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Through a Glass Darkly
Community care and elderly people

Melanie Henwood

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The author

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Summary

The care of frail elderly people is a matter both of increasing urgency and major uncertainty. Community care policies have come under increasing scrutiny over the past decade. Three factors have been particularly influential.

First there has been the dawning awareness of the consequences of an ageing population, allied with other demographic and social changes that are likely to reduce the supply of carers, (frequently referred to as 'the demographic timebomb') Albeit, that such trends could have been anticipated, and did not simply arrive overnight. Second there has been a general criticism over the reality of community care. Third, a managerialist critique of inefficiency in the organisation and control of publicly funded community care has emerged.

Precise policy objectives for the care of elderly people have, over the years, been few. The central objective of *Caring for People* is similarly global, with the aim of providing support to enable people to remain in their own homes 'wherever feasible and sensible'. This apparently simple objective may, however, be deceptive, and the issues involved much more complex.

The belief that properly targetted and more efficiently organised services will enable people to be maintained in the community may be ill-founded. The realities of interaction between health and social care (both at strategic and operational levels) remain a formidable barrier to co-ordinated care. More significantly, the wholesale adoption of a largely untried model of care begs a number of major questions about the prospects for real achievement. The most recent extensive empirical analysis of the impact of services (including innovative services) suggests the scale of likely improvement is uncertain, but more modest than has typically been assumed.

The managerialist critique which has informed *Caring for People* provides only a partially developed model for policy. It is essentially an analytic tool which identifies and describes the shortcomings of current practice; its prescriptive elements are far less well grounded. The belief that improving efficiency will enhance the value and achievements of services is largely an act of faith. Such faith, moreover, cannot be reinforced by the evidence on the marginal returns achieved by most home care services.

Alongside these important issues about the prospects for community based care, are equally vital questions around residential and nursing home care. Policy in relation to such services has been developing largely by default. This was first apparent in the – by now well known – perverse incentives provided by the social security system. Perhaps more significant are developments which suggest the quiet disengagement of the NHS from any responsibility for continuing care. The boundaries of the NHS are arguably being redrawn, and appear to be excluding individuals' entitlement to nursing care in old age. The shift which has taken place between public care and private nursing homes, can be seen to have also entailed a shift in financial responsibility from the public sector to individuals and their families.

The failure to develop the model of NHS nursing homes can be seen as a particular manifestation of the redrawing of boundaries, and is to be especially regretted. The experimental NHS nursing homes which began in the early 1980s provided an exemplary and cost-effective model of care, the extension of which should be reconsidered.

These are the issues expolored in this paper. It begins by examining the background to current community care policies. In particular, it considers the demographic context, and the development of critical appraisals of community care, which have combined to produce powerful pressures for change.

The essence of the new approach to community care lies in the emphasis placed on enabling people to remain at home. Section 2 considers the issues which must be addressed in achieving such an objective, and the impediments which may frustrate it.

Despite the emphasis on domiciliary support, the role to be played by residential and nursing care remains crucial. Much of the debate around community care has been driven by anxieties about public expenditure on residential services (particularly in the private sector). This has overshadowed consideration of central policy issues in relation to residential care. Section 3 focuses on these questions and draws special attention to the respective responsibilities of health and social services authorities. Recent developments suggest that at least some parts of the NHS no longer regard nursing home services as health care – a position with profound consequences for elderly people's rights to universal and free health care.

Community care and elderly people

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The concept of community care in Britain is of long standing. It can be traced from at least the 1950s, and the ideas – even if not the terminology – are evident in a skeletal form from the turn of the century. Despite its long standing, community care has been ill-defined and subject to a variety of interpretations. Such lack of clarity has hampered attempts to specify policy goals and objectives, or to evaluate practice. In 1981 the DHSS set itself the task of studying and clarifying the term, which it observed – 'seems to mean very different things depending on the context in which it is used' (DHSS, 1981a, p.7). The attempt to provide a definitive statement was abandoned, and the report noted the difficulty of discussing objectives which 'range from the very specific to all encompassing approaches to care giving'.

By the end of the 1980s, however, the policy was coming under increasing scrutiny. This reflected a number of factors, but in particular it appears to have been driven by three converging streams. The dawning awareness of demographic change was joined by the force of criticism over the reality of community care as it was experienced 'on the ground', and – in particular – by the emergence of a 'new managerialist' approach to the organisation and control of public services. Before turning to examine innovatory approaches to the care of elderly people, it is important to explore these influences. Not only do these factors provide an explanation and context for recent policy developments, but they provide a framework against which to assess those developments: are policies taking sufficient account of demographic changes, and are they doing so in a manner which satisfies the extensive critique of past practice?

Demographic pressures

The growth in the numbers of elderly – and of very elderly – people is by now well known. The 'demographic time bomb' emerged during the 1980s as an alarmist phrase much used (and abused) by politicians and commentators as casual shorthand to refer to a complex pattern of demographic trends. The phrase is misleading, and of little real use, but it accurately conveys the sense of urgency and panic which has surrounded the increasing awareness of the ageing of the population alongside the decline of other age groups (notably young people aged 17–24), and wider changes in family trends. A report on senile dementia from the Health Advisory Service epitomised just such policy anxieties, with its concern over 'the rising tide' of frail elderly people, the consequences of which 'will soon be upon us in full flood', threatening to 'overwhelm the entire health care system' (1982, p.1). The 1989 white paper on community care was less alarmist, but acknowledged the central pressures arising from demographic change:

> *Most people needing community care are elderly (...) Growth will be greatest amongst the very elderly who are also most likely to be disabled and in greater need of community care* (Department of Health, 1989, para 8.10)

At the same time, the white paper also acknowledged 'the major contribution' of carers, and recognised 'that demographic trends will have implications for the future availability of carers'.

An ageing population

The ageing of the population is a distinguishing characteristic of the demography of developed countries. Britain is today experiencing the most profound changes in its population – the culmination of trends which have been in progress since the mid-nineteenth century. A reduction in mortality has interacted with a long term downward trend in fertility (i.e. birth rates) and together these have produced 'an ageing population'. That is, the proportion of the population who are children has fallen, while the proportion who are elderly has risen. The profile of the population has shifted from the classic pyramid where most of the weight is at the bottom, to a rectangular or barrel shape, with a more even distribution of age groups. Much of the concern about these developments relates to the apparent shift in 'dependency ratios' – the increase in 'non-productive' populations relative to the numbers and proportions economically active.

Very similar trends have been evident in other developed countries, and Japan currently experiences the lowest levels of mortality anywhere in the world – suggesting there is scope for further improvement in Britain and elsewhere. Within Europe trends have been similar, but although Britain has one of the highest proportions of elderly people, it also has one of the lowest life expectations compared to other member states (although the differences are small).

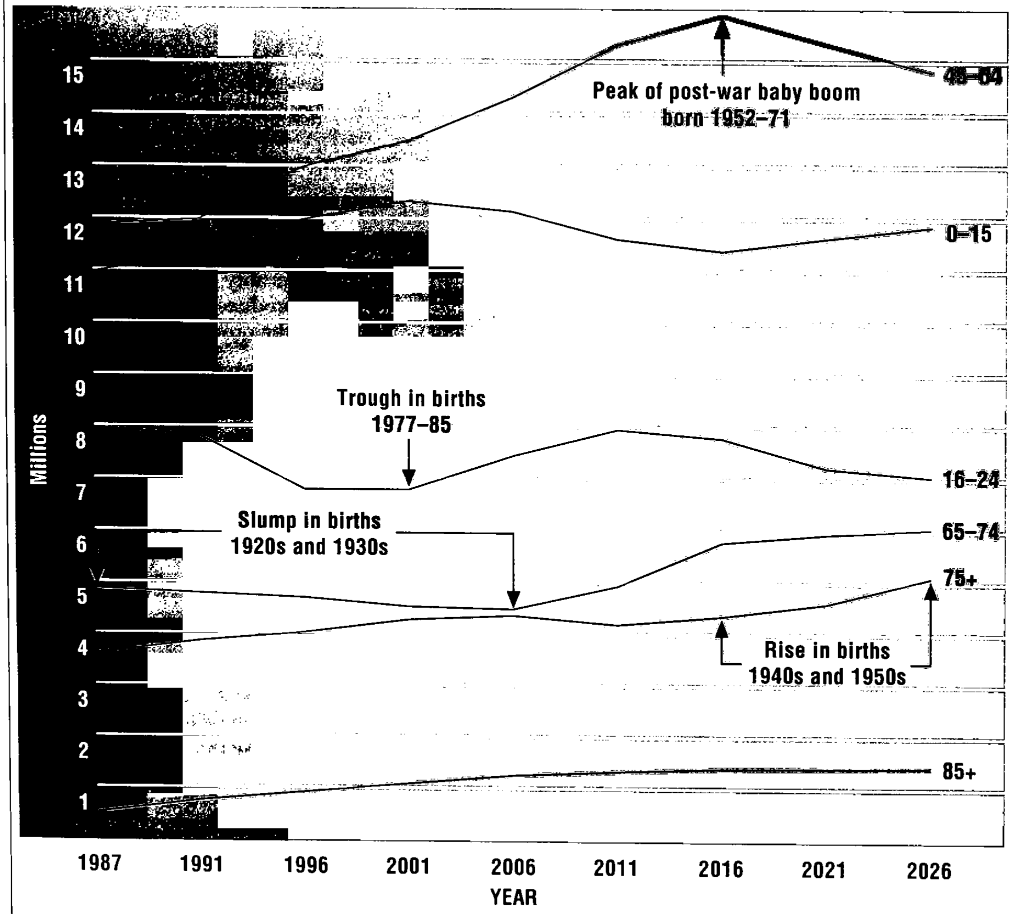
The growth in the numbers and proportions of older people in the population is a twentieth century phenomenon – as indicated in Table 1. The population census of 1901 found fewer than two million people in Britain aged at least 65 (representing less than 5 per cent of the total population). By 1951 – half way through the century – the numbers had risen to more than 5 millions, and more than doubled as a proportion of the population. Current estimates (1989 based) assume an elderly population of almost 9 millions, representing almost 16 per cent of the population. Ironically, while today there is more concern than ever about the 'growing elderly population' it is important to emphasise that the fastest rate of growth in fact took place in the first half of the century, with a trebling in the numbers aged at least 65.

The composition of the elderly population is changing, reflecting – in particular – birth trends earlier in the century. Table 1 and Figure 1 both indicate a fall off during the 1980s and 1990s of the 'younger elderly' (i.e. those aged 65–74), while major increases are apparent among those aged 75–84, and 85+.

- In 1991 44 per cent of the elderly population were aged at least 75, compared with less than one third in 1951. By 2041 it is expected that for the first time the proportion of elderly people aged at least 75 will have exceeded fifty per cent.
- Between 1991 and 2011 it is expected that the number of people aged over 65 will increase by more than 700,000; almost three quarters of this increase will be accounted for by the rise in the numbers aged 75+.

The decline in numbers of younger elderly people is the result of low birth rates in the 1920s and 1930s. Birth rates before and immediately after the First World War, on the other hand, were high. The very elderly cohorts do not begin to reflect the trough in births of the twenties and thirties until well into the next century, by which time the younger elderly cohorts upturn once more, with the ageing of the post-world war two 'baby boom'. The increase in the very elderly population also

Figure 1 Age structure of the projected population, 1987–2026, Great Britain



Source: Population Projections, 1987–2027, pp2 No. 16. Government Actuary Department, OPCS 1989.

Table 1 The Elderly Population: past, present and future (Great Britain)

Thousands and per cent total population

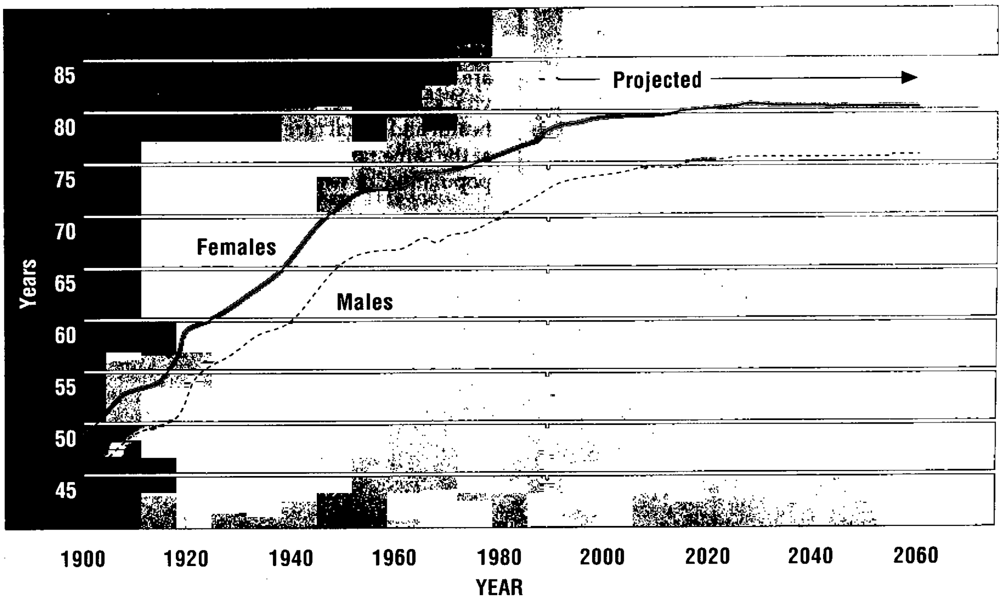
Date	65+	%	75+	%	85+	%
Historical trends 1901 to 1981						
1901	1734	4.7	507	1.4	57	0.15
1931	3316	7.4	920	2.1	108	0.24
1951	5332	10.9	1731	3.5	218	0.45
1961	6046	11.8	2167	4.2	329	0.64
1971	7140	13.2	2536	4.7	462	0.86
1981	7985	15.0	3053	5.7	552	1.03
Projections (1989 based)						
1989	8758	15.7	3850	6.9	819	1.5
1991	8838	15.8	3922	7.0	876	1.6
2001	9022	15.7	4324	7.5	1149	2.0
2011	9546	16.3	4435	7.6	1312	2.2
2021	10784	18.2	4801	8.1	1324	2.2
2031	12328	20.7	5568	9.4	1507	2.5
2041	12468	21.2	6365	10.8	1715	2.9

Sources: 1901–1981 Census data OPCS. OPCS: *1989 based National Population Projections* pp2 No.17, HMSO, 1991.

reflects the greater relative improvements in mortality being experienced by people aged over 60. Previously, the growth of the elderly population has been largely due to the improved chances of survival from birth to 65 (Benjamin and Overton, 1981).

The expectation of life at birth provides an indicator of the level of mortality experienced by a particular generation. As Figure 2 shows, life expectancy has risen by more than twenty years this century (reflecting, in particular, the reduction in infant mortality).

Figure 2 Expectation of life at birth according to mortality rates experienced 1901–89 and projected for the future, United Kingdom.



Source: OPCS (1991) *1989 Based National Population Projections,* Series pp2 No, 17, HMSO.

- in 1989/90 expectation of life at birth was 72.7 years for males, and 78.3 for females.
- by 2028/9 life expectation for males is projected at 76.2 years, and 81.0 for females.

Implications of an ageing population

The numbers of elderly people are obviously significant, but it cannot be assumed that all elderly people – or even all the very elderly – will be frail and in need of care. Old age is not synonymous with dependency and ill health. It is a minority (albeit a numerically large one) which experience extreme dependency. Nonetheless, there are clear associations between advancing years and increasing frailty.

The likely need for care in old age is mediated by many factors including household structure, socio-economic circumstances, and extended family networks, alongside levels of disability and ill-health.

In recent years considerable data have been collected on the extent of disability and dependency among elderly people. Snapshots provided by both the OPCS disability survey (1988), and the General Household Survey (OPCS, 1989) generate a baseline for estimating the size and nature of the 'at risk' groups, both now and in the future.

The General Household Survey included various measures of mobility and self-care capacity among older people. While the vast majority are able to manage to live independently, significant minorities experience considerable difficulties. The increase in incapacity is very steep among the most elderly (see Table 2). For example:

- While only 5 per cent of people aged 65–69 are unable to manage stairs alone this is true of

  14 per cent of those aged 75–79
  24 per cent of those aged 80–84
  47 per cent of those aged at least 85

If present trends continue, the following increases might be expected:

- Between 1985 and 2001 the numbers of elderly people unable to bath or shower without help could increase by a quarter – an extra 179,000 people.
- Over the same period the numbers unable to walk down the road could also grow by a quarter – an increase of 270,000 people. More than 80 per cent of this increase would be accounted for by people aged 85+.
- If age specific rates of disability remain unchanged, average levels of disability are likely to rise as a larger proportion of the elderly population reaches extreme old age. For example, while in 1985 13 per cent of all people aged 65+ were unable to walk down the road, by 2001 this would be true of 15 per cent of the cohort.

The OPCS disability survey (1988) employed a measure of disability in terms of impairment to activities of daily life. The results indicated:

- Almost 6 million adults in Britain experience some level of disability.
- Almost 70 per cent of disabled adults are aged at least 60.
- Among the most severely disabled this rises to almost 75 per cent.

