



# The economic case for community-based care

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# Outline

1. Making the economic case for community-based care
2. Crystallizing the case for de-institutionalisation: economic evidence
3. Looking to the past and the future of care for older people
4. Shaping care systems to enable people to live at home as long as they wish

# 1. Making the economic case for community-based care

# What can community-based care do?

## Functions from the perspective of individuals

- Care coordination
- Long-Term Care “assistive care” services:
  - *Personal care*: support with limitations in Activities of Daily Living: bathing or showering, dressing, eating, getting into and out of bed or chairs, using the toilet, walking short distances, continence care
  - *Nutrition and household management*: support with limitations in Instrumental Activities of Daily Living: shopping, preparing and serving meals, managing medication, house cleaning and maintenance, managing money and bills
  - *Support for wellbeing and social participation*: transportation, psychological counselling, facilitated peer-to-peer support, facilitating activities that support well-being and encourage social and community engagement
- Long-Term Care “health” home care:
  - Preventative care, disease management, rehabilitation, palliative care
- Support for unpaid (family) carers:
  - information and skills, reducing burden through formal care and specific respite services, measures to mitigate detrimental health and wellbeing effects.

# Community vs institutions

What can economics tell us?



# Cost-effectiveness: comparing outcomes and costs

- An intervention, service, treatment, care approach... is cost-effective when, compared to another has:
  - **Lower costs for the same improvement in outcomes**
- Is community-based or residential care more cost-effective? Not easy because costs and outcomes:
  - Are not easy to **measure** properly
  - **Range** of costs and outcomes considered needs to be identical (particularly difficult to include all the community-based costs due to fragmentation, family care input often not counted)
  - Need to compare fairly the **characteristics** of the persons living in residential vs domiciliary settings, differences in strengths, needs and preferences
  - Costs and outcomes may be very different for some groups, even if “on average” we might see fewer **differences**





# What are the outcomes we should measure for long-term care?

- Broadly defined as quality of life
- We can use care-specific instruments such as ASCOT that consider 8 domains, based on extensive consultation with persons with care needs:
  - Personal cleanliness and comfort
  - Food and drink
  - Safety
  - Clean and comfortable accommodation
  - Social participation and involvement
  - Control over daily living
  - Occupation
  - Dignity
- And consider the outcomes for family carers

More about ASCOT: <https://www.pssru.ac.uk/ascot/>

## 2. Crystallizing the the case for deinstitutionalisation: overview of economic evidence



## Crystallising the Case for Deinstitutionalisation:

COVID-19 and the Experiences of Persons  
with Disabilities

Martin Knapp, Eva Cyhlarova, Adelina Comas-Herrera,  
Klara Lorenz-Dant

Commissioned by former UN  
Special Rapporteur on the  
Rights of Persons with  
Disabilities  
Published May 2021

# Crystallising the Case for deinstitutionalisation

What is the situation today in relation to  
institutionalisation of persons with disabilities and  
older persons?

What has been the impact of COVID-19 on  
institutional care? How have governments  
responded?

