

System-level evaluation of the Better Care Fund

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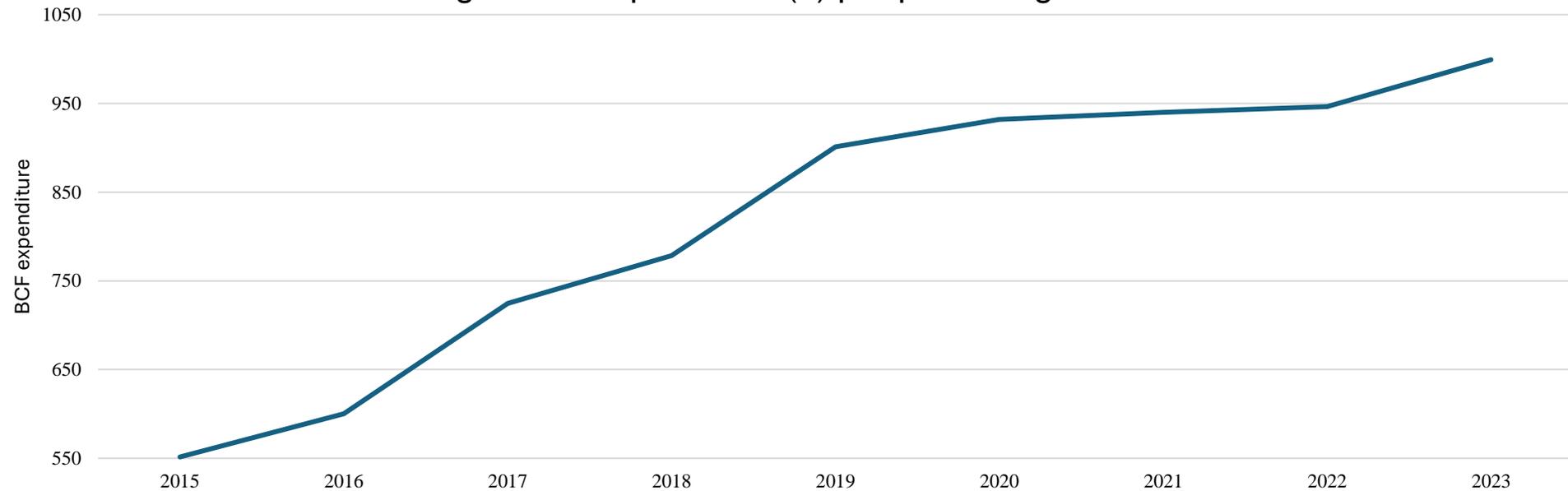
Disclaimer: This research is funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme, conducted through the Quality, Safety, and Outcomes Policy Research Unit (NIHR206117). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Overview of the Better Care Fund (BCF)

- Help the NHS and social care work more closely together by creating a shared budget and a joint planning process
- Objectives:
 - Promote people's independence in their communities
 - Provide the right care, at the right place, at the right time

Overview of the Better Care Fund (BCF)

