Prevention and Alternatives to Residential Care:
A Review of the Evidence

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Personal Social Services Research Unit
PSSRU Discussion Paper 2870
February 2014
www.pssru.ac.uk
Abstract

Background

The gap between rising demand and constrained resources means that the health and social care system needs to pursue efficiency gains. Therefore, there is growing interest in promoting ways to meet the health and social care needs of older people in a more efficient and cost-effective way.

Method and materials

This study is a literature overview commissioned by Oxfordshire County Council in the context of their strategy for adult social care and has explored the most recent and robust research evidence in the UK and other countries, on some of the priority issues for social care for older people: prevention and alternatives to residential care.

Results

Literature on prevention suggests that adaptive technologies may provide a good return on investment under specific scenarios. However, there is scarce quantitative evidence about the cost-effectiveness of other preventive interventions. Regarding the cost-effectiveness of alternatives to residential care, evidence is also inconclusive. Rigorous analysis of residential care should consider the costs of both formal and informal care.

Conclusions

Community care can be more cost-effective than residential care, even from a societal perspective in which the contribution of informal caregivers is taken into account. Also, reducing investment in low-level and preventative services as a measure to cut budget may have a significant impact on future need for health and social care services. Finally, further research on the cost-effectiveness of preventive measures and on a range of community care alternatives to residential care for older people is required.
Prevention and Alternatives to Residential Care: A Review of the Evidence

The demand for health and social care has increased and is expected to continue to rise for several reasons, including the increasing numbers of older people. At the same time, resources for health and social care are severely constrained because of public expenditure restraint required to manage the large public sector deficit. The anticipated gap between rising demand and constrained resources means that the health and social care system needs to pursue efficiency gains. A more efficient system requires significant planning and implementation of new strategies. There is growing interest in promoting ways to meet the health and social care needs of older people in a more efficient and cost-effective way.

Oxfordshire County Council has developed a vision to support and promote strong communities so that people live their lives as successfully, independently and safely as possible. The council has defined underlying values for their strategic priorities which include choice, independence and prevention, stating the following key elements of the strategy:

1) To keep people well through investment in services that prevent some people from needing social care, reducing or delaying the need for care.
2) To ensure people can live a life free from abuse and the fear of abuse.
3) To ensure people have more choice and control over the way they are supported.
4) To develop long term support options that reduce the number of people admitted to care homes (especially residential care homes which do not provide nursing support), increase alternatives to care and develop community support that continues to keep people safe in their own homes.
5) To facilitate a market of good quality services that can be used by everyone.

Furthermore, the council is seeking greater integration of health and social care to face the current challenges of both health and adult social care services.

This literature overview was commissioned by Oxfordshire County Council in the context of their strategy for adult social care and has attempted to bring together the most recent and robust research evidence on some of the priority issues for social care for older people: prevention (including reablement) and alternatives to residential care. The review is mainly focused on UK studies published since 2000 but, to enrich the discussion, literature in other countries has been also considered. We summarise first literature on prevention and then literature on alternatives to residential care, and finally present some concluding remarks about the evidence base.
Before embarking on a review of the evidence on prevention and alternatives to institutional care, it is important to define some commonly used terms in the literature as explained in Box 1.
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Box 1. Useful definitions

**Economic evaluation:** A comparative analysis of two or more alternatives courses of action in terms of the costs and consequences.

Types of economic evaluation:
- Cost-minimisation analysis - Comparison of costs of alternatives that have the same health outcome.
- Cost-effectiveness analysis - Comparison of costs and disease-specific health outcomes.
- Cost-utility analysis - Comparison of costs and generic health outcomes (e.g. QALY)
- Cost-benefit analysis - Comparison of costs and health outcomes valued in monetary terms


**Adult social care:** Long-term care. It has been defined in the Caring For Our Future White Paper (DH 2012:13) as ‘care and support [which] enables people to do the everyday things that most of us take for granted: things like getting out of bed, dressed and into work....’