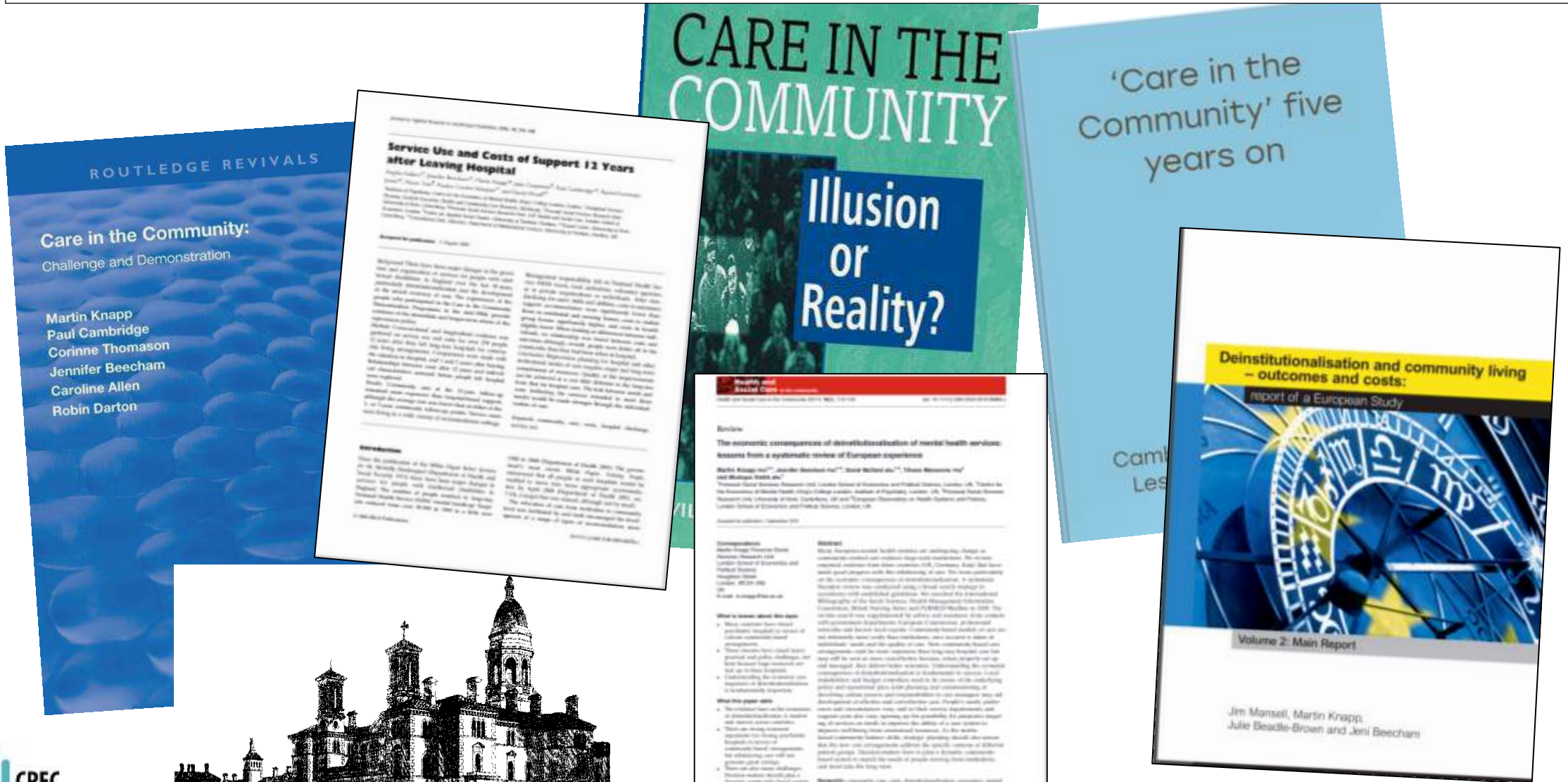
What are the arguments for deinstitutionalisation?

What policy and other measures can be and are  
being taken to shift the balance of support from  
institutional care to community-based services?

Knapp, Cyhlarova, Comas-Herrera,  
Lorenz-Dant *CPEC report 2021*

[https://www.lse.ac.uk/cpec/assets/documents/  
CPEC-Covid-Desinstitutionalisation.pdf](https://www.lse.ac.uk/cpec/assets/documents/CPEC-Covid-Desinstitutionalisation.pdf)

# Building on 40 years of research on deinstitutionalisation



# Effects of COVID-19 in care homes (*across most countries*)

LTC Covid website



<https://ltccovid.org/>

- Inadequate protection from the virus – high infection rates
- High death rates
- Restrictions on visitors
- Denial of access to health care
- Denial of access to community activities
- Constraints on movement *within* settings – enforced isolation

# Economic evidence?

## Summary for mental illness / psychosocial disabilities

“The evidence from deinstitutionalisation in **high-income countries** is unequivocal – when hospital closure programmes have been done reasonably well, and not used as a reason to reduce the overall mental health budget, the overall **quality of life, satisfaction, and met needs** of people with long-term mental disorders who move from hospital to community care is improved.”



“In terms of the **overall global picture** regarding deinstitutionalisation, community-based models of care **are not inherently more costly** than institutions, once the needs of individuals and the quality of care are taken into account. “

# 3. Looking to the past and the future of care for older people

National experiences



# Looking back to look forward



# Projections made in 2001 on the future number of people in care homes in England

	2000	2010	2020
Demographic base case	400,500	429,000	493,000
Assumptions based on a “shift” to community care	400,500	406,000	447,000