Fig 1 BCF expenditure (£) per person aged 65+



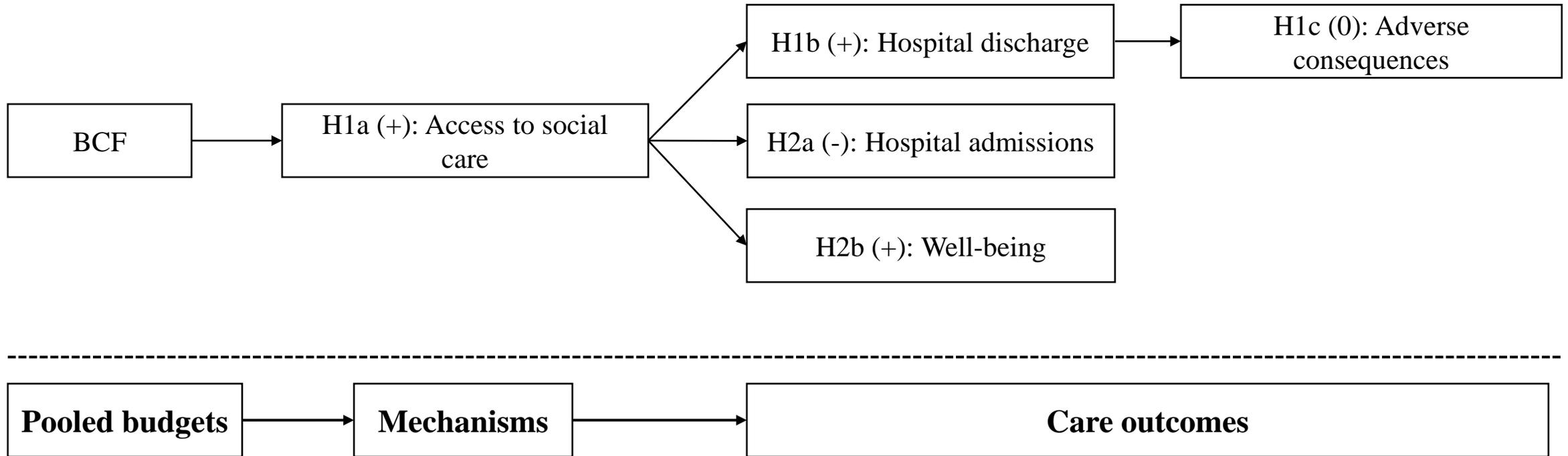
- Increasing investment in BCF

Overview of the Better Care Fund (BCF)

- Mixed evidence (Forder et al., 2018; Stokes et al., 2019)
 - Short follow-up period
 - Limited outcome metrics
 - Unclear about the underlying mechanisms
- Study objectives: examine the effect of the BCF in promoting a change in the organisation, activity, and funding of health and social care. Specifically:
 - Explore whether the level of BCF activity is associated with changes in system-level outcome indicators.
 - If it's effective, how does the BCF produce these effects?

Overview of the Better Care Fund (BCF)

Fig 2 Mechanisms of the BCF on system-level outcomes



Methods

Data

- Publicly available sources, e.g. NHS Digital, the Office for National Statistics, and the Department for Work & Pensions.
- Period: 2013-2019

Independent variable

- BCF expenditure per older person

Dependent variables

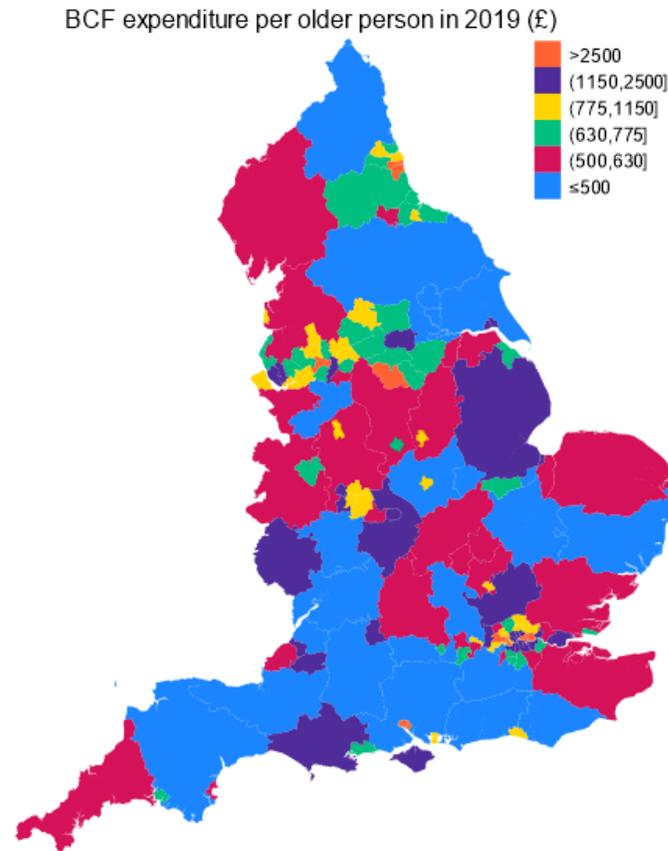
- Delayed transfers of care (DTOC), emergency readmissions, hospital admissions, depression rates, and access to social care

