

Cost-effectiveness in social care: conceptual basis, methods & examples

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Cost-effectiveness in social care: conceptual basis, methods & examples

- A. The production of welfare framework
- B. Economic evaluation: the basics
- C. Outcome measurement
- D. Cost measurement
- E. Making trade-offs
- F. Example: computerised therapy for depression
- G. Example: supporting family carers
- H. Example: personal budgets
- I. Conclusions: some challenges



A

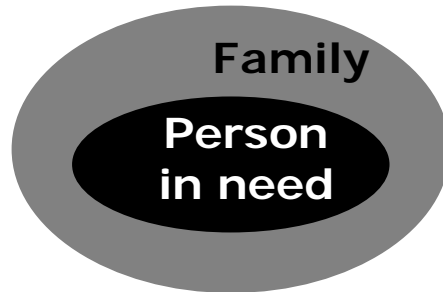


The 'production of welfare' framework

A person with health / social care needs...

Person
in need

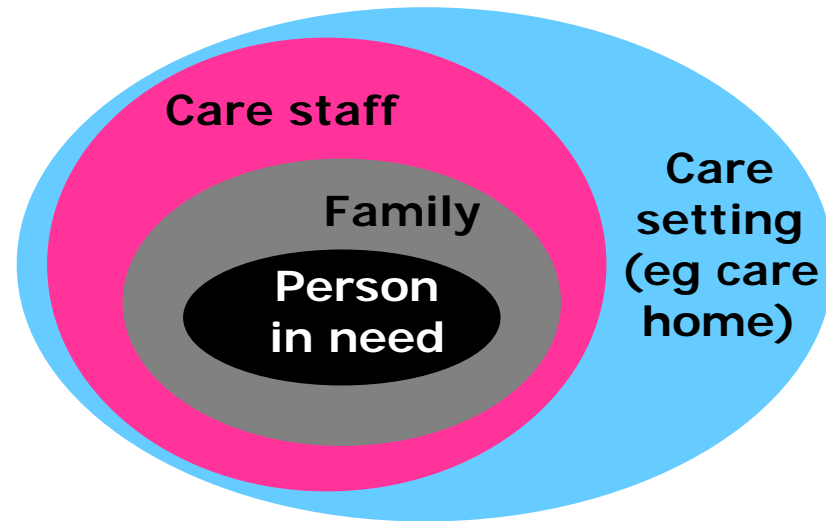
... supported by family / community ...



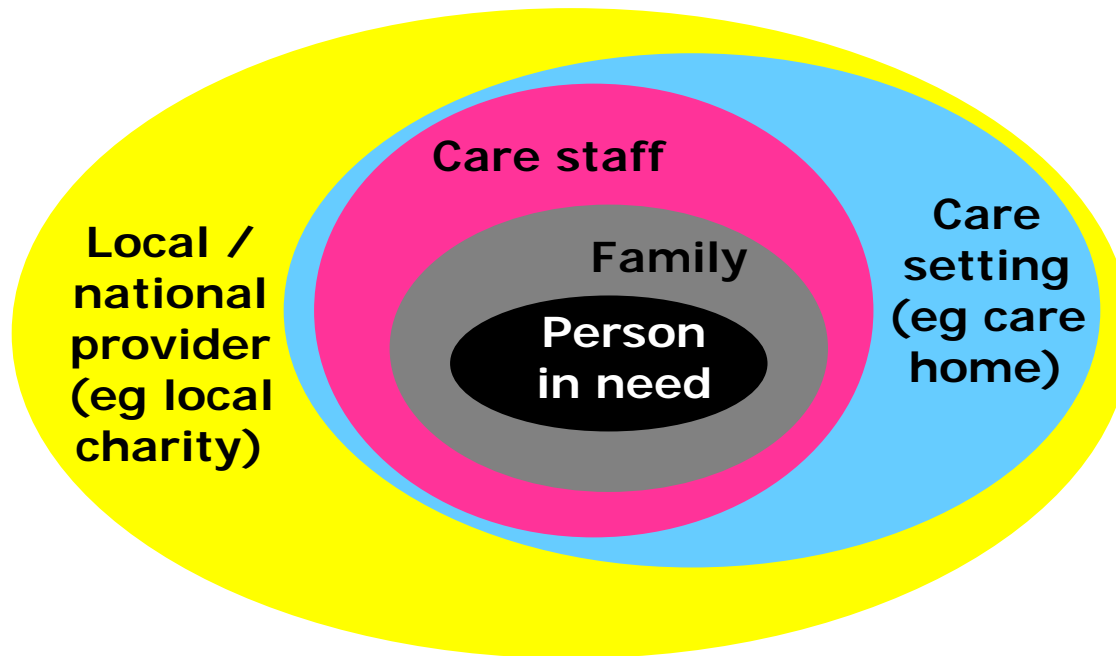
... with skilled help from professionals ...



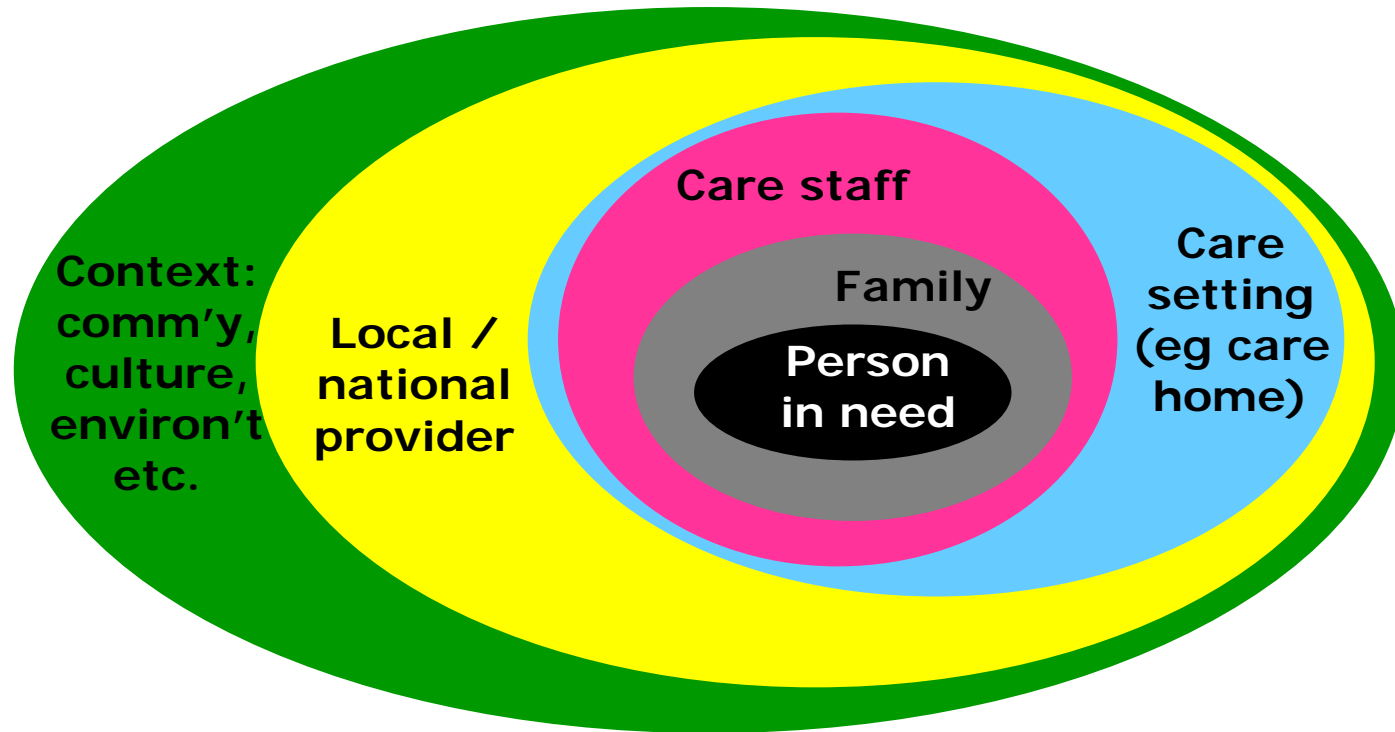
... working in a care / treatment setting ...



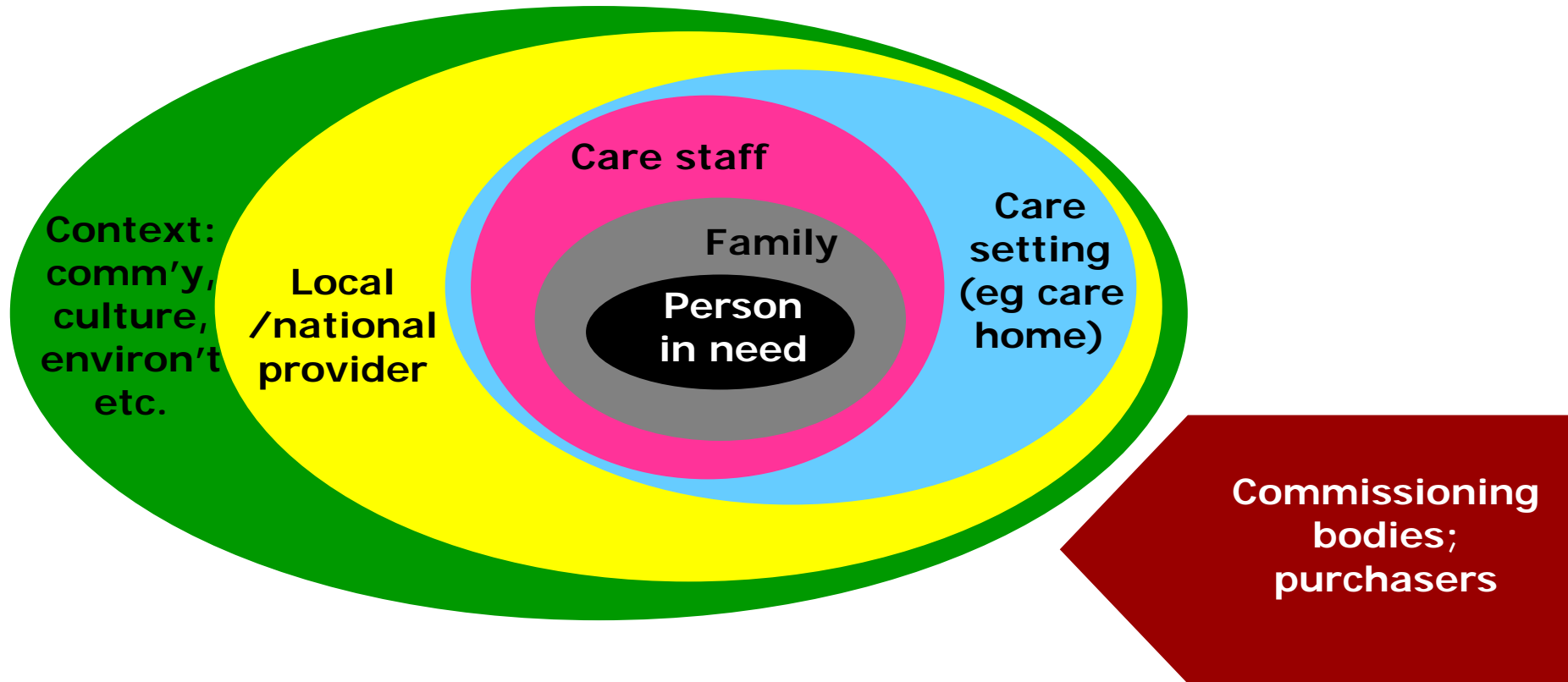
... managed by a local provider ...



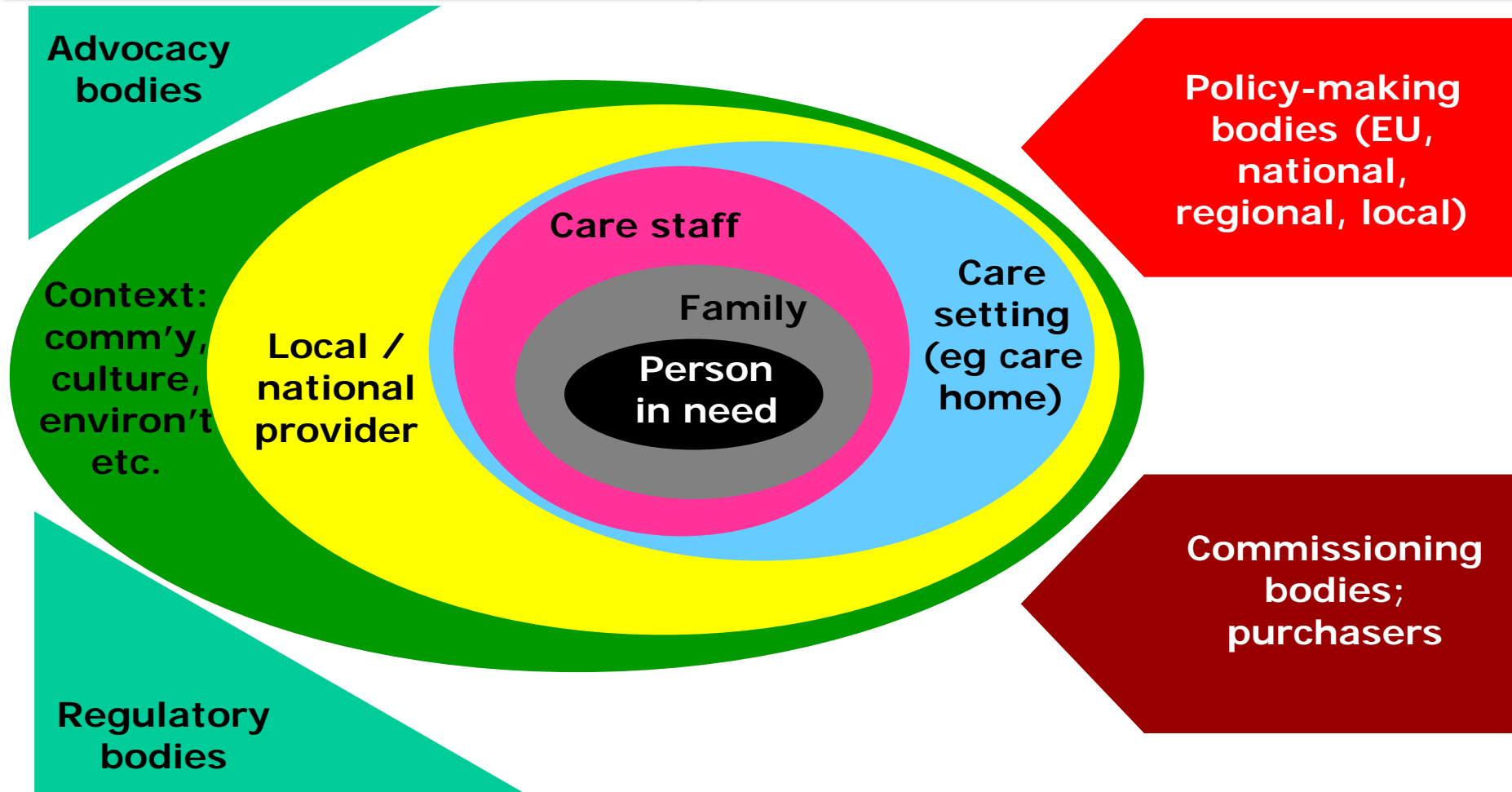
... within a particular community, cultural,
environmental (etc.) context...



