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## Royal Commission Secretariat meeting with PSSRU - evaluating community care for elderly people

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The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the United Kingdom Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas—including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three sites:

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**ROYAL COMMISSION SECRETARIAT  
MEETING WITH PSSRU**

**EVALUATING COMMUNITY CARE FOR  
ELDERLY PEOPLE ['ECCEP']**

Bleddyn Davies and José-Luis Fernández  
February 1998

**September 1996**

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## ROYAL COMMISSION SECRETARIAT MEETING WITH PSSRU

### EVALUATING COMMUNITY CARE FOR ELDERLY PEOPLE [‘ECCEP’]

ECCEP is the second stage of a before-after study of the community care of elderly people before and after the reforms.

This paper describes the study, outlines which outputs are scheduled to be available when, mentions some findings which relate to Royal Commission concerns. What can not be conveyed is the light which this substantial and rich data set throws on post-reform community care.

#### STUDY QUESTIONS AND DESIGN

##### Questions

One aim is to provide rich *description*. The kinds of description which it can provide will be unique among the research collections available during the next few years.

Currently, it is the only large collection for a cohort through time which combines two characteristics.

- It is based on depth interviews at more than one point in time focused on the *beliefs and rationales underlying action; need-related circumstances; perceptions of the experience of each stage of service and its effects*. The main emphasis is on richness through time, not sample size at a point in time. It is an attempt to dig beneath the few standard descriptive measures (and so lack of subtlety about causation and effects) which typify large sample studies, and to understand how patterns of resource utilisation, need-related circumstances, costs and outcomes reflect process, what drives process at the field level, and how processes relate to broader structures and policies.
- It is the only one based on the *three actors whose perceptions and interactions matter most* to who gets what and with what effect in the crucial stages of the community care career of those brokered by the social services departments: the users, the principal informal caregiver, and the care manager.

These characteristics gives it a rich potential for statistical description.

Secondly, it is designed to provide the basis for tackling two sets of *issues which dominate argument about equity and efficiency* and how to improve them.

- One is *targeting and patterns of utilisation*. The context of the policy argument of the period will be remembered. Targeting was one of the main policy slogans of the eighties and early nineties. The first stage of this before-after study suggested that some overstated their criticisms of utilisation patterns during the 1980s, but targeting criteria were vague. There was a bias in the development of the system, I had argued in *Matching Resources to Needs* (1986). The growth had been used for purposes other than to securing better matching of resources to needs at the individual level, far less a

better matching which improved efficiency. That is, there had been a neglect of the core tasks of care management and the incentive structures at that level.

We ask what are now the patterns of utilisation. To what degree are they defensible by the criteria suggested by care professional and 'ological argument, and equity and efficiency criteria developed from our knowledge of production relations.

- The second is the *productivity of services*<sup>1</sup>. Better targeting was to be associated with greater concentration of resources on those who could afford to contribute to the costs of their services, and those in greatest need. *Resources Needs and Outcomes* (1990), the book based on the before-stage of this study, argued that the 1989 white paper logic could fail to work because its policy of concentrating publicly-subsidised resources on relatively fewer would depend on substantial marginal productivities of the services for the outcomes which really matter. The analyses for the first stage of the before-after study suggested that most services had invisibly low marginal productivities for most recipients for most outcomes which mattered most to the success of the white paper policy. Our accounts of other countries showed this to be quite a common problem, though rarely conceptualised in that way.

We argued that the productivity of services depended on two factors. On the one hand, they depended partly on *the flexibility of the matching of the aims, skills, processes, timing of individual services to the individual needs and wishes of users and caregivers*. Individual services should become more flexible in their responses to individuals and one another's contributions. But such flexibility is easier to achieve by creating new supply organisations around new personnel, commitments, skills and values, than by changing these in existing organisations; particularly in a competitive environment. So authorities like Kent had run policies based on the belief that the flexibility of services could be improved by exposing them to competition and consumer power, the ideas being in circulation among a few as early as the mid 1970s. The argument surfaced during the mid 1980s. The emphasis on mixing the economy of care and on the enabling role of the ssd as regulator, commissioner, purchaser, broker and care management agencies did appear to distract from management focus on service development. There seemed to be little in the system to lead to the development of traditional services per se, little to teach the lessons of service developments in other countries. One example which we have studied is 'shelter-with-care' (Davies, 1998).

