# Building community capital in social care: Is there an economic case?

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## ABSTRACT

Current debates in many countries about the sustainability of public commitments include discussion of the adequacy and affordability of collective health and social care responses to the rapidly growing needs of ageing communities. A recurrent theme in England is whether communities can play greater roles in preventing the emergence of social care needs and/or in helping to meet them. A number of approaches have been suggested, employing a range of concepts and terms, including community development, community capacity-building and creating social capital. We investigated whether initiatives of this kind generate cost-savings to the public purse and more broadly to society. We used a cost-benefit approach and decision-modelling techniques to demonstrate potential costs and economic consequences in a context where evidence is limited and there is little opportunity to collect primary data. We found that there could be sizable savings to the public purse when investing in community capital-building initiatives at relatively low cost. We discuss the limitations of our analysis and recommend collection of better outcome data.

## INTRODUCTION

Supporting independence, promoting choice and encouraging prevention have been local and national social care policy emphases in England for many years. But pursuit of such laudable ambitions is restricted by many things, not least the availability of resources of money, time or effort, both public and private. One immediate and pervasive consequence is the need to consider very carefully how these various resources *are*, or *could* be used to achieve better individual and community outcomes.

A recurrent theme in policy discussions, and one that has attracted growing attention in recent years, is whether communities can play greater roles in preventing and meeting social care needs. (By social care we mean the help and support provided that allows people to retain (or regain) their independent lives, control and dignity, as defined by the Department of Health.) A number of approaches have been suggested, employing a range of concepts and terms, including building

community capacity, investing in social capital and fostering community development. For example, Labour governments in the UK after 1997 emphasised community engagement through Local Area Agreements and Neighbourhood Renewal, the Single Regeneration Budget, the New Deal for Communities and Health Action Zones (Wright *et al.*, 2006; Cabinet Office, 2001). The present UK Coalition Government's vision, partly exemplified by its commitment to 'Big Society' but ranging wider, includes ideas for increasing local involvement, moving service provision and decision-making closer to local communities (Cabinet Office 2011; DH 2010). There are plans to create new neighbourhood groups, especially in deprived areas. Volunteering is strongly encouraged, as is the creation of social enterprises and other organisations with charitable status which might take over local state-run services. Independent community organisers are also proposed. In their Foreword to *A Vision on Adult Social Care* – the Coalition Government's first policy statement on social care – the Secretary of State and Minister of State for Care Services argued: 'Care must again be about reinforcing personal and community resilience, reciprocity and responsibility, to prevent and postpone dependency and promote greater independence and choice' (Department of Health, 2010).

Building community capital (as we term the approach in this paper) might involve utilisation of a range of community assets, and is argued to have the potential to benefit communities as a whole while providing personal benefits for individuals and families. Among the outcomes of such activities could be higher levels of trust, greater personal independence, higher levels of participation in community activities and reduced social isolation (e.g. see McCabe, 2010). In turn, these could offer a level of personalisation that is perhaps unattainable through traditional service models and thereby improving health and wellbeing, and so reducing reliance on care services (DH, 2010). The versatility of community capital initiatives in responding to individuals' needs potentially gives rise to a wide range of benefits, not confined to people needing health and social care support, or to those at risk of needing such support in the near future. These might include the improvement and sustaining of neighbourhoods, greater equity in access to care and support, and the inclusion of marginalised groups (Sherrieb *et al.*, 2010; Boyle D, 2005). Among the consequences might be greater community safety, increased levels of citizen participation, improved physical and social environments, and increased levels of support that helps people to do their jobs and find employment (Milton *et al.*, 2011; Bruce *et al.*, 2011; Eversole, 2010; Buonanno, 2009).

Community capital-building initiatives of this kind are not primarily concerned with improving efficiency, but at a time when social care budgets are particularly tight, it is pertinent to ask what roles these initiatives might play in achieving better individual and community outcomes from available resources. In short, is there an economic case for community capital-building?