Figure 3 charts the pattern in the incidence of disability. The steep rise with age – especially at the most severe levels of disability – is graphically illustrated.

Future trends

With the continuing increase in life expectancy, and the growth in numbers living into extreme old age, what is the nature of the extra years gained – are they years of active life? This is a question of vital significance, with major implications for health and social care needs – will these needs rise at the same rate as the growth in the elderly population, or will they increase slower or faster?

Table 2 Activities of daily living: percentage usually unable to manage on their own.

	Age					
	65–69	70–74	75–79	80–84	85+	90+*
Cutting toenails	16	24	34	48	65	78
Bathing self	4	5	10	16	31	35
Brushing hair (women)/ Shaving (men)	1	1	1	3	7	20
Washing face and hands	-	1	1	1	3	12
Feeding self	-	1	-	1	2	4
Negotiating stairs	4	5	10	17	31	34
Getting to the toilet	1	1	2	2	7	15

Source: OPCS *General Household Survey 1986*, HMSO 1989, Tables 12.14 and 12.31
*Data on 90+ sample derived from Bury and Holme, 1990, Table 5.

Table 3 Projected changes is self-care capacity 1985–2025, Great Britain

	1985	1991	2001 (000s)	2011	2021
Unable to bath/shower unaided					
65–74	193	197	188	204	239
75–84	345	366	381	375	417
85+	208	272	356	407	410
All 65+	746	835	925	986	1066
Unable to walk down the road					
65–74	290	295	282	307	446
75–84	488	518	540	531	591
85+	315	412	540	617	622
All 65+	1093	1225	1362	1455	1659
Unable to cut toe nails					
65–74	965	983	937	1022	1197
75–84	1120	883	921	906	1008
85+	436	569	747	853	861
All 65+	2531	2435	2605	2781	3066

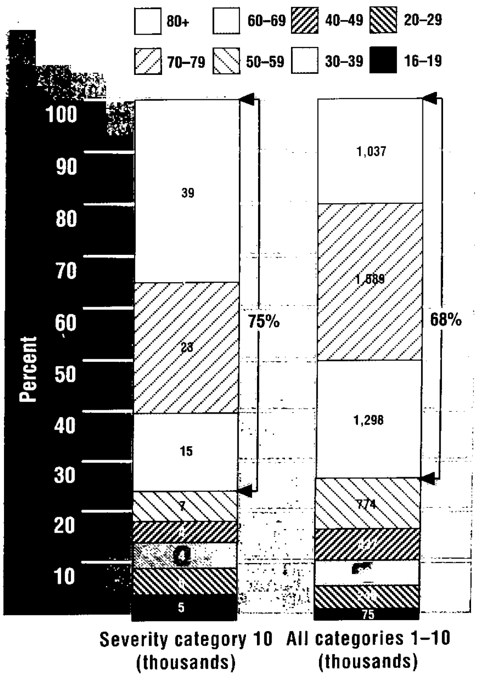
Note: Figures are derived by applying the age-specific rates of incapacity from the 1985 General Household Survey to the projected population in each year (1989 based estimates).

A controversial debate has been conducted around such matters for at least the last decade, precipitated especially by an article in the *New England Journal of Medicine* in 1980. Fries (1980) argued that the nature of old age is changing, and maximum life expectancy has been attained. According to this theory, most people are expected to live a long and healthy life, with a brief period of illness at the end, and with 'natural death' soon following

The alternative view, has been argued by Schneider and Brody (1983) who have emphasised the likely increase in average dependency among the elderly population as the proportion of very elderly people increases, and chronic disease occupies a larger part of the life span. This view has received support from a recent analysis of data from the United States, Europe, Canada and the United Kingdom which indicated that life expectancy has increased more rapidly than disability free life expectancy, with the result that the proportion of life spent free of dependency has fallen. Mortality reductions have not been matched by improvements in morbidity, "but is rather a result of the increase in the life expectancy of people with poor health". thus producing 'a pandemic' of mental disorders and chronic disease in later life (Robine and Ritchie, 1991, p.457). Overall, however, it is probably true to say that the debate between these two theories of ageing is inconclusive and will only be resolved with time.

Nonetheless, it is clear that the rise in numbers of elderly and very elderly people is

Figure 3 Disabled adults in private households by age and severity level, Great Britain.



Source: OPCS (1988), *The prevalence of disability among adults*, HMSO. Table 3.3

Table 4 Life expectancy (LE) and disability free life expectancy (DFLE) in years, by sex in United States and England and Wales, with disability free life expectancy as percentage of life expectancy.

Year	LE	Men DFLE	DFLE/LE(%)	LE	Women DFLE	DFLE/LE(%)
United States						
1970	67.0	54.8	81.8	74.6	60.4	81.0
1980	70.1	55.5	79.2	77.6	60.4	77.8
England and Wales						
1976	70.0	58.2	83.1	76.1	61.7	81.1
1981	71.1	58.5	82.3	77.1	60.6	78.6
1985	71.8	58.7	81.8	77.7	61.5	79.2

Source: Taken from table v in Robine, and Ritchie, (1991).

unprecedented, and will have wide-ranging ramifications.

By any measure their needs present a formidable challenge to health and social care services. Moreover, this challenge has been magnified by simultaneous demographic developments in other spheres. These are the other, highly volatile, elements of the so-called 'demographic timebomb'. The downturn in the numbers of young people, alongside major changes in family structure and patterns of family life, are likely to have profound effects on the 'supply' of care both in the formal and informal arenas.

Demographic decline

The recognition of young people as a vanishing species apparently dawned on the Nation's employers with some shock in the late 1980s. The NHS is especially vulnerable to the fall in numbers of young people, since it has been heavily reliant on this annually renewed pool of labour to fuel the nursing service. The Department of Health's Strategy for Nursing (1989b) fully recognised the consequences of the continued low birth rates. In addition to a much reduced 'pool' of potential recruits, other employers will increasingly be in competition for suitably qualified schoolleavers, 'so that nursing would be hard put to retain even its customary share' (Department of Health, 1989b). The present and future needs for caring labour have implications not only for the NHS, but also for local authority social services, and for private and voluntary agencies. The demands on all of these may be further intensified because of wider social and family change.

Family trends

There is a considerable volume of academic and research literature which demonstrates the central role played by the family in community care (for a review see Parker, 1985). At the risk of over simplification, the basic equation has more than a ring of truth; namely, that care in the community largely equals care by families, which in turn largely equals care by women.

The 1985 General Household Survey of informal carers (Green, 1988) confirmed the picture which had been sketched by numerous small studies since the early 1980s. The survey indicated:

- One adult in seven in Britain is a carer (about 6 million people overall).
- Over 75 per cent of carers are looking after an elderly person.
- Four out of five carers are looking after a relative, with two in five caring for one or both parents.
- The likelihood of being a carer rises with age, peaking in mid-life when 16 per cent of men aged 45-64, and 24 per cent of women, are carers.

The future 'availability' of such care is uncertain, and is influenced by major changes taking place in population structures, patterns of marriage and divorce, and women's economic activity.

At the very time when the numbers potentially needing care are rising, the numbers who have traditionally been the carers – or who have formed the potential caretaker pool – are falling. While family change is usually analysed and discussed in terms of its impact on the nuclear family (the relationships between partners and the effects on children), the consequences of change in extended family structures is a neglected territory, but one with profound implications. In many ways the family unit is less stable than in the past, it is also smaller (and continues to shrink), and increasingly both partners will be engaged in paid employment outside the home. All of these changes raise questions about the continued capacity of the family to care for elderly and other dependent members. A report on carers by the House of Commons Social Services Committee suggested that 'the largest single factor which may affect informal care in the future is the level of participation of women in the labour market', and that 'the policy implications of these demographic trends need to be addressed urgently' (Social Services Committee, 1990, para.19).

The reality of community care

The pressures for change in community care which developed during the 1980s were intensified by emerging evidence about the nature and experience of such care 'on the ground'. The detail of the development of community care from the days of the Poor Law onwards need not be traced. It is important, however, to recognise a number of evolving phases. In its early stages, community care was defined primarily in negative terms; it was the opposite of institutional care. This simple dichotomy between institution and community delayed the development of specific objectives for community care and contributed to the general uncertainty surrounding the policy and its practice.

The pursuit of care outside large institutions was evident first of all in the fields of child care and mental incapacity. The report of the Curtis committee (Care of Children Committee, 1946) condemned the physical, social, cultural and emotional deprivations evident in much institutional care of children, and was instrumental in the emergence of fostering as the preferred approach for children in care (Packman, 1975).

The terminology of community care first became apparent in 1957 when the Royal Commission on the law relating to mental illness and mental deficiency recommended the shift from hospital to community based care. The 1962 Hospital Plan envisaged wholesale closure, with the planned halving of the 150,000 psychiatric hospital beds by 1975, with most of the remaining provision within general hospitals rather than specialised institutions.

While community care policy in relation to all client groups has been basically similar, there have, nonetheless, been some important differences. As the Audit Commission observed in 1986, 'guidance on the development of community based services for elderly people is far less specific than it is for mentally handicapped and mentally ill people. There are no indications of how the balance of care should change'. Unlike services for these other groups, there has not been a trend in services for elderly people entailing a shift from a largely hospital based service to a community based one. Most elderly people have always been cared for (or not) within the community.

Criticisms of the policy emerged even in early days. With characteristic insight, Titmuss questioned whether community care was 'fact or fiction', and criticised the lack of progress, finding little evidence 'of attempts to hammer out the practice, as distinct from the theory, of community care' (Titmuss, 1968, p.105). Such conclusions strike a clear resonance with more recent criticisms. Walker, for example, has emphasised the 'huge gulf between political slogans, some popular perceptions and the day-to-day reality of community care' (1982, p.13), and Sir Roy Griffiths also reflected on the gap between political rhetoric and policy on the one hand, and between policy and reality in the field (1988, para.9).

The definition of community care for elderly people took a significant turn in 1981. While contributing little to the need to clarify specific aims and objectives the white paper, *Growing Older*, provided a succinct statement of responsibilities for community care:

> *Whatever level of public expenditure proves practicable, and however it is distributed, the primary sources of support and care for elderly people are informal and voluntary. These spring from the personal ties of kinship, friendship and neighbourhood. They are irreplaceable. It is the role of public authorities to sustain and, where necessary, develop – but never to displace – such support and care. Care in the community must increasingly mean care by the community* (DHSS, 1981b, para 1.9).

The care in, and care by, dichotomy is significant. On the one hand, it acknowledges the reality that most community care is care by the community (often a euphemism for family care), while at the same time it apparently endorses this as the most appropriate model. The white paper must be interpreted in context. The Conservative government which took office in 1979 was, in many respects, profoundly different both in style and substance from previous administrations. The scaling down of government intervention in all spheres was a central objective, and was to be accompanied by the promotion of private enterprise and individualism. The reduced reliance on statutory services, and the increased emphasis on the role of 'the whole community' espoused by *Growing Older* was clearly consistent with the broader attempt to 'roll back' the frontiers of the Welfare State.

Care by the community

Increasingly evidence about the nature of care by the community began to emerge during the early 1980s. As the Equal Opportunities Commission (EOC) observed in 1982, that evidence suggested:

> ... *that 'community care' has in reality meant care by individuals on an unpaid and often unaided basis* (EOC, 1982, p.iii)

Following the work of the EOC, carers became the focus of much research and survey activity. Throughout the 1980s, the emerging conclusions from such work contributed to the development of a composite picture about carers and their experience of caring.

The substantial evidence about the nature of family care which was emerging also stimulated the development of a further stream of criticism. The feminist critique emphasised the exploitative nature of community care policy for women oppressed by the 'moral imperative to care' (Finch and Groves, 1980).

Baldwin and Parker have similarly argued that in policy terms carers inhabit a strange 'Alice in Wonderland' world 'where they are the main providers of community care but never the subjects of policy that deals with the provision of care' (1989, p.157).

The Griffiths report on community care (see below) published in 1988 reflected similar sentiments to the 1981 white paper *Growing Older*. While acknowledging the major role played by families, friends and neighbours, the report emphasised that this would continue to be the primary means by which people are enabled to live in the community. Moreover, the Griffiths proposals took 'as their starting point that this is as it should be'.

The subsequent white paper on community care (DHSS, 1989) also recognised the role of the informal sector, but adopted a much stronger position concerning the supportive role to be played by statutory services. The second of the key objectives listed in *Caring for People* was, accordingly, to 'ensure that service providers make practical support for carers a high priority'. Assessments of need are to take account of the wishes and requirements both of carer and cared for, and also of the carer's continued ability to provide care. Services are to be flexible and should enable clients – and their carers – to exercise choice (para 3.2.6).

Wistow and Henwood (1991) argue that the Griffiths report and *Caring for People* demonstrate increasing awareness of, and response to, the issues raised by the feminist critique of community care, and by the mounting evidence concerning the nature and experience of community care. It would be misleading, they suggest, to represent the intention of the latest policy as the crude substitution of unpaid for paid care, or as part of a wider shift in the balance of collective and family responsibilities. While the intentions and aspirations of the new approach have yet to be matched by outcomes (and these may prove problematic for a number of reasons), nonetheless, the placing of carers' needs and interests at the heart of the white paper's core objectives, would seem to indicate a degree of policy learning and development that should not be disregarded. *Caring for People* is unequivocal in stating that 'a key responsibility of statutory service providers should be to do all they can to assist and support carers' (DHSS, 1989, para. 2.3).

The spirit of new managerialism

Alongside the evolution of the concept of community care, and the emerging evidence about the nature of that care, are other influences. From the mid-1980s challenge and criticism began to mount from a different quarter. The critical analysis which came from the Social Services Committee (1985); the Audit Commission (1986), the National Audit Office (1987); the Public Accounts Committee (1988), and Sir Roy Griffiths (1988), was altogether harder edged. It raised central questions about the best use of public expenditure, and about responsibility and accountability of both central and local government. This 'new managerialism' as it has been termed (Davies, 1987) has been highly influential, and has been incorporated as a central feature of the community care reforms. The characteristics of this managerialist concern are epitomised in the analysis of community care developments by the House of Commons Committee of public accounts. This stated that any changes resulting from the Griffiths review 'should ensure, as a prime objective, that individuals receive adequate and appropriate forms of care which also provide good value for money' (Public Accounts Committee, 1988, para.3).

Radical change needed

The Audit Commission report can be seen to mark a particular turning point. Its thorough analysis, the conclusion that 'radical changes' were needed, and the offer of 'strategic options' for consideration ensured attention. Without such changes the Audit Commission's outlook was bleak:

> *The result will be a continued waste of scarce resources and, worse still, care and support that is either lacking entirely, or inappropriate to the needs of some of the most disadvantaged members of society and the relatives who seek to care for them* (Audit Commission, 1986, p.5).

In documenting the 'slow and uneven progress' in achieving community care over thirty years or so, the Audit Commission identified 'fundamental underlying problems which need to be tackled directly' at both local and – more particularly – central government levels. These problems related to a number of areas, but in particular concerned structural and financial arrangements. Organisational fragmentation between health and social services was seen to be parallelled by the separation of budgets, impeding the shift of resources from health to social care. The identification of the 'perverse effects' of social security policies which appeared to be undermining community care policies, was also particularly influential. A central objective of the community care reforms is therefore to end the 'built-in bias towards residential and nursing home care, rather than services for people at home'.

The events following the Audit Commission report are well documented. The subsequent appointment of Sir Roy Griffiths to review the use of public funds in supporting community care and his advice 'on the options for action that would improve the use of these funds as a contribution to more effective care' (Griffiths, 1988, p.iii) have been extensively analysed (see, for example, Hunter and Judge, 1988).

The Griffiths report, and the eventual white paper introducing the Government's plans for community care (DHSS, 1989), can both be seen as encapsulating the spirit of new managerialism. Thus, Sir Roy Griffiths provided what he saw as a framework for the development of a system of 'political and managerial responsibility underpinned by a suitable financial system'. The appointment of Sir Roy to review the policy was itself highly significant and consistent with the style of government being pursued by the Thatcher administration with its respect for private enterprise and the values of the market place. Bringing a perspective drawn less from health or social care practice than from business and retail, Griffiths was derisory about the 'lack of refined information systems and management accounting' which in the private sector would result in 'a quick and merciful liquidation' (para 28). *Caring for People* clearly reflected the same ethos in

> *seeking to establish the right financial and managerial framework which will help to secure the delivery of good quality local services in line with national policy objectives* (DHSS, 1989, para 1.7).

In expecting social services authorities to discharge their responsibilities effectively and efficiently, the Department of Health underlined the likely need to strengthen existing management arrangements:

> *In particular, they will need to give attention to the adequacy of systems for planning, accountability, financial control, purchasing and quality control (...) The aim should be to ensure that all the available resources are put to best use, consumer choice and involvement are enhanced, and flexible services are provided which are tailored to individual need* (DHSS, 1989, para 3.1.4).

Caring for People may thus be viewed as a manifesto for the new managerialism in community care.

Conclusion

This section has examined the factors underlying recent developments in community care policy for elderly people. The increase in the numbers of elderly – and more especially of very elderly – people has been a major source of pressure. A potent catalyst, however, has been added by the identification of simultaneous demographic, social and cultural changes taking place in family life, all of which seem likely to diminish the future supply of informal care.