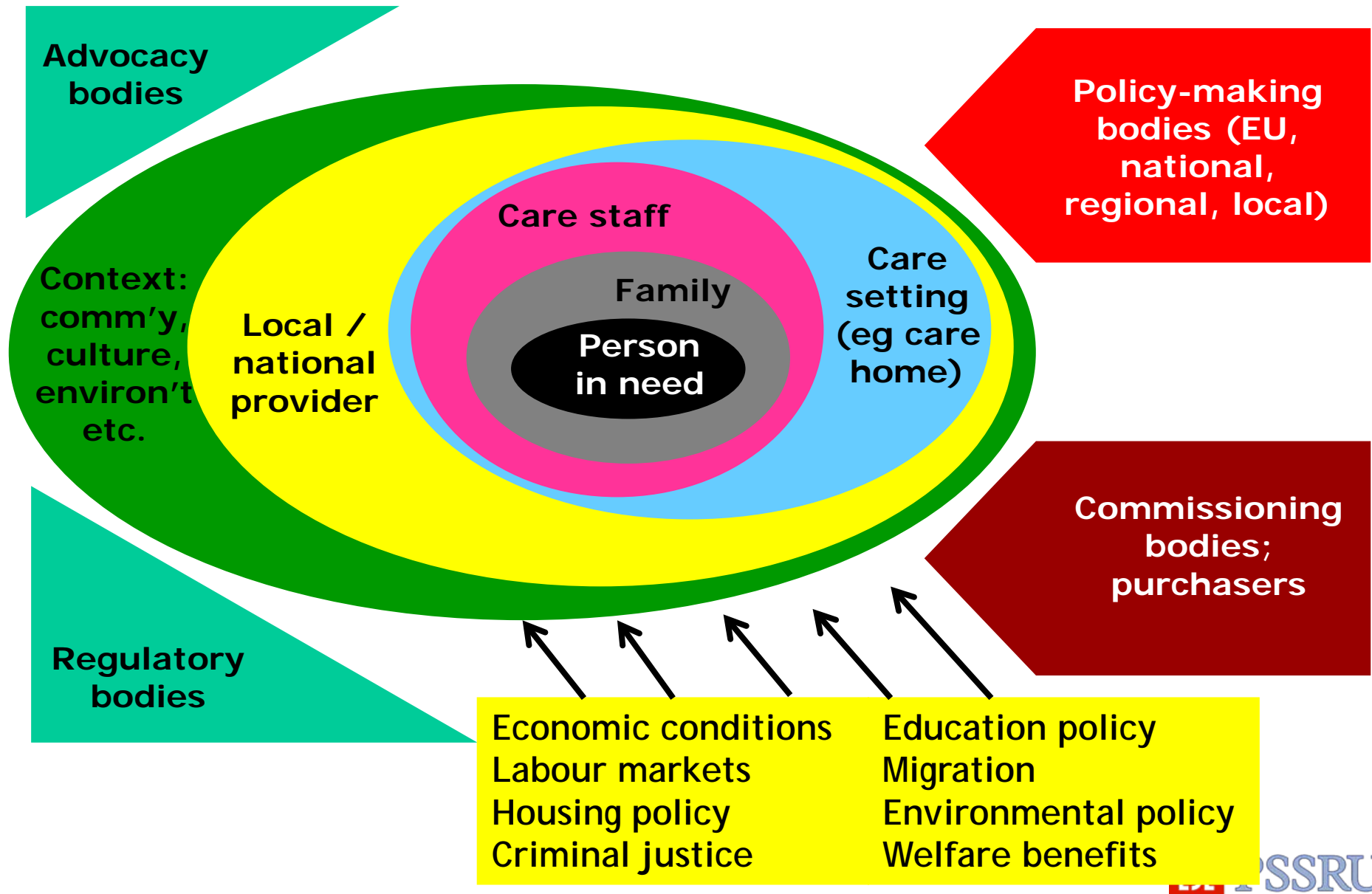
... whose services are commissioned ...



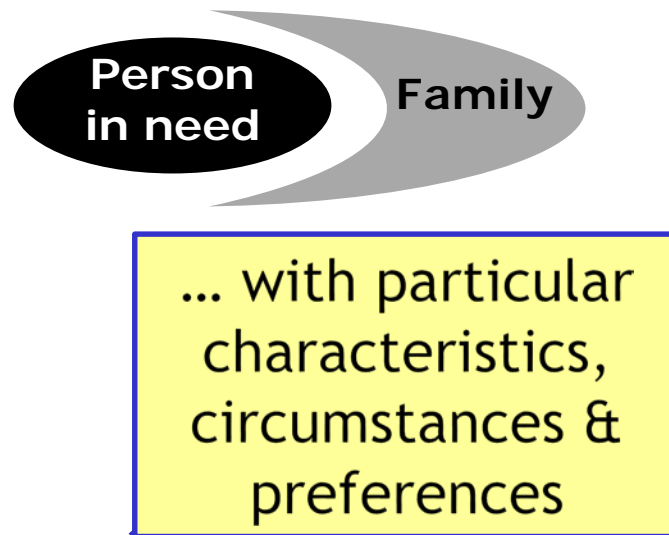
... within strategic policy, regulatory, advocacy contexts...



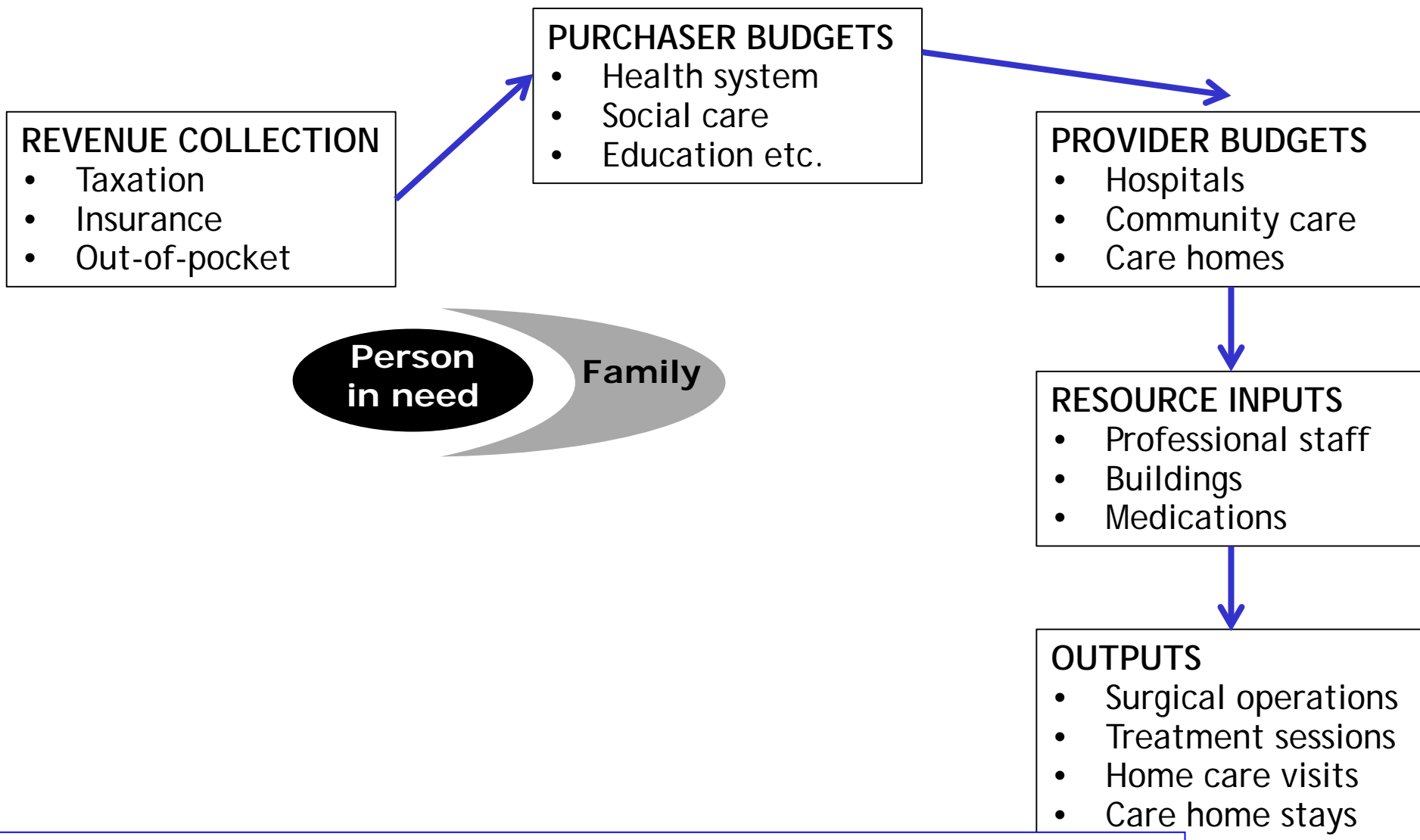
Bombarded by many external influences



A simplified social care system

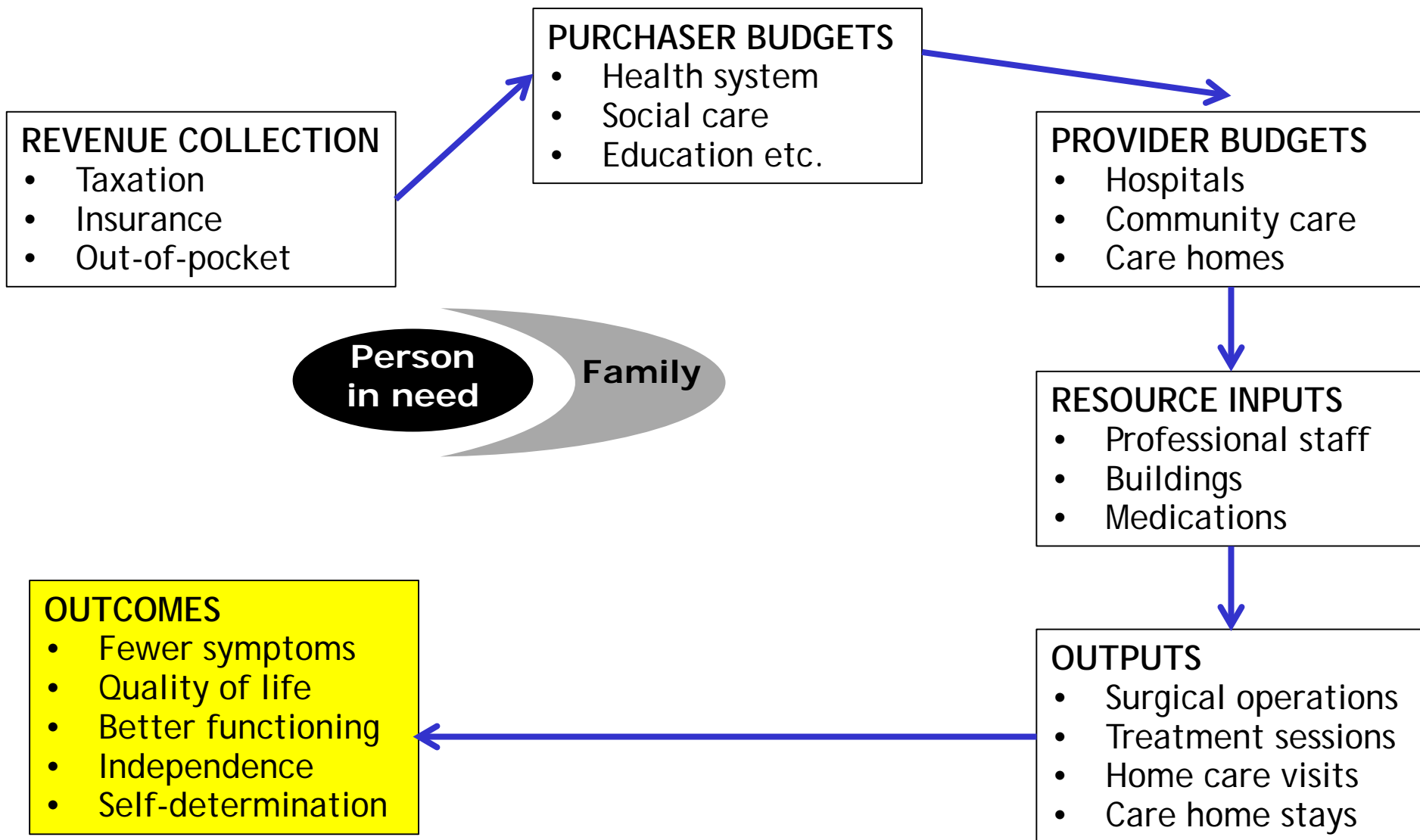


A simplified social care system

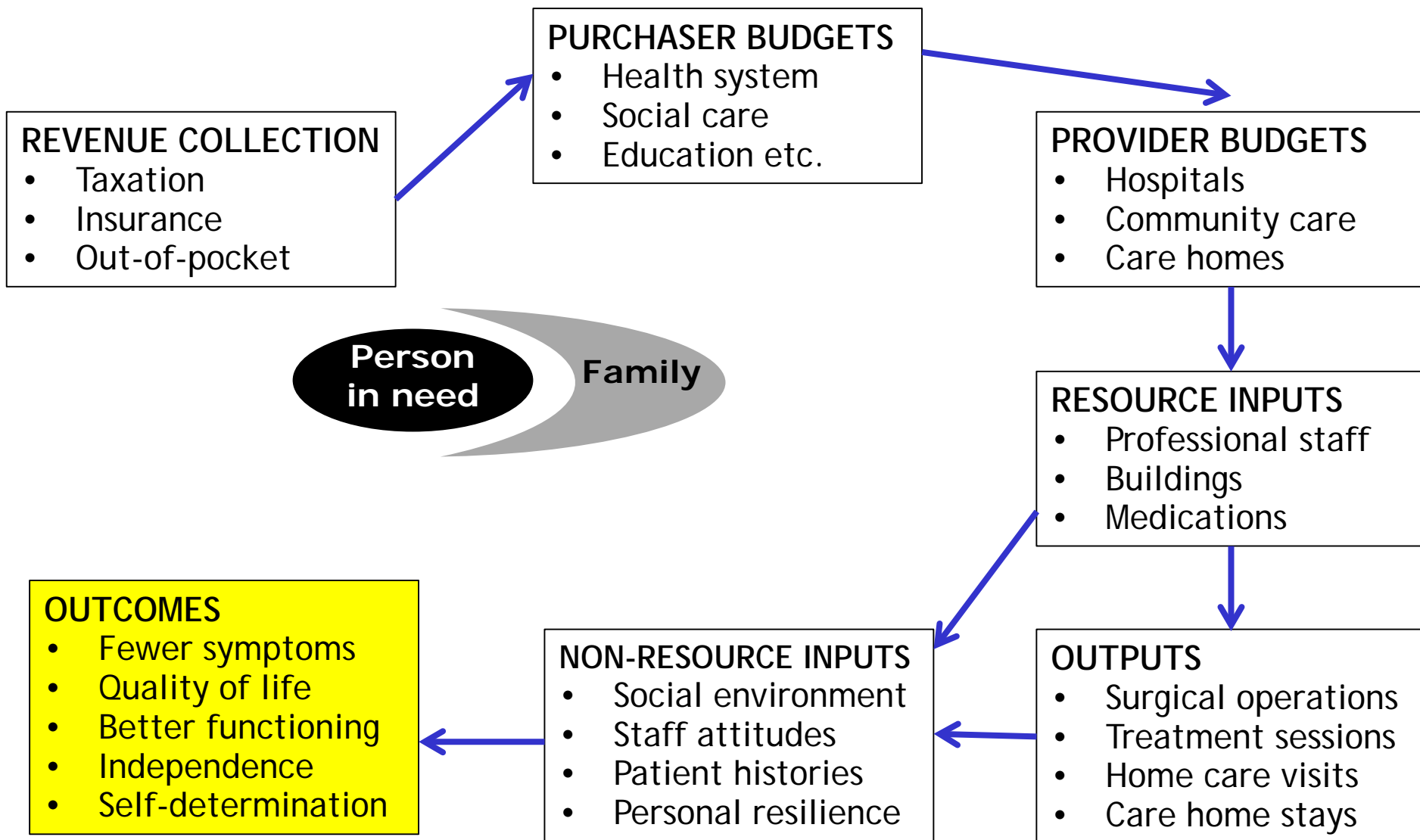


Davies & Knapp *Old People's Homes and the Production of Welfare*, 1981; Knapp *The Economics of Social Care*, 1984