**METHODS**

In seeking to address this question we did not to try to cover the full span of community capital-building initiatives but to examine a few approaches recommended in national policy documents or developed locally because of their perceived benefits. After discussion with a range of people working in community initiatives, central and local government officers and researchers, we eventually chose to focus on three approaches that are commonly implemented (often under different names): time banks, befriending and community navigator initiatives. For the third of these we looked at debt and housing support. We did not attempt to generalise to other approaches.

**Economic evaluation**

The primary aims of any system of care and support are to prevent needs arising, to meet them when they do, and – although emphasised only recently in many national policy statements - to ensure the active participation of people affected. The overarching intention could be seen as the improvement of wellbeing. This is the *effectiveness* aim. Alongside it runs the *cost-effectiveness* aim: from given resources, to achieve better outcomes for people who use services, people who support them (their carers) and people at risk of developing a need for such support.

In pursuing an aim such as cost-effectiveness in an area such as social care, the term 'resources' should be interpreted broadly to encompass not just the budgets of public and independent sector bodies but also the unpaid time of family and other carers. The opportunity costs of (say) lost employment also need to be considered, where relevant. And when thinking about the effectiveness side, the interpretation of outcomes should be wide enough to cover all impacts on individual wellbeing as well as broader social impacts such as trust, independence and community participation or reduced levels of antisocial behaviour and social isolation. One evaluative approach suitable in this context is cost-benefit analysis (e.g. Sefton *et al.,* 2002). (The social return on investment (SROI) approach which is currently quite prevalent has many similarities if undertaken thoroughly.) By attaching a monetary value to these outcomes, cost-benefit analysis seeks to compare – in the same currency units – the resources expended with the outcomes achieved.

As noted earlier, we focused on initiatives for which there was strong support, perhaps strong evaluative evidence, of effectiveness along one or more outcome dimension. We used simple decision-modelling techniques to estimate the economic consequences. Decision models allow the researcher to draw together evidence from a range of sources to simulate the outcomes and/or costs of alternative courses of action (e.g., as described by Drummond *et al*., 2005). To populate our models with parameter values, we carried out a rapid review of the literature for each of the three initiatives. We chose a one-year time horizon because the quality of available longer-term evidence was poor.

We were not able to collect much primary data because of our limited research budget, and so our analysis examined the economic case for an 'average' or 'typical' community capital-building initiative, based on anticipated costs and economic consequences. We examined costs and benefits from a range of perspectives, with a focus on the public sector viewpoint (i.e. spending by and savings to the state). An assignment of monetary values to certain outcomes (quality of life improvements) was carefully explored from a societal perspective. Throughout the analysis we were conservative in our assignment of monetary values to outcomes.

We searched published and 'grey' literature, looking for studies that evaluated the effectiveness of these interventions. Together with expert opinion (see acknowledgements), this evidence informed the design of the pathways linking community initiatives to potential costs and outcomes. We examined different assumptions about the mix of paid and unpaid staff to reflect different scenarios, each with potentially different impacts on the costs of interventions.

**Time banks**

Time bank participants contribute their skills, practical help or resources in return for services provided by fellow participants. Time, rather than money, is the community currency. Time banks appear to lead to improvements in social inclusion. For example, a 2001 survey in the UK found that time banks were more successful than traditional forms of volunteering in attracting socially excluded groups (Seyfang, 2002). While benefits such as improved independence, wellbeing and social inclusion cannot easily be assigned monetary values, there is evidence that time-banking has the long-term potential to generate savings to local and national budget-holders (New Economics Foundation 2002a; Simon 2003). Examples of positive physical and mental health impacts, an increase in self-esteem and confidence, improved employment prospects and decreased reliance on alternative forms of paid and unpaid support have been attributed to time bank participation (Lasker *et al,.* 2011; Collom, 2008; Seyfang, 2001).

*Potential economic consequences*

Three groups of potential outcomes with economic implications were therefore identified: the value of service hours created; the increased probability of participants returning to employment or volunteering (stemming from increased self-esteem and confidence, acquisition of skills, and new social relationships and networks and reduction in benefit claims. Individuals benefit because of the services and activities they receive which they would otherwise only have been able to access by paying a fee. We valued these consequences by applying an estimated market price to the kinds of activities typically exchanged at time banks, multiplied by the average number of hours a member was estimated to receive over one year. A proportion of this is likely to represent savings to social care and other public expenditure depending on the exact nature of the time bank and the services exchanged.