The emergence of an increasingly vociferous critique of the experience of community care has also been a contributory factor. The evidence concerning the poor support available to most carers has gained strength alongside the recognition of the potential scarcity of such carers. The needs of carers are, accordingly, afforded high priority in the new model of community care presented by *Caring for People*. It is important to recognise the shift in perspective which appears to have occurred, with a new emphasis on practical support for carers. Whether the shift will be more apparent than real as many critics fear – will only become evident with time.

The managerialist critique of community care presented, in particular, by the Audit Commission, and endorsed by Sir Roy Griffiths, added further weight. Not only was it clear that community care was slow and uneven in its progress, but waste, inefficiency, and ineffective care were endemic.

This brief analysis of the background to the new model for community care also provides a conceptual or evaluative framework against which to judge developments. In turning to consider new approaches to care for elderly people it needs to be asked: are services responding to the demographic challenge? Are they redressing past inadequacies, and paying particular attention to the importance of supporting carers, and are services pursuing the twin objectives of efficiency *and* effectiveness?

2 Care at home

The new approach to community care reflects, as we have seen, the confluence of a number of influences. Managerialist concerns over efficiency are especially clear in the direction of services now being espoused. The apparently simple objective of developing community rather than residential based services may, however, be deceptive. This Section argues that, in fact, the issues involved in improving targeting and increasing efficiency in home care services are complex, and the way forward is by no means clear.

The success or failure of the objectives of *Caring for People* (Department of Health, 1989) will depend most of all on the extent to which community services are able to provide an effective alternative to residential and nursing care. It is arguable that this proposition makes a number of assumptions which may prove ill-founded. *Caring for People* assumes implementation of the reforms to be essentially unproblematic. However, as Wistow and Henwood (1991) have pointed out, there are important respects in which this position appears naive. In particular, there remain major problems with policy and service coordination between health and social care. In addition, the general lack of experience of most local authority social service departments in constructing and managing individually tailored care packages raises major questions about the wisdom of the wholesale adoption of a largely untried model.

The new managerialist critique, which has been embraced by the government and characterises current community care policy, is only partially developed as a basis for policy formulation. Essentially, the approach has informed a descriptive and analytic critique of current practice; its prescriptive elements are far less well developed or grounded.

If the prime objective is to reduce the need for residential services by better targeting of home care, questions need to be asked about the nature and effects of such services. The most comprehensive analysis of the relationship between resources, needs and outcomes in community care in Britain (Davies *et al.*, 1990) provides some salutary conclusions. There is evidence not only that targeting is indeed poor, but that services have little effect as indicated by a range of outcome measures. Changing the nature and content of services in order to improve their 'marginal productivities' is a far more challenging task than simply improving targeting. Without such changes, the prospects are poor. The implicit policy is of meeting need by raising service levels, an approach which Davies *et al.*, suggest 'risks serious diswelfares and concomitant political opprobrium as the inevitable scandals break'.

The first, and foremost, of six key objectives of service delivery stated in *Caring for People* is:

> *to provide the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible. Existing funding structures have worked against the development of such services. In future, the government will encourage the targeting of home-based services on those people whose need for them is greatest* (Department of Health, 1989, para 1.11).

This statement simultaneously conveys a number of messages. First, it emphasises a commitment to the development of community-based care as an effective alternative to residential provision. Second, it acknowledges the frustration of such objectives by existing funding mechanisms, and third in stressing the need for better 'targeting' of home-based care it recognises inefficiencies in the existing pattern of home care service provision and utilisation – an issue which has increasingly been identified over the past decade (Davies *et al.*, 1990). The scale of the challenge facing community care in pursuing the objectives of *Caring for People* becomes apparent when present inefficiencies are examined.

Inefficiencies in home care

The changing nature of home care, and the need for such change, has been the focus of various reports since the mid 1980s. The inefficiency of much local authority expenditure on services for elderly people was identified by the Audit Commission (1985). Against the background of the increase in the elderly population, the Audit Commission report argued in favour of the extension of domiciliary and community rather than residential based care, and for improved management of such services (1985). The Commission highlighted concern over the nature of local authority expenditure which was such that 2 per cent of the elderly population 'account for well over half social services' expenditure on services for the elderly with a further 13 per cent accounting for the balance. Over 80 per cent of elderly people receive no social services support at all' (1985, p.7). The potential demand for social services from growing numbers of frail elderly people was seen to be without any 'realistic limit'. Under such conditions, it followed that 'these services must be managed well if they are not to be overwhelmed'. The Commission identified five main areas in which inefficiencies were evident.

- Inappropriate placements in residential care, often because of poor management (lack of assessment; inadequate admissions screening, and lack of community support).
- Community services not directed to those who need them most.
- Inadequate co-ordination of health, housing and social services.
- Inadequate management of community services.
- Service waste.

The Social Services Inspectorate (SSI) of the Department of Health similarly set out 'to examine issues of effectiveness and efficiency in an important, changing and diversifying social service' (SSI, 1987, para 1.1.1). The SSI found that all of the county Social Service Departments (SSDs) they investigated were pursuing issues around policy change in moving towards a more flexible and intensive personal care service 'for people who will otherwise require institutional care'. A research review of County Council strategies for elderly people and their carers conducted in 1988 also found the great majority of counties were addressing the development of domiciliary services, and in particular were concerned with the shift towards a more flexible home care rather than home help style of service (Barritt, 1990).

The emerging view of the home help/home care service as a *substitute* for residential provision is a relatively recent one. Certainly the service was not originally developed for such a purpose. Originally enshrined as part of the National Health Service Act of 1946, authorities were empowered to provide

> ... *domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged or a child not over compulsory school age* (quoted in Dexter and Harbert, 1983, p. 12).

The service rapidly became dominated by elderly clients, and indeed came to be regarded almost as an entitlement of old age. However, the provision on the one hand of an intensive domiciliary service to enable the most frail elderly people to avoid residential care, and on the other, of a minimal but more universal domestic service for elderly people, are not easily compatible. They require different types and levels of care, different service inputs and different objectives.

The change from home help to home care

Sinclair and Williams' (1990) review of domiciliary services identified the central issue in the debate about how the home help service should be used in these terms: should the service provide relatively large numbers of people with basic cleaning and shopping help once or twice a week? Or should it provide fewer, more dependent people with a more intensive and frequent personal care service? While the question appears simple, the implications are, in fact, wide ranging and complex.

The SSI inspection of home help services identified the essential issue as the need for 'a change of gear', a transition which it acknowledged was complex and problematic. Change is necessitated along a number of dimensions in terms of *who* receives services, *what* kinds of support they receive, and *when* they receive it (SSI, 1987, para 3.1.4). The SSI examined the use of home help resources in terms of both 'cover' and 'intensity'. 'Cover' refers to the proportion of the relevant population receiving a service, while 'intensity' indicates the amount of service provided per client (Davies *et al.*, draw a similar distinction in terms of 'horizontal' and 'vertical' target efficiency). There is a tension, even an incompatibility, between the two indices. As the SSI observed, a high coverage but low intensity service is unlikely to have achieved much movement from domestic to care tasks, or much diversification in the type of clients helped (SSI, 1987, para 3.2.4).

The limited usefulness in the past of Department of Health planning guidelines in this respect is particularly obvious. In the 1970s, the Department of Health established per capita levels of provision as guidelines for various core services. For every 1,000 population aged 65+, for example, local authority SSDs were expected to provide 25 residential places; 3–4 day centre places; 12 home helps and 200 meals per week. The operation of these normative standards, which provided no indication about the desired direction of policy, was open to various criticisms. Wistow has identified three particular shortcomings:

> - *they were expressed as levels of service production (inputs and intermediate outputs) rather than as outcomes for users;*
> - *while acting as proxies for need and thus tending to discourage local analysis of the level and structure of need, the guidelines themselves were apparently derived more from 'best professional judgement' than analysis;*
> - *they focused attention on a relatively narrow range and mix of service options, thereby discouraging innovations and the more flexible use of resources.* (Wistow 1990, para 2.4)

Despite finding that all the surveyed authorities were aware of and discussing the need for shifting their approach to home care, the SSI concluded that 'the aspirations for change of SSD managers were outrunning the behavioural and resource allocation changes being achieved'. In particular, better 'cover' was more likely to be achieved than 'intensity'. This was perhaps unsurprising given a general lack of systematic assessment for home help, or the existence of clear policy objectives and guidance (both omissions which *Caring for People* aims to redress).

The apparent mismatch between policy aspirations and practical achievements indicates the particular difficulties of policy change in this area. Indeed, the SSI made the management of such change the subject of a subsequent report (1988). The impediments are many – both managerial and political. Considerable resources may be 'locked up' in the existing pattern of service and the particular style of service cannot be changed overnight. Resistance is likely to be encountered both from the workforce, the clients (among whom the service is remarkably popular), and also from the community more generally. The existence of a high acceptance service such as the home help (i.e., requests for help are rarely refused) means that any deliberate targeting is likely to be resisted by those who may lose the service, and by politicians who may lose local support. Tony Elson, Director of Social Services in Kirklees, has described the problems which he encountered in moving towards a more intensive and targeted home care service:

> *The consequence of that is you actually reduce rapidly, very rapidly, the number of people getting the service. The backlash from that came from many of the clients who found the services were being reduced or stopped altogether. Those clients and their carers brought their grievance to local politicians who found it very difficult to cope with. Put in very crude terms, if you provide ten times as much service per high dependency client as per low dependency client, you can represent that another way. What we were doing was replacing ten votes with one vote. I don't want to sound cynical, but councillors need to take account of the impact of policy on their political futures* (Elson, 1989, p. 10).

Questions of entitlement to service are ones which will become increasingly important in a targeted service.

Targeting care

The general absence of formal eligibility criteria for the home help service; the lack of assessment of need and the matching of appropriate services, and the stretching of a limited service over large numbers of clients, are all characteristics which make it highly unlikely that such care will be either effective or efficient.

The SSI found most authorities had formulated and agreed a set of 'general principles' around services for elderly people. These emphasised such values as the need to provide flexible and local services which respected people's individuality, and helped them remain independent (SSI, 1987;). However, clear policies were often absent. It is important to distinguish between 'formal' policy (ie that which is written down and managerially or politically endorsed), and 'informal' policy (which will reflect the implicit attitudes, assumptions and beliefs of service staff). Policy in relation to home care might be expected to reflect elements of both. However, the SSI found there was no effective linking of the two, and the direct involvement of home help organisers in service planning was minimal. The SSI concluded that while there was much 'purposive activity 'towards policy development much of this was directionless, and lacking any strategy. While some authorities were making progress, 'overall there was a problem of policy drift' (SSI, 1987, para 2.7.7).

The lack of general policy for the direction of home care is matched by poor case management. The SSI found referral and assessment procedures were overshadowed by demand management; 'skilled and disciplined assessment, careful identification of individual needs, and construction of care packages were all conspicuous by their absence' (SSI, 1987). Intensity of service varied little; the SSI found three quarters of home help clients received three hours or less help each week.

The evidence presented by the SSI is not unique. The picture of inefficiency is confirmed by other analyses. There are questions both about whether the service is reaching the 'right' people, as well as whether the services respond adequately to different levels of need. The General Household Survey reports on elderly people (carried out in 1980 and 1985) provide a larger, nationally representative sample for analysis.

Secondary analysis of the data by Bebbington *et al.*, (1989) to investigate target efficiency in the allocation of the home help service to elderly people is illuminating. Over the period between 1980 and 1985, there was a slight increase in the proportions of elderly people who had received home help support in the previous month (from 8.7 per cent to 9.3 per cent). Some improvement in coverage might have been predicted given the increase over the same period in the number of home helps per 1,000 elderly population (from 6.6 to 7.2). However, the improvement in coverage (or 'horizontal target efficiency') was accompanied by *weakening* targeting, or 'vertical target efficiency'.

Table 5 indicates the probability of service receipt with increasing isolation and disability

Table 5 Elderly persons living alone receiving some help, by degree of disability, social isolation, and year

	GHS 1980		GHS 1985	
	Not isolated %	**Isolated** %	**Not isolated** %	**Isolated** %
Able to manage:				
8 to 10 tasks	4 (553)	5 (376)	7 (591)	7 (346)
5 to 7 tasks	29 (133)	42 (94)	48 (99)	58 (67)
4 or fewer tasks	60 (126)	73 (75)	58 (88)	76 (33)
All living alone	17 (812)	21 (545)	18 (778)	20 (446)

The figures show the proportion of people of given disability and social support who receive the home help service: for example in 1980, 4 per cent of people who were not socially isolated and were able to do 8–10 tasks, were receiving the home help service.

Social isolation: is visited by, or goes to visit, friends and relatives weekly or less often.

Able to manage without help: shopping, cleaning paintwork, cleaning windows, sweeping floors, jobs involving climbing, small amounts of laundry, going up/down stairs, getting around the house, taking a bath, walking outdoors.

Source: Bebbington *et al.*, (1989)

among elderly people living alone.

The gender bias of home help allocation and the poor support in particular for female carers, have also been confirmed by GHS data. Comparing the results for 1980 and 1985, Bebbington *et al.*, (1989) drew three conclusions:

- Both vertical and horizontal target efficiencies are higher for women than men, that is, the service appears better targeted on women, with service allocation more closely linked to disability.
- Among elderly people living alone, the balance between horizontal and vertical target efficiency is higher for men (implying more generous levels of provision for men).
- Discrimination is evident between the sexes in households of two or more persons. The difference in vertical target efficiency indicates that the home help service is less likely to be provided to women who are not themselves disabled, that is, may be acting as carers. This is apparent in Table 6 which indicates that it is the wife's rather than the husband's disability which leads to service allocation.

Elderly people living alone are more likely to receive home helps, while carers are relatively unlikely to be supported by such services. This is especially important in the context of the supposed priority which *Caring for People* attaches to supporting carers. Such a finding is also consistent with a wealth of other research (for a review see Parker, 1990), and with the General Household Survey of carers which revealed that two thirds of co-resident carers, and half of those with a dependant living elsewhere, received no regular help from any services whatsoever (Green, 1988).

The analysis by Davies *et al.*, (1990) of more

Table 6 Receipt of the home help service among married couple households in the 1980 and 1985 General Household Surveys

	1980 GHS		1985 GHS	
	Number %	**Receiving H–H** %	**Number**	**Receiving H–H**
Circumstances				
Neither disabled	593	1	527	2
Husband only disabled	53	11	35	6
Wife only disabled	60	27	65	25
Both disabled	6	33	8	50
Total	712	5	635	5

Source: Bebbington *et al.* (1989)

than 500 elderly social services clients allows for extensive examination of the need responsiveness of service provision. A much firmer pattern of home help consumption is apparent for those living alone, and there is evidence of carers being viewed 'as substitutes for home help'. In general, Davies *et al.*, conclude:

> *The differences between need groups provide little evidence of sophistication in targeting services on those who are most at risk of admission to residential care, or on those imposing the greatest burden on informal carers* (1990, p. 74).

The allocation criteria appear to be more rational and consistent in relation to single elderly people living alone than for other groups. In general, variety of need was not matched by variety in consumption, and the mean provision of a little over two hours of home help a week is 'a depressing indicator of the degree to which patterns of consumption of home care services were contributing to the prevention of unnecessary admission to residential care' (Davies *et al.*, 1990, p.54).

Sinclair and Williams (1990) conclude in their review of the research that under-provision of the service is actually a much greater problem than is misallocation. Such a conclusion might be supported by Bebbington and Davies' analysis of the 1980 General Household Survey (1983), which estimated that 64 per cent of people judged to be in need of the home help service were not receiving it, while 28 per cent of those receiving it were not in need.

Sinclair and Williams (1990) rightly identify three main areas of criticism of domiciliary care:

- Inflexibility
  Services are not tailored to the individual requirements of recipients.
- Resource Allocation
  Services are not generally allocated to those in greatest need, and take little account of carers' needs.
- Caring Style
  Domiciliary services generally provide low levels of support over a long period, but often with a lack of integration with other relevant services.

The third of these areas has also been addressed by other commentators. Goldberg and Connelly (1982), for example, have highlighted the stagnation of services. Once established patterns of care tend not to be reviewed or changed, and opportunities for rehabilitation may thus be missed. This is also linked to the lack of integration with other services. In theory, home helps might be in an ideal position to monitor their clients and to mobilise other services. In practice, home helps rarely perform such a pivotal role.

The implications of the criticisms of domiciliary services, suggest Sinclair and Williams, indicate the need both for complementary services, and for changes in the role of home helps themselves.

The health and social care interface

Operational co-ordination

Improved targeting of services also has major implications for service co-ordination, and the relationship between health and social care inputs. The divide between health and social care is not a black and white one. The problems of managing the interface between the two are legion, and may become more intense in future. The difficulties are evident on a number of levels, in relation both to planning and practice. Government policy on collaboration between these two services has focused mainly on the mechanisms of joint planning and joint finance. *Caring for People* described the record of joint planning as 'mixed'. While modest successes can be pointed to, achievement 'nevertheless falls short of the aspirations of the mid-1970s' (1989, para 6.9). There remains considerable uncertainty about future arrangements for joint planning, and the planning arrangements in the new approach to community care have been much criticised. The House of Commons Social Services Committee, for example, believed:

> *... that so far the arrangements for collaboration between health and local authorities both in the compilation of community care plans and in the delivery of services have not been sufficiently spelled out* (House of Commons, 1990, para 22).