**Assistive/Adaptive technology (including equipment):** It has been defined as ‘an umbrella term for any device or system that allows an individual to perform a task that they would otherwise be unable to do or increase the ease and safety with which the task can be performed’ (the Royal Commission on Long Term Care, Tinker et al. 1999: 81). However, some authors like Heywood and Turner (2007) use ‘assistive technology’ or ‘adaptive technology’ to refer to electronic devices and ‘equipment’ to portable items.

**Extra care housing:** ‘meets the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation’ (Darton et al. 2012). In UK literature: ‘very sheltered housing’, ‘enhanced sheltered housing’, ‘supported housing’, ‘integrated care’, ‘housing with care for later life’, ‘ExtraCare’, ‘close care’, ‘flexi care’, ‘assisted living’, ‘retirement village’, ‘retirement community’ and ‘continuing care retirement community’ are all used (Croucher et al. 2006).

**Institutional care:** Care in care homes with nursing and personal care (nursing homes) or with personal care only (residential care homes).

**Non-institutional care:** Includes ‘community-based’ services such as home care, day care, community equipment and professional support and housing with care other than in care homes. ‘Community-based care’ or ‘home care’ terms are used interchangeably in the literature (Chappell et al. 2004).

**Informal carer:** A relative or friend who provides unpaid support to someone who is ill or disabled with personal tasks such as dressing or bathing or who offers other sorts of practical or emotional support (Milligan, 2000).

**Reablement:** Provision of services to support older people to remain in their own home or housing with care in the community.
**Prevention**: Measures seeking to break the cycle of unplanned admissions to hospital or unnecessary moves into residential care. Proactive measures which reduce older people’s dependency levels, or slow their decline. They also offer an opportunity to improve quality of life and independence, while potentially also saving money.

The following concepts are included within the prevention agenda (Wanless Report, 2006:169):

- Public health and low-level services preventing or delaying the need for social care services by reducing people’s dependency, disability and ill health.
- Prevention in the sense of preventing inappropriate use of more intensive services for people with given dependency, disability and ill health.

**Prevention**

It has been acknowledged that the practice of targeting resources for long-term care on those with the greatest need has led to problems such as reduced numbers of people receiving community care services (Wanless Report, 2006). An emphasis on choice, independence and prevention has been explained in various policy documents (Department of Health 2005, 2006, 2010).

The assumption has been that preventive social care will ultimately lead to improved outcomes and cost savings and, thus, prove to be cost-effective in the long term. However, evidence about the impact of preventive interventions is inconclusive. The main findings suggest that:

- Literature on prevention is focused on reducing hospital admissions (for instance, through reducing falls and their effects such as hip fractures) and on reducing institutional care by maintaining independence or limiting the loss of decisional autonomy (Challis *et al.* 2001; Boyle, 2004; Heywood and Turner, 2007; Netten *et al.* 2011; Snell *et al.* 2013).
- There is scarce robust quantitative evidence about the cost-effectiveness of preventive interventions (Wanless Report, 2006; Snell *et al.* 2013). Defining the cost and outcomes of preventive interventions is challenging considering the complexity of service provision and funding (Goodacre *et al.* 2008).
- It is often difficult to establish a clear causal link between a specific service and the outcomes (Wanless Report, 2006). An important body of research on prevention is focused on assistive/adaptive technologies. It provides examples of reductions in demand for health and social services. While some studies explore the cost and outcomes of preventive interventions, other studies estimate the effects of unmet needs on mental health and independence of older people and other family members.
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(Schneider et al. 2003; Boyle, 2004; Milligan, 2006; Heywood and Turner, 2007; Snell et al. 2013).

• The range of benefits of adaptive technologies is well documented (Snell et al. 2013). Some authors suggest that assistive technology can be cost neutral but also can provide cost benefits (Goodacre et al. 2008).

