

## **Shaping the debate on health and social care:**

### **Purpose**

For discussion.

### **Summary**

This paper is in two parts. The first part gives an overview of the Commission on the Future of Health and Social Care in England, along with the headline messages from its interim report. This provides background for the discussion with Geoff Alltimes from the Commission (and Richard Humphries from the King's Fund).

The discussion with Geoff Alltimes and Richard Humphries will lead into a separate but linked discussion on the LGA's own work on redesigning the health and social care system. The second part of this paper therefore sets out proposed key messages and an outline of planned activities and products.

### **Recommendations**

Members are asked to note the first part of this paper as background to the discussion with Geoff Alltimes from the Commission on the Future of Health and Social Care in England.

For the second part of this paper Members' views are sought on both the LGA's key messages on the redesign of health and social care, and the planned activities and products to support local government and other systems leaders in leading this agenda locally.

### **Action**

LGA officers to progress activity in line with Members' comments.

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11 June 2014

## **Part 1: The Commission on the Future of Health and Social Care in England**

### **Recommendations**

1. Members are asked to note the first part of this paper as background to the discussion with Geoff Alltimes from the Commission on the Future of Health and Social Care in England.

### **Background to the Commission**

2. The Commission on the Future of Health and Social Care in England was launched in June 2013. The Commission is independent but is funded by the King's Fund which has also agreed its terms of reference, and has appointed its members. The Commissioners are:
  - 2.1. Kate Barker CBE(Chair), business economist and former member of the Bank of England's Monetary Policy Committee.
  - 2.2. Geoff Alltimes CBE, chair of the LGA Health Transition Task Group and former chief executive of Hammersmith and Fulham Council and NHS Hammersmith and Fulham.
  - 2.3. Lord Bichard, cross-bench peer and chair of the Social Care Institute for Excellence.
  - 2.4. Baroness Sally Greengross, cross-bench peer and chief executive of International Longevity UK.
  - 2.5. Julian Le Grand, Richard Titmus Professor of Social Policy at the London School of Economics.
3. The Commission is exploring whether the post-war settlement, which established the NHS as a universal service free at the point of use and social care as a separately funded, means-tested service, remains fit for purpose. It is considering three broad questions as part of this:
  - 3.1. Does the boundary between health and social care need to be redrawn? If so, how and where? What other ways of defining health and social care needs could be more relevant?
  - 3.2. Should the entitlements and criteria used to decide who can access care be aligned? If so, who should be entitled to what and on what grounds?
  - 3.3. Should health and social care funding be brought together? If so, at what level (i.e. local or national) and in what ways? What is the balance between the individual and the state in funding services?

### **The Commission's assessment of the problems with the current settlement**

4. The Commission published its interim report, 'A new settlement for health and social care', on 3 April and Councillor Gillian Ford attended the launch event on behalf of the LGA. In its report the Commission highlights three systemic problems with the current settlement:
  - 4.1. Lack of alignment in entitlements to health and social care in England. Each system is subject to different assessments of needs and means resulting in people with

11 June 2014

- conditions that have similar burdens (e.g. cancer and dementia) making very different contributions to the cost of their care.
- 4.2. Lack of alignment between funding streams. The NHS is broadly funded out of general taxation and operates with a ring-fenced budget, whereas social care is funded via local authorities, which still retain discretion about how much they spend.
  - 4.3. Lack of alignment in organisation. The two systems are commissioned separately resulting in problems for coordination and integration.
  - 5. The Commission's 'stake in the ground' to address this lack of alignment in entitlements, funding and organisation is: "a single, ring-fenced budget for health and social care which is singly commissioned, and within which entitlements are much more closely aligned". The Commission notes that this does not imply a "single, nationalised deliverer of care" and could instead involve "one common form of commissioning from many diverse providers".
  - 6. In addition to problems of 'alignment' the Commission identifies two further issues: first, 'adequacy' – that not enough public money is spent on adult social care; and second, 'affordability' – that if change is needed it needs to be affordable given the underfunding of social care and the severe financial pressures on the NHS.

