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Ageing with disability: using financial mechanisms to facilitate intersectoral collaboration

The deaf-blind author and pioneering advocate for people with disabilities, Helen Keller, has been attributed as saying "*alone we can do so little. Together we can do so much*". Too often governmental and non-governmental organisations working in aging and disability can be isolated within the high walls of the castles in their fiefdoms meaning that opportunities to improve ageing with disability are lost. Intersectoral activity may be resisted if it is perceived almost like a hostile attempt by one organisation to scale the ramparts of another castle for their own purposes without considering the implications for the other sector.

A consensual approach maybe more productive with different organisations in the aging and disability spheres lowering their respective drawbridges and facilitating collaboration to provide better services and supports. Collaboration across sectors and agencies is of critical importance. As individuals age they are increasingly likely to acquire the sudden onset of a disability or just experience symptoms of gradual functional decline. At the same time more and more people with disabilities acquired earlier in life are reaching older age. If collaboration leads to better outcomes this not only benefits people as they age, it also potentially has benefits for governments and society.

Measures that protect and promote quality of life and wellbeing for people ageing with disability may help to reduce or delay the need for substantial care and support. Even small improvements in health and/or in ability to maintain independent living, as well as achieving synergies in the provision of services, eliminating duplication of effort, are likely to have

positive downward impacts on these future costs (Zingmark, Norstrom, Lindholm, Dahlin-Ivanoff, & Gustafsson, 2019). For example, there is potential to improve outcomes and reduce the costs of delayed discharges from hospital by increased collaboration between the health and housing sectors in the provision of reablement services for frail older people with disabilities that can help in their rehabilitation (Kjerstad & Tuntland, 2016; McDaid, Park, Eliot, Livsey, & Swan, 2014). Early action to identify chronic health problems in people with physical and intellectual disabilities can also help ensure that longer life expectancy means more time spent in good quality health (Garcia-Dominguez, Navas, Verdugo, & Arias, 2020).

These potential benefits are not restricted to reducing the need for health, social care and other services. There are also benefits from maintaining health, wellbeing and independence. Older people are consumers whose spending power can help stimulate the economy, something that is particularly important in the current global economic climate. For example, in 2015 the UK government estimated that all 10.4 million households with one or more disabled members had a combined income of £249 billion ($360 billion), or £23,900 ($34,600) after housing costs had been paid (Department for Work and Pensions, 2016). Similarly, the average annual income for UK pensioner couples in 2017 was £23,500 ($33,600) (Department for Work and Pensions, 2018), while an earlier study calculated that they made a positive net contribution to the UK economy (even accounting for higher health and social care costs of £40 billion ($57 billion) in 2010 rising to £77 billion ($110 billion) by 2030 (Royal Voluntary Service, 2011).

There is thus a business and economic case to foster better outcomes in this population. It also has policy resonance, potentially relieving some of the increased pressure on welfare systems. Policy makers have, for example, spoken of the importance of better integration across sectors, as well as more direct involvement of aging with disability service users in co-producing health and social care services (Ouellette-Kuntz et al., 2019). Already there has been a shift in some long-term care policies towards aging in place, with more co-production of care services through collaboration between stakeholders from the private, public and voluntary sectors (Alders & Schut, 2019). These approaches need, however, to do more to include populations with specific needs, including people aging with or into disability.

In this chapter we argue that financial mechanisms should be more widely used to stimulate collaboration between sectors that can support aging with disability. We focus on these issues

because funding issues can present major impediments to collaboration. In different sectors, funding streams may have tight restrictions on their use and be subject to different financial incentives and cost-containment concerns. A predominance of vertical policy-making structures and funding silos may reduce the prospects for intersectoral work (Corbin, Jones, & Barry, 2018; Rantala, Bortz, & Armada, 2014; Wong et al., 2017).

This challenge is compounded when one sector is disproportionally financially responsible for the delivery of any action, e.g. protecting health and wellbeing, but does not perceive that it will enjoy many of the benefits of the action (McDaid & Wismar, 2015). This will be particularly relevant if a sector perceives that it must take on a substantial extra workload without receiving adequate additional resources. For example, social care budget holders may be reluctant to fund activities to promote community leisure and other activities to reduce risks of social isolation and loneliness in people aging with disability unless benefits such as reduced future demand for home and community-based care can be identified.