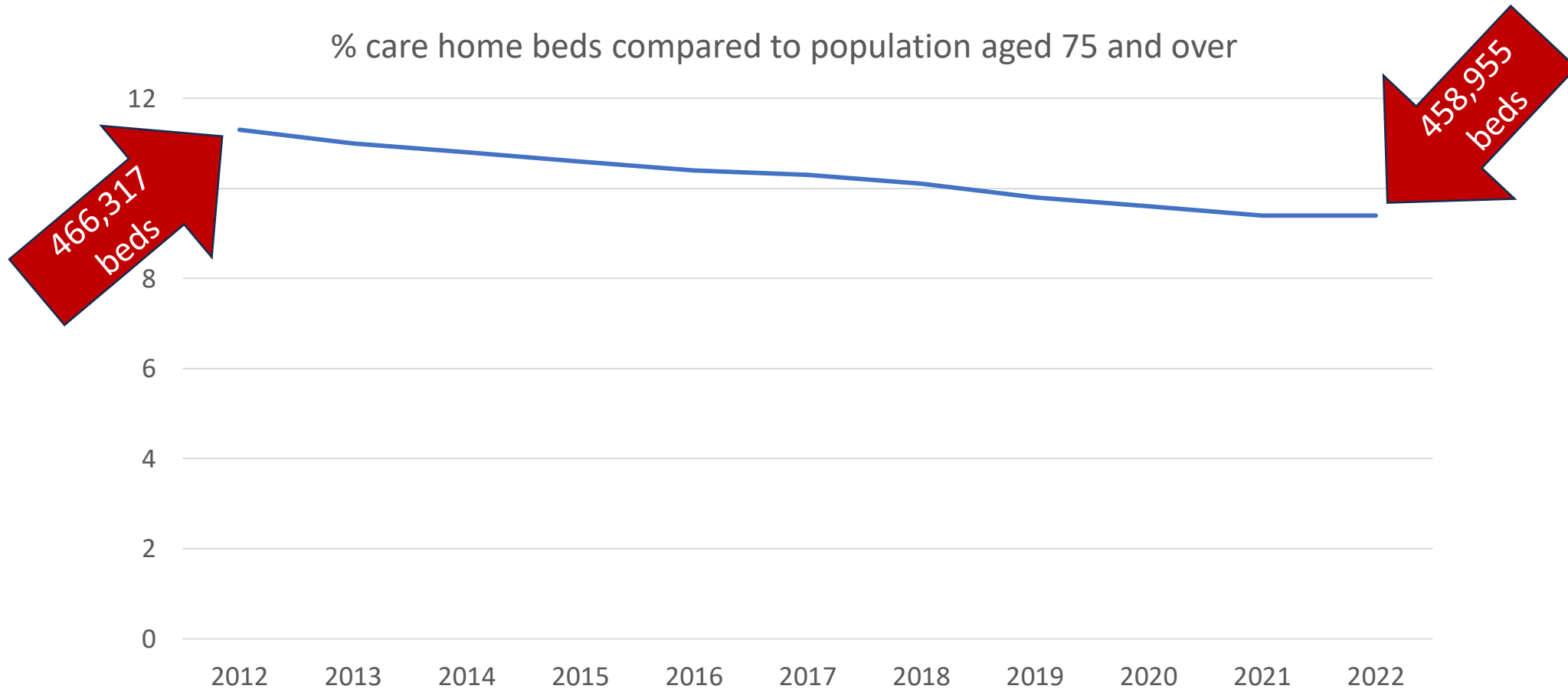
Source: Comas-Herrera A, Wittenberg R and Pickard L (2001) Projections of demand for residential care for older people in England to 2020. PSSRU Discussion paper 1719. <https://www.pssru.ac.uk/pub/dp1719.pdf>





# What did actually happen?

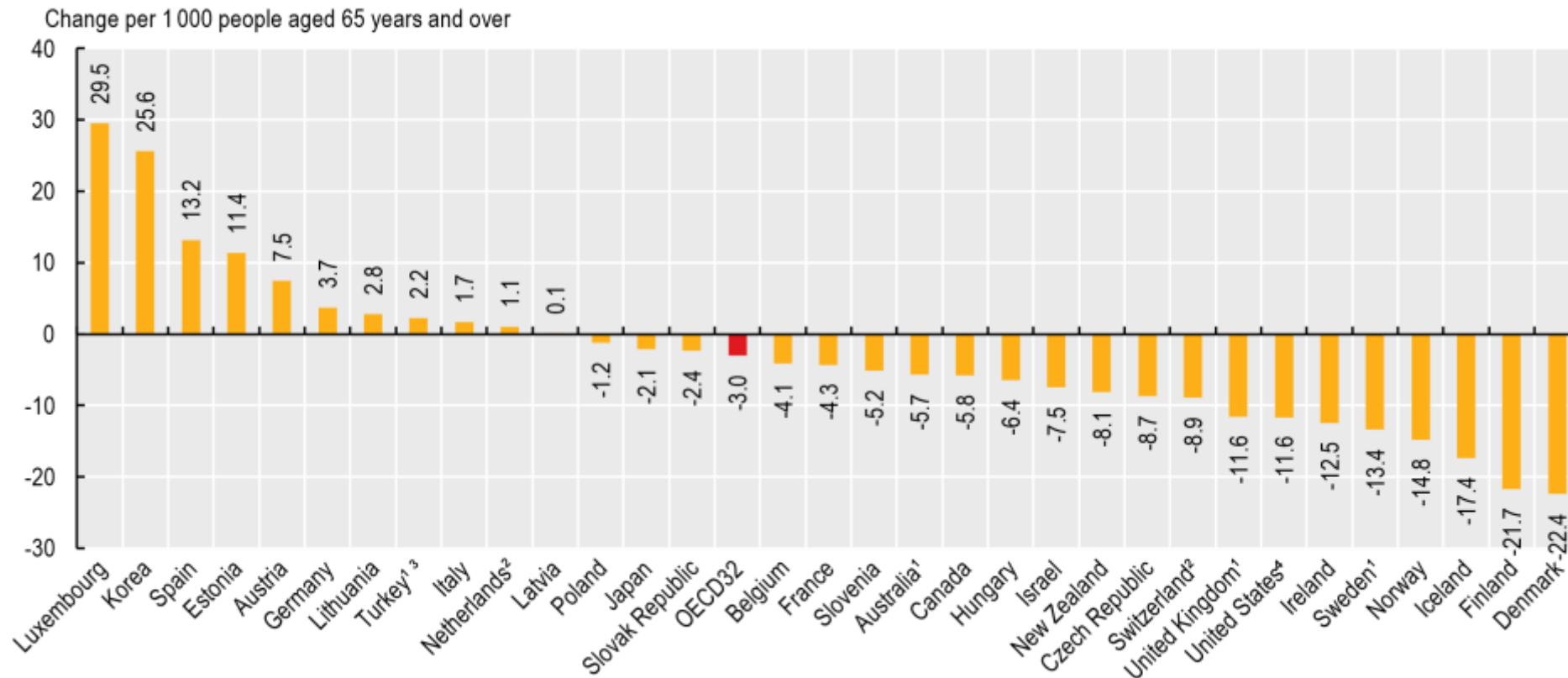
# Decline in the number of care home beds in England (2012 to 2022)



Source: <https://www.nuffieldtrust.org.uk/resource/care-home-bed-availability>

# International context: a move away from institutional care

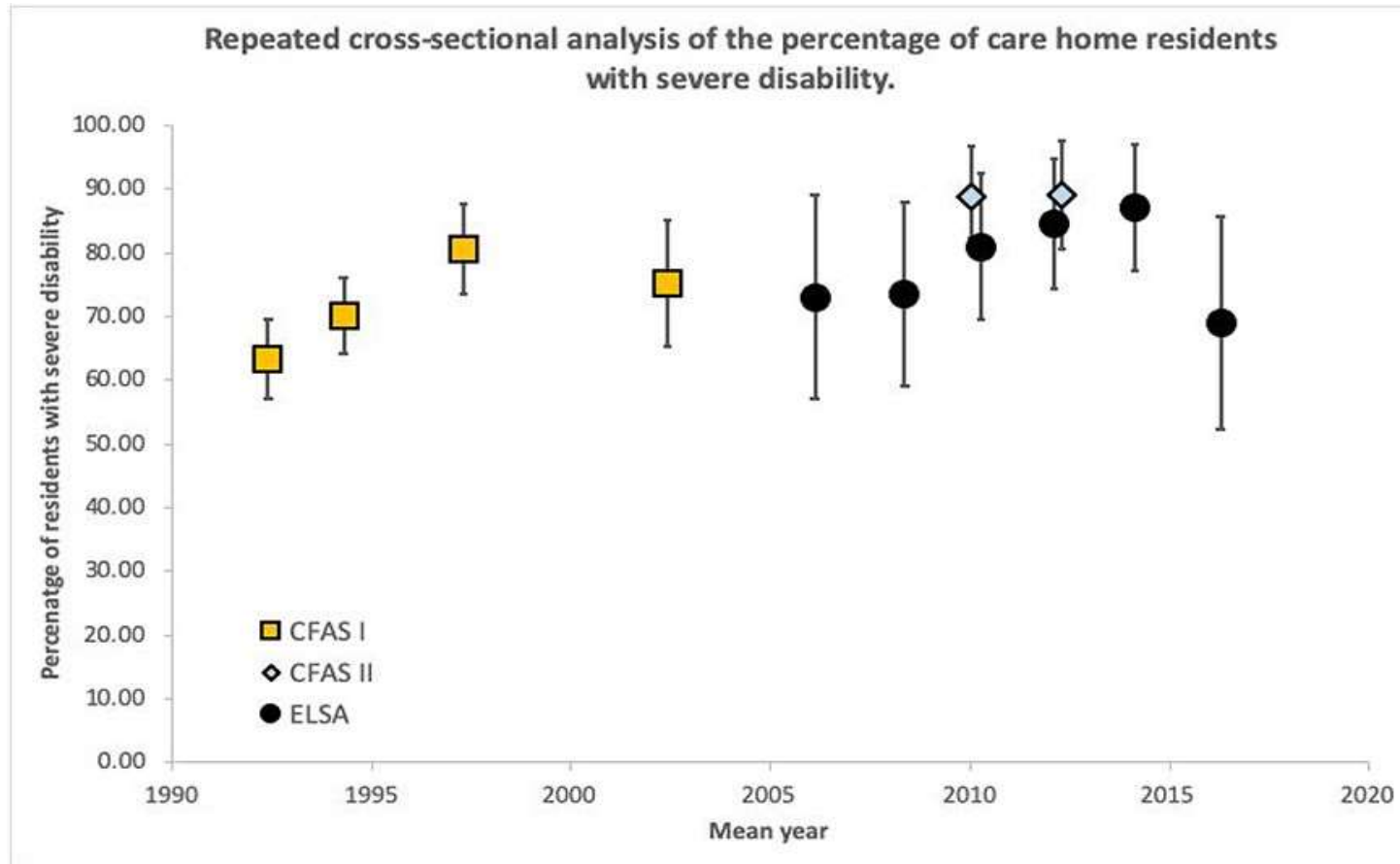
Trends in long-term care beds in institutions and hospitals, 2009-19 (or nearest year), OECD



<https://www.oecd-ilibrary.org/sites/b1410379-en/index.html?itemId=/content/component/b1410379-en>

## How? Care homes became used, increasingly, by people with the highest levels of dependency

Prevalence of severe disability amongst care home residents from 1992 to 2016 in CFASI/II and ELSA studies



Findings:  
Between 1992 and 2016, the share of care home residents in England and Wales with severe dependency increased from 63% to 87%

# An important piece of the puzzle: housing with care

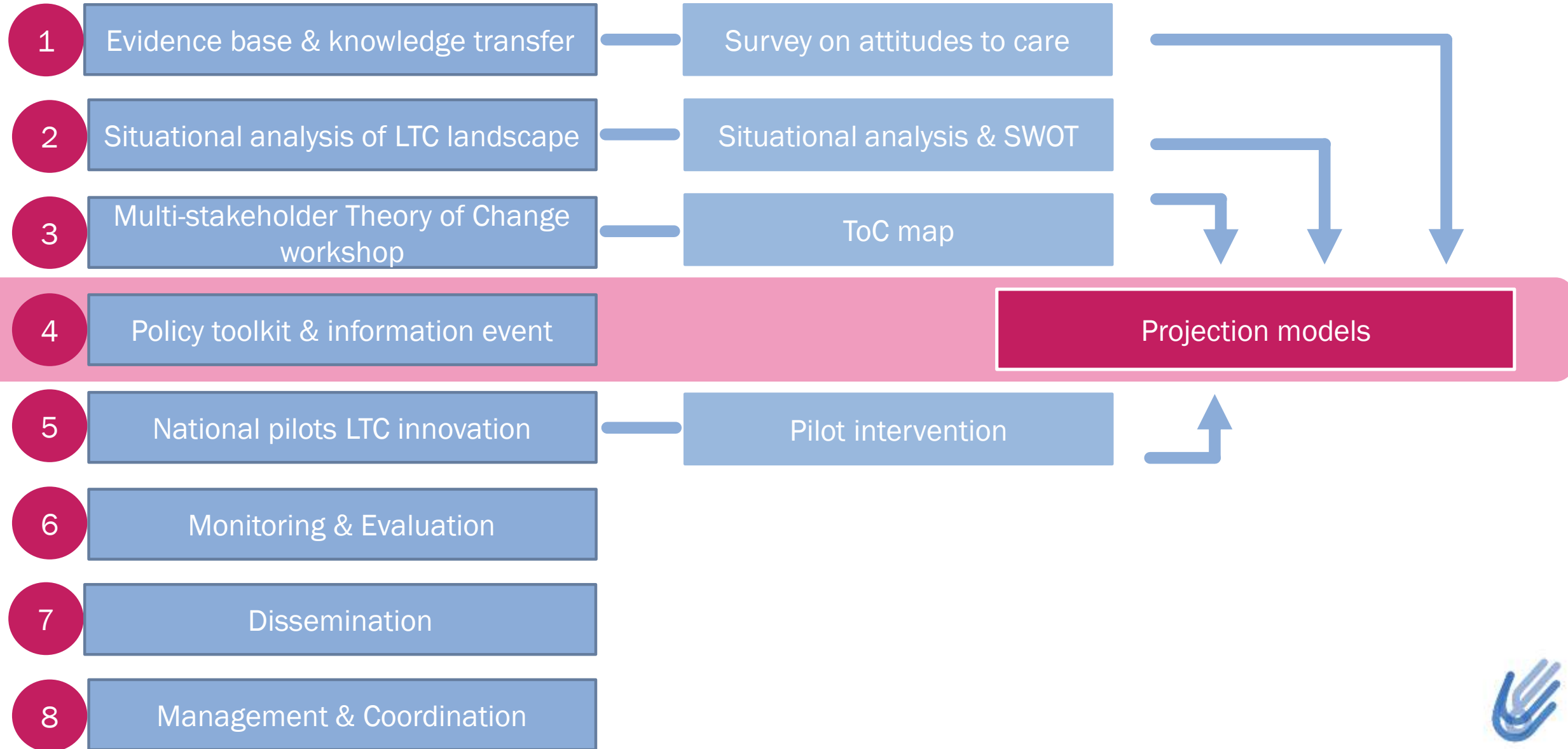


- Extra care housing, assisted living, retirement villages, independent living, assisted living, close care and very sheltered living... (retirement communities)
- People live in their own purpose-built, self-contained household, and access care and meals on-site. Care provided by staff who are available 24h.
- Accommodation is a 1 or 2 bedroom flat/bungalow that is available for sale, rent or shared ownership, domestic services and communal facilities are typically available, as well as a 24h emergency help through an alarm system.
- Providers are regulated and registered with the Care Quality Commission
- Estimated 520,000 places in the UK.

Source: [https://www.housinglin.org.uk/assets/Resources/Housing/Support\\_materials/Reports/HLIN-Mears\\_ECH\\_Market\\_Analysis.pdf](https://www.housinglin.org.uk/assets/Resources/Housing/Support_materials/Reports/HLIN-Mears_ECH_Market_Analysis.pdf)

# Looking forward

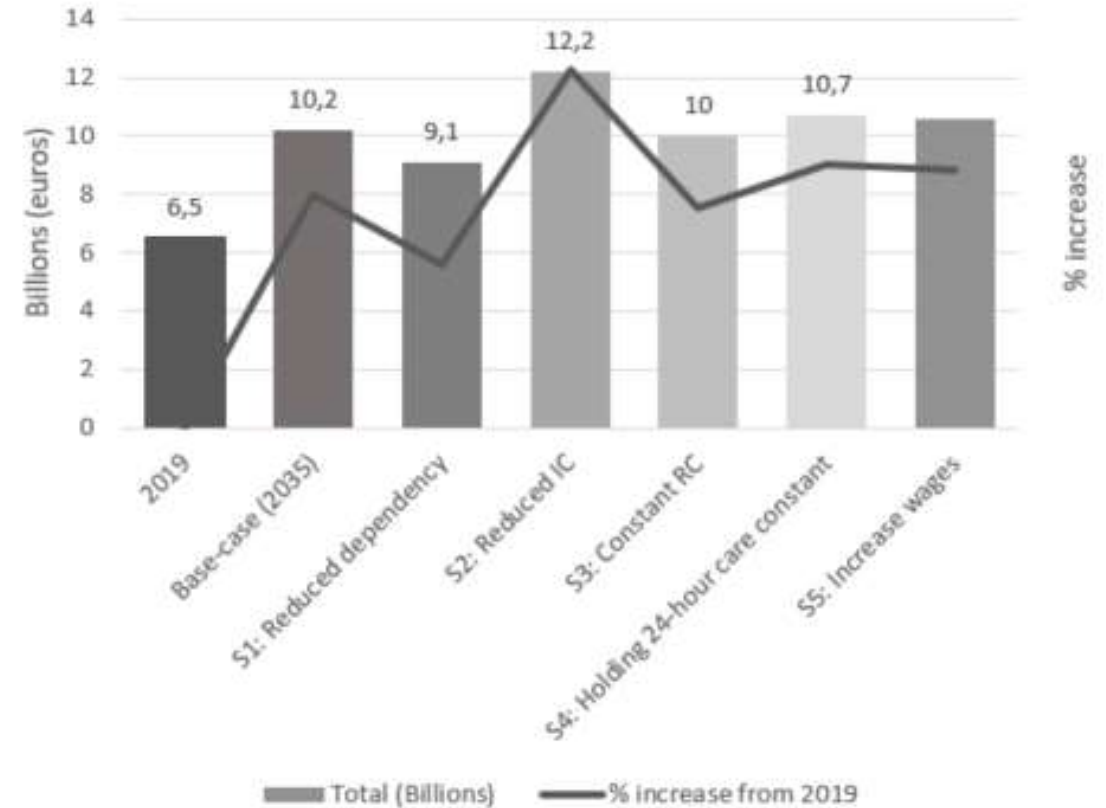
# InCARE PROJECT COMPONENTS





# PROJECTED CHANGES IN PUBLIC LTC EXPENDITURE IN AUSTRIA BY 2035 (INCARE PROJECT)

- Increase in number of individuals with care needs will already increase budget significantly by 2035
- Reduction in dependency (naturally) would only marginally help expenditure
- A reduction in informal care would result in highest expenditure needed
- Targeting residential care & increasing home- and community-based care as a potential option for minimizing expenditure
- Increase in wages: puts pressure on expenditure but likely necessary given difficulties recruiting & retaining

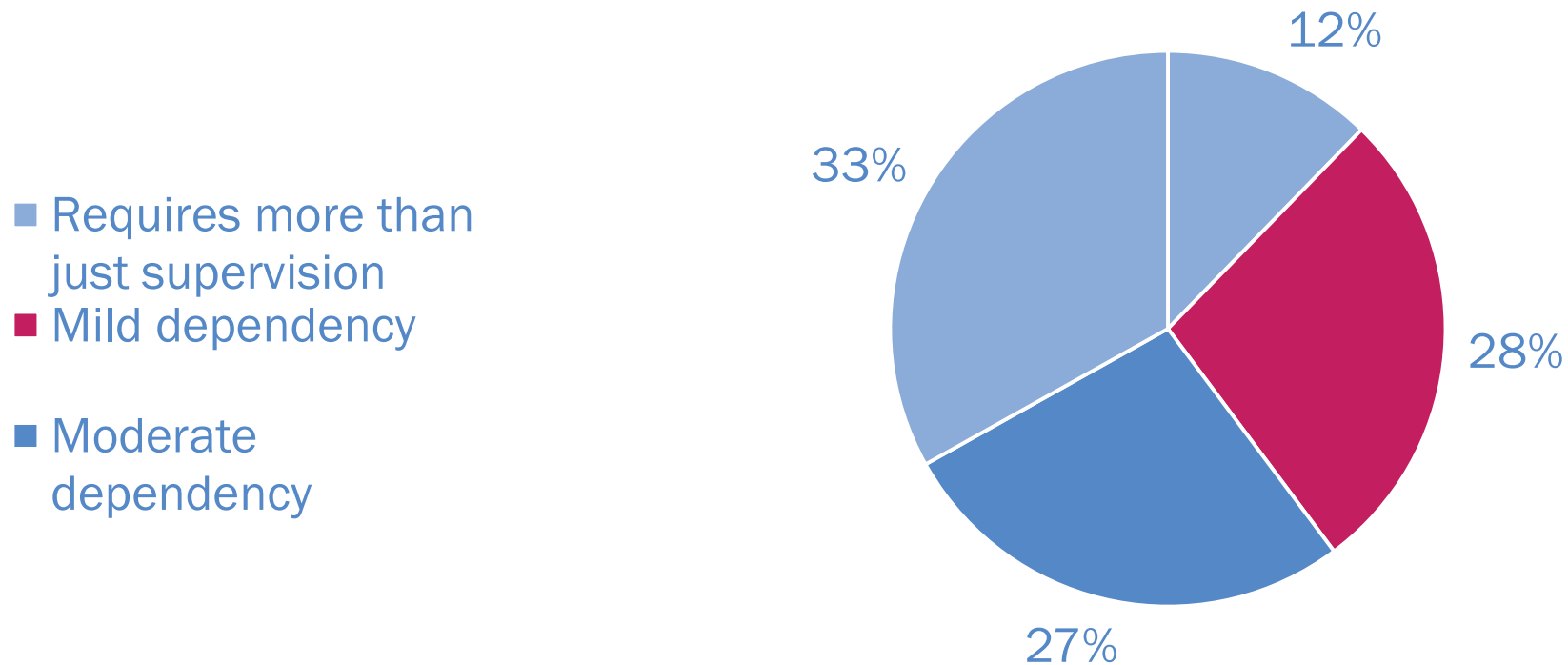


Expenditure as % of GDP	2019	Base-case (2035)	S1: reduced dependency	S2: reduced IC	S3: Targeted RC	S4: 24-hour care constant	S5: Increase wages
	1,23	2,18	1,94	2,56	1,99	2,27	2,28



# SPAIN: HIGH POTENTIAL FOR DE-INSTITUTIONALISATION?

Distribution of care home residents in a study in Albacete, by dependency level (2020)



Source data from:

Mas Romero, M., Avendaño Céspedes, A., Tabernero Sahuquillo, M. T., Cortés Zamora, E. B., Gómez Ballesteros, C., Sánchez-Flor Alfaro, V., López Bru, R., López Utiel, M., Celaya Cifuentes, S., Peña Longobardo, L. M., Murillo Romero, A.,, ... Abizanda, P. (2020). COVID-19 outbreak in long-term care facilities from Spain. Many lessons to learn. PloS one, 15(10), e0241030.