But, on the other hand, it depended on *mixing services in the best way*. *Resources Needs and Outcomes* (1990), the main book from the before-stage study, argued that both depended on the performance of care management tasks. There had to be the mechanism to provide service suppliers with the *incentives* to match resources to individual needs, and care management arrangements were among the most important of these at the individual level. And it was the performance of the core care management tasks which would provide the continuous matching of the service input mix to often changing situations.

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<sup>1</sup> By 'average productivity' of an input is met the average level of a 'final output', a benefit valued in its own right, associated with the amount of the input. By 'marginal productivity' is meant the increase in the level of the final output associated with an additional unit of the input.

So ECCEP is designed to investigate the productivities of services for a wide range of outcomes, to relate the productivities to the circumstances of individuals, to processes, to the influences on processes.

These two foci are illustrated in the transparency showing the operational aims of ECCEP. Transparency 1 (#538).

- Its first set of questions correspond to utilisation and productivities. The description is statistical, largely based on modelling
- The second set of questions links proximate causes to processes which influence the utilisation and productivities.
- The third is about the effects of broader factors
  - eg across areas, how local priorities, as described by the managers, affected the utilisation patterns etc
  - and across time. Eg (a) the new focus on targeting, and (b) the new focus on performing core tasks of care management

## Design

Transparency 2 (#785) summarises the design. The focus is the field level. That reflects the basic argument which has underlay two of the most established streams of PSSRU work on community care of the elderly, the development of budget-devolved care management in experiments launched between 1974 and 1985, and this evaluation programme: the developmental bias against putting in place the policies and arrangements to secure the matching of resources to needs at the individual level in a way which improved equity and made the most efficient use of public resources.

The core of the design is interviews with the three sets of persons: the users, their main informal caregivers, their care managers. The logic of our argument made us put these triads at the centre of our collection design. The whole study *looks in* at that world through the crucial set-up stages and during the subsequent six months, *looks out* from the triads at the service inputs and roles of the personnel of other field agencies and other caregivers, and *looks upwards* at the policies and structures of the ssds.

The numbers are not large. In design, the priority was given to richness through time rather than sample size. There is a vast amount of information for each user. Among the kinds of information are (a) need-related circumstances and perceptions of them, how they have evolved through time leading to first assessment; (b) beliefs and rationales underlying action, including, eg some of the values and opinions about the legitimacy of aspects of policy; (c) perceptions of the experience of each stage of service and service effects at each stage;

Other items complement the interviews with triads.

- Continuous tracking of gross needs, ssd and health resource utilisation until only a small proportion remain in the system.
- Monitoring of policy history through documents etc. There was intermediate based on interviews with managers in four of the authorities, reported in *From Vision to Reality in Community Care* (1997). So we have a fuller history of the decade prior to and including the early years of the reforms.

The comparison with a decade ago is aided by the features of a before-after design: seeking similar information from the same groups of actors in the same areas.

### **Planned production of publications**

There are two streams.

We are committed to a stream of *five descriptive reports* between now and the end of June. Their purpose is to make available the most interesting of the information about need-related circumstances, process, and effects. From these, we shall be developing one (perhaps more) monograph, but on a longer time scale.

The ECCEP results are being looked at in the context of the big national data bases, eg the 1995 GHS. But of course they have all those variables missing from GHS and the others which are fundamental to analysis at any level of generality; eg cognitive impairment, behavioural disturbance, depression and morale, the structures of the caregiving and social network, strain on caregivers, etc. ECCEP can relate these to the more subtle variables; for instance, relationships and attitudes.