Given the centrality of resources to policy implementation, well-designed approaches that ensure appropriate funding may help to overcome barriers and disincentives to intersectoral collaboration. These mechanisms can help facilitate genuine co-production of strategies across sectors. They can also be designed to better involve different stakeholders, such as the voluntary sector, as well as informal carers in different welfare regimes. To look at these issues we draw on literature on how different funding mechanisms and financial incentives have helped facilitate joint actions between the health and social care sectors and the consider whether and how they can be used to support people aging with or into disability.

What do we know about using financing mechanisms to facilitate intersectoral collaboration?

There remains a very limited literature specifically on financing mechanisms used for ageing with or into disability. This literature focuses on barriers to collaboration between these sectors rather than solutions. Much of the discussion concerns measures to influence individual behaviour rather than the behaviour of organisations, most notably empowering older people and those with disabilities through the use of different forms of cash transfer or vouchers that have been introduced to purchase services and supports from different sectors,

agencies and the private sector that they feel best meet their needs (Carbone & Allin, 2020; Roets et al., 2020; Woolham, Daly, Sparks, Ritters, & Steils, 2017). Social prescribing, a mechanism whereby health system funds are used to purchases activities and services outside of the health system to support groups, such as people with mental health problems, chronic illness and disability, are another mechanism that stimulates intersectoral thinking targeted at individuals (McDaid, Damant, & Park, 2019). Other examples aimed at individual behaviour include the use of financial, tax and other incentives to encourage continued participation in work (Laun, 2017) or even physical activity (Harkins, Kullgren, Bellamy, Karlawish, & Glanz, 2017).

There are, in contrast, few examples of structural approaches to encourage sectors to work together on aging with or into disability but that may be because these issues do not have great prominence within the portfolios of health, social care, housing and other agencies that may provide relevant services. We can however draw on the growing evidence base on the use of financing mechanisms for intersectoral collaboration involving the health sector that could be applied to aging with disability (Jakovljevic et al., 2019; Johansson & Tillgren, 2011; McDaid & Park, 2016; McGuire et al., 2019; Rantala et al., 2014).

Previously we reviewed the role of financial and regulatory measures in encouraging collaboration across sectors to promote better health and wellbeing. This review was not specifically focused on any age group or condition but different mechanisms that are helpful to better collaboration and co-production were identified (McDaid & Park, 2016). The most frequently used of these mechanisms were earmarked funding, delegated financing and joint budgeting.

Earmarked funding

Earmarked funding conditional on collaborative activity can be allocated to multiple organisations for a shared project or goal. The process for allocating funding may be prescriptive, stipulating that funding is linked to use of a specific cross-sectoral programme to address an issue, or it may allow for innovation in the way in which that priority issue is addressed. It can also be a competitive process where organizations from two or more sectors

may have to collaborate to develop a proposal regarding how funds will be used to any specific issue.

Example that are particularly relevant include earmarked funding from the Population Health Fund (PHF) (Public Health Agency of Canada, 2007) and latterly the Innovation Strategy of the Public Health Agency of Canada (Office of Evaluation, 2015). Under the PHF national and regional projects resulted from a competitive bidding process in which applications had to demonstrate that intersectoral work would be undertaken, for example linking academic, community, educational and voluntary sector organizations within and outside the health sector. Evaluation found that the PHF facilitated intersectoral actions, with some projects sustained beyond the lifetime of the grant through the successful acquisition of funding from other sources. A limitation was that many smaller one-off projects had insufficient time to generate evidence on which activities had worked, with limited project funding for evaluation and did not share lessons learnt. When the PHF was replaced by an Innovation Strategy the programme structure changed to adopt a phased longer-term funding approach, focused on projects of larger scale. This financing model for intersectoral partnership working led to the development of sustained and expanded intersectoral programmes across Canada.

