University of Kent

THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

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The impact of personal health budgets on quality of life and well-being

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Key Objectives

To identify whether personal health budgets improved outcomes from the health and care system for people by giving them greater choice and control over the type of support they accessed and the way that support was organised and delivered

Three questions:

Was there evidence that personal health budgets led to better outcomes as compared with conventional service delivery?

Was there evidence to suggest that specific implementation models led to better outcomes for budget holders?

What other factors were associated with outcome change?

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Quantitative Outcome Data Collection

Baseline and 12-months after consent

- Dependency levels
- Socio-demographic information
- Socio-economic information
- Receipt of informal care

Outcome measures

- Health-related quality of life (HRQOL) using the EQ5D scale
- Care-related quality of life (ASCOT)
- Psychological health using GHQ12
- Subjective well-being

Main Outcome Measures

Health-related quality of life (HRQOL) using the EQ5D scale

5 domains covering mobility; self-care; usual activities; pain/discomfort; anxiety/depression

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Care-related quality of life (ASCOT)

8 domains covering care-related quality of life

Control over daily living

- I have as much control over my daily life as I want
- Sometimes I don't feel I have as much control over my daily life as I want
- I have no control over my daily life

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Quantitative Data Analysis

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Evaluating impact

Controlled trial with a pragmatic design

…both intervention and control groups could differ at baseline

… d*ifference-in-difference* approach

Net off any differences in experience (costs or benefits) at baseline from differences at follow-up

To safeguard against the possibility of bias between the two groups, multivariate difference-in-difference models

Baseline characteristics were 'controlled' for:

- socio-demographic factors (for example, gender, age, baseline dependency, accommodation, ethnicity);
- socio-economic factors (for example, education, benefit receipt); and
- health status (for example, health condition and comorbidities)

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Missing data

Missing data imputations

Highly complex evaluation – missing data

Missing at random – imputed values for missing data using underlying patterns in the dataset

Active sample of 2,235 cases

- 1,171 in the personal health budget group
- 1,064 in the control group

Pattern of missing data:

- Missing at random
  - 1,656 cases (74.1% of the active sample) with outcomes data (at follow-up)
  - 2,104 cases (94.1%) with at least some service data
  - 2,133 cases (95.4%) with either outcomes data or service data

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The impact of personal health budgets on outcomes

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Personal health budgets associated with an improvement:

- Care-related quality of life (ASCOT)
- Psychological well-being (GHQ-12)

Health conditions

- Chronic Obstructive Pulmonary Disease → positive impact on outcomes

Health-objective and subjective measures

Personal health budgets did not appear to have an impact (positive or negative) on health status *per se* over the 12 month follow-up period.

No significant difference in mortality rates between the two groups.

Personal health budgets did not have a significant effect on health-related quality of life (EQ-5D) compared to the control group.

The impact of implementation models on outcomes

Model 1

- Personalised budget is known before support planning
- Flexibility in what help can be purchased
- Deployment choice (including DP)

Model 2

- Budget is known before support planning (but may not be personalised – a set amount)
- Service directory
- Deployment choice (including DP)

Model 3

Budget is known before support planning (but may not be personalised – a set amount)
Lack of flexibility with services
No deployment choice

Model 4

Budget is not known before support planning
Flexibility in what help can be purchased
Variation in the degree of deployment choice

Model 5

Models 1 and 2 combined

The impact of implementation models on outcomes

Personal health budgets with models 1 and 4 implementation showed a significant effect relative to controls on care-related quality of life (ASCOT)

Personal health budgets with model 2 implementation were associated with better outcomes than controls on psychological well-being (GHQ-12)

Both effects were picked up in model 5, which combined models 1 and 2

Common factor between the effective models

The level of choice and flexibility in the services that can be purchased from personal health budgets.

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The impact of personal health budget size on outcomes

Assumption

Personal health budgets of £1000 or less in each service category were provided in addition to conventional services in that category.

Budgets over £1000 for each category of service were provided as a substitute for conventional service in that category.

Impact on outcomes

£1000 + budgets had a positive impact on care-related quality of life (ASCOT) and psychological well-being (GHQ-12).

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Summary

Personal health budgets impact on well-being and quality of life rather than health *per se*

Benefits appear to stem from:

Value people place on increased choice and control → Brings capacity to improve quality of life

Clear guidance for the national roll-out personal health budgets

Any Questions?

www.phbe.org.uk