Secondly, we are committed to report the detailed analysis of the two themes

- *Marginal productivities of service inputs for final outputs, marginal costs of outputs of value in their own right, the costs of target outcomes, the optimal allocations of inputs to achieve target outcomes, what outcome mixes are compatible with the budget given prices, how these vary between user circumstances and area systems.* The main types of models used are cost and production functions. Transparencies 3 and 4 (#424 and 425) describe the general form of these models and illustrate the questions which they answer.

We are scheduled to present a first report about seventeen production functions to the Department at the end of March. The work so far covers the usual issues of returns to scale, the complementarity and substitution of services. A second report is due at the end of June. It will handle joint supply, and use the results in optimisation models. Later work will fill out the analyses by relating these essentially descriptive results to the how and the why, and to take into account the longer-run consequences shown by our tracking.

- *The efficiency (given equity criteria) and 'ological defensibility of utilisation patterns.* One argument is that the research-based and other argument from 'ologies, the evidence-based knowledge and conventional wisdom among care professionals like geriatricians etc, create a prima facie case for believing that there are some factors to which utilisation should be responsive in a certain direction. But there are also other factors to which response is likely but undesirable; eg specific constraints on resources which cannot be justified by local policy prioritisation. The idea is described in Transparency 5 (#575). First, ECCEP is analysing the relative influence of indicators of differing degrees of defensibility.

Secondly, the cost and production functions will be used with utility functions the prices of inputs to construct optimisation models. These will give an external

criterion for efficiency. It will then be possible to contrast the observed with what the models suggest to be the most efficient pattern. It is hoped thus to generate interesting argument about what would be the most efficient degree of response to need-related circumstances; thus testing and adding precision to the insights from the ologies and care professions.

The equity criteria can be based on starkly different philosophical positions. One is that only broad disability, cognitive impairment and the behavioural disturbance of the individual should be considered as relevant to need. That is the implication of the criteria by which some schemes hand out indemnity benefits or service packages. The British assumption has been different. ECCEP is being used to consider the implications of adopting some of the individualised and narrower criteria applied elsewhere; for instance, in the Connecticut partnership, the Israeli LTCI scheme, some US State medicaid schemes, the second white paper on the British partnership proposals.

Again, a report is due by the end of June. We shall be hard pressed to produce the complex analyses and present them as intelligibly as is possible. So again, the work will continue. Again, it will be necessary to take into account the longer-run effects.

*Tightening before-after comparisons.* It will be important to make the before-after comparisons as rigorous as possible. That will require putting the two data bases together, computing similar variables from them both, producing statistical descriptions and modelling using the combined sets. It will be an opportunity lost if we do not use our large collection of historical material about the evolution of policy argument in the authorities over more than a decade. The comparisons will be made from the Autumn.

## **SOME FINDINGS AND ROYAL COMMISSION ISSUES**

The data base can produce work illuminating of many aspects of the Commission's work. What follows are brief comments on only some of the findings of potential importance. Transparency 6 (#786) lists them.

- *Marginal productivities of service inputs.* The results so far have been statistically stable. The models fit well for a list of some - perhaps most - of the most important outcomes by which one would evaluate the success of community care by the 1989 white paper and other criteria: extended care, two dimensions of morale, the reduction of stress on caregivers, the conferment of a sense of control over their own lives among users, the perceived ability to undertake tasks of daily living, satisfaction with services, satisfaction with the process by which the Set-Up phase processes of care management were conducted, what the users perceive to be shortfall in assistance with areas of living to which the social services relate, users' perception of the degree of improvement in the their capacities for performing activities of daily living, principal informal caregivers' satisfaction with the amount of help received to cope with their problems rather than for helping them to continue as caregiver. There are significant marginal productivities of service inputs for these and other outcomes.