Analysis

- Fixed effects
- Instrumental variable
- Generalised method-of-moments (GMM)
- Generalised estimating equations (GEE)

Results

Fig 3. Better Care Fund spending across England



Results

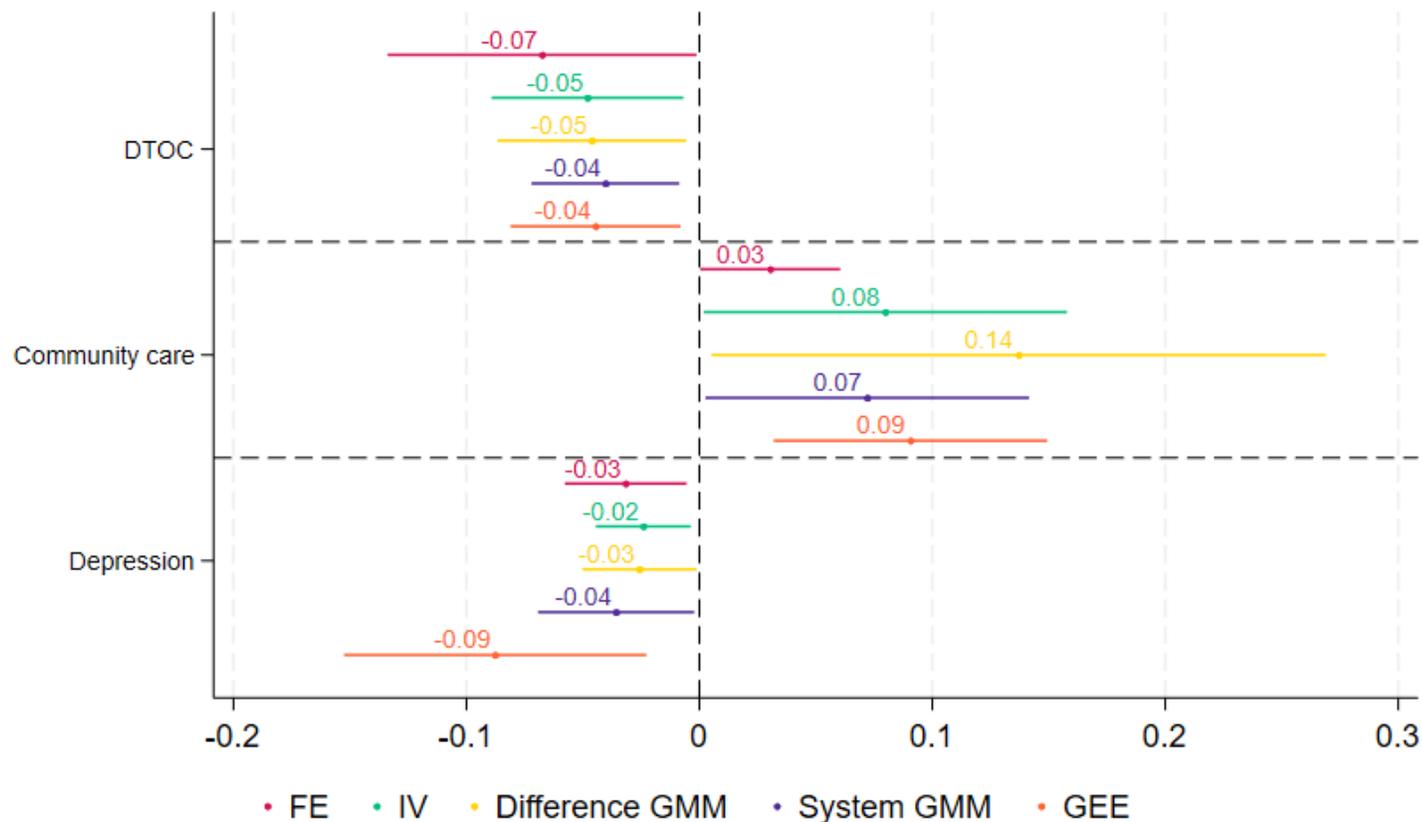
Table 1 Results of fixed effects model for healthcare utilisation and well-being