Leaving the statutory responsibilities of the NHS largely unchanged, but assigning lead responsibility for community care to local authorities, will mean – suggest the Social Services Committee – that joint working, planning and collaboration between the NHS and local authorities will 'be at least as vital, but no more structured than hitherto'.

The multi-faceted nature of community care needs is well documented, as is the failure to provide correspondingly integrated services (for example Challis *et al.*, 1988). The consequences of this 'organisational fragmentation and confusion' were indeed one of the five fundamental underlying obstructions to community care identified by the Audit Commission (1986). While accepting that local authority social services departments should have the lead responsibility in developing community care, *Caring for People* also emphasised the importance of other needs. The interface between health and social care is the most significant of these. As *Caring for People* acknowledges,

> *Community care is about the health as well as the social needs of the population (...) In some individual cases, it may well be difficult to draw a clear distinction between the needs of an individual for health and social care. In such cases, it will be critically important for the responsible authorities to work together* (1989, para 4.1–4.2).

Whether the problems with joint planning and co-ordination are resolved by *Caring for People* is debatable. While claiming to propose 'a fresh approach to collaboration and joint planning by clarifying who does what', the white paper nonetheless repeated familiar exhortations that 'further efforts are needed to improve co-ordination between health and social services' (para 6.1). Criticisms of the proposals have suggested, however, that the changes might create incentives less for collaboration than for service differentiation and boundary defence (Wistow, 1990; House of Commons, 1990).

It is worth quoting the forceful conclusions of the Social Services Committee at some length:

> *We seriously question whether the new arrangements will provide any better framework or incentives for the two to work together (...) We remain to be convinced that without greater incentives to work together the risks associated with the introduction of competition in community care will outweigh the benefits claimed for it by the Government. In particular, without the assurance that sufficient resources will be available to meet the demands of the new policies, both health and local authorities will have incentives to distinguish rigidly between 'health' and 'social' care needs. This may lead them to seek to assign responsibility for providing services to the other agency rather than, as is necessary, working together to provide the best possible services needed by vulnerable people living in the community* (House of Commons, 1990, para 93).

Co-ordination is likely to fail in the future for precisely the same reasons as in the past. The approach is one which Challis *et al.*, suggest is 'shaped by the assumption that there is such a thing as rationality in policy making independent of, and indeed opposed to, the rationality of politics' (1988, p. 1). The white paper's analysis of the problems in developing community care is broadly correct, and closely follows other critiques. However, in seeking to provide the right financial and managerial framework it is assumed that the delivery of services in line with national objectives will necessarily follow. This view of implementation as unproblematic ignores the interactive realities of process and practice (Wistow and Henwood, 1991).

Whatever the problems of co-ordination at a strategic and policy planning level, there are major *practical* problems in day to day interaction at the boundary of health and social care. This is especially clear in relation to home helps and district nursing services.

Home helps and district nurses

The increase in numbers of very elderly people, the rise in hospital throughput and the reduction in NHS continuing care, are all likely to contribute to multiple and complex needs for health and social care community services. The emergence of more heavily dependent elderly clients is also to be expected as the result of attempts to prevent or defer residential admissions in favour of maintaining people in the community. The nature of care needed by this group is the traditional province of neither the home help service, nor the district nursing service.

Charnley and Bebbington (1988) argue that the significance of the interface between community nursing and home care is new: in the past, the services have operated from distinct bases for distinct client groups. It is precisely the expansion of the role of the home help service into home care which raises issues about how best to organise and co-ordinate personal care.

Twigg (1986) suggests that this crucial home care/nursing interface has been relatively neglected in terms of academic and research interests. The NHS/SSD interface has tended to be either investigated in relation to joint planning and joint finance (Glennerster *et al.*, 1983; Challis *et al.*, 1988), or around doctor/social worker relations. As Twigg observes, the home care interface is intrinsically interesting, because of the issues it raises in relation to personal care, but it is also going to become increasingly important – indeed pivotal – in the new context for community care which takes effect from April 1993.

The uncertainty about professional demarcation does not apply to the entire range of tasks between home care and nursing. Twigg's analysis, and that of others, identifies dressing and – especially – bathing people as areas of greatest uncertainty and potential conflict. Some restriction of activity occurs within both services according to particular procedures and organisational structures. Thus, the NHS distinguishes appropriate tasks between trained and untrained (auxiliary) staff, while on the social services side there is typically a distinction between formal and informal task acceptance.

Unclear boundaries

A lack of clarity over boundaries between the two services inevitably involves individuals in making judgements about what they should or should not do. Individuals' lack of detailed knowledge concerning the roles and practices of their counterparts in the other service leads to uncertainty about responsibilities. The nursing service often attempts to distinguish, for example, between medical and social baths, but clearly this can be arbitrary. On the home care side there may be a prohibition on giving medication to clients, but in practice many 'turn a blind eye' to such practices. Much is left to individuals' discretion, and what particular home helps will or won't do varies considerably. Reporting on research in ten local authorities Twigg observes:

> *Thus taking the case of bathing, the task most often the focus of dispute, although none of the authorities explicitly required home helps to do baths, and many explicitly forbade them, it was clear that many home helps did assist clients (...) This aspect of discretion clearly depended very much on the attitude of the particular home help, and furthermore of the particular home help in response to a particular client. Where personal care was mentioned, it was frequently accompanied by comments about there having been built up closer relations between the helper and the client. It was clear that the feature defining the situation was that these were voluntaristic relationships structured around choice, personality and friendship, more than around professionally defined roles* (1986, pp.11–12).

While the management of the home care interface is important, and increasingly so given the changing nature of both home care and nursing services, there are other issues besides simply deciding who should do what. The day to day activity of both services, and the pressures they face, are such that staff are likely to respond defensively: defining their own area of professional operation, and off loading other activity to other agencies where appropriate (Charnley and Bebbington, 1988). The Health Service is in a particularly difficult position, needing to balance the demands of a growing community workload, while also resisting the apparently expansionist claims of social services on their professional territory. Such an atmosphere is not conducive to the development of co-ordinated care packages. The overlap in the clientele of community health and social services means, suggest Charnley and Bebbington that 'the best possible outcomes depend upon the effective combination of resources', but 'in a pluralistic system of welfare, that very combination presents conflicting interests among the various service providers...' (1988, p.3).

The co-ordination of health and community care services raises issues both about service substitution and interdependency. That is, the extent to which service inputs are interchangeable in some areas, and complementary in others. In order for either of these aims to be pursued deliberately, it is a pre-requisite that services are responsive to individual need. Too often this is far from being the case. Bebbington and Charnley (1990) studied a sub-sample of 176 elderly people who were clients of both health and social services. The research indicated inadequate case management and lack of coordination: 'assessment, determining services and review were all inefficiently managed. Liaison was non-existent for the majority, and opportunities for substitution were missed'. Routine contact between the services (which was defined in terms of correspondence, telephone conversations, or one-off meetings) took place for less than half the clients. Regular contact (in the form of regular liaison or case conferences) was evident in only 12 cases. A major consequence of this lack of routine contact and collaboration was that opportunities for substitution were rarely taken – evident in the fact that more of one service was associated with receipt of more of the other. If the services were functioning as substitutes, more of one service would imply less of another.

Davies *et al.*, (1990) also found a positive correlation between receipt of home care and other services, especially community health services. This could either indicate service duplication or complementarity. In fact, Davies *et al.* suggest it is indicative of the poor targeting and responsiveness of community social services:

> *The study shows that it is the community health services more than the community social services whose provisions are most responsive to variations in functional capacity* (1990, p. 269).

The lack of responsiveness of social care to variations in functional incapacity, therefore leaves community health services having to be more responsive. Detailed analysis of the allocation of different service inputs indicated that while there are substantial variations in the amounts of social services allocated to individuals, 'there are only small differences in average consumption between those in different need categories. Within most need groups, the majority of recipients receive low levels of service and higher allocations to others in the same need group are largely unrelated to their broader need related circumstances' (Davies et al., 1990, p. 74).

Innovation and development

The 'new approach' to community care which is embodied in *Caring for People* has revolutionary potential to transform the service into a needs focused, individually managed, efficient system (Wistow and Henwood, 1991). What is radical, however, is not the underlying ideas or concepts so much as the intention to introduce them on a universal basis. Many of the elements of the *Caring for People* model have long been apparent in local initiatives and instances of good practice. The Audit Commission (1986), for example, tempered the 'bleak picture' it painted of community care with case examples of successful initiatives, in an attempt to demonstrate 'that community-based care need not be just another attractive concept'. *Caring for People* itself acknowledged the particular source of much of the inspiration behind case management in the work of Kent, Gateshead and Durham (para 3.3.3). The Kent model – known as the 'community care approach' – has been extensively described and analysed, notably in the work of the Personal Social Services Research Unit (PSSRU) at the University of Kent.

'Innovation' emerged during the 1980s as the latest part of the lexicon of social policy analysts and practitioners, and became a virtual synonym for good practice. Yet innovation, of itself, carries no particular virtue, nor any assurance of good quality or efficient service.

Ferlie (1986) suggests that innovation is essentially about change and its management. A distinction can be drawn between quantitative, and qualitative change, and a shift can be identified from the former to the latter. In the early 1970s the primary change emphasis within social services departments was on rapid quantitative development (i.e. growth), which was typically concentrated around capital based residential services. The shift to revenue based, community care focused services became apparent by the end of the decade.

The importance attached to innovation or change, Ferlie argues, depends on the response to actual or anticipated shifts in the environment. Thus during times of stability, innovation is unlikely to be seen as a central managerial task. However, the combination of demographic, financial, professional and external factors, which became apparent in the late 1970s and have since intensified, 'indicate an environment which is far from static' and where innovative adaption might be predicted.

The in-coming Conservative government of 1979 brought a commitment to reducing overall levels of public expenditure, and policies towards the PSS subsequently reflected the twin themes of public expenditure compression alongside the pursuit of cost-effectiveness (evident in the increasing emphasis on voluntary and informal services, for example).

Qualitative innovation has been concerned with the development of input substitution; that is, the use of alternative service inputs which are cheaper and/or more cost effective than conventional services. These developments coincided with the emerging critique of residential care; not only were residential services costly and of benefit to relatively few people, but the philosophy and ideology of community care were increasingly opposed to such provision. Innovations in community care have included developments which could entail considerable role change and alteration of service boundaries – both of which, as we have already seen, are highly problematic. Bebbington *et al.*, (1986) classify innovatory services under three broad headings:

1

PERSONAL CARE IS DIFFERENT

The interface between health and social care in relation to personal care does not merely raise issues about professional demarcation and task differentiation, it also raises important and difficult matters about inappropriate relationships and taboo, which Twigg argues 'mark the boundaries between states of privacy, intimacy and the public realm' (1986). Because of the wider cultural assumptions and meaning concerning public and private spheres, it may be that social services departments face greater problems in managing the area of personal care than does the health service.

The traditional province of the home help (i.e. non-personal, domestic care) raises no such problems. These are, Twigg argues, the sort of tasks that in ordinary daily interaction people perform for one another. By contrast, it may be seen that personal care does not fit this model.

> ***It is for this reason that personal care is so often conceived of as nursing activity, despite the fact that the skills required are not in any real sense medical. What the medical model offers here is the means for the negotiation of these boundaries through the restructuring of the social body into the medical body*** **(Twigg, 1986, p. 16).**

Twigg suggests that because home helps do not have a comparable ideological structure to that of district nursing within which to locate such personal care, they are left to resolve the issues within particular personal relationships with individual clients. The costs to individual home carers (in terms of anxiety and concern) may be considerable. Moreover, such an approach is highly discretionary and idiosyncratic and does not provide a reliable foundation on which to build a consistent approach to the management of personal care.

It is possible that the care assistant role will develop along a route which borrows some of the props and symbols of the nursing profession, although this will intensify issues about professional boundaries. What is currently lacking is an appropriate model for this new form of care which belongs neither to the traditional province of nursing, nor to the essentially domestic home help service. Evidence on clients' views about the home help service suggest considerable resistance to the move towards personal care. Sinclair *et al.* (1988) found a concern among clients not to involve home helps in personal or private matters. Similarly, Bebbington *et al.* (1986) found only 1 per cent of home help clients wanting a more personal care service, compared with 13 per cent who wanted additional housework.

- augmented home care
- new forms of residential care (including respite services)
- boarding out (adult fostering schemes).

It is the first of these which is most significant; the most common form of service innovation which has developed and spread during the 1980s has been concerned with more intensive domiciliary care.

As discussed above, the shift from a home help to a home care service model has been encouraged by both the Audit Commission and the SSI. In addition to crossing (or attempting to cross) the boundary between home helps and nursing auxiliaries, such schemes are also characterised by a greater flexibility in terms both of working practices and out of hours services.

Are innovations effective?

The development of innovations (and the direction now being advocated for community care in general) reflects, implicitly at least, an assumption that new forms of service are able to substitute for residential or hospital based care, and to do so in ways which are not only more effective, but also more efficient than conventional services. Is this view supported by evidence? Few innovative authorities have built in any evaluation of their developments. In attempting an external analysis Ferlie encountered various problems, including the fact that innovators were rarely able to provide the level of financial information needed to conduct comparative costs analysis.

The analysis of the relationships between resources, needs and outcomes in community care by Davies *et al.*, (1990) found that clients who received large volumes of service were in very similar circumstances to those (at comparable levels of need) who received less. They were, for example, no less likely to enter residential care. Of particular significance was the conclusion that the innovations studied were also unlikely to affect the overall impact of services greatly. The only 'innovation effect' which could be discerned was in relation to users' felt vulnerability.

> *There was no sign of the hypothesised effect for life satisfaction, consumers' desire for extra help, the user's degree of satisfaction with the experience of social services, the client's assessment of the impact of home help or home care, and the fieldworker's view of the success of the intervention* (1990, p.250).

Examination of the innovations also revealed other features. Innovative activity was typically concentrated on the enhancement of service content, rather than on case management. Small scale projects were unlikely to successfully maintain dependent elderly people at home in isolation from other community services (SSD or NHS based), yet few explicit case management roles emerged. Improved joint working can be seen as central to achieving community care objectives, but not only did Davies *et al.*, find few operational developments in case management, but no evidence of any joint management.

Considered in the light of such findings, Victor and Vetter's description of one intensive home care scheme as 'rearranging the deckchairs on the Titanic' (1988) makes some sense. However, while this judgement may be too pessimistic, Davies *et al.*, agree that typically innovative schemes 'did not achieve high marginal productivities at the levels of inputs at which they were operating' (1990, p.24). Such findings create a dilemma. Davies *et al.*, observe that great effort and resources will be needed to improve targeting and the effects of home care services, 'but the scale of improvement achievable is uncertain'. Such conclusions have profound implications which have been totally overlooked by the new direction in community care policy which fails to question whether the desired shift in objectives can be achieved merely by improving targeting and raising service levels. In particular, there are questions about what it is that services are doing and whether the nature of services themselves (and not merely their volume) must be reappraised.

The community care approach

Alongside innovative services such as those enhancing home care, are more comprehensive innovations, most notably those such as the Kent community care scheme. The community care approach implicitly contains both a critique and prescription. It has been developed to address specifically the shortcomings and inadequacies of routine service delivery. That is, a wide variety and range of needs are not generally met by the inflexible and limited nature of services available. Such services as are provided, moreover, are rarely comprehensive; they meet needs only partially, and do so in ways that may take little account of individual's wishes or preferences. Finally, services are typically fragmented with little or no co-ordination. In short, Challis and Davies argue:

> ... *the picture of resource provision for the frail elderly is all too often that of a series of piecemeal contributions from a range of different services, with no one having an unambiguous responsibility for taking a broader view of need beyond their particular remit. Assessments and care plans tend therefore to be 'service-oriented' rather than 'client-centred', piecemeal and not holistic, defining needs in terms of available packages of care rather than individual problems* (1986, p.1).

The community care approach is intended to tackle these problems while developing alternative forms of support in the community to residential and long-stay hospital care for frail elderly people. The approach is founded upon a system of case management by social workers responsible for the construction and maintenance of individual packages of care. Responsibility for resource allocation decisions (subject to particular limits) is decentralised to fieldwork staff. In many respects, therefore, this is precisely the model envisaged in *Caring for People.*

The community care approach is concerned not only with the better matching of needs and services, but with doing so in the most cost-effective manner. A cost-awareness is encouraged among staff making the critical resource allocation decisions.

Evaluation

The evaluation of the community care scheme undertaken by PSSRU has three dimensions:

- destinational outcomes (ie where clients end up)
- quality of life outcomes (the effects both on clients and carers)
- costs and cost-effectiveness

The community care scheme has apparently been highly successful in enabling people to remain in their own homes. Comparisons were made between matched pairs of elderly clients receiving and not receiving the scheme, after one year, 69 per cent of the community care scheme clients were still at home, compared with 34 per cent of the comparison group. The survival rate of the group was also higher among those in the scheme. Significant improvements were also apparent in both subjective well-being and quality of care for the recipients of community care compared with clients receiving standard services.