Delegated financing

Another approach to consider is delegated financing (Schang & Lin, 2012). This involves allocating funding to an independent statutory organization, such as a public health foundation, frequently from multiple budgetary sources, not just health budgets (Schang, Czabanowska, & Lin, 2012). If properly independent of government, organizations operating through this financing mechanism may be more sustainable as they can be less vulnerable to government budgetary and electoral cycles (Greaves & Bialystok, 2011). They can decide which projects and activities to fund, with many projects being intersectoral.

Joint budgeting

Joint budgeting (also known as resource pooling) is a third approach to funding intersectoral collaboration in which two or more sectors share their resources to address a specific issue (McDaid, 2012). It is perhaps the most frequently used of these three approaches and has been

used for specific health and social care service projects for different client groups, including older people in England through the Better Care Fund which brings to together health care system funds with local government social care funds, ‘with the intention of better, more joined-up services to older and disabled people, to keep them out of hospital and avoid long hospital stays’ (Harlock et al., 2020).

Pooling funds from health and social care services may help to reduce administration and transaction costs, thus generating economies of scale through shared staff, resources and purchasing power while facilitating more rapid decision-making (Mason, Goddard, Weatherly, & Chalkley, 2015). Under this mechanism, financial resources can be shared in a number of ways, including budget alignment. For example, shared budgets between the health sector and a local municipality can be arranged to meet agreed health promotion aims. Funds are often time limited and sometimes there may be an agreement to jointly fund a post for an individual who will be responsible for providing services and/or attaining objectives relevant to both sectors. Budgets across organizations might also become fully integrated, with resources and the workforce fully coming together; however, most initiatives stop short of fully pooling resources.

An important point is that joint budgeting can be either mandatory or voluntary. It may be accompanied by legislation, regulatory instruments and detailed legal agreements between sectors. Some have, for example, included specifying a host/lead partner for the budget and clarifying the functions, agreed aims and outcomes and levels of financial contributions by different sectors, as well as relevant accountability issues. In the short term, mandatory budget pooling and a de facto requirement for different sectors to collaborate may facilitate intersectoral actions and provide opportunities for mutual learning across sectors. However, the imposition of mandatory schemes may lead to resistance to collaboration from different sectors, which may threaten the long-term sustainability of schemes.

Evidence from partnerships between health and social welfare services in the United Kingdom suggests that there may also be a reluctance to collaborate beyond what is stated in specific contracts and detailed legal partnership agreements; good accountability mechanisms, as well as clear legal and financial frameworks, need to be in place (Glendinning, 2003; Mitchell, Tazzyman, Howard, & Hodgson, 2020). Tensions have also been seen in some local Better

Care Fund programmes in England where there was a lack of agreement on how money should be spent, nor on how the risk of any financial losses from programmes should be shared (Harlock et al., 2020). If mutual learning or trust does not develop between sectors, then mandatory partnerships may be difficult to sustain if mandatory joint funding ceases. In contrast, although voluntary partnerships may take longer to develop, they may be more sustainable as a result of the trust that evolves between sectors over time.

Using economic arguments to strengthen the case for enhanced intersectoral working

Partners need to perceive collaboration to be in their own interests by adding value to what they can achieve in isolation. Too often, stakeholders from one sector do not look at the consequences of an action for their partners. Economic arguments can be used to address this issue. This is done by identifying and placing a monetary value on outcomes of interest to each sector in any collaboration, even if these outcomes appear tangential to the primary goal, in this case of better aging with disability. It is particularly helpful to present cogent arguments indicating that the collaboration will be a win-win for all partners (McDaid & Wismar, 2015).

Consider a hypothetical voluntary arrangement between health care budget holders and local government leisure service budget holders to pool funds to tackle social isolation and loneliness in frail older people. There is increasing evidence that loneliness has an adverse impact on the physical health of vulnerable populations (Leigh-Hunt et al., 2017), and that leisure and other social activities can help to reduce the risk of loneliness (Gao et al., 2018). Demands for future expensive health care services may thus be reduced if health care budget holders invest resources in this type of non-clinical activity. Similarly, local governments may be more prepared to invest resources in tackling loneliness, something that may not see as a core activity, if they are presented with the growing evidence base that high levels of loneliness are a risk factor for cognitive decline (Luchetti et al., 2020). The costs of providing social and long-term care for dementia account for a large share of expenditure for local governments in many countries; relatively low-cost investment in measures to tackle loneliness may then appear more attractive.

