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Delivering effective social/long-term care to older people: why we must call in the debt

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Delivering Effective Social / Long Term Care to Older People

BLEDDYN DAVIES

INTRODUCTION

This chapter is primarily about achieving efficiency in pursuing ends from means, given equity. It discusses only some themes:

- The number, variety and complexity of evaluation criteria in the context of growing resource scarcity and efforts to clarify priorities and achieve greater efficiency.
- Emphasis on flexibly matching service inputs to outcomes and user circumstances through time. Boundaries between care modes have become less distinct, though some factors have excessively slowed the process of boundary erosion. (By a care mode is meant a set of services and resources, any combination of which can be used during one stage of a journey as a periodic or continuous recipient of care; for example, care in a care home providing its own hotel and care inputs.) There has been greater awareness that the effects on outcomes depend on service mixes and levels in ways which are mediated by user risks, needs and other circumstances. The concept 'targeting' has become more important but also more sophisticated, particularly in countries in which their governments are held responsible for achieving an efficient 'system' covering a high proportion of citizens. In some countries there is evidence of quick improvements in performance in important respects, though it may be difficult to maintain the rate as more difficult problems are engaged.
- To create greater flexibility, better performance of 'care management tasks', particularly assessment, monitoring and review, is needed. There is evidence that the emphasis on care management can contribute greatly. There has been more attention

to better management of transitions between and through need states and service modes. Though insufficiently, fitting care management arrangements to the circumstances of users, groups and system circumstances has occurred, with more application of concepts like 'chronic disease management' and boundary redefinition and crossing, and creation of jobs with skills better matched to needs.

- With greater explicitness and complexity of outcomes, attention to the opportunity costs of improvements in some and the form of losses in others, evidence being both from the comparison of the performance of countries and from research into the relations between service inputs and outcomes within countries. Clearer prioritisation is essential. Though relations between service inputs and outcomes can through time be improved, and there is scope for using resources more efficiently, against a background of rising demands, the main costs of improvements of one kind remain the other benefits forgone.

Entry themes – the first appearance of a new client – reflect common features in changes in care systems:

- A gestalt switch from assuming that need and user/caregiver wishes are relatively simple and uniform, and are appropriately met by a relatively narrow range of standardised services, to assumptions that needs and wishes are many, various and often complex, requiring requisite variety and complexity for a population with rising expectations. Policy values reflect ambitions of users and caregivers about autonomy and lifestyles. In consequence, there have been discussions (and in some countries the

introduction) of new forms of benefit payable to persons with long term care need, and of such policy principles as 'joined-up government' across 'policy silos', 'person-led' assessment and care planning, and 'carer-blind' service allocations.

- Attempts to develop home and community care arrangements allowing higher proportions of dependent persons to be supported with care in their own homes or in homely settings in the community (OECD, 1996).
- Changes in welfare mix associated with the shift from 'unicentric welfare systems dominated by state provision to more mixed forms in which state provision is explicitly integrated and balanced with private and informal sources', involving 'alterations in dominant ideologies of welfare in which traditional social rationales are expanded to include economic and market criteria' (Baldock and Evers, 1992; Kraan *et al.*, 1991).

Space allows discussion of only some implications.

POLICY EVALUATED BY A WIDER RANGE OF MORE COMPLEX OUTCOMES

Conceptualisation of and research on the newly prioritised outcomes occurred before policy reforms gathered momentum in the US and UK, and was to varying degrees reflected in evaluations of leading experiments like the US long term care channeling demonstration and the UK Kent Community Care Project and its descendants. In contrast, the evaluative criterion primarily used by policymakers was 'cost reduction or neutrality accompanied by user/carer benefits'. Understanding the more complex outcomes made that criterion seem narrow, trapped into a discourse dominated by agency interests, distracting attention from key issues and policy possibilities.

