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*This Bulletin is published by the Personal Social Services Research Unit at the University of Kent at Canterbury.*

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# Introduction

*Chris Gostick*

I am both flattered and diffident to have been asked to introduce this important edition of the PSSRU Bulletin: flattered because of the very high reputation PSSRU now holds among all of those engaged in the social welfare business, whether as managers, practitioners, policy makers or researchers; diffident because I suspect that like many I am not entirely confident that I understand as fully as I should the rigorous theoretical arguments underpinning the work of the unit, or the sophisticated methodology employed in their research. This Bulletin, however, is an important bridge between those two positions, bringing together short articles and summaries of much of the current and recent work of the unit in a clear, straightforward and easily accessible way, while pointing the way to the increasing library of books and monographs produced by the unit for those requiring more detailed information on specific topics.

This Bulletin is also significant in other respects. For one thing it is the first to be published since the full implementation of the community care reforms that PSSRU research has done so much to shape and underpin, so it is particularly appropriate that this should be a special issue on the general theme of Community Care. Second, it is now close to the twentieth anniversary of the establishment of the Unit at Canterbury in 1974, and given the recent report of the Williams Committee and the current review of personal social services research commissioned by the Department of Health, this seems a particularly good time to the enormous importance of units such as PSSRU which can generate a consistent stream of research over time, while also building and refining a comprehensive theoretical framework within which policy and practice can be developed and sustained.

But the PSSRU is far more than just a static repository of data or ideas. By consistently building on the three complementary strands of research established in 1974, under the single overarching theoretical framework of the Production of Welfare model —

■ variations in needs and provision be-

tween different localities;

- innovations in services, especially for elderly people; and
  - the crucial relationship between resources and outcomes —
- researchers in the unit have been able to develop an increasingly sophisticated understanding of the underlying processes of social welfare operated by large scale bureaucratic organisations; to test this understanding empirically; and then to undertake and evaluate experimental studies, such as the well known Kent Community Care project, which allow new responses to those processes to be developed.

The Kent Community Care project has already gone down in history as the foundation of the current reforms, but it is worth reminding ourselves that this was the first explicit attempt to introduce a managed process encompassing clear assessment of needs; explicit costing of resources; measurement of a wide variety of needs and outcomes; and then to analyse the resulting relationships with complex modelling techniques. As an experimental study involving close management attention and additional resources, there is no doubt that the project always had a fair wind; but replication studies elsewhere have consistently produced similar results; and studies reported in this issue of the Bulletin again demonstrate how these same outcomes can also be achieved where the approach is adopted as standard practice in busy local offices.

It is through this process of continued replication and refinement that units like the PSSRU are able to develop a more comprehensive understanding of complex processes. By bringing together a critical mass of researchers over a long period coupled with wide experience and an international perspective, and a clear intellectual focus, the eventual policy and practice outcomes transcend the sum of the individual projects undertaken, and it is this which gives such units their strength and vitality.

The Kent Community Care project also demonstrates the length of time it takes to translate a potentially good idea into a systematic policy framework, and it is this ability to 'think long', coupled with the flexibility to undertake rapid short-term research programmes on emerging issues, which characterises the best work of units

such as the PSSRU, and which it will be important to continue to sustain in any reorganised approach to personal social services research in the future.

Since that early pioneering work on services for elderly people in Kent, the Unit has broadened its work into a whole range of client groups and activities, and it is particularly heartening to see the new emphasis on mental health studies reported in this issue, for example.

A glance at the contents of this Bulletin will show the great diversity of work now being undertaken at the PSSRU, but all is based around the unifying themes of the Social Production of Welfare, and the Mixed Economy of Welfare. It is no accident, of course, that these are also the central themes that characterise the current community care agenda in the United Kingdom, although I suspect that most of us would not usually refer to them in quite that terminology. But beneath those two rather technical terms lie all the important issues that those on the front line of the reforms are now grappling with as we move beyond establishing basic organisational foundations for community care, and on into the full development and implementation of new systems and approaches.

The issues we face are about improvement in assessment and the role of care managers; about targeting resources on those in greatest need, and the degree of concentration of those resources; about developing choice and diversity, and the encouragement of user involvement; about achieving pluralism of provision (the so-called mixed economy of care), and about improving the quality and regulation of services; as well as about the actual costs of services, and the critical relationships between resources, needs and outcomes.

All of these are issues on which the PSSRU has something important to say and to contribute. While not all of these themes are directly represented in this issue in the form of specific articles, information on them does appear somewhere within the Bulletin, together with much more. It would be hard to identify another UK research unit that could respond to such a comprehensive agenda with such a range of work. But even more important, the PSSRU

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provides not just a research perspective, but brings together the current issues of research, management and practice within a coherent framework, so that the unit material has something to say to all of us, wherever we are located within the community care process. This is a measure of the achievement of the unit and its staff over the past two decades, and it is hardly surprising that many of us remain diffident in the face of that achievement.

Such achievement is not without its costs, however, and in its early days the PSSRU had a not entirely undeserved reputation for unnecessarily complex argument shrouded in a leaden prose style. More recently Unit publications have shown an increased ability to present complex ideas in a relatively clear and simple way. I hope that is equally true of the papers in this Bulletin, which I have worked hard to try and influence. If they are not easily readable it will be a measure of how far I too have now been absorbed by the Unit culture. One thing I have not been able to overcome is the Unit's continuing delight in the unconventional metaphor, the scholarly pun, or the use of obscure acronyms. I suspect that these are now so much part of the culture as to be irreversible.

Nonetheless, I look forward enthusiastically to the opportunity for introducing the thirtieth anniversary edition of the Bulletin in

2004. Although beyond that, despite the renowned longevity of academic social scientists, especially those with an economic turn of mind, I suspect (and indeed hope) that by then many of us will have handed over to a new generation of production of welfare entrepreneurs, many of whom will have received their formative research training and intellectual experience in important units like the PSSRU, and it will be to them that we shall look for the continued high quality of community care research in the next decade and beyond.

In the meantime I do commend the contents of this, and the many previous PSSRU Bulletins, as essential reading for all who are involved in either community care, or the social welfare business more generally, in whatever lowly or exalted position.

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Chris Gostick was Director of Social Services for Westminster City Council until early 1993, and is now Community Care Development Manager for North West Thames Regional Health Authority. He has been Associate Lecturer and Visiting Research Fellow at the University of Surrey since 1980, with a particular interest in personal social services research, and is Secretary to the Association of Directors of Social Services (ADSS) Services Evaluation, Research and Information Committee.

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# Problems in Estimating Unit Costs of Community Care

*Ann Netten*

The need for costs information continues to grow. Policy makers need costs for community care plans, purchasers to negotiate contracts and set budgets, providers to secure funding and identify prices. Even within the Department of Health (DH) a variety of potential uses for unit costs of services has been identified: costing the effect of demographic changes or new policies on public expenditure, option appraisal such as the cost-effectiveness of different modes of care, and performance indicators.

The DH is commissioning a number of exercises to enhance the level of knowledge about unit costs. As part of this the Unit Costs Programme of work aims to draw together state of the art unit costs research, identify important gaps in knowledge and initiate an agreed approach to the process of estimating unit costs. The strategy adopted was to estimate 'building blocks' of cost information in order to provide an approach that was as flexible and valid as possible. The first stage was to identify the key elements in constructing unit costs: client group; type of service; providing agency; resource type (for example, capital, labour and overheads); activities (for example, time use, tasks and commodities); and causes of variation (for example, regional issues, population scatter and dependency of clients).

## Problems and gaps

The process of compiling the information into a 'schema' for each service and a validation exercise on the first report which incorporated these schemata served to highlight a number of gaps and problems in the current level of knowledge about unit costs. These were of three types: lack of data, changing services and problems in defining units.

### Lack of data

Across services there is a basic lack of information, particularly about overheads and capital costs, which resulted in the report drawing on, in some cases, quite long-standing research findings. This was of great importance when pricing capital as it frequently represents a high proportion of unit costs and estimates are highly sensitive to different assumptions.

### Increasing variety of service

The services included so far have been defined by the world of community care which preceded the introduction of the NHS and Community Care Act. But an explicit aim of the reforms is an increased diversity of services to enhance consumer choice. The changes are already under way. For example, the increasing importance of resource centres providing day, domiciliary and residential services means that services provided by such centres will need separate and careful costing.

### Defining units to cost

Even among existing services there are problems of definition. For example, day care covers an enormous range of provision. Some centres provide a wide variety of commodities such as personal care, physiotherapy and group therapy in addition to the basic level of social contact and meals provided by most establishments. In using cost information, planners, evaluators and policy makers need to know the average cost of different types of day care services.

The issue of deciding exactly what unit should be costed and obtaining the necessary information is at its most acute when establishing the cost of professional involvement. For example, if the unit to be costed is a domiciliary visit, it is essential to know the relationship between the time spent with a client and time spent on other activities. But care management tasks such as coordinating and planning services may depend more on the number of services involved with the client than with the amount of time the professional spends in direct contact with the client.

## The way forward

The process of drawing together and validating information about unit costs has identified a number of problems but provides a valuable basis for future work. Concerns about confidentiality in order to maintain a 'level playing field' when pricing services to purchasers could well serve to reduce rather than enhance the amount of cost information that is available.

By linking in to other research, both within and without the Unit, the will develop

both the level of sophistication and the extent of information about unit costs. Links with three projects will be used to generate information about professional time use. Work on staff activity in mental health teams (see the update on page 14) is providing a useful starting point for the development of a methodology to investigate the most appropriate way to cost professional time. Future work includes a new study being undertaken by the National Institute for Social Work on the changing role of social work practitioners. The forthcoming study of changes in community care of the elderly between 1984 and 1995 (see the update on page 24) will provide an opportunity to investigate the most appropriate way to approach the problems inherent in estimating unit costs of day care for elderly people.

Ongoing work will also serve to extend the range of services for which unit costs are available. Existing links with research in mental health (for example that described here on pages 6-7) have served as a valuable source of data. Similarly, costing services for children will be incorporated, based on past projects, a current study of the costs of child assessment in social services and new work on child psychiatry. Work from the Centre for Health Economics at the University of York will provide costs of a wide variety of services for people with learning difficulties including innovative services, respite care and services based in resource centres.

By forging such links it is hoped that the Unit Costs Programme will provide a forum for the exchange and development of information that should be of value to researchers, policy makers and practitioners in the drive to the more efficient and effective use of resources.

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Thanks are due to Steve Smart for his work on the original report and to all those who participated in the validation exercise. Thanks also to members of the working group: Martin Knapp (chair), Andrew Bebbington, Jeni Beecham, Kirsteen Smith, Raphael Wittenberg and Ken Wright.

A report, *Unit Costs of Community Care 1992/93*, has recently been published: see page 20 for details.



# Funding Mental Health Services

Jeni Beecham\*

The mental health research at the PSSRU currently comprises about a dozen projects ranging over a variety of 'mental health economics' topics. Within the production of welfare paradigms, the estimated costs of supporting clients are used to examine client, practice and policy issues. This approach allows applied research to be located within both a theoretical framework and a clinical or service delivery context.

One of the issues examined in PSSRU research is the funding of care. Here we consider the contributions of service providing agencies to the costs of service packages using data from four research projects on community-based care for people with serious mental health problems in London.

*Psychiatric reprovion* (): From this wide-ranging research project, funded by North East Thames Regional Health Authority, data are available for 341 people who were interviewed one year after dis-

charge from two long-stay psychiatric hospitals. Each person was formerly an in-patient for at least a year, and no one aged over 65 had a diagnosis of dementia.

*The Daily Living (DLP)*: This innovative support service was established at the Maudsley Hospital in 1987. The service provides a home-based treatment programme for people who would otherwise be admitted to emergency in-patient care. A randomised controlled trial compared DLP users with people with serious mental health problems receiving standard in-patient treatment.

*The Community Support Team (CST)*: In Greenwich, a team of community psychiatric nurses is providing an intensive support service within a care-management structure. Using a similar research protocol to DLP, clients were matched with people receiving standard CPN care from a generic team. As with DLP, data from the last interview are used (18 months after entry

to study) to provide the closest approximations to 'steady-state' service use and costs.

*The Maudsley Outreach Support Team (MOST)*: This service is specifically targeted at people who are perceived to have unmet needs and are 'hard to reach'. It aims to provide an accessible service for people who can use only the standard configuration of services in times of crisis, despite the need for ongoing support.

Table 1 shows the distribution of costs between agencies involved in providing services — the funding pattern. Cost proportions are calculated from data on the comprehensive costs of support, which include all services used. In , where many specialist placements are used, 85 per cent of costs are accounted for by accommodation. The lowest percentage absorbed by these costs is still over a third of the total (MOST). Off-site services, such as out-patient services, day care, social work and other peripatetic professionals, are not

**Table 1**  
**Proportion of total costs of community care funded by each agency**

Funder	Research project					
	NETRHA	DLP		CST		MOST
	%	Cont	Exp	Cont	Exp	%
Client/family	29.3	28.8	41.2	2.3	2.1	12.4
Project	0.0	0.0	14.1	0.0	6.3	26.8
District health authority	49.9	51.8	17.8	70.8	65.2	33.4
Family health service authority	0.5	0.3	0.3	0.9	0.8	0.1
LA social service department	9.9	7.1	2.7	10.7	19.2	2.0
LA, other departments <sup>1</sup>	4.7	9.4	19.3	1.9	2.6	16.8
Voluntary organisations	5.7	2.2	1.4	0.6	0.9	3.2
Law and order services	– <sup>2</sup>	0.2	3.1	12.7	2.8	5.3
Miscellaneous services	0.0	0.1	0.0	–	0.1	–
Sample size	341	68	74	30	32	26
Average weekly cost per client (£) <sup>3</sup>	493	312	213	368	280	486

## Notes

1 Includes housing, housing benefit, education

2 Less than 0.05% contribution to total cost

3 Updated to 1992/93 prices using Hospital and Community Health Services pay and prices index

only important elements of individual care packages but also absorb varying amounts of the total costs of care.

The *project* category includes several sources of money: and MOST were financed by new Department of Health monies, and dedicated district funding was available for the CST. In the NETRHA study, financial transfers ('dowries') were set up at the beginning of the closure programme and are included in the *district health authority* figures. At the time of data collection no services used by clients were provided through NHS Trusts.

Even with special financing arrangements there were costs to other agencies, but the input of new services tends to alter the funding pattern. One of the aims of DLP, for example, was to reduce use of in-patient hospital services, the most costly of health authority services. This has meant a large reduction in funding from the district health authority and a higher proportion borne by the local authority as clients have spent longer periods in their own homes. The new service also significantly reduced the total costs of care for this client group (Knapp et al., 1993).

In direct contrast to the contribution of the district health authority, the *family health services authority* funds less than 1 per cent of support in each project yet general practitioners play an important role in the care of people with mental health problems. More than half of each sample saw a GP at least once in the period before interview, often for psychiatric as well as general health care.

Comparing the two CST columns, we see three areas in which the distribution of costs for the experimental group is different from the control group. First, although clients were accepted into the study at point of discharge, rather than admission to hospital (as with ), there was a small reduction in district health authority funding. Second, the social services department funds a higher proportion of the total. Third, there was a considerable reduction in the proportion of funding from law and order services, which includes police, probation, court and prison. Funding from these services is low across all projects, and the services tend to be used intensively by a few clients. In the CST control group these costs were raised considerably by the

imprisonment of three clients (McCrone et al., 1993).

In both the CST and MOST projects, staff from the new services have expanded the traditional role of the community psychiatric nurse to provide services more commonly associated with other agencies. This is particularly noticeable in the MOST service, where the project funded a high proportion of the care packages. It is innovative services such as these which can point the way forward for mental health care, and the injection of dedicated project funds aids their introduction. The termination of these funds signals the need for service providers to be aware of their costs in order to set their prices accurately. Purchasers, however, must also be aware of the cost consequences of selecting one model over the other: a service which is less expensive to the health sector, for example, may require a greater level of funding from social services or from the service user.

Policies to encourage development and change in community care services have often focused on funding, for example the joint finance arrangements and 'dowries' introduced in the early 1980s. More recently, funds totalling about £500 million have been transferred to social services departments to pay for residential, nursing and domiciliary care of elderly people, 85 per cent of which is to be spent on independent providers, including, in this case, the NHS. The effect of such policies is often difficult to measure, particularly as the distinction between *who funds* and *who provides* services is not always clear. For example, the voluntary sector funds a higher proportion of support in the project than in any other, but this was still only 6 per cent of the total. Many services, however, were *provided* by these organisations — accommodation facilities, day care, social clubs and some peripatetic support. The *funding* for these services came through social security entitlements or health and local authority grants. There were only a few services where subsidies were made from the voluntary organisations' own resources.