Overcoming barriers and seizing the opportunity

We believe that there is a real opportunity to use financial mechanisms to stimulate interaction and bridge the aging and disability sectors to allow for better aging with disability. There are potentially substantial benefits, not just to the health and social care sectors, but to the wider economy of promoting better aging and the maintenance of independence in this population group. Historically, responsibility for aging and disability has often rested with multiple agencies, potentially in different sectors with different hierarchical and administrative structures. This may make collaboration difficult, but there is evidence broadly in the health, social care and public health sectors that financial mechanisms can incentivise collaboration between sectors.

Options to consider include earmarking funding for activities to support aging with disability conditional on an intersectoral approach being taken. Ongoing financing of intersectoral activities could also be made conditional on effective monitoring and achievement of defined outputs and outcomes. This could include phased funding that could eventually lead to replication and/or scaling up, as has been used by the Innovation Strategy of the Public Health Agency of Canada.

Funding may also be delegated to a specific independent agency that has a remit to work across the aging and disability sectors; much can be learnt from health promotion foundations that operate along these lines, such as the Victorian Health Promotion Foundation in Australia. Pooling budgets across sectors, to support the needs of people aging with disability is another option. In England, the Better Care Fund allows local health budget holders to pool some funds with local government to promote health ageing and reduce the need for crisis interventions. This English model also provides an example of how establishing a legal and regulatory framework for these partnerships can help in the way they function, for instance by allowing staff from either organisation to be paid in a comparable way. It also promotes accountability and transparency on how funds are spent.

The literature has also identified many different potential barriers to implementation of financing mechanisms. They can include poor leadership, a lack of buy-in from different stakeholders, organizational resistance to change, worries over impacts on core function, insufficient resources, imbalanced hierarchical structures and differences in work culture (McGuire et al., 2019). Many of these issues boil down to the concept of trust. Intersectoral

collaboration requires trust to be built between partners regardless of the financing mechanism. Building trust is particularly important when different sectors voluntarily come together to collaborate and share resources. This necessarily relies more heavily on trust and open discussion; in turn, mutual learning and innovation is enhanced by the development of trusting relationships. Creating collaboration champions and co-location of ageing and disability organisation personnel may also have a positive impact on establishing trust. Shared targets and rewards, flexibility in planning, and access to external mediation if necessary can also help (McDaid & Park, 2016; McGuire et al., 2019).

It is also clear that identifying outcomes of interest to all potential intersectoral partnerships, as well as the economic costs and payoffs, can help to facilitate partnerships. This requires creative thinking recognising that sectors may have very different priorities. However, it also means that there may also be a need for compensation mechanisms, i.e. the additional transfer of funds across sectors may be helpful when it is not possible to generate economic win-wins for all sectors (Johansson & Tillgren, 2011). Even where there are economic win-wins, these may not be realised for some years, so it is important that these financing mechanisms are adequately resourced.

Reviews also suggest that many successful experiences in the use of financial mechanisms are more likely to operate at a local rather than national level, with local government often central to intersectoral activities identified. This may be because local governments are usually well positioned to lead intersectoral processes by influencing several sectors that can be fundamental to health, such as land use, transportation, environmental protection, leisure services, education and community development.

Conclusion

Potentially there is a wealth of innovative practice on the use of financing mechanisms to stimulate intersectoral collaboration; this may include examples of good practice that support aging with disability that have not come to the fore. A first step is to have platforms in place where existing expertise and knowledge on financing mechanisms from different local and national contexts can be shared to help services collaborate to support people aging with or into disability. Going forward it is also important to formally evaluate the effectiveness and

cost-effectiveness of these financial mechanisms in different contexts, including the use of different strategies to help smooth their use, such as creating the conditions for mutual learning and trust. In this way the aspiration of Helen Keller that '*together we can do so much'*, perhaps through more joined-up, integrated care and support that meets the needs of all of those aging with disability might be realised.

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