Other developments have been to:

- Complement indicators of broad and ultimate outcomes of the whole intervention with indicators of narrow and immediate effects of each service; for instance, Geron *et al.* (2000).
- Elaborate routine systems with individualised data for users linking outcome measurement with financing, quality improvement, policy and practice analysis, and practice and practice management themselves. Perhaps the most impressive is the Minimum Data Set / Resident Assessment Instrument (RAI-MDS), the product of vast investment since the late

seventies. It does not meet all needs. It does not directly ascertain user and carer satisfaction with service, does not collect certain kinds of information affecting users' and carers' subjective perceptions of services, and it demands a high degree of investment and commitment at all levels to implement and continue to operate carefully for the data to be of high quality.

- Increasingly seek to rehabilitate and re-enable as well as partially to compensate for disability. The assumptive worlds of social and some healthcare services have been dominated by attempting to compensate for functional disabilities. For many mainstream users, the assumption dominated policy for targeting, the source and nature of information sought in assessments (within the UK, little information or input from health professions), sectoral and so professional autarchy in care planning, in the performance of service (for instance, quickly doing tasks for the users as compared with slowly teaching and helping the user to become more independent). In the UK and US, the increasing pressure on public budgets since the mid seventies was accompanied by a contraction of activity on less essential tasks, and a shift of resources away from persons at lower risk of catastrophic outcomes or admission to institutions of long term care (Davies *et al.*, 2000; Estes, 2000; Estes and Swann, 1993). The reforms made the UK system highly efficient in targeting those at high risk of admission, and effective in reducing their use of care homes by providing home care. But it had not achieved the kind of coordination, cooperation, collaboration or structural integration which would make health and social care services and other resources complementary and produce a better balance of therapeutic and compensatory needs (Davies *et al.*, 2000). From the late 1990s, however, integration has been highly prioritised and powerful incentives created to improve it (Department of Health, 1998). Despite differences in institutional context, the US also faces some of the same challenges in rebalancing and more effectively combining compensatory and therapeutic outcomes, and in integrating social and healthcare skills and resources to do so (R. A. Kane, 1995, 1999).

SERVICE INPUTS, NEEDS AND OUTCOMES

Research on the influence of variations in service quantities and mixes on outcomes has been

developed to complement comparisons of the impact of models overall. Results confirm that, as with most other personal services aimed at complex outcomes, variations in user circumstances have great influence on the states which services are aimed to modify, and that the impact of similar service depends greatly on these circumstances. Therefore, matching resources, and how they are used, to user circumstances is key to equity and efficiency. For that, account must be taken of the substitutability and complementarity of services, and service 'productivities' (the outcome produced with different service levels), specifically 'marginal productivities' (additional benefit from additional input), for each important outcome in relation to their prices.

The earliest British productivity studies illustrated the need for better matching of resources to needs at the individual level (Davies *et al.*, 1990). Services were not matched to needs, so any marginal productivities tended to be too low to be estimable. A decade later, after five years of reform, the pattern had changed (Davies *et al.*, 2000). There were productivity effects for a wide range of outcomes: approximately 100 effects for seven broadly defined services ('home care', 'day care' and others) for seventeen benefits for users and carers of direct evaluative importance: 'final outputs'.

The productivity effects reflect the complexity which theoreticians postulate and practitioners observe:

- Many individual circumstances mediate relationships between service levels and outputs.
- The additional inputs to require increased benefits of some kinds depend on the level of other benefits achieved.
- Often, one of several services can be used instead of others to produce a benefit; that is, many are often to a substantial degree 'substitutable' for other services. It had been argued that potential substitutability is one of the most important features of the relations between ends and means in community-based care (Davies and Challis, 1986). Because of it, big gains can be made by choosing the most efficient service combinations for the circumstances. Conversely, failure to adjust service mixes to different prioritisations of benefits costs a great deal in benefits forgone by users and carers. This is shown by simulations of service mixes which by maximising one output create 'collateral' losses in the level of other benefits.