This article describes the funding of psychiatric care before the recommendations of the NHS and Community Care Act 1990 came into force. Under the new arrangements, a wider range of providers are en-

couraged to enter the market with a greater variety of services. The most visible effect of the new arrangements will be to reduce the proportion of costs to the user while raising that borne by social service departments. For example, 12 per cent of the sample live in specialist accommodation provided by private individuals or organisations, but the charges are met by the clients' own resources (usually social security entitlements) and included in the *client/family costs*. (This category also includes the living expenses borne by the client and by other household members but does not include the costs of informal care.) Although the number of clients moving to these establishments has reduced over time (Hallam et al., 1993), recent changes in funding mechanisms may allow social services departments to argue that their financial contribution to mental health care has increased without substantially altering their current level of activity. Nevertheless, for people with serious mental health problems, it is likely that the health sector, as provider of hospital-based services, will continue to dominate the funding of care.

## References

- Dansie, A., Beecham, J. and Knapp, M. (1993) The costs of MOST, PSSRU Discussion Paper 909.
- Knapp, M., Beecham, J., Koutsogeorgopoulou, V., Hallam, A., Fenyo, A., Marks, I. and Connolly, J. (1993) Home-based and hospital-based care for people with serious mental health problems: the costs and cost-effectiveness of the Daily Living Programme, PSSRU Discussion Paper 857.
- , A., Beecham, J., Knapp, M. and Fenyo, A. (1993) The costs of accommodation and care: community provision for former long-stay psychiatric hospital patients, submitted to *European Archives of Psychiatry and Clinical Neuroscience*.
- McCrone, P., Beecham, J. and Knapp, M. (1993) Community psychiatric nurses in a Community Support Team: a cost evaluation of the Greenwich innovation, PSSRU Discussion Paper 794/3.

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\* I gratefully acknowledge the contribution to the work described here of many PSSRU colleagues, and collaborators outside the Unit.

# Length of Stay in Residential and Nursing Homes

Robin Darton

From 1 April 1993, local authorities have been responsible for assessing new applicants for public funding for private and voluntary residential and nursing home care. Existing residents were given 'preserved rights' to income support, and a government working party, the 'Algebra Group', developed a formula for transferring social security funds for new applicants to local authorities. The phasing of the transfer of funds and the distribution across local authorities was calculated using information on turnover from two surveys of length of stay in residential care and nursing homes, and information from a survey by the Benefits Agency of the areas of origin of residents receiving income support.

Under the new community care arrangements, local authority planners and care managers also need information about the length of stay of residents in residential and nursing homes. Ideally, this should be related to individual characteristics, such as age, sex, and health and dependency status. Most studies of residential and nursing homes have been cross-sectional, and estimate the average length of stay for current residents, *not* the completed length of stay for discharged residents. Furthermore, the uncompleted length of stay will be underestimated in the expanding private residential and nursing home sectors.

As a first stage in research on completed length of stay, the PSSRU undertook a study in 1992, in collaboration with a London borough, a metropolitan district and a county council, to examine length of stay, turnover, source of admission and source of finance. Since a cohort of new admissions would have to be studied for a considerable period to produce information on length of stay, the turnover of existing residents over a fixed period of time was obtained. A period of one year was considered initially, but was reduced to three months to provide information more quickly. Health and dependency information was not collected, to minimise the burden on respondents and because a cohort study would be more appropriate for predicting length of stay from these factors.

## Design of the study

A census of residents in local authority, voluntary and private residential homes and independent nursing homes was conducted in February 1992. The census forms were returned to the homes in May to obtain the date of discharge and destination for residents leaving during the intervening period. Basic information about the home and information on new admissions during the three months was also collected. The number of homes providing information is shown in Table 2.

## Results

These relate to residents in the homes in February 1992. Table 1 shows the completed length of stay of residents who left the home between February and May 1992 and the uncompleted length of stay of those in the February survey. The uncompleted length of stay figures include short-stay residents, but there will only be a small proportion of these at any given time, particularly in the independent sector. Although the uncompleted length of stay of residents will be related to the age of the home, any relationship with the completed length of stay would only be indirect, for example if residents admitted to newer homes were more frail. There was no consistent relationship between the two measures. For local authority and voluntary residential homes the mean uncompleted length of stay was approximately two standard errors below the mean completed length of stay, corresponding to the 5% level of statistical significance, although only 25 residents left the voluntary residential homes. For private nursing homes the mean uncompleted length of stay exceeded the mean completed length of stay, a statistically significant difference at the 0.5% level. For private residential homes the mean completed length of stay was lower than the mean uncompleted length of stay, but the difference was not statistically significant.

Overall, 98% of residents in local authority homes and approximately 80% in independent homes for whom the information was available had their previous home address within the authority, but the propor-

tions varied between the three authorities. A larger proportion of residents in local authority residential homes and private residential and nursing homes in the London borough came from outside the authority, while nearly all those in the voluntary residential homes, several of which had been transferred from the local authority sector, came from the authority. In the metropolitan district, 87% of residents in private residential homes and 69% in voluntary residential homes came from the authority, compared with 70% in both types of home in the county council, and in both authorities approximately 80% of private nursing home residents came from the authority. Residents in independent homes who came from the authority were more likely to have been admitted from hospital (42%),

**Table 1**  
Mean uncompleted and mean completed length of stay (months)

	Uncompleted	Completed
<b>Local authority homes</b>		
Mean length of stay	37	46
Standard error	1.0	4.0
Number of individuals	1726	148
<b>Private residential homes</b>		
Mean length of stay	31	29
Standard error	0.7	2.6
Number of individuals	1534	112
<b>Voluntary residential homes</b>		
Mean length of stay	36	56
Standard error	1.8	10.7
Number of individuals	544	25
<b>Private nursing homes</b>		
Mean length of stay	21	17
Standard error	0.4	1.1
Number of individuals	2621	221
<b>Voluntary nursing homes</b>		
Mean length of stay	21	17
Standard error	1.9	3.1
Number of individuals	182	9
<b>Private dual registered homes</b>		
Mean length of stay	25	26
Standard error	1.8	3.7
Number of individuals	283	37
<b>Voluntary dual registered homes</b>		
Mean length of stay	85	114
Standard error	7.2	—
Number of individuals	110	1



while those who came from outside the authority were more likely to have been admitted from private housing (42%). Hospitals provided the main source of admission of residents, except in voluntary residential and voluntary dual registered homes which, together with private residential homes, had the largest proportion of residents who had been owner occupiers, living alone.

In 1991, the overall ratio of admissions of long-stay residents to the total number of places was approximately 33% for local authority and private residential homes and voluntary nursing homes, 45% for voluntary residential homes and private dual registered homes, and 60% for private nursing homes.

In the London borough, 16% of residents in local authority homes paid the full cost charge, and 31% paid the minimum. The corresponding figures were 9% and 41% in the county, and 2% and 34% in the metropolitan district. In the London borough, similar proportions of residents in independent homes were supported by private means, income support with topping up and income support without topping up, although these varied considerably between the different types of home. In the county, 50% were supported by private means, ranging from 37% in private nursing homes to 70% in both private and voluntary residential homes, and 29% were supported by income support without topping up, ranging from 12% in private residential homes to 42% in private nursing

homes. In the metropolitan district, 26% were supported by private means, and 51% were supported by income support without topping up. Overall, residents from outside the authority were slightly more likely to be supported by private means, principally in private residential homes in the metropolitan district and in private residential and nursing homes in the county.

## Policy implications

Under the new arrangements for public funding of residents in independent homes, the length of stay and turnover of residents will have important financial and administrative implications for local authorities. The discrepancies between the uncompleted and completed lengths of stay for some types of home indicate that local authorities should not rely on using uncompleted lengths of stay, although for private residential homes the two figures were very similar. Underestimates of length of stay, and corresponding overestimates of turnover would lead to problems of finding sufficient places, probably resulting in increased fees charged by providers, and bed blocking in hospitals, while overestimates of length of stay would lead to of facilities and increased unit costs.

In an earlier study, reported in PSSRU Bulletin No. 8, levels of physical disability, incontinence and confusion among residents of local authority homes were found to be

intermediate to those recorded for private residential and private nursing homes, while antisocial behaviour was more prevalent in local authority homes. One possible explanation for the greater mean length of stay for local authority homes than for private residential homes may be that residents with confusion have relatively long lengths of stay. As local authorities reduce their provider role, the profile of resident dependency in independent homes may change, for example by receiving more long-stay residents with confusion, with consequent implications for length of stay and turnover.

The extent to which individuals move to independent homes in different areas depends on the amount and type of provision and its attractiveness. Homes catering for privately-funded residents tend to have higher charges, and thus a high level of in-migration of such residents to independent homes will reduce the available provision locally, and tend to drive up the general level of charges.

In order to respond effectively to the changes introduced in April, local authorities cannot rely on using information about overall levels of provision, but will have to monitor length of stay, turnover and migration, and the resident characteristics related to length of stay, to create an accurate picture of the actual availability and the response of providers of residential and nursing home care.

**Table 2**  
**Source of admission and source of finance**

	No. of homes	Home address in authority	Source of admission		Source of finance		
			Hospital	Owner occ. alone	Private topping up	IS with topping up	IS without
		(%)	(%)	(%)	(%)	(%)	(%)
Local authority homes	56	98	24	14	–	–	–
Private residential homes	103	82	30	26	39	22	34
Voluntary residential homes	22	81	10	21	36	24	36
Private nursing homes	85	79	52	11	28	15	52
Voluntary nursing homes	7	86	57	14	32	25	40
Private dual registered homes	6	79	46	17	41	15	42
Voluntary dual registered homes <sup>1</sup>	2	25	0	24	43	0	3

**Note:**

1 Source of finance not known for 55% of residents.

# The London Costs Problem

*Andrew Bebbington and Aidan Kelly*

The high cost of local authority services in London is a long-standing issue in the allocation of central government grants to local authorities. These grants attempt to achieve both equity and efficiency. Equity is achieved by allocating grants in proportion to both the needs for services and the local resources (council tax) available to pay for them. Efficiency is promoted by allocating grant sufficient to provide the given level of services at national average unit costs. Some allowance is made for variation in the cost of providing services that result from factors beyond the control of the authorities. For example, the London Labour Cost Index (LCI) is used in Standard Spending Assessments (SSA) to allow for higher labour costs in London. This index is computed from the average hourly wage rates in all sectors of employment, private and public, using the New Earnings Survey. From a 15 per cent differential in the mid 1980s, the LCI for Inner London now stands at 26 per cent.

Expenditure on personal social services has risen 3.5 per cent per annum over the decade from 1979 to 1989, but this has been absorbed entirely by higher unit costs, resulting in a decline of 1.4 per cent per year in the total volume of services produced

(Bebbington and Kelly, 1992). Given this importance of unit costs in PSS trends, it is not surprising that London has been adversely affected. Figure 1 clearly indicates that Inner London SSDs have higher unit costs and higher unit cost inflation. Social services unit costs in Inner London have always exceeded the cost adjustment made in allocating grants: the gap actually widened from 34 to 57 per cent higher over the 1980s. The question is whether London SSDs should be fully compensated for these higher unit costs, when it has been argued that they result from avoidable factors such as poor management arrangements (Audit Commission, 1987). The London Costs project aims to throw light on this question.

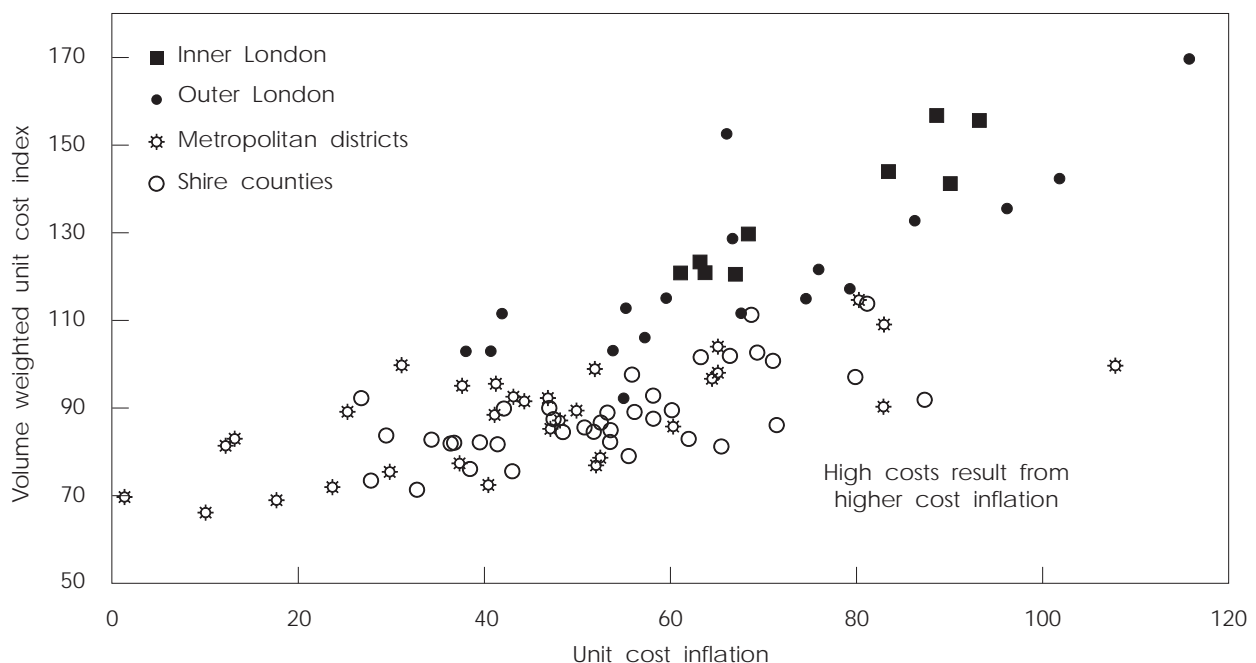
## Findings

- Of the 57 per cent higher unit costs differential in the volume-weighted average unit cost across the ten main services, 35 per cent is due to higher staff unit costs and 16 per cent to productivity, taken as the volume of service units per member of staff (Bebbington and Kelly, 1991a).
- A range of research studies report higher vacancy and turnover rates, skills short-

ages and greater difficulty finding suitable staff. These may be taken as indicators of the degree of labour market pressure experienced by London SSDs (Bebbington and Kelly, 1991b).

- The wage differential between Inner London and the rest of England for local authority social services staff is higher than for teachers or nurses. The highest differential occurs for local authority junior administration and clerical staff (Bebbington with Kelly, 1993).
- The survey of local authorities indicates that social work staff in London are no younger or less experienced than elsewhere. The high costs of staff in London are due to London weighting, appointments further up scales (social workers), to a shorter working week, and to a range of bonuses and incentive payments (residential workers), many of which are now being scaled down. Turnover has greatly reduced during the recession (Bebbington with Kelly, 1993).
- A survey of personnel in four authorities indicates that labour costs per employee hour for Inner London in 1990/1 are 26 per cent higher than the rest of England, very close to the London Labour Cost Allowance (Bebbington with

**Figure 1**  
The impact of unit cost inflation, 1979-1989



Kelly, 1993).

Several other orthodox explanations of high costs in London were not substantiated. Occupancy rates of facilities are no longer much worse in London, nor do authorities use inefficient means of care. There is little systematic evidence that clients' characteristics are cost-raising except in the case of children from ethnic minorities in care (Bebbington and Kelly, 1991a).

- High unit costs are not associated with party control, but costs are slightly lower in those authorities that are politically stable. Unit costs seem to have risen least in those authorities which have had a declining local revenue base, particularly metropolitan districts in the north east of the country (Bebbington and Kelly, 1992).
- The 'gap' between Inner London and the rest of England has closed since 1989, but the Outer London differential is now higher than the Inner London one. By 1990/91, average staff costs had become higher in Outer London than Inner London (with Kelly, 1993).

## Implications for Standard Spending Assessments

The current level of the London Labour Cost Index used in SSAs now appears to be equal to the average higher cost of labour for personal social services in Inner London. However, the LCI excludes non-staff costs, and these are also higher in London, probably because non-staff expenditure mostly goes on labour-intensive provision such as contracted-out services.

Unit costs are influenced by central government grant allocation policies and rate-limitation decisions, as well as labour market conditions. Expenditure restraints in London authorities, combined with the onset of recession, appear to have created an opportunity for many social services managements to erode restrictive practices, make efficiency savings and thus contain unit costs. Case study evidence suggests that the methodological distinction between factors within and beyond the control of authorities is far from clear in practice: labour market pressures are a significant factor mediating managerial initiatives aimed at cost containment.

The London Implementation Group may soon confront the heroic assumptions appeared to make about the capacity of London Social Services to respond to hospital closures (Tomlinson, 1992). The London Costs project suggests that cost inflation has reduced capacity, and management pressure has already reduced the 'organisational slack' that might otherwise have been available to assist the transition.

## References

- Audit Commission (1987) *The Management of London's Authorities: Preventing The Breakdown of Services*, Occasional Paper 2, Audit Commission, London.
- Bebbington, A.C. and Kelly, A. (1991a) The London Costs Project stage one report, PSSRU DP757.
- Bebbington, A.C. and Kelly, A. (1991b) The London Costs Project second stage proposal, PSSRU DP776.
- Bebbington, A.C. and Kelly, A. (1992) Trends in unit costs for local authority personal social services, PSSRU DP799.
- Bebbington, A.C. with Kelly, A. (1993) Area differentials in labour costs of personal social services and their relevance to Standard Spending Assessments, PSSRU DP898.
- Medical Education and Research, HMSO, London.

