitted, operated on and discharged is one that does not reflect the reality of modern healthcare. However, the institutional environment in which health and social care is provided does not reflect this.

There are elements of the care funding system that try to reflect the unbreakable relationships between hospital treatment and care outside hospital. For example, under 'continuing healthcare' rules, the NHS is required to offer full funding to those with complex care needs in later life without means-testing even outside hospital settings. The difficulty of defining where healthcare begins and ends in such circumstances is reflected in the fact that just 18 per cent of people were approved for such funding (National Audit Office 2017: 10) after their first assessment and there is a growing volume of appeals. The whole process is regarded as highly complex.

In addition, those who live in England and are in registered nursing homes but who are not eligible under the continuing healthcare rules receive a flat-rate payment towards the cost of their nursing care.[3] Once again, this is recognition of the inseparability of nursing care and personal care, but the fact that the payment is flat-rate reflects the huge difficulty, if not the impossibility, of defining and costing the nursing care element. In Scotland, personal and nursing care is paid for by the government, but the 'hotel costs' (food, laundry etc.) are paid for on a means-tested basis by the individual. Of course, if people are receiving care in their own home from relatives or friends, the government does not bear the cost of this.

3 This is paid directly to the nursing home. The scheme is explained at: https://www.nhs.uk/chq/Pages/what-is-nhs-funded-nursing-care.aspx

These contorted policy solutions arise from the entirely different policy frameworks within which healthcare and other forms of care are provided. There is no solution to the challenge of integrating health and social care whilst policy remains within the existing framework. The boundaries can shift one way or the other, or specific policy initiatives can be proposed, but the fundamental need for a boundary between the two sectors exists under current institutional arrangements. However, when it comes to people's care needs, it is simply not possible to divide people into two categories: those in need of medical interventions who should be in hospital and those who are not and who should be at home or in a care home. At the same time, one cannot divide care into two categories – nursing care and personal care. This problem will become more complicated as the population ages and as technology leads to the development of new ways of providing health and personal care and of combining the two, especially in non-hospital settings.

Technology and integration

Whilst there has never been a clear divide between health and social care, technology is blurring the lines further – or at least it should be. Smartphones, for example, can be used to monitor a large number of medical conditions whilst assessment can take place remotely. Phones can be used to monitor glucose levels in diabetics and control insulin uptake more precisely. In addition, phones can be used to monitor people's location and, of course, web cameras can be used to observe somebody if that is necessary. This allows people to move into their homes from hospital more quickly or to stay out of other forms of institutional care. They might be receiving medical care in their homes, or perhaps the devices can be monitored by people who provide personal care. X-ray machines and blood-testing kits are now portable allowing procedures and assessment to take place in the home instead of in a GP's surgery or hospital. 'Tremor spoons' can be used to monitor people with Parkinson's disease and can substitute for manual assessments that take place within hospitals.[4]

Interestingly, organisations in the state of Victoria in Australia have formalised these developments. They have developed the concept of a 'Hospital in the Home'. This allows patients to receive acute treatment in their home in the same way they would in hospital. This approach is used for those in need of emergency treatment as well as those in need of acute care and for patients discharged from hospital. Various smart devices are used in the assessment and care processes. In 2009 an independent review confirmed the Hospital in the Home as a well-established model of care that is safe and effective and highly valued by patients, carers and

4 For further discussion, see Gretton and Honeyman (2016).

staff.[5] Again, this demonstrates how nursing and social care have become integrated with medical care and the settings for all three are now diverse.

5 See: ‘Hospital in the Home’, https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/hospital-in-the-home and ‘Hospital in the Home information sheet’, https://www.thermh.org.au/sites/default/files/media/documents/hith_information_folder_march_2010.pdf

Technology in healthcare lagging behind

However, though there is a range of possibilities for technology to change healthcare radically, the actual changes in healthcare and social care have been limited, at least in the UK. The development of technology has revolutionised the provision of other services over the last 60 years. In both the rail and airline industries, the number of fatalities has crashed almost to zero largely as a result of the adoption of technology. The way in which televisual entertainment, telephony and data processing are carried out has changed beyond all measure. Technology not only involves the provision of new products and services, it changes radically how services are delivered and how they are combined with each other. An obvious example is the case of televisual services. Even 20 years ago, for example, most people could not imagine watching television programmes on their telephones.

Meanwhile, healthcare seems to stagnate by comparison, despite the technological developments mentioned above which are exploited at the margin. It is true that technology has led to the introduction of new services and new ways of delivering specific services. Laparoscopic (keyhole) surgery, for example, is one of many technological developments over the last 25 years. A number of new drug and minor surgical interventions have improved heart attack survival rates and so on. What has not happened, however, is a radical change in how health services are delivered. Arguably, this is connected to the stagnation in healthcare productivity. Overall, the quality adjusted productivity figures for the NHS show growth of less than 0.8 per cent per annum over the 20 years to 2015 (ONS 2018a) with half of the total productivity gain taking place in four years from 2011 to 2014 when resources were tightly squeezed. Productivity of government-funded social care has actually fallen by 0.7 per cent a year in the 20 years from 2017 (ONS 2018b).

Perhaps most notably, the basic principles of how medical assessments are made and care is provided have not changed. A patient with symptoms still telephones for a 5-10-minute appointment with a local GP. The patient has to attend the GP surgery and often wait a significant amount of time to be seen. Although some minor procedures are now dealt with in a general practice surgery, the GP will normally either prescribe a course of treatment, tell the patient treatment is not necessary or refer the patient to a specialist. The same will apply for the specialist appointment and any subsequent required hospital treatment (whether as an inpatient or outpatient). If a person becomes frail, they may be looked after in their home by relatives, normally being taken to hospital for any medical interventions that are necessary and, if care needs become more demanding, there is likely to be a transfer to a care home where care is provided almost wholly by person-to-person interaction.

These processes survive as if email, apps, home monitoring, portable equipment, skype and facetime and the internet more generally had never been invented. Patient time and any difficulties patients have travelling are entirely uncosted. The mode of delivery of services generally requires the patient to physically visit a medical practitioner's premises. Secondly, the idea that any of these services could be provided remotely (whether by a practitioner in the patient's own country or by service providers abroad) is never considered. The idea of combining monitoring with home visits in the provision of long-term care is also in its infancy.

Integration and competition

Of course, it is because these problems and challenges are understood, that political parties and others are discussing the integration of health and social care. However, their integration is not as simple as integrating two businesses in different parts of a clearly-defined supply chain. It is not as if we have a manufacturing business producing cars without wheels and another producing wheels so that the car maker has to decide whether to buy the wheel maker or carry on buying wheels from the independent wheel maker. Health and social care involve complex interactions between needs, possible responses and personal preferences that vary from person to person and will often involve ethical considerations. There will be transaction costs between different aspects of the care process which will partly dictate the relative efficiencies of different approaches to integration of health and social care provision.[6] Whether and how and at what stage in the supply chains processes and service provision should be integrated is the key question, the appropriate answer to which may vary from individual to individual and be different in different circumstances (for example, in rural and urban areas).

Thus, meaningful integration of health and social care is not possible with our model of nationalised healthcare and a mixed economy in social care. Indeed, even if the whole health and social care system were centrally planned or the boundary between health and social care controlled by government to a greater degree, it would not be possible for the government to engineer a system of provision that best met the welfare of patients and consumers. Furthermore, in such a government-controlled system,

6 See Williamson (2008) for a general discussion of transactions costs and their importance in economics.

there is no meaningful way of experimenting with different approaches and adopting those that maximise welfare for a given cost.

This is a particular example of how knowledge is dispersed and why markets are necessary. Knowledge about costs and preferences in relation to different ways of providing and integrating health and social care simply cannot be known without the possibility of market and civil society provision offering different approaches with individuals and families choosing between them. Do people prefer care in the home to care in the hospital? If so, what additional value do they put on their preferred setting? To what extent are people willing to trade reduced probabilities of dying for care in a home rather than a hospital setting? The answers to these questions are the classic 'unknown unknowns' which can only be discovered by allowing entrepreneurial endeavour (see, for example, Kirzner 1996).

In response to criticism, it is often argued that the NHS is efficient in the use of resources.[7] In an administrative sense, this may be true, though Niemietz (2016) argues that this is because of crude rationing: more sophisticated measures of efficiency put the UK system in the bottom third of rich-country health systems. However, the real question when it comes to efficiency is whether resources are used to meet the needs and preferences of patients. Efficiency in any meaningful sense becomes more difficult to achieve through centralised planning when there is no general consensus about both the ends of healthcare and the means of achieving the ends. Surgical interventions, vaccination programmes, the treatment of infectious diseases, and so on were important aspects of the services to which all were given access when the NHS was created and it might be possible to organise the provision of such services through central planning with a tolerable level of efficiency. However, when health and social care are delivered simultaneously, both preferences and costs regarding the relative value of different forms of service and their modes of provision are naturally dispersed and can only be discovered by entrepreneurial endeavour.

An additional element of this problem relates to uncosted patient and family time in the UK health and care system. When goods and services are provided in markets, preferences for speed of delivery and customer time involved in their procurement are factored into prices. For example,

7 See, for example, the Commonwealth Fund study, which ranks the UK health system as 3rd (out of 11 studied) for administrative efficiency – though 10th for outcomes (see Commonwealth Fund 2017).

different forms of child care have different costs, and parents can choose between them depending on their preferences for saving their own time as compared with the higher costs of more convenient options: this is not possible in the delivery of health care. There is no way of avoiding queueing time or of booking a doctor's home visit whilst paying a charge that reflects the increased time to the doctor, even if the benefit in terms of time saved hugely outweighs the cost of the visit.[8] In addition, there is the possibility, as noted above, of consultations being undertaken remotely.

These trade-offs, which become ever-more complex as medical conditions become more complex and forms of treatment and consultation more diverse cannot be rationally weighed up in a system which is, to such a large extent, centrally planned.

8 Many readers will be familiar with taking an elderly relative to the GP. The time taken may well be several hours between the patient and their carer as compared with the cost of (for example) a five-minute journey by the doctor.

Investment, innovation and competition

There is much debate in the economic literature about the right environment for investment and innovation. Jones (2013), for example, takes a line similar to that of Mazzucato (2013), arguing that invention and innovation have come from large firms and important discoveries have been led by state financing (for example, research financed by the US defence budget). Baumol (2002) on the other hand argues that innovation arises from large firms seeking competitive advantage. Radical disruption also often comes from new entrants challenging the working methods of incumbents: Google and other tech firms are often given as examples of small challenger firms being responsible for radical innovation.

Even if the contestable ideas of those who support significant state intervention in the process of innovation are accepted, there is no evidence that nationalising and centrally planning the entire system of provision of a service and determining the structure in which it is delivered from central government will provide an environment conducive to innovation in terms of either the integration of methods of delivery of different aspects of health and social care or the adoption of innovations. On the whole, those authors who support great government involvement in the process of innovation are proposing that the government supports research rather than delivery.

When it comes to healthcare provision, there is certainly little evidence that a structure based on government-led delivery mechanisms will have long-term planning horizons. Bartholomew (2004) discusses the fall in UK-led innovation since the NHS was created. A recent National Audit Office Report (NAO 2018) criticised the NHS for focusing on short-term cost saving measures rather than long-term transformation. The successive failure of centrally-planned IT projects is a symptom of the problems of

centrally planning the implementation of innovation in a system which prevents competition between providers that chose to adopt innovations in different ways.

Whether the development and adoption of technology in healthcare and homecare requires subsidy from the government or is best delivered by large or small firms is beyond the scope of this short paper. However, there is little doubt that a centrally planned and unified system of health and social care is not best placed to create an environment in which innovation is effectively and efficiently delivered and in which health and social care will be appropriately integrated in response to the specific needs and wishes of those being cared for.

Conclusion and policy proposals

The question of the integration of health and social care is not a new one. The issue was considered by Beveridge. It has always been explicit policy that there should be some separation between health and care and one of the reasons for this related to views about the different obligations of families and the government when it came to funding and provision. This original rationale was not misguided. However, the ways in which medical and social care can be integrated are now so complex and varied that a model of state provision of healthcare and a mixed economy for social care, if it ever were appropriate, cannot easily be sustained. That seems to be widely understood.

Those on the left have called for integration of health and social care into one enormous service. The result of this would involve the central planning of activity in this area on an unprecedented scale. It would also involve the rejection of the mechanism which is most likely to promote rational and efficient integration. Furthermore, health and social care involve – perhaps increasingly – ethical decisions and views on the appropriate mode of provision on which different people have different preferences. Such preferences cannot be effectively reflected in a system centrally planned by the state.

Rather than nationalising the provision of social care, a route that is more likely to lead to rational integration could involve the development of social insurance models for healthcare which could then be extended to social care according to the preference of the insured.

Niemietz (2016) proposes that the UK adopts such a model of healthcare provision, which would be closer to that which exists in countries such as Germany, The Netherlands and Switzerland. Universal access can be achieved by subsidising premiums according to income and cherry picking

can be avoided in various ways described by Niemietz. Crucially, the government's role can be limited, but can include setting a baseline for insured provision. Whether further risks above the baseline are insured would be a matter for the insurer (which might or might not be a profit-making institution) and the person insured. How healthcare was provided, the extent to which social care was insured and the mechanisms of integration and choices available would also be a matter for the insurer and insured, as long as the basic standards and forms of care were offered. Individuals could combine insurance with paying for other services out of pocket or with care provided by family and friends. Different insurers could try alternative approaches so that there could be experimentation followed by the proliferation of successful models. Insurers with different ethical perspectives could also provide cover, widening choice.

If there is to be better integration of health and social care with the development of solutions involving the wider adoption of technology, the answer should involve reforming the way in which healthcare is provided and financed and then promoting a permissive approach to its integration with social care. Under this model, not only would there be no institutional block on integration, integrated health and social care provision would be a natural extension of the health insurer's role if that was the preferred approach of the insured.

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