



A funding settlement that works for people, not services

Emma Stone

Director for Policy and Research, Joseph Rowntree Foundation, UK

Claudia Wood

Programme Adviser, Joseph Rowntree Foundation on Paying for Long Term Care, UK

Abstract

This article is about how to fund care and support for a growing, and increasingly diverse, population of older people. We ask whether it is possible to create a funding settlement for long-term care that meets four criteria. These are: fairness; transparency; sustainability (financial and social sustainability); and capacity to support the outcomes that people want and value. Can we create a funding settlement that starts from people's lives – not service-based assumptions?

Key words

Care; funding; outcomes; older people; ageing; services.

Introduction

We are at a critical point in the history of social care reform. A process that arguably began with the Joseph Rowntree Foundation (JRF) Inquiry into the Costs of Continuing Care in 1996, followed by a succession of commissions and consultations, seems finally to be drawing to a close. It has been a tortuous journey, spanning four separate administrations and, as it turns out, all three major political parties. But 2011 may just be the year that a new settlement for social care funding is agreed upon.

At the time of writing (August 2010), we await the Comprehensive Spending Review, which will set the pace of care funding for the next four years, and an articulation of the Coalition Government's vision for adult social care. The Commission on Funding of Care and Support is due to make its recommendations in July 2011. The Law Commission will also propose its recommendations on a new social

care statute next year and together, it is hoped, these will form the foundations of a permanent settlement for how we all contribute towards our care in later life and the system that delivers it. The big question is: will the proposed funding settlement and statute be aligned with each other and – critically – with a vision for social care that is designed around people's lives, rather than around existing services?

Several alternative models have been developed over the last 15 years, some drawing on systems used in other countries, which can have important lessons for the UK (Glendinning & Bell, 2008). The JRF, International Longevity Centre UK (Lloyd, 2008) and The King's Fund (Humphries, 2010), among others, provide useful overviews, outlining the pros and cons of variations of co-payment, social insurance and hybrid models. But in weighing up the minutiae of how each system functions, we have all risked losing sight of the end goal: people.

Only a funding system acceptable in principle and in practice to those who contribute to it will survive over time. The NHS owes its longevity to this fact. Only a funding system aligned with the whole of people's lives, as well as their relationships with families and communities, will succeed in delivering care and support fit for the 21st century.

The principles

Everyone agrees that there are three key principles for a future funding settlement (Hirsch, 2006; Collins, 2009). It has to be:

1. fair
2. transparent – simple to understand
3. sustainable.

This provides a good basis on which to compare the range of current models, but it is not the whole picture.

'Fairness' is open to interpretation and will look very different depending on one's ideological perspective or values (Keen, 2008; Keen & Bell, 2009). 'Sustainable' is often taken to mean financially sustainable – that is, capable of raising adequate funds to cover care costs both in the immediate and longer term. Less consideration is given to whether care funding is *socially* sustainable: will today's care funding settlement be appropriate as society's expectations of social care, community support and informal care change? Will it be flexible enough to cater to the needs and preferences of an increasingly diverse population (Blood, 2010a; 2010b)?

In posing these questions it becomes clear that we cannot isolate the 'how' of care funding from the 'what' is being funded. In order to be truly deemed fair, to be understandable by resonating with the reality of our lives, and to be financially *and* socially sustainable, a future care funding settlement must be able to fund and facilitate, even incentivise, the *type* of support people want. To do this effectively, the settlement must start with an understanding of how people live their lives. This is very different from a focus on services or settings (for example, own home, care home).

Consultation with service users as part of JRF's Shaping our Lives project found that people express their needs and aspirations, and live their lives, in terms of self-defined *outcomes* rather than services. While recognising that the term itself can be problematic and subject to different interpretations, the concept of outcomes – or aspirations or life goals – is particularly important in this context. First, because outcomes are distinct from, and rarely fall into, types of service or setting. People can adopt very different ways of achieving the same outcomes and prescribing a service (ie. the *way* in which an outcome is achieved) will not be appropriate for everyone. Second, because people express their desire to achieve outcomes from a holistic perspective, thinking about housing, transport, employment, income and benefits, and broader issues around discrimination and equality, without separating these into neat service areas (Turner *et al*, 2003; Beresford *et al*, 2008).