# Five Years On: Supporting People with Learning Disabilities

*Martin Knapp*

Long-term care in hospital for people with learning disabilities will soon be a thing of the past. Care in community settings is generally seen to be more appropriate. A study by Paul Cambridge, Lesley Hayes, Martin Knapp and Eriko Gould, supported by the Joseph Rowntree Foundation, looked at the lives of 215 people who left long-stay hospital five years earlier.

At the time they left hospital, three-quarters of the sample were aged under 50, half had been in hospital for more than 21 years, and half were rated by hospital staff as profoundly or severely disabled. At that time, most could not bathe or dress without assistance, and very few could shop alone, manage their financial affairs or use public transport.

## One year in the community

Everyone moved to well-supported, planned accommodation, generally of better quality than in hospital. After a year, people had acquired many new self-care skills, but there was some exacerbation of mild behavioural problems. They had more choice about daily activities, and made extensive use of ordinary community facilities, though integration remained a commonly unmet aim. Users expressed greater satisfaction about their social networks. Community care was more costly than hospital, but greater expenditure brought better user outcomes. (Full details in Martin Knapp et al., *Care in the Community: Challenge and Demonstration*, see page 22.)

## Five years on

Four years later — and five years since they left hospital — we asked these people to participate in a follow-up evaluation. Our findings are encouraging, though challenges remain for community care. (A full report on the five year study will be published later in 1993.)

**Service principles and accommodation** — Care management, normalisation and a commitment to user involvement are widely adopted principles and, by the criteria of normalisation, community accommodation is better than hospital. A third of the sample live in hostels, residential homes or hospital; one in eight live independently (and few others want to

move to such settings); and one in four live in unstaffed accommodation. Overall:

- ordinary lifestyles have been established;
- privacy is generally respected;
- residents are involved in the day-to-day running of facilities;
- routines are usually flexible;
- most people exercise choice over activities;
- staff-resident relationships are not overly formal;
- most people have opportunities to manage key aspects of their lives.
- However, some institutionalised practices have crept into some settings. For example, reductions in staffing have made it harder to maintain arrangements for promoting 'ordinary living', and some community accommodation is quite remote from town centres and

other areas of social interaction.

**Employment and income** — Only 7 per cent of people have jobs (paid or unpaid), most in sheltered or supported employment. Financial barriers discourage full-time work, for loss of benefits jeopardises supported accommodation. Although staff help people to claim benefits, income is not always adequate to provide desired standards of care, let alone compensate for a paucity of social contacts, employment opportunities and personal belongings.

**User outcomes** — Since our interviews one year after hospital discharge, people have acquired new skills: managing their own financial affairs; taking up opportunities to use community facilities; independently planning or organising weekly activities; and counting and handling money. They

have made new friends (while also expressing a desire for more) and have chosen to become more self-determining in activities and lifestyles. They are largely coping well with the many challenges thrown up by these changes. They have certainly not 'slipped through the net' of community provision.

Changes were more pronounced in the first year after leaving hospital than in the subsequent four years. Indeed, although good practices have been introduced, there have also been occasional warning signs that some community services are in difficulty. (In the extreme, people in one former project were forced to return to hospital because of disagreement between a voluntary organisation and the health authority over costs and service orientation.) We found evidence that higher levels of expenditure produced better skills attainments, but the link was weak. However, user satisfaction remains high.

**Service utilisation** — Many community services are used, but gaps and unmet needs remain. Staff reported that a fifth of the sample have access to inappropriate education because of segregation, age-inappropriateness or inadequate targeting, though users did not generally report dissatisfaction. Staff perceptions of day support and clubs are similar: too much segregation, too little variety, inappropriate targeting (providers sometimes underestimating users' abilities and range of interests), and limited potential for development. Almost one in ten respondents reported difficulties of access to social work services. A third of the sample need better support from volunteers acting as advocates.

Average weekly cost is £598 (1992 prices), the same as the cost of community care one year after these people left hospital, but 16 per cent higher than hospital costs.

## Implications

People with learning disabilities can enjoy better lives in the community than in hospital with improvements being enjoyed in many aspects of life. However, not everyone is better off, and some areas of community support need more attention. In particular, access to employment remains a major problem, and income levels are low.

**Figure 1**  
Former long-stay hospital residents:  
215 people interviewed and assessed  
five years after leaving





# Mapping the UK Voluntary Sector

The UK is one of twelve countries in a major international study of the voluntary sector. Other countries are the USA, France, Germany, Italy, Japan, Hungary, Brazil, Egypt, Thailand, Ghana and India. UK research began in 1990 and is set for completion in mid-1993. The key objectives of the study — which was initiated by the Institute for Policy Studies, Johns Hopkins University, Baltimore — are set out below.

A common core definition of the voluntary sector is being used across participating countries. The definition is broader than the set of registered charities when applied in the UK. There is also a common research framework which includes consistent instrumentation where this is appropriate and required, and a common classification of the sector's activities. This *International Classification of Nonprofit Organisations* (ICNPO) has been specially developed by the Baltimore team in consultation with participating countries, and identifies eleven major groups and 24 activity subgroups. It has been specially designed to link in with existing national and international Standard Industrial Classifications, but at the same time has been refined to capture and appropriately differentiate the full contribution of different types of voluntary body. The eleven major groups or 'industries' are: Culture and Arts; Education and Research; Health; Social Services; Environment; Development and Housing; Civic and Advocacy Organisations; Philanthropic Intermediaries; International Activities; Trade Unions, Business and Professional Associations; and Not Elsewhere Classified.

## The statistical mapping of the sector

The project's description of the sector's profile in terms of major statistical indicators — including sources of income, scale of expenditures, paid employment and volunteer involvement for each of the ICNPO subgroups — is at the heart of the project. A full picture of the sector has been sought by a combination of maximum exploitation of extant government, independent and umbrella body data holdings,

often including secondary analyses, with new targeted surveys of 'industries' and localities. Targeted 'top down' surveys have fed into the mappings of Social Services and Environment, for example, while at the local level we have drawn on our own original mappings of the sector in Canterbury and Thanet, Liverpool and (in collaboration with the National Institute for Social Work) Camden. Survey data on the sector in Staffordshire (conducted by its Training and Enterprise Council), together with a number of other locality studies, have also been utilised.

This two-pronged mapping strategy allows us to capture the full variety of the sector's activities, ranging from prominent multi-million pound charities such as Barnardo's and the Salvation Army to small self-help community groups often relying entirely on volunteers, such as stroke clubs and HIV/AIDS support groups. The accompaniment of these data with focused, theoretically-informed policy analyses in collaboration with the National Council for Voluntary Organisations, backed up by over 30 interviews with key players in national and local government, religious organisations, trade unions and the sector itself, will provide a unique snapshot of the nature of the sector in the early 1990s, and an account of its recent development.

## Prospects

A major re-appraisal of the role of the state is now under way in much of the world. In the UK this has been prompted by a number of factors, including dissatisfaction with the cost and effectiveness of exclusive reliance on government to solve the social and developmental challenges of our time, recognition of the added value inherent in pluralism, and a general desire to mobilise private action for public purposes. The voluntary sector is increasingly being called upon to complement and substitute for government action in contexts where informal action and commercial enterprise have been found to be or are believed to be inadequate, inappropriate, or inefficient. The problem is that these expectations for enhanced roles for the voluntary sector have not been informed by a clear understanding of what the voluntary sector is or how it operates and is financed. This project will go a considerable way towards resolving this difficulty and, for the first time, it will allow systematic comparison between countries.

Contact: Jeremy Kendall (ext. 7637) or Martin Knapp (7552)

### Box 1

#### Johns Hopkins comparative nonprofit sector project Research objectives

- to describe the size, scope, internal structure, finances, and legal position of the voluntary sector in each country;
- to gain a clearer understanding of the evolving role of this set of institutions in different cultures;
- to examine the relations between the voluntary sector and other institutions, including government and business;
- to provide a systematic basis for comparing the experience of voluntary organisations in different parts of the world;
- to improve awareness of this sector on the part of public and private leaders and the general public; and
- to provide a sounder basis for evaluating policies which concern the voluntary sector.

### Lewisham Care Management Scheme: Staff Activity

This research is based in two innovative community mental health teams for older adults. They provide an open access service which is community focused, offering assessment, treatment and support services for older adults living at home. Most of the multidisciplinary team (including psychiatrists, social workers, occupational therapists, psychiatric nurses and psychologists) offer a specialist service and also act as key workers for clients referred to and assessed by the service.

The Team also offers support and training to other community services such as residential homes, and runs and assists community-based therapy groups. In addition, some Team members play specialist roles in other parts of the mental health service such as hospital wards. The service has recently been further adapted by the addition of two specialist social work 'case managers' providing long term support to some elderly people with dementia.

This new service model raises a number of interesting questions. One of these concerns the way in which staff members in a community setting deploy their time. It is of importance both for practice and for purchasers and providers of health and social care to understand the costing of staff time and input to clients. This is difficult given the novel service, diverse roles of staff and non-institution-based services provided.

As part of a larger evaluation, this study examines how, over a two week period, time is spent by all members of the Team using a self completed and pre-coded Activity Record.

#### Aims:

- to describe the style of working of personnel in this innovative service;
- to look at the differences between the style of work of disciplines in the Team, including those members with a full-time Team commitment and those with other specialist roles in the rest of the service;
- to contrast this with the style of work of new specialist social work case managers. This should permit the distinction between 'key worker' /short-term as-

essment models of support and long-term specialist 'case management' styles to be more clearly characterised;

- to look at the factors influencing style of work of team members;
- to examine the implications of this for the costing of community mental health professionals' time.

Contact: Richard von Abendorff (ext. 3624), David Challis (7587) or Ann Netten (3644).

### CPNs as Case Managers

Funded by South East Thames Regional Health Authority, this collaborative study looked at reorganisation of the Community Psychiatric Nurse (CPN) service in Greenwich, with individual staff acting as case managers and client advocates. These new Community Support Team (CST) arrangements were compared with standard, 'generic' CPN services. Each person included in the randomised controlled study had a diagnosis of psychotic disorder (schizophrenia or affective psychosis) excluding organic disorders; a duration of illness of more than three years; more than two hospital admissions during the previous three years; and was aged 18-64. Everyone had been referred to the specialist psychiatric services by consultant psychiatrists or ward teams at the point of discharge from hospital (usually after short stays) or during community residence at the point at which CPN support was considered necessary.

Matt Muijen (Research and Development in Psychiatry) and Geraldine Strathdee (Institute of Psychiatry) led the evaluation of social and clinical outcomes. They found marked differences between the CST and generic CPN services in terms of the number and type of contacts, but no differences in numbers of admissions, length of stay, social functioning, psychopathology or users' and relatives' satisfaction.

The PSSRU looked at service utilisation and cost, collecting comprehensive data on all services used in the three months before referral and during three consecutive treatment periods of six months. We found that care package costs for those people supported by the 'generic' team were £109 per week higher than for those supported by the new Community Support Team (1992-93 prices). However, the difference

was only significant in the first six month treatment period. In the longer term, cost differences were not significant. Not surprisingly, the CPN input was significantly greater and more costly for the CST group, and CPNs worked on a wider range of tasks. The ability of these case managers to target services on client needs reduced reliance on specialist accommodation, substituting more appropriate and less costly alternatives.

Full details can be found in McCrone, P., Beecham, J. and Knapp, M. (1993) Community psychiatric nurses on a Community Support Team: a cost evaluation of the Greenwich innovation, DP 794/3, PSSRU.

Contact: Martin Knapp (ext. 7552) or Jeni Beecham (3792)

### Lewisham Care Management Scheme: Long-Term Outcomes

This study is based on two innovative community mental health teams for older adults covering different geographic areas within the same health and social service district. Each multidisciplinary team offers a home-based assessment, treatment and support service using the skills of the group of professionals, focusing on the needs of both clients and carers. It is designed to increase the quality of assessment and treatment in the community, preventing unnecessary admission and enabling high quality hospital discharge and follow up in the community.

Although the population eligible for the service as a whole has been well delineated and the characteristics of clients of the service, such as diagnosis and referral source identified (using the Team's own data base), little has been done to look at the pattern of the Team's involvement with clients and the long-term outcome of the population supported. An innovative development has been the addition to the Team of two specialist social work 'case managers' to support in the long term people with dementia assessed by the Team as needing extra support.

The study is designed to provide a picture of a cross-section of the caseload of such a team and the outcome of their intervention following up cases over eighteen months.

## Aims:

- to describe the characteristics of a cohort of clients receiving the Team's service by diagnosis, previous team referral history and demographic factors providing a picture of prevalence;
- to describe the referral pattern of clients to the service and their throughput over the eighteen month period;
- to examine the outcome of the service on clients after eighteen months in terms of patterns of survival and placement;
- to consider the range of factors influencing the pattern of the services' involvement with clients, including demographic factors, diagnosis and previous team referral history;
- to contrast this pattern of team caseload and outcome with the special caseload taken on by the case managers.

Contact: Pamela Brown (ext. 3689), Richard von Abendorff (3624) or David Challis (7587)

#### Domiciliary Care in England and France

During the last decade, the PSSRU has hosted visits several times a year from groups of personnel working for various French agencies in the field of health and social care of the elderly. The visitors have had talks here, and have used the PSSRU as a base from which to visit field sites. They come here particularly because of their interest in PSSRU arguments and experiments on care managed community care. The awareness in France of this work has led to PSSRU members contributing to studies on care of the frail elderly undertaken by French and Belgian government agencies. This project developed as a result of the visits. The project's objectives are:

- to describe quantities of services in French home care (there are similar data already available on community services in England) and
- to look at how this changes through time for cohorts of new recipients of domiciliary services in three sites in France over two years.

The French results will be compared with data for twelve areas in England and Wales collected for *Resources Needs and Outcomes* (Davies et al., 1990) and in the new study

with a similar design, described elsewhere in this issue (see: *Equity, Effectiveness and Efficiency*, page 24). The three French sites are in a semi-rural département in Normandy, where the social services is the relevant agency; in a Paris suburb, where a team for the coordination of services for the elderly is involved; and in an area in the Nord-Pas de Calais region.

There has been much comment in French government reports on the PSSRU care management models, particularly the ('Kent') Community Care Project. The *Fondation de France* hopes that the project will contribute to the understanding of French domiciliary care systems in a way which will help to develop some care management experiments. It is hoped that this would be done in collaboration with the PSSRU.

Contact: Bleddyn Davies (ext. 7634) or Robin Saunders (3873)

#### Comparative Community Care Programme

One set of general questions has been addressed by evaluations of each of the PSSRU community care projects: for whom (if anyone) has care-managed community care proved beneficial; in what way; to what degree; at what costs to whom; why; and how can the best features be used in current development of community care? The main unit of analysis in these evaluations is the case. The concern addressed has been whether there is evidence for investing in care-managed community care.

The objective of this project is to focus on what is relevant now that care-managed community care has become a cornerstone of British policy. It will do so by tackling questions for which the main unit of analysis is the project itself, or a group within each project. This requires the simultaneous comparison of data from all the projects. Examples are: to what degree were targeting and outcome differences due to differences in the need-related circumstances of local populations and the policies and practices of local service providers; how did the interaction between the case managers and health service personnel affect outcomes; what opportunities and constraints on the de-

velopment of care-managed community care were set by local policy cultures; in what ways did the practice of care management differ for subgroups of the targeted persons between; and what are the implications for matching care management arrangements to client needs in a triaged system with varying care management arrangements for persons in different circumstances?

The PSSRU has also acquired data for programmes and projects which embody some but not all of the features of the PSSRU models. The programme will collect data for other programmes from this country and abroad. It will analyse the evidence around similar questions. The main publication so far is the study of the Sheppey and Tonbridge programmes, *Budget-Devolved Care Management in Routine Programmes: Outcomes of Two Experimental Evaluations*, to be published in the PSSRU series later in 1993.

Contact: Bleddyn Davies (ext. 7634) or David Challis (7587)

#### Community Care in Action: the role of costs

A day conference organised by the PSSRU on the importance of good quality cost information was held in London on 17 May 1993. The day was introduced by Clive Smee, chief economic advisor to the Department of Health, and brought together the perspectives of research (Martin Knapp and Ken Wright), health authorities (Chris Gostick and Mary Richardson), the Support Force (David Claridge) and the Audit Commission (David Browning). Jenny Bernard of Birmingham Social Services chaired the conference, which was attended by over 150 people from local and health authorities, the voluntary and private sectors, the Department of Health and academic organisations. A report of the proceedings will be available shortly from the PSSRU.



# PSSRU Books and Monographs

## OLD PEOPLE'S HOMES AND THE PRODUCTION OF WELFARE

**Bleddyn Davies and Martin Knapp**

Routledge & Kegan Paul, London, 1981  
(hbk, pp. ix + 256). ISBN 0 700 0700 0  
Available from the PSSRU at £2.95

## THE ECONOMICS OF SOCIAL CARE

**Martin Knapp**

Macmillan, London, 1984, £40.00  
(hbk, pp. xiv + 251). ISBN 0 333 289 58 2.