We can not be sure that we are not seeing marginal productivities which were there, but to which a decade ago we were blind, although they then existed. But we do not believe that to be so. The search reported in *Resources Needs and Outcomes* (1990), and again in later modelling for *Community Services and the Production of Welfare* (forthcoming), would, we think, have revealed at least some of them.

If this apparent improvement is shown to be genuine, it an important success of the reform of community care.

- *The defensibility of patterns of utilisation.* At the level of the kind of variable, the responsiveness is much more to individual need-related circumstances than to the most indefensible factors; eg specific supply constraints. The modelling strategy tried to ensure that the ordering of the entry of groups of variables did not result in a bias towards the over-estimation of the defensible by first searching the more defensible and finally admitting the least defensible, and then by reversing the order of admission of variable groups. The results for groups are illustrated by Transparencies 7 and 8 (#783, #784). The patterns seem at first sight to be more defensible than those of a decade ago. If that result is confirmed, that, too, is an important success of the reforms.

We have not systematically worked through the reasons for these improvements. But two facts are striking from the *how* and *why* evidence.

- First, compared with the pre-reform period, our interviews with managers at all levels revealed what is a striking consistency of purpose within authorities, and to a lesser degree across authorities in what their managers at all levels saw to have been their authorities' priorities. What managers perceived appeared to influence the patterns. There was not this consistency during the mid 1980s. It was not then a purposefully-managed system of community care. That is much more the case now, even though authorities are at very different points in their absorption of the new ends and means, and we are observing how the local authority environment always has its fiscal and other shocks which can brutally derail excellent long-run development.
- Secondly, only a few progressive authorities systematically tackled the performance of the core care management tasks systematically in all their areas prior to the reforms. But from 1993 all were obliged to do so as well as they could, or face scathing reports from the Social Services Inspectorate and the Audit Commission. We have reservations about what care management policy and arrangements were implemented by the authorities. Few were conscious of the state of the art argument in even the national, far less international literature (Davies, 1992). Also, the lack of consistency in the way in which users and care managers and principal informal caregivers described need-related circumstances reinforce evidence from other evidence, some from other PSSRU projects, that assessment is too haphazard in coverage and imprecise in content - indeed, it appears unnecessarily amateur (Challis, Carpenter and Traske, 1996). Other factors would have played a part, particularly the growing emphasis on personal care, though that emphasis is partly a response to the pressure from performing the care management tasks. (The most rapid growth of the more innovative and flexible independent provision came too late to affect the crucial early stages of the career of the 1995 cohort.)



- '*Case particularism*' and '*perceived need complexity*'. At the level of the individual variable, it is striking how important are influences which are either special to minorities of cases, or which are more subtle need-related circumstances. Of particular interest is the degree to which the needs-determined variation is caught by the kind of reliable and relatively 'objective' variable which are preferred for use as the qualifying criteria in allocations in long-term care insurance policies, eg the number of personal care tasks with which the user has great difficulty or finds impossible. These account for a smaller part of the variation explained by need-related circumstances than other variables. Allocations respond to a wider range of variables, many of which are more subtle. First, as would be expected in the period of the Carers Act, caregivers' circumstances have great influence; but allocations in insurance systems focus on the disabled individual. But also, much of the variation is explained by the kind of variable which is the very opposite of 'objective', and about there is great opportunity for moral hazard. What we see is a mixture of '*case particularism*' and '*perceived need complexity*'. There are many areas of medicine, psychiatry, clinical psychology, the work of geriatric nurse practitioners and other arenas of the care professionals in which the practitioners claim the importance of case particularism and need complexity for their own caseloads - though they often deny it for others.

