Joined-up Rationing? An Analysis of Priority Setting in Health and Social Care Commissioning

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ABSTRACT

Joint commissioning is an important part of the current health and social care context and will continue to be crucial in the future. An essential component of any commissioning process is priority setting, and this paper begins to explore the idea of integrated priority setting as a key element of health and social care commissioning. After setting out the key terminology in this area and the main priority-setting processes for health and social care, the paper describes a number of barriers that might be encountered in integrated priority setting. We argue that there are significant barriers in financing, accessibility, evidence and politics, and it is important that such barriers are acknowledged if priority setting is to become a component of joint commissioning. While these barriers are not insurmountable, the solution lies in engagement with a range of stakeholders, rather than simply a technical process.

KEY WORDS
joint commissioning; priority setting; health and social care

Introduction

The notion of collaboration has been central to health and social care policy for some time, and it is widely accepted that health and social care organisations need to work together in order to deliver services effectively (Glasby & Dickinson, 2008). On this wider collaborative agenda joint commissioning has emerged as an important function in the pursuit of high-quality care (Dickinson & Nicholds, 2011). Although the recent NHS White Paper (Secretary of State for Health, 2010) alters the commissioning landscape, it does not diminish the importance of joint commissioning. Although most joint commissioning has been concerned with the relationship between PCTs and local authorities, it may also take place between a range of statutory bodies, professionals, service users

and the public, as a broader feature of the public policy landscape. Joint commissioning will remain a key area of concern, and arguably become even more important as public health functions transfer to local authorities.

> *The arrangements for joint planning between the NHS and social care must remain… joint working and commissioning between PCTs and LAs will be of increased importance to deliver better outcomes for patients, service users and their carers.* (DH, 2010 p6)

These changes take place in an increasingly tight fiscal context. With ever more demands by an increasingly older population with chronic diseases and multiple morbidities from ever-tightening health and social care budgets, this can pose significant challenges for health and social care commissioners who are required to make difficult decisions about what they need to spend money on. Against this background, it could be argued that population-level priority setting, which seeks to target resources where need and capacity to benefit are greatest, might be a helpful tool for commissioners (Williams & Robinson, 2011). Arguably, it is the commissioner's responsibility to ensure that resources are distributed fairly and efficiently across patient and service user populations. If this is the case, then it is important that priority setting is carried out in a joined-up manner. This paper therefore explores the idea of integrated priority setting as a key element of health and social care commissioning. It begins by identifying the distinctive features of current resource-allocation processes in each setting before considering the barriers to adoption of a more integrated approach.

Terminology
Although the reality of budget constraints is felt across the health and social care spectrum,

much of the theory and research in this area has focused on the allocation of resources to **health** services. In particular, this can be seen in relation to notions of 'priority setting' and 'rationing', which are common features of the health policy and management literature but less prevalent in social care. Although these terms are used interchangeably by many health commentators, Klein (2010 p389) distinguishes between them on the following grounds.

> *Priority setting describes decisions about the allocation of resources between the competing claims of different services, different patient groups or different elements of care. Rationing, in turn, describes the effect of those decisions on individual patients, that is, the extent to which patients receive less than the best possible treatment as a result.*

Thus rationing can be understood as the lived impact on service users of priority-setting decisions. In combination, priority setting and rationing can be understood as **the processes by which services that may be of benefit to users are withheld on grounds which include cost**. In this article we adopt and apply Klein's definitions to both health **and** social care (in the case of the latter substituting 'service users' for 'patients'). Priority setting can be enacted at a number of decision-making levels, including the setting of overall budgets for health and social care services (by either national or local government), the distribution of these resources between competing programmes, services and interventions, and the placing of limitations on access in relation to service user groups or individuals.

Priority setting in health care
Despite undergoing some decentralisation in recent years, the NHS remains subject to considerable central command and control,

and this is reflected in its approach to cost containment. Before the introduction of the purchaser–provider split in the 1990s, ceiling budgets were imposed on NHS providers so that decisions over the withdrawal or withholding of care were made largely at the 'bedside' by physicians (under the cloak of clinical judgement), or else patients were put on waiting lists so that spending was delayed. Although this implicit approach can still be seen in the NHS, there has been a marked shift towards development of more explicit approaches, not least as a result of the introduction of commissioning (Ham & Robert, 2003). At national level this can be seen in the work of the National Institute for Health and Clinical Excellence (NICE), whose guidance on access to new interventions is binding on all NHS organisations. In keeping with an evidence-based approach to priority setting, NICE invests heavily in systematic reviews of the effectiveness and economic evaluations of the cost-effectiveness of new interventions. Responsibility for population resource allocation decisions not covered by NICE rulings currently lies with primary care trusts (PCTs), which discharge approximately 80% of the NHS budget.

Through the work of NICE and PCTs, health care priority setting has become synonymous with application of evidence on the population costs and benefits of health care interventions. For example, the requirement for PCT priority setting to be informed by best evidence is enshrined in the Labour government's 'world class commissioning' competencies (DH, 2009). However, PCTs have yet to demonstrate that they can call upon sufficient authority and resources to implement high-profile decisions, especially when they are opposed by interest groups and other stakeholders (such as patients, industry, government and the judiciary). Concerns over the legitimacy of PCT decisions (not to mention the degree of genuine autonomy from government that they are granted) have been accompanied

by recognition of the limitations of the evidence-based model of priority setting in general (Holm, 1998). In response, commissioners have been urged to incorporate more meaningful public engagement in decisions (Waite & Nolte, 2006) and to follow robust process criteria for decision making (Daniels & Sabin, 2008).

In summary, then, resource allocation in the NHS is in a process of transition from implicit, patient-level rationing to explicit, population-level priority setting, and the key decision-making responsibilities at population level currently sit with NICE and PCT commissioners. However, there is also a strong counter-strain of government policy which emphasises the importance of patient choice and personalisation in service delivery, for example through the introduction (albeit on a small scale) of individual budgets for patients and service users. What is more, the new Coalition government has recently announced both a shake-up of commissioning (with PCTs to be replaced by GP consortia) and removal of the duty to implement NICE rulings on new technologies. Although priority setting is therefore a significant element of health care commissioning, the level at which decisions are made, and the preferred approach to making them, are subject to considerable uncertainty.

Priority setting in social care

In comparison with the NHS, priority setting in social care is much more decentralised, despite attempts to reduce variation. The White Paper *Modernising Social Services* (DH, 1998) acknowledged that eligibility criteria for social care access were patchy and led to variation that was both confusing and unnecessary. The Fair Access to Care Services (FACS) framework was introduced in order to operate a single eligibility decision for all adults seeking social care support. The guidance categorises the risks faced by individuals into four bands: critical, substantial, moderate and low. These risks are

both immediate and long-term so that responses might support a preventative approach. Despite this national framework, councils still have a high degree of autonomy in how they plan service responses to the needs of individuals. Under FACS, resource allocation is constrained primarily by assessment processes and eligibility criteria. Individuals are assigned to categories of need, local authorities deciding which categories will be funded for social care. Eligibility criteria therefore are the primary mechanism of priority setting, and rationing effects flow from local authority decisions on the level of need at which services will be funded. Adults are also means-tested and charged, and this may also influence subsequent take-up. There are a lot of people who may qualify for support on the grounds of need but whose income makes it better for them to self-fund.

Recent reports suggest that about three-quarters of councils now meet critical or substantial needs only, and this is set to rise to 80% in 2011 (Dunning, 2010). In 2006 just over half of councils supported moderate needs, but increasing demand and a tightening economic context have contributed to this shift. A recent test case has also allowed local authorities to cut back on services that were previously provided. Kensington and Chelsea Council was recently judged to be acting lawfully in withdrawing services that it had previously commissioned (Brindle, 2010). Another feature of the social care approach is reliance on the judgement of professionals and practitioners involved in the assessment process and then in care management in guiding individuals in their care packages.

As noted earlier in this article, individual health budgets are currently being piloted in the NHS. However, the notion of direct payment, individual budgets and personal budgets has a much longer history in social care (Glasby & Littlechild, 2009). The rationale underpinning this reform programme is that devolving budgets to

the lowest possible level will mean that money is better spent as individuals prioritise spending according to their specific needs and preferences. Essentially, under these conditions the service user makes the resource allocation decisions, with a reduced role for planners and professionals. This agenda signals a shift away from looking at care at population levels to an individual, micro-commissioning level, although local authorities still have a broader power of well-being. One of the implications of this personalised, self-directed system is that there is a much weaker narrative on population-based decision making than is the case in health care commissioning. There is some concern that this could weaken services that are best commissioned for populations (Harlock, 2009). As an example, day care centres might not have a sufficient critical mass in the short term to make these services viable.

There is also somewhat of a disconnect in micro-level commissioning and a preventative agenda. Individual-level commissioning focuses attention on those who have been identified as eligible for care, but does not take account of those who are not (although through joint strategic needs analyses local authorities are tasked with developing more universal advice and information services). A consequence is that those who are not judged eligible for social care on the basis of need but might self-fund may not be able to access information about which services they need, as this is not readily provided as a public service by all local authorities. If individuals do not access support, then there is a danger that their condition will deteriorate, with the result that the cost of their care is higher to the state in the longer term. Although providing information and advice to all individuals in advance of a crisis has been a component of recent policy initiatives (this is one of the six elements of the 'national care service' proposed by Labour in 2009/10, for example), as yet it is not embedded as good practice in all areas of the country.

Given the divergent trajectories travelled by health and social care commissioners, and the different circumstances in which they currently find themselves, any attempt to implement joined-up priority setting is likely to experience considerable obstacles. We address a number of these in the remainder of this article. There is a burgeoning literature which tackles the thorny issue of health and social care collaboration (Glasby & Dickinson, 2008). The concern here is with barriers which relate specifically to priority setting and resource allocation.

Barriers to joined-up priority setting
Financing services

In the NHS funds are raised primarily through general taxation and then distributed by government among commissioners to allocate on behalf of their patient populations. Although plurality and competition have been encouraged in the delivery of health care, the flow of resources therefore remains relatively simple. The reliance on centrally collected, tax-based revenue also means that, at the point of access, patients remain largely shielded from the financial transactions involved. Irrespective of the merits or otherwise of these arrangements, they represent a marked contrast to the picture that has developed in social care – most notably in relation to the expanded role afforded to local government, but also in the prominence of means-testing, co-payments and devolvement of budgets to individual service users.

Clearly, these differences present obstacles for 'joined-up rationing'. In particular, the asymmetry of the respective decision making, accountability and resource allocation structures make collaboration difficult to implement. For example, who should take responsibility for ensuring that allocation of funds between health and social care at national and local levels is proportionate? Which health care decision makers are best

placed to feed into design of social care eligibility criteria? And similarly, which health bodies should work with local authorities to agree on the level of social care need that can, and should, be funded? Conversely, who from a social care context should be involved in the priority-setting activities of health care commissioners (for example GP consortia)? The danger is that the mismatch in decision-making structures will lead to lack of equivalence in the roles and remits of collaborating priority setters.

Another area of divergence in the funding of care has emerged since the introduction of payment by results in the NHS, under which provider organisations such as hospitals are reimbursed according to activity, using a nationally set tariff. The absence of a set price for social care interventions (although pathway-based tariffs may be on the way) means that local authorities are able to set user charges at varying levels, thereby exacerbating variation in budgets and service availability. Recently the Department of Health has started to rectify the perverse incentives involved in activity-based funding by changing emergency admission tariffs so they are not reimbursed when patients are re-admitted within a particular time period. This might incentivise acute trusts to work with other health and social care partners in a more preventative manner, but this mismatch in funding processes and regimes remains.

Accessing services

As we have seen, in social care priority setting is largely embedded in needs assessment criteria, and rationing takes place by applying funding thresholds to these needs-based categories of eligibility. The implications for service users are that, depending on assessment of their need, they may have services denied or withdrawn, or be required to pay charges for them. The picture is very different in the NHS, which is based on collectivist principles of fairness and redistribution

(although these have steadily eroded during its lifetime). These principles are expressed in a commitment to delivering a comprehensive service, accessed without charge at the point of delivery. Thus no patient with legitimate health care needs should be denied care irrespective of condition severity. However, this has led to longstanding difficulties in managing the gap between need (or demand) and available resources, resulting in deferral of treatment through waiting lists as well as 'bedside' rationing.

However, these strategies are increasingly accepted as being outdated (in the era of the sophisticated service user), and budget holders have been compelled to find new ways to reconcile the principle of comprehensiveness with a context of increasing resource constraint. The Labour government's development of both national priorities (for example through the work of NICE) and the local commissioning function are the latest in a long line of government strategies designed (at least in part) to tackle this widening gap. These differences in the way in which supply is constrained in health and social care have implications for the integration of priority setting. Most notably, the strategies employed in social care – denying services to those with lower levels of need, setting user charges at different levels in different localities – are simply not available to those seeking to implement explicit priority setting in health care.

Evidence and resource allocation

As already noted, the dominant narrative informing health care priority setting, both domestically and elsewhere, is the evidence-based model. It reflects both the traditional medical model associated with health care (with its associated hierarchy of evidence) and the more recent emergence of quantitative tools for information synthesis and decision support. Developments in health technology assessment (HTA), quantitative needs assessment and cost-effectiveness analysis (CEA) have encouraged resource allocators to seek technocratic solutions to the painful choices resulting from resource scarcity. Outcome measures such as Quality Adjusted Life Years (QALYs) decontextualise the benefits of interventions in a way which appears to enable investment decisions to be made comparatively across clinical and service areas. In health care, therefore, there are strong calls for priority setting to follow the recommendations of analyses reporting quantitative summary measures of the relative merits of investment options (Williams, 1998).