From national statistics on volunteering we estimated the likelihood of an individual entering formal volunteering because of their engagement with a time bank and multiplied this by the number of hours that a volunteer is estimated to spend on average with volunteering activities over the course of a year. Similarly, we assumed a certain likelihood of someone moving into employment based on information from other community development schemes and also by consulting experts for their views. We conservatively valued volunteering at the minimum hourly wage rate and employment with an average wage rate of people moving from incapacity and other benefits into employment. Table 1 lists the parameters used for this model, the values ascribed to them, and the sources of evidence.

*Wellbeing improvements*

We valued the likely wellbeing improvement of a socially isolated person who has more social contacts and support after becoming involved with the time bank scheme. We applied a health utility to the additional number of days a person with extended social networks and support is likely to spend mentally well compared to their socially isolated counterparts. (Health utilities are established through surveys which ask people about their preference for certain health states on a scale from 0 to 1 where 1 represents full health and 0 represents death.) An indicative economic value was calculated from the proportion of a quality adjusted life years gained through time banks.

*Costs of running time banks*

A 'time-broker' is usually appointed to coordinate time bank activities, operating from an office base with a computer to record transactions. We looked first at the costs if a volunteer takes on this role, estimating overheads and trainings costs from Curtis (2010), and dividing by the number of participants. We estimated a higher cost value if the time-broker post was filled by a full-time employed person. We also examined the effect of additionally assuming an upper value if the post of time bank coordinator was filled by a full-time person employed by a local authority.

**Table 1: Parameter description and values for time bank schemes (TB)**

| Parameter | Description | Value used for analysis (*per recipient*), 2010 prices | Sources |
|---|---|---|---|
| Unit costs for TB coordination | Lower estimate if coordinator is unpaid, higher value if paid £23,000 per year; assumed is TB of 50 participants | £607 (£312-£902)/year | Gaskin, 2003*;* Curtis 2010: Unit cost for Family support worker |
| Likelihood of becoming a volunteer because of involvement with TB | Derived from comparison between proportion of individuals volunteering in socially excluded neighbourhoods versus non socially excluded groups | 4.5% | *DCLG Citizenship survey* 2008-2009 (*Department for Local Communities and Government*, 2010); Seyfang and Smith, 2002 |
| Average number of hours of services received | Calculated for a 12 months from: 2,950hrs of service provided/ received by 68 members over a 18 months period | 29hrs/year | Evaluation reports for Rushey Green time bank in *New Economics Foundation*, 2002b; *Time Banking UK*, 2001 |
| Average value of services | Average market price for activities typically exchanged at TB such as child care, transport, IT courses, fitness, arts and crafts. | £17.5/hr (£5-£30) | Websites of community organisations; Curtis, 2010 |
| Likelihood of returning to or entering employment because of involvement with TB | Derived from information of success of community development schemes in achieving employment in deprived areas | 4.5% | Informed by expert opinion and performance reports in *Citizen Advice Bureau* (2009; 2010) |
| Average value of employment | Average wage rate per annum for people who moved from incapacity benefits into work | £11,132 | Perkins *et al.,* 2009 |
| Average value of volunteering | Minimum wage rate per hour of £5.8 multiplied with the average hours people surveyed stated that they volunteer (12.5hrs) | £870 | Perkins *et al.,* 2009; *Department for Local Communities and Government* (2010a) |
| Out-of-work benefits | Weighted average for three benefit types: Incapacity benefits, income support, Job Seeker's Allowance | £80/wk | DWP statistics on benefit expenditure 2009/10; ONS for statistics on no. claimants |
| Value of quality-adjusted life years (QALY) gained | Usually evaluated through surveys by which people are asked how much they are willing to pay for one additional year of survival in perfect health | £20,000 | *National Institute for Clinical Excellence* (2008) |
| Health utility for mild to moderate depression | Quality of life value that is assigned whereby 1 is full health and 0 is death | 0.69 | Revicki and Wood, 1998 |
| Average number of days with depressive symptoms because of social isolation | Derived from the additional number of days socially isolated older people spend on average in depression compared with their less isolated | 38days/year | Keyes *et al.*, 2005 |

| | counter parts | | |
|---|---|---|---|

## Befriending

Befriending is social support provided by an individual 'befriender' through an affirming, emotion-focused relationship developed over time. Befriending has been shown to alleviate social isolation and prevent or reduce loneliness and depression, particularly among older people (Windle *et al.*, 2009; Charlesworth *et al.,* 2008).