### **The Commission's ideas for bringing additional resources into the system**

- 7. The Commission identifies three broad ways of bringing additional resources into the health and social care system and these are summarised below.
  - 7.1. Option 1: more efficient use of existing resources:
    - 7.1.1 Improve productivity.
    - 7.1.2 Shift resource within health and social care to improve integration – out of acute hospital activity and into primary, community and social care.
    - 7.1.3 Optimise services outside of hospital for end of life care. *An independent review of palliative care commissioned by the government in 2010 suggested that optimised services outside hospital could reduce the numbers of deaths in hospital by 60,000 by 2021, reducing hospital costs by £180 million per year.*
    - 7.1.4 Rationing or limiting the NHS.
  - 7.2 Option 2: raise more private funding :
    - 7.2.1 New or extended NHS charges:
    - 7.2.2 Remove the blanket exemption from prescription charges for those aged over 60 and restrict free prescriptions for older people to those on pension credit. *Could raise c. £1.5 billion.*
    - 7.2.3 Raise the prescription charge within existing rules – i.e. from £8.05 to £10. *Could raise £100 million.*
    - 7.2.4 Remove all exemptions for the prescription charge but lower the charge to 45p so it still raised the current £450 million. *A £1.45 charge with no exemptions would raise an additional c. £1 billion.*
    - 7.2.5 Extend charges for dentistry.

11 June 2014

- 7.2.6 A £10 charge to visit the GP/have a GP telephone consultation, see a practice nurse or other primary care professional. *Without exemptions this would raise c. £3 billion.*
- 7.2.7 A £10 charge for A&E attendances. *Could raise c. £220 million.*
- 7.2.8 A £10 charge for outpatient attendance. *Could raise c. £700 million.*
- 7.2.9 A charge for hospital stays in line with the ‘hotel cost’ charge associated with residential care for food and accommodation. *A £10 charge for each day in hospital could raise c. £500 million.*
- 7.2.10 Develop an insurance market and other financial products.
- 7.2.11 Provide tax relief on private medical insurance so that more people were treated in the private sector thus lifting a burden off the NHS.
- 7.2.12 Introduce a ‘patient passport’ so that patients would be able to take the average cost of their treatment in the NHS and spend it in the private sector, topping that up as required to afford the cost of private care.
- 7.2.13 Remove tax disincentives on workplace health and wellbeing programmes.

7.3 Option 3: raise more public finance:

- 7.3.1 Introduce a hypothecated tax for health and social care.
  - 7.3.2 A wholesale switch to classic social insurance.
  - 7.3.3 Divert existing benefits – for example, means-test Attendance Allowance, winter fuel allowance, and free TV licences, and tax higher-rate taxpayers on free bus passes and concessionary travel.
  - 7.3.4 Changes to the tax regime for pensions – for example, levy National Insurance contributions on private pensions in payment, levy National Insurance contributions on employer contributions to pensions, scrap the ‘tax free’ pension lump sum, restrict tax relief on pension contributions to the basic rate of tax.
  - 7.3.5 Apply National Insurance to those working on past state pension age.
  - 7.3.6 Forgiveness of capital gains tax at death.
  - 7.3.7 Increase inheritance tax.
- 8 This is a long list of options, many of which are complex, it is designed to stimulate a debate about how we pay for health and social care in the future. In its final report (expected in the Autumn) the Commission will judge any such proposals using the following criteria:

- 8.1 Are the proposals equitable?
- 8.2 Are the proposals efficient – i.e. do they deliver high quality services from available resources?
- 8.3 Are the proposals affordable both now and for the future?
- 8.4 Are the proposals consistent with notions of individual and collective responsibility?
- 8.5 Are the proposals responsive to the needs of users and carers?
- 8.6 Are the proposals transparent and can they be clearly interpreted?

**Next steps**

- 9 The Commission is currently running a ‘call for responses’ to its interim report based on the five questions below. The LGA will be submitting a response based on the discussion at the Community Wellbeing Board with Geoff Alltimes and Richard Humphries.