Analysis of the costs involved in the scheme suggest a small advantage to the social services department, but *greater* costs to the health service because of increased longevity. Nonetheless, the elements of costs incurred are different. The costs to the NHS of the community care scheme are in terms of short-term acute admissions, and geriatric day care; while the costs for the control group are more likely to be in the use of long-stay beds. In the care of the very dependent, 'the community care scheme appeared to be substituting for long-term hospital care, producing health care savings for this group' (Challis and Davies, 1986). Research into an early example of a home care service in Coventry reached rather different conclusions, suggesting greater costs to the social services – largely outweighed by savings to the health service (Latto, 1982).

The results of the community care approach are certainly dramatic, as Davies and Challis argue, the scheme:

- halved the probability of death, halved the probability of entering an institution, and doubled the probability of individuals continuing to live in their own homes;
- improved individuals' perceptions of well-being;
- improved the capacity of individuals to perform activities of daily living independently;
- improved the quality of care;
- relieved informal carers of some 'diswelfares', and reduced costs to them (1986, p. 509).

The authors are nonetheless careful not to claim too much for their model (which was an evaluation of the programme in just one geographical area).

While the precise effects reflect the 'unique historical context' in which they took place, Davies and Challis argue, however, that the evidence indicates the success of the community care project according to a wide range of criteria. Moreover, much of this improvement appears due to 'inputs' which can be replicated, and therefore 'the community care approach is one worth developing:

> *The strategy has suggested such a large margin of advantage to community care and forged sufficiently strong links between experimental inputs, causal processes and outcomes that this greater efficiency cannot seriously be questioned* (Davies and Challis, 1986, p.570).

Critical reaction

The achievements of the Kent community care scheme, and others like it, appear to be beyond doubt. However, the particular approach to care which the model entails has not escaped criticism. If, in attempting to operationalise the *Caring for People* approach, more local authorities attempt to replicate this scheme, it is important to be aware of the implications of going down such a road.

Criticism has focused particularly on the low costs of the scheme, and the extent to which these are due to the low payments to helpers. A central objective of the community care approach is the substitution of low for high cost inputs. The high cost resources are places in residential care; while low cost inputs are provided by the labour of people who are either already part of the client's social network, or who represent new resources mobilised from the community. In the Kent scheme most of these additional resources were helpers recruited through local advertising and selection. The recruitment process made it clear to applicants that the work should not be considered as a job in the usual sense, with no guaranteed regular income.

Helpers receive some payment for their work; payments are specified for given tasks rather than for the amount of time spent in their performance.

This is often seen as one of the advantages of the scheme since helpers can themselves choose how much time to spend with the person they are caring for.

The disadvantages of the approach, however, must also be considered. Examining the issues from a feminist perspective, Clare Ungerson has underlined the 'complete lack of employment rights' afforded these (mainly female) helpers (1990, p. 18). The specific remuneration only for tasks actually performed means that sickness or holiday pay do not exist. There also appears to have been a deliberate attempt to keep payments to helpers low in order not to rise above tax and social security thresholds.

The structuring of payments within the eligibility criteria for social security benefits, and liability for tax, was based on 'some evidence that such factors affected both the decision to offer help and the amount of help proffered' (Davies and Challis, 1986, p.439). Very few of the helpers received sufficient payment from the project to be classified as employees.

Formal and informal: a blurred distinction

The payment of what are often token sums to 'helpers' raises central issues about the distinction between formal and informal care. Ungerson argues that the re-formulating of the boundary between public and private, formal and informal, arenas makes certain assumptions. On the one hand, it assumes that paying individuals to care 'excludes the more effective and loving elements'. On the other, it assumes it is possible and right to recruit people on the basis of nominal payments, and in the belief that such care will be the best quality since it is principally being performed for love rather than money (Ungerson, 1990, p.21).

The separation of formal and informal care is artificial. The Kent scheme certainly found its helpers exceeding the terms of their original 'contracts' and undertaking additional tasks because of the attachments they established with individual clients. However, there is no reason to assume that this happened only because of the essentially unwaged nature of the work. As Leat and Gay have argued, 'payment and care are not antithetical – payment does not negate caring just as non-payment does not guarantee it' (1987, p.62).

Paying for informal care raises complex issues and moral questions. The hybrid area between formal and informal care which the Kent community care scheme and others like it have developed particularly focuses attention on the exploitative nature of low paid care. Leat (1990) has argued that 'money is both crucial and irrelevant to paid carers'. That is, many could not or would not care without some payment; yet if payment ceased, many would be unable simply to stop caring. The main advantage claimed for schemes such as Kent is their flexibility and responsiveness. Against this, it might be argued, that extending payment risks bureaucratising and stifling such a system. However, as Ungerson points out, there is no necessary logical connection 'between very low pay and versatility and imagination on the one hand, and reasonable pay and bureaucratic strangulation on the other' (1990, p. 30).

Leat argues that the essential issue must be about the quality of care which is provided. High quality care is more likely where such care is highly valued. Money is only part of such a context, but it may be a more important part than many acknowledge.

Whatever the arguments about the rights and wrongs of paying for care, and whether or not this merely institutionalises the exploitation of women, the further extension of paid informal care may be unrealistic. The same trends which are likely to reduce the supply of family care (see Section 1) are likely to have precisely the same effects on the supply of formal or quasi-formal care. That is, fewer potential carers available, and greater market competition for the labour of those who are available (both from the caring sector and other areas of the labour market). The use of 'helpers' and the payment of token sums is therefore an unreliable approach to the challenge of organising care for frail elderly people.

Conclusions

This section has examined a number of issues in relation to the central policy objective of developing care for frail elderly people at home.

Existing inefficiencies and poor targeting of services are apparent. Recognition of these problems has been a central element of the managerialist critique, and the Audit Commission and the SSI have increasingly advocated improvements in targeting. While many social services departments acknowledge the need to shift towards a more focused home care rather than home help service model, there has been little evidence of *strategic* development towards such an objective.

Effective community care for frail elderly people depends critically upon the integration and coordination of health and social care. There remain major misgivings about the policy framework for such endeavour created by *Caring for People*. In particular, there are fears that the incentives of the system are less likely to lead to collaboration than to service differentiation and boundary defence.

In addition to the continuing problem of managerial and structural fragmentation of services, are the practical problems of service integration at the operational level. Such problems are especially evident in relation to the disputed professional territory between home care and

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PRIVATE DOMICILIARY CARE

The deliberate development of a more mixed economy of care is a central objective of the community care reforms. To date, almost all of the development of private provision has been in the residential and nursing home sector. A distinction needs to be made between informal and organised private domestic help. The purchase of private domestic care on an informal ad hoc basis has a long history. Evidence from both the Family Expenditure Survey and the General Household Survey suggests that the purchase of such care is concentrated among social classes I and II and appears to be inversely related to need (Parker, 1990). The organised private domiciliary care market is currently small scale, but the potential for rapid expansion is enormous. Midwinter's review of private domiciliary care (1986) suggested some 200-300 such agencies operating in England and Wales. Most of these were of the 'cottage industry' type involving very small scale agencies, but as Midwinter observed there were 'one or two' large companies now breathing heavily on the sidelines'. Unlike private residential care, the home care market has not been subsidised or otherwise encouraged. A number of factors, however, are coming together which suggest this may be an area of considerable development over the next decade. In particular:

- **Local authorities will, in future, be expected to make maximum use of the independent sector 'and so increase the available range of options and widen consumer choice' (Department of Health, 1989, para 1.11).**
- **The targeting of home care services on those in greatest need will entail the withdrawal of services from clients whose needs are primarily domestic rather than personal. Many of these will look elsewhere for such domestic help.**
- **The rising real incomes of the younger elderly cohorts will create a larger group of people seeking to purchase a range of personal (and financial) services.**
- **The extension of charges for local authority services is also an objective of *Caring for People.* The narrowing of the gap between the cost of public and private care may lead many people to choose what they perceive as more acceptable private services.**

The delay in the full implementation of the community care reforms means that a contract culture in the private domiciliary care field will not emerge overnight, and only a minority of social services departments currently have contracts with independent home care services (Booth, 1990).

The implications of a private domiciliary sector for regulation and quality assurance mechanisms may be profound. If residential care has proved difficult to regulate, and inspection has tended to concentrate on measurable physical conditions rather than on other indicators of 'quality of life', how much more difficult will it be to judge quality of care outside institutional settings?

At present there are no registration or accreditation arrangements for private domiciliary care (other than as employment agencies). However, there are signs that the independent sector is attempting to provide its own professional accreditation – or at least adherence to a code of practice – under the auspices of the United Kingdom Care Association (UKHCA).

auxiliary nursing. Research continues to demonstrate the lack of coordination and liaison in day to day practice, with resulting service duplication and overlap.

The way forward set out in *Caring for People* seeks an improvement in the efficiency of services, with a new emphasis on care at home, and the widespread adoption of service models generally viewed as innovative. There is general consensus that community based services are the preferred option, however, the current policy may be over-optimistic about what can realistically be achieved. The underlying belief of the model is that improved targeting and reduced service inefficiencies will automatically generate the returns which are sought. However, the evidence which is accumulating on the effects of services, including innovative services, indicates the benefits to be generally few and marginal. Evaluated against a number of criteria, consumers who receive greater concentrations of service do not generally fare better than those receiving standard services. Importantly, consumers of enhanced services seem no less likely to enter residential care.

The exception to this pattern is provided by the achievements of the Kent Community Care Scheme (and of similar models). These differ from other innovative services in adopting a client centred and comprehensive case managed approach.

The majority of social services departments have not developed a community care approach along the lines of Kent or Gateshead, and will not generally be able to do so in the immediate future. Experience of such an approach in this country is limited, and the one authority which has spread the scheme throughout its area has still only achieved a caseload of less than one third of the numbers of residents in its own homes. Davies *et al.*, (1990) also underline the difficulties in moving a scheme from innovation to mainstream, and the shock which can reverberate through the system when the protective stockade around a 'special scheme' is removed.

The effects of increasing resource inputs alone appear to be few and weak. Davies *et al.*, conclude that the modernisation of long term care will 'require resources and effort, and success cannot be guaranteed'. Change, it seems, will be even more difficult to achieve than has been assumed. The requirement not only to improve targeting, but also to enhance the effects and outcomes of services is likely to be satisfied only by substantial investment in the management of change, and specifically in the development of rigorous case management.

One of the claims often made for the community care schemes is that their results can be achieved at no greater cost than for conventional services, but with a greater proportion of overall costs being accounted for by investment in case management. There may be problems with adopting this model if the low costs are primarily the result of the use of low paid labour – an approach which is unlikely to offer either an acceptable or a viable model.

It is apparent that merely improving the efficiency and targeting of resources is unlikely to produce the level of benefits which are expected. Without similar attention being paid to what it is that services are achieving, and how such effects can be enhanced, the prospects for achieving the objectives of *Caring for People* at the level of individual outcomes will be remote.

Residential and nursing care

The major challenge in the provision of long term care of elderly people in the 1990s will undoubtedly be the development of effective community based care. As the previous section has indicated, much remains to be done in making such services more appropriate, flexible, better targeted, and generally more efficient. If care in the community is to offer an effective alternative to residential care, much greater effort and investment will be required. Moreover, as the evidence from the PSSRU analysis indicates (Davies *et al.*, 1990), significant marginal productivities from such investments will probably only accrue if case management approaches are extensively adopted.

A different challenge, and a separate set of issues relate to the development of residential and nursing care. This is an area of policy which has been something of a backwater for the last thirty or so years. Ironically, perhaps, the new emphasis on community care has been due in large part to recent developments in residential provision, particularly the rapid growth of the publicly financed independent sector, which occurred in the absence of any overall policy. Conversely, the new approach to community care raises questions about residential services which are either new issues or have been long ignored. These include, questions about the role of residential provision within the overall spectrum of care; about individual choice; about the relationship between residential care and the development of other forms of collective living (sheltered housing, close care etc.); about the distinctive contributions of both health and social care to the long term residential sector, and – perhaps most importantly – questions about quality.

From last resort to positive choice

Perspectives on residential care – whether in the public mind, in policy or research terms – changed little from the 1950s to the early 1980s. The early development of community care was pursued largely as a reaction against the worst excesses of institutional care. Seminal work by Peter Townsend (1962) raised the fundamental question of whether there could be any place at all for the long stay institution in a civilised society. He concluded that

> ... *communal homes of the kind which exist in England and Wales today do not adequately meet the physical, psychological and social needs of the elderly people living in them, and [that] alternative services and living arrangements should quickly take their place* (Townsend, 1962, p.430).

The existence of poor quality care does not, however, necessarily mean such care should not be provided at all. It could be a powerful argument in support of improving standards and regimes.

Throughout the 1960s and 1970s poor quality care continued to receive sporadic attention from research and official inquiries. Residential care of elderly people continued also to occupy a marginal position on the boundaries of social policy. The role which such provision should play was ambiguous and controversial. The establishment of the Wagner review in 1985 was, in retrospect, a particularly significant development in attempting to clarify the role of residential care, and the changes which would be required to enable it to respond to changing needs. The subsequent Wagner report (1988) was noteworthy for attempting to shift the focus from a view of residential care as a service of last resort, to one which sees movement into care as 'a positive choice'. Contrary to early critiques, the Wagner committee believed that residential services had much to offer as part of a wider spectrum of social care. Life within the institution, Wagner argued, should be 'a positive experience ensuring a better quality of life than the resident could enjoy in any other setting' (Wagner, 1988, p.114).

Why there should have been this shift in focus demands explanation. In part, at least, the Wagner Committee were reacting to and describing a situation which was already evident: that is the rapid expansion both of residential care and other forms of collective living.

The growth of residential care

Between 1976 and 1986 the numbers of residential home places in the UK grew by more than 40 per cent, from 198,300 to 283,000. By 1990 there were 326,100 places. More interesting than the overall growth in numbers is the relative contributions of the different sectors. As Table 7 indicates, the overall provision of local authority residential care fell in the second half of the 1980s. At the same time, the contribution of the non-statutory – especially of the private – sector greatly expanded. In the ten years between 1976 and 1986 the number of residential places in the private sector grew by

Table 7 Nursing, residential and long stay hospital care of elderly, chronically ill and physically disabled people, by Sector, 1970–1990 (UK).

	Residential Home Places			**Nursing Home**	**Long Stay Geriatric**	**Total Places**
	LA	**Private**	**Voluntary**			
1970	108700	23700	40100	20300	52000	244800
1976	128300	25800	41000	24000	49000	268100
1980	134500	37400	42600	26900	46100	287500
1985	137100	85300	45100	38000	46300	351800
1990	130500	155600	40000	123100	49100	498300

Source: *Care of Elderly People, Market Survey 1990–91*, Laing and Buisson 1990, Table 2.2.

more than 260 per cent (and between 1980 and 1990 by over 400 per cent). While in 1976 local authorities provided around 70 per cent of all residential care (with the remainder spread fairly equally between private and voluntary sectors), by 1986 local authorities were providing under half of the total volume, while the private sector had increased its share to 40 per cent of the market (Wistow and Henwood, 1990). Since 1986 these trends have become increasingly marked.

Some increase in the volume of residential care would have been expected in order to keep pace with demographic pressures, and in particular the growth of the very elderly population. Examining the developments, the 1987 Firth report on the funding of residential care concluded that only around half of the actual increase which had occurred might have been expected on the basis of such pressures (Firth, 1987).

Laing's review of the private health market has reached similar conclusions:

> *By 1989 an estimated 29% more elderly people were in long term care establishments than would have been if age-specific rates had remained unchanged from a base year of 1981. Put another way, it is estimated that demographic change alone should have generated demand for an additional 8,500 private care home places in England between 1988 and 1989, plus another 3,000 to make up for static public sector provision. But the actual net increase was 30,000* (Bosanquet *et al.*, p.61 1990)

Social security subsidy

The rapid growth in private residential care has been fuelled by the explosion in social security expenditure. Supplementary Benefit (Income Support from April 1988) expenditure on people in independent residential and nursing homes rose rapidly from an annual £10 million to £878 million between December 1979 and May 1988. Recent official estimates suggest an out-turn figure of £1,400 million by the end of August 1990 (Social Security Committee, 4th report, minutes of evidence 11 June, 1991). Such trends are well known. The 'perverse effects' of social security policies were first identified by the Audit Commission report (1986). This highlighted the fact that the availability of Income Support for residential rather than community based care meant that 'social security policies appear to be working in a way directly opposing community care policies'.

The need to control the growth of this open-ended and non-cash limited budget was a principal objective of the Griffiths report (1988) and of the subsequent community care legislation. The delay in the legislative timetable, however, means that the underlying rate of growth in social security expenditure is set to continue until April 1993. The need to control the budget is likely to precipitate some interim action from the Government (Henwood, Jowell and Wistow, 1991), and steps to restrict the transfer of local authority residents to private care trusts were introduced in August 1991.

The availability of social security subsidy to residential care is unlikely, however to provide a full explanation of recent trends. The rapid rise in property values during the 1980s also undoubtedly contributed to the expansion of private care, and encouraged the entry of speculative developers. It might also be asked, however, what the growth of private care might indicate about individuals' care preferences.