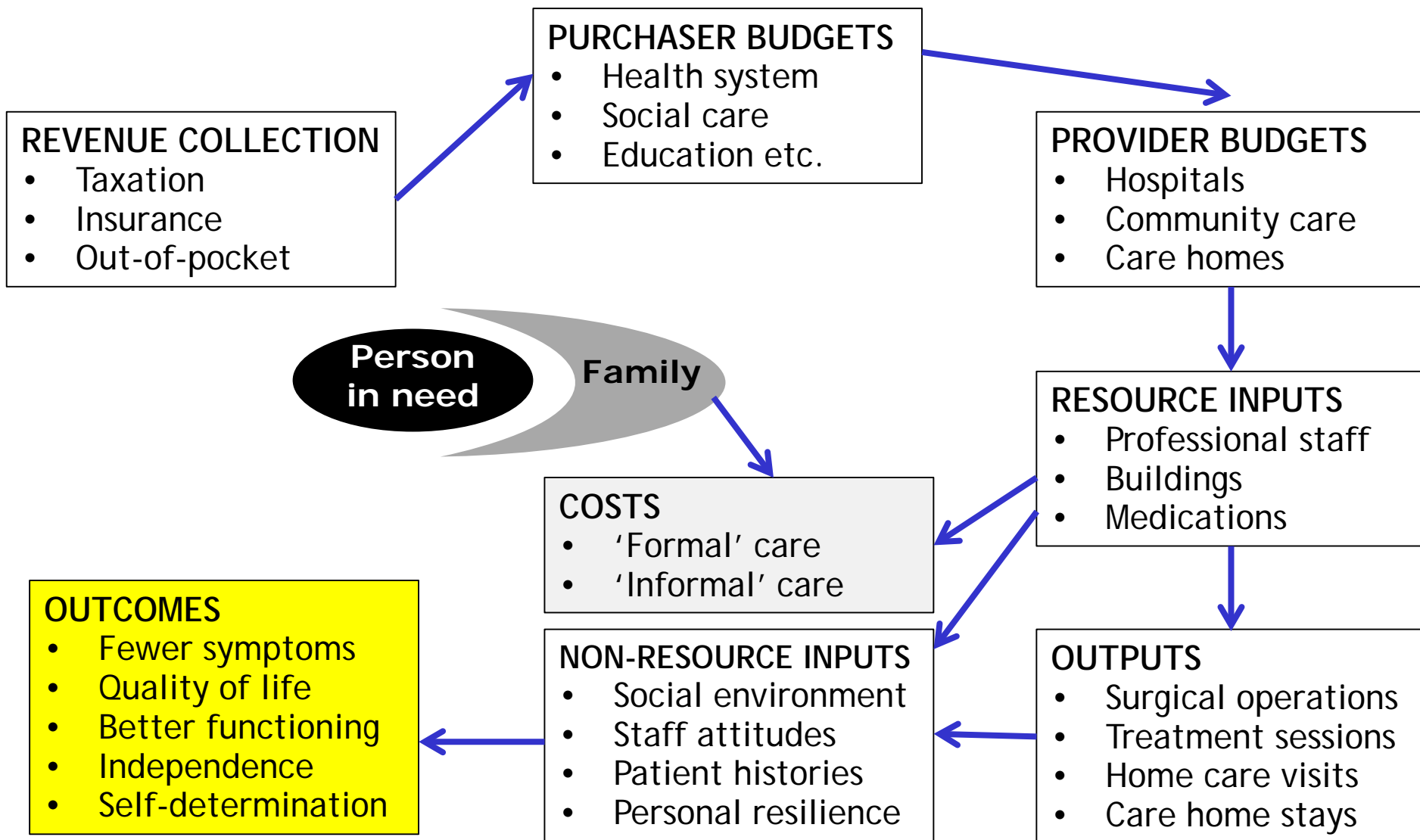
Outcomes are the key element



Achieving outcomes is not straightforward



Delivering care generates costs



And is the whole social sector fair?

How to pay for social services?

REVENUE COLLECTION

• Taxation

Can we prevent /reduce needs?

Individual preferences?

How much choice do we allow?

OUTCOMES

• Fewer symptoms

**What works?
How to improve outcomes?**

Integrated working across sectors?

• Education etc.

**Family roles?
Supply of unpaid care?**

And if it works, is it worth it? Is it affordable?

- Social environment
- Staff attitudes
- Patient histories
- Personal resilience

How to incentivise providers?

PROVIDER BUDGETS

Institutional or community-based?

Care homes

What workforce is needed? What equipment? Etc.

Buildings

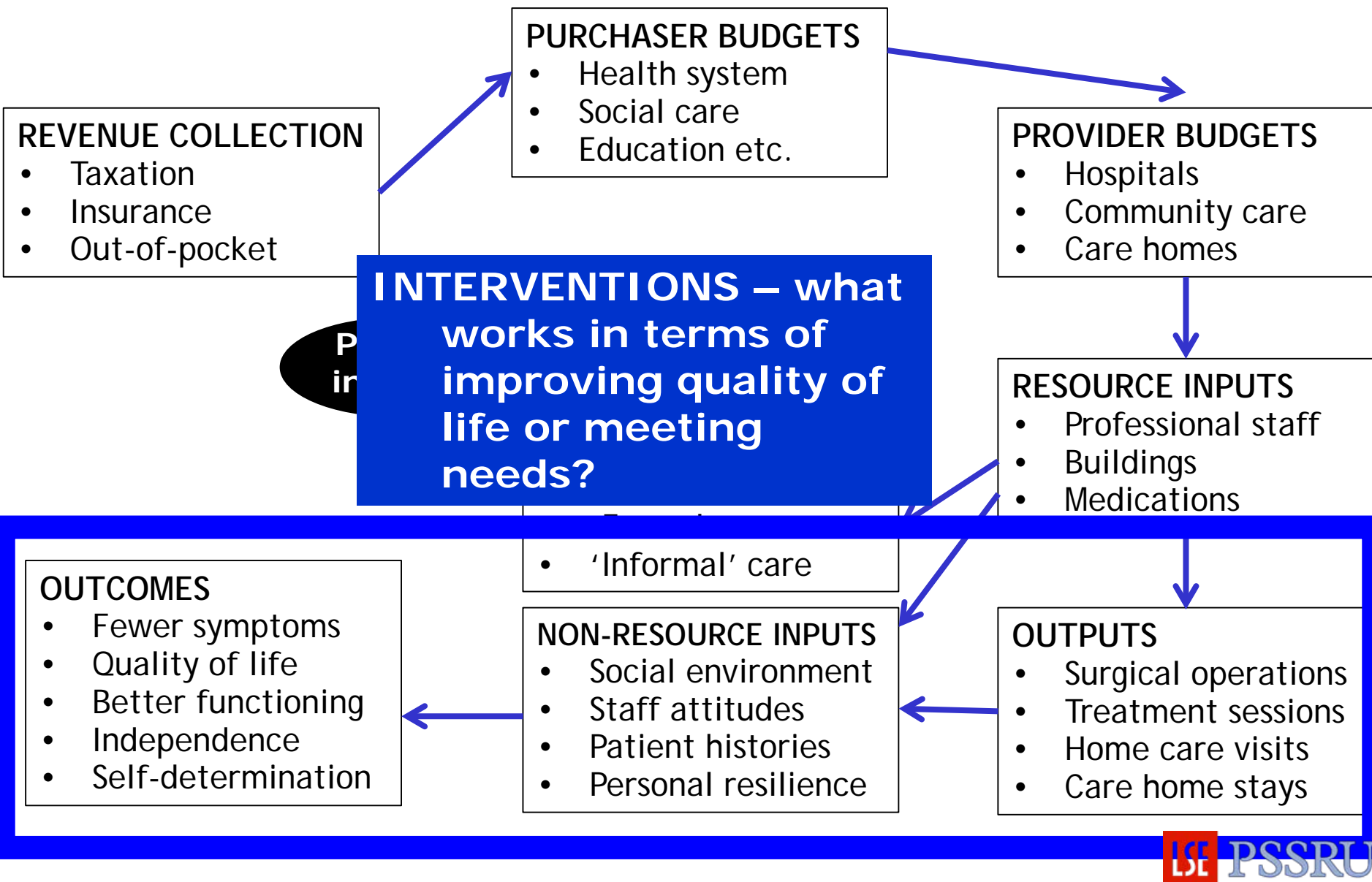
New technology?

How to improve service quality?

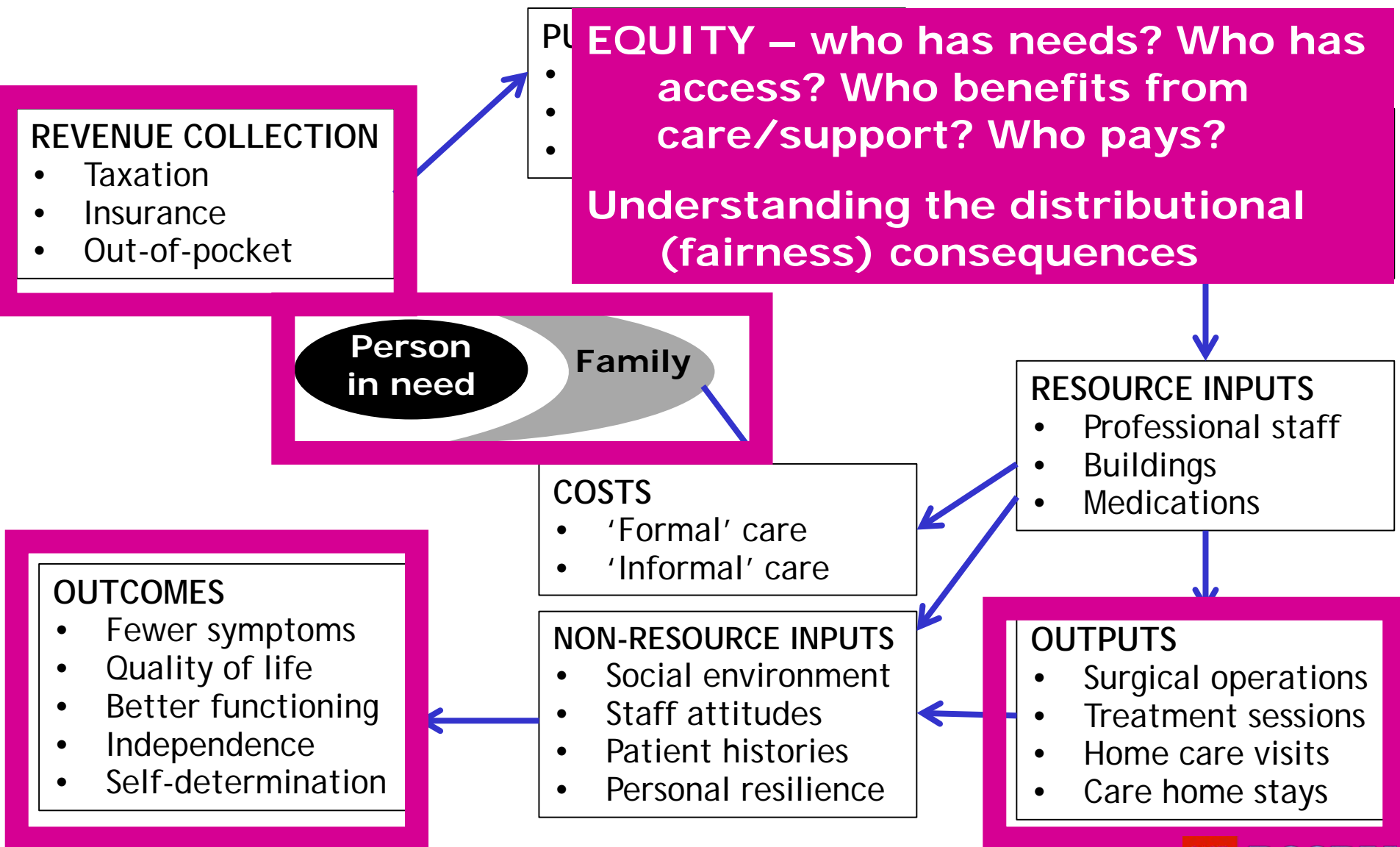
Self-referrals

How to regulate provision? And what to regulate

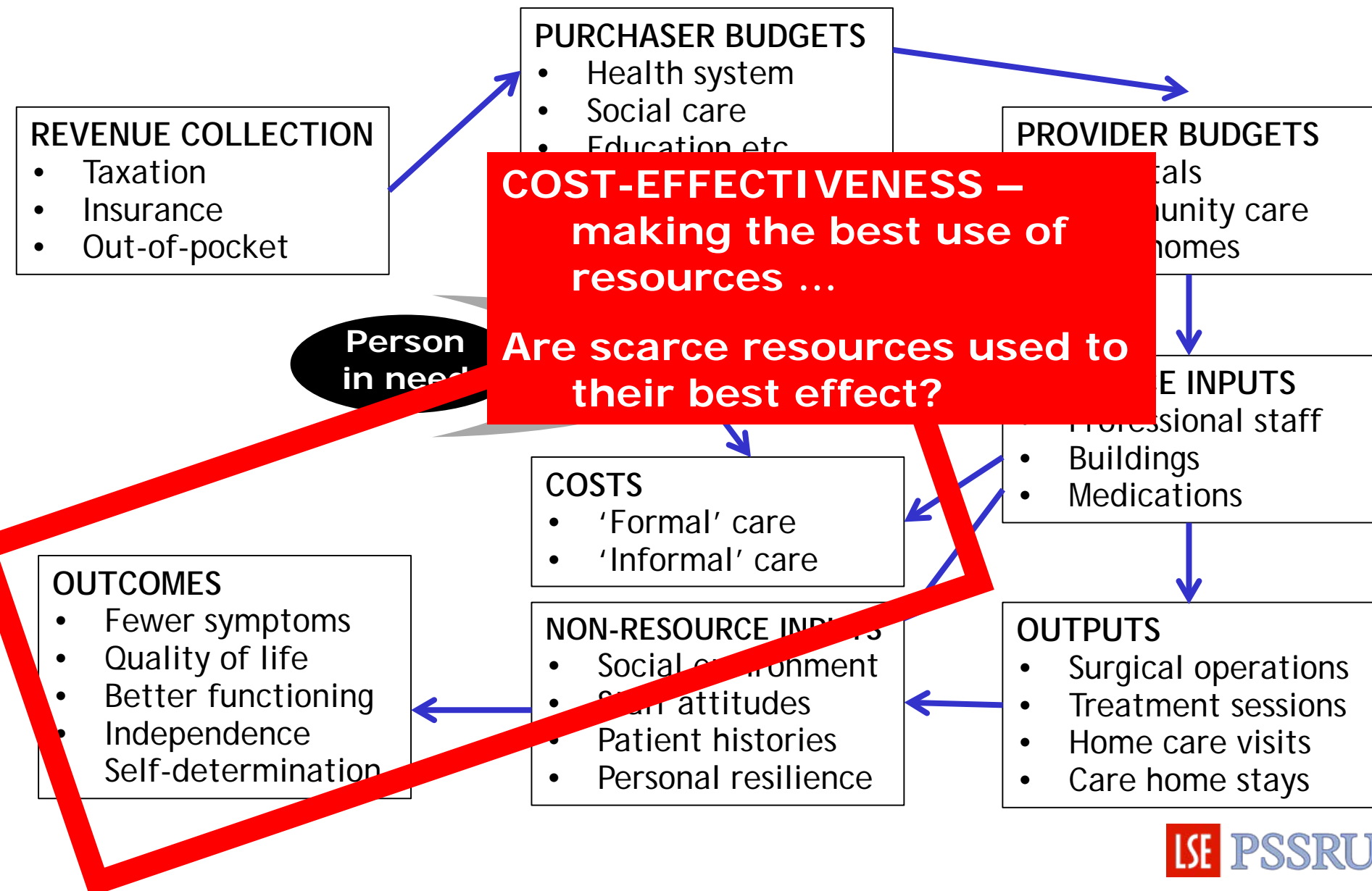
Key policy themes for us: what works?



Key policy themes for us: fairness?



Key policy themes for us: cost-effectiveness?