This has significant implications for social care funding, which by its very definition operates within a social care 'silo'. Delivering funding to achieve 'cross departmental' outcomes would prove extremely challenging. But this is clearly something that older people (and social care service users more generally) want. When older people living in residential care homes were asked to identify their outcomes for 'a good life' in a residential care home, none were specifically service related and all required multiple services working together to achieve them (Bowers *et al*, 2009). JRF has further work underway to identify and validate what older people with the highest support needs want and value from life, but it is already clear from existing evidence that service-based assessments and delivery seldom make sense to people (Blood, 2010a). Service-led distinctions between (for example) social care and health do not resonate with how people live their lives, and cause confusion for users and practitioners (Beresford, 2010).

So, in order to create a funding settlement that is compatible with how people live their lives, and what they want and value from life, we must add a fourth principle:

4. capable of supporting self-defined *outcomes*.

Why is an outcomes-based funding system so important?

Perhaps in response to the substantial body of research that forcefully demonstrates the irrelevance of service silos to people's lives, independence and sense of well-being, the current care system is increasingly interested in outcomes-based delivery. The Adult Social Outcomes Toolkit (ASCOT) developed by the Personal Social Services Research Unit (PSSRU) is the latest example (see: www.pssru.ac.uk/ascot). Outcomes-based commissioning is becoming more common (in policy if not in practice). Outcomes-based assessments are now a central pillar of personal budgets. The Law Commission's proposed new Social Care Statute is set to create a system based around outcomes rather than service entitlements. The last thing we need is a funding settlement that maintains old service-based assumptions about social care or privileges certain types of support or setting (such as residential care or home care) over others.

It is not just keeping up with care delivery on the ground that makes an outcomes-based care funding system so important. A system that begins with an understanding of people's lives and resonates with their lived experiences is likely to be publicly acceptable, and therefore sustainable, over the longer term. We should also keep front of mind that we are an increasingly diverse nation – in terms of our different needs, life experiences, lifestyles and expectations – shaped also by ethnicity, nationality, gender, sexual orientation, belief, social class and age (Blood, 2010b; Centre for Population Change, 2010). A system that is overly prescriptive regarding service entitlements will soon become restrictive and will date very quickly as society moves on. And society will move on in its understanding of care and support, of the roles and responsibilities of the individual, family, community and state, and indeed of later life itself and what older people are entitled to by comparison with

younger people. In contrast, a system that starts with a focus on facilitating outcomes can be adaptable enough to survive even when technological breakthroughs or wider social, economic or political transformations have re-created what we think of as social care.

What would a settlement enshrining all four principles look like?

If we consider each of the four principles in turn, it may be possible to establish which elements of existing funding models are most promising.

What is fair?

Fairness is a problematic term ultimately requiring a value judgement to be made regarding what is socially and morally acceptable to the majority of the public (Keen & Bell, 2009). At the very least, there is a consensus that a fair model in the UK must have a minimum entitlement – a safety net – for the poorest in society, and the amount people contribute must be related to their ability to pay. Funding care from general taxation is popular with some for its simplicity, parity with the NHS and its progressive element, ie. people pay according to their income (Beresford, 2010). However, there are other forms of fairness that also need to be taken into account.

Intergenerational fairness is very important in care funding, given that the system will need to work for successive generational cohorts. This includes cohorts of comparatively affluent and asset-rich (even if income-poor) older people, as well as those of working age who have incomes, but may not have the opportunity to build up assets like previous generations. A care levy, paid for through a combination of National Insurance (NI) and inheritance tax, with the latter reducing for successive cohorts of older people, is a very interesting and potentially effective way of catering to the different financial situations of different generations. As this is also based on National Insurance contributions, it also achieves within-generation redistributive fairness (Hirsh & Spiers, 2010; Burke, 2010).

