The economic imperative: Balancing quality and cost in the long-term care of elderly people

Martin Knapp

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THE ECONOMIC IMPERATIVE: BALANCING QUALITY AND COST IN THE LONG-TERM CARE OF ELDERLY PEOPLE

Martin Knap

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Today I have been reminded of a comment from Sir Alec Douglas-Home who said: `There are two problems in my life. The political ones are insoluble and the economic ones are incomprehensible.' Many of you here today would doubtless share the former Prime Minister's sentiments. The political philosopher Thomas Carlyle called economics the dismal science. It has also been dubbed the science of scarcity. Clearly economists are not in danger of collapsing under the weight of popular acclaim.

But a lot depends on how you approach a problem such as the role of economics. And it is clear from the discussions today that a lot depends on how we approach the problems of achieving quality care, and of balancing quality and costs. I therefore want to wander down some economic paths in these 20 minutes and hopefully bring some relevant information to your attention. I want to suggest that we don't simply see cost as a *constraint* on quality, but that we see costs - i.e. resources - as opportunities to enhance quality.

What is clear, despite its historically bad press, is that the demand for economics has multiplied many times over in recent years. This is especially true in relation to the planning, provision

and evaluation of services for elderly people.

Scarcity

What are the reasons for this increased interest in economics? What are the sources of demand? There are perhaps five basic demands:

Accountability - Economics is needed to inform the traditional matters of probity, regularity and accountability, as well as more recent emphases on clinical audit, quality assurance and other issues which we have been discussing today.

Policy - Economics is needed: to contribute to the pursuit of efficiency and effectiveness; for the pricing of, and contracting for services; for bottom-up needs-led planning etc. I will come back to the policy issues in a moment.

Product development - A third demand for health economics is in relation to product development. For example, pharmaceutical companies are increasingly being called upon to give cost-effectiveness as well as pharmacological justifications for their products. More generally and more relevantly economics is needed for the appreciation of the social consequences of new product developments, including new service arrangements.

Practice - Economics can contribute to the better organisation of care management, particularly where devolved budgets are concerned. Generally, economics can contribute to better awareness of the financial consequences of clinical and care practice decisions.

Research - Finally, there is a demand for economics `simply' to satisfy intellectual curiosity. There has always been a desire to explore new developments and to gain a more rounded view of care or treatment options.

But what lies behind these demands? The answer, not surprisingly and perhaps not cheerfully,

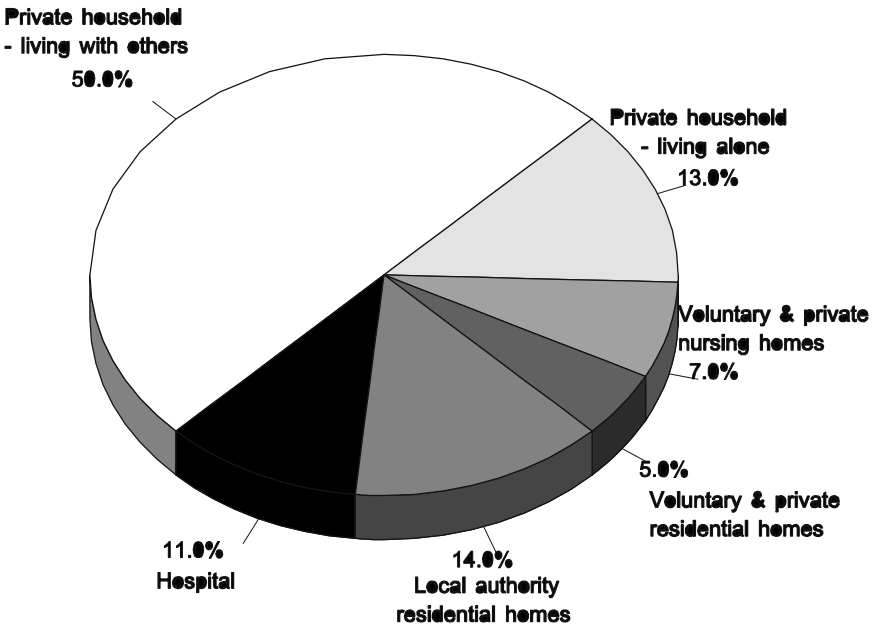
is scarcity.