## MATCHING RESOURCES TO NEEDS IN COMMUNITY CARE

An evaluated demonstration of a long-term care model

**Bleddyn Davies and David Challis**

Ashgate, Aldershot, 1986, £47.50  
(hbk, pp. xxxii + 658). ISBN 1 85742 113 2

## CASE MANAGEMENT IN COMMUNITY CARE

An evaluated experiment in the home care of the elderly

**David Challis and Bleddyn Davies**

Ashgate, Aldershot, 1986, £32.50 (hbk, pp. xvi + 289); £9.95 (pbk)  
ISBN 0 566 05287 3 (hbk)  
ISBN 0 566 05816 2 (pbk)

## EFFICIENCY-IMPROVING INNOVATIONS IN SOCIAL CARE OF THE ELDERLY

**Ewan Ferlie, David Challis and Bleddyn Davies**

Ashgate, Aldershot, 1989, £30.00 (hbk, pp. xii + 212). ISBN 0 566 07049 9. A supplementary volume of tables (pbk, pp. iv + 202) is available from the PSSRU at £5.50

## HELPERS IN CASE-MANAGED COMMUNITY CARE

A study of the motivations, rewards and management of helpers in the Thanet Community Care Project

**Hazel Qureshi, David Challis and Bleddyn Davies**

Ashgate, Aldershot, 1989, £25.00 (hbk, pp. v + 242), ISBN 0 566 056809 X

*(The four preceding books, in hardback, plus the Darlington monograph, are available at the special price of £115 for the set from Anne Walker at the PSSRU.)*

## THE PRODUCTION OF WELFARE APPROACH: EVIDENCE AND ARGUMENT FROM THE PSSRU

**Edited by Bleddyn Davies and Martin Knapp**

Supplement to Volume 18 of *The British Journal of Social Work*, 1988, (pbk, pp. iv + 187)  
Available from the PSSRU at £4.95

## CARE IN THE COMMUNITY: THE FIRST STEPS

**Judy Renshaw, Roger Hampson, Corinne Thomason, Robin Darton, Ken Judge and Martin Knapp**

Ashgate, Aldershot, 1988, £25.00 (hbk, pp. x + 201)  
ISBN 0 566 05737 9

## AIDS: THE LOCAL AUTHORITY RESPONSE

**Andrew Bebbington and Pat Warren**

PSSRU, Canterbury, 1988 (pbk, pp. xii + 85). Available from the PSSRU at £6.50. ISBN 0 904 93802 6

## THE DARLINGTON COMMUNITY CARE PROJECT: SUPPORTING FRAIL ELDERLY PEOPLE AT HOME

**David Challis, Robin Darton,**

**Lynne Johnson, Malcolm Stone,**

**Karen Traske and Barbara Wall**

PSSRU, Canterbury, 1989 (pbk, pp. vi + 66). Available from the PSSRU at £3.50, or £3.00 per copy for orders of ten or more. ISBN 0 904938 04 2

## CASE MANAGEMENT IN SOCIAL AND HEALTH CARE: THE GATESHEAD COMMUNITY CARE SCHEME

**David Challis, Rosemary Chessum,**

**John Chesterman, Rosemary Luckett**

**and Karen Traske**

PSSRU, Canterbury, 1990 (pbk, pp. vi + 96). Available from the PSSRU at £4.50. ISBN 0 904 93 806 9

## RESOURCES, NEEDS AND OUTCOMES IN COMMUNITY-BASED CARE

A comparative study of the production of welfare for elderly people in ten local authorities in England and Wales

**Bleddyn Davies, Andrew Bebbington and**

**Helen Charnley, with Barry Baines,**

**Ewan Ferlie, Michael Hughes**

**and Julia Twigg**

Ashgate, Aldershot, 1990, £37.50 (hbk, pp. xix + 493). ISBN 1 85628 130 2

## PRIVATE AND VOLUNTARY RESIDENTIAL AND NURSING HOMES IN CANTERBURY AND THANET

Report of a survey for Canterbury and Thanet Health Authority and Kent County Council Social Services Department

**Robin Darton**

PSSRU, Canterbury, 1990 (pbk, pp. viii + 36). Available from the PSSRU, at £3.00. ISBN 0 904938 07 7

## CARE IN THE COMMUNITY: CHALLENGE AND DEMONSTRATION

**Martin Knapp, Paul Cambridge,**

**Corinne Thomason, Jeni Beecham,**

**Caroline Allen and Robin Darton**

Ashgate, Aldershot, £30.00 (hbk, pp. vi + 378); £14.95 (pbk)  
ISBN 1 85742 071 3 (hbk)  
ISBN 1 85742 069 1 (pbk)

## COSTING COMMUNITY CARE: THEORY AND PRACTICE

**Ann Netten and Jeni Beecham (eds)**

Ashgate, Aldershot, 1993, £32.00 (hbk, pp. xii + 214); £14.95 (pbk). ISBN 1 85742 098 5 (hbk); ISBN 1 85742 102 7 (pbk)

## A POSITIVE ENVIRONMENT

Physical and social influences on people with senile dementia in residential care

**Ann Netten**

Ashgate, Aldershot, 1993, £28.00 (hbk, pp. viii + 126); £12.95 (pbk)  
ISBN 1 85742 107 8 (hbk)  
ISBN 1 85742 112 4 (pbk)

## CARE MANAGEMENT, EQUITY AND EFFICIENCY: THE INTERNATIONAL EXPERIENCE

**Bleddyn Davies**

PSSRU, Canterbury, 1993 (pbk, pp. xiv + 169). Available from the PSSRU at £9.50. ISBN 0 904938 28 X

## UNIT COSTS OF COMMUNITY CARE 1992/93

**compiled by Ann Netten and Steve Smart**

PSSRU, Canterbury, 1993 (pbk, pp. 62). Available from the PSSRU at £7.50  
ISSN 0969-4226, ISBN 0 904938 36 0

## FORTHCOMING

### PRIVATE AND VOLUNTARY RESIDENTIAL AND NURSING HOMES: A report of a survey by the PSSRU and the CHE

**Robin Darton, Eileen Sutcliffe and Ken Wright**

### SOCIAL CARE IN A MIXED ECONOMY

**Gerald Wistow, Martin Knapp, Brian Hardy and Caroline Allen**

Open University Press, forthcoming 1993

### BUDGET-DEVOLVED CARE MANAGEMENT IN ROUTINE PROGRAMMES: Outcomes of two experimental evaluations

**Bleddyn Davies and John Chesterman**

Ashgate, Aldershot, forthcoming 1993

### CASE MANAGEMENT IN GERIATRIC CARE: The Darlington Community Care Project

**David Challis, Robin Darton, Lynne Johnson, Malcolm Stone and Karen Traske**

Ashgate, Aldershot, forthcoming 1993

### CASE MANAGEMENT IN SOCIAL AND PRIMARY HEALTH CARE: The Gateshead Community Care Scheme

**David Challis, Rosemary Chessum, John Chesterman, Rosemary Luckett and Karen Traske**

Ashgate, Aldershot, forthcoming 1994

### THE COSTS OF MENTAL HEALTH SERVICES

**edited by Martin Knapp**

Ashgate, Aldershot, forthcoming 1994

### COMMUNITY CARE IN THE UK AND OVERSEAS: New Agenda and Challenges

Papers from the 21st anniversary conference of the British Society of Gerontology

**edited by David Challis, Bleddyn Davies and Karen Traske**

Ashgate, Aldershot, forthcoming 1994

### COMMUNITY SERVICES AND THE SOCIAL PRODUCTION OF WELFARE PSSRU MSCEP group

These publications are available through bookshops, or direct (post free) from the PSSRU. Cheques for orders from the PSSRU should be made payable to 'UNIKENT'. There is an order form opposite.



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# Current PSSRU Research Programmes

These two pages give brief descriptions of current Unit work categorised by programme — a series of related studies — and individual projects. Listed are: ■ project title ■ description ■ stage of work in June 1993 ■ PSSRU members currently working on the project (with telephone extension numbers in brackets).

For general information please contact Anne Walker at the Unit: 0227 764000, ext. 7672.

## Services for Elderly People

This work has two complementary streams: projects whose focus is care-managed community care and projects whose focus is targeting and the production of welfare in general, including other innovations.

Programme managers: Bledwyn Davies and David Challis.

## Care Management Projects

Instigating and evaluating experimental and developmental projects.

## Gateshead Community Care Scheme

An evaluation of a social services scheme to delay or prevent admission to institutional care using social workers as care managers with devolved budgets. Some results published. Monograph available and book forthcoming.

David Challis (7587)  
John Chesterman (3757)

## Gateshead Health and Social Care Scheme

Evaluations of social services and a joint care management service for frail elderly people based in a primary care setting centred on social workers as case managers and a multidisciplinary team. Some results published. Monograph available and book forthcoming.

David Challis (7587)  
John Chesterman (3757)  
Karen Traske (3689)

## Kent Home Care Research: Development in Pilot Areas

A study of the introduction and implementation of an extended care management service to support frail older people in the community.

Analysis underway.

David Challis (7587)  
Pamela Brown (3689).

## Lewisham Care Management Scheme

An evaluation of a care management service for elderly people suffering from dementia based in a multidisciplinary community mental health team.

Ongoing.

David Challis (7587)  
Richard von Abendorff (3624)  
Pamela Brown (3689)

## Darlington Community Care Project

An evaluation of a scheme to discharge elderly patients from long-stay hospital care to their own homes with support from care managers and multi-purpose care workers.

Monograph available. Book forthcoming.

David Challis (7587)  
Robin Darton (7643)  
Karen Traske (3689)

## New Models of Care Management: Monitoring and Evaluation

Description and general analysis of patterns of variation in care management and assessment arrangements being developed in pilot projects and more generally. Examples to be more systematically evaluated.

To commence 1993.  
David Challis (7587)

## Sheppey and Tonbridge Community Care Programmes

An evaluation of two routine programmes based on the Thanet ('Kent') Community Care project, using social workers as case managers.

Book forthcoming 1993.

Bledwyn Davies (7634)  
John Chesterman (3757)

## Care Management: International Argument and Evidence

A review of care management arrangements in community and long-term care in various countries, showing how they reflect system contexts and client needs, and describing leading programmes and evaluation evidence about their impact on equity and efficiency.

Monograph published; papers also available. Material being collected for second edition.

Bledwyn Davies (7634)

## Comparative Community Care Project

Developing argument about what arrangements for case-managed community care fit what client and carer circumstances and local contexts. Based on analyses of PSSRU community care projects and other data bases from UK and elsewhere.

Ongoing.

David Challis (7587)  
Bledwyn Davies (7634)

## Targeting and the Production of Welfare in Community and Residential Care

Monitoring and evaluating standard and innovative mainstream provision.

## Changes in the Community Care of Elderly People 1985-95 (CCEP)

Major collection of data on needs, resources and outcomes in the same areas as the Domiciliary Care Project (1984-90) to show effects of changes in community care policies and other factors.

Associated with other projects: Unit Costs, Methodology of Needs-Based Planning, and Targeting Community Care in England and France.

Main statistical data collection about cohort of new recipients to be made after 1993.

Bledwyn Davies (7634)

## Monitoring the Social Care of Elderly People (MSCEP)

Papers being produced on the local development of community care. Continuous monitoring of development in four of the authorities and Kent and less detailed investigation in remainder.

Monograph in preparation.

Bledwyn Davies (7634)  
Robyn Lawson (3879)

## Targeting, Needs, Resources and the Community Care of Elderly People

Secondary analyses to illuminate targeting dilemmas.

Papers available.

Bledwyn Davies (7634)  
Barry Baines (3653)

## Community Social Services and the Social Production of Welfare

Applying the characteristic framework and techniques of the 'social production of welfare' approach to data from the Domiciliary Care Project (1984-90) to develop argument focused on dependants and others in primary social networks. In particular the argument is about the provision of social services in the mixed economy of care. Linked with MSCEP.

Ongoing. Papers published and book, *Community Services and the Social Production of Welfare*, in draft.

Ann Netten (3644)  
Bledwyn Davies (7634)

## Targeting Community Care in England and France

Comparison of who gets what quantities of services in three areas of France with data collected for *Resources, Needs and Outcomes*, and *Changes in Community Care of Elderly People*.

Bledwyn Davies (7634)  
Robin Saunders (3874)

## Charges, Resident and Facility Characteristics of Residential Care and Nursing Homes

A study in seventeen authorities. Report and papers available.

Robin Darton (7643)  
Ken Wright (CHE, York)

## Length of Stay and Financing of Shelter-with-Care

Preliminary study of length of stay, means of financing and source of admission in 1992. Follow-up study of cohorts of admissions to shelter-with-care after 1993. Predicting admissions post-1993. Linked with CCEP. See article in this Bulletin.

Robin Darton (7643)

## Methodology of Needs-Based Planning

Work with selected local authorities, evaluating the methodological basis of needs-based planning for elderly people. Linked with CCEP. Beginning in 1993.

Andrew Bebbington (7525)  
Bledwyn Davies (7634)

### Unit Costs of Community Care

Drawing on ongoing and past research to produce an annual report on the unit costs of a wide range of services. Research includes analysing the costs of social work time and child care services.

Linked with work at CHE and NISW and the PSSRU Lewisham and Targeting & the POW projects.

Ongoing. First report available.

Ann Netten (3644)  
Jeni Beecham (3792)  
also Martin Knapp (7552),  
Andrew Bebbington (7525),  
Raphael Wittenberg (DH),  
Ken Wright (CHE, York) and  
Kirsteen Smith (CHE, York)

### Changing roles and functions of social work practitioners — costs and time use

This new NISW study will be evaluating the impact of community care reforms on social work practitioners. PSSRU involvement focuses on the estimation of costs and time use.

Starting July 1993.

Enid Levin (NISW)  
Ann Netten (3644)  
Jan Pahl (NISW)

### Economics of Mental Health Services

A programme of projects evaluating mental health services.

Programme manager:  
Martin Knapp.

### NETRHA Psychiatric Reprovision

Cost-effectiveness and associated analyses of community care for former long-stay psychiatric hospital residents.

Various papers published.  
Research running since 1986, continuing to 1996.

Jeni Beecham (3792)  
Andrew Fenyo (7610)  
Angela Hallam (7844)  
Martin Knapp (7552)

### Daily Living Programme

Cost-effectiveness evaluation of innovative community support scheme for people entering hospital with serious mental health problems.

Collaborative with Institute of Psychiatry.

Report and papers 1993.

Martin Knapp (7552)  
Jeni Beecham (3792)  
Vivien Koutsogeorgopoulou (7953)

### Care Programme Approach

Study of the service, organisational and expenditure implications of the care programme approach in mental health services.

Report and papers 1993.

Justine Schneider (7891)  
Martin Knapp (7552)  
Jeni Beecham (3792)

### Costs of Schizophrenia

Estimates of prevalence, accommodation arrangements and service utilisation by people with schizophrenia in England. Examination of cost implications of various policy options.

Report 1993.

Shane Kavanagh (3877)  
Martin Knapp (7552)  
Jeni Beecham (3792)

### Northern Ireland Care in the Community

Evaluation of development of community care for former long-stay hospital residents, including outcomes and costs.

Ongoing, running to September 1993.

Martin Knapp (7552)  
Jeni Beecham (3792)  
Shane Kavanagh (3877)

### Long Term Care in the Community

Outcomes and costs for people with learning disabilities who left hospital five years earlier.

Monograph and Rowntree Findings to be published 1993.

Martin Knapp (7552)  
Paul Cambridge (3755)

### Other Research

Among other projects in this mental health programme are:

- child psychiatry — three economic evaluations of new developments
- care in the community in Scotland
- evaluation of East Lambeth case management initiative
- respite care for families of people with psychoses
- residential care costs and needs
- cost-effectiveness of psychotherapy
- homelessness and mental health problems.

### The Mixed Economy

Programme manager: Martin Knapp.

### The Mixed Economy of Care

Description and evaluation of the mixed economy of care in England, particularly focused on commissioning, providing and market development. Runs to 1996.

Collaborative with the Nuffield Institute for Health, University of Leeds.

Martin Knapp (7552)  
Julien Forder (3872)  
Jeremy Kendall (7637)

### Comparative Non-Profit Sector Project

UK component of twelve-country study of scale, scope, characteristics of the voluntary sector. Includes historical, legal and policy aspects.

In collaboration with the Johns Hopkins University, USA, to 1993.

Jeremy Kendall (7637)  
Martin Knapp (7552)

### Volunteer Labour Supply

Study of the factors which encourage or discourage people from volunteering.

In collaboration with Volunteer Centre UK. Commenced 1993.

Martin Knapp (7552)  
Vivien Koutsogeorgopoulou (7953)

### Children in Care

Programme manager: Martin Knapp

### Assessment

Cost study of assessment services for children and young people in one London borough.

Report 1993.

Jeni Beecham (3792)

### Intermediate Treatment

Cost-effectiveness study of intermediate treatment as an alternative to custody.

Report 1993.