*Potential economic consequences*

In discussions with experts working in the community sector, many potential benefits of befriending schemes were suggested, such as reduction in health service visits, need for self-care and falls by older people. We focused on outcomes backed up by reliable evidence that befriending reduces the risk of depression, achieved through a reduction in loneliness (Wilson *et al.,* 2007, Cacioppo *et al.*, 2006). We conservatively assumed a decrease in loneliness by one standard unit on the Revised UCLA scale (Russell *et al.*, 1980) which measures feelings of social isolation and loneliness, and translated this into a reduction in depressive symptoms measured on the Centre for Epidemiologic Studies – Depression Scale (CES-D; Radloff, 1977). A reduction in costs to the public sector was modelled based on evidence of greater service use by people with depression and a reduction when symptoms are alleviated. The parameters used in the model, the values ascribed to them and sources are presented in Table 2.

*Costs of befriending schemes*

We took mean length and number of sessions typically provided per person per year from figures provided in the review by Mead *et al.,* (2010). For a minimum value, we estimated the cost per hour from data on the resources required to support volunteers (Gaskin, 2003). We tested the impact of higher values for volunteering based on overhead cost data for management, supervision and training for staff.

*Wellbeing improvements*

Wellbeing improvements associated with an expected average reduction in mentally unhealthy days of a previously isolated person were estimated following the same approach as that used for time banks. Two scenarios were considered: one in which the effect lasted for a full year and one in which the improvement in mental wellbeing only lasted for the duration of the intervention. For our base-case modelling, we took the average of the two time periods.

**Table 2: Parameter description and values for befriending Interventions**

| Parameter | Description | Value used for analysis (*per recipient*), 2010 prices | Sources |
|---|---|---|---|
| Duration of the BF | On average, 1 hour sessions provided over 12 weeks | 12hrs | Mead *et al,*. 2010 |
| Unit costs of befriender | Costs of overheads, supervision and training divided by the average number of hours volunteered in England (12.5hrs) | £7.5/hr (£4.8-£10) | Gaskin, 2003; Curtis, 2010 |
| Average increase in | Depressive symptoms measured on | 2.62 | Cacioppo *et al.*, 2006 |

| depressive symptoms because of loneliness | CES-D | | |
|---|---|---|---|
| Costs associated with an increase in depressive symptoms by one standard unit | Depressive symptoms measured with BDI which closely correlated with CES-D; costs include health service costs and home helps but no other social care services | £14.5 | Beecham *et al.*, 2008; Wilcox *et al.*, 1998 |
| Value of quality adjusted life year | See table 1 | £20,000 | See table 1 |
| Health utility for mild to moderate depression | See table 1 | 0.69 | See table 1 |

## Community navigators

Community navigators act at the interface between community and public services where mainstream support fails to reach vulnerable groups such as people with disabilities or mental illness (Turning Point, 2010; Stalker *et al.,* 2008). Navigator schemes are thought to lead to earlier and more appropriate access to public services (Anderson and Larke, 2009). Responding to unmet needs, navigators and similar signposting schemes operating in deprived areas in England often provide emotional, social and practical support in relation to housing and debt problems (Citizen Advice Bureau, 2009; 2010). In our model we assumed that for a certain proportion of individuals, problems can be resolved through low-level support provided by the navigators themselves without the need for further agency involvement.

*Potential economic consequences of debt advice*

Pathways for the model were drawn from national survey data which show that debt problems are associated with increased likelihood of loss of employment, take up of unemployment benefits, more days taken off work, physical and mental health problems We linked this to evidence showing the likelihood that debt advice interventions are effective in alleviating debt problems (see Table 3 for parameters and sources).