Panel A	DTOC	DTOC (acute)	DTOC (non-acute)	Reablement care	Community care	Institutional care
BCF	-0.068*	-0.015	-0.116	-0.096	0.030*	-0.008
	(0.034)	(0.039)	(0.099)	(0.052)	(0.015)	(0.012)
N	858	858	858	857	712	858
Panel B	Nursing home	Residential care	Emergency readmissions	Reablement performance	Emergency admissions	SCRQoL
BCF	-19.384	-0.008	-0.010	-0.006	-0.053	0.034
	(20.256)	(0.013)	(0.007)	(0.010)	(0.036)	(0.039)
N	858	858	853	572	572	855
Panel C	Mobility	Self-care	Activity	Pain	Depression	
BCF	-0.075	0.047	-0.166	-0.080	-0.316*	
	(0.113)	(0.082)	(0.102)	(0.112)	(0.132)	
N	572	572	572	572	572	

Note. All models controlled for covariates, LA fixed effects, and year fixed effects. Standard errors were clustered at the LA level. *p < 0.05, **p < 0.01, ***p < 0.001.

Results

Fig 4 Sensitivity analysis



Results

Table 2 Association between BCF expenditure and DTOC, community care, depression by year

Time	DTOC				Community care				Depression	
	2015	2015-16	2015-17	2015-18	2015	2015-16	2015-17	2015-18	2015	2015-16
BCF	-0.070	-0.070+	-0.064+	-0.068*	0.032	0.005	0.021 ⁺	0.030*	-0.296 ⁺	-0.316*
	(0.048)	(0.037)	(0.034)	(0.034)	(0.031)	(0.011)	(0.012)	(0.015)	(0.161)	(0.132)
N	429	572	715	858	284	426	569	712	429	572

Notes: Standard errors were clustered at the local authority level. All models controlled for covariates, local authority fixed effect, and year fixed effects. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Discussion

A summary of main results: higher BCF spending

- Facilitated hospital discharge, without any adverse consequences
- Reduced population-level depression rates
- Increased community services (social care) utilisation
- These effects became more robust over two years or longer

Discussion

Why did the BCF facilitate hospital discharge?

- Greater access to community care supports continuity of care between acute care and other settings, e.g. patients' own homes
- This finding highlights the substitution between health and social care (Allan et al., 2021; National Audit Office, 2017; Spiers et al., 2019; Walsh et al., 2020)

Discussion

Why did BCF spending reduce depression?

- Access to social care in the community, e.g. social prescribing and streamlined needs assessment
- These services, tailored to individual preferences, may enhance well-being (Harlock et al., 2020)

Discussion

No statistically significant effects on other outcomes, e.g. institutional care admissions and SCRQoL. Why?

- Generalised metrics shaped by complex determinants beyond the BCF (Forder, et al., 2018)
- Limited BCF budget: 5% of total commissioner spending in 2021 (Reed et al., 2021)
- Improvements may take a longer time to be evident

Discussion

Limitations

- Without considering BCF implementation, e.g. variations in sub-scheme spending
- Unobserved confounders

Discussion

Theoretical contribution

- Extend existing explanations of how pooled funding influences hospital discharge and well-being (Forder et al., 2018; Mason et al., 2015; Stokes et al., 2019)
- Enrich literature on the effectiveness of BCF by considering well-being indicators, an aspect emphasized by policymakers but underexplored
- Highlight the long-term effects of BCF implementation: implementation lag

Discussion

Practical implications

- Support the continued implementation of BCF schemes
- Policymakers should recognise that the benefits of the BCF require a longer time to be evident
- Inform other countries to develop pooled funding to integrate health and social care sectors

Thank you for your attention!

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