Martin Knapp (7552)  
Charlotte Salter (7586)

### AIDS

Programme manager:  
Andrew Bebbington.

### Community Services for People with AIDS

A study of the range of costs of local authority AIDS/HIV services, and of their development in London.

Report and monograph published; case study of services in London under way.

Andrew Bebbington (7525)  
Pat Warren (3756)

### Landmark Study

An evaluation of services provided through the Landmark, a South London HIV centre.

Reporting stage.

Andrew Bebbington (7525)  
Pat Warren (3756)

### Needs Indicators

A programme of projects designed to stimulate need indicators that reflect the implications for resources of judgements about ends and means in the social care of areas' populations.

Programme manager:  
Andrew Bebbington.

### Unit Costs of Personal Social Services in London

Fieldwork stage.

This research distinguishes cost-raising factors which are beyond the control of local authorities from those which are potentially avoidable.

Andrew Bebbington (7525)  
Aidan Kelly (7845)

### Healthy Active Life Expectancy

A joint project with the OPCS which is producing quantitative estimates of HALE for the UK and examining factors that influence it.

Running to December 1993.

Ongoing series of papers.

Andrew Bebbington (7525)

### Equity and Efficiency: Comparative Studies

The utilisation of a collection of data about local authority needs, provisions and spending since 1974 for studies of territorial justice and efficiency.

Ongoing. List of papers on request.

Andrew Bebbington (7525)  
Bleddyn Davies (7634)

# New Books

## ***Care Management, Equity and Efficiency: The International Experience***

**Bleddyn Davies**

**PSSRU, Canterbury, 1992, xiv + 169 pages. ISBN 0 904938 28X. Price £9.50 (paperback)**

This book, the first international review of the field, draws on Professor Davies' unique range of knowledge of care management programmes around the world, based on visiting, studying and advising them over more than a decade. Care management is being developed and applied quickly and vigorously in countries in every continent. This book evaluates the equity and efficiency case for its development in the light of argument, experience and research evidence on leading implementations of the concept.

The book:

- describes how care management has been a common component of responses to widespread changes in the goals of community and long-term care policy and how it aims to help overcome the obstacles to achieving these goals
- summarises the logic which connects the well-supported performance of care management tasks to aspects of equity and efficiency, illustrating the causes of the inefficiencies which it is intended to tackle
- describes variations in care management models, how models reflect the differences of their contexts, and how care management can be adapted to fit client circumstances and the characteristics of local service systems
- reviews the evidence about the equity and efficiency effects of care management programmes
- draws conclusions about the potential of care management models and about how it can best be realised

## ***Costing Community Care: Theory and Practice***

**Edited by Ann Netten and Jennifer Beecham. Published by Ashgate, Aldershot, 1992. 214 pages, paperback (ISBN 1 85742 102 7) £14.95, hardback (ISBN 1 85742 089 5) £30.00**

Valid and useful costings in social and health care depend not only on a knowledge of costing theory but also in overcoming the practical difficulties involved. The authors of this book draw on fifteen years of research at the Personal Social Services Research Unit to describe both the theory and the practice of costing, and its uses.

*Costing Community Care* differs from other books which address the

subject by acknowledging and discussing the practical difficulties of costing, and by examining in detail the interface between theory and practice. Principles and methodologies are identified, and pragmatic approaches to achieving valid data in the face of practical difficulties are described. Examples from empirical research are used to illustrate particular issues and four case studies are included which reflect a variety of methodologies and policy issues.

## ***Unit Costs of Community Care 1992/93***

**Compiled by Ann Netten and Steve Smart. Published by the PSSRU, Canterbury, 1993. 62 pages, paperback (ISSN 0969-4226, ISBN 0 904938 36 0), £7.50**

There is a growing demand for information about the costs of community care. More specifically, there is both a need for and a lack of accurate information on the unit costs of services. Although there has been research which has included a costing element and research that can inform the costing process, there is a need to establish an agreed set of guidelines on what exactly constitutes, say, the cost of providing an hour's counselling by a social worker, or the cost of a GP consultation.

It is anticipated that this report will be the first in a series bringing together the most up-to-date information about national unit costs of services. The intention is to produce a reference volume providing readers with sufficient detail for them to amend or adapt the unit costs presented to suit their own particular purposes. Each report will contain a set of cost 'schemata' containing specific information about the cost of each service covered; a commentary detailing the basis for the estimates; price indices; a reference list of key studies; a glossary and indexes.

## ***A Positive Environment?***

***Physical and Social Influences on People with Senile Dementia in Residential Care***

**Ann Netten**

**Published by Ashgate, Aldershot, 1992. 126 + xii pages, paperback (ISBN 1 85742 112 4) £12.95, hardback (ISBN 1 85742 107 8) £28.00**

This book describes an investigation into the relationship between the residential care environment and the welfare of residents with senile dementia. Unlike many studies of residential care, the study included aspects of both the physical and social environments and examined how these affected residents over time.

Innovative approaches to assessing environment were used and the book describes a model using quantitative techniques to analyse outcomes for residents. The results are set in the context of current policy issues and provide pointers for specifying standards for the care of residents with senile dementia. The potential for innovative schemes building on the results of the study is discussed, and the concept of 'informal care homes' is introduced.



FORTHCOMING 1993

***Budget-Devolved Care Management in Routine Programmes: Outcomes of Two Experimental Evaluations*****John Chesterman, David Challis and Bleddyn Davies. Ashgate, Aldershot**

The Sheppey and Tonbridge Programmes were routinely implemented programmes intended to apply the Thanet model of care managed community care, fully exposed to system pressures, not protected projects of national interest with PSSRU support. The book describes and discusses:

- the nature of the programmes, their contexts and histories
- outcomes for clients and carers, the costs of target outcomes, and the costs of care management
- implications for handling concerns about the impacts of introducing care management and implementing the new policies

FORTHCOMING 1993

***Case Management in Geriatric Care: the Darlington Community Care Project*****David Challis, Robin Darton, Lynne Johnson, Malcolm Stone and Karen Traske. Ashgate, Aldershot**

This project was developed to provide integrated case management across health and social care for frail elderly people who would otherwise need long-stay institutional care. It was cited as an exemplar of case management in the 1989 White Paper on community care. Case managers with devolved budgets, who were members of the geriatric multidisciplinary team, were responsible for coordinating packages of care and for deploying the work of home care assistants. These were multi-purpose workers who assisted a range of health care staff and undertook personal and do-

mestic care tasks for clients, reducing duplication of effort and providing clients with 'one face of care'.

The book provides a full evaluation of this service and considers the practice of case management, its effects for clients and carers and the costs of providing care. It also examines the subsequent development of the service following the evaluation and considers the implications for the development of case management in the UK.

***Researching the Voluntary Sector*****Susan Saxon-Harrold (Head of Research, Charities Aid Foundation) and Jeremy Kendall (PSSRU). CAF Publications Department, 48 Pembury Road, Tonbridge, Kent TN9 2JD, £45.00**

An edited collection of research papers which explore themes around charitable giving by individuals and companies and its relationship to the delivery of community care, the funding pressures faced by charitable trusts, and the emerging role of voluntary organisations.

It is intended for three major audiences: researchers interested in the voluntary sector at a local, national and international level; centres and institutes which might explore collaborative programmes; and members of the general public who are interested in voluntary activity and service at home and abroad.

FORTHCOMING 1993

***Social Care in a Mixed Economy*****Gerald Wistow\*, Martin Knapp, Brian Hardy\* and Caroline Allen. (\* Nuffield Institute for Health, University of Leeds) Open University Press**

This book describes the mixed economy of community care in England and analyses the efforts and activities of local authorities to promote and develop it. It is based on national documentary and statistical evidence and on more detailed research with 24 local authorities, and includes a case study on the transfer of residential homes to the independent sector. The book traces:

- historical changes leading up to the development of the mixed economy
- local interpretations of central government policy
- how authorities have in practice been developing mixed economies
- opportunities and incentives for promoting a mixed economy
- obstacles to the development of a mixed economy

***Markets and Managers: New Issues in the Delivery of Welfare*****Peter Taylor-Gooby and Robyn Lawson (eds.) (Professor of Social Policy at the University of Kent, and Research Officer at the PSSRU.). Open University Press, Buckingham, 1993, 170 pages, paperback (ISBN 0 335 15789 0) £12.99, hardback (ISBN 0 335 15790 4) £37.50.**

Over the past decade, the British welfare state has undergone the most fundamental reforms since the Second World War. Much discussion of current policy focuses on the global issues of cuts, privatisation and the scope of the state sector. This book argues that the organisational reforms of the 1990s are also of far-reaching significance and will play a major role in setting the agenda for welfare policy into the next century.

This book differs from other recent publications in its emphasis on the changes in the organisation and delivery of services. It examines the emergence of the new managerial ideology in central and local government, considers the similarities and differences between the UK and other European countries, reviews policy change across a range of public services, evaluates competing explanations of why the transformation has occurred, and discusses future developments. It will be of value to a wide range of students and welfare practitioners.

### ***Care in the Community: Challenge and Demonstration***

**Martin Knapp, Paul Cambridge, Corinne Thomason, Caroline Allen, Jeni Beecham and Robin Darton.**

**Ashgate, Aldershot, 1992, 394 pages, pbk (ISBN 1 85742 069 1) £14.95, hbk (ISBN 1 85742 071 3) £30.00**

This book describes in full the PSSRU's evaluation of the Care in the Community demonstration programme of 28 projects.

Who moved to the community from hospital under the programme? Did their lives change for the better, or for the worse, and how? What were the costs? Did the projects meet their objectives? How did the projects differ, what were the pitfalls new projects must avoid, and how can they maximise their chances of success? What were the local and national backgrounds to the programme and what can we learn from it for the future?

The book answers these and other questions, in four parts:

- Introduction to the pilot programme, the projects and the clients; the policy contexts; the objectives; the research methodology
- The process of care: financing, accommodation and service use, staffing, case management, joint working
- Evaluation: outcomes for clients and others, and costs, for each of the client groups — people with learning difficulties, people with mental health problems, elderly people and people with physical disabilities
- Policy and practice implications

### **Targeting Dilemmas in Community Services for Elderly People**

This is based on the secondary analysis of data collected in the Unit's Domiciliary Care Project of 1984-90, and other sources like the Disability Survey. The focus is the targeting dilemmas created by the relationship between needs, numbers and estimates of what impact services have on the outcomes reported in the PSSRU book *Resources, Needs and Outcomes* and the draft book *Community Services and the Social Production of Welfare*. A selection of papers, all of which are available from the PSSRU, includes:

- Bebbington, A. and Davies, B. (1989) Target efficiency of the home help service in 1985, DP619/3.
- Baines, B. and Davies, B. (1991) Attitudes to residential care and the subsequent probability of admission: analysis of a cohort of new recipients of community-based social services, DP780.
- Davies, B. (1991) A universal challenge: making the best use of community-based and residential care modes, DP778.
- Davies, B. (1991) Divisions of labour and home care in England and Wales, DP737.
- Davies, B. and Baines, B. (1991) On life-time costs and targeting, DP738.
- Davies, B. (1992) New policies and old logics: costs information and modal choice, DP820.
- Davies, B. and Kheradmandnia, N. (1992) On the sensitivity of need estimates to targeting criteria, DP791.
- Davies, B. (1991) British home and community care: research-based critiques and the challenge of the new policy, DP807.

### **HIV/AIDS services: approaches to purchasing**

Initially the people most affected by HIV/AIDS came from groups unused to calling upon the welfare system. This, together with the uncertainties of dealing with a new client group and the initial deprofessionalisation of statutory care staff, has led to people with AIDS and HIV becoming the focus of — and indeed often initiating — novel approaches to care, particularly around self-help and the development of the voluntary sector. But, as with other service user groups, changes in health and social care due to the NHS and Community Care Act 1990 have many implications for them, particularly its emphasis on needs-led services. In the past the needs of people with HIV/AIDS for statutory care have mostly been derived from service providers, with the danger of needs being defined by service options available.

Of particular relevance is coordination of care, which was identified early as problematic because of considerable fluctuation in needs. The progression of HIV disease is sporadic and unpredictable, often involving periods of acute illness interspersed with longer periods with minimal health needs. It therefore seems reasonable to assume that people with AIDS and HIV would be ideal candidates for care management, where case level purchasing could potentially offer a speedier response, drawing upon a wider mix of services and matching these more appropriately to need. However, there are fears that previously open-access services may be limited by contracts and that the service 'menu' might itself be restrictive.

In our current programme we are looking at these issues from both ends of the purchasing spectrum: one project looks at gaining user views on their needs to inform macro purchasing, whereas the other is involved in micro purchasing at case level with an emphasis on user outcomes.

In the first project we are working with South East London Purchasing Agency (SELCA), which was established in 1991 by the three district health authorities of Camberwell, West Lambeth, and Lewisham & North Southwark to assess the needs of the districts' residents and to manage service contracts with providers to deliver services. It was the first consortium of its kind in England, and the area it covers has one of the highest incidences of AIDS and HIV in the UK (Bebbington and Warren, 1990). With SELCA we are looking at two major issues:

- user views on the services they receive, their satisfaction with HIV services and their volume of use; and
- user views on unmet needs and how their needs could be better met.

In the second project we are working with two London boroughs, Hammersmith & Fulham and Lambeth, who have implemented different approaches to care management. The first devolves budgets to case level, with emphasis on service contracting, while the second operates a specialist model emphasising collaborative working, with budgets not attached to clients. These authorities are comparable in their service structure but their approaches are distinct. Our aim is to identify the strong features of each approach

with respect to:

- identification of people in need;
- assessment of care needs;
- planning and securing the delivery of care;
- monitoring quality; and
- reviewing client needs.

To date health and local authorities have enjoyed targeted Department of Health funding to allow development of appropriate HIV services, but future funding practice is less clear, particularly for local authorities. The monitoring of quality and efficiency in service delivery in relation to assessed needs will rely on an understanding of both bottom-up and top-down issues and the characteristics of AIDS/HIV which affect demands for care.

The research programme at the PSSRU will seek to compare issues across these two projects, although they are different stages. The SELCA study is nearing completion; the care management study is in an early phase, with fieldwork about to begin.

#### Reference

Bebbington, A. and Warren, P. (1990) AIDS: Facing the second wave, a survey of community services in South London, *Social Service Research* 1: 7-23.

Contact: Andrew Bebbington (ext. 7525) or Pat Warren (3756)

### Monitoring the Social Care of Elderly People

This project has monitored the development between 1990-93 of policy and services for elderly people in four of the authorities studied in the Domiciliary Care Project. The main evidence is documentary and interviews with managers and others in area field agencies. Robyn Lawson and Bleddyn Davies have followed the evolution of the purchaser/provider split and mixed economy of provision in Kent since 1990, with particular reference to home care. A first paper (DP 743) reports progress up to April 1991 (see also Bulletin No. 8). It discusses the implications of the approach and suggests four issues to watch over time: the roles of the centre and the periphery; how the market in social care develops; supports for the market, such as information and payment systems; and transaction costs. A follow-up study is under way for completion in summer 1993.

Contact: Bleddyn Davies (ext. 7634) or Robyn Lawson (3879)

### The Social Production of Welfare: putting theory into practice

The social production of welfare () is a developing theoretical framework primarily for analysis the delivery of social care to elderly people. It is an extension of the production of welfare approach which underlies much of the research undertaken in the PSSRU. It represents the basic unit of analysis as the informal care network which is engaged in the production of commodities such as housework and personal care. Social service interventions are concerned with enhancing this production or substituting for informal care production when disability or life events result in more being demanded than the informal care network can supply.

If it is to be of practical importance in analysing and formulating policy, the initial seed of insight must be fed with practical applications. It is in resolving and analysing empirical issues that such frameworks develop into valuable tools for research and policy investigations.

To date SPOW has been used in: theoretical analyses of consumption of social services; costing and describing the role of informal care; the supply of care — workers, informal carers and others like volunteers and paid helpers in community care; the Thanet experiment in case managed community care; and in drawing together the economic implications of ageing. Current developments in community care have emphasised the importance of assessing needs rather than eligibility for services. The concept of commodities provides a link between needs and service provision which is being exploited in the Unit Costs programme of work and is to be integrated into the design of a major study of efficiency and effectiveness in the delivery of social care to elderly people (outlined on page 24).

#### Selected references

Netten, A. and Davies, B., (1991) The social production of welfare and consumption of social services, *Journal of Public Policy*, 10, 331-347.

Netten, A. (1991) An economic approach to the study of social care of elderly people: a perspective on informal care, PSSRU DP 781.

Contact: Ann Netten (ext. 3644) or Bleddyn Davies (7634)

### New study New Models of Care Management

In the community care changes in the UK, as elsewhere, assessment and care management have been seen as critical to the achievement of the goals of the new policy. They are crucial to the point of interface between institutional care and home-based care, whether the setting is hospital, nursing home or residential home. The expectation is that effective assessment and care management will achieve, at least at the margin, a degree of downward substitution and more appropriate placement and discharge of people from institutional care. Within this context the PSSRU has been responsible for a series of demonstration studies in care management in the UK and has also examined care management systems in other countries.