Policy criteria for a 'good' social care system

- Respectful of rights, dignity, culture, individuality etc.
- Good quality services
- Effective (in terms of outcomes)
- Equitable (in terms of access, payments etc)
- Equitable (in terms of wellbeing level)
- Protects vulnerable groups
- Solidaristic (i.e. not socially divisive)
- Efficient (see later)
- Affordable

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- Fewer symptoms
- Quality of life
- Better functioning
- Independence
- Self-determination

NON-RESOURCE INPUTS

- Social environment
- Staff attitudes
- Patient histories
- Personal resilience

OUTPUTS

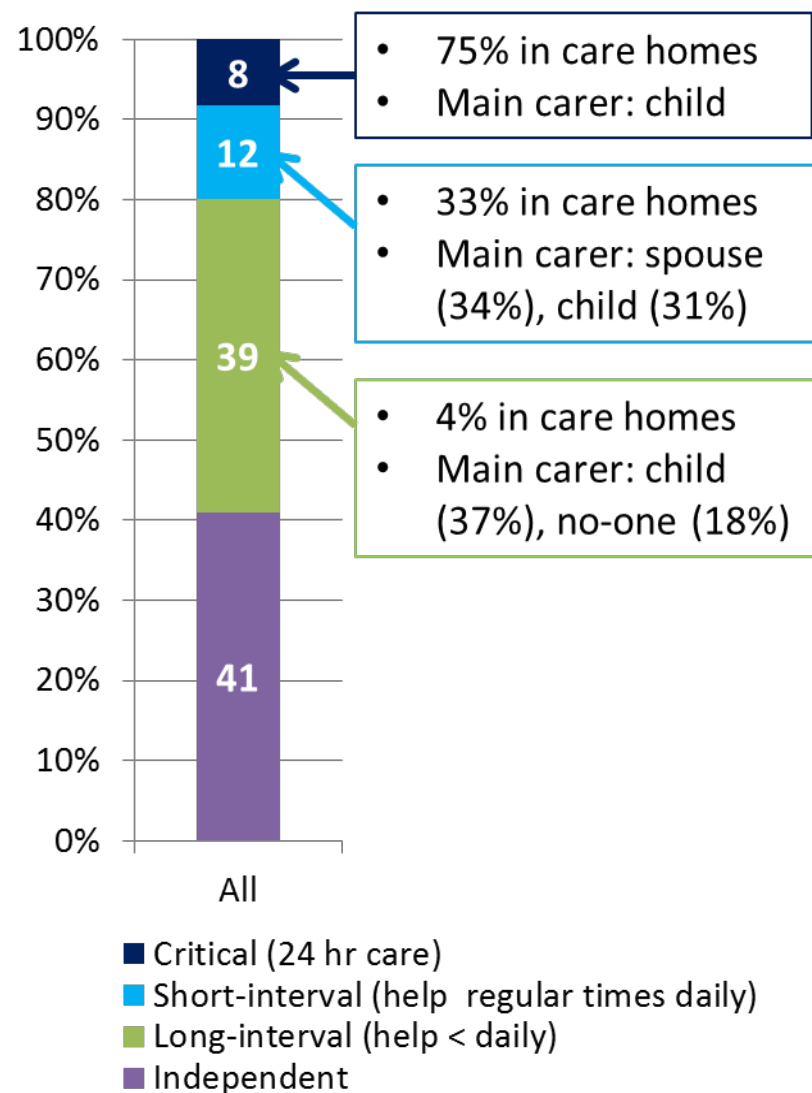
- Surgical operations
- Treatment sessions
- Home care visits
- Care home stays

B

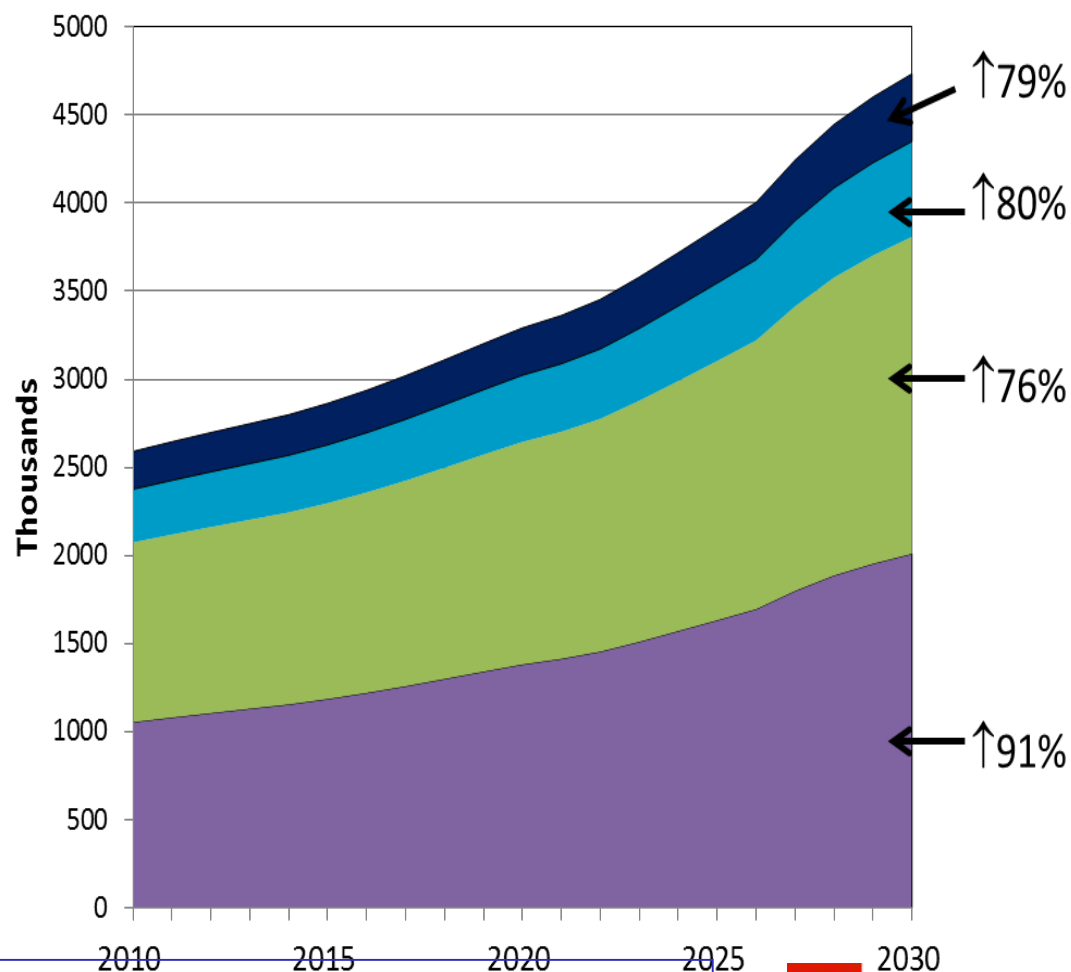
Economic evaluation: the basics



Ageing: implications for care needs

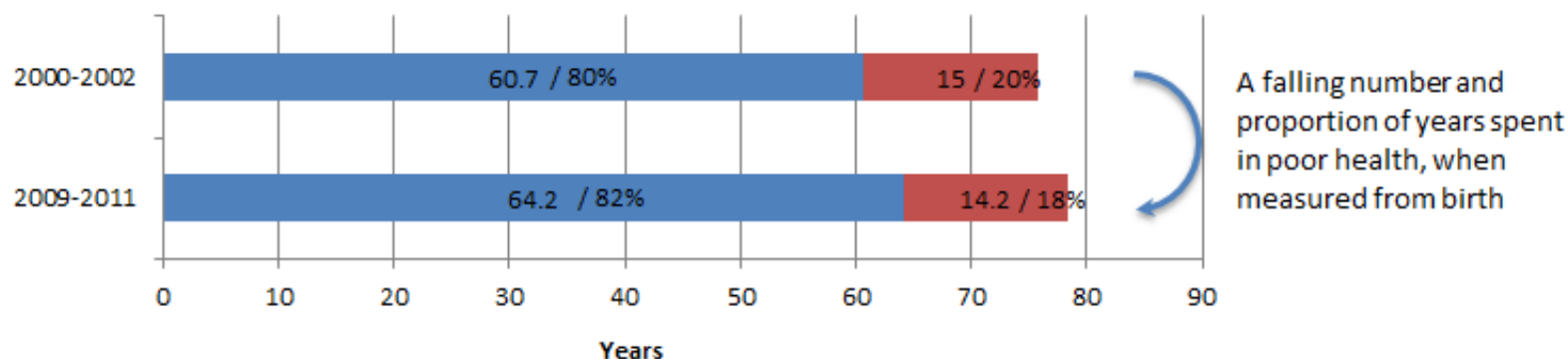


Projected numbers in E&W aged 80+ by interval-need dependency, 2010-2030



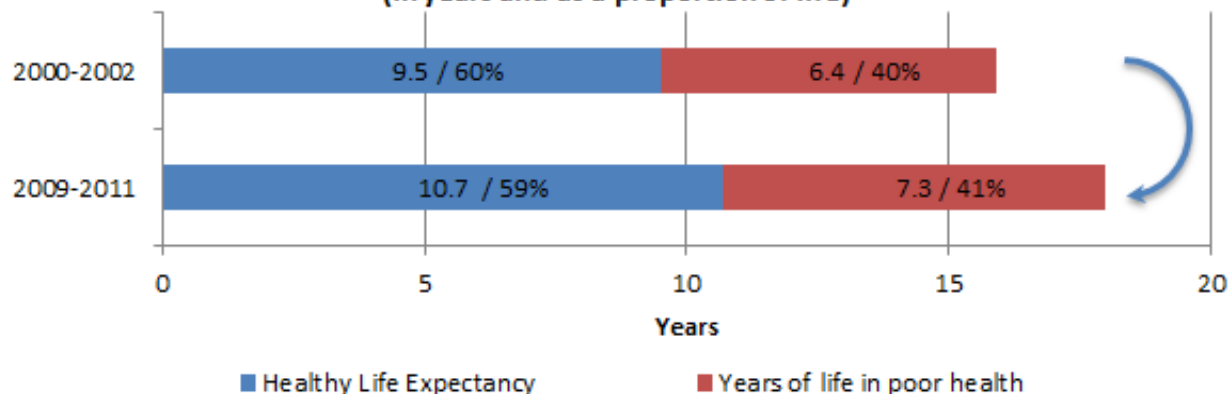
Changes in life expectancy & healthy life expectancy: males, UK, 2000-02 to 2009-11

For males at birth (in years and as a proportion of life)



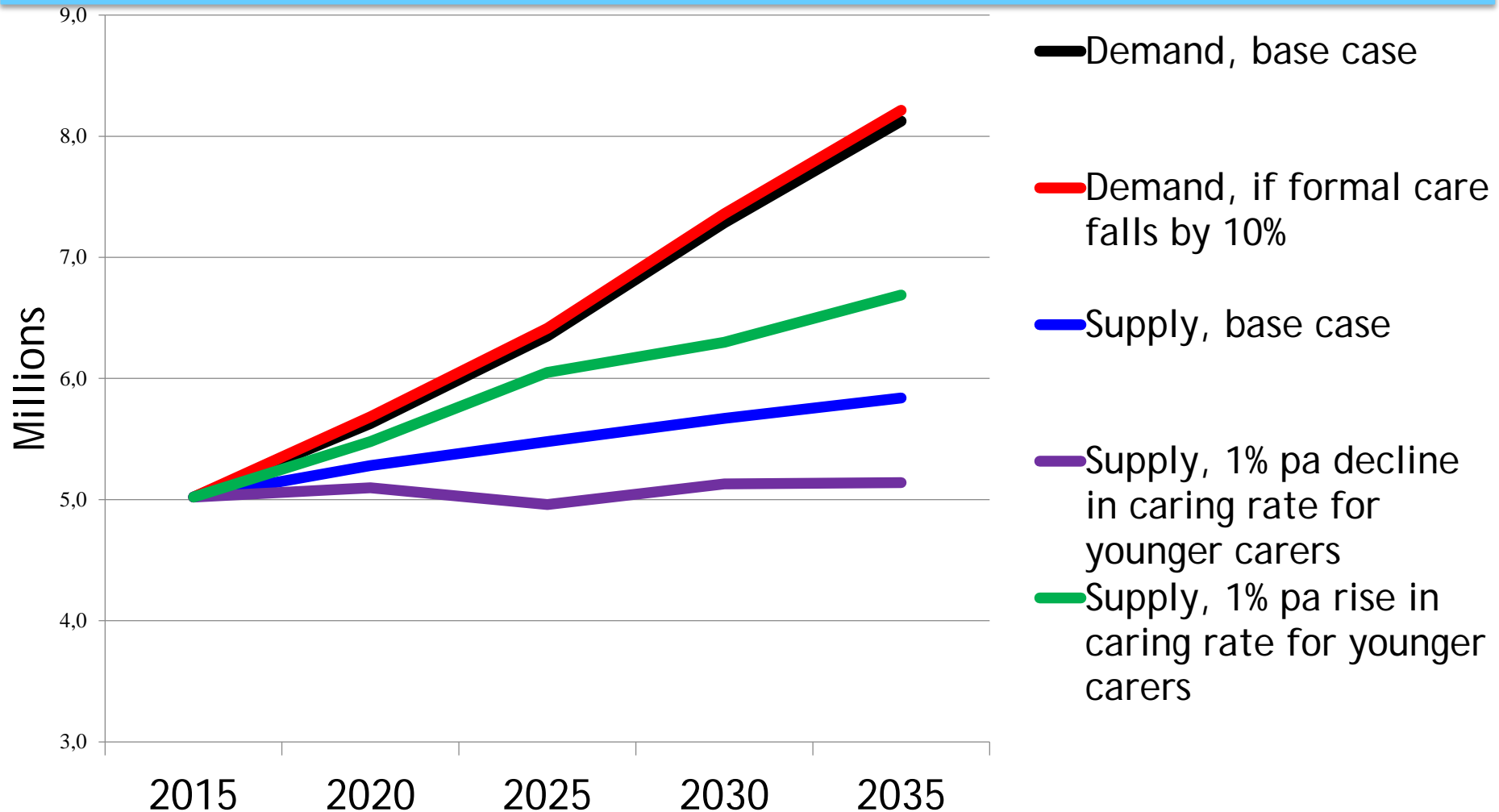
A falling number and proportion of years spent in poor health, when measured from birth

For 65 year old males
(in years and as a proportion of life)



A growing number and proportion of years spent in poor health, when measured from 65

Projected demand for, and supply of unpaid care for older people in England



Decision-makers need economic evidence

Why?

- Because resources are **scarce**.
- So we - society - cannot meet every need, or agree to every request, or accommodate every preference.
- And so we - society - must **choose** how to get the best out of our available resources.

Consequently ...

- ... any new service or 'intervention' will be looked at very carefully: Is it **effective**? Is it **affordable**? And is it **cost-effective**?
- Under what circumstances would a decision-maker **NOT** want to know the economic implications?

What kind of economic evidence can help decision-makers make better decisions?

- **Overall costs** of a 'need' (e.g. autism), how those costs are distributed, and patterns of association
- Cost of an **intervention** (e.g. a psychological therapy) **compared to its alternative(s)**
- Cost of an intervention **compared to savings** it generates (and how any savings are distributed)
- Cost of an intervention relative to **outcomes** it achieves (& compared to alternative interventions)
- An understanding of how **economic incentives** might change patterns of behaviour.

More useful but more complicated

What kind of economic evidence can help decision-makers make better decisions?

- **Cost-of-illness** or **cost impact** studies – to raise awareness of the overall impact
- **Budget impact** studies or (?) **cost-minimisation** studies – to check current affordability /save money
- **Cost-offset** studies – to check current or future affordability of an investment
- **Cost-effectiveness, cost-benefit** or similar studies – to examine efficiency: Is it worth it?
- **Behaviour / nudge** studies – to understand how incentives might change behaviour for the better

Decision-makers' questions

Imagine you have developed a new drug (call it 'Treatment 2')

You want to sell it as replacement for today's usual / most commonly used drug ('Treatment 1')



A decision-maker with a limited budget will have 5 questions:

1. Does this new treatment work?
2. Is it affordable?
3. Is it more effective than current treatment?
4. Is it cheaper than current treatment?
5. Is it more cost-effective?

1. Does this new treatment work?

Treatment 2

Effects - on a patient's
symptoms, social
functioning, quality of
life

2. Is it affordable?

Treatment 2

Costs - price of the treatment, costs of other services used, effect on employment

3. Is it more effective than current treatment?

Treatment 2

Effects - on a patient's symptoms, social functioning, quality of life

Treatment 1

Effects - on a patient's symptoms, social functioning, quality of life

4. Is it cheaper than current treatment?

Treatment 2

Costs - price of the treatment, costs of other services used, effect on employment

Treatment 1

Costs - price of the treatment, costs of other services used, effect on employment

5. Is it more cost-effective?

Treatment 2

Effects - on a patient's symptoms, social functioning, quality of life

Treatment 1

Effects - on a patient's symptoms, social functioning, quality of life

Treatment 2

Costs - price of the treatment, costs of other services used, effect on employment

Treatment 1

Costs - price of the treatment, costs of other services used, effect on employment

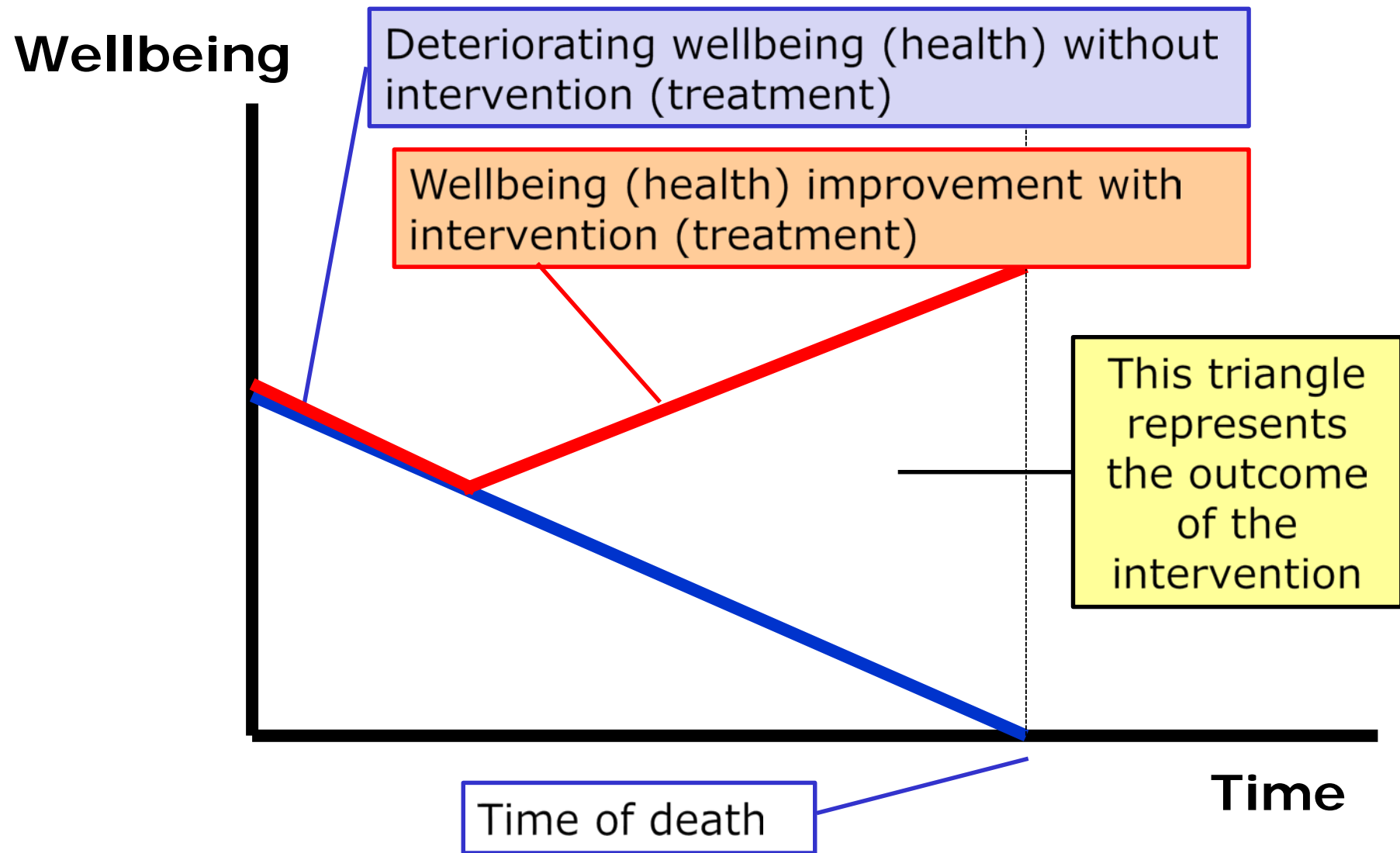
An economic evaluation needs all 4 elements

C



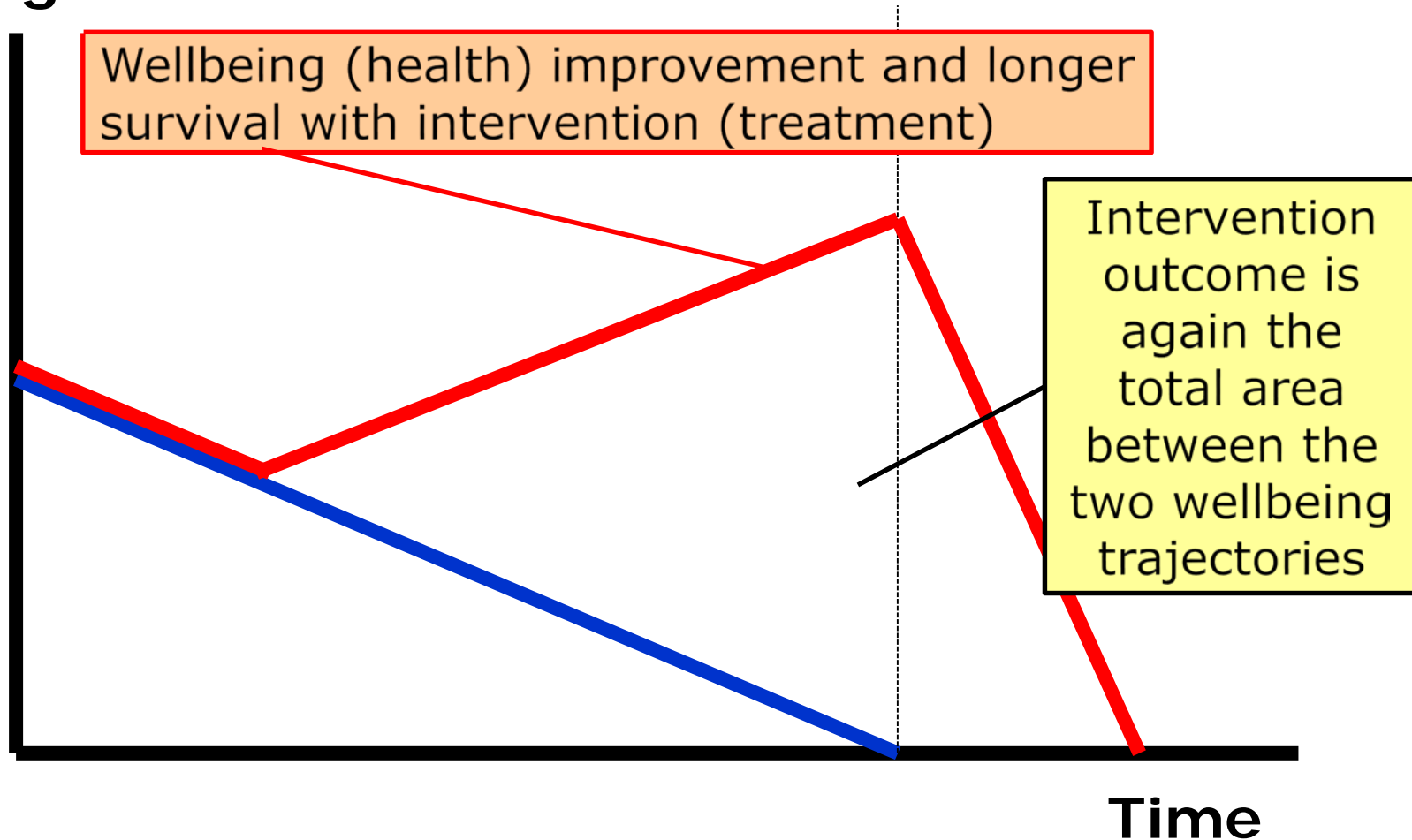
Outcome measurement

Measuring outcomes - 1



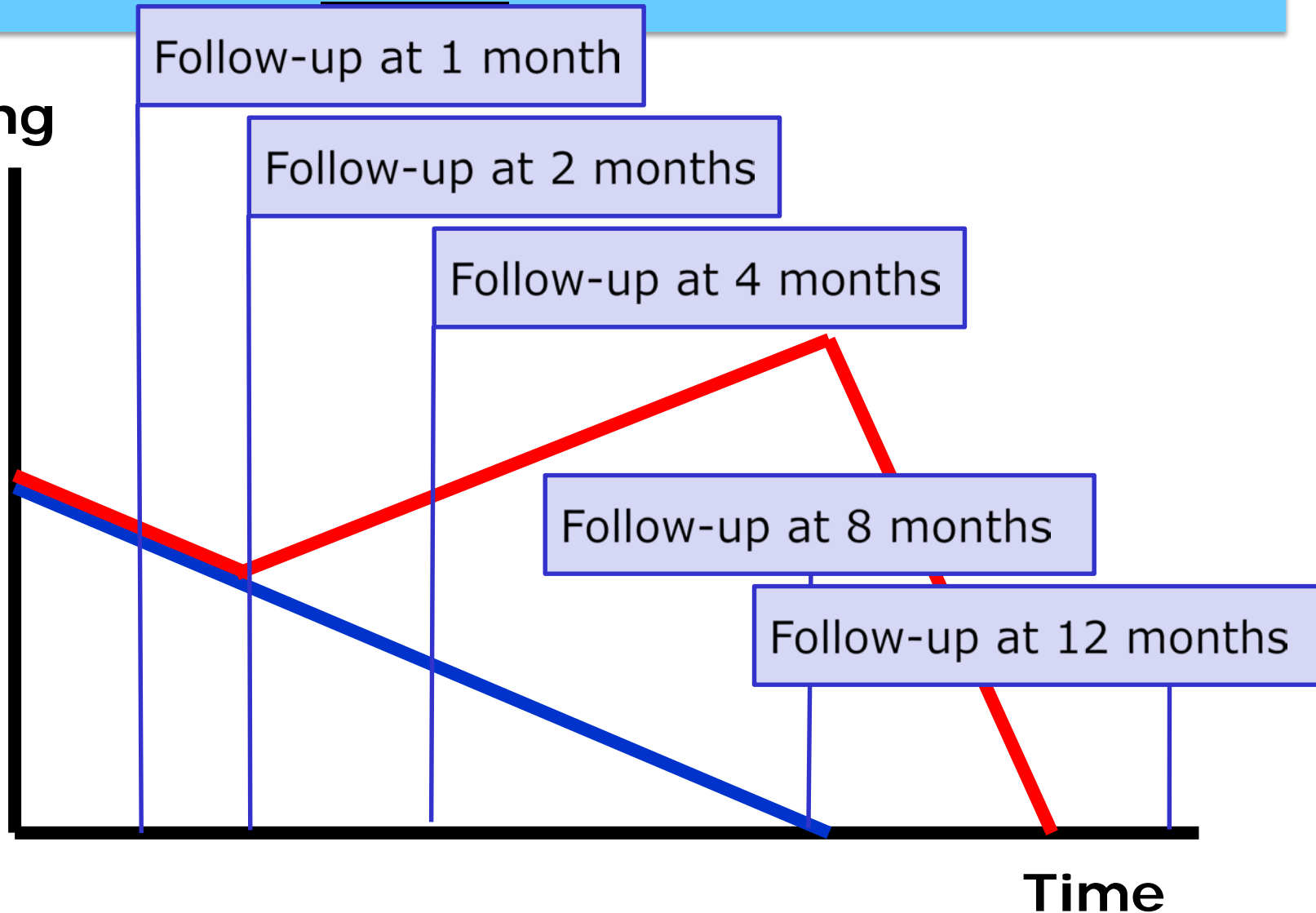
Measuring outcomes - 2

Wellbeing



Outcomes - when to measure them?

Wellbeing



Outcomes - what are they?

Ideally, they should be:

- a. directly linked to service aims (e.g. extent to which needs are met)
- b. involve service users in selection of dimensions ...
- c. ... and in generating some ratings
- d. quantitative ...
- e. ... using robust measures
- f. assessing change over time
- g. assessing change in comparison to an alternative scenario ...
- h. ... so allowing comparison with other studies, settings, uses of resources.



Social care outcomes - ASCOT

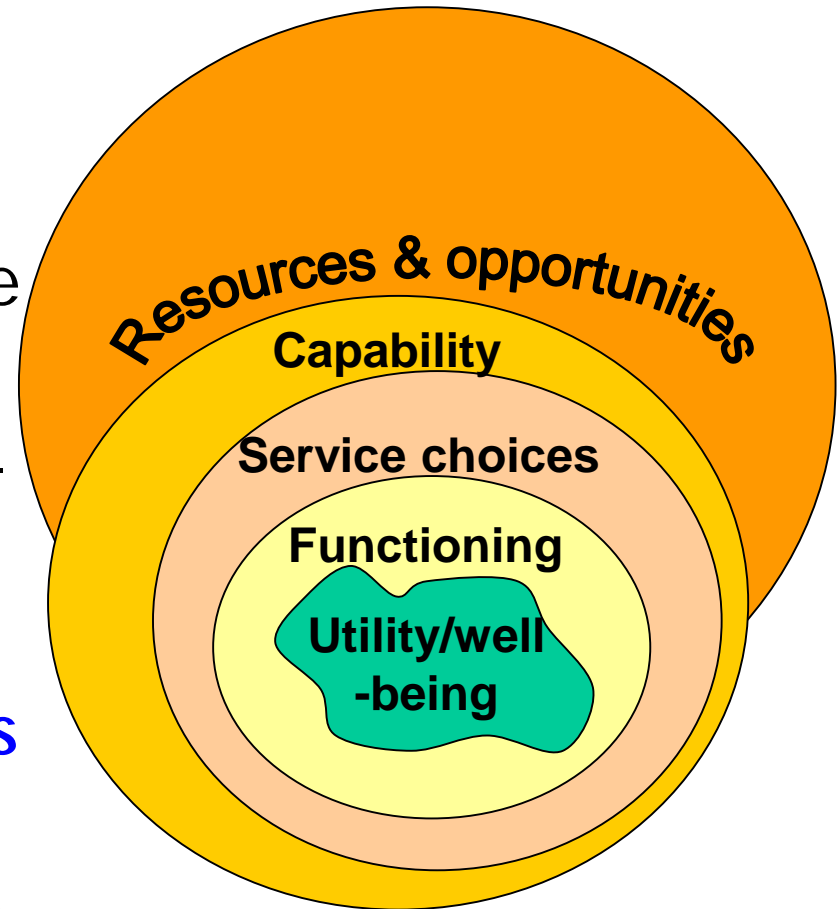
Led by Ann Netten, Julien Forder, Anne-Marie Towers (PSSRU, Kent)

What is the impact of social care on quality of life?

Fundamental aim is (social care-related) utility, happiness or wellbeing

Influenced by **functioning states** (see next slide)

The emphasis is on **capability** to achieve improved functioning



Social care outcomes?



- o Personal cleanliness and comfort
- o Food and drink
- o Safety
- o Clean and comfortable accommodation
- o Social participation and involvement
- o Control over daily living
- o Occupation
- o Dignity

Inspection criteria:

Safety (protection from abuse and avoidable harm)

Effectiveness (good outcomes, good quality of life, based on best available evidence)

Caring (staff involve and treat people with compassion, kindness, dignity, respect)

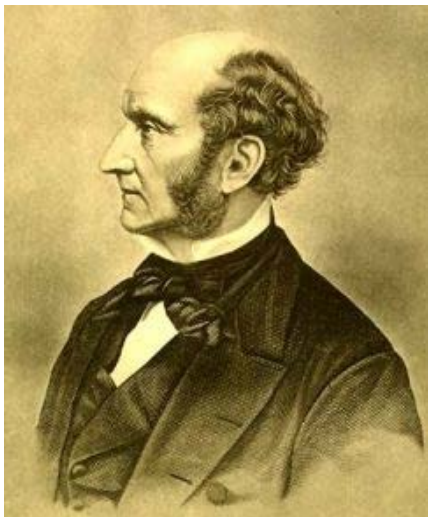
Responsive (services organised to meet people's needs).

Well-led (leadership, management & governance assure high-quality person-centred care, supports learning & innovation, promotes open & fair culture).

Utilitarianism, utility & health economics



Jeremy Bentham



John Stuart Mill

Utilitarianism - an **ethical theory** that argues that the best course of action is one that maximizes utility, defined as maximizing total benefit & reducing suffering.

Utility in **economics** is the satisfaction or happiness derived from consumption / use of a good or service.