The analysis has worked through what difference it would make to apply various qualifying criteria from the international literature. Examples are the Clinton Plan, the Connecticut Partnership, the partnership white paper of 1987, the Israeli LTCI system. The results are summarised in two transparencies, Transparencies 9 and 10 (#733 and #717). The transparencies show the proportion of current users who would be excluded by alternative qualifying criteria based on the number of personal care tasks of daily living persons cannot perform without aid or supervision (ADLs), the number of household and other instrumental tasks which they cannot perform without aid or supervision (IADLs), cognitive impairment (CI) and behavioural disturbance (BD).

These results are a challenge. Can one so create effective partnerships in which insurance interests are combined with others in such a way as to be able to combine the relative subtlety and defensibility of current allocations, much improvable though they are, with the handling of moral hazard without creaming or adverse selection - and at the time reinforce and advance effectiveness and efficiency in supply?

One way forward may be an area monopolist SHMOs, Social/Health Maintenance Organisations, carve-out HMOs recruiting a wide risk pool, or LAMOs, carve-out HMOs for all persons in an area already with substantial care needs. The essence is that they are financially at risk, more than that premia play a big part in their income. (Income streams include specially risk-adjusted capitation payments and copayment.) Is the area SHMO, the LAMO, entirely incompatible with what may emerge from the NHS white paper's ideas for a primary care-led, area- focused, gp-commissioning NHS? The nature of the LAMO concept is that the care management, purchasing, and market management and quality regulation functions drive them, not the sale of insurance policies. Competition need not be absent from the area SHMO or LAMO, first because there can period contracts open to competition. The bigger the area, the less the Tibout effects and uncompensatable risks of adverse or favourable selection, though the lower the degree of effective competition: a main point of the HMO idea. Secondly, there can be ways of introducing choices of benefits additional to a national

or local minimum financed entirely by the LAMO, through individual and group policies which are so defined and regulated so as to reduce the risks of creaming or adverse selection. The Dutch have pursued this idea. Linked to ECCEP and has been the study of carve-out models for the high risk elderly, by visits and site discussions as well as by literature. The American literature about how carve-out models, and how 'managed care' treat those with chronic illness and handicaps is developing fast as the Administration has encouraged making managed care the basis of Medicaid.

Two groups in the PSSRU are building up expertise, the ECCEP group and the group on mental health economics. There has been work on carve-out managed care models for the elderly of the HMO and other types from their first emergence in the USA (Davies, 1986, Davies and Challis, 1986, Davies et al., 1990; Davies, 1992; Davies, 1994).

- *The marginal productivity of direct payments.* A grant from the Fondation de France allowed the partial replication of the first stage of the ECCEP study in four areas of France matched to ECCEP areas. In the absence of evidence from Germany, it is the best we have about the potential productivity of such benefits for narrow community care goals. It illustrates both the potential of an indemnity benefit of a direct payment type, and the consequences of having in the UK a community care benefit which is not analysed as part of the wider community care system. The French ACTP amounts to a community care benefit. Our estimates imply that the return from ACTP is much better than from attendance allowances, as judged by marginal effect on recipients of community-based services in matched French and English areas; though overall, the British system is more efficient in making admission of recipients less likely. The productivity curves for ACTP and attendance allowances are shown in Transparencies 11 and 12 (#458 and #459).

We have in this context followed through the new consumer-directed models in the USA, in the literature and by paying visits to discuss them with their managers and evaluators. Some flexibly fit the nature and degree of consumer direction to the need-related circumstances and wishes of the case. Subtle factors affect which elderly users want to undertake the direct mobilisation and management of their care. One conclusion is that mixed models allowing flexibility in what is handled by the consumer, and what by the care management agency, can have powerful advantages. But the experience of the consumer-directed models reveal the legal and administrative intricacies. It will be important to study the 'technology' and modus operandi they are developing. It will also be important to search for the consequences of the recruitment as paid helpers of relatives excluded under the terms of the British guidance on direct payments.