Given that care has an inequitable impact on men and women, as women tend to provide the majority of informal (and formal) care and are more likely to need care themselves due to longevity, we also need to consider gender fairness (Himmelweit & Land, 2008). A funding settlement that takes into account informal care as a form of contribution, in lieu of financial contributions to a funding/insurance pot, would ensure those who leave the labour market to care for relatives can continue to build up their own care funding contributions. A funding settlement that takes into account the additional costs of financial and respite care for informal carers when calculating people's contributions would also be a step in the right direction, as would one that allowed for an entire family's needs to be taken into account when funding a package of care for one individual within that family.

A fair settlement will also have to take into account the fact that older people of tomorrow will reflect the increasingly diverse younger population of today (Centre for Population Change, 2010). This requires a funding settlement that is flexible enough to enable a highly diverse population of older people to achieve their desired outcomes and not exclude or penalise any one group. This raises questions about the entitlements, for example, of disabled people with support packages already in place who turn 65 years old. Recent JRF-funded research into the over 50s living with HIV is another good example of how our changing society will directly affect the population of older people in years to come (Power *et al*, 2010).

What is sustainable?

A financially sustainable funding settlement must generate revenue in the immediate term, to support the provision of care for current older people (doing so in the context of an increasing ageing population and the chronic underfunding of social care over recent decades), as well as generate sufficient resources over the longer term for future cohorts. A two-stage funding system, combining immediate payments plus gradual contributions, could achieve this (Hirsch

& Spiers, 2010), as might insurance models that transfer risk to the private sector rather than individuals or the state (Lloyd, 2008). General taxation (which will always be a significant mechanism of generating revenue for social care, for example for younger disabled adults) is increasingly regarded as financially unsustainable in relation to the costs of long-term care of older people. This has prompted a few to raise questions about the financial sustainability of the current funding system for the NHS and the place for greater use of co-payments and top-ups here too (Featherstone, 2010; Reform, 2010) – although the spectre of exacerbating even further increases in health inequalities would surely come into play in advising against such an approach.

We must also consider sustainability in a wider sense. A settlement that can effectively generate resources, but which is unacceptable to those contributing, will *not* be sustainable. This is the concept of *social* sustainability, closely associated to fairness, in that a settlement that is generally seen as fair is more likely to be socially sustainable over time.

Social sustainability also requires recognition that individuals are part of families and wider communities. They can provide support to, and be supported by, the wider community. A socially sustainable funding settlement will have to reconsider the wider networks and dynamics involved in providing and receiving support through family, friends and community (Gandhi & Bowers, 2008) and facilitate individual and community responsibility *but at the same time* not pre-suppose an endless supply of 'free' informal care (Brindle, 2008).

These elements come together in relation to the provision of low-level support (*'that bit of help'* as the JRF Older People's Inquiry termed it), and emerging debates around care and Big Society (debates that are nothing new within the field of social care). We know people value preventative services (Raynes *et al*, 2006). Is it possible to get a funding settlement that is capable of balancing both short-term and long-term needs? Any funding settlement that narrowly targets only older people with the highest needs is a recipe

for escalating costs. This is not to ignore the critical role of individuals, families and social networks in meeting care and support needs themselves: any society that fails to enable mutuality, reciprocity and self-help is also a recipe for escalating costs.

What is transparent?

The current system of social care eligibility and its funding is opaque and confusing for those who need care and support (Hirsch & Spiers, 2010). To be transparent and easy to understand, a new funding settlement will need to state clearly how much people are expected to contribute, and what they will get in return. The minimum entitlement, or safety net for the poorest, will need to be explicit.

One easy to understand option is the tax-funded universal care model (Beresford, 2010), whilst Hirsch and Spiers suggest ring-fencing portions of existing revenue streams as an alternative but equally transparent approach. Both approaches are compulsory forms of contribution. Voluntary insurance systems could *only* work if our society were in a fundamentally different place than it currently is – with markedly different attitudes towards age and towards acknowledging the likelihood that we may require care and support when we are older. Creating such a high level of awareness will take sustained, excellent and effective awareness raising, information, advice and advocacy so that people understand the vital importance of contributing to care costs, and are clear about what they can expect in return for contributing. This would allow people to make the sometimes rational choice *not* to contribute to their care if they have very low incomes and are likely to be eligible for state-funded care in later life. Currently, information – accompanied by advice and advocacy – are highly valued but in short supply. However, even with the best of information and advice services, we must recognise that any non-compulsory approach to preparing for later life risks some people remaining unengaged and unwilling to contemplate their own poor health.