In **health economics**, utility is a generic outcome (health-related quality of life or wellbeing) that health systems seek to maximise (subject to resource constraints and other considerations).⁴³

Measuring utility (QALYs) - health care

- Utility - a generic measure combining quality and quantity of life
- Different dimensions of health-related QOL are combined using societal weights
- The *QALY (quality-adjusted life year)* is one example of a utility measure
- QALY range: 0 (death) to 1 (perfect health)
- Evaluation question: how many **additional QALYs** are generated by treatment (relative to a comparator)
- The most commonly used QALY-generating measure in Europe (and globally) = **EQ5D**

D

Cost measurement



Measuring care costs - the options

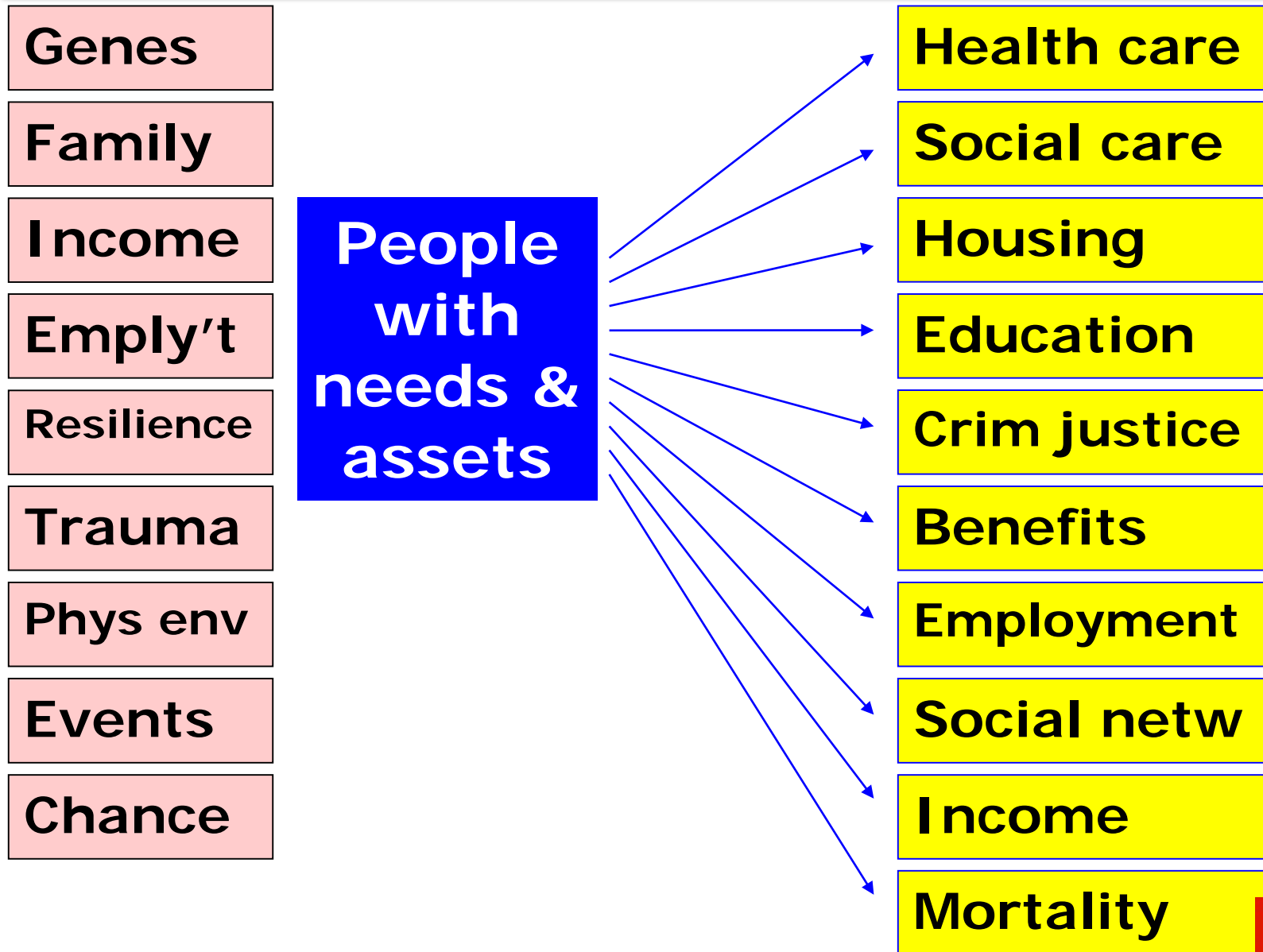
- **Prices**, charges ...
- **Expenditure** figures, divided by number of people supported or number of sessions delivered
- **Opportunity costs** - the benefit forgone by losing the use of a resource in its best alternative use

The PSSRU annual volume, *Unit Costs of Health and Social Care*: detailed costs **for England** -
<http://www.pssru.ac.uk/project-pages/unit-costs/2014/>

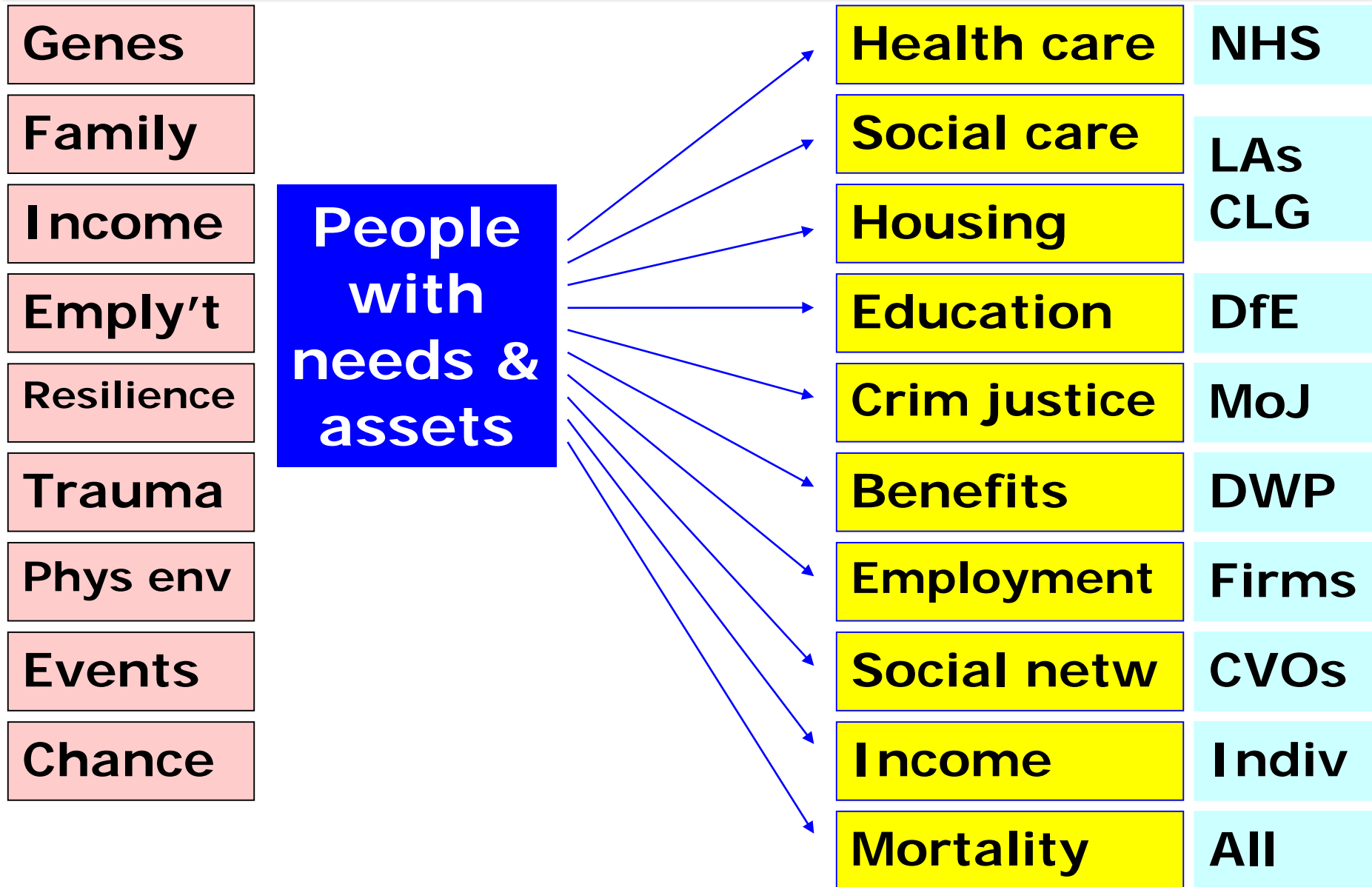
Opportunity costs

- Resources are scarce – we need to choose how to employ them; to choose between alternative claims, needs, wants.
- As choices are made so we get a definition of cost ...
- ... in terms of the value of alternatives or opportunities missed (the benefit forgone by losing its best alternative use)

Which costs?



Potentially many budgets



Cost dimensions in health & social care studies

Breadth depends on study perspective

Health & social care system perspective

- Inpatient services
- Outpatient, A&E
- Community health
- GP time
- IAPT
- Social work inputs
- Residential care settings, etc.

Public sector perspective

- Health & social care
- Education services
- Criminal justice
- Welfare benefits, etc.

Societal perspective

- Public sector services
- Not welfare benefits
- Lost productivity
- Unpaid care

Measuring costs in practice

- Collect data on **service use** ...*
- ... and attach **unit costs** to each of those services
- Collect data on **employment** patterns ...
- ... and attach costs to lost employment (**lost productivity**)
- Collect data on **unpaid care by families** and others ...
- ... and attach **(opportunity) costs** to these inputs
- Calculate **total costs** (depending on the study perspective)

* We use the CSRI - adapted to context

Some things to remember about costs

- o Addressing many social care and related needs is very labour-intensive, and so the cost per user to a care system may already seem is already **high** ... and will get higher (the 'relative price effect').
- o But costs also fall to **other services/budgets** ...
- o ... including to the **employment** sector
- o ... and to the '**welfare (benefits) sector**'
- o **Individual users** often bear some costs ...
- o ... and so do **families** and **communities**
- o And those costs can **persist** for long periods
- o Moreover, many of those costs are **hidden from view** - e.g. unpaid inputs from family & other carers

E

Making trade-offs



The core economic question

If the policy/practice question is:

‘Does this intervention work?’

Then the economic question is:

‘Is it worth it?’

So ... we must define what we mean by ‘work’ and by ‘worth’ – hence we must define **outcomes** and **costs**.

Often the decision-maker faces difficult (perhaps controversial?) **trade-offs**



Trade-offs: Is it worth it?

If an intervention is more effective and also more costly, then calculate the cost per unit gain in effectiveness. Crunch question: **Is it worth it?**

Trade-offs: Is it worth it?

If an intervention is more effective and also more costly, then calculate the cost per unit gain in effectiveness. Crunch question: **Is it worth it?**

So we first need to calculate ***the incremental cost-effectiveness ratio (ICER)***, which is ...

$$ICER = \frac{(C_2 - C_1)}{(E_2 - E_1)}$$

= the cost of achieving an incremental improvement in an outcome measure

Possible CEA results

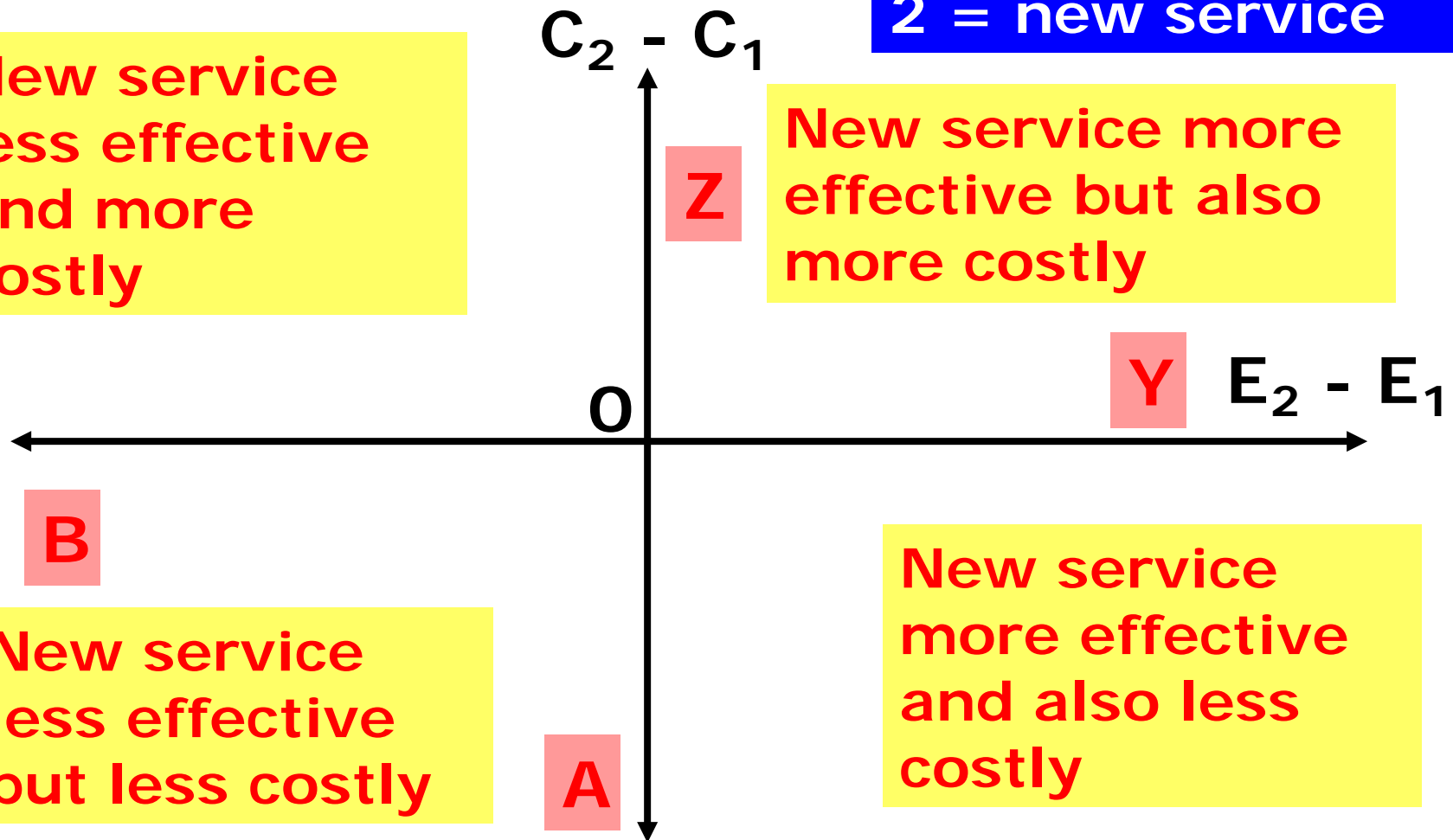
C = costs
E = effects
1 = old service
2 = new service

New service
less effective
and more
costly

New service more
effective but also
more costly

New service
more effective
and also less
costly

New service
less effective
but less costly





Trade-offs: Is it worth it?

If an intervention is more effective and also more costly, then calculate the cost per unit gain in effectiveness. Crunch question: **Is it worth it?**

With the ICER we then have the following options:

- Show decision-makers the cost-effectiveness findings; ask them to choose their preferred option.
- **Acceptability curves (CEACs)** illustrate choices
- Ask decision-makers for their **willingness to pay**.
- Set a **threshold**, rigidly or as a guide. E.g. the National Institute for Health and Care Excellence (NICE) in England & Wales – generally uses cost per **QALY** to compare across disorders/diseases.

Main types of health economic evaluation

Cost-effectiveness analysis: Outcomes measured in 'natural' or 'familiar' units (fewer symptoms, reduced needs, better functioning, lower family burden, etc.)

Cost-utility analysis: Outcomes measured using a uni-dimensional, generic 'utility' scale (eg QALYs - the number of quality-adjusted life years gained)

Utility scores - increasingly reported in health care research studies (... gradually in social care too), and increasingly requested by decision-making bodies.
They are simple and powerful, but have limitations

Main types of health economic evaluation

Cost-effectiveness analysis: Outcomes measured in 'natural' or familiar' units (fewer symptoms, reduced needs, better functioning, lower family burden, etc.)