• The review of evidence has shown that there are some serious methodological problems in gathering evidence of the cost-effectiveness of adaptations, equipment and assistive technology (Heywood and Turner, 2007; Snell et al. 2013).

• Not all adaptations save money and delay in undertaking adaptations or supplying equipment may lead to more costly and inefficient decisions (Heywood and Turner, 2007).

• Integration between health and social care services is critical to bring about the desired shift in services towards the main goals of prevention (Wanless Report, 2006).

• Reducing investment in low-level and preventative service might have significant implications for both health and social care sectors (Snell et al. 2013).

Assistive/Adaptive Technology, Housing Adaptations, Improvements and Equipment

Research has demonstrated that the provision of housing adaptations and equipment for disabled people improves many outcomes such as enhanced quality of life, improved mental health, reduced fear of accidents, and the prevention or deferral of admission to residential care (Schneider et al. 2003).

The literature on housing adaptations is the result of work in various disciplines such as medicine, housing studies, ageing studies, economics, health-economics and occupational therapy. The evidence is complex and there are some serious methodological problems (see Heywood and Turner, 2007 for a detailed explanation). One of the basic problems is defining terms like a fall or knowing whether one has taken place. Another difficulty is studying the effects of the adaptations on isolated ‘health states’ and measuring levels of disability under different circumstances. For instance, developing activities of daily living measures of someone unable to walk and is immobile compared to someone unable to walk but equipped with electric mobility.

Despite difficulties, housing adaptations, improvements, equipment and assistive technology show benefits in terms of savings and improvements in independence and quality of life (Heywood and Turner, 2007; Goodacre et al. 2008; Snell et al. 2012).

Goodacre et al. (2008) contribute to the scarce UK quantitative evidence on the topic. They explore the adaptability of properties and the costs associated with different packages of adaptations, assistive technology (AT) and care after the first 5 and 10 years. They also
consider the availability of both formal and informal care. Using data on 82 properties, their findings reveal that substitution of some AT for some formal care results in savings. Even when considering older people with different care needs, AT may be cost neutral or can provide cost benefits. As would be expected, the costs of the basic AT package vary from 10% to 45% of residential care costs, considering a period equivalent to average life expectancy. The analysis suggests: ‘the potential higher costs and risks associated with providing AT and adaptations to users with more extensive disabilities may be offset by shorter break-even periods’. In summary, the most important finding of the study is that AT can be cost neutral or provide some cost benefit because it is used to supplement or substitute for care.

In a recent literature review of the implications for health and social care budgets of investment in housing adaptations, improvements and equipment, Heywood and Turner (2007), on behalf of the Office for Disability Issues, describe the potential improvement in outcomes and reduction in costs, e.g. savings to health and social care budgets, in four major areas (examples are described in detail in Heywood and Turner, 2007):

1. Saving by reducing or completely removing an existing outlay: the cost of residential care and the cost of intensive home-care. For instance, a social services authority was able to save £4,900 per week in residential care for ten people after spending £37,000 on equipment for 183 people.

2. Saving through prevention of an outlay that would otherwise have been incurred: the prevention of accidents with their associated costs, prevention of admission to hospital or to residential care and prevention of the need for other medical treatment. There was evidence of savings of all these kinds. Falls leading to hip fractures involve a cost of £726 million in the UK in 2000. Housing adaptations might reduce the risk of falls.

3. Saving through prevention of waste: much of the waste in regard to adaptations comes from under-funding which results in delays, or the supply of inadequate solutions that are ineffective or psychologically unacceptable. One local authority spent £89,000 in one year on adaptations for applicants who, because of long delays, died before they could obtain any real benefit from them.

4. Saving through achieving better outcomes for the same expenditure: Adaptations produce improved quality of life for 90 per cent of recipients and also improve the quality of life of carers and of other family members. According to systematic reviews and small studies, the most consistent health outcome of adaptations is mental health improvements.

Their findings suggest that there are some housing adaptations, improvements and equipment which imply better outcomes and lower cost. In those cases, the housing adaptations might be an alternative to residential care, prevent hip fractures or speed up hospital discharge. We should be cautious when interpreting and generalising the results.
because not all adaptations save money and delay in supplying adaptations or equipment might lead to more costly and inefficient decisions.

The range of benefits of adaptive technologies is well documented (Snell et al. 2012). The outcomes can be broadly classified in direct returns (reduction in demand for health and social care services) and wider outcomes (improvements in independence, mental health and quality of life). Despite an increasing body of research, there is little quantitative evidence in the UK estimating the benefits to the state and to individuals.

Snell et al. (2012) provide the first estimates of the outcomes of adaptive technologies for England. They use evidence from the literature and a range of informed assumptions in order to create a quantitative model to provide a range of estimates of the costs and benefits of adaptive technologies (but they do not explore their cost-effectiveness in comparison with alternatives types of long-term care). They estimated the model based on three different scenarios: conservative, central and optimistic.

Based on the PSSRU Unit Costs of Health and Social Care 2011, Snell et al. (2012) report a list of costs of common types of adaptive technology. Adaptive technologies include a variety of interventions ranging from devices (e.g. grab rails) costing less than £100 on average to bath/shower adaptations costing on average £8,000.

Table 1 summarises findings on the effect of adaptive technologies which result in the reduction in demand for health and social care services (considering the value to the state and value to individuals) and improvements in the quality of life measured by Quality-adjusted Life Year (QALY) gains. The total combined value of reductions in demand for services and monetised QALYs for the conservative, central and optimistic scenario is £1,640, £2,101 and £2,802, respectively.

Table 1. Effect of adaptive technologies

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Reductions in demand for health and social care services(a)</th>
<th>Improvements in the quality of life of the dependent person(a,b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>£261</td>
<td>£1,379</td>
</tr>
<tr>
<td>Central</td>
<td>£579</td>
<td>£1,522</td>
</tr>
<tr>
<td>Optimistic</td>
<td>£1,079</td>
<td>£1,723</td>
</tr>
</tbody>
</table>

\(a\) per person per annum

\(b\) QALY gain

Snell et al. (2012) also estimated the returns per pound invested in adaptive technologies achieved for a mean period of six years after their installation. In the central scenario, each
pound invested gives a return of 58 pence due to reductions in demand for health and social care services and improvement in the quality of life with a value of £1.52. At the national level, a client base level of 45,000 older people who benefited from adaptations might generate reductions in health and social care expenditures of £156 million over the estimated lifetime of the equipment and improvements to quality of life equivalent to £411 million over the same period.

These findings suggest that adaptive technologies provide a good return on investment under all the scenarios presented above. Therefore, one of the main policy implications of this study is that reducing investment in low-level and preventative services might have significant adverse implications for both health and social care sectors.

Alternatives to Residential Care

On the basis on their review on the relative costs and effects of community-based care and residential care for older people, Weissert et al. (1988) concluded that the results of rigorous studies before the 1990s reveal that both institutional and non-institutional care services raised overall demand for health services. Moreover, they argue that cost-effectiveness of non-institutional care settings was not at all conclusive and that additional research was needed to better understand the conditions under which cost-effectiveness result (see Weissert et al. 1988:32, 33 for further explanation).

Since the 1990s, there is evidence that home care can substitute for residential care arguing for its cost effectiveness (Chapell et al. 2004). The main findings of the literature are:

- The major contribution of informal caregivers to long-term care needs to be acknowledged (Chapell et al. 2004; Croucher et al. 2006; Goodacre et al. 2008; Milligan, 2006). Box 2 explains in detail the relevance of informal care giving.
- Evidence on the cost-effectiveness of community care as an alternative to residential care is not at all conclusive. Additional research is still needed to better understand the conditions under which cost-effectiveness will result.
- From a societal perspective, cost-effectiveness analyses of inclusive models of alternatives to residential care should include the costs of both formal and informal care (Chapell et al. 2004).
- There is debate over the effect of the service options in non-institutional care settings on older people’s independence and decisional autonomy (Milligan, 2006).
Box 2. Informal Care

There were approximately 5.4 million informal carers in England in 2011 of whom more than half provided care to older people aged 65 and over. From 2003 to 2026, the ‘demand’ for informal care is expected to increase sharply, by around 45% (Wanless Report, 2006).

Informal care-giving has been the focus of a small but growing field of research interest. Most of the studies point out that overall costs of care increase considerably when the opportunity costs of informal care are included (Oldman, 2000; Schneider et al. 2003; Patel et al. 2004). For instance, experience in the UK shows that informal care constitutes up to 40 per cent of the total costs of dementia care (Schneider et al. 2003). Patel et al. (2004) demonstrated that the inclusion of informal care costs when studying stroke unit groups rose by 45% or 134% depending on the method of informal care cost estimation.

The opportunity cost of informal care can be estimated using two main methods: measured at the national minimum wage (the opportunity cost method) and measured as replacement wages (cost of a social services home help worker). However, there is a controversy regarding which of these is the most appropriate method for costing informal care (Schneider et al. 2003; Patel et al. 2004).

Using data on 132 people with dementia in London, Schneider et al. (2003) studied the predictors of informal and formal care costs, such as physical disability, level of cognitive impairment, and living in residential care settings. They studied the potential substitution and supplementation between informal and formal care. Dementia is associated with relatively more informal inputs than physical disability, but physical frailty is associated with relatively more formal care inputs. In the early stages of dementia care, informal care is a ‘supplementation’ of formal care. However, when older people with dementia enter residential care, informal care becomes a ‘substitute’ for formal care inputs.

When informal care time is taken into account, findings comparing the cost of community care and residential care are contradictory. Schneider et al. (2003) demonstrates that, contrary to popular belief, residential care is less costly than community care. By contrast, a cost minimisation analysis in Canada shows that community care is significantly less costly (Chapell et al. 2004) even when the costs of informal care are taken into account. We should be cautious when interpreting and generalising the findings. It is important to remember that the relative costs of institutional and non-institutional care settings may vary by country or area and the relative package costs may vary by factors, such as the levels of need of older people.

Researchers have demonstrated the adverse effects of caring on informal carers’ quality of life and argue that developing more inclusive models of care in residential care setting is imperative. However, evidence adopting a societal perspective in models of long-term care...
is limited. Following a narrative approach studying twenty carers, Milligan (2006) explores care-givers’ experiences and views in the transition process from home to residential care in New Zealand.

Despite a relatively small study, the findings give some insights on the complexity of informal caregivers’ contribution to long-term care and their caring experience suggesting the blurring of the boundaries between formal and informal care in residential care settings. Transition from home to residential care involves a wide range of mental distress in carers including feelings of guilt, fear and loneliness that might occur not just in the ‘initial stage of transition’, but over time. The findings also suggest that the contribution of informal carers is important for an accurate assessment of needs and care of residents in institutional settings. Informal carers play an important monitoring role for the quality of care provided in residential homes.

**Extra care housing**

According to the first large-scale evaluation of extra care housing funded by the Department of Health (Netten *et al.* 2011:4), ‘it could be argued that extra care housing is the embodiment of many of the core principles of current social care policy: prevention, personalisation, partnership, plurality and protection.’

Housing with care in the UK has emerged as an alternative to residential care while supporting people to live independently. The UK Government has followed a policy vision to maintain older people in their homes as long as possible (DH, 2010). Between 2004 and 2010, the Department of Health provided more than £200 million through the Extra Care Housing Fund (DH 2003, 2005, Department of Communities and Local Government).

The aims of housing with care in the UK are to promote independence, security, availability of care and support, reduce social isolation, provide an alternative to residential or institutional models of care, offer residents with a home for life and improve the quality of life of residents. Research has clearly confirmed the major positive effects of housing with care models in terms of social integration, friendship formation, close relationships, mutual support, formal social activities, social connectedness with the world outside, and volunteering.

A diversity of schemes in the UK has been established depending on local priorities and processes, for instance, the type of needs they are intended to meet, the local partnerships established for their functioning, and local funding (Croucher *et al.* 2006).
Comparability of schemes is difficult given the multiple differences between them. Firstly, they have particular design features. Some authors highlight the components to promote at the same time ‘better quality of care and better quality of life’, offering greater autonomy to older people. Secondly, there is no single model dominating the way how services are provided in the UK. Some schemes are seen as a replacement for residential care while others are designed not just to provide care, but also to promote social interaction. The scale of schemes is also relevant when comparing across schemes. Some authors argue that one of the benefits of retirement villages or communities, a recent phenomenon in the UK, is that they might develop an integrated community. However, at the same time, they might favour the creation of older people ‘ghettos’ and therefore promote social segregation.

Housing schemes are also different according to the range of allocation and eligibility criteria. That is one of the reasons why estimating the impact of housing with care schemes on health status is not straightforward. Some schemes accommodate people with a range of care needs, others accommodate people who need no care to live independently when accepted, and others focus on people with certain health conditions (when health and care needs are recognized, which might not always be the case).

A further distinction is the tenure offered by the schemes. Residents can be tenants, leaseholders or owners. There are schemes offering only rental properties while others also offer the chance of buying.

Croucher et al. (2006) identify 11 recently published evaluations of housing with care in the UK. Their review of the literature concludes that housing with care may be an alternative to residential care but not a replacement. The main results that emerge from the evidence are:

- There are high levels of satisfaction with very sheltered housing among tenants. Evidence shows that housing with care offers tenants more independency, privacy and security. However, there is a small proportion of older tenants who would have preferred to remain in their own homes.

- Housing with care may be an alternative to residential care, but not a replacement.

- Evidence demonstrating the cost-effectiveness of housing with care relative to residential care, or to care in the home is inconclusive. However, it seems to suggest that housing with care is more expensive than residential care, and in some cases cheaper than home care.

- We know very little from the current evidence base regarding how well housing with care supports people who are looking after a sick or disabled partner.

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1 Researches have tried to compare them using particular design features, such as the services and facilities they are expected to provide (Baker, 2002; King, 2004; Riseborough and Fletcher, 2003).

2 For instance, Berryhill Village, Ryfield Village, Hartrigg Oaks.
Despite scarce evidence about the assessment of residents’ quality of life in housing care schemes, studies support the idea that residents of housing with care enjoy an improved quality of care than they would in residential care.

Greater difficulties arise in making international comparisons of extra care housing schemes. Some countries like the USA, Canada or Australia depend on the private sector for housing provision. By contrast, European countries rely on major involvement of the public sector. Despite existent differences, in countries like Denmark, the Netherlands, Finland and Sweden, housing and care provision for older people has developed in similar ways to the UK.

Recently, nineteen extra care housing schemes were evaluated comparing costs and outcomes between these schemes and care homes (Netten et al. 2011). Three main key areas were explored: (i) delivering person-centred outcomes, (ii) cost and cost-effectiveness, and (iii) improving choice (see Netten et al. 2011 for a detailed discussion on additional findings such as the importance of careful design, location of schemes and economies of scale).

- Delivering outcomes: Outcomes were generally very positive. Overall, physical and cognitive impairment tend to improve for residents of housing schemes.

- Cost and cost-effectiveness: Higher costs were associated with: living alone, levels of physical and cognitive impairment, need for nursing-type care, presence of a long-standing illness, higher levels of well-being, non-integration of housing management and care arrangements, higher staff turnover, larger housing association size, being located in London. Extra care housing is a cost-effective alternative to residential care for people with the same characteristics due to better outcomes and similar or lower costs.

- Improving choice: Residents moving into extra care housing have high expectations focused on more social interaction (Netten et al. 2011).

We know very little from the literature in the UK regarding the characteristics of residents in extra care housing and residential homes due to the problems of comparability across schemes or with residential homes. Darton et al. (2012) contribute to this gap in the literature by studying 609 residents who moved into 19 extra care housing schemes and 494 residents who moved into care homes.
Levels of physical and cognitive impairment were lower in extra care schemes than in residential care homes. There is a sharp contrast in the proportion of people admitted who have cognitive impairment: 3% in extra care schemes and 39% of residential care home admissions. Results also show that residents who move into housing with care were less likely to have received informal care relative to those who move into residential homes. Interestingly, the difference in residents’ profiles in extra care housing and residential care might suggest that in fact a very small proportion of places in extra care housing represent a true alternative to residential care. Further research needs to be done on the mechanisms to balance the levels of residents with high, medium and low care needs to support extra care housing as an alternative to residential care. In other words, schemes need to offer care to the more severely disabled people. Darton et al. (2012:95) also suggest that in ‘evaluating the impact of extra care, consideration needs to be given both to the outcomes for residents with equivalent characteristics to those moving into care homes and to the outcomes for those who are more able.’

**Cost-effectiveness of extra care housing**

There is little evidence demonstrating that housing with care is a cost-effective alternative to residential care, perhaps because it is particularly challenging to make like for like comparisons between extra care housing and residential care. Regarding the outcomes, Darton’s et al. (2012) study should add considerably to the understanding of extra care housing outcomes for residents with equivalent characteristics. Estimation of the costs of extra care housing however is difficult because of a lack of consensus about a suitable cost model, differences in the way to compute and measure costs, lack of transparency, and calculation of cost transfers between groups.

Few studies have attempted to estimate the cost-effectiveness of extra care housing schemes, and those which have been conducted reveal contradictory results. Bartholomeou (1999) shows that Extra Care housing is not cost-effective. By contrast, Baker (2002) and Netten et al. (2011) conclude that housing with care is a cost-effective alternative to residential care. Findings suggest that the complexity and range of funding and charging arrangements for Extra Care housing makes the analysis a very difficult task. Findings should be treated with caution when interpreting and generalising in different contexts.

Further research is needed to support the identified gaps in the UK literature, for instance, how well schemes work for older people from ethnic groups, gender roles and relationships in highly female environments, end-of-life care, who benefits most from housing with care (the fit and the frail), and quality of life in specific types of schemes (Croucher et al. 2006).

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3 This problem has been previously identified as the balance between low-level and high-level social care (Wanless Report, 2006)
Outcomes: Independence, choice and control for older people

Maintaining independence and decisional autonomy is vital to quality of life in long-term care. The Secretary of State for Health argued in 2002 that the resident’s capacity to exercise personal autonomy should be maximised in England (Secretary of State for Health, 2002). Long-term care must meet care needs of older people and enable them to have independence, greater choice and autonomy in their daily lives. Alternatives to residential care will favour older people’s decisional autonomy while considering their preferences and expectations.

Evidence about perceptions of choice by older people in institutional and non-institutional care settings in the United States is inconclusive (Hulicka et al. 1975, 1983). However, recent evidence in Northern Ireland has shown that older people living in residential care homes perceived themselves to have greater decisional autonomy in daily life than clients receiving domiciliary care in private households and in nursing homes. Indeed, the findings suggest that decisional autonomy is often constrained by the staff and by informal carers.

The generalisability of the findings may be limited to the characteristics of the residents: (i) the proportion of residents with physical and/or cognitive impairment and (ii) the residents’ level of ability or willingness to accept a degree of risk in daily life activities.

Further research is needed to explore the extent to which staff and informal carers support or enhance the decisional autonomy of older people in order to understand the levels of quality of life in residential or other non-institutional care settings.

Health and Social Care Integration: the development of intermediate care

As explained above, integration between health and social care services is critical to bring about the desired shift in services towards the main goals of prevention. In particular, integration has been focused around the difficulties of reducing delayed discharges from hospital and avoiding unnecessary admissions to it, especially of older and frail patients. Despite the emphasis on the development of ‘intermediate care’, policy documents state the difficulty underlying the shift from ‘partnership’ towards ‘integration’.

There is some evidence indicating that care schemes and housing with care might reduce demand on health services. For instance, an evaluation of the retirement community ‘Hartrigg Oaks’ shows that it allows early discharge from hospital and prevents hospital admission (Kingston et al. 2001).

Qualitative data of 214 residents in 45 residential and nursing homes, and 44 older people receiving domiciliary care in private households. Only 52% of residents in institutions and 30% of older people living in private households had a high level of decisional autonomy (Boyle, G., 2004).
An example of the need to integrate health and social care services is given by Challis et al. (2001), who studied care-management arrangements for older people and those with mental health problems in 131 local authorities. The authors concluded that at that time very few social services departments had a specialist care management service for older people. Although 97% of social services departments had a goal of providing alternatives to institutional care, only 5% has developed intensive care-management (e.g. a multidisciplinary assessment, the co-ordination of substantial health and social care inputs within a care plan, while adjusting provision as needs fluctuate due to physical and cognitive impairment) for older people (Challis et al. 2001). A clear suggestion is that linking intensive care-management in community-based care with secondary health care, such as geriatric medicine, might increase the effectiveness in promoting non-institutional care settings.

The discussion of rehabilitation for older people has been increasingly important in the debate about health and social care integration. Despite its importance, there is insufficient evidence to compare the effects of institutional care homes versus hospital environments or non-institutional environments on older people’s rehabilitation outcomes. Ward et al. (2008, 2009) reviewed the evidence studying older people with stroke and with fracture of neck of femur. Their findings suggest that more rigorous studies to compare the effects of different care settings are needed to inform decisions relating to older persons’ rehabilitation, for the following reasons: (i) the description and specification of the environment is often not clear, (ii) the components of the rehabilitation system within the given environments are not adequately specified and, (iii) little comparability between control and intervention sites.

Discussion

We conclude by summarising the overall findings of the review by offering some thoughts on recent evidence about prevention and alternatives to residential care, and reflecting on some of the gaps in the literature.

One of the main findings from this review is that, while policy in the UK places emphasis of pursuing choice, independence and prevention, the evidence base exploring those topics is still limited, but increasing.

Regarding preventive interventions, research has well documented the range of benefits of assistive/adaptive technologies. Despite methodological difficulties in analysing reductions in demand for health and social care services and measuring improvement in quality of life, studies have shown that adaptive technologies have net social benefits when implemented appropriately with no delays.
Another key finding is that the evidence on cost-effectiveness of alternatives to residential care is inconclusive. This is due at least partly to the difficulties in placing a value on the important contribution of informal carers. As explained previously, there is controversy regarding appropriate methods for costing informal care. Furthermore, while an important body of research is focused on exploring older people’s independence and decisional autonomy, once again, the cost-effectiveness analysis is inconclusive.

In summary, three important conclusions may be drawn from this review. First, community care settings can be considered cost-effective from a societal perspective in which the contribution of informal caregivers is taken into account. Second, reducing investment in low-level and preventative services as a measure to cut budgets may have a significant impact on future need for health and social care services, on costs to the state and to individuals, and on the quality of life of older people and their family members. Finally, further research is required, especially on the cost-effectiveness of a range of preventive measures and on the cost-effectiveness of a range of community care alternatives to residential care for older people with different levels of need.
References