A positive choice?

Fewer people might enter residential care given improved levels of community support, but it may be that residential care is less unpopular than has long been assumed. More specifically, as Challis points out,

> *It may also be the case that the unacceptability of public care with its failure to shake off the legacy of the Public Assistance Institution has obscured this* (Challis, 1987, p.30)

Whatever the issues concerning the use of public funds in paying for the growth of private residential care, it has undoubtedly enabled some people to enter high quality private care which they would not have been able to afford with their own means. The poor quality of much local authority residential accommodation is well known. The fact that much of the capital stock is old and often previous workhouse accommodation is likely to influence public perceptions. Perhaps because of the unappealing nature of this type of accommodation, demand has been low, and the proportion of elderly people in such care has – until recent years – increased very little, despite the growth of the very elderly population.

In countries such as Australia and the United States much larger proportions of elderly people enter residential care or choose to live in campus style retirement communities. In Australia about twice the proportion of people aged over 75 live in residential homes than is the case in Britain (14 per cent compared with 6.8 per cent). Roy Parker's analysis of developments in Australia (Parker, 1988) identified a different attitude towards such homes which are not viewed 'with disfavour or as a last and unpalatable option'. The fact that Australia did not share the British Poor Law experience and historical legacy may be particularly important in shaping the more positive image of the residential sector. Parker observed no signs from the outward appearance of homes that admission would be a distasteful prospect. Moreover, the fact that relatively large proportions of people do enter such homes may reinforce expectations that this is a normal or common experience in old age. The more positive view of residential care in other similar countries raises questions about important features of such provision, and issues of quality (see Box 3)

Sheltered housing

Within Britain the successful development of private sheltered housing and 'close care' schemes might also suggest a re-evaluation of the supposed abhorrence of collective living by the British public. Unlike the provision of residential and nursing care, developments in this area have not been fuelled by public subsidy, and market trends might therefore provide a reliable barometer of consumer preference.

The development of the market has been extremely rapid. While there were only 2,500 units of private sheltered housing for sale in 1983, this had reached 80,000 by 1988 (Bosanquet *et al.*, 1990). Many of the larger companies providing private residential and nursing care have diversified into linked sheltered housing and close care schemes. These have successfully attracted clientele, and might be expected to develop more rapidly in a more favourable economic climate. The 'niche marketing' has attempted to target the relatively fit, younger retired owner occupiers in a broad middle to upper income range, although the majority of those entering such schemes are still the over 75s rather than those in the so-called 'third age'. As the proportions of elderly people who are home owners continues to rise, the size of this market might be expected to grow. The successful expansion of sheltered housing for sale (notwithstanding the present slow down in the property market in general) apparently indicates

3

QUALITY OF CARE

During the 1960s and 1970s research evidence, inquiry reports and government guidance all indicated concern over poor quality and overly institutional residential homes. In the 1980s concerns shifted to a broader focus on 'quality of life' aspects, with an emphasis on features such as privacy, autonomy and minimal surveillance (Peace, 1988).

Concerns to promote the 'right' institutional environment have pursued the themes of 'normalisation' and underlying principles of care. While the registration and regulation of the private care sector has focused on building and staffing issues, the code of practice, *Home Life*, (Centre for Policy on Ageing, 1984), stressed issues of individual value and dignity:

> ***... underlying all the recommendations and requirements set out in this code is a conviction that those who live in residential care should do so with dignity; that they should have the respect of those who support them, should live with no reduction of their rights as citizens (except where the law so prescribes), and should be entitled to live as full and active a life as their physical and mental condition will allow*** **(Centre for Policy on Ageing, 1984, p.15).**

How much change can really be achieved may be open to question. Peace suggests that some aspects of institutional living are always going to be incompatible with models of domestic family living, 'and although it may be important for us to try to minimise the differences between domestic home and residential home, it often proves tokenistic to do so' (Peace, 1988, p.225). Much can be done to improve living environments in terms of greater personal space, and greater choice over everyday aspects of life, but more fundamental change may also be necessary:

> ***... in order to create settings where old people are valued, we still have to find ways of replacing the dependent status commonly attached to elderly residents/patients, and its connotation of helplessness, with attitudes that recognise the potential for interdependence and reciprocity between residents/patients, staff and relatives: an interdependence not just at the level of activity, but also with respect to past experience and life history. In this way we may achieve the ultimate goal where institutional care is seen as another part of community care; without such a reappraisal it may prove impossible to promote the 'right' institutional environment*** **(Peace, 1988, p.232).**

substantial latent demand for residential or quasi residential care.

As well as challenging assumptions about 'what people really want', the growth of private sheltered care also apparently rejects, or at least challenges, many of the conclusions about such developments in the public sector. Special housing for elderly people has a long history in the public sector, dating from the days of charitable almshouses. Evaluations of public sheltered housing in recent years have concluded that the particular features of sheltered schemes (a warden; alarm system; company and communal facilities) are much less important in people's reasons for moving to sheltered housing, than the desire for more suitable housing which is easy to look after and economical to heat (Butler *et al.*, 1983). An accompanying critique has identified the consequences of treating housing needs in old age as 'special', and failing to pay adequate attention to the importance of warm, manageable, 'ordinary' housing (Wheeler and Henwood, 1985). Again, this appears to over-simplify the issue; housing needs apart it is clear that some people – perhaps more than has been assumed – will choose to enter sheltered housing in whatever sector.

The philosophy of 'normalisation' (Wolfensberger, 1972) which has underpinned the development of social services in recent years and which is further underlined by *Caring for People,* is challenged by such evidence. It may be that different standards and assumptions are applied to people in the public and private sectors. If the normalisation ethos essentially means that people should be able to follow a lifestyle available to the general population, that must include the ability to make choices, even if such choices run counter to professional views about good practice.

Unnecessary residential admissions

The rapid development of publicly financed private residential care has been accompanied by much critical commentary. In addition to the 'perverse incentives' objections of the Audit Commission and others, are those which point to the potential waste of resources in providing residential care for people who 'don't really need it', As Wistow has remarked,

> *... one could be forgiven for thinking that entry into SSD homes and hostels was invariably preceded by the most careful and systematic assessment of needs and consideration of alternatives. Evidence from research, however, suggests that admission procedures in the public sector tend to be somewhat less rigorous in practice and that significant degrees of 'misplacement', take place* (Wistow, 1987, p.18).

Certainly there is widespread evidence that there are people living in the community who are at least as, and often more, dependent than those in residential homes. This does not indicate anything about the 'right' level of provision; should more of those living in residential homes be living in the community, or is it the case that more of those in the community, should actually be cared for in residential homes? Such questions cannot be answered simply by reference to dependency levels. Circumstances will also reflect individuals' needs and preferences, including, the availability of carers and other support. Bradshaw's research on people entering private residential homes found evidence of some people who were apparently not in need of residential care, but who were there because of the lack of services available in the community. However,

> *Some of those who entered homes unnecessarily went in of their own volition – to be safe. Others who entered homes unnecessarily went in against their will, advised and assisted by relatives with a vested interest, even if only for peace of mind* (Bradshaw, 1988, p.180).

Dependency and misplacement

Further evidence on dependency and provision of residential care is provided by Pattie and Heaton's research in the York health district (1990). The research findings – on more than 750 elderly people – indicate a general association between type of care and dependency levels, although there is considerable overlap.

Pattie and Heaton evaluated residents against a Behaviour Rating Scale (BRS) graded A to E. Grades A and B describe independent or minimally dependent people; Grade C indicates moderate dependency – 'a level of dependency typical of those in the care of social services homes'. Grades D and E signify, respectively, high and maximum dependency. A fuller description of the scale is presented in Box 4.

Table 8 shows the distribution of BRS grades by type of care. The following conclusions can be highlighted.

- 84 per cent of the total sample are of moderate or higher levels of dependency (C and above).
- 58 per cent need high levels of care (grades D and E) 'and are likely to need residential care as the alternative of supporting such people at home is likely to be very costly or a very heavy burden if they live with relatives'.
- 16 per cent are of fairly low levels of dependency (grades A and B), 'and would not appear to "require" residential care; it is likely they could manage in less intensive settings or at home with quite low levels of support. In

Table 8 Distribution of Behaviour Rating Scale grades by type of care (Numbers and per cent). Grades

Type of Care	**A**	**B**	**C**	**D**	**E**	**Total**
Hospital – Geriatric	0	0	2	6	36	44
%	(0)	(0)	(4)	(14)	(82)	
Hospital – Psychiatric	0	0	1	6	40	47
%	(0)	(0)	(2)	(13)	(85)	
Local Authority Part III	12	34	81	62	54	243
%	(5)	(14)	(33)	(26)	(22)	
Private Nursing Home	3	15	51	57	127	253
%	(1)	(6)	(20)	(23)	(50)	
Private Residential Home	15	42	57	24	32	170
%	(9)	(25)	(37)	(14)	(19)	
Total	30	91	192	155	289	757
%	(4)	(12)	(25)	(20)	(38)	

Source: Pattie and Heaton (1990), Table II

> future, with better systems of assessment, one would not expect such a high proportion of such people to be in residential care' (Pattie and Heaton, 1990, p.9).

If the different types of care are examined separately it is clear that hospitals and nursing homes are generally providing care for a more dependent population. Less than half (48 per cent) of those in Part III (local authority) care, and one third of those in private residential homes are rated as highly dependent (D&E), compared with almost all the hospital residents, and almost three quarters of those in private nursing care.

Residents who are assessed as Grade C dependent (moderately impaired) are those most likely to be on the border line for alternative patterns of care. Overall, 25 per cent of the sample fell into this category, and accounted for one third of residents of both part III and private residential homes. Very few people of this dependency were placed in hospital, but 20 per cent of nursing home residents fitted this category. Many of these – both in nursing and residential provision – could probably be maintained at home given appropriate support.

Considered overall, the research does not indicate *widespread* misplacement, but the degree of this is nonetheless significant. It could be argued that those with the lowest assessed dependency are wrongly placed, 'and could certainly have remained in environments offering less intensive care, had appropriate, perhaps even small amounts of, support been offered', while 16 per cent of all residents were within these categories, this was true of 19 per cent of Part 3 residents, and 34 per cent of those in private homes. If Grades A to C are considered together the proportion who may be misplaced rises to 41 per cent (52 per cent of those in part 3, and 67 per cent of private care home residents).

It is important to emphasise that just as some people may be placed in homes when their need for care is questionable, others could need *more*

4

BEHAVIOUR RATING SCALE DESCRIPTION

Grade A	**No impairment: independent elderly – comparable to those living without support in the community.**
Grade B	**Mild impairment: low dependency – likely to include those needing some support in the community, warden-supervised accommodation and the better residents in residential accommodation.**
Grade C	**Moderate impairment: medium dependency – people functioning at this level are likely to need residential care or considerable support and help if at home.**
Grade D	**Marked impairment: high dependency – it is within this category that there is the greatest overlap between those in social services homes and those in hospital care.**
Grade E	**Severe impairment: maximum dependency – this level is seen most often in psychogeriatric wards and the ones who remain in community homes/ EMI hostels often present considerable problems to staff in terms of their demands on staff time.**

Source: **Pattie and Heaton (1990), Appendix D1**

intensive support. The Grade D residents (high dependency) can be further classified into degrees of dependency. D2 describes those who are more physically dependent, often confused and frequently incontinent. Thirty per cent of high level dependency residents in private residential homes, and 40 per cent of those in Part III accommodation were so classified. As Pattie and Heaton observe:

> *there is clearly a fairly high number of people who should perhaps be receiving more intensive care* (1990, p.13)

A comparison of Pattie and Heaton's findings with other recent research in this area indicates considerable variation, and problems of methodological approach and interpretation. As Table 9 indicates, hospital patients are the only ones for whom there is a high degree of consistency in findings (that is, there are very few low dependency patients in hospital, and high proportions of very dependent people). The disparate results across the other studies are very striking – especially in the work of Moon *et al.* (1990). Partly this illustrates the difficulties of comparison between different analyses. However, it also underlines the extreme variation which does seem to characterise misplacement, ranging from a minority of cases to very considerable proportions.

Continuing care and the NHS

Whatever the successes of community care, some residential provision will still be needed. While *Caring for People* stated the main policy objective as being to provide the necessary services and support to enable people to live in their own homes or in 'homely' community settings, it is nonetheless acknowledged that:

> *Residential care homes and nursing homes will continue to play an important part in meeting people's care needs. Some people will always need more support than can be reasonably provided in their own homes or in sheltered housing* (DHSS, 1989, para 3.7.1)

As the above discussion has pointed out, how much residential provision will be needed is unclear, and policy is extremely ambivalent. However, recent developments do at least challenge the view that this will be for a very small group.

Whatever the trends in publicly funded care,

Table 9 Comparison of five studies of dependency in residential care

		Type of Care			
Author	**Definition**	**Hospital**	**Local Authority Part III**	**Private Residential Homes**	**Private Nursing Homes**
1. % Low dependency people in residential care					
Gibbs & Bradshaw (1988)	'Not in need/ not in need if	-	-	17.2	-
Moon *et al.* (1990)	'Low need'	4	-	75	36
Whittome (1985)	'Less than moderate'	1.5	29	38	0
Parker *et al.* (1988)	'independent/ low dependency'	2	9	-	-
Pattie & Heaton (1990)		0	19	34	7
2. % High dependency in residential care					
Moon *et al.* (1990)	'High/very high need'	69	-	4	24.5
Whittome (1990)	'Very severe'	67	30	17.7	72.5
Parker *et al.* (1988)	'Maximum dependency'	73	38	-	-
Pattie & Heaton (1990)	'Maximum dependency'	84	22	19	50

Source: Pattie and Heaton (1990), Table IV around 40 per cent of private and voluntary care home residents are currently privately funded. Some of these will become dependent on public finance as they exhaust relatively small capital reserves. On the other hand, a number of factors are likely to increase the size of the self financing sector. In particular Laing suggests the following will be significant:

- Levels of owner occupation and hence of capital assets, and also of other wealth (such as personal and occupational pensions) will continue to increase among older people.
- New financial products in the long term care market will stimulate the purchase of private care.
- More discriminating customers will emerge as the post-war generation ages (Laing, 1990, p.41).

Laing, however, also points out that the growth of such privately financed care will be dependent on how far elderly people are willing to spend assets they might otherwise bequeath (and, indeed, how willing their families will be to stand by and watch them do it).

Discussion about residential care frequently includes nursing homes in the same debate. Different issues may be involved, however, not least because of the different responsibilities for providing such care. What is, and what should be, the contribution of the NHS to continuing care needs?

While the major responsibility for community care is to rest with the local authority, *Caring for People* also emphasised the responsibilities of health authorities.

> ... *there will be others, in particular elderly people with mental handicaps together with other illnesses or disabilities, whose combination of health and social care needs is best met by care in a hospital setting. There will be a continuing need for this form of care* (DHSS, 1989, para 2.5).
>
> *Health authorities will need to ensure that their plans allow for the provision of continuous residential health care for those highly dependent people who need it* (DHSS, 1989, para 4.21).

There are a number of questions about the role of the NHS in making such provisions which are generally referred to as 'continuing care'. *Ensuring* that continuous health care is available need not be the same thing as directly *providing* such care. Policy documents since the mid-1970s have, however, indicated that the NHS should make hospital provision for the minority who require long term hospital care. Nonetheless, there is considerable evidence that the NHS is disengaging from such provision.

There appears to be a considerable mis-match between the official commitment to providing NHS continuing care facilities on the one hand, and practical developments on the other. The Association of Community Health Councils for England and Wales (ACHCEW) has highlighted the problems in terms of deteriorating quality and choice:

> *The supply of continuing NHS care of elderly people is falling well short of the demand and there is evidence from several sources that much provision which is available is of poor quality. Pressure is too often placed on elderly patients and their relatives to move out of hospital into private nursing homes with little or no consultation, choice or information. Once they are receiving private nursing care, many residents experience financial difficulties and consequent distress* (ACHCEW, 1990, p.1)

Withdrawal from continuing care

A survey of Community Health Councils by ACHCEW (1990) found 77 per cent of respondents reporting a reduction in the provision of continuing care beds over the last three years. The closure of such hospital beds has not been off-set by the development of other more appropriate NHS continuing care facilities. The result, claims ACHCEW, is 'that some elderly people, their relatives and carers are faced with the discovery that there is no NHS provision for non-acute nursing needs' (1990, p.4). Health authorities are not generally replacing their own facilities with contractual beds in private nursing homes. The ACHCEW survey found only one third of health authorities had contractual beds, and of these half had 30 or fewer beds by such arrangements.

While much of the analysis of private sector developments in residential care has concentrated on the financial savings this offers local authority social services departments, it is clear that the system has also been to the advantage of health authorities. The present system contains no incentives for the NHS to provide continuing care; indeed, quite the reverse. The NHS cannot charge its patients for such care; transferring patients to long term care in the independent sector where patients are either self-financing or supported by social security, is therefore an attractive option for health authorities anxious to control expenditure. As with many social services departments, there is also evidence of health authorities seeking to transfer their own continuing care provision to the independent sector (Age Concern, 1991).