**Table 3: Parameter descriptions and values for community navigator scheme – debt advice**

| Parameter | Description | Value used for analysis (*per recipient*) | Sources |
|---|---|---|---|
| Duration of CNS | On average, 1.5hrs per week over a period of 12 weeks | 18hrs | Assumption based on caseload information from CNS in Hartlepool, UK |
| Unit cost of CNS | Lowest estimate based on mix of paid (one third) and unpaid staff (two third) Highest estimate based on paid staff only (£23,000 per year) | £34/hr (£19-£49) | Curtis, 2010: Family support worker; table for costs for unpaid staff |
| Likelihood that *debt* problem can be met directly by navigators | This is an estimated proportion of individuals whose issues can be solved with low level emotional and practical support without requiring statutory involvement. | 10% | Assumption informed by expert opinion |
| Likelihood that *debt* advice alleviates debt problems | Taken from the literature for face-to-face debt advice | 56% | William and Sansom, 2007; Pleasence *et al.,* 2007 |
| Reduced risk of losing | Derived from proportion of people | 10.5% | English and Wales Civil and |

| employment because of alleviated *debt* | surveyed who stated that they lost their job because of their debt problems | | Social Justice Survey, 2004; Advice Agency Client Study, 2007 |
|---|---|---|---|
| Reduced likelihood of person taking up out-of-work benefits because of *debt* | Derived from the proportion of people surveyed who stated that they had taken up out-of-work benefits because of their debt problems | 6% | English and Wales Civil and Social Justice Survey, 2004; Advice Agency Client Study, 2007 |
| Reduced likelihood of person taking time off work associated with alleviated *debt* | Derived from proportion people surveyed who stated that they had taken time off work because of their debt | 42% | English and Wales Civil and Social Justice Survey, 2004; Advice Agency Client Study, 2007 |
| Average number of days taken off work by an individual with *debt* | Derived from the average number of days taken off work by people with depression | 30 days | Skapinakis *et al.*, 2006; Health and Safety Executive UK, 2005/6 |
| Out-of-work benefits | See table 1 | £80/wk | See table 1 |
| Reduced likelihood that individual visits GP because of *debt* | Derived from proportion of individuals surveyed who reported that they experienced health problems because of their debt and had visited their GP as a result | 21% | English and Wales Civil and Social Justice Survey, 2004; Advice Agency Client Study, 2007 |
| Average number of GP visits because of *debt* | Derived from number of GP visits that individual stated they had because of their debt | 3.5days | English and Wales Civil and Social Justice Survey, 2004; Advice Agency Client Study, 2007 |
| Cost of GP visit | Cost per GP consultation | £53 | Curtis, 2010 |
| Cost of referral to statutory *debt* advice service | Costs of visit to Citizens' Advice Bureau or Job centre Plus | £196 | Legal Services Commission |
| Health utility for mild-moderate depression | See table 1 | 0.69 | See table 1 |
| Health utility for mild depression | Quality of life value assigned to mild depression | 0.73 | Revicki and Wood, 1998 |

*Potential economic consequences of housing advice*

It was more difficult to establish pathways linking housing support to outcomes and their economic consequences. Although there is evidence of negative consequences of poor housing and homelessness (Villanueva, 2004), there is for example little evidence on the effectiveness of low-level support in avoiding homelessness (Pawson *et al.*, 2007). Links between homelessness, addictions, mental and physical health problems, domestic violence and criminal behaviour are complex and there are no national data on how people move between housing services or the associated outcomes and costs.

The following steps were taken. First, we estimated cost-savings for a reduced average risk of an individual becoming homeless. This was based on estimates from different data sets including the population at risk of homelessness together with national data on average proportions of those for whom it is likely that a statutory duty applies to provide assistance. Second, a pathway was drawn for the proportion of individuals who are supported by the navigators and benefit from the direct low-level support. This leads to a reduction in crises services and averts contacts with the statutory housing sector (see Table 4 for parameters and sources).

*Wellbeing improvements*

The evaluation of improved wellbeing outcomes that can be attributed to the debt (housing) advice and signposting was based on the expected likelihood that the intervention is successful in reducing depression symptoms associated with debt (unstable housing situation). See Tables 3 and 4 for the parameter values used in the models. The reduction in depressive symptoms was conservatively estimated to correspond to an improvement from moderate to mild depression and utility was valued in the same way as described earlier

*Costs of community navigator schemes*

The costs of navigator interventions vary according to assumptions made about the employment of staff and volunteers. We considered two scenarios, one in which navigators were paid staff, and one where schemes are run by a mix of paid (one-third) and unpaid (two-thirds) staff. Paid navigators were assumed to be employed by local authorities and to operate on similar salary and terms (caseload, overheads) to family support workers. Costs for volunteers were based on estimates from Gaskin (2003).

**Table 4: Parameter descriptions and values for community navigator scheme - housing**

| Parameter | Description | Value used for analysis (*per recipient*) | Sources |
|---|---|---|---|
| Duration of CNS | See table 3 | 18hrs | See table 3 |
| Unit cost of navigator | See table 3 | £34/hr (£19-£49) | See table 3 |
| Likelihood that *housing* problem can be met directly through CNS | Proportion of individuals whose issues can be solved with low level emotional and practical support without requiring statutory involvement. | 20% | Assumption informed by expert opinion |
| Likelihood of someone accessing *housing* service because of CNS and eligible for assistance | Derived from proportion of individuals who meet the homelessness criteria for statutory support among those who access housing, and applied to population estimated to be in need | 11% | DCLG P1E Homelessness returns (quarterly): homelessness decisions 1998-2010 and housing application statistics 2010 |
| Reduced risk that person experiences depressive symptoms because of alleviated *housing* problems | Derived from proportion of people surveyed who stated that they experienced depression because of their housing situation | 56% | Villanueva (2004) |
| Cost of crisis service | Estimated by A&E attendance and admission | £97 | Department of Health, 2011 |
| Costs of *housing* prevention service | Average cost per prevention work | £1,764 | Research by Heriot Watt University 2009: Pawson *et al.*, 2007 |
| Savings because of *housing* prevention | Average across different prevention schemes including rent deposit, finder's fee, family mediation, domestic violence victim support | £2,430/year (£2,516-£3,752) | Pawson *et al.*, 2007 |

**RESULTS**

**Time banks**

Time bank costs ranged from £312 per person per year if the scheme was run by volunteers only to £902 if paid staff were employed. The mean of these two (£607) was taken for our base case modelling. The economic consequences stemming from a 'typical' time bank were estimated to exceed £1,300 per member. Of those, short-term cashable savings to the government would include reduction in benefit claims estimated at £187. The net economic benefit of a typical time bank – even when looking at only a narrow range of outcomes – would be approximately £670 (Table 5). If the economic value of quality of life improvements is included, the net benefit was even larger.

**Table 5: Costs and economic consequences of time banks per person per year**

|  | Calculation | Mean value |
|---|---|---|
| **Cost of intervention** | See table 1 | |
|  |  | £607 (£312-£902) |
| **Economic consequences** |  | |
| ⊕ Employment | 0.045*£11,132 | £501 |
| ⊕ Reduced benefit claims | 0.045*£80*52 | £187 |
| ⊕ Volunteering | 0.09 (midpoint DCLG citizenship survey 0.06-0.12) *£5.8*12.5hrs/months*12 | £78 |
| ⊕ Value of services received | 29hrs*£17.5 | £508 |
| **Net benefit (government)** |  | **£667** |
| ⊕ Quality of life improvements | (38/365)*(1-0.69)*£20,000 | £645 |
| **Net economic value** |  | **£1,312** |

## Befriending

Befriending interventions costs ranged from £58 to £120 for a one-hour per session provided over a 12-week period; for our base case analysis we used an average of £90 (Table 6). Our calculations showed that befriending achieved an economic value of more than £490 per person when quality of life improvements are considered. While a befriending scheme was likely to require average resources of £90 per person, a cashable return was estimated at £38, primarily consisting of potential savings to the NHS.