The guidance provided from central government about assessment and care management is of a more specific kind than much previously issued. Nonetheless, the material permits a wide range of experimentation and variation by local agencies as they develop systems to fit their particular context. Since the precise forms and structure of assessment and care management are not defined, as agencies develop systems and modify them to meet their needs it is likely that patterns of variation which are more or less similar will tend to emerge. Where these are systematic and coherent the variation could be defined as constituting a particular form of care management. Models of care management are likely to vary according to the client group for whom the service is devised, the degree of dependency of the clients who receive this service, the formal goals of the service and the setting within which it is located.

This new study is being undertaken to identify the characteristics of the different emergent models of care management and their prevalence. Using survey information and interviews with key actors in authorities, it will attempt to map the developments. Further work will look at the relative benefits and costs, and patterns of operation of these different models.

Contact: David Challis (ext. 7587)



**New study**  
**Community Care of Elderly People:**  
**Changes in Equity, Effectiveness**  
**and Efficiency 1984-95**

This project aims to provide rigorous descriptions and explanations of who gets what, where, and with what effects; to compare analyses for the mid/late 90s with those for the mid/late 80s; and to develop argument about how to handle the dilemmas of community care. Funded by the Department of Health, this project is seen as partial fulfilment of its promise in *Caring for People* and *Policy Guidance* to commission research on the impact of the changes.

Scale, rigour, focus, long time horizons and dissemination are the main features of the programme. The design allows the work to provide firm evidence about controversial and varying phenomena. A project which started collecting field data in late 1984 provides a large and rich data base for comparison with the mid/late 90s. The focus of the collection was a large sample of new recipients of community care services drawn from twelve areas in England and Wales covered by the lowest unit of social services organisation. Interview data from elderly persons and their informal carers were supplemented with material from field personnel and managers in a wide range of organisations. Resources and location were tracked over three years, covering practice perceptions, organisation and policy, innovation and change. This project will collect comparable information in the same areas for the mid/late 90s. We are now starting to recruit the team of six persons in the Unit to work full-time with part-time contributions from others.

After each phase of the collection, we shall describe things which have hitherto been invisible either because field personnel, managers and policy makers are too near or too far away. We shall therefore provide a continuous stream of published papers and reports over the whole life of the project. Those interested should write to Anita Whitley to be put on the circulation list.

Contact: Bleddyn Davies (7634)

**The Cost-Effectiveness of**  
**Intermediate Treatment**

This project, funded by the Department of Health, looked at the cost-effectiveness of intermediate treatment (IT) in relation to the costs and outcomes of other sentences. The study design produced three samples of young people: 140 with an IT sentence, 136 sentenced to custody, and 154 given a supervision order without an IT requirement.

We collected comprehensive cost and service utilisation data, and interviewed 'principal information holders'. We distinguish three time periods. The *intensive period* (the effective sentence, which varies according to the sample group), the *follow-on period* (the twelve months after the end of the intensive period for each sample member), and the *full period* (the combined intensive and follow-on periods).

Over 60 different services were used by members of the IT sample during the full period, provided and funded by many statutory and non-statutory agencies. This shows that an IT sentence does not simply impose a cost on the local authority IT service, but has implications for many other budgets. During the intensive period, the cost to the IT service itself averaged £133 per week (1988/89 price levels), which represents only 52 per cent of the overall cost of £253. Residential and foster care placements account for 24 per cent of overall cost, and the police and the NHS each account for over 5 per cent. Although costs in the follow-on period were considerably lower than in the intensive period, they can remain high for some people and some services. Taking account of the *full* cost ramifications of sentences, by combining the intensive and follow-on periods, the IT service accounts for only 49 per cent of the total costs. Overall, we estimate that an IT sentence can be expected to cost over £4,000 (1988/89 prices) during the intensive period and almost £1,000 in the year which follows.

**Further details:** Knapp, M., McCrone, P., Drury, C. and Gould, E. (1993) Intermediate treatment: user characteristics and the prediction of costs, chapter 12 in Netten and Beecham (eds) *Costing Community Care*, Ashgate, Aldershot.

Contact: Martin Knapp (ext. 7552)

**Health Economics at the PSSRU**

Within the wider context of multidisciplinary work in the study of health and social care, the PSSRU is expanding its involvement in the field of health economics. The objectives are:

- to maintain high standards of scholarship in the economic study of health and social care services and related activities;
- to encourage innovative work, both theoretical and applied, in all areas within our interests;
- to develop clear and accepted methodological principles, for example, for cost measurement and pharmaceutical evaluations;
- to contribute to teaching and training in health economics and related areas;
- to create a lively intellectual climate for the development of ideas in health economics;
- to promote wider contacts with researchers and others in this field and to participate in the activities of organisations and practitioners and researchers.

Health economics makes a major contribution to the the PSSRU's programmes of work on services for elderly people, unit costs of community care, economics of mental health and the mixed economy. In addition, in collaboration with Canterbury Business School and Pfizer UK, researchers at the PSSRU are using a variety of methodologies to study pharmaceutical markets and evaluate a range of medical interventions, including treatments for depression, oral fungal infections, benign prostatic hyperplasia, osteoarthritis, rheumatoid arthritis and streptococcal pharyngitis.

**Selected publications**

- Knapp, M. and Kavanagh, S. (1992) Health economics relevant to developments in community psychiatry, *Current Opinion in Psychiatry*, 5, 314-319.
- Netten, A. (forthcoming 1993) An economic approach to the study of social care of elderly people: a perspective on informal care, in J. (ed.) *Informal Care in Europe*, Social Policy Research Unit, York.
- Stewart, A. (1993) Pharmaceuticals, economic evaluations and formularies, PSSRU DP871
- Stewart, A. and Phillips, R. (1993) Paediatric streptococcal pharyngitis: simulation model of GP prescribing practice, PSSRU DP910.
- Stewart, A. (1993) Discounted prices and prescribing costs for selective serotonin reuptake inhibitors, PSSRU DP916.

Contact: Martin Knapp (ext. 7552), Alan Stewart (3260) or Denise McKell (4022)



# New Drugs and Economic Evaluations

Alan Stewart

Pharmaceutical innovations pose many problems for health services professionals, but the amount of health care provided within pharmaceutical budgets can be expanded if the economic effectiveness of new pharmaceuticals is considered alongside their purely clinical effects. Drugs and Therapeutic Committees and other bodies assessing new drugs should consider that products with higher list prices are not necessarily more expensive treatment options than existing, much cheaper, drugs. Incorporation of economic analysis may show apparently more costly products to have beneficial impacts on the amount of care that can be provided within fixed budgets. In the public health care systems of Australia and Ontario, Canada, economic evaluations have been incorporated into the standard licensing requirements for new drugs. But what pressures do clinicians in the UK face with regard to their pharmaceutical budgets and what problems are being posed for their decision making on new products?

**Proliferation of new pharmaceutical products** — Increasing numbers of products are coming onto the market, with therapeutic ranges similar to existing products and usually at much higher prices. They often have comparable clinical efficacy, usually differing in side-effects profiles and increasingly in the treatment regime, with many offering shorter courses or simpler, once-daily treatments. With so little clinical differentiation, cost-effectiveness may be the only way to measure the relative desirability of alternative products.

**NHS reforms** — The establishment of Trusts is leading to a growth in the number of budget-holding entities, with new locations for budgetary control and more financial flexibility.

**Purchaser/provider split** — The growth of separations in role, governed by a variety of different types of contract, may introduce more careful scrutiny of the cost-effectiveness of treatments.

**Budget/cost constraints** — These are a problem for health and social care agencies in most countries. Economic and demographic factors are generating increased demands at a time of tighter controls on re-

sources, creating pressures for more efficient use of available health care resources.

**Structural cost constraints** — The pressures outlined above are also an explicit part of some of the current reforms in the organisation of UK health and social care services. In some areas there are clear opportunities to change and improve the existing use of funds, for example where budgets have been devolved down to lower levels of responsibility, often creating opportunities for 'virement', the shifting of monies between different accounts. Where such changes are cost-effective, that is they increase the amount or quality of health care provided within the given cost constraints, this switching of funds could be used to enhance the role of pharmacotherapy at the expense of surgery or, of course, the reverse.

Health economics can highlight opportunities to relieve budgetary pressures, by identifying more cost-effective options. In some cases this might involve using higher-priced drugs, as they may reduce problems with side-effects and so reduce overall treatment costs. The potential role of health economics in assisting with budgetary pressures and cost constraints on health care provision has been shown in Australia. As from January 1993, all new drug submissions before the Pharmaceutical Benefits Advisory Commission must include an economic analysis. The evidence on safety and efficacy obviously retains its primacy, but once these points have been established, a new drug must be compared to the most widely-used drug in current practice for a particular condition and be shown to be at least as cost-effective.

Examination of the full impact of a treatment option can only be beneficial to the provision of care. Where opportunities for virement exist, as discussed earlier, a 'smarter' approach to the drug budget can make a better use of that budget, if it considers the full impact of all prescribing decisions. And such considerations are already becoming more important for fundholding GPs, who are faced with fixed budgets. To maximise the health care that they can provide for their patients, they must optimise their prescribing, a problem that can be assisted by economic analysis.

A major consideration in this area is whether it is ethical to introduce economic considerations into evaluation of clinical options and specifically of pharmaceutical alternatives. This question was addressed in a recent article by Professor Tony Culyer, of the University of York, concerned with the question of the morality of efficiency in health care<sup>1</sup>. In his discussion he stressed that, in providing care to people with needs, clinicians are faced with constant choices over allocation of resources, such as their own time. Efficiency becomes a means towards improved decision making and possibly a way to optimise the use of budgets, to provide the maximum amount of health care within the limits set by available resources. Given these premises, he concludes that 'it is ethical to be efficient, since to be inefficient implies failure to achieve the ethical objective of maximising health benefits from available resources'.

When clinicians choose new pharmaceuticals, they should view this process as one of considering alternative, and optional, packages of treatment. There are more cost implications to a new pharmaceutical product than just the price of a packet of tablets. Decision making will benefit from wider perspectives, specifically through the inclusion of economic evaluations. These techniques can improve the efficiency with which health care providers utilise available resources in the service of the patient population. This objective is not in conflict with ethical objectives, but is complementary to the pursuit of these ethical objectives. Without doubt, it has a vital role to play in the future expansion of health care provision.

## Reference

- 1 Culyer, A.J. (1992) The morality of efficiency in health care — some uncomfortable implications, *Health Economics*, 1, 7-18.

# Care Programming From Birth to Two

Justine Schneider

Researchers rarely get a chance to study a new system of care from its inception. The introduction of care programming for all specialist psychiatric services in April 1991 gave us such an opportunity. Care programming resembles care management: it requires the appointment of a named key worker, multidisciplinary assessment, periodic review, and documentation of needs and care plans. Care programming is designed to support people with 'severe and enduring' mental health problems, by targeting secondary care at those in greatest need.

We recruited three health districts which were well under way with care programming. During 1992 we interviewed 60 staff in these areas (psychiatrists, managers and key workers) and collected data from the key workers for 60 service users. The evolving nature of care programming meant that our approach had to adapt to changing circumstances and had three phases. The first consisted of semi-structured interviews with staff, about the advantages and disadvantages of care programmes and obstacles encountered. The second phase involved structured interviews with key workers, about which client groups were placed on care programmes, which professionals acted as key workers, how much staff time was devoted to assessments and

reviews, and whether service users were involved. The third phase collected detailed data about service receipt, housing and personal expenditure to enable us to cost the care packages over a six-month period.

We found broad approval for the principles of care programming and some reservations about the demands it placed on limited resources. A few people felt that it was superfluous — 'we were doing that already' — but, when pressed, admitted that care programming was more rigorous than pre-existing systems of care. Key workers were mainly community psychiatric nurses, with a number of other mental health professionals. Most reported positive experiences of care programming so far. There was evidence that it had not yet been applied to all mental health service users but was being targeted at those who had the highest levels of dependency. Involvement of users and carers was still in its early stages, but since we did not interview service users, our information on this subject is limited.

Two-thirds of people on care programmes had unmet needs in the short or longer term. Accommodation was a problem for 35 per cent, and other unmet needs included services which might have been

provided by the health authority, such as psychology and physiotherapy, as well as those which could be candidates for Mental Illness Specific Grant monies, such as daytime occupation, social support and living skills. Systems for feeding unmet needs into planning processes were being set up in the areas studied.

In our analysis of service receipt and costs, we looked at different subgroups, including those with a diagnosis of schizophrenia, people aged over 65 and those aged under 65. Table 1 shows the costs of care, excluding accommodation and personal expenditure, for these groups. Although the relationship between diagnosis and service costs was only tenuous, costs in one area were significantly higher, for a variety of reasons, including supply-side factors and local pricing levels. Since the area with the highest service costs also had the most training in, and experience of, care programming, this could tentatively be taken as evidence of efficient targeting of services at those most in need.

Care programming is still fairly young, and is competing for priority with other changes in health and social care, but having followed its development from birth to two years old there is already evidence that it can have positive effects on standards of service provision and mental health care practice, as well as making an important contribution to mental health policy. The impact of care programming on outcomes for service users will be a crucial area for future monitoring and evaluation.

**Table 1**  
Costs by service provider and client group

£ per week (1992/93 levels)	All subjects	People with schizophrenia	People aged 65 or over	People aged under 65
	N = 60	N = 35	N = 21	N = 39
Hospital inpatient treatment	104.71	105.97	146.42	79.20
District health authority	41.72	38.09	58.52	31.61
Family health services authority	1.74	1.48	1.99	1.59
Social services department	28.38	27.53	29.73	27.58
Service user or relatives	3.60	2.95	8.20	0.84
Other	8.34	3.42	4.54	10.60
Total	188.49	179.24	249.40	151.42

## References

- Department of Health (1990) The care programme approach for people with a mental illness referred to specialist psychiatric services, Joint Health/Social Services Circular HC(90)23/(90)11.
- Schneider, J., Hayes, L., Beecham, J. and Knapp, M. (1993) Care programming in mental health: implementation and costs in three health districts, PSSRU DP922/2, .
- Schneider, J. (1993) Care programming: assimilation and adaptation, *British Journal of Social Work*, 23, 4.

## See also:

- North, C., Ritchie, J. and Ward, K. (1993) *Factors Influencing the Implementation of the Care Programme Approach*, HMSO, London.

# The Mixed Economy of Care Research Programme

Martin Knapp and Julien Forder

A major programme of research is being funded by the Department until March 1996 to describe, monitor and evaluate the developing mixed economy of social care. It is led by Martin Knapp and Gerald Wistow (Nuffield Institute, University of Leeds). The programme comprises three elements:

- Description of *the broad development of a mixed economy of social care*, including the purchasing and providing functions.
- Description and evaluation of *the organisation and structure of supply*, including the comparative performance of different providers (private, voluntary and public), the incentives at work, and the implications of a mixed economy for providers in the various sectors.
- Description and evaluation of *the development and regulation of social care markets*, including the respective balance of power or influence between purchasers, providers and users in different market settings.

The research programme is designed to enable 'before and after' comparisons on an inter-service, inter-user and inter-authority basis. The intention is to chart the consequences — for agencies (purchasers and providers), users and carers — of the arrangements currently being established. The programme builds on the recent study, *Managing the Mixed Economy of Care*, which the Department commissioned from the same PSSRU-Nuffield Institute research team in 1990-92. This earlier study found evidence of a widespread cultural shift, with an increasing acceptance of local authorities' changing role and the diminution in direct public sector provision. However, the study also found evidence of differing interpretations of the enabling role; a strongly-held view that, in terms of market creation, 'social care is different'; and a general caution about the extent to which the diversification of supply was immediately feasible. This has generated a forthcoming book, *Social Care in a Mixed Economy* (see page 21 for details).

As recently emphasised by the Secretary of State and other Ministers, the government expects to see evidence from local authorities that they are actively developing, and funding, a more mixed economy. This new

research programme is designed to provide an important independent descriptive and analytical account of developments over the next four years. It will report findings at appropriate stages throughout the study in a range of publications. These include a *Mixed Economy of Care (MEOC) Bulletin*, a working paper series and associated publications. The *MEOC Bulletin* will be distributed to local and health authorities, voluntary and private sector organisations, and research groups. The aim is to provide an accessible and up to date account of our key research findings and associated policy implications. The first *MEOC Bulletin* (October, 1992) summarises some of the findings of our first two years' work.