<https://doi.org/10.1371/journal.pone.0241030>

189 residents in a care home Albacete



# Denmark: deinstitutionalization and proactive home care

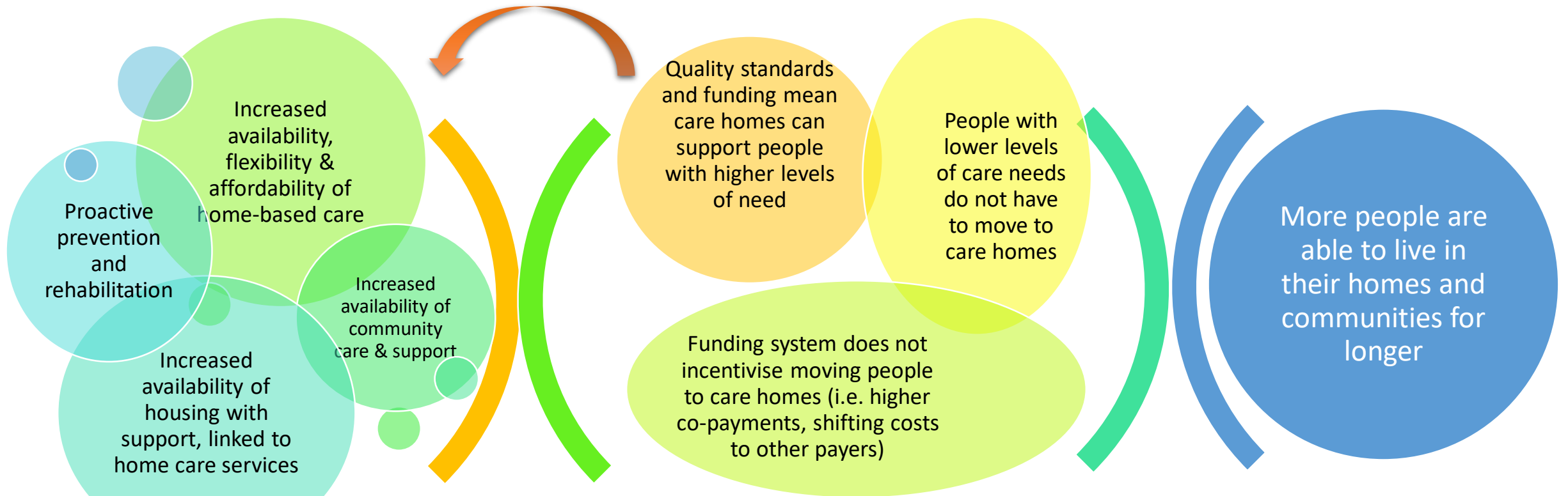
- Frontrunner on deinstitutionalization (early 70s)
  - Modern nursing homes: own independent apartment (kitchen, bathroom and normally two separate rooms, doorbell, mailbox) in complex that also has common facilities.
  - People living in nursing homes are legally tenants and receive their own pension (instead of pocket money previously), decide which services to buy (cleaning, food, laundry). Pay rent for accommodation with rent subsidies for people with low pensions.
  - Publicly funded care services are available to people in nursing homes in the same way as those living in the community.
  - No user fees or co-payments for home care (although generosity has declined over time), of for care for people in nursing homes.
- Current emphasis: **proactively avoid or delay functional decline** as much as possible, to improve quality of life and reduce pressure on the care system.
- **Preventative home visits** for individuals aged 70 and over, at least twice a year to assess general health status, functioning and social isolation/loneliness, advice on how to sustain health and functional ability and guide people towards available support services (also for people living in nursing homes)
- **Reablement model**: municipalities assess whether persons with care needs could benefit from short-term rehabilitation programme, adaptive approach to care provision reflecting user's evolving care needs, multidisciplinary teams.

# From a super-aged country: Japan's emphasis in day care

- While home care is important in Japan, day care has a really important role
- 2019: 1,077,609 users of day care, 971,432 users of home care (LTCcovid [Japan report](#))
- Since 2006 promoted as a preventative care policy for people who only require light care, aiming to reverse functional decline
- Predominantly used to address social participation needs, but also support for hygiene and health, exercise and eating and supporting families ([Naruse & Yamamoto-Mitani, 2021](#))
- Policy emphasis in reducing unpaid carers leaving jobs also linked to investment in day care (survey findings that day care was service most conducive to continue working) ([UNESCAP](#))
- Experiences with intergenerational care (with children's day care)

4. Shaping care systems to enable people to live at home as long as they wish

# An incipient theory of change on how a care system can support people living at home for longer



Strengthen care in the community

Care homes can focus on people more intensive/complex care needs

More people are able to live in their homes and communities for longer