Transparency is also about eligibility criteria and needs assessments. The public is entitled to clarity on how, when and why they would be able – or unable – to access the support to which they have contributed. This is something that any and all funding models need to address (irrespective of whether they are outcomes-based or service-based).

What is an outcomes-based funding settlement?

While linking a funding settlement to *outcomes* is relatively unexplored territory, the good news is that none of the main funding models proposed actually *preclude* an outcomes approach.

Minimum entitlement and cash-based models

An outcomes-based settlement will need to define a set of outcomes that the public can expect as a minimum entitlement – either from the government as a safety net, or in return for a minimum contribution. Any funding model currently configured around a minimum entitlement to *services* could be adapted to allow for a minimum entitlement to *outcomes*. Similarly, any funding model that currently presumes the accumulation of a non ring-fenced ‘pot’ of cash, to be returned to a person upon needing care, could accommodate an outcomes-based model – presumably as the pot of cash in question can be spent on anything that person sees fit. Only models based on an estimate of costs of a specific type of care (for example the idea of insuring against residential care) would prove unsuitable in their current form.

Co-payment models

We must bear in mind that the setting of outcomes is a subjective and personal process, which must have individuals at its heart (Turner *et al*, 2003; Beresford *et al*, 2008; Bowers *et al*, 2009). Therefore, a minimum entitlement to outcomes needs to be complemented by a system that enables individuals to define their own outcomes and use their care funding to achieve those

outcomes. Co-payment models are very conducive to this, as the minimum entitlement to outcomes could be designated as 'state funded', while the additional contribution made by individuals could be reserved to achieve additional self-defined outcomes. This would of course mean that the very poorest older people might have limited opportunity to set their own outcomes – reliant as they would be on the state-funded minimum entitlement. The design of that minimum entitlement would therefore be crucial, and should build on the extensive knowledge we already have about what people who use and give care want and value. The very nature of an outcomes-based approach should mean that all individuals have greater opportunity to influence *how* those outcomes are met, thereby delivering greater choice and autonomy than would be the case with a minimum entitlement to a prescribed type of *service* or a prescribed type of setting.

Insurance-based models

To raise the individual funds necessary to secure self-defined outcomes, some form of insurance-based model would also work. Self-defined outcomes and how they might be achieved would, by definition, be extremely variable. The range of costs is likely to be large. Therefore, a model that pooled the risks of some people requiring very costly support would offer a financially sustainable approach. The drawback of current insurance models is that they pay out on (with premiums calculated on) the risk of needing services (for example, residential care) and the cost of those services. Adapting this to calculate the risk and costs of outcomes may not be viable. We are not aware that anyone has attempted to do this yet (which isn't to say that it shouldn't be tried).

Calculating the risk and cost of need as an admittedly imperfect proxy for outcome costs could be one solution. Both voluntary and compulsory insurance models are viable in this context, and could be combined with a care levy system (Hirsch & Spiers, 2010) to pay for the premiums in a way that is progressive and fair across generations.

The challenges of an outcomes-based model

Defining a minimum entitlement

We know that people do not identify outcomes in single service areas, but rather talk about their lives in relation to health, care, housing, transport, employment, income and benefits, as well as maintaining and developing friendships and social relationships, a meaningful community life, and personal identity and self-esteem (Godfrey *et al*, 2004; Raynes *et al*, 2006; Bowers *et al*, 2009; Blood, 2010a).

A minimum entitlement that (if a co-payment model were used) would be paid for by the state would need to include (or at least recognise) all of these various aspects of a person's life. Social care outcomes cannot be defined in isolation from the rest of people's lives. Nor can they be defined, designed in, or delivered against without co-production involving users, carers and frontline practitioners – and with the active support and buy-in of commissioners and suppliers (Mauger & Deuchars, 2010). As such, ASCOT (see: www.pssru.ac.uk/ascot), a valuable but nonetheless narrowly defined set of care-related outcomes, could be used as a basis that would need to be supplemented with other wider outcomes. Unfortunately, the current focus on the integration across health and social care doesn't appear to have extended to other areas such as housing, even though we know housing is critical in enabling people to enjoy later life (HAPPI, 2010).

Calculating the cost to the state

The costs to the individual – or the state in a co-payment model – of funding a minimum entitlement will need to be determined. This has proven a challenge for existing models, and many are still not wholly certain how much the overall costs or contribution levels will be (particularly if the settlement includes a voluntary insurance element, as premiums will depend on the number of people who decide to contribute). Calculating the costs to the individual and the state could be even more difficult for an outcomes-based model, in that

we do not have readily available unit costs for the achievement of outcomes, and in any case this will vary from person to person, from family to family, and from locality to locality.

If we assume the state will pay for some portion of care in a co-payment model, it may be the case – particularly in the current economic climate – that the state may have to consider how much it is willing and able to contribute to people's care, and set outcomes within those financial parameters. These parameters would need to take into account the diversity of people's care needs and networks, which would directly affect how much support people required to meet the minimum outcomes. It is likely that the government would provide very different amounts of funding to different people, to achieve the same outcomes. That said, the government will still have to ensure that the funding provided can deliver a minimum set of outcomes that is generous enough to be meaningful to people and act as an acceptable safety net for the poorest older people with the highest needs. That minimum entitlement would ideally include scope to support a degree of lower-level as well as high-level support. A variant of the methodology developed to define a 'minimum income standard' (Hirsch & Spiers, 2010), the Sarkozy Commission's attempts to cost societal well-being (see www.stiglitz-sen-fitoussi.fr/en/index.htm) and others, could help provide a benchmark as to how much the government should be prepared to pay to ensure the minimum entitlement is set at an acceptable level.

Calculating individual contributions

The same applies to the setting of people's contribution levels. It is unrealistic to aspire to meet every self-defined outcome (even from a risk-pooled insurance system); this would soon become financially unsustainable. Premiums would rise dramatically if, for example, a person were to set particularly aspirational outcomes or choose to meet those outcomes in a highly costly way. To overcome this the funding settlement would have to start with a set amount of funding that people could

spend in any way they felt was appropriate to meet their own outcomes. This would essentially be a version of the cash-based funding models already in existence, where the amount given to an individual to spend is determined by need (though locally variable) and not ring-fenced. If an outcomes-based funding settlement were to take this approach, all those who had paid a defined contribution would be entitled to a sum based on assessed need, rather than paid out according to specific services, and would be able to use this money to achieve self-defined outcomes.

While such an approach would not be able to predict what outcomes people may want to achieve, it *would* recognise that most outcomes are more costly to achieve if a person has higher levels of need. This would mean that those with the highest needs would have a larger sum to spend on achieving their self-defined outcomes, as they are most likely to require more support in achieving them, without anyone dictating what those outcomes should be. Indeed, by providing funding independent of prescribed services, such an approach may well incentivise a more iterative, co-produced and personalised outcome-setting process.

This would also be compatible with an insurance model as the premium that individuals would be required to pay would be based on an estimation of the likelihood of having certain levels of need in later life (rather than requirement for a certain service). This would be viable as long as the amount people received according to their need was clearly defined (so actuaries could calculate the cost of the risk and calculate premiums accordingly). This would also ensure the system was transparent for the public.

There are, of course, two obvious flaws with this approach. The first is an issue of timing. In current cash-based models there is a pre-defined point at which a person can access their funding. As we are discussing *care funding* models, it is understandable that most models allow access to funding at a point when a person *needs social care*. This in itself is a contested issue – for example, should funding be released to a person to spend when they

reach 'substantial or critical' need so as to ensure they have adequate funding for later life? Or should a more preventative approach be taken, and funding provided to people to enable them to purchase preventative and low-level care – that 'bit of help'?

An outcomes model complicates this decision even further. A person's self-defined outcomes will usually focus on aspects of life we might define as requiring 'low-level' social care, ie. staying at home, seeing friends and family. But, as explained, outcomes will usually also require the input of housing, health, transport, community, work and leisure services at the same time. It may therefore prove very difficult to define when an older person 'needs' access to their pot. Should it be when they have low-level *social care* needs? Or when they have need for funding to enable them to meet their housing or transport outcomes? Or when they want additional money to build their social capital? Setting too low a point will see a person's pot used up too quickly, potentially leaving them without sufficient funding to cover a time when they have more significant health and care needs. But setting it too high will leave many people unable to achieve the outcomes that are so important to them (and that may delay or reduce higher costs down the line), and leave them only able to access funding once the opportunity to achieve those outcomes has passed.

The second problem is that self-defined outcomes bring with them a risk of being inappropriate for the person defining them. For example, they may undermine a person's health or well-being, or they may not take their family or carer's well-being into account, thereby reducing social sustainability. In granting one person's outcomes we might limit or endanger another's. Some form of co-production and oversight could be used in the defining of outcomes, as is currently the case with personal budgets, in order to ensure outcomes are both appropriate and *sufficiently aspirational*, and taking a proportionate, rather than averse, approach to risk.

Of course, these are just some of the flaws that will be immediately evident to those who are already keenly aware of the difficulties of

assessing need in a holistic, meaningful way. But there is surely potential to develop an actuarial model that builds up from the best of current knowledge where assessments of needs and definition of outcomes have been co-produced, and where people with lower as well as higher levels of need are empowered to access the care and support they require to enjoy later life.

Conclusion

JRF recognises that combining the following criteria into a single care funding settlement is a challenge:

- fairness
- transparency
- financial and social sustainability
- capacity to support self-defined outcomes.

Existing models have attempted to define and deliver on the first three but the fourth remains elusive. No model explicitly recognises the importance of facilitating (ideally incentivising) the achievement of self-defined outcomes – which itself is contingent upon other critical elements being in place (for example, significantly increased readiness on the part of commissioners and suppliers as well as demand for co-production; a greater understanding of the role of individuals, families and communities in caring and supporting each other; and clarity about the life outcomes to which we can expect to be entitled).

As such, many models remain limited by service-based assumptions – whether explicitly or implicitly. This is understandable given that narrow services are more easily quantified. It is much easier to design a model where a pot of funding is accumulated and entitles a person to a type of service with an associated unit cost. It is altogether more difficult to entitle a person to funding to meet an *outcome* that may not even fall within a standard definition of social care.

However, an outcomes-based settlement is not wholly out of reach. The key may be to link entitlement to need, which can be a valuable if imperfect predictor of the costs of meeting outcomes (even if those outcomes are as yet undefined). This has been achieved on an

individual scale with personal budgets, and there is a growing number of sources that can help develop a minimum entitlement of outcomes that would form the basis of such a settlement.

We believe it is critical for any funding settlement to start with people's lives not services, and to facilitate – indeed, incentivise – more positive and progressive approaches to care and support.

Implications for policy and practice

- Any future funding settlement needs to:
 - start with people's lives – not existing services
 - facilitate and incentivise more progressive approaches to care and support
 - be flexible enough to work for an increasingly diverse population
 - combine four principles: fairness, transparency, sustainability (financial and social) and capacity to support self-defined outcomes.
- There are a number of practical challenges of implementing this approach, including:
 - defining a minimum entitlement to outcomes
 - quantifying and calculating the costs of this minimum entitlement in order to establish costs to the state
 - identifying a means of predicting different individuals' potential outcome costs, in order to calculate individual contributions
 - setting the point at which a person can access their care funding to meet their outcomes (as this may be much earlier than when they have a defined care need).

Address for correspondence

Emma Stone, email: emma.stone@jrf.org.uk

Claudia Wood, email: claudiawood@bethere.co.uk

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