The research team will also be producing working papers — *MEOC Studies* — on specific issues. The intention is to make these more comprehensive and detailed than the main project. One of these examines the opportunities for, and barriers to, the development of markets for social care services (Knapp et al., 1993). It describes the steps local authorities are taking to develop markets, the reservations they are expressing, and some of the implications for their future roles. Three particular areas are then examined in detail: the separation of the purchaser and provider roles; commissioning and contracts; and market forces and failures. Finally, the paper draws out some broad implications for lo-

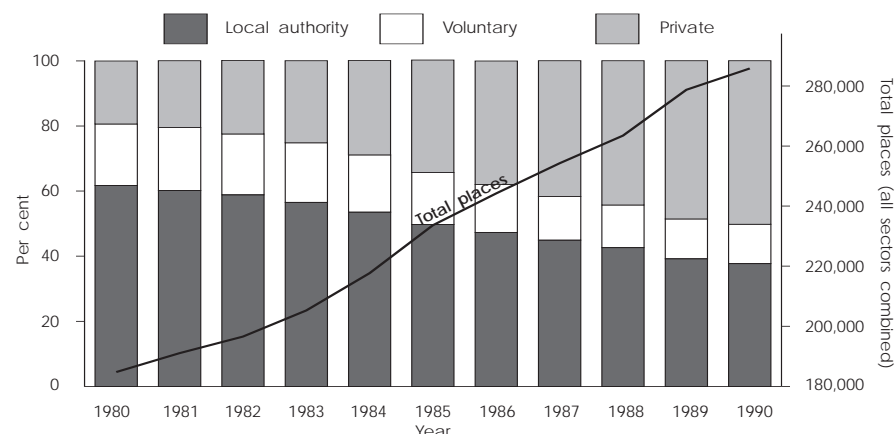
cal authorities as key players in social care markets.

A second paper considers the impact which the 1990 NHS and Community Care Act is having in reshaping health and social care services across the UK (Forder and Knapp, 1993). From 1993, the Act required social security payments, previously made in direct support of many residents of voluntary and private residential and nursing homes, to be transferred to local authority social services departments to allocate for residential care. What are the implications of the community care reforms for the voluntary sector? This paper examines some of the main challenges facing this sector: the blurring of the boundaries between public, private and voluntary sectors, the combined implications of the emphases on community care and competition, and the effects of contracts.

## References

- Forder, J. and Knapp, M. (1993) Social care markets: the voluntary sector and residential care for elderly people in England, in S. Saxon-Harold and J. Kendall (eds) *Researching the Voluntary Sector*, Charities Aid Foundation, Tonbridge.
- Knapp, M., Wistow, G., Forder, J. and Hardy, B. (1993) Markets for social care: opportunities, barriers and implications, Discussion Paper 919, PSSRU.
- Wistow, G., Knapp, M., Hardy, B. and Allen, C. (1993) *Social Care in a Mixed Economy*, Open University Press, Buckingham.

Figure 1  
An example of changes in supply, 1980-1990:  
Percentage by sector and total residential places for elderly and younger physically handicapped people



# The Costs of Schizophrenia

Shane Kavanagh

Although schizophrenia is a rare condition, it receives considerable public attention due to its long-term prognosis, the detrimental effect on the quality of life of both sufferers and their families, and some well publicised cases where sufferers have caused physical harm or even death to themselves or others. A diagnosis of schizophrenia means that sufferers experience 'positive' symptoms such as hallucinations and delusions during the first episode of their condition, followed by longer-term 'negative' symptoms such as slowness, under-activity and social withdrawal.

Little has hitherto been known about the balance of care and service use for people with a diagnosis of schizophrenia. No single source of information is available to provide the necessary data, so data from a variety of sources such as epidemiological surveys, psychiatric case registers, large scale community health surveys and specialist surveys of the prison population and the homeless have been synthesised in a Department of Health-funded PSSRU study to yield an estimate of the balance of care (Kavanagh et al., 1993). Given the general paucity of available data, the estimates

presented in Table 1 are the best possible, but should still be viewed as indicative rather than absolute.

**Table 2**  
The annual cost of schizophrenia by agency (1992/93 prices)

Agency	Cost (£m)
District health authorities	1066.2
Family health services agencies	9.7
Law enforcement agencies	51.4
LA social services departments	138.9
Department of Employment	7.4
Voluntary sector	48.3
Dept of Social Security/clients	812.8
<b>Total</b>	<b>2134.7</b>

## The balance of care

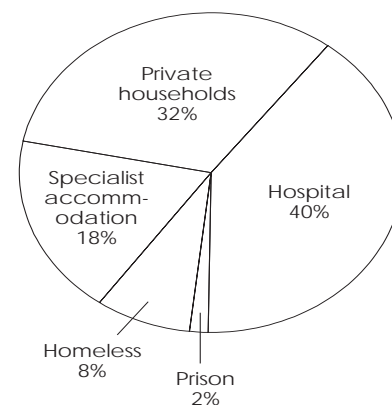
People with schizophrenia move between the different classifications outlined in Table 1 as their degree of morbidity and their social circumstances alter. However, at a system level the number of people in each category will remain broadly the same over short periods of time. Each of the rather wide categories outlined in Table 1 includes people with differing care needs. For some people the place of accommodation and the care provided may well be inappropriate. Although it is beyond the scope of this article to comment fully on current care arrangements, the presence of people with schizophrenia among the homeless and prison populations is obviously a major cause for concern. Criticism of the failure of health and social care services to provide a 'seamless' service has led to the introduction of the care programme approach, reports such as that of the Reed Committee on mentally disordered offenders, the enquiry into homeless people with mental illness, and the present debate about community supervision orders.

## Service utilisation

The estimated costs of current provision of services for people with schizophrenia were also calculated in our study, using in-

formation on service receipt derived from a number of sources, and costed using approximate long-run marginal opportunity costs (Netten and Beecham, 1993). Table 2 allocates these costs by agency. Figure 1 shows that the costs of care for the relatively small proportion of people accommodated in hospital is larger than the total cost to all other public agencies combined.

**Figure 1**  
Costs by care setting (1992/93 prices)



Total: £40.488m per week

## Implications

A more detailed discussion of the issues raised here can be found in a fuller report (Kavanagh et al., 1993). This also analyses the impact of introducing a number of innovative arrangements shown in pilot experiments to be effective on both agency resource requirements and the balance of care. The costs presented here do however illustrate a public health problem that has considerable impact on the budgets of public care providers. The total estimated economic impact of schizophrenia is even greater when the costs of lost production and informal care are considered.

## References

- Kavanagh, S., Knapp, M., Beecham, J. and Opit, L. (1993) The costs of schizophrenia care in England, PSSRU DP920.
- Netten, A. and Beecham, J. (eds) (1993) *Costing Community Care: Theory and Practice*, Ashgate, Aldershot.

**Table 1**  
The number of people with schizophrenia in each care setting

Accommodation/care setting	Number
Private households	67500
Specialist non-hospital accommodation	14400
Short-stay hospital inpatients (less than six months)	9600
'New' long-stay hospital inpatients (more than six months, less than five years)	6900
'Old' long-stay hospital inpatients (more than five years)	3700
Homeless — board and lodgings	3510
Homeless — hostels	16150
Homeless — sleeping rough	620
Prisoners — sentenced	585
Prisoners — remand	720
<b>Total</b>	<b>123685</b>



# Healthy Active Life: How Long?

Andrew Bebbington

We live in an ageing world. On average in the UK we live 50 per cent longer than at the turn of the century: life expectancy for men has increased from 46 to 73 years, for women from 50 to 79. In 1900 one person in 20 was over the age of 65: by 2020 it will be one in five. This pattern is being repeated worldwide, and indeed the pace of growth in numbers of elderly people is faster in the developing than the developed countries (Kinsella and Taeuber, 1993). The rise in life expectancy has been perhaps the most vital indicator of the improvement in the human condition, and an important token of national status.

For individuals this increase in life expectancy beyond the age of retirement gives rise to the optimistic dream of a golden period of carefree rest and leisure towards the end of one's life. But a number of assumptions are crucial to this vision: most of all the maintenance of good health and freedom from disability. Does the rise in life expectancy mean that health is improving? Does the onset of chronic illness come later in life? Or will it simply mean increased years of dependency, and a society characterised by 'a pandemic of chronic disease and disability, and associated mental disorders' (Kramer, 1980)?

These questions are extremely important to policy as well as to individuals, for two reasons. First, there is a rising tide of belief that health care should pay more attention to raising the quality of life and less to simply prolonging life. This is becoming increasingly important as the spiralling costs of high-tech medical care confront societies with the need to make choices about what kind of health services to provide.

Second, there is concern about the planning implications of an ageing population. Given that chronic ill-health is concentrated among elderly people, will we need to spend far more on health care?

These concerns have given rise to a major international effort to determine trends in health in a manner comparable with that of life expectancy. Although this is best done by tracing individual life histories, methods have been developed which enable estimates to be made from cross-sectional health surveys and censuses. As a result,

over the last five years, estimates of healthy active life expectancy have been prepared in many developed countries and also in some developing countries. However, the goal of precise international health comparisons has not yet been achieved, partly because of different social constructions of disability.

The UK has been one of the front-runners in this field, partly due to its long tradition of health-related surveys. Some of the conclusions being drawn are as follows.

First, if we define chronic ill-health in the manner of the national disability survey of 1986, measuring 13 key types of disability, each from mild to severe, then men may expect to live in full health for 64 years, or 89 per cent of their lives, while women may expect 67 healthy years, or 86 per cent of their lives. Although women live longer they can expect a longer period of ill-health, especially at the more severe stages of disability.

Second, there are other factors which make for considerable variations in healthy active life expectancy, often much larger than variations in life expectancy itself. Initial investigation points to a north-south divide in England, people in the south east having an expectation of three or four more years compared with the least favoured areas in the north. Social class differences appear to be even more dramatic, as much as nine years between top and bottom, and are probably increasing. But as always in studies of social class variations in health there remain methodological caveats. Variations between social groups, particularly minorities, can be studied in much more detail following the inclusion of the question on limiting long-standing illness in the 1991 Census, and this is a major topic of our present research.

Finally, evidence about changes through time is crucial to policy, if not to our entire assumptions about the world we will inhabit in the first part of the next century. And here the evidence is not encouraging. During the 1980s there was a steady advance in life expectancy, but no increase in years of healthy active life expectancy (Bebbington, 1991). People may expect that the two extra years of life gained over the

last twenty years to be lived in chronic ill health. This broad picture has been confirmed by recent research in the US, Canada and Australia.

We should not necessarily be too pessimistic, but rather regard this as a warning. Over the last century trends in health have changed considerably. Most of the original gains in life expectancy were due to improvements in infant mortality, and then in the acute illnesses affecting children and young adults. It has only been comparatively recently that life expectancy has increased at the upper years of life. A national health policy which is focused on 'the promotion of good health and the prevention of disease' (Department of Health, 1991) will help to bring about the necessary improvements. To help with targeting this objective, our current research is aiming to establish not just how much life is shortened, but how much healthy, active life is lost to each of the main diseases.

Healthy Active Life Expectancy (HALE) is a joint project with the Office of Population Censuses and Surveys, funded by the Department of Health. Its aims include producing measures of HALE at specific ages, examining some of the social factors influencing HALE, showing the effect on HALE of major disease categories, reviewing methods of calculating HALE and comparing results with other industrialised countries.

## References

- Bebbington, A.C. (1991) The expectation of life without disability in England and Wales, 1976-88, *Population Trends* 66, 26-29.
- Bebbington, A.C. (1992) Expectation of life without disability measured from the OPCS disability surveys, chapter 2 of J.M. , M. Blanchet and J.E. Dowd (eds) *Health Expectancy*, OPCS Studies on Medical and Population Subjects No. 54, London.
- Bebbington, A.C. (1993) Regional and social variations in disability-free life expectancy in Great Britain, PSSRU DP793.
- Department of Health (1991) The health of the nation: a consultative document for health in England, Cm 1523, HMSO, London.
- Kinsella, K. and Taeuber, C.M. (1993) *An Aging World II*, US Bureau of the Census International Population Report P95/92-3.
- Kramer, M. (1980) The rising pandemic of mental disorders and associated chronic diseases and disabilities, *Acta Scandinavica* 62, 282-297.

# Care-Managed Community Care: Outcomes from Two Routinely-Implemented Programmes

*John Chesterman and Bleddyn Davies*

Another description of the results of PSSRU-designed care management. Why?

Budget-devolved care management applying variants of the model evaluated in the Thanet ('Kent') Community Care project has been shown to improve outcomes in the Thanet, Gateshead and Darlington experiments. However, all the experiments reported so far are just that: 'experiments'. The Thanet project was closely managed with a large PSSRU input. In subsequent projects there was an attempt to ensure that the crucial features of the Thanet arrangements, procedures and practice were applied and cultural continuity maintained. The Unit provided more than 'technical assistance'. There was some (though varying) participation in management.

By contrast, Sheppey and Tonbridge were evaluations of programmes which were implemented as routine developments. The programmes were two among some two dozen being developed to cover the whole of Kent. The decision to implement them was made by senior area management in response to a resource incentive provided by headquarters, not to a special interest in or commitment to the model. Indeed, their implementation was less systematic than would be expected in social services departments (SSDs) following good managerial practice and Department of Health guidelines in putting into place care management pilots, and drawing on the now much larger amount of writing about care management practice in the

PSSRU projects and others. The care managers had only two advantages. They each spent a short time in Thanet, and they attended periodic meetings of all the care managers in the authority to discuss matters of mutual concern and have talks on topics of common interest from other professionals.

So the results are of interest because they suggest how well the model might work in less favourable environments.

## Programme context

Budget-devolved care management is intended to be able to respond flexibly to local circumstances: those affecting the needs of elderly persons and their caring networks, and those reflecting the physical and assumptive resources of formal care systems. Sheppey is a low-income area of poor housing and depressed industry, with a working class culture which Ray Pahl (1984) described as having an 'intensely conservative and traditional set of household practices for coping with difficult material circumstances'. In contrast, Tonbridge itself is a prosperous town with light industry, surrounded by villages with many higher-income families and a buoyant labour market. The programme also covered Malling and surrounding villages, where there was more low-paid agricultural employment, and higher unemployment.

## Evidence

The same core evidence was collected for these programmes as for the Thanet community care experiment and its descendants. These are summarised in Box 1. However, the time over which the data were collected was shorter than in the main experiments and numbers were smaller, so differences between programme and comparison groups are less likely to be statistically significant.

## Findings

- The programme groups enjoyed gains on many indicators.
- Many of the differences in means between the programme and the comparison groups were smaller than in Thanet. The small sample size meant that fewer of these differences were statistically significant.
- The overall costs to the SSD and the NHS differed little between the two groups, so the programmes achieved their aims without additional costs over the time period studied.
- The two programmes described here differed in important respects. The results in Sheppey resembled those in Thanet and Gateshead more than did the Tonbridge and Malling ones. For instance, the degree to which programme clients felt more able to cope than people in the comparison group was statistically significant at the 0.1 per cent level in all three areas.
- The balance of care, measured by cost, between different agencies was quite different in these two studies. In Sheppey higher care management costs to the SSD were associated with reduced costs to the NHS. In Tonbridge, costs to the SSD were not greater, but NHS costs were significantly lower for the programme group.

## Targeting and triaging

Our community care projects have been successful because they were targeted at those for whom the best results would be achieved by the PSSRU model of flexible

### Box 1

#### Evaluation design

- A quasi-experimental design with post-selection matching of comparison and experimental cases.
- Assessment and evaluation interviews with clients and principal informal carers by a qualified and experienced social worker (JC) at admission and one year later, supported by continuous observation of the programme at work and interviews with the care managers.
- Continuous tracking of utilisation, costs, and place of residence in detail over one year, in lesser detail over six years for people on the programme.
- The analysis of the client review and information system common to the Thanet implementation and replications of the same model.
- Interviews about the motivations, rewards and management of the programme conducted with programme 'helpers': paid and unpaid volunteers who complemented the service inputs.

care management, encouraging user- and carer-centredness, but also seeking to make the most effective use of (always adequate) resources. The targeting was in effect done by networks of persons who both knew the users at first hand and understood the potential and limitations of the particular programmes. It follows that care management will best fulfil its potential if there is 'triaging', or selection, not just by the likely need for greater and lesser care management, but also between teams operating with different care management arrangements. This is why so much of the recent intellectual effort of the PSSRU — in our own experiments and the analysis of the international literature (Davies, Bebbington, Charnley and colleagues, 1990; Davies, 1992) — has been directed towards trying to show what the implications of needs and the characteristics of systems are for the choice of care management arrangements.

#### References

- Chesterman, J., Challis D. and Davies, B. (forthcoming 1993) *Budget-Devolved Care Management in Routine Programmes: Outcomes of Two Experimental Evaluations*, PSSRU Studies, Ashgate, Aldershot.
- Davies, B. (1993) *Care Management, Equity and Efficiency: the International Experience*, PSSRU, Canterbury.
- Davies, B., Bebbington, A., Charnley, H. and colleagues (1990) *Resources, Needs and Outcomes in Community-Based Care*, PSSRU Studies, Ashgate, Aldershot.
- Pahl, R. (1984) *The Divisions of Welfare*, Basil Blackwell, Oxford.