Cost-utility analysis: Outcomes measured using a unidimensional, generic 'utility' scale (eg QALYs - the number of quality-adjusted life years gained)

Cost-benefit analysis: Outcomes measured in **monetary** units (£, \$...) = value of outcomes achieved or (new) **wellbeing** units

Economic evaluations: differences in scope

CEA

Compare treatment models for one 'need group' only
→ so ... fine for clinicians and others making case-level decisions

CUA

Compare treatment models across the whole system → so ... needed by strategic health bodies, ministries of Health

CBA

Compare resource use across the whole economy → so needed by governments for macro/national decisions

F



Example field:
computerised
therapy for
depression

Beating the Blues (BtB)

Computerised Cognitive Behavioural Therapy for treating anxiety and depression

- **Design:** n=274 primary care patients (aged 18-75) with depression and/or anxiety disorder; not currently receiving face-to-face psychological therapy. **RCT**
- **Interventions:** 'Beating the Blues' (BtB) – 8 sessions (50 mins each) of therapy on top of treatment as usual vs. treatment as usual (TAU) *alone* (= discussions with GP, referral to counsellor, practice nurse or MH professional, etc.)
- **Aims:** To evaluate effectiveness and cost-effectiveness of BtB compared to TAU.

BRITISH JOURNAL OF PSYCHIATRY (2004), 185, 44–54

Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial¹

JUDITH PROUDFOOT, CLASH RYDEN, BRIAN EVERITT, DAVID A. SHAPIRO, DAVID GOLDBERG, ANTHONY MANN, ANDRE TYLIE, ISAAC MARKS and JEFFREY A. GRAY

Background Preliminary results have demonstrated the clinical efficacy of computerised cognitive-behavioural therapy (CBT) in the treatment of anxiety and depression in primary care. The common mental health problems of anxiety and depression are leading causes of disability (Sturt, 1999). Compared with pharmacotherapy, cognitive-behavioural therapy is as effective in the short term

as the Programmable Questionnaire System (PROQSY). Patients were excluded if they had active suicidal ideas, a current or lifetime diagnosis of psychosis or organic mental disorder, or alcohol or drug dependence; had been taking medication for anxiety and/or depression continuously for 6 months or more immediately prior to entry; were unable to attend eight sessions at the surgery; or were unable to read or write English. Recruitment took place in general practices in London and south-east England. Patients were identified by their general practitioner or by screening with the GHQ. Patients were approached for screening while they sat in the waiting room, or if the medical records indicated that they had a current prescription

Aims To determine sample, the dependent variable was this therapy upon demographic variables.

Method A sample of anxiety and/or depression allocated to receive medication, computerised treatment as usual, assessment at 6 months.

Results The computerised treatment group showed a significant improvement in depression, adjustment, without treatment, duration or severity of episode and positive attributes interacted with computerised treatment for usual treatment for patients. Computerised treatment was more effective than usual treatment.

Conclusions CBT is a widely applicable and/or effective treatment for anxiety and/or depression.

Declaration of interest J.A.G. are minority commercial suppliers of BtB, and D.G. are consultants to Ultra.

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BRITISH JOURNAL OF PSYCHIATRY (2004), 185, 55–65

Cost-effectiveness of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial¹

PAUL MCCRONE, MARTIN KNAPP, JUDITH PROUDFOOT, CLASH RYDEN, KATE CAVANAGH, DAVID A. SHAPIRO, SOPHIE ILSON, JEFFREY A. GRAY, DAVID GOLDBERG, ANTHONY MANN, ISAAC MARKS, BRIAN EVERITT and ANDRE TYLIE

Background Cognitive-behavioural therapy (CBT) is effective for treating anxiety and depression in primary care, but there is a shortage of therapists. Computer-delivered treatment may be a viable alternative.

Aims To assess the cost-effectiveness of computer-delivered CBT.

Method A sample of people with depression or anxiety were randomised to usual care (n=128) or computer-delivered CBT (n=146). Costs were available for 123 and 138 participants, respectively. Costs and depression scores were combined using the net benefit approach.

Results Service costs were £40 (90% CI –£28 to £148) higher over 8 months for computer-delivered CBT. Loss of employment costs were £407 (90% CI £196 to £618) less for this group. Valuing a 1-unit improvement on the Beck Depression Inventory at £40, there is an 81% chance that computer-delivered CBT is cost-effective, and it revealed a highly cost-effective cost per quality-adjusted life year.

Conclusions Computer-delivered CBT has a high probability of being cost-effective, even if a modest value is placed on unit improvements in depression.

Declaration of interest J.P. and J.A.G. are minority partners in the commercial exploitation of Beating the Blues, the computerised therapy program used in the study and D.G. and J.A.G. are occasional consultants to Ultra plc; K.C. works for Ultra plc.

another paper (Proudfoot et al, 2004, this issue).

Intervention

The computerised therapy program used (Beating the Blues) consisted of a 15 min introductory video followed by eight 50 min sessions of cognitive-behavioural therapy (further details available from the authors upon request). General practitioners and practice nurses were kept informed about the patients' progress by means of automatically generated computer printouts following each session. Treatment as usual consisted of a variety of interventions, including discussions with the general practitioner, referral to a counsellor, practice nurse or mental health professional, and treatment of physical conditions.

Outcome measures

Clinical measures were recorded at baseline and at a number of follow-up points. This was a cost-effectiveness analysis, and it was therefore appropriate to use the primary clinical outcome measure in the evaluation. Further analyses used an economic measure, the quality-adjusted life year (QALY), to compare the cost-utility of the interventions. The primary clinical outcome measure was the change in the level of depression, rated using the Beck Depression Inventory (BDI; Beck et al, 1996), between randomisation and 6 months following the end of treatment (which was around 8 months following randomisation). Other clinical outcome measures used were the Beck Anxiety Inventory (BAI; Beck & Steer, 1990) and the Work and Social Adjustment (WSA) scale (Marks, 1986).

Where BDI scores were missing, values were imputed using best subset regression analysis in Stata (StataCorp, 2002). The independent variables were the available BDI scores (pre-treatment, post-treatment, and at 1 month, 3 months and 6 months following treatment), as well as BAI and WSA scores and a number of socio-demographic characteristics (age, gender, ethnicity, employment status, marital status, length of illness and whether antidepressants were being taken).

A secondary outcome measure was an estimate of the number of depression-free days in the 8 months following randomisation, on the basis of BDI scores at four assessment points (immediately post-treatment, and 1 month, 3 months and

¹See pp 44–54, this issue.

BtB: effectiveness results

- BtB better than treatment as usual on clinical measures of **symptoms** (Beck Depression Inventory, Beck Anxiety Inventory) and **functioning** (Work and Social Adjustment Schedule)

A more intuitive measure?

- BtB group had more **depression-free days** over 8 months (90 vs 60 days)

A more generalisable measure?

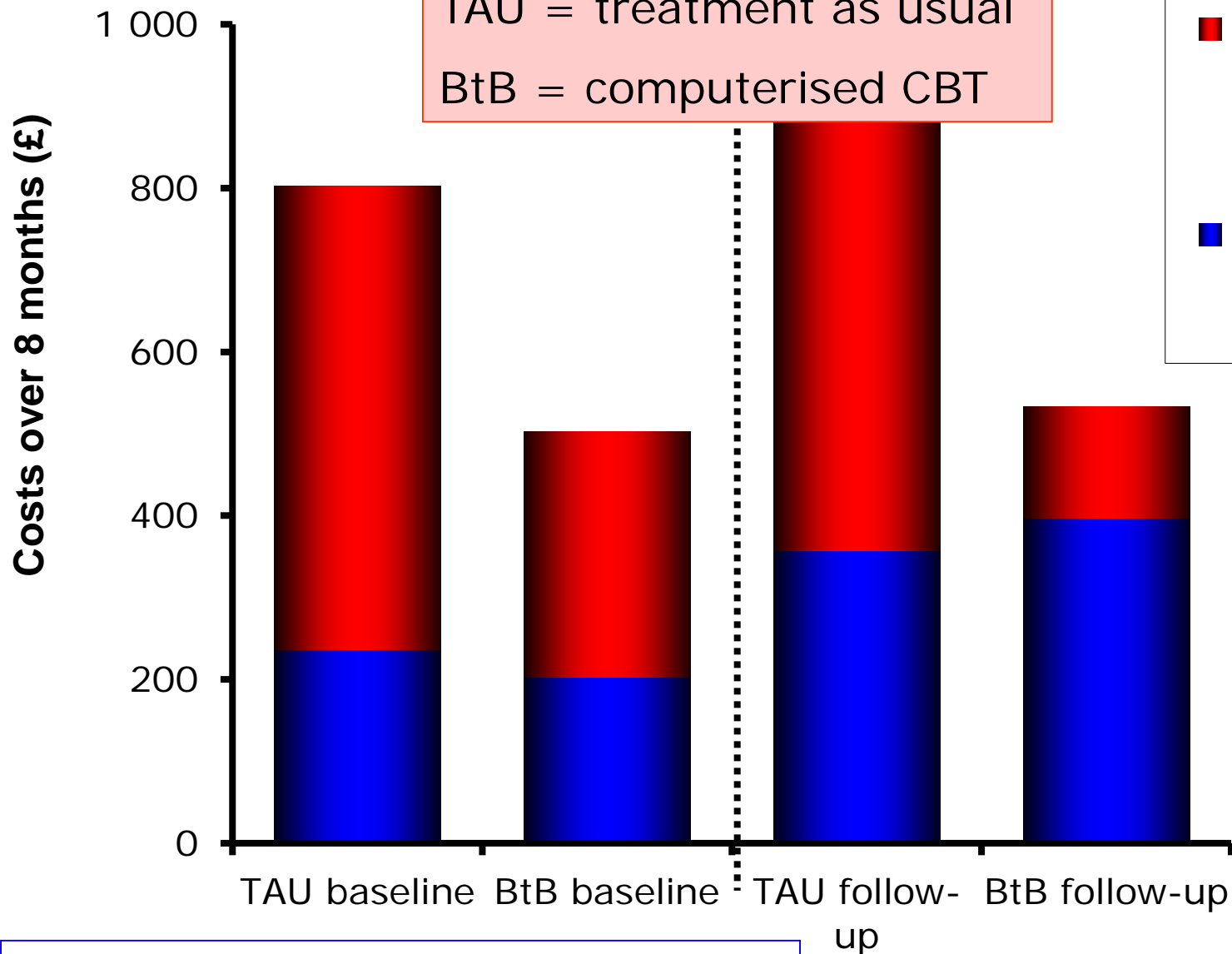
- Incremental **QALY gain** of 0.032 for BtB over treatment as usual

BtB: cost results

TAU = treatment as usual
BtB = computerised CBT

■ Lost employment

■ Health & social care



So is Beating the Blues cost-effective?

Cost-effectiveness ... in the clinical (psychiatric) field?

- What is incremental cost relative to incremental difference in clinical measures (e.g. Beck Depression Inventory)?
- ICER = £21 per unit improvement on BDI

... in a more publicly engaging sense?

- What is the cost per additional depression-free day?
- ICER = £2.50 per depression-free day

... in a wider health system context?

- What is the cost per additional QALY?
- ICER = £2190 per QALY gained - which is very low compared to NICE threshold ... and influenced NICE guidance

... from the wider societal perspective?

- Bringing in the effects on employment further supports BtB

So ... different outcome measures are useful for different audiences

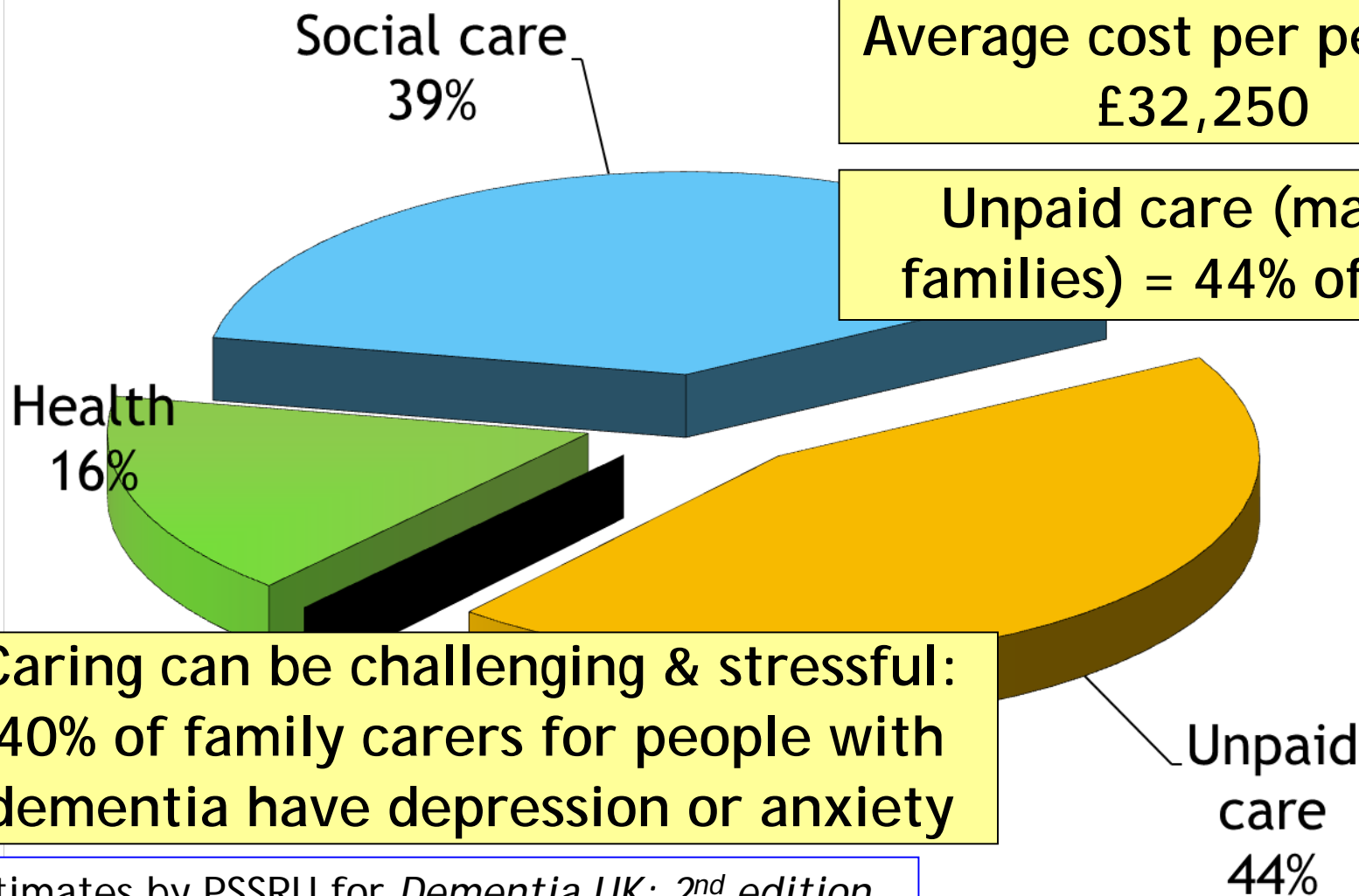


Example:
supporting
family carers

Annual cost of dementia in the UK

Total cost = £26.3 billion
Average cost per person =
£32,250

Unpaid care (mainly
families) = 44% of total



Caring can be challenging & stressful:
40% of family carers for people with
dementia have depression or anxiety

Estimates by PSSRU for *Dementia UK: 2nd edition*
published by the Alzheimer's Society Nov 2014

START: a manual-based coping strategy for family carers of people with dementia

Individual programme (8 sessions over 8-14 weeks, delivered by psychology graduates + manual); carers given techniques to:

- understand behaviours of person they care for
- manage behaviour
- change unhelpful thoughts
- promote acceptance
- improve communication
- plan for the future
- relax
- engage in meaningful, enjoyable activities.

START study of dementia carers

Carer health & QOL

Mental health gains at 8m and 24m

QALY gains at 8m and 24m

Patient health & QOL

No differences in health or QOL

Delayed care home admission *not sig.*

Costs (*not significantly different*)

Increased carer costs at 8m

Reduced total service costs at 24m

Cost-effectiveness

£118 per 1-point change on HADS-total; £6000 per QALY at 8m.

START 'dominates' usual care at 24m

Pragmatic trial: START vs usual support.

n=260 family carers of people with dementia, in North London area.

Analyses at 8, 24, 60 months after end of intervention.

Effectiveness, cost-effectiveness, personal experience.

