about, for example, how the principle of 'substituted judgement' and the 'inquisitorial' mode of hearing are working out in practice. Creyke's concern about the substitute payee schemes in Australia echo the problems of those operating in England and Wales. The Law Commission have proposed reforms to the appointee scheme. Given the many thousands of people in Britain who are dependent upon someone else to handle their pension, such reform is long overdue.

Department of Health and Social Welfare,
The Open University,
Milton Keynes, Buckinghamshire

Costs of Care

Paul Plant

Kavanagh, S., Schneider, J., Knapp, M., Beecham, J. and Netten, A., Elderly people with cognitive impairment: costing possible changes in the balance of care, *Health and Social Care in the Community*, 1 (1993), 69–80.

The 1990 National Health Service (NHS) and Community Care Act, and subsequent government guidance documents, have set out the direction for change in the provision of health and social care for elderly people in the United Kingdom. Included amongst the goals of these changes are: a reduction in the use of long-stay hospital accommodation, delayed admission to residential care from private households, and better support for carers. This paper considers a number of policy options for changing the pattern of services for elderly people with advanced cognitive impairment, and attempts to estimate the cost of providing such packages of care in England as a whole.

Potential service changes are evaluated against a baseline option, which is simply to continue offering the same packages of care which are available now. Using data from the Office of Population Censuses and Surveys' Disability Survey, they consider the number of people with advanced cognitive impairment and then estimate the cost of these current packages of care. The options considered were: living alone in a private household; living with others in a private household; a local authority residential home; a private or voluntary residential home; a private or voluntary nursing home; and a long-stay hospital. The results demonstrated that, for example, the estimated average weekly cost of living alone in a private household was £206.76, compared to £729.44 for those in long-stay accommodation. These

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costings, and the estimates for policy options, were based on their own research and secondary data analyses.

The second option considered is 'to extend the availability of respite care to the carers of the approximately 160,000 elderly people with advanced cognitive impairment living in shared private households, so as to lessen the burdens of informal care and allow elderly people to remain in the community longer before entering institutional care'. The authors cost this policy option on the basis of a single study which evaluated a specialist family support unit that offered tailor-made packages of care with a mix of other community services. On this basis, the comprehensive weekly cost would be £281 for the package, or a total of £5,405 million for England. This represents an increased cost of £367 m., over the baseline total of £5,038 m.

Developing the theme of community support to private households, the authors consider providing enhanced home support to the 43,000 people living alone in the community. The aim of such services would be to enable people to live in their own homes longer, and to improve their quality of life. The scheme they used as a model to base their cost estimates stressed the coordination of existing services, as well as providing staff to supply practical assistance, care, and sitting services. This option was found to cost an additional £119 m. per annum over the baseline, or £260 per week for the package.

Two policy options to reduce long-stay hospital provision were costed. The first would move the estimated 34,000 in-patients with advanced cognitive impairment into a combination of local authority residential homes (54%), voluntary or private residential homes (18%), and private and voluntary nursing homes (28%). The second would move hospital patients to NHS nursing homes. This option has been shown to be preferred by relatives, to improve ability to perform activities of daily living, and to reduce costs compared to hospital, whereas there is little evidence about the effectiveness of the first option. The first option would lead to an overall cost saving of £757 million. The overall figure masks however important differences with respect to who would meet the costs of this package of care. Health Authorities would save a total of £1225 m., but all other founders of health and social care would have their expenditures increased. The second of the options, designed to reduce the number of people in hospital beds, would lead to an overall resource saving of £571 m. The problem with both of these estimates is that they assume all people with advanced cognitive impairment would be eligible for the care package. It is likely, however, that a proportion of them will have additional

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health problems that would require alternative service provision, or mean that it would be inappropriate to remove them from hospital.

The sixth option looked at by Kavanagh and colleagues is one which would provide specialist residential care for the estimated 45,000 elderly people currently in local authority homes, by altering certain environmental characteristics. The model considered was one of offering a high level of therapeutic input based on 'reality orientation', which has been shown to offer a cost-effective alternative to hospital. The costs of substituting this higher quality residential service for standard local authority care were found to be £199 m. more than presently-available standard packages of care. The final two options considered combinations of the others to estimate the costs of providing universal changes in provision. The total package was estimated to cost an extra £114 m. per annum. This figure rises to £400 m. if it is assumed only 50% of people in long-stay hospital beds are able to transfer to other care settings.

The authors conclude that quality could be improved at very little cost, and might even be accommodated largely from existing finances if long-stay hospital provision was reduced. The factors are also discussed that might cause supply constraints to inhibit the expansion of community-based care.

SUMMARY

Kavanagh *et al.*'s paper provides illustrative costings of the policy options for enhancing community based provision for people with advanced cognitive impairment. Such estimates require many assumptions, but these probably are the best that can be made given current knowledge. As some of the assumptions are open to debate, further work is needed to examine the sensitivity of the costs to different assumptions. Different service options should also be considered, because for a number of the proposed packages of care, single studies are the source of data of effectiveness and costs. The paper does, however, offer a best guess at the national cost of a comprehensive, community-based, range of services to this group. The conclusion, that a better quality of care could be offered for only a modest increase in cost, and that this could be financed largely from existing resources, is important and should be communicated to policy makers.

South East London Health Authority,
London SE1 7RJ

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