**See also:** Care management: observations from a programme of research, by David Challis in this issue, page 33.

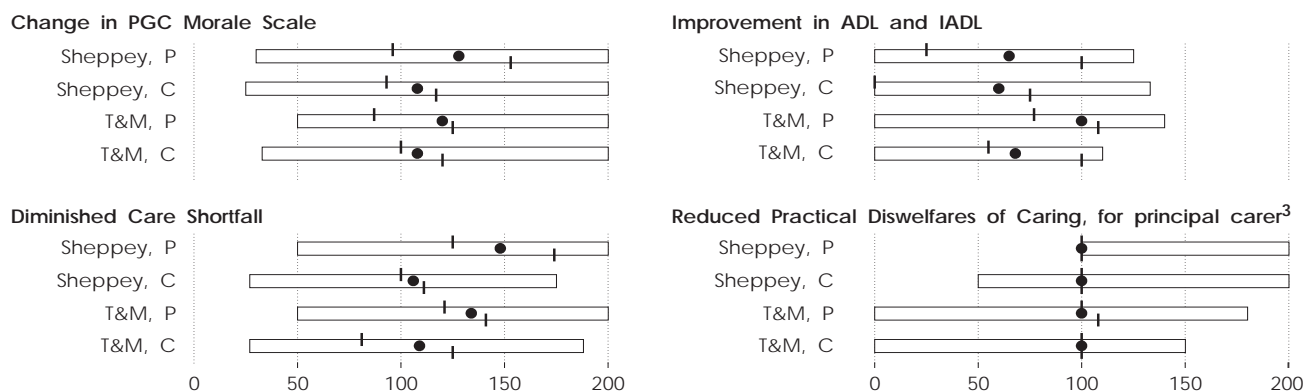
## Box 2 Principal outcomes

Table 1: Place of residence after one year

Permanently resident	SHEPPEY		TONBRIDGE & MALLING	
	Programme	Comparison	Programme	Comparison
	%	%	%	%
In own home	72	44	83	60
Residential home or hospital	18	28	8	26
Died	10	28	9	13
N	32	32	23	23

- In both programmes, higher proportions were at home after one year than in comparison groups.
- Changes in scores on indicators of aspects of psychological wellbeing suggested that elderly persons in the programme group who remained at home for the whole year were advantaged compared with the comparison group.
- People receiving care management suffered fewer unmet needs, particularly in Sheppey. The benefits were larger, and so even with such small numbers, more differences were statistically significant. It was interesting that the programme more than held its own in the performance of tasks where congregate settings have a natural advantage. The programmes may have targeted residential care on those for whom it would convey most benefits.
- There were some benefits for the principal informal carers of people on the programme, although the numbers and differences were too small for more than a few to be statistically significant, partly because a high proportion of users lacked persons who satisfied our definition of 'principal informal carer'.
- In Sheppey, costs per week to the social services were increased, but weekly costs to the NHS were reduced to an equivalent extent, so the difference in the combined costs was not statistically significant at a high level. The Tonbridge pattern was different. The costs of programme cases to the SSD were not significantly greater, but their NHS costs were lower to a degree which was significant at the 5 per cent level. Although their total costs to the two agencies was lower for programme cases, the differences were not statistically significant at a high level.

Figure 1  
Ranges, quartiles and medians for some important outcomes



1 T&M = Tonbridge & Malling; P = Programme group; C = Comparison group

2 The bars indicate the range from minimum to maximum, the dots the medians, and the lines the first and third quartiles.

3 Only a minority had informal carers who satisfied our definition of principal carer. The distributions include cases without principal carers.

# In the Market for Bargains

Martin Knapp

Question: what's the difference between a pound of apples, a hundred ICI shares and community care? Answer: none. In the 1990s they will all be bought and sold on the market.

To most people a market is a collection of vendors' stalls offering goods at competitive prices. If you want apples, you wander from one fruiterer's to the next, comparing price and quality, choosing a variety to suit your taste and budget. If the apples you buy this week taste awful, you complain to the stallholder next week, or you take your custom elsewhere. If others feel the same, their combined market forces will persuade the stallholder to drop the price or stock different varieties.

The government hopes that similar market forces will improve community care. How? If their own provision is costly, local authorities should have financial incentives to contract out to private and voluntary organisations. Competition should encourage providers to push service quality up and prices down. There should be more choice. And greater participation by users and carers should make the public sector more responsive to their needs and wants. But can community care markets work as well as fruit markets? Will market-driven community care meet government expectations?

Some local authorities are raising ideological objections, anxious about the morality of 'welfare for profit' and the 'commercialisation of care'. Important as they are, I will lay these objections to one side and concentrate on the *practical* implications of community care markets.

One concern is that there will be insufficient competition between providers to produce quality and choice improvements or to allow local authorities to negotiate lower prices.

In parts of the country there are too many independent residential and nursing homes, but nowhere do there appear to be enough domiciliary, day or respite services. Today's providers may be unable or unwilling to expand or diversify. Fragile infrastructures and unhappy experiences with public funding may leave voluntary organisations reluctant

to expand, fearing loss of autonomy or diversion of roles. And the private sector may see the potential profits to be too small or uncertain, especially if the capital outlay would be high or if existing providers threaten a price war.

Nobody yet knows whether new providers will come to the rescue of beleaguered community care markets. But if they do, they may find that the best response to the enormous buying power of local authorities is to merge or collude to develop counterbalancing power. Local authorities may need to assist new providers to establish themselves. If there are only a few providers, they could wield sufficient market power to control price, nature, quantity or quality. The market will be working against the interests of users and taxpayers.

Provider power of this kind might arise if markets become highly specialised and segmented with only a few providers in each. This presents a problem to authorities wanting to encourage service variety to extend the choices open to care managers and users (thus improving targeting), for each different contract generates extra negotiation, management and monitoring. By buying only standardised services, these costs are cut and authorities can engage in price competition.

There is a big difference between apples and community care. The enjoyment from an apple is immediate and unequivocal. You buy apples often enough for your purchasing decisions to be influenced by memories of the taste of the last one. By contrast, community care quality and its effects are famously hard to measure. Outcomes are defined in terms of effects on users and carers, but are uncertain, technically complex and of long gestation. Moreover, the need-generating characteristics of some users make it hard for them to participate in decision making. Anyway, few can acquire market experience by 'shopping around', for many services are purchased only once. It can be risky for users to move from one provider to another when quality or outcomes are revealed to be unacceptable.

Of course, there are risks if you buy ICI shares, but the stock market has developed a secondary market in information, popu-

lated by well-informed brokers. The parallels with social care are obvious: care managers and advocates are needed to guide users, and portfolios on actual and potential providers are needed by authorities to guide purchases.

The root of the problem is that information is scarce and/or costly. Indeed, the *transactions costs* of acquiring the information, and negotiating and monitoring contracts, could exceed the efficiency savings expected from commissioning services from lower-cost providers.

There are therefore important differences between the markets for apples, ICI shares and community care.

Leaving community care allocation to Adam Smith's 'invisible hand of the market' could be disastrous. Indeed, authorities should use two very visible hands — as service commissioners and market managers — to shape new markets:

- Authorities should encourage new providers and diversification.
- They should not unthinkingly reward price-cutting in case it is a short-term ploy to ward off competition.
- They should offer contracts to independent providers without threatening their diverse and important contributions.
- They should beware market fragmentation, but they should not standardise commissioning or services if it destroys their responsiveness to different needs.
- In lieu of complex monitoring, they should give more opportunities to users to express their views.

Generally, authorities will need to develop local 'trade and industry policies' to stimulate, regulate and massage the emerging community care markets into good shape. Community care has characteristics which distinguish it from most other marketed goods and services. This does not make community care markets unworkable, but it makes it imperative that local authorities intervene with well-tempered power and accumulated expertise.

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A version of this article first appeared in *Community Care*.



# Care Management: Observations from a Programme of Research

David Challis

The PSSRU has undertaken a series of studies of case management services for frail elderly people, referred to throughout this Bulletin as the Thanet, Gateshead, Darlington and Lewisham studies (Challis and Davies, 1986; Davies and Challis, 1986; Challis et al., 1990, 1991a, 1991b). The latter study is still in progress (see *Update* in this issue). Here the terms 'case management' and 'care management' have been treated as equivalent. These studies were cited as examples of case management in the White Paper *Caring for People*. They examined a model which provided case managers, who worked, with devolved budgets, with relatively small caseloads of the most vulnerable elderly people. The findings are remarkably consistent.

In all settings there was a reduction in the use of institutional care facilities, and all the available data indicate that the quality of life of elderly people and their carers receiving these case management services improved significantly more than those receiving the usual services. Furthermore these gains were achieved at no greater cost than clients receiving existing services over the same period, suggesting greater efficiency in care provision.

There are a number of areas for the development of care management illuminated by these studies. These include who receives case management, whether budgets can be devolved, the availability and skills of staff for case management, linkages between health and social care and the managerial implications of this new system of services.

## Targeting

The services were all carefully targeted on those for whom there was considerable potential of substituting home-based for institutional care. Although improvements in welfare at similar cost to usual patterns of service were found, indicating greater efficiency, the results did not on the whole indicate significant cost savings. The only exception to this was where the institutional alternative was long-stay hospital care. Therefore it is probable that if the

same case management approach were applied to those with a slightly lower level of need, where the opportunity for substitution of institutional by community care is less, then costs could rise. This is because individuals whose needs fall just below that of present institutional care currently receive relatively low levels of provision, but case management, with more detailed assessments, could well lead to increased home care expenditure. Thus careful targeting appears to be one of the factors associated with the positive effect of these studies on admissions to institutional care and stability of cost, reflecting the experience of large-scale case management schemes overseas.

## Financial devolution

The evidence suggests that control over resources is a crucial factor in enabling case managers to respond more effectively to the varied individual needs of elderly people, not only in the UK but also in other countries. Lacking such control of resources, the case manager can merely make requests to the providers of other services but such brokerage provides relatively little power to ensure adequate provision or effective coordination. Much better outcomes are possible when the case managers are able to adapt care plans flexibly to reflect the individual circumstances of users and carers. It is the capacity to influence both the type and content of service available that permits genuine individualisation of care. However, the difficulties of making such changes which balance decentralised decision with effective accountability should not be under-estimated, particularly in view of the organisational traditions in service agencies.

## Style of case management

Within the case management literature there is a debate about the style of case management which may be characterised as between 'administrative' and 'clinical' case management approaches. Some agen-

cies looking at the core tasks of case management appear to see them rather more as administrative activities than requiring staff with human relations skills. However, the studies indicate that case management has been successful in performing the core tasks through combining practical care with the use of human relations skills, including counselling and support, not only to carers and users but also to direct care staff. Conversely an 'administrative' approach would be more likely to fragment such activities as resources to be purchased separately where necessary.

This problem is evident in discussions about the separation of assessment and provision, or 'the purchaser/provider split'. A variety of case management programmes show that the essence of the assessment process involves engaging a person, forming a relationship, giving advice, and therefore at an early stage, a range of human relations skills. Even the indirect work of case management, involving coordination, linking formal and informal networks, requires the case manager to support and train key workers in close contact with the service user. A more 'clinical' model of case management requires a combination of direct and indirect work, or in more traditional social welfare language, the integration of casework and service arrangement. The administrative model risks developing insensitivity in the new care arrangements, which may be particularly great in the absence of appropriately trained staff to act as case managers.

## Linkages with the health care system

For those vulnerable elderly people on the margin of institutional care, effective health care provision, as well as social care, is essential. Two settings offer obvious opportunities for making linkages between case management services for the elderly and health care. Primary care provides a setting for case finding and identifying social care needs with the development of screening in general practice for the over

75 population. Also, developments in geriatric medicine and psychogeriatrics in the United Kingdom suggest that these environments offer considerable potential for case management services which are targeted at the very frail, particularly where those services are community-focused.

## Matching case management arrangements to client and local area circumstances

Case management arrangements can be seen to differ by such factors as setting and form of separation of purchaser and provider. Both the UK and other evidence suggest that the most effective form of case management arrangements will vary according to the circumstances of different groups of clients, local area characteristics and the nature of their local health and social care systems.

## The organisational infrastructure of case management

Effective client level work is dependent on appropriate organisational infrastructures. The devolution of budgets is one area of

concern but there is also a need to consider factors such as improved information systems and new management approaches to quality assurance, rather than traditional models of procedural adherence in bureaucratic hierarchies. Without change at all levels in organisations providing care there is a risk of only producing slight changes and of existing patterns of care acquiring new labels without substantive change in the experience of service users and their families. For example, bulk purchasing on a large scale may well have no impact for the user who requires a particular solution to their needs since it may only be substituting an insensitive private/voluntary monopoly provider for an insensitive public sector provider. This is unlikely to lead to the development of more client-centred approaches.

## Realising the potential of case management

In view of the kinds of changes in the pattern of community care which are desired, and policy makers' expectations of the role of case management as one of the processes to achieve these changes, it is essential to be specific about target populations, the precise features of models of case management which are effective, the extent of freedom permitted to practitioners within

these models, management of these services and how they relate to health care. In the absence of such clarity, investment in case management systems could risk being a more expensive response that fails to produce real gains in welfare or changes in the pattern of provision.

### References

- Challis, D., Darton, R., Johnson, L., Stone, M. and Traske, K. (1991a) An evaluation of an alternative to long-stay hospital care for frail elderly patients: Part I The model of care, *Age and Ageing*, **20**, 236-244.
- Challis, D., Darton, R., Johnson, L., Stone, M. and Traske, K. (1991b) An evaluation of an alternative to long-stay hospital care for the frail elderly: Part II Costs and outcomes, *Age and Ageing*, **20**, 245-254.
- Challis, D. and Davies, B. (1986) *Case Management in Community Care*, Ashgate, Aldershot.
- Challis, D., R., Chesterman, J., Luckett, R. and Traske, K. (1990) *Case management in social and health care*, PSSRU, Canterbury.
- Davies, B. and Challis, D. (1986) *Matching Resources to Needs in Community Care*, Ashgate, Aldershot.

### Box 1

#### Some key features of effective care management

Targeting and screening	Establish a clear, shared definition of target population and adequate methods of identifying that population
Budget devolution	Keep financial control as close as possible to field decision making, with service allocation and expenditure authorisation at the same level
Style of case management	Avoid segregation of interpersonal skills from service provision; integrate social work and social care
Linkages with health	Consider benefits of different locations for different case management services, eg hospital, primary care or community mental health settings
Responding to local features	Ensure service model can vary according to local conditions and opportunities, eg rural-urban mix, differing patterns of NHS provision
Management of case management	Develop management of case management as well as client level work, eg facilitation, monitoring, quality assurance

# Endpiece

*Bleddyn Davies*

The strategy of the Department of Health (DH) for funding research has changed, but will production of welfare (POW) research have as much influence on policy under the new terms?

## The new research policy

The six-year rolling unit contract is to go. Instead there are to be a 'small number' of 'centres', research organisations with more DH funding than even the biggest units, with ten-year contracts, and a more ambitious set of tasks. For other research groups, the DH could provide a programme contract of as yet undetermined maximum duration.

There is some evidence suggesting a new respect for the long-run contributions of research-based argument in the new thinking. It is an acknowledgement that policy and practice would best be developed by a combination of innovative, independent research and analysis, and specific policy requirements, what the Williams Committee\* refers to as 'science-push/demand-pull'. One of the key arguments of the Committee, whose report is reflected in the new research strategy, was that it is essential to consolidate and spread 'science-push/demand-pull' processes in the management of change. Research and analysis groups should influence the evolution of policy and practice thinking as well as provide the argument and information for which the policy world currently acknowledges a need.

## The need for researchers

DH statements acknowledge the importance of not losing its best people. There must be a sufficient number of well supported groups and individual researchers who are highly expert, technically sophisticated, close to the policy and practice worlds, with a career commitment to the DH policy areas, able to manage and lead as well as to do research. The DH always recognised that it needed its researchers, but for another reason which remains valid. Without them the DH could not get done the high quality applied research for which policy processes in the DH create an

enormous demand: for instance, estimates of the costs of this; the evaluation of the costs and outcomes of that. In particular, it is clear that in important areas like community care, people with good jobs to fill are simply unable to recruit able and experienced researchers of middle and senior rank.

## Implementing the policy

A key to the success of implementation is the degree to which contract forms fit the time perspectives reflected in the cultures of the leadership of the research groups. Nationally, we cannot afford to reduce the potential of the research community to make the big long-run contributions. The success of the policy will depend greatly on how far the implementation succeeds in building on groups which have an unchallengeable record in creating and developing 'science-push' processes.

The environment of the new centres should be conducive to 'science-push'. But 'three or four' centres with tight enough remits to provide focus will hardly cover more than a few patches in the health and personal social services field, because in some patches, centres would still need the stimulus of argument from elsewhere to counter tendencies to a numbing orthodoxy, and because there are practical reasons why many of those with the flair for leading research combining short-term and long-run impacts will not be able to move.

So we shall continue to be very dependent on persons and groups outside centres. Therefore the DH must ensure that in a decade's time, there will be persons in DH-funded organisations other than centres, operating their research programmes in ways which develop the long-run science-push on policy and practice as well as provide useful information for the present. The contract culture will become still more powerful and pervasive during the next decade. The competition for research funds will become even fiercer. Will those researchers working outside the centres become conditioned by the pressure (and rewards) of working on grants and contracts to such a degree that they do not develop the art of us-

ing projects of immediate significance to develop a policy argument over a decade or more? The pressure is foreign to our experience because the contract culture in research is new here. However, one can see from American research how the mode of funding comