Commission on the Future of Health and Social Care in England: A New Settlement for Health and Social Care

Introduction

1.1 Care England, a registered charity, is the leading representative body for independent care services in England. Our membership includes organisations of varying types and sizes, amongst them single care homes, small local groups, national providers and not-for-profit organisations and associations. Between them they provide a variety of services for older people and those with long term conditions, learning disabilities or mental health problems.

1.2 We welcome the opportunity to respond to such an important consultation. As the Interim Report states, the NHS is facing an increasing funding crisis and the social care system has been underfunded for many years. With the demands faced by an ageing population with ever increasing needs, we absolutely agree that the status quo is no longer fit for purpose and fundamental systemic change is essential.

1.3 When one considers the way in which health and social care services are funded abroad, it is apparent that in comparison, the English system charges too much for the latter and not enough for the former. This can be seen in the sense that the French system – widely believed to be the best healthcare system in the world – imposes small costs for hospital stays and ambulance services, whilst developed nations such as Germany and Japan fund a far higher proportion of social care than government here does.

1.4 Aneurin Bevan was right to say that the NHS 'lifted the shadow of fear from the homes of millions' by making health care dependent on need and not wealth, but sadly the shadow still looms large over the millions of individuals with social care needs. A balance has to be struck in which inequalities are removed from both systems and this response and the attached vision provide ways in which this could be achieved.

A new settlement

2.1 We completely agree that a new settlement is needed in health and social care. Further to this, we agree with the Commission's suggestion of a single, ring-fenced budget. One of the most powerful moments during the accounts provided by the experts during the launch of the Interim Report, was from Dominic 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 needs.

2.2 This is scandalous when this is of absolutely no concern to the patient/service-user, whose only concern is either being given the facility to cope with or cure their condition. A single ring-fenced budget for health and social care services would mitigate any resource competition between different bodies and would instead mean that their primary concern would be working together to use the joint

resource for the purposes of delivering great outcomes for the individual in question.

2.3 Although such a move would represent a profound and welcome cultural change, the only concern is that this shift would not translate into attitudinal change. By this, we mean that the traditional belief that health care is still more important than social care may exist even within a pooled budgetary system. This fear is supported by a similar dichotomy between mental and physical health where the latter has precedence over the former, despite the fact that both services are largely commissioned from the same budget.

2.4 For a pooled budget to work, professionals from each sector have to understand the value of the work that their counterparts in other sectors perform. If this were to be achieved, then a pooled budget has the potential to radically transform the way in which health and social care is delivered for the better and we would fully support it.

How should the new system be balanced?

3.1 The aim should always be to achieve equal support for equal need, regardless of where that support comes from. We feel that to say otherwise would defeat the object of having a pooled budget. However, the current system has to move away from traditional structures and ways of thinking.

3.2 In his first speech as Chief Executive of NHS England, Simon Stevens said that 'our traditional partitioning of health services … no longer makes much sense' – we are inclined to agree with him in a structural sense.

3.3 Care – especially dementia care – should be delivered in an environment as closely resembling the home as possible. We believe that as well as breaking down the barriers between health and social care through pooled budgets and commissioning, the same has to be done in the actual delivery of care.

3.4 At present, the only care delivered in the community is social care, with most forms of health care being delivered in unfamiliar hospital settings. We believe that more health care should be delivered in community settings to increase the quality of life that individuals receiving health care experience whilst enabling them to maintain their independence. This would not only reduce the current strain on hospital capacity – and save money – but would also enable services to intervene to assist an individual before they reach crisis levels.

3.5 Although such a change would mean that less money would be spent on health and social care but in a more productive way, the savings achieved would not be sufficient enough to not have to raise revenue to fund both the NHS and social care.

3.6 This means that more profound revenue raising change has to occur and while experts from both sectors can identify resource need and savings that can be made from their own budgets, it is up to government to make decisions regarding the reallocation of resource from elsewhere and to put these to the electorate.

3.7 The reaction to the Interim Report in the press mainly centred on this being the end of the free at the point of use NHS; this is flawed in the sense that people do not take into account that they already pay for the health service through their taxes, in addition to the fact that they already pay for a number of services, such as prescriptions, optical and dental treatment. When one considers that even in Sweden, which is often hailed as the model for public services, individuals pay between £10 and £20 for a GP appointment, there is scope for a range of charges to be brought in to fund the NHS.

3.8 As well as GP charges, there could be a means-tested charge for hospital stays, which is capped at a certain level – such as £100 per year in Sweden, and small charges for other services, such as the use of an ambulance (£1.60 in France), which would count towards the cap. As long as such charges are capped at a sensible level and subsidised for those who cannot afford to pay them in full or in part, this should raise a significant amount of revenue, whilst not creating health inequalities.

3.9 Despite the ruling out of social insurance as an option for funding health and social care, we believe that such a system may have its merits. In Japan where a long-term insurance scheme is funded by the government paying half; all those aged between 40 and 64 paying a third through contributing an additional 1% of income tax; everyone over the age of 65 paying a sixth with their fees determined according to a fixed tariff of premium rates; and the rest coming from co-payments; one can find an example of a social insurance scheme that is far more equitable than the current system of funding for older people's services in England.

3.10 The general problem around insurance is the fact that young people are not willing to pay for a service that they believe that they will never have to use. If the funding for long-term care were to come from middle-aged and older people, it would be far more politically acceptable in the sense that individuals in these age-ranges are far more aware of the fact that they may not be able to live independently in perpetuity and are willing to take steps in case they are not. If a social insurance scheme is conceptualised in a fair and user-friendly way, we therefore believe that it could be a workable solution to the crisis in the care of older people.

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