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CONFERENCE ABSTRACT

Resource allocation in integrated care settings: what works? Case of Health and Social Care Partnerships in Scotland

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Background: The move towards integration between health and social care, as embodied in the Public Bodies (Joint Working) (Scotland) Act 2014 and similar acts in England and Wales, challenges local delivery organisations to consider the cost, quality and the value of services provided for local populations. To meet this challenge, especially when set against a background of public sector austerity, managers and staff need robust, effective frameworks to help them make decisions which are defensible and based on sound evidence. Given the intention of the above legislation, such frameworks for priority setting must also be able to aid decisions about the appropriate balance of care (i.e. the respective amounts of resources devoted to the NHS, social care and other relevant providers).

One such framework for priority setting is Programme Budgeting and Marginal Analysis (PBMA). PBMA is a generic economic framework and offers an analytical approach for assessing the costs and benefits of alternative courses of action, which could assist with identification of the effects of resource shifts and areas for disinvestment among programmes. Programme Budgeting (PB) involves the presentation of estimates of expenditure and activity across and within 'programmes' of care or service delivery. Marginal Analysis (MA) involves evaluation of incremental changes in costs and consequences when resources in programmes are used in different ways; essentially analysing the effects of changing the balance of expenditure within a given budget. MA identifies where additional resources should be targeted, where reductions should be made if expenditure must be cut, and how resources can be reallocated to achieve an overall gain in benefits with no overall change in expenditure.

In order to test out the feasibility of using such a framework in newly formed Health and Social Care Partnerships (H&SCPs), three pilot sites in Scotland were selected: Highland, Ayrshire & Arran and Perth & Kinross. We worked closely with Highland, who conducted the process in two localities (one urban and one rural), and I will focus on the lessons learned from using such a framework in these integrated care settings.

Methods: Interviews were conducted with those working in Highland to learn about their understanding of current priority setting processes. Workshops outlining the economic principles and theory of PBMA were held in both localities and from this Advisory Groups were formed to lead the process in each site, and field notes have been gathered from working with these groups and associated events.

Highlights: The PBMA process provided the pilot sites with a transparent, inclusive and structured approach to prioritisation. It promoted debate and critical appraisal of options amongst stakeholders based on an understanding of the benefits and costs associated with the potential choices and provided a basis by which decisions could be justified. By considering the current use of resources across a programme, alongside the potential alternatives, the PBMA process combines investment with disinvestment decisions.

A particular strength was the role and composition of the Advisory Groups. The benefit of including other stakeholders, such as service users, carers and service providers, alongside statutory providers in a co-production approach was evident.

The pilots required investment to apply the technique, generate buy-in, facilitate meetings, liaise with public representatives, perform analysis and present results. Although some of the time required for this will have been associated with establishing the process, there will be a recurrent cost required to administer it on a regular basis. In addition, clinician's time will need to be protected to allow participation.

To ensure the process is effective will require robust datasets on, for example, current service patterns, resource utilisation and outcomes, and population needs assessments. There is a risk that this places a significant additional demand on local systems. However, it could be argued that this level of information is what is required for effective prioritisation and its unavailability is a problem for current processes rather than for PBMA.

Conclusion: Despite some barriers to implementation, the test sites were very positive about the approach taken and allowed them to progress with a decision making process while changing thinking of those involved of how decisions are made and resources can be (re)allocated within health and social care. The structured approach allows for organisations to be more explicit about the basis of decisions and focus on the entirety of resources.

As a result, PBMA has been included in Statutory Guidance in Scotland as an approach for use in developing Strategic Commissioning Plans by H&SCPs established under the new legislation.

Keywords: resource allocation; priority setting; balance of care; integration; strategic commissioning