Costly also is the failure to adjust to differences in circumstances with respect to relative prices and availability of services. Some services seem under-utilised in relation to others. In particular, day and respite care appear to be under-utilised. Home care appears to be relatively over-utilised compared with newer services. Where the estimates of marginal productivities varied substantially with service levels, it was more common for higher service levels to be associated with lower marginal service productivities for home and day care – a situation described by economists as 'diminishing returns'.

The combined impact of the effects suggested that services conferred large and widespread benefits on users and informal carers. Effects are well summarised by two performance indicators for each benefit. One, the *Risk Offset of Productivity Proportion [ROPP]*, measures the degree to which the effects of risk/need factors are offset by service impacts. Its rationale is that the principal objective is to offset the consequences of risk factors. The other, the *Cover of Productivity Proportion [COPP]*, measures the proportion of the entire sample affected by the productivity effects. Service impacts in the UK estimated that ROPPs were 18 per cent or higher for seven important benefits, including the number of additional days spent at home rather than in residential homes (32 per cent); the indicator of the reduction in the felt burden of caregiving among principal informal carers (25 per cent); the indicator of users' increased sense of empowerment over daily living (24 per cent); improvements in personal care and household care due to service inputs ascribed by the user to the service impacts (22 and 23 per cent); and the degree of satisfaction of the user with the level of service being received (18 per cent). Other significant effects are for socialisation and intra-familial relationships.

Research with the same objectives has been advocated by leading scholars in the US; see, for instance, Weissert *et al.* (2003), and authors in the *Journal of Ageing and Health*, volume 11, number 3.

IMPACTS OF CARE MANAGEMENT INPUTS

Non-comparable designs usually make it difficult to infer the effects of improved care management from independent studies from periods before and

after major changes in care systems. In England, the reforms announced in 1989 intended to make the better performance of care management the 'cornerstone' of a logic involving other changes radically affecting every aspect of the system (Department of Health, 1989). A study conducted from 1985 replicated after the reforms a conclusion reached by the Department of Health on the basis of its inspections and reviews of the evidence: 'this focus on individual care management, focused towards helping more people to live in their own homes, was the key change to the system' (Department of Health, 1998; Davies *et al.*, 2000).

Most of the earlier studies were single experiments in the US, UK and Canada. The results were extensively analysed (Applebaum and Austin, 1989; Davies and Challis, 1986; Hughes, 1988; Kemper *et al.*, 1987; Weissert, 1990; Weissert *et al.*, 1988; Weissert and Hedrick, 1994). By the evaluative criteria set by the funding agencies, results for most of these highly diverse projects were disappointing, partly because of the designs of the collections and analyses, partly because of 'implementation gaps', partly because of weaknesses in model logics. It was difficult to infer the effects of care management itself from most of the early projects.

However there were clear lessons.

- The key mechanism, the substitution of home and community services for nursing homes, could work only for populations at high risk of substantial nursing home use, so targeting was key. Targeted users not only had to have disability-related circumstances increasing the probability of nursing home use but also be at high risk of utilisation for a range of other reasons. UK experiments focused on substituting for residential care worked better partly because targeting reflected a wider range of the predictors of admission to care homes, and partly because their logic was more systematically based on creating incentives at the field level to make support arrangements more flexible and more responsive to costs and benefits (Davies and Challis, 1986). The importance of incentives was also recognised by American analysts (Weissert, 1990). A UK study based on pooled social services and health service budgets was clearly successful because of successful targeting and its use of workers combining health and social care functions in flexible support patterns, though partly because of the high unit cost of long-stay hospitals compared

with what was shortly to become their direct equivalent, nursing homes (Challis *et al.*, 1995).

- Care managers particularly need incentives, information, and frameworks helping to optimise the balance between service productivities and prices. For instance, reanalysis of the channelling project data suggested that the project seriously lost efficiency because its packages contained excessive quantities of social home care and insufficient inputs of home healthcare (Davies, 1992; Greene *et al.*, 1993).
- Patterns of demand generated by care managers were more likely to provide strong incentives to providers and others to adjust their supply and other aspects of their behaviour when the care management arrangements channelled a substantial proportion of total demand, were expected to endure, and when there were mechanisms for informing managers and providing agencies about the patterns created by care-managed demand, care managers' perceptions about unmet and inefficiently or inappropriately met needs because of the absence of services, care managers' observations reflecting shortfalls in quality, and the like.

