Personal health budgets (PHBs) aim to encourage the health care system to become more responsive to each patient’s needs. However, it has been suggested that PHBs could be divisive, may not reach those most in need and could even prove counterproductive. Mark Greener reports on the issues involved.

Reducing the increasing human, clinical and economic tolls imposed by diabetes taxes the minds of politicians, clinicians and charities. In October 2014, for example, Public Health England reported that, on average, just 36% of people with diabetes met treatment targets for blood pressure, glycaemia and cholesterol. Even England’s best performing area only reached all three targets in 48% of people with diabetes. Moreover, each week approximately 120 people with diabetes have a limb amputated.

Against this background, personal health budgets (PHBs) aim to improve outcomes ‘by placing patients at the centre of decisions about their care’. PHBs offer, the Department of Health (DH) suggests, ‘greater choice and control’. In particular, PHBs allow patients to work ‘alongside health service professionals to develop and execute a care plan,’ that could include, for example, therapy, personal care and equipment. Fundamentally, PHBs intend to encourage the health and social care system to become more responsive to each patient’s needs.

‘We are committed to giving patients with long-term conditions greater choice, flexibility and control over the health and care support they receive. We are working with NHS England and clinicians to extend personal health budgets in a sustainable and clinically effective way,’ a DH spokesperson says. However, Diabetes UK and Wasim Hanif, Professor of Diabetes & Endocrinology at University Hospital Birmingham and a leading expert on diabetes in ethnic minorities, warn that PHBs could be divisive, may not reach those most in need and could even prove counterproductive.

Holding your purse strings

The government aims that ‘eventually’ commissioners will offer PHBs to everyone in England who could benefit. Since April 2014, people eligible for NHS Continuing Healthcare could ask for a PHB. (NHS Continuing Healthcare refers to care arranged and funded by the NHS for individuals in the community with complex ongoing health care issues, such as needing community nurses, specialist therapists or personal care.) Some people with diabetes-related complications will be eligible for NHS Continuing Healthcare.) PHBs for NHS Continuing Healthcare became a right in October 2014. Commissioners can also offer PHBs to people with long-term conditions or mental health problems.

PHBs allow patients or their representatives to agree health and wellbeing outcomes with one or more health care professionals. Patients know how much money they have to design their care plan, which they can spend ‘in ways and at times that make sense to them’. The NHS can hold the PHB or pay a third party, a patient or their representative.

Results from pilots run between 2009 and 2012, the DH spokesperson remarks, ‘provided good evidence’ to justify rolling out PHBs, including direct payments for health care. The DH piloted PHBs in several conditions including 174 people with diabetes. On average, the PHB for people with diabetes was £5286, although this ranged from £1–263 970. People with diabetes used their PHB to fund social care (mean £583, range £0–£179 790), well-being (mean £590, range £0–£4103), ‘therapy and other nursing’ services (mean £29, range £0–£5492), and ‘other health’ interventions (mean £1978, range £0–£127 284). However, PHBs did not significantly affect HbA1c, the clinical measure for diabetes used in the pilot, compared to conventional service delivery during one year’s follow up.

The pilot also found that people need ‘clear, accessible information’ about PHBs and some patients and representatives need advocates. Brokers can also help patients and carers to choose and access support. Brokers, according to NHS England, ‘need to be creative and committed to finding all possible ways to enable people to make their own decisions’. However, pilot sites reported that finding good brokerage services ‘had not been easy’.

‘Personal budgets have shown some benefits in social care. For example, a personal budget allows the parents of a disabled child to employ carers who almost become members of the family and who develop a relationship with the child. Without a personal budget they may have to rely on whoever the social services can send around at the time,’ remarks Nikki Joule, Policy Manager at Diabetes UK.

‘PHBs for most people with long-term conditions generally and diabetes in particular are not here yet. But they are clearly coming closer.’

Indeed, the DH and NHS England are assessing methods to ensure that more people have access to PHBs, the spokesperson said. However, the DH notes that there are still outstanding issues around implementing PHBs for large numbers of people and, therefore, ‘any further roll out must be carefully considered’.

Will PHBs reach those in most need?

Nevertheless, the extent to which PHBs will help people with diabetes is a moot point. For example, Professor Hanif, Chairman of the Diabetes Working Group at South Asian Health Foundation (SAHF), remains unconvinced that PHBs would improve services for minority groups, who are often at the highest risk of developing diabetes and its complications.

For example, those of South Asian origin – about 3 million people in the UK – are between three and six times more likely to develop type 2 diabetes than white Europeans. Around 388 000 South Asian people live with diagnosed or undiagnosed type 2 diabetes in the UK. ‘If we want an equitable health service for people with
diabetes we need to target the most disadvantaged groups, such as the white poor and people from ethnic minorities living in inner cities,’ commented Professor Hanif. ‘PHBs are most likely to benefit the middle-classes in green suburbia.’

‘We have yet to see much evidence of how PHBs will benefit people with diabetes,’ Nikki Joule adds. ‘Indeed, it’s hard to see where they’ll help. The vast majority of NHS spending for people with diabetes meets clinical needs rather than requirements that PHBs could help meet. PHBs won’t, for example, help people with diabetes access the expertise of specialist nurses and diabetologists and the other medical services that they need.’

Despite her reservations, Nikki envisages ‘a few’ examples where PHBs could, in theory, help, such as funding gym memberships or counselling and education at a time that suits the patient. ‘Some people with diabetes may prefer to use the PHB to access these services rather than, for example, attend a routine appointment with a GP or practice nurse who is not an expert in diabetes,’ she suggests. ‘But on the whole there is no evidence that PHBs will be useful in diabetes.’

PHBs also aim to connect ‘people within their local communities’. Professor Hanif accepts that PHBs might have a limited role in, for example, funding culturally competent education, such as allowing a group of Muslims to understand the PHBs, could, in theory, help, such as funding gym memberships or counselling and education at a time that suits the patient. ‘Some people with diabetes may prefer to use the PHB to access these services rather than, for example, attend a routine appointment with a GP or practice nurse who is not an expert in diabetes,’ she suggests. ‘But on the whole there is no evidence that PHBs will be useful in diabetes.’

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Budgets are already under pressure and PHBs probably will not help people access expensive treatments. Indeed, PHBs could add pressure to already stressed drug budgets. Professor Hanif comments that diabetes accounts for between 10% and 12% of the NHS expenditure. ‘Secondary care spends between 80% and 90% of this managing complications, many of which better care would have avoided,’ he notes.

Drugs account for about 5–10% of NHS expenditure on diabetes, Professor Hanif remarks. ‘NICE has yet to reject a drug for diabetes,’ he points out. ‘They are cost-effective and relatively cheap compared to, for example, certain cancer drugs. Despite this, some managers and commissioners see the diabetes budget as an easy target to raid. They may allow only the cheapest drug from a class onto the formulary. But, in general, we don’t have the head-to-head studies to say which is the best drug for each patient. In some cases, the cheapest drug might be the least effective.’ Whether commissioners will mount further raids on drug budgets to fund PHBs remains a moot point.

In the final analysis, the move towards PHBs is probably more political than clinical or economic. ‘PHBs seem to be part of an ideology that people should take more individual responsibility for their health. It sounds good, but PHBs may not deliver the support that people need and could add to the burden of those already struggling with self-management,’ Nikki concludes. ‘The onus is now on the people advocating PHBs for diabetes and other long-term diseases to provide examples and evidence of how the PHBs will improve care.’

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References