There is scarcity in relation to just about everything associated with the long-term care of elderly people. Relative to what we want or what we think we need, there aren't enough geriatricians, social workers, community nurses. There aren't enough hours in a GP's day. There aren't enough domiciliary care services, day care places, drugs, or in-patient beds. There aren't even enough economists. The only things which perhaps may not be scarce any more - with attendant difficulty for the many people involved - are residential and nursing home places, which some people would argue to be *over*-supplied in some parts of the country.

And what causes this scarcity? The key influences include: public sector resource constraints; demographic trends; higher standards of care; and users' and carers' expectations of better quality care. I will not go into detail in relation to these things, but I am sure they will be familiar to you.

Thus, when we look at the balance of care for elderly people with dementia in England in 1991 (see figure 1), you will appreciate that there are pressures to increase provision in many of these service areas. The estimated 320,000 elderly people with dementia will grow more numerous every year for a couple of decades, and there will be pressure to improve the quality of support. I am certain that the pressure to obtain an economics perspective will continue to grow at least as fast.

Figure 1
Elderly people with dementia (England 1991): balance of care



Community care - new strategies

A particularly important consideration is that the policy context has changed enormously. This, too, will increase the demand for economics perspectives. The 1990 NHS and Community Care Act contained four core strategic dimensions of relevance to the long-term care of elderly people.

? The first strategic objective is to move the community care system away from supply-led to needs-led services. Services should be more sensitive and responsive to the needs and preferences of users and their carers. Thus care management is expected to promote greater responsiveness at the micro level. Better inter-agency planning and collaborative commissioning are examples - hopefully - of improved macro responsiveness.

? The second dimension concerns the balance between institutional and community care. Central government is encouraging LAs and the NHS to shift the emphasis away from institutions. Thus long-term hospital provision is being run down in favour of care in community settings, and the use of residential and nursing home care is being discouraged when good quality support can be provided in users' own homes.

? Third, there is encouragement for greater mixing of the `economy of care' - greater pluralism in provision (with greater roles for private and voluntary agencies), more systematic but hopefully better regulation of practice and quality, and (probably in the longer term) a greater variety of funding sources.

? Fourth, the government wants to alter the balance of decision-making and funding between the NHS and local government. Substantial additional purchasing power has been shifted from the DSS to local authorities, making it more difficult, for example, for health authorities to discharge hospital in-patients to nursing homes without their agreement and funding.

Cost information

In each case, the government wants the care system to move (seamlessly) from left to right. And in each case, there is a need to get the balance right between pursuing better quality and ensuring that we can afford the implications. `Getting the balance right' means pursuing certain criteria for the allocation of resources, most notably the criteria of efficiency, equity, effectiveness and economy.

How, then, can economics contribute to the pursuit of quality? Most non-economists I meet, when they learn of my profession, either assume that I am some kind of glorified accountant, or they immediately leap to the assumption that I am a rabid pro-marketeer. I rather hope that I am neither, but I am going to have to pander to the first of those particular prejudices by looking today mainly at costs. I also have to confess that I spend a sizeable proportion of my research time looking, with considerable interest, at the developing social care markets. I will not have time today to dwell on the latter, although my PSSRU and Nuffield Institute colleagues and I are uncovering some very interesting findings from our work - currently - in 25 English local authorities, with 80 P&V residential care homes, and with a slightly smaller number of domiciliary care providers.

It must be stressed that costs have a valid part to play. Ignore or discount them at your peril! There is, for example, little point in pursuing grand policy strategies or designing neat user-level care packages if you have no idea of the cost consequences. Planning in a costs vacuum is not daft; it is *irresponsible, and potentially dangerous*.

But once you look for costs you will probably find that decent costs information is rarely available, and certainly not as good in quality as we need for effective planning and practice. In constructing or using cost information, what principles should we adopt?

I would impress four basic principles upon you:

? comprehensiveness

? variations - explore and exploit

? like-with-like comparisons

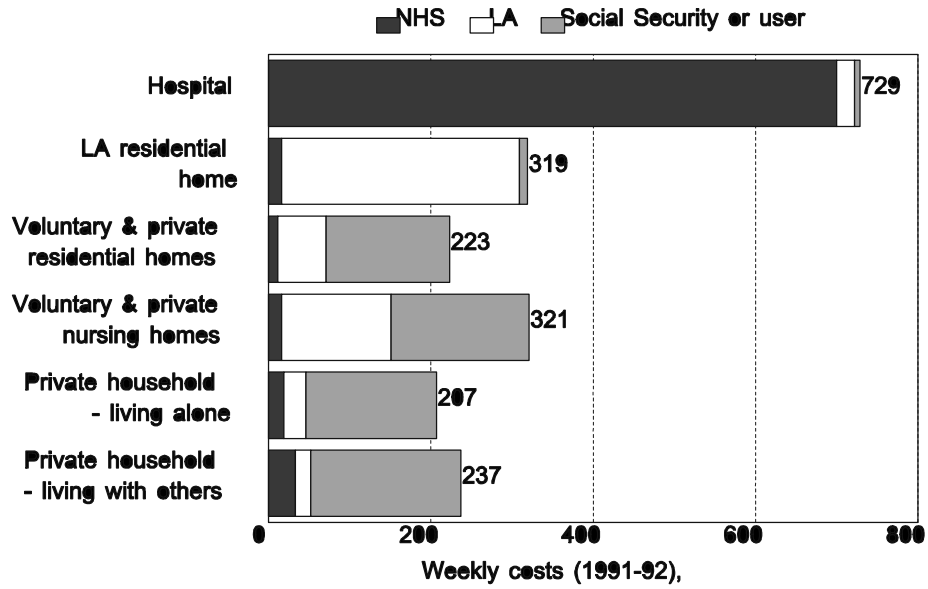
? integrate costs with outcomes

In setting these out, my aim is not to treat you like economics undergraduates, or to convert you all to economic evaluators, but to emphasise the desirable qualities which any utilisation of cost information should look for. That is, I want to help you to become critical users of, or commentators of the cost information provided to you by your finance departments, the research community, local and health authorities, central government, etc.

Comprehensive costs: The first principle is that costing should, where possible and where sensible, be comprehensive. That is, we should not allow policy and practice in, say, the health service to be influenced or directed *only* by information on health service costs, for we also need to know the cost implications for local authorities, the DSS, voluntary and private organisations, users and carers.

I can illustrate this with the balance of care for elderly people with dementia (figure 2). The slide shows the major contributions to different cost settings by each of the main agencies or funders. The slide has the post-1993 community care arrangements imposed on to the 1991 population figures.

Figure 2
Elderly people with dementia (England 1991): baseline costs



Variations - explore and exploit: No self-respecting geriatrician, nurse, social worker or care home manager would talk in terms of the `average user', so we should not allow our policy or practice discussions to be dominated by data on `average costs', even though this is a convenient starting point.

It costs very different amounts to support different elderly people, even in ostensibly similar care settings. These variations need to be recognised, analysed, interpreted and exploited. I cannot go into detail here, but any of you familiar with the PSSRU's research over the past 20 years will recognise this emphasis on the *individual* user, carer, care environment and relationship.

Like-with-like comparisons: Third, we need to ensure that like-with-like comparisons are made. We must not make silly comparisons of chalk and cheese. Too many cost statements that I come across - some from central government, some from other tiers of government, some from pressure groups - make comparisons which can at best be described as mistakenly erroneous, but which sometimes have the distinct whiff of wilful misinterpretation.

I am also reminded frequently of what another economist once called the Roman Emperor Fallacy (....). This relates to cost, outcome and quality comparisons of, for example, hospital or residential care with domiciliary-based options.

Integrate costs with outcomes: The final costing principle is to make sure that costs data are not viewed in isolation from outcomes data. It is helpful to illustrate my arguments here by offering you a little conceptual framework (figure 3). However, I am mindful of a definition which Ronald Reagan once offered: `An economist is someone who sees something working in practice and who then wonders if it will work in theory'. My point is that we need a sound theoretical base for any evaluation or policy argument.

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The production of welfare is an organising framework, not a piece of profound theorising, and one that is multi-disciplinary, not exclusive to economics. It summarises a complex set of linkages (not all identified in the diagram). It points to the non-resource inputs which get missed in most evaluations; and it points to the complex set of factors exerting an influence on quality of user and carer life, and quality of care. Generally, it is a helpful framework for pointing to the links between - the balance between - quality and costs.

Now, *of course* you cannot expect to have to run through the production of welfare framework every time you are pondering on how to intervene to provide support for a particular user. But I am regularly disappointed to discover how many decisions in relation to the care of elderly people are taken on the basis of so little information or on such narrow premises. Obviously there are occasions when there simply is not the time to consider every issue and aspect, but too many decisions are based on woolly, incomplete thinking.

Resource keys

If we approach the problem of balancing quality and cost by taking the wider view, and by taking notice of these four basic principles, we won't avoid the problems of scarcity, competing wants and needs, and the like. But I am prepared to wager that adherence to the principles in this broader-based approach will open up a *broader* range of policy and practice options for addressing scarcity, and for using our available resources to achieve quality outcomes for elderly people.