There is no evidence that such developments are a matter of deliberate government policy. Indeed, the then Health Minister Virginia Bottomley, stated precisely the opposite in a letter to the Patients' Association in August 1990:

> *It is not government policy to encourage health authorities to reduce the number of long stay beds in favour of the private sector* (quoted in Age Concern, 1991, p.4).

Deliberate or not, it is arguable that policy is developing by default, and there is a need for clarification. If a specific contribution is to be made by the NHS, government action may be required to ensure that this is the case. The statement in *Caring for People* that long stay hospital wards exist 'in parallel with the provision of nursing care by the private sector', and that 'whether this requires an increase or a reduction in the level of continuous health care provided through the NHS will depend very much on local circumstances', could appear to provide encouragement for precisely such a transfer to the private sector as is taking place. Such developments have been a source of much concern in many quarters, and have fuelled political controversy over the alleged 'privatisation' of the NHS.

The role of the NHS

The case in favour of the NHS playing a direct role in providing continuing care can be made on a number of levels. In particular, it is unlikely that the independent sector will be able to meet all needs, or will be available to do so. The distribution of private care is extremely uneven. The under provision in some areas and apparent surplus in other makes it unlikely that elderly people would have guaranteed local access to private nursing home care. Moreover, the evidence that many nursing homes are not providing care for a comparable group of people as are receiving long term hospital care, raises questions about the capacity of the independent sector to meet the needs of the most frail and dependent.

An Age Concern discussion paper on continuing care units within the NHS (1991) raised a number of other concerns about the NHS withdrawing from the area. For example, NHS continuing care capacity may have a distinctive contribution to respite care provision. *Caring for People* emphasises the importance of respite provision in supporting carers. Such care is generally provided by the NHS, and without some continuing care capacity, this will be under threat. Certainly the independent sector will want to maintain high occupancy rates which will not easily allow for respite beds.

Rehabilitation might also be more likely to take place in NHS long term care than in private nursing homes, both because of different expertise within the NHS, but also reflecting different incentives. Private nursing homes have no incentive to move patients back home. Age Concern comment that

> *Some independent nursing homes may offer full rehabilitation programmes, while others may have neither the experience nor facilities to rehabilitate people back into the community. Nor may they be able to supply the panoply of therapeutic services required to achieve such rehabilitation. A geriatrician points to the fact that non geriatric specialties often write people off as hopeless and many of them will go into private nursing care and stay there permanently. In contrast, in a geriatrics department most of the patients who are referred for continuing care are eventually discharged to their own homes or residential homes* (Age Concern, 1991, p.13).

A related point, therefore, is whether the general care in the NHS is better, or should be better – setting the standards for continuing care.

Continuing care and the medical perspective

The role of geriatric medicine in continuing care of older people is unclear. The evolution of geriatric medicine as a specialism since the second world war has seen a growing emphasis on rehabilitation and acute medical care (Lewis and Wattis, 1988). There has been a parallel rise in concern over 'bed blocking' which as Hall and Bytheway suggest, is a term which

> ... *represents certain beliefs about the purpose of hospitals. Blockage is a symptom not just of mismatch between services and needs, but also of frustration at the shading of the line between medical and social intervention* (1982).

'Bed blocking' refers to patients who remain in hospital beds while, in the view of medical and nursing staff, they no longer require such care. Factors preventing discharge may be both clinical and social. Social factors include the lack of, or unwillingness of, relatives to provide support; and poor social and housing conditions. Clinical factors include lack of agreement over responsibility between medical and dementia services on the one hand, and between medical and social care on the other.

Chadwick and Russell (1989) argue that the distinction drawn between the 'partly sick and partly well' – between the social and medical – is

> *inextricably linked to issues of resource-managment, so that to define a frail elderly person as 'well' within a ward setting, may also be to acknowledge, for example, that a bed for that person is no longer available ...*

The boundaries between health and illness, between medical and social care, are thus fluid and shifting. The dilemma of those who are too well for hospital, but too frail for residential care is familiar. Chadwick and Russell argue the social/medical issue is both concerned with conceptual problems of definition, but also with administrative and professional problems of resource boundaries. A sharp distinction between acute health care and social care militates against a more holistic approach which has been advanced in at least some quarters of geriatric care.

> *In caring for frail elderly people, professionals are confronted with conceptual ambiguities, and with the limitations of a welfare system that has artificially categorised old people's needs. In the context of present-day bed shortages in the NHS and part III residential care, we see professionals using such limitations as part of a strategy for the control of their own resources. Frail elderly people's needs are, in part, being defined by the welfare options that are, or in many cases are not, available to them* (Chadwick and Russell, 1989, p. 293)

Quality of long term hospital care

Quality is a multi-faceted concept (see also Box 3). While many of the worst examples of geriatric hospital care may have disappeared, it is the case that much care is still provided in drab and unappealing environments. As the Health Advisory Service has observed, 'the brazen neglect of years gone by has been replaced by a pattern of care which is hygienic but still predominantly institutional' (1986). A review of Health Advisory Service reports (Age Concern, 1990) draws attention to the poor quality of much continuing care provision. While many health authorities have made great progress in their long stay provision for elderly people, 'unknown numbers of elderly people spend their final days in wards and under care regimes which are no longer acceptable as part of good practice' (1990, p.1). Such shortcomings have been highlighted on previous occasions. In 1987, Peter Horrocks prepared his final annual report as Director of the Health Advisory Service (HAS), and reviewed twelve previous reports in so doing. He concluded,

> *that long-stay wards consistently offered environments which were unable to provide privacy, homely surroundings, personal space and possessions or adequate furniture* (Age Concern, 1990, p.2).

The Age Concern review examined 22 HAS reports published between May 1988 and May 1989 and documented continuing evidence of unsuitable buildings; inappropriate care; traditional custodial daily routines, inadequate staffing levels and lack of training. The review 'bears continuing witness to an unjustifiable scandal in the quality of life for some elderly people in NHS long-stay care' (1990, p.7).

Evidence that change can be achieved in the quality of long stay care, and can be cost-effective, is provided in the experience of the three experimental NHS nursing homes (see Box 5).

5

NHS NURSING HOMES

Three experimental nursing homes were established by the then DHSS in 1983 and 1984. The homes are small (24, 25 and 30 bedded), community based and nurse managed units (although with all admissions assessed and referred by consultants). The Health Care Research Unit of the University of Newcastle was commissioned by the DHSS to evaluate the experiment. The evaluation was designed to compare the structure, process, intermediate and final outcomes of care in ordinary continuing care hospital wards and in the three experimental NHS nursing homes, and a number of conclusions can be highlighted:

- ***NHS nursing homes provide a more positive environment.***

  Physically the nursing homes are distinguished from hospital wards most notably by the provision of single rooms for most nursing home residents.

- ***Nursing homes are no more costly than NHS hospital wards.***

  Higher nursing staff costs in NHS nursing homes are offset by other savings in revenue costs. In most cases nursing homes will actually be cheaper to run.

- ***Improved outcomes can be obtained from NHS nursing homes.***

  In relation to a range of measures of activity level, and resident views, care in nursing homes is valued more highly, and seen to be more effective than ordinary continuing care hospital provision.

The evaluation concluded that

> ***... residents in the three experimental NHS nursing homes were not disadvantaged; this form of care was preferred by both residents and relatives; and it was no more expensive than continuing care provided in NHS hospitals. We therefore recommend that NHS nursing homes be developed as continuing care accommodation* (Bond et al., 1989, p.51).**

NHS nursing homes: a model of good practice?

These NHS nursing homes were established in the early 1980s as an experiment in improving the quality and nature of continuing care provision. Could such homes move away from an institutional character? Could quality of life for residents be enhanced (in terms of physical and social environment, and in the attitudes and style of staff)? It may be that the pursuit of normalisation objectives is incompatible with care within a traditional medical/nursing environment. Bond *et al.*, (1989) point out that the development of geriatric medicine has strongly influenced the organisation of the hospital care of frail elderly people. Moreover, the dominance of the acute medical model (stressing recovery and discharge) which underpins geriatric medicine overshadows the contribution of nursing, which 'has failed to define its caring role'

Against this background, the introduction of NHS nursing homes as nurse-managed units was highly significant, and signalled a radical change from the way care was traditionally provided in

NHS hospital continuing-care wards. Not surprisingly, therefore the development was not without its critics. Partly in response to this the DHSS commissioned an evaluation of the demonstration project.

The evaluation which was undertaken (by the Health Care Research Unit of the University of Newcastle upon Tyne) was extensive and multidimensional. It was designed to compare the structure, process, and intermediate and final outcomes of care provided in conventional continuing care hospital wards and the three experimental NHS nursing homes.

Compared with NHS hospital wards the three nursing homes provided a more positive environment for residents, which was associated with higher activity levels. The physical environment of the homes was also different – most obviously in the provision of single rooms for most of the NHS nursing home residents, and other differences were also apparent:

> *... their size, greater variety of spaces, spatial organization and greater prosthetic quality are also important. The three NHS nursing homes were better endowed with nursing staff than all but one of the hospital wards* (Bond *et al.*, 1989, p.44)

Importantly, and perhaps surprisingly, NHS nursing homes appeared 'no more costly' than NHS hospital accommodation. Higher nursing staff costs in the nursing homes were off-set by savings in other revenue costs. Various assumptions were built into the evaluation, and most scenarios found NHS nursing home accommodation likely to be less costly than continuing care hospital accommodation. In addition to measures of cost and quality, a survey was undertaken of attitudes towards the different type of accommodation. More positive views existed about the physical and social environment of nursing homes compared with hospitals.

Improving the quality of continuing care facilities has been an issue over many years. In designing the experimental nursing homes it was believed that changes were required in the physical and social environments as well as in the attitudes of staff. The physical design of the homes was informed by discussion and debate 'of the essential features of good quality', and the creation of private space was a central feature. Moreover, there was considerable emphasis on the relationship between the homes and the community in which they were located:

> *Homes were intended to be small enough to provide a community facility, but economics of scale encouraged the development of small institutions rather than more independent, domestic sized living accommodation, with shared domestic and care services. Emphasis was placed on the integration of the facility into the local community so that residents were part of a larger community rather than of an institution. Friends and relatives, for example, would be encouraged to visit residents as if they were in their own homes. In providing care, staff were to maximise residents' autonomy and choice* (Bond *et al.*, 1989, p.48).

Thus the experimental nursing homes effectively implemented all of the received wisdom about what constitutes good practice in long term residential care . Not only was it possible to achieve better quality and more desirable institutional environments, but it was also possible to do so in a style which was more cost-effective, and no more expensive, than conventional NHS long stay accommodation. In *Caring for People* the Government endorsed the model of continuing care represented by such homes, stating that:

> *... care is best provided in small units, which can develop a more home-like atmosphere than is often possible in wards in large hospitals. Such units can offer patients their own room or personal space, and an informal style of care, without, for example, a formal daily timetable or staff uniforms* (DHSS, 1989, para 4.2).

However, in failing to delineate the actual continuing care responsibilities of the NHS 'which exist in parallel with the provision of nursing care by the private health sector', there is little real encouragement, and no incentive for the development of this model of care. A major opportunity to transform and redirect the nature of continuing care within the NHS has apparently been lost.

Choice and equity

Many of the issues which arise in relation to NHS continuing care and private care are particularly clear around hospital discharge. The Department of Health has issued guidance on procedures (Circular HC(89)5), and an accompanying booklet to the circular states:

> *Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees under a contractual arrangement. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges.*

In her letter to the Patients' Association, the then Health Minister Virginia Bottomley elaborated the process:

> *The decision as to the type of appropriate care required by each individual person is made by the consultant in charge of the case. Where the consultant decides that a patient needs hospital treatment,*

> *then that will be provided. Where, however, the consultant decides that the person requires long-term nursing care, then government policy is to encourage the provision of sufficient satisfactory alternatives in the independent sector, to enable elderly people and their families to have a choice of care provision, if they wish. If the patient in an NHS bed does not feel willing to accept responsibility for private nursing home fees and is not in a condition to return to their own home, they should remain under the care of the health authority* (quoted in Age Concern, 1991, p.4).

This effectively describes a highly anomalous situation which implies the following:

- Hospital treatment is distinguished from long term nursing care. The former is the responsibility of the NHS, the latter might be.
- People should have a choice of nursing care provision in the independent sector.
- People who do not want to or feel unable to accept responsibility for private nursing home fees will remain the responsibility of the NHS.

There is considerable evidence that adequate consultation does not take place prior to discharge, and patients are not given sufficient information on their rights and choices (ACHCEW, 1990; Age Concern, 1991).

Age Concern refute the claim that discharge decisions are made by consultants purely on medical grounds. There is, they argue, evidence that assessment decisions are affected by the need for efficient use of the hospital system and speedy patient throughput. Practices which see people unsuitably discharged either to their own homes without adequate support, or to residential or nursing homes which they may neither want nor be able to afford, are contrary to good hospital discharge arrangements. The arguments in support of the NHS having a direct role in continuing care provision must be seen in the light of these issues.

The issue of choice between remaining in NHS care and entering private care does not seem to be a choice between equal options. If NHS continuing care wards are grim, rather than small homely units, *anywhere* else might seem preferable. Moreover, if there is no continuing care available within the NHS considerable pressure may be put on patients and relatives to find a place in the independent sector. There is also evidence of people entering such homes in the belief that social security benefits will cover the cost, and subsequently discovering this is not so. The ACHCEW report is the latest of many to highlight the problems of shortfall between social security benefits and private home fees. There is also evidence of homes charging for 'extra' services. Almost half of CHCs who responded to the ACHCEW survey found nursing home fees did not cover the cost of chiropody or incontinence aids. Physiotherapy and occupational therapy are also frequently charged for as 'extras'. What is particularly significant is that these are services which people would have free access to if they were in their own homes or in an NHS hospital. As ACHCEW have observed,

> ... *residents and their families are being asked to make additional payments for essential health services* (1990, p.12).

What emerges therefore is a picture of inequitable patterns of care.

- Some elderly people will be cared for in NHS facilities; these will vary in quality from the excellent to the abysmal, but patients will not be charged for their care.
- Other elderly patients, who will not necessarily differ in medical or clinical terms from the first group will find themselves paying all or some of the costs of care in a private nursing home. Their security of tenure in such accommodation is not guaranteed, and if they become unable to meet the fees, or are judged too dependent for the home to cope with, they may be asked to leave, or to accept poorer quality of care by moving into a shared room.
- Yet another group may enter private care as social security funded residents. They may find few homes who will accept such residents (and may therefore have to go further afield), or will find they receive poorer quality care than fellow residents who are self-financing.

The ACHCEW survey concluded that for people who can afford private care, the expansion of non-statutory services may offer greater choice and better care. But, for those who cannot afford private care, there is little and diminishing choice.

There is an urgent need to clarify the responsibilities of the NHS in providing and/or purchasing continuing care for elderly people. The current position is confused and inequitable. The care available to people appears to be largely a matter of chance.

Whether care is provided in the public or private sector is not the main issue. What is far more significant is the consequences which placement has for individuals *entitlement* to comprehensive and free health care. Henwood and Wistow (1991) point out that the shift towards providing continuing care within the private sector, and the accompanying reductions of NHS geriatric capacity (from 58,000 beds in 1978 to 53,000 in 1988),

> ... *could be justified as an attempt to establish more homely and less institutional nursing care for long term patients. However, the expansion of the private sector is not, in the main, occurring under contrac-*

> *tual arrangements, which would ensure such benefits are secured. The use of nursing home beds in the independent sector in fact appears to be contingent on individuals' entitlement to social security.* (1991, p.6)
>
> *... there appears to be a shift in financial responsibility from the NHS to the social security system. Moreover, because of the inadequacies of the income support system being used for these purposes, there is also a transfer of responsibility from the NHS to individuals and their families* (1991, p.7).

It is a measure of the seriousness with which these issues are being viewed that they were the focus of an inquiry by the Social Security Committee of the House of Commons (Fourth report, 1991). Moreover, such was the significance of the matter for both the Department of Social Security, and the Department of Health, that the two committees became the first since 1979 to meet concurrently. Perversely, the two committees are not empowered to agree a joint report. The Health Committee did, however, 'fully endorse the findings of the Report by the Social Security Committee and recommend it to the House'.

Although largely considering the issue of the financing of private residential home fees, the committee also addressed the central issue concerning the responsibilities of Health Authorities for continuing care:

> *We understand the reasons why health authorities devolved responsibility for funding long term nursing care onto the Social Security budget, but the consequences have been grave. We find it extraordinary that the stage has now been reached when the representatives of health authorities can tell us in all seriousness that such nursing care is "not a function ... of the health service". It may well be that the type of care and environment provided in nursing homes is much to be preferred to the old geriatric wards, but that care was provided free to the patient, and we fail to see why many people should now be put in the situation where they have to pay all or part of the fees. The fact that nursing homes are run by those outside the NHS does not mean that the funding for the patients in them should not come from the NHS. Indeed, health authorities have a duty to pay for people being cared for in nursing homes on discharge from hospital and we believe that this power should be used much more often than evidence to us suggests is the case at present* (Social Security Committee, Fourth Report, 1991, para 93).