Currently looking at carer mental health, care home admission & costs at 60m

Review of evidence on carers

Evidence on four main areas:

- services aimed at carers
- services aimed directly at people with care needs
- work conditions
- cash benefits.

What impacts on:

- Employment (carers)
- health, wellbeing
- income, wealth and assets
- changes in supply

Robust, quantifiable evidence used in our modelling of economic impacts:

- **Statutory care leave** - potentially increases unpaid care provision and increases employment, possibly combined with other interventions.
- **Flexible working arrangements** - improve carer employment outcomes.
- **Formal care** - increases supply of low-intensity unpaid care & decreases higher-intensity caring that is less compatible with employment. Home care, PA support, day care most effective for those caring 10+ hrs per week

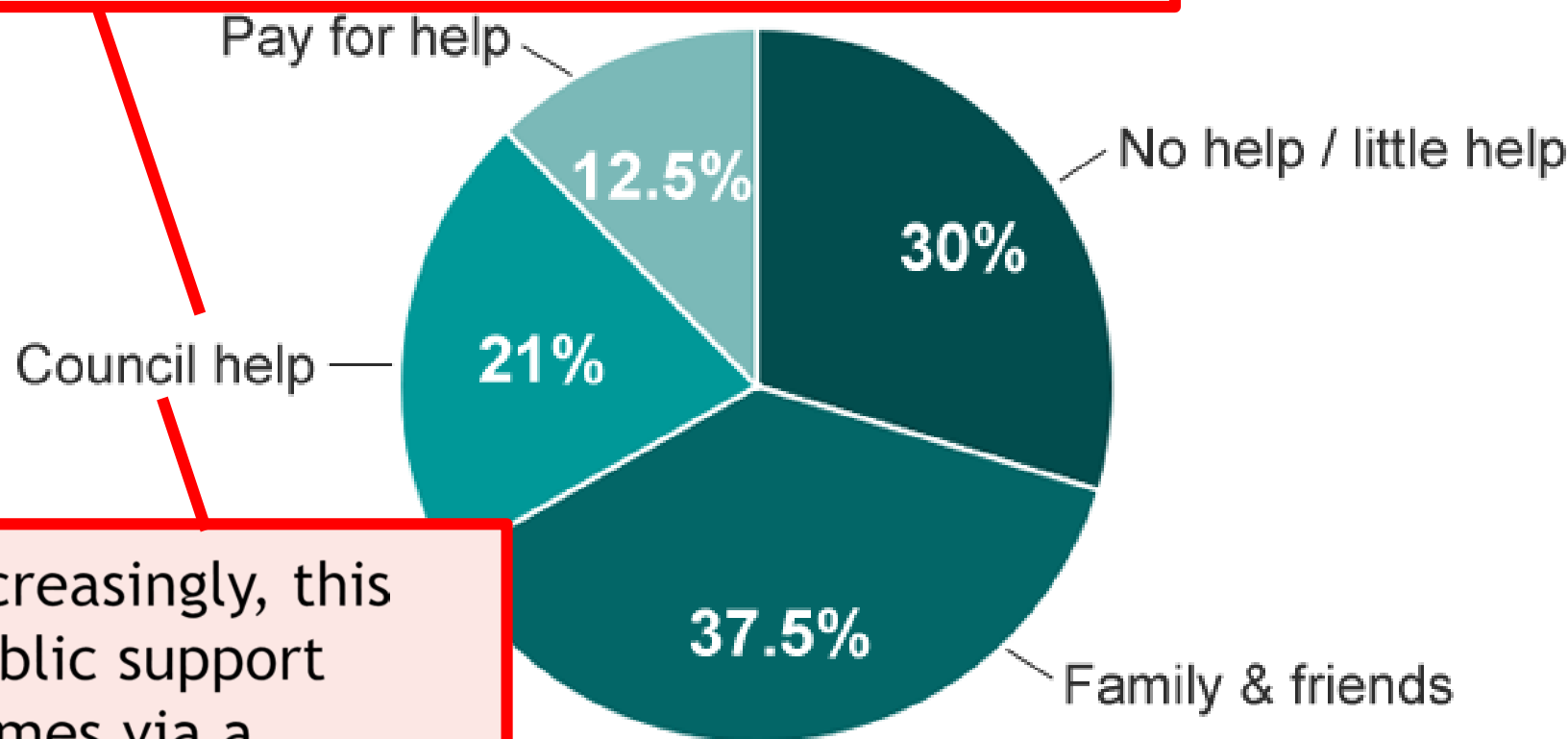


Example:
personal
budgets

“Every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings” (Department of Health 2010).

care

h



Increasingly, this public support comes via a personal budget

Digital, Carers UK

Why 'personalisation' *generally*?

Facts:

- Individuals have **different needs, preferences & circumstances**
- People have been denied their **rights** as individuals
- Un-personalised ('block') treatment / care is **discredited**
- Frequent **non-responses** to treatments / care delivered today

Hypotheses:

- Individuals want greater opportunity for **self-determination** - to participate, choose, take control
- **Empowering** people leads to more responsive systems; and to better outcomes & greater cost-effectiveness
- ... and encourages **family & community action**
- Empowering **disadvantaged groups** is fairer
- Encouraging **personal responsibility** for health (lifestyle, diet, tobacco, alcohol ...) improves longer-term health & reduces costs

Un-personalised / personalised care



1900. (Below) The kitchens at St Marylebone
London vol 3, 1903)



Personalisation of care (& health) has been central to government policy for >15 years.

- ... to promote **choice & control**
- Pilot programme of individual budgets (now called personal budgets) in England from 2005
- Evaluated in the **IBSEN study**

Individual / personal budgets - how?

- A **direct (cash) payment**, held by service user or (if lacks capacity) by a carer/family member (= 'indirect payment').
- 'Account' held / managed by **local authority** in line with user's wishes, to pay for community care services commissioned by the LA.
- Account with a **third party (service provider)**, 'spent' by user in direct negotiation with the provider. This allows individual to draw on existing or new contracts to suit their needs without taking on direct budget management responsibilities.
- ... Or some mix of the above.

The IBSEN evaluation

CORE QUESTION → Do individual (personal) budgets offer a **better way to support** disabled adults and older people than conventional methods of resource allocation and service delivery?

If so, **which models work best** and for whom?

Evaluation dimensions

User experience

Carer impact

Workforce

Care management

Provider impact

Risk & protection

Commissioning

Outcomes

Costs

Cost-effectiveness

IBSEN - design

- **Randomised trial** – IB and comparison groups (but lots of flexibility within those groups re how individuals used their budgets)
- Follow-up interviews after 6 months → some challenges (logistical, instrumentation, interviewee exhaustion, proxy respondents ...)
- In-depth interviews with 20% of users – assessment and support planning
- Interviews with lead officers (in councils, providers, commissioners, other managers, Adult Protection etc.
- Interviews and diaries – care managers, team leaders
- Add-on study of impact of IBs on *carers*

Personal budgets bought 'new' services

Accommodation	Employment and occupation	Health-related
Cleaning service	Going out: trips/cinema etc.	Private health care
Decorating service	Classes/arts and crafts	Massage for carer
Gardening service	Gym membership /swimming	Alternative therapy
	Computer maintenance	... Dating agency
	Admission fees for service user and PA	

The views of personal budget holders (1)

Comment on standard care:

"That's all they recognise, just your personal care, being washed and all that. And you know, other things are so much more important to your well-being." (Older person)

Personalisation - benefit:

"It's given me more say and I can do more."

(A woman with physical disability able to go on holiday, employing her sister as her carer)

The views of personal budget holders (2)

Reluctance to take responsibility:

"I don't want to be dealing with that sort of thing at my age, dear." [I.e. the 'hassle costs' of choice]

Anxiety or unwillingness to manage money

"Carers are all laid on for me at the moment and I haven't got the time and I haven't got the brain really to work out financial details or anything like that, and I'm quite happy with the arrangement I've got."

Able and willing to handle finances without stress

"So I thought, right, I can do this cheaper myself so ... I went to a smaller, cheaper and far superior agency."

IBSEN study: outcomes & costs

Domain	Pooled sample	Subgroup differences?
Quality of life	No difference	IBs better for mental health subgroup
Psychological well-being	No difference	IBs worse for older people
Social care outcomes	No difference*	No difference*
Satisfaction	IB better	IBs better for physical/sensory disability group
Costs	IB slightly lower	No difference

* IBs offered more 'felt control' when analysed for the overall sample and the learning disability group

IBSEN: factors linked with cost variations

<u>Regressor variables</u>	<u>Coeff't</u>	<u>p</u>
Individual budget group	-0.103	0.24
Count of lack of problems with ADL activities	-0.155	0.00
Count of lack of problems with ADL activities (squared)	0.002	0.00
Evidence of cognitive impairment	0.191	0.03
Mental health user group	-0.562	0.00
Age of service user	-0.009	0.00
Principal carer living in the household	-0.222	0.01
Service user is employed	-0.669	0.01
Service user is white	0.420	0.01
User refused Individual Budget (within intervention group)	1.033	0.08
Support plan not in place by time of interview	0.299	0.05
Constant	8.101	0.00

GLM, with logarithmic link function and Gamma variance function. Pseudo-R² = 11.5%.

Glendinning et al *IBSEN report* 2008; Jones et al *Public Money & Management* 2011

Overall conclusions from IBSEN

- Individual (personal) budgets have positive effects:
 - Quality of life, social care outcomes, satisfaction
- But outcomes were much less positive for older people:
 - Concerns about managing budgets
 - Need more ongoing support
- Levels of support were found to influence the outcomes achieved ...
- ... and various factors generated cost variations ...
- ... with implications for cost-effectiveness.

Impact: Although the Government didn't wait for IBSEN results before proceeding with national roll-out of Personal Budgets, it did take account of findings (especially for older people).

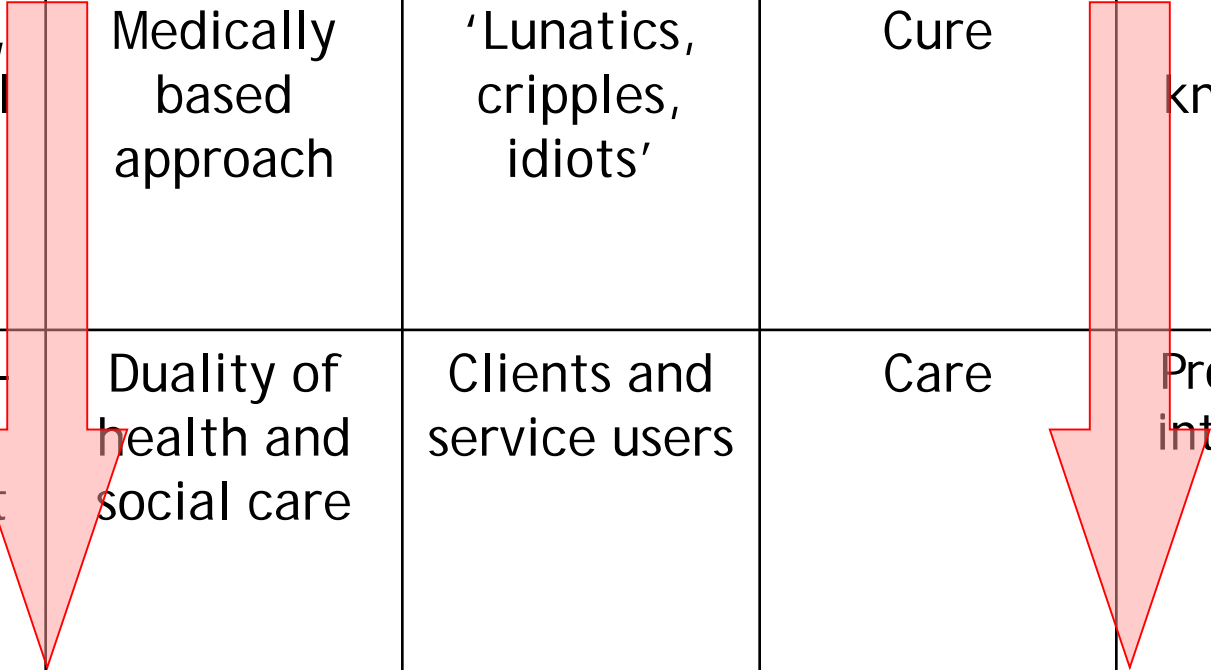
Changes in approach over 60+ years

Segregated, institutional care	Medically based approach	'Lunatics, cripples, idiots'	Cure	Doctor knows best

(Borrowed from a presentation by Robin Murray-Neill)

Changes in approach over 60+ years

Segregated, institutional care	Medically based approach	'Lunatics, cripples, idiots'	Cure	Doctor knows best
Community-based care and support	Duality of health and social care	Clients and service users	Care	Professional intervention

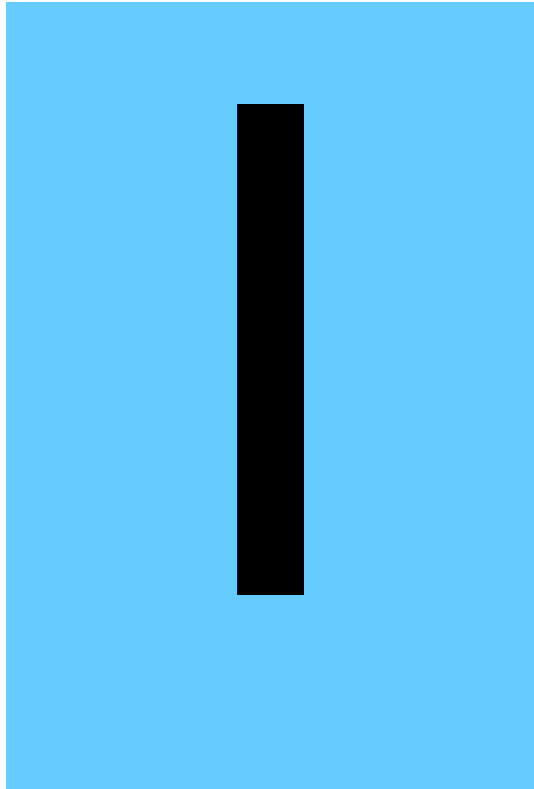


(Borrowed from a presentation by Robin Murray-Neill)

Changes in approach over 60+ years

Segregated, institutional care	Medically based approach	'Lunatics, cripples, idiots'	Cure	Doctor knows best
Community-	Duality of	Clients and	Care	Professional
Risk & responsibility have been increasingly shifted to the individual: it will probably continue				
Personalised support Precision medicine	Socially based & recovery approaches	Citizens with equal rights & opportunities	Independent living Self-directed services	Individual knows best Co- production

(Adapted from a presentation by Robin Murray-Neill)



Conclusions - some challenges

Challenges of social care economic evaluations

- i. Many public/social services have impacts in **many domains**...
- ii. ... and hence costs can range widely over **different budgets** (central & local government; public, private & third sectors)
- iii. There may be a **mismatch** between the budget paying for the service and the budget(s) benefitting from pay-offs
- iv. Some economic impacts are **hidden** (e.g. effects on carers)
- v. Some impacts are **delayed** (e.g. effects of better early years care on adulthood employment & earnings)
- vi. Some are **long-lasting** consequences (over the life-course?)
- vii. Some **outcomes** are hard to measure and/or contested
- viii. Some interventions may be cost-effective but actually require additional expenditure - i.e. they are **cost-increasing**
- ix. ... and some apparent savings may not be **cashable**
- x. There are often **wide variations** in costs & outcomes

Responding to those evaluation challenges

- a. Gather **evidence** on all economic impacts: long- & short-term; narrow & broad; cashable & non-cashable.
- b. Conduct the **best possible** cost-effectiveness (etc.) analyses
- c. Include careful analyses of inter-individual (etc.) **variations**
- d. **Share findings** far and wide; highlight pay-offs relative to investment for each organisation & year, and their 'cashability'.
- e. Some challenges suggest simple negotiation on **compensation**
- f. Some challenges suggest more complicated discussion around joint commissioning, pooled budgets or some **joint strategy**.
- g. Sometimes **one dimension of pay-off** alone may be sufficient to justify investment or compensation: others are a bonus.
- h. And maybe **short-term gains** are sufficient to justify action: longer-term pay-offs are a bonus.
- i. Remember: being '**worth it**' is not a scientific decision; it is a **value judgement**.

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Thank you for your attention

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