**Table 6: Costs and economic consequences of befriending per person per year**

|  | Calculation | Mean value (range) |
|---|---|---|
| **Cost of intervention** | Lowest value: 12hrs*£4.8=£58 Highest value: 12hrs*£10=£120 | **-£90** (£58-£120) |
| **Economic consequences** |  | |
| ⊕ Reduction in health services costs (and home helps) | 2.62*£14.5 | +£38 |
| **Net (cashable) benefit** |  | **-£52** |
| ⊕ Quality of life improvements (reduction in depressive symptoms 3-12 months) | Lowest value: (38/365days)*(1-0.69)* £20,000* 0.25=£162 Highest value: (38/365days)*(1-0.69)*£20,000=£645 | +£404 (£162-645) |
| **Net economic value** |  | **+£424** |

| Return on investment | 0.58-4.71 |
|---|---|

## Community navigators (debt advice)

Our modelling suggests that the cost per person supported through a community navigator service could be as little £340, although in our base case analysis we assumed a mean value of £611 (Table 7). When navigators provide support and advice around debt, the reduction in state expenditure on benefits and health services was potentially £162. Because costs for crises and mental health services were omitted from the analysis, potential savings to the NHS are likely to be somewhat higher than the indicated £22. At the same, costs of £176 were estimated to occur for the additional use of the statutory debt advice agencies. Before considering quality of life improvements, the net economic benefit of signposting to debt advice services would exceed £360, most of which would be because of the expected productivity gains. If quality of life is valued in monetary terms, then the expected economic benefit would be expected to exceed £1,200.

**Table 7: Costs and economic consequences of community navigators (debt) per person per year**

| | Calculation | Mean value |
|---|---|---|
| **Cost of the navigator intervention** 12wks x 1.5hrs | Lowest value £340 Highest value £882 | Mean £611 |
| **Economic consequences** | | |
| ⊝ Costs of increase in number of referrals to debt advice agency | 0.9*£196 | £176 |
| ⊕ Employment outcomes | 0.56*0.105 x £11,132 | £655 |
| ⊕ Reduced out-of-work benefit claims | 0.56*0.06 x £80 x 52wks | £140 |
| ⊕ Reduced productivity loss from time taken off work | 0.56*0.42 x (30/235) x £11,132 | £335 |
| ⊕ Reduced health care costs | 0.56*0.21 x 3.5 x £53 | £22 |
| ***Net benefit*** | | **£365** |
| ⊕ Quality of life improvements from depression improvement (for 9 months) | 0.56*(0.73-0.63)*0.75 *£20,000 | £840 |
| **Net benefit economic value** | | **£1,205** |

## Community navigators (housing advice)

Potential cost-savings per person that can be attributed to the navigator scheme because of a possible resolution of housing issues without further involvement from the statutory sector were estimated to range from £20 to £353 (Table 5). A mean of £187 was taken in our analysis. The estimated values for cost savings due to avoided homelessness or an averted statutory homelessness duty ranged from £267 to £2,724, with a mean value of £1,496. Most potential savings accrued to the local authorities, with a smaller proportion (15%) to the NHS. The alleviation of depressive symptoms associated with people's improved housing situation was valued at £840 for the 9-month period after the intervention had taken place.

**Table 8: Costs and economic consequences of community navigators (housing) per person per year**

| | Calculation | Mean value (range) |
|---|---|---|
| **Cost of the navigator intervention** | Lowest value: 18hrs*£19/hr= £340 Highest value: 18hrs*£49/hr= £882 | **£611** (£340-882) |

| Economic consequences | | |
|---|---|---|
| ⊕ Cost-savings for reduced use of crises and housing prevention services | Lowest value: 0.2*£97.6=£20 <br> Highest value: 0.2*£1,764=£353 | £187 |
| ⊕ Cost-savings for homelessness duty averted and avoided homelessness | Lowest value: 0.11*£2,430=£267 <br>   – Of which 100% are savings to the housing sector <br> Highest value: 0.11*£24,765=£2,724 <br>   – Of which <br>     ▪ Health services (ca. 15%) £409 <br>     ▪ Housing services and day support (ca. 85%) £2,315 | £1,496 |
| **Net benefit** | | **£1,072** |
| ⊕ Quality of life improvements from depression improvement (for 9 months) | 0.56*(0.73-0.63)*0.75*£20,000 | £840 |
| **Net benefit economic value** | | **£1,912** |