The early projects financed by the Australian Community Options Programme added other lessons, many compatible with earlier American and British experience and comparative and meta-analysis (Capitman, 1985). In particular, the Australian initiatives show the influence of project context – for instance, project 'auspices' (Department of Health, Housing and Human Services 1992).

The presence of care management arrangements is now so much part of the wallpaper that in many programmes it is the substantive innovations and general features of the setting (like the style of chronic disease management) which are emphasised, though the performance of care management tasks in ways complementing the other scheme inputs is clearly key to their success.

WITHIN-PROGRAMME MATCHING OF CARE MANAGEMENT INPUTS TO USER CIRCUMSTANCES, SYSTEM CHARACTERISTICS AND PRIORITISED OUTCOMES

Like other services, the productivity of care management is contingent on users' need-related

circumstances and risks. Therefore the quantity and nature of care management must be matched to user needs, and balanced well with other inputs.

Except for relatively homogeneous caseloads and programmes whose teams face similar case mixes, there is a risk of inequity and inefficiency if the only mechanism for the matching is at the team level in the context of informal policy, without the support of an agency- and/or system-wide policy framework and mechanisms to adjust resources to enable them to be applied. Some American programmes have formal triaging mechanisms for intensive care management. Examples are programmes of care management by insurance companies for high-cost users due to chronically disabling conditions, and a few Medicaid programmes, such as Ohio's PASSPORT program (Diwan, 1999; Kunkel and Scala, 1998).

English social care management to a greater extent matches the time intensity and professional background of care managers to user circumstances. National policy guidance set out a series of 'levels' defined in these terms.

- There is great and arguably excessive local variety at the intra-authority as well as inter-authority levels (Challis *et al.*, 2002; Weiner *et al.*, 2002).
- Despite the wide area variations, the system overall is well described as providing the three levels hypothesised in reports of the Social Service Inspectorate in the late nineties (Laming, 1997): a more intensive level where the care manager is fully professionally qualified and engaged wholly on care management and complementary casework tasks; a coordinative level, providing on average fewer hours of care management input by workers who are often not fully professionally qualified and combine care management with other service-management tasks; and an 'administrative' level, in which there is virtually no face-to-face contact.
- Users are matched to level on the basis of aspects of complexity arguably associated with differences in the productivities of different levels, but the matching is loose, with great variation between teams and larger areas in the probabilities of users being matched to the higher level.
- The main effects of care management inputs are 'indirect' rather than 'direct': on what is produced from the other services, not what is directly produced by the care management itself. Indirect effects have always been argued to be the highest common factor

in the rationale for care management development (Davies, 1992).

- Care management inputs during the Set-Up phase of the care-managed career appear to be under-provided relative to services over the whole of the users' career; that is, the ratio of marginal productivities of the case-appropriate level of care management inputs during the Set-Up phase to prices is higher than the ratios of marginal productivities to prices for service inputs.
- Productivities of intensive care management are highest for more complex cases irrespective of the level of inputs. Productivities of coordinative care management are higher for other users. Greater care management inputs are associated with improved outcomes up to the average number of hours of input. Beyond that, the gains seem to be slight, and indeed may actually diminish. In contrast, the productivity curves for coordinative care management suggest increasing marginal productivities with larger inputs. Therefore, it is important to ensure that the increased resources to intensive care management should be more than matched by increased resources to coordinative care management, given the increasing marginal productivities and that the numbers receiving each level might well need to be roughly equal, though there are features of the dynamics of allocation in social services departments which might result in the opposite. (Davies and Fernandez, 2004).