If I had another couple of hours I would at this point run through some of the key research findings which meet the criteria set out earlier for good costs information, and which provide us with pointers for the development of services for the long-term support of elderly people. Instead, I want to jump straight to my conclusions and reflect on what I would call the *resource keys* to successful care - keys which are suggested by available research findings and current experience. These are the keys which purchasers and others must turn if they are to achieve

better quality while maintaining a sensible balance with cost.

Resource adequacy: Spending more on the treatment and support of elderly people looks to be a safe starting point, for there clearly remain many unmet needs and inappropriate interventions. More and better service inputs appear to be needed from a range of professionals and agencies.

Resource adequacy is thus a fundamental resource key. However, there are - as we economists are boringly fond of reminding you - opportunity costs. What you spend on Peter you don't have available to spend on Paula. So, while it may be highly desirable to allocate more resources to the long-term care of elderly people, we must remember that this will take resources from elsewhere. Now it may be that `the elsewhere' is something we think, as a society, that we could well do without: do we need to keep another nuclear submarine in service; or a big pay rise for NHS managers, local authority social workers or university professors; or another income tax cut? In reality and locally the choices are stark and difficult: if we increase spending on this client group or service, what spending do we have to cut elsewhere and with damage to other user groups and services?

Anyway, resource adequacy is not enough on its own as a resource key.

Resource timeliness: The second resource key emphasises the need for the appropriate distribution of resources *over time*. When my colleagues and I in Canterbury were evaluating the Care in the Community Demonstration Programme in the mid 1980s it was clear that successful moves from long-term hospital care to life in a community setting was crucially dependent on having the right resources in place at the right time. And many LAs today are having difficulties shifting the balance of care away from residential and nursing homes in favour of domiciliary care because the domiciliary care providers are not yet in place.

Resource distribution: Improvements in the health and quality of life of elderly people and their carers is often the result, not of a single intervention by a single agency, but the cumulative or

combined effects of a range of health, social care, housing and other services. We must look at the funding balance, and maybe recommend the movement of resources from one agency to another.

Both traditional public sector `line budgets' and free-for-all market systems can create an unhelpful environment in which fragmented decisions are taken, not necessarily informed by the wider context. And the uneven distribution of costs and benefits between agencies and over time can create real disincentive problems. *Resource flexibility* - about which I will say no more on this occasion - is also essential.

Resource coordination: This leads naturally to the need for providers and purchasers to coordinate their plans with and between their agencies. That coordination is needed at the strategic (system) and tactical (case) levels.

? At the *strategic or system level*, coordination could range from needs-based planning (using and sharing epidemiological and service-based estimates of need) to collaborative - what we used to call joint - service planning and possibly collaborative purchasing.

? At the *tactical or case level*, a lot of attention is currently focused on care management, emphasising comprehensive needs assessment, client and carer participation, improved coordination of service responses and the monitoring of their impacts. But care management or other coordinating mechanisms cannot achieve all that is expected of them if they are launched into a local policy vacuum, or if there is a lack of inter-agency understanding, or no (single) point of access to the multi-agency system, or no powers to challenge poor service responses.

In setting out a strategy for improving quality we need to be turning *all* the keys - ensuring that resources are right in all of these respects.

A question of approach

I said at the beginning, when citing the bad press which economics has sometimes received that the solution you obtain rather depends on how you approach the problem. How we define, assess and assure quality, and whether we see costs as constraints or opportunities, depends on the approach taken. Let me therefore repeat - albeit with less eloquence - a tale told by Umberto Eco.

Two priests were kneeling next to each other in prayer. Suddenly, one priest lit up a cigarette. `You can't do that', said the other. `The bishop won't allow it. I should know, for I asked the bishop only the other day if I could smoke while praying, and he was horrified at the suggestion'. `Ah', said the other, in between deep puffs on his cigarette, `It is all a question of approach. *I* asked the bishop if I could pray while smoking'.

NOTES

rtin Knapp is Professor of the Economics of Social Care, Personal Social Services Research Unit, (PSSRU), versity of Kent at Canterbury and Professor of Health Economics and Director of the Centre for the nomics of Mental Health, Institute of Psychiatry, University of London. ***This presentation builds on a ber of current and recent PSSRU and CEMH research activities. Citations are not given in the text, but her details can be given if required. This paper is lodged as PSSRU Discussion Paper 1113.***