## DISCUSSION

Today's macroeconomic climate makes it imperative that available or newly-created capital is used to achieve the best outcomes for individuals, communities and society as a whole, alongside other agreed outcomes such as equity. This imperative applies as much to community capital as to financial or human capital. Although community initiatives are widely seen as having the potential to improve quality of life for individuals and communities, in the absence of economic scrutiny, they run the risk of being 'pigeonholed as a "feel good" story of no wider significance' (Callison, 2003) – a reference to time banks but equally applicable to community development projects more generally. There is therefore a pressing need, not just to identify novel and effective approaches to the prevention and meeting of need, but to demonstrate that they are economically attractive.

Many individuals and organisations have an interest in encouraging greater cost-effectiveness, including health and social care commissioners, local and national taxpayers, regulatory, monitoring and auditing bodies, and of course community initiatives themselves. Each of these entities would certainly also be pursuing additional aims, which is a reminder not just that cost-effectiveness is one of a number of appropriate objectives for a care and support system, but that its pursuit will often need to be tempered by other considerations. This could mean that decisions are rightly taken not to *maximise* efficiency in some absolute sense, but to achieve the best use of resources in the context of a range of objectives.

We have shown how the use of decision analytic modelling can simulate the economic impact of some typical community capacity-building initiatives compared to what would happen in the absence of such initiatives. Simple modelling techniques can chart the pathways that people might follow, whether through services or through 'life events' (such as getting a job), or in terms of changes in their wellbeing. In this study, the models were highly simplified and 'average' representations of reality, because of the limited availability of evidence in this field. We offer our empirical conclusions as *very tentative* indications of economic impact, and as an illustration of the potential of this kind of modelling approach in this kind of context. We calculated the costs and economic consequences of three particular community initiatives – time banks, befriending and

community navigators. Our approach was pragmatic, low-cost and rapid in comparison to studies that rely on primary data collection. We made extensive use of published, unpublished and experiential evidence, and worked closely with local and national experts. Our calculations were conservative in that we were only able to attach monetary values to a subset of the potential savings or benefits, and because we were cautious in estimation of impacts and economic values.

Our findings suggest that there could be savings to the public purse when investing in relatively low-cost community capital-building initiatives. Each initiative we looked at generated net economic benefits in quite a short time period. Our findings are therefore consistent with, although used different methods from, some other studies in the UK. For example, the evidence from the Partnerships for Older People Pilots in England showed that these low level, upstream activities for older people were indeed cost-effective: for every extra £1 spent on these activities, there was approximately a £1.20 additional benefit in savings on emergency bed days (Windle *et al.*, 2009). The success of a range of preventative, community based interventions in improving quality of life and mental wellbeing in particularly among older people has been demonstrated before by programmes such as LinkAgePlus (Department of Work and Pensions, 2006). The preliminary evaluation of Deep Outreach found that the number of users with clinical levels of depression fell from 45% to 35% (Younger-Ross, 2008).

In the current climate, national governments as well as local stakeholders concerned with commissioning or providing these kinds of initiatives will increasingly seek to establish their economic benefit, in the context of their specific objectives, funding streams and target groups. This has implications for future data collection in this field, which should embrace the need for economic analysis, including standardised cost and quality of life measures. In order to allow valid comparisons of findings across initiatives, methodological standards are needed that are accepted by local stakeholders and agreed with national policy makers.

Despite the limitations, the cost-benefit approach that underpins the analyses described in this paper should provide a helpful starting point for establishing a framework that can be used by community capacity-building initiatives to develop their own business case to inform local commissioning. It can be applied as performance and service improvement tool that is able to focus on a set of outcomes for which there are strong and well defined links to a reduced use of public resources. This information is useful to reflect on and enhance the cost-effectiveness of an initiative and to inform resource allocation decisions at a regional and national level.

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