- *Multiple medical and social pathology and problems.* ECCEP confirms the large numbers of users with a range of medical, social, environmental and material problems. PSSRU has experimented with care management arrangements combined with the partial integration of health and social care personnel, with new divisions of labour within teams, but with clear, though multiple, accountabilities. Today's community care recruits many of those for whom coordination between health, social, and other care agencies can yield the highest returns (Davies, 1997).

However, the experience of attempting to secure a high degree integration through multi-disciplinary teams illustrates that except when they recruited the already-motivated to teams with exceptionally good leadership, the investment costs of making them work in the integrated way desired are high. They also have high running costs, as some of our ECCEP writings illustrates.

The approach being applied in ECCEP analysis is to attempt to estimate numbers and the circumstances with different degrees of need for immediacy of coordination, arguing that integration pays off best where the response times for action by those from other professions must be lowest for the gains to be made. Also, the community care costs of such diseases as clinical depression are to be linked with evidence about the potential for cure by costed psycho-socio-pharmaceutical treatment packages, to estimate rates of return from treatment. (For depression, for instance, Banerjee (1996), has shown a high success rate from such treatments.) The gains are only partly in the cure of the disease. Such diseases exacerbate others, and cause social care needs. It is hoped to undertake to make (albeit crude) estimates of these knock-on effects and so of the broader rates of return from treatment. That approach is to be contrasted with the wholesale introduction of integrative models on a large scale. To work through the argument, the ECCEP team is discussing collaborations with medical researchers. The ECCEP team is particularly looking at the success of various American models combining coordination of all areas of health with carve-out hmo-type financing mechanisms, some of the earlier literature reviews of these having been completed.

Linked with this is the attempt to establish risk factors for preventable deterioration. Recent meta-reviews suggest that their counterparts of five years ago failed to show the promise of approaches because they insufficiently distinguished the key prerequisites for impact. The improvement of early preventive interventions is of great importance for the generation of social care need, and the whole profile of change in healthy life expectancy, and so projections of demand, supply and costs of community care (Wittenberg, et al., 1998). ECCEP argument based on analysis and literature reviews remain at an early stage.

Linked also is the dismay generated by the pain caused by no longer serving some users who would have obtained service at the time of the first cohort, but who had been excluded by the time of the second cohort, partly in order to provide more costly packages, partly to cope with increased demand. This dismay is not supported with evidence about the productivity of interventions for those excluded. The reanalyses for the first cohort will allow us to describe precisely who no longer obtains service, and to estimate the productivities of the old style of service for them, indicating the risk factors which predict high probabilities within the group. Related, but not the same point, it was a finding from the reanalyses of the social care experiments in budget-devolved care management, the Kent Community Care Project and its replications, that the ratio of gains to costs from interventions tended to be higher among those who were least disabled (Davies and Chesterman, 1998). Again, the ECCEP analysis will attempt to reveal whether the types of case with high ratios of gains to costs in the KCCP and its replications are now excluded.

## CONCLUSIONS

The ECCEP collection is providing useful insights into post-reform community care, and of the effects of the changes of the last decade. With its focus on the three persons whose perceptions and interactions most count during the crucial stages of care-managed careers, the focus on beliefs and rationales underlying action; need-related circumstances; perceptions of the experience of each stage of service and its effects, and a design which looks out and up from these triads and follows them through time, it contains much information which the Royal Commission would not get from elsewhere.

The results already suggest conclusions of importance for the future of community care. First, there is the evidence of substantial service productivities, apparently a great advance during the last decade. Secondly, there is the defensibility of the patterns, again apparently much improved during the last decade, despite apparently serious inconsistencies in the perceptions of need-related circumstance by the different triad members reflecting what we suspect to be an amateurism in assessment practice. Thirdly, there is the issue of the prevalence of combinations of medical, social, and environmental pathology and problems, with still patchy coordination of health and social care. Fourthly, there is the evidence of case particularism and perceived need complexity and the possible consequences for equity and efficiency of applying the kind of crude and user-focused rules as minimal qualifying criteria and guides to the level of indemnity to be provided.

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