- 9.1 Do you agree with our conclusion that a new settlement in health and social care is needed?
- 9.2 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?
- 9.3 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?
- 9.4 If your answer is yes to question three, 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)?
- 9.5 Do you think that adequate funding for health and social care requires:
  - 9.5.1 Increased charges in the NHS? If so, for what?
  - 9.5.2 Increased charges for social care? If so, for what?
  - 9.5.3 Cuts to funds from other areas of public spending, re-allocating it to health and social care? If so, from what?
  - 9.5.4 An increase in taxation? If so, which taxes would you favour increasing?
  - 9.5.5 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?
  - 9.5.6 All of the above? If you answer yes to this, and think that elements of all or some of these changes may be needed, which mix would you favour, and to what degree?

## **Part 2: Redesigning the health and social care system – influencing the agenda**

### **Introduction**

10. In the run up to the General Election, the LGA is developing its influencing messages on the key issues facing local government. The redesign of adult social care and health will be prominent in all of our influencing work. Though LGA policy formulation is led and signed off by our Executive, we want to make sure that we test the messages and our products and activities with the Board at an early stage to ensure that they shape the messages and the products. In short:

- 10.1 **Have we got the key messages right?**
- 10.2 **If not, what should they be?**
- 10.3 **How can our products and activities best help shape the debate locally and nationally on the redesign of the health and care landscape?**

### **Key messages**

- 11 **Strategic LGA messages** – The LGA proposals for a sustainable future for local government in the run-up to the General Election will be launched at the LGA Annual Conference in July. The document is currently in development so it is not possible to share the detailed propositions but messages relating to the redesign of the health and social care landscape will form a central plank. Broadly the proposals are likely to cover:
  - 11.1 greater personalised care that focuses on prevention and early intervention, starting with early years;

11 June 2014

- 11.2 through Health and Wellbeing Boards greater local accountability for all health, public health and adult social care services;
- 11.3 greater alignment of commissioning for people with long-term and complex needs;
- 11.4 improving incentives within the health and care system to promote prevention and health improvement;
- 11.5 promote a consistent set of tests for local elected members to lead discussions with their communities on service redesign; and
- 11.6 further development of integration beyond 2015/16, including: a larger pooled budget; more locally defined targets; recognition of the need for some 'double running' to ensure a smooth transition.

### **Planned activities and products**

- 12 We are planning a number of activities and products to promote our messages on the redesign of health and social care and to support local system leaders. They are outlined below.
  - 12.1 **Building a cross-sector narrative on integrated care** – we plan to launch the joint narrative on integration with a wide range of partners in the summer. The messages are consistent with those outlined in the 2015 Challenge (launched by NHS Confederation on 6 May and supported by LGA) and the LGA influencing document (referred to above). It will outline a shared vision for an integrated health and care system and recommend action by national Government on: support to local political, clinical and professional leaders to lead the redesign of local health and care systems; alignment of financial incentives to promote integration; promote shared accountability with fewer performance and outcomes measures; support on information sharing; sector led support on self-management; greater focus on co-commissioning of primary care; enable a longer-term approach to investment and service change; and support multi-professional training and workforce redesign and planning.
  - 12.2 **Five Key Tests for redesigning health and social care** – This aims to give elected members and other system leaders a consistent and rational framework with which to test proposals for redesign and to engage with their local communities. We hope to co-badge with other national organisations.
  - 12.3 **Case studies** - work has commenced on developing case studies of areas where political, clinical, professional leaders are working together with providers and the community to co-design the health and care landscape. We hope to co-brand and promote the case studies with other key national stakeholders.
  - 12.4 **Activity at NHS Confederation and LGA Annual Conferences** – Carolyn Downs took part in a panel discussion at NHS Confederation conference in June. Simon Stevens, Chief Executive of NHS England will be giving a plenary address at the LGA Annual Conference. There will also be a networking event at the conference for Health and Wellbeing Board Chairs at which we hope to launch the joint narrative on integration.
  - 12.5 **Roundtable on reforms to incentivise prevention and health promotion** – roundtable with health economists and local government finance experts, possibly

11 June 2014

written up as a discussion document in partnership with other national organisations.

- 12.6 **National conference on redesigning health and care** – 22 October, LGA. Free conference at LGA for health system leaders to hear about progress and challenges on integration and BCF. Jointly with other national partners from the NHS.

#### **Recommendation**

13. To seek CWB views on the LGA key messages on the redesign of health and social care.
14. To seek CWB views on the planned activities and products to support local government and other systems leaders in leading this agenda locally.