The English national government have produced and are attempting to secure the local implementation of improvements in care management around a 'Single Assessment Process' in the context of a National Service Framework for elderly people. Matching care management arrangements to user circumstances is intended to become more flexible through time, reducing the effects of initial errors in allocation; and more flexible at a point in time with respect to professionals' inputs and responsibilities. (Coordination across professional and agency boundaries is much more powerfully an objective of the NSF and the SAP than it was of the reform policy of the early nineties.)

DISCUSSION

This chapter has mentioned only some strands.

- *Targeting is key.* First, good targeting requires both that those allocated resources have benefits which are great compared with the costs – ‘vertical target efficiency’ – and that those for whom the benefits are great compared with the costs are allocated resources – ‘horizontal target efficiency’ (Bebbington and Davies, 1983; Davies, 1981; Davies *et al.*, 1990). Perhaps UK reforms initially, and many US programmes, focused too little on the latter. Secondly, targeting concepts and definitions should reflect the number, variety and complexity of aims and the variety of risks and needs and service characteristics affecting the relationship between service levels and mixes and the achievement of the aims. Crude screening criteria are inadequate for the full task. Targeting criteria must make allocations reflect user variations in risks, needs, likely service effects on the risks and needs, and the relative value of the different benefits (Davies and Challis, 1986; Davies *et al.*, 2000; Weissert, 1990; Weissert *et al.*, 2003). That insight is reflected in changes in processes in, for instance, the French Allocation Personnalisée d’Autonomie and Australian assessment.
- *Adapting systems to present appropriate incentives for equity and efficiency, and provide conditions for them to work.* Despite the role of incentives argument in influential projects, English policy agencies have rarely made these logics key to what is put into effect. Incentivisation was the basis of the logic for the design of care management arrangements, some arrangements whose rationale was incentivisation were recommended in national policy guidance, but field agencies often did not introduce them. That there is much unfulfilled potential in the emphasis on care management and commissioning of services – including to at least some degree shortfalls in service supply – is to a great extent due to the absence of incentives logics of requisite sophistication for the contexts. American managed care models are based on the incentives argument. Disappointment with the performance of most programmes, including those for persons dually eligible for Medicare and Medicaid, illustrates how difficult it is to base design on realistic causal argument as well as to secure implementation of all the model features essential to make the causal processes operate (Kane *et al.*, 2003).
- *Recognising the dilemmas but potential gains from ‘consumer-directed’ ‘direct payment’ models.* In the US, important elements of their rationale are the efficiency-improving consequences of additional

flexibility at the case level, together with savings on intensive care management and matching to individual needs and wishes (Doty *et al.*, 1996). Evaluations continue to show that some fears have been exaggerated and most show gains of certain kinds, implying that cash and counselling models are an important alternative for some. Evidence confirms prior expectations about the targeting patterns likely to yield the greatest gains, but actually achieving the most successful pattern of utilisation is not straightforward. The problem could be worse where a choice between a consumer-directed and a ‘professional’ model is stark, allowing selection of only some areas or aspects and tasks for self-direction, and where changes in the sphere of self-direction cannot be adapted flexibly through time. The very differences in perspectives between professionals and lay users which contribute to the gains illustrate differences in judgements about the consequences of alternative courses of action, and no one group has a monopoly of prescience. The effect may be a loss with respect to some benefits – for instance, less undesired use of institutions for long term care – not because the user deliberately chooses that loss, but because of misjudgements. Also many consumer-directed models around the world imply very different – and in some respects less sophisticated – equity criteria than those defined in the reform visions in countries who initially chose different financing and delivery models.

There will be immense and continually changing challenges. Studies of service productivities which simulate the consequences of alternative prioritisations of outcome illustrate that what we face are so often prioritisation dilemmas, not problems capable of solution by superior efficiency and improved technique, though it is easy to neglect the latter in the passionate advocacy of the former (Davies *et al.*, 2000). What is at first glance attractive to citizens and politicians in its beguiling simplicity may actually contribute less to welfare than a complex system balancing many criteria and using a wide repertoire of financing and delivery models.

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