The delay in the implementation of the community care legislation increases the likelihood of these problems intensifying. In the count down to April 1993 all of the pressures and incentives on health authorities are for them to divest themselves of continuing care services. If action is not taken to curb such activity the NHS may find itself without any long term care facility. Its capacity to manage a comprehensive health service will accordingly be much reduced.

If the NHS seeks to disengage from continuing care there are disturbing questions about the prospects for geriatric medicine within the health service. Bond *et al.*, (1989) characterise the stages in the development of geriatric medicine since the early 1950s. Initially the focus was on the institutional care of chronically ill people, and the development of the distinction between acute, rehabilitative and long-stay care. The second stage saw a move towards the community, with closer links with general practitioners and other community services. The third stage recognised the preventative aspects of geriatric medicine, with emphasis on the role of primary health care services. Thus, Bond *et al.*, observe

> *... the work of Departments of Geriatric Medicine has steadily expanded and currently comprises a wide range of activities but, in general, all departments set out to provide a service for a defined population and provide a comprehensive range of facilities* (1989, p.4).

Bond *et al.*, note an emerging fourth stage in the evolution of geriatric medicine, which is characterised by the run down of continuing care beds in favour of care at home or in other institutions, particularly in the private sector. If this stage continues to develop, they suggest, it threatens to destroy the comprehensiveness achieved over the last four decades. Moreover, the scope for research, experimentation and service development within NHS geriatric care could vanish, with fragmentation of acute and chronic services.

Conclusions

The view that residential care will be increasingly residual is challenged by developments in recent years, and in particular by the apparent demand for residential and nursing home care from individuals and their families.

Policy in relation to residential care has developed largely by default. While there has been debate about the 'perverse incentives' created by social security policies, there has been a relative neglect of other policy issues such as the relative responsibilities of local authorities and the NHS. The role of the NHS in relation to continuing care responsibilities has become increasingly confused. There are signs that health authorities are continuing to disengage from either providing or financing such care. In the light of evidence concerning the continued poor quality of much long stay NHS provision some might view this as a welcome development. However, to the extent that this represents a redrawing of the boundaries of the NHS, with a transfer of responsibility for financing long term care to the social security system, and to individuals and their families, the implications are profound. The current situation was perhaps epitomised in evidence given by the National Association of Health Authorities and Trusts (NAHAT) to the Social Security Select Committee, in which it was stated that 'the provision of nursing home type care is not a function, in the view of the Association, of the National Health Service' (Social Security Committee, Fourth Report, Minutes of evidence, 21 May 1991). Symptomatic of the withdrawal from long term care has been the failure to develop the model NHS Nursing Home piloted in the early 1980s. The three experimental homes appeared to be highly successful and cost-effective, and there would seem to be a strong case for continued investment in this area. Not only would this provide a high quality form of NHS care for frail elderly people, but it would provide a safeguard to maintain the NHS as a comprehensive health service. Without such measures there is enormous potential for destabilisation of the system, with blocked beds resurfacing as a major issue in the 1990s.

4 Issues and conclusions

This paper has examined the future of community care of elderly people and has argued that this is a matter both of increasing urgency and major uncertainty, with a lack of clear vision. Three conclusions, in particular, can be highlighted.

First, the belief that community services can provide a viable alternative to residential care is largely an act of faith which has been little tested in practice. Such evidence which does exist suggests that achieving the objectives of *Caring for People* will be much more difficult that has been assumed.

Second, major questions surround the role of the NHS in continuing care. It is apparent that there has been a disengagement of the NHS from responsibilities in this area. Moreover, this move has entailed a redrawing of the boundaries of entitlement to free health care, with increased individual responsibility for arranging and financing long term nursing care in old age. In the view of the Social Security Committee of the House of Commons (and endorsed by the Health Committee) the obligation of Health Authorities to provide nursing care should be strictly enforced and 'Health Authorities should not evade what are properly their responsibilities'.

Third, and related to the above, has been the failure to develop the model of NHS Nursing Homes piloted in the early 1980s, despite substantial evidence that these offered a high quality and cost-effective approach.

Other issues and conclusions arise on a number of inter-related levels, and these are reviewed below (see also Box 6).

Individuals and families

The care of dependent people in Britain has always primarily taken place within the family. It is a minority of elderly people who end their days in residential or nursing home care. This remains true despite recent increases in the numbers entering care.

The caring role of the family has been increasingly acknowledged in recent years, driven in part by the growing evidence on the nature and extent of such care (Green, 1988). However, while the rise in the numbers of elderly people especially of the very elderly and most frail – is likely to increase the numbers and proportions reliant on family support, the 'supply' of such care is becoming less certain. As Section 1 indicated, the family is undergoing substantial change in patterns of marriage and divorce, and in socio-economic trends, all of which may reduce its caring capacity.

The new approach to community care, as outlined in *Caring for People* (DHSS, 1989) seeks to make carers' interests a central priority, and as such it signals a major shift in policy (which remains to be matched in practice). Nonetheless, there appears to be inadequate recognition of the likely implications of demographic trends which may reduce the future supply of carers.

Other issues likely to have direct effects on individuals relate to the planned increase in service

6

POLICY ISSUES IN THE 1990s

A number of issues and questions have been identified in this report. Some of the most significant of these are summarised below.

- ***Caring for People*, represents a major shift in policy towards carers, and makes support a central priority.**
- **The belief that community services can provide a viable alternative to residential care has been little tested in practice.**
- **The evidence which does exist suggests that achieving community care for frail elderly people will be much more difficult than has been assumed, and will be contingent upon substantial investment in case management.**
- **The interface between health and social care remains problematic both at organisational and practice levels. These problems are not resolved by the new approach to community care, and the question of a unitary purchasing agency for community care might be reconsidered.**
- **The role of residential care needs to be reassessed. Recent trends suggest that demand and preference for such provision may be greater than has been assumed.**
- **The role of the NHS in long term care of elderly people needs to be clarified, and the responsibilities of health authorities in this area properly enforced. The apparent withdrawal both from provision and finance of continuing care suggests a redefinition has taken place in individual entitlement to free and comprehensive health care, but has occurred in the absence of any public debate or new legislation.**
- **NHS nursing homes provide an excellent model for continuing care, and the widespread development of this approach as a replacement for long stay geriatric care should be considered.**

targeting. The emphasis on targeting help on people in greatest need is being accompanied by the less publicised withdrawal of service from the less dependent. Those Social Services authorities which have already achieved some shift away from a home help model towards home care have followed this route, and service users with more domestic than personal needs have been encouraged to use the independent sector. The move towards a home care service seems likely to be achieved by the virtual disappearance of a conventional home help model of service. That is, service coverage is being sacrificed or diluted in the interests of enhanced service intensity.

Powerful efficiency arguments might be advanced in support of this trend. As Section 2 described, the conventional model of the home help service is, in many respects inefficient. The service has tended to be allocated in a high acceptance approach (requests for help are rarely refused), and there has, accordingly, been little development of eligibility criteria, and hence little matching of need with appropriate service. The stretching of a limited provision over large numbers of clients means that average intensity is around three hours of service per client per week. These conditions make it highly unlikely that the service will be either effective or efficient. Nonetheless, in moving rapidly towards the other end of the continuum other problems may arise. The withdrawal of service from clients with lesser needs may reduce the capacity of home care to operate in a preventive or rehabilitative mode. It might also imperil the vital contribution of such support to carers' respite, where relatively minimal service inputs can make the difference between coping and collapse with much greater resource implications as a result of such supposed 'efficiency'.

Service orientation

The emphasis in *Caring for People* on providing the necessary support to enable people to continue living 'in their own homes wherever feasible and sensible' raises questions about future directions. Two areas, in particular, are central. First, what are the real prospects for developing community services which can substitute for residential/nursing support; and second, what is and what should be the scale and role of residential care?

The scope for home care services operating as an alternative or subsitute for residential/nursing home care is uncertain. At present, elderly people living alone are more likely than those living with a partner or others to receive home help services. Carers are not generally well supported by home care, and are frequently treated as substitutes for formal services. This is especially important in the light of the emphasis on supporting carers enshrined in *Caring for People*, and indicates the considerable difficulty of meeting this objective alongside the requirement to target help where need is greatest.

Particular innovations in home care – such as the Kent community care scheme – underline the potential for intensive support to achieve real change. The community care approach was able to achieve much better outcomes for individuals than conventional service models – including halving the probability of death or of entering an institution, and doubling the probability of individuals remaining in their own homes. The price of such achievements, however, may be great, particularly in terms of the costs (financial and other) falling on individual home carers. The deliberate use of what is virtually a black economy of labour cannot be seen as a general model to be widely replicated. It is likely, therefore, that the adoption of a properly funded community care approach would be significantly more costly than suggested by the Kent experience.

In the absence of deliberate case management, merely improving targeting and raising service intensity is of dubious merit. While advocated by the SSI, and endorsed by the ethos of *Caring for People*, the model has been largely untested and fails to question or examine service outcomes. The analysis conducted by Davies *et al.*, (1990) concluded that clients did not appear to benefit significantly from enhanced service inputs, and seemed no less likely to enter long term care. Such conclusions do not contradict the evidence of the community care scheme, rather they indicate that achieving such changes will require a much greater investment in service management.

Inefficiencies in many aspects of community care were identified by the Audit Commission (1986). A principal aspect of inefficiency concerned the operation of the residential care system. The general lack of assessment and inadequate admissions screening, allied with the 'perverse incentive' of the social security structure, were believed to have generated widespread inappropriate placements. There has been relatively little research on this issue, and no nationally representative survey. Comparison of various studies indicates considerable variation of practice, covering a range from minimal to extensive misplacement.

The question of appropriate or inappropriate placement, however, is by no means straightforward. The assessment of dependency alone fails to allow for wider social circumstances, or to take account of individual's needs and preferences. The availability of residential/nursing care provision appears to be a major determinant of its use. As Bond *et al.*, (1989) point out, this raises questions around choice, and in particular whether access to residential resources should be uncontrolled, and – if not – on what basis it should be rationed. As Section 3 documented, the expansion of residential services in the last ten years has been unprecedented. The rate of growth has been much greater than would have been required simply to keep apace with demographic demands, but is probably not fully accounted for by the encouragement provided by social security subsidy. The widely accepted view that residential care is particularly abhorrent to the British public must be challenged and reconsidered. The relatively high proportion (40 per cent) of residents of private homes who are self-funded, and the apparent continuing demand for such homes (and for care housing schemes) adds particular support to this challenge.

Health and social care

The move towards a community centred approach to care raises particular practical problems around the interface between home helps and district nurses, which in part reflects wider difficulties of the health and social care divide. The development of personal care does not easily fit within a social services framework. The more the home help service evolves from a domestic to a nursing model, the more difficult this becomes. An essentially personal service moves into a realm which is widely perceived, particularly by clients, as a medical or nursing domain. At the same time, such care – often likened to the help that would normally be given by a caring relative – does not usually require full nursing skills, and it may be inefficient to use these.

The problems in managing care between home helps and district nurses indicate both the difficulties of defining boundaries between the services, and the incentives for both services to attempt precisely to delineate these in order to safeguard the demands on their respective resource pools.

The new approach of *Caring for People* fails to address the continuing problems of health and social care co-ordination, at either an organisational or practitioner level, and merely repeats the familiar exhortation for authorities to work together. The likely failure of this advice may be judged from past experience and the generally poor record since the 1970s of joint planning and collaboration.

If the realities of practice and process make it unlikely that the boundary between health and social services will be dissolved by good will, more fundamental change may be required. The Audit Commission's analysis of the problems of community care (1986) identified a number of strategic options for change. One of these was the unitary purchasing of both health and social care. In general practice fund holding there has already been some experimentation with a unified budget for health and community care. The results of this will be of considerable interest, and the operation of a unified budget would seem to merit serious consideration. There is evidence of some authorities developing local commissioning consortia (Audit Commission, 1992). However such developments are likely to be as variable as previous models of joint working.

The nature of long term care

Much of the recent debate about residential and nursing care has concentrated on ideological issues around the apparent shift towards a privately provided, but in part publicly funded service. Important while these issues are, there is a danger of them overshadowing more fundamental debate about the nature and quality of care provided.

As William Laing has observed, nursing and residential homes:

> *... still provide a lower standard of amenity than the general public has come to demand in, for example, hotel accommodation and holidays abroad* (1990, p.4)

Nonetheless, he argues that in the independent sector such standards have been rising both in response to market forces, and the requirements of inspecting authorities. The operation of the arm's length inspection and registration units might be expected to raise standards throughout the residential facility. In addition to registering and inspecting independent residential homes, the same standards will for the first time also apply to the local authorities' own homes. However, given the poor quality and amenities of much public provision, the standards are unlikely to be set initially at very high levels.

There remain significant anomalies with the inspection/regulation arrangements. The arm's length status of the inspectorate is some way from the wholly *independent* inspectorate which has been strongly argued for. Moreover, the attachment of the units to local authorities also means that there is an absence of common registration standards across the country. The guidance issued by the Department of Health does not provide definitive standards, 'but rather a guide and information resource to be used flexibly in the development of evaluative criteria'.

Residential homes in all sectors will be the responsibility of the local authority. Nursing homes, however, will continue to be registered and inspected by health authorities. In the future, local authorities may well find themselves purchasing nursing care for individuals, while having no control over the nature or quality of that care provided.

Although the new legislation brings local authority residential provision within the regulation of an inspectorate, NHS long stay geriatric care remains unregulated, other than through the Health Advisory Service (HAS). The evidence from recent HAS reports continues to give cause for concern over the standards of care provided in old and often dilapidated Nightingale wards.

The opportunity to develop an effective NHS alternative to continuing care wards in the form of NHS nursing homes appears to have been lost. In view of the considerable and persuasive evidence on both the effectivenss, high quality, and efficiency of these nursing homes, this is to be much regretted, and the further development of this model should be reconsidered as a matter of urgency.

Attention has been diverted from this wider development not by the expansion of conventional continuing care wards (which are fast disappearing), but by the growth of independent nursing homes. The NHS has been able to increasingly disengage from responsibility both for the provision and finance of long term care. There is enormous potential for destabilisation of the acute hospital system once the NHS and Community Care Act becomes fully functioning in 1993, and hospitals are no longer able to effect discharges by utilising individuals' entitlement to social security (and hence of public payment of private home fees).

Rights and entitlement

The increasing use of private nursing homes in lieu of continuing care within the NHS appears to have altered the boundaries of entitlement to NHS care. The shortfall between levels of income support and nursing home fees means that many individuals and their families will have to find some means of bridging the divide. The choices available to clients who are reliant upon public finance are being reduced as this group becomes less and less attractive to private providers. The small numbers of elderly people who remain as continuing care patients within NHS hospitals are relatively advantaged: they are not financially responsible for either the nursing care or any additional medical and ancillary services. Individuals who enter private nursing homes are effectively disenfranchised of their rights as NHS patients.

Individuals who need continuing care, who cannot find this within the NHS, and who do not qualify for income support, are having to purchase their own care – often necessitating the sale of their home in order to realise assets. For people who have been able to obtain significant capital during their lifetime, there may well be increasing and attractive choices in organising care in later life. The gradual emergence of long term care insurance and other financial products directed towards the affluent younger elderly cohorts is indicative of this. Most elderly people, and particularly the oldest, single elderly who are most likely to need long term care, are however the least likely to have substantial personal assets – capital or otherwise.

The expansion of owner occupation has been extremely rapid since the second world war, and deliberately promoted during the 1980s. The gradual awareness that one of the costs of acquiring such assets could be responsibility for meeting the costs of care in old age, could promote a substantial political backlash. It will also encourage the exploration of legal loopholes and avoidance strategies. The better off, with their access to financial and legal advice, will be the most likely to take advantage of these possibilities.

A policy agenda for the 1990s

The issues in the care of elderly people in the 1990s are substantial. As the foregoing discussion has indicated, there can be no grounds for complacency. *Caring for People* is, in many respects a revolutionary document. Properly resourced and fully implemented it has enormous potential to establish a framework which is needs centred and individually oriented. Nonetheless, the white paper, and the subsequent legislation, were perhaps more notable for what they omitted than contained. Some of the most fundamental issues, which had been identified by the Audit Commission and others, have simply not been addressed. The most significant of these concerns the interface between health and social care. At the margins, the divide between these two services is artificial. Moreover, as social care becomes increasingly personal, it will be more difficult to distinguish it from nursing care. The remaining service boundaries create a major impediment to comprehensive care. The difficulties of co-ordinating services, and of putting in place arrangements which encourage co-operation rather than defensiveness appear as intractable as ever. The question of a unitary purchasing authority for health and social care services is one which has been long avoided. In the interests of efficiency, and – more importantly – of individuals well being, it might be that this should now receive serious consideration.

Major questions must also be asked about service objectives and their attainment. The policy response to the managerialist critique of community care has led to an almost obsessive concern with reducing inefficiency and improving financial management. There has not, however, been similar attention paid to what it is that services are trying to achieve, nor whether they succeed, and the vision of the future is at best blurred and partial. Without a clearer focus, the next steps in long term care will be a major leap in the dark, and the attainment of the objectives of *Caring for People*, may prove to be beyond reach.

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