This evidence-based model of priority setting is subject to critique in multiple respects (Black, 2001). For the purposes of this article, however, it is sufficient simply to note the absence of any comparable recent trends in prescriptions for social care commissioning. This is not surprising, given the profession's roots in a social model of well-being (in contrast to the medical model prevalent in health care). Successful interventions in social care are explicitly linked to notions such as lived experience, adaptation and empowerment which are inherently difficult to codify and measure (Dickinson, 2008). Put simply, there is no social care equivalent of the QALY, although some recent work seeks to redress this lack (Netten *et al*, 2005). This means that the sorts of abstract, comparative assessment of population-based interventions which have become an increasingly common feature of health care commissioning are less feasible in a social care setting.

Political contexts

One of the consequences of the profile and popularity of the NHS as a national institution is that it is likely to remain a centralised institution subject to strong government control and reform. There is currently minimal local authority jurisdiction in relation to health care, although this might increase with the proposed transfer

of public health functions to new health and well-being boards. Although development of clinical leadership has increasingly become an area of focus (Ham & Dickinson, 2008), the medical profession retains both high status and significant levels of autonomy in the NHS. The power of local commissioners to lead priority setting is therefore weakened by the relative strength of national government and clinical opinion. Health care systems, and by implication the commissioners operating within them, are also subject to intense industry lobbying over reimbursement of expensive treatments (Williams, 2009), and it is politically risky for a treasured institution to engage in spending cuts and/or explicit withholding of treatments and services.

We have seen that social care is administered at local level with a strong hand for locally elected representatives and relatively little routine interference from ministers. Local authorities operate within the parameters set down under Acts of Parliament, and have a range of mandatory and discretionary functions. Only where there are particular cases of concern over the safeguarding of the public or where local authorities exceed their statutory powers do they tend to be challenged. The public profile of social care is also more negative than that of health, and it has been argued that public pressure is more likely to be for reductions in expenditure on social care than for increases (Bergmark, 1996). This means that rationing and variations in patterns of service delivery are unlikely to be received as negatively by the general public as in health. Delivery of social care is not associated with the same degree of proliferation of expensive interventions that characterises the health sphere (although clearly buildings-based services such as care homes and day centres are costly). For these reasons, one might hypothesise that decisions to reduce, withhold or deny care are politically more acceptable, albeit still controversial, in a social care setting than they are

in the NHS. This again poses problems for any putative integrated priority-setting function.

Moving forward

It is important that such barriers are acknowledged if priority setting is to become a component of joint commissioning. While it may not be feasible to overcome these obstacles entirely, at least in the short term, there are a number of factors which may help to lessen their impact. For example, there is a recent precedent in pooling budgets, and this may help to reduce some of the asymmetries of decision making in health and social care systems. Research in the area of health care priority setting indicates that priority-setting activities should be firmly embedded in structures of governance and performance monitoring in order to avoid becoming tokenistic and/or impossible to implement in practice (Robinson *et al*, forthcoming). Further alignment of funding models might also result from the trend in health towards both individualised budgets and greater levels of patient co-payment for selected interventions. Ultimately, however, the over-arching models of health and social care funding can only be fully aligned by macro-level reform, and so the role of national government is crucial (Glasby *et al*, 2010).

With regard to service access, it is not clear that the barriers to integration posed by the different models of health and social care can be overcome without, in effect, one side adopting the other's model. Resource allocation in both health and social care is driven, at least formally, by notions of need, and in this respect there is room for collaboration. However, the mechanisms for denial of services prevalent in social care are not obviously available to the NHS, at least not without further compromising of its underpinning values. Nor is it obvious that social care would benefit from wholesale adoption of an NHS model of population-based priority setting instigated by generation of quantitative evidence

of the effectiveness (and cost-effectiveness) of interventions, because social care services appear less amenable to such evidence. Both of these issues – the different mechanisms for rationing care and the types of 'evidence' privileged in each context – pose considerable difficulties. However, we would argue that in relation to the role of evidence both parties would benefit from greater dialogue, social care by exploration of the potential benefits of investing in population-level evidence generation, and health by development of less narrow measures of service 'outcomes' and a more sophisticated appreciation of the impact on service users and their families.

Finally, in relation to political contexts, both health and social care agencies are required to manage their authorising environments – the key government, public and stakeholder groups whose support is required if priority setting is to be considered legitimate. Central government plays a much stronger role in the activities of the NHS, arguably, than it does in social care, where local government structures have the potential to affect design and delivery of services. However, what is common in both these environments is that priority setting (and commissioning) is more than simply a technical exercise. Rather it is a complex process that requires the engagement of a range of stakeholders, and it goes well beyond simply being able to employ the right kind of tool to come up with the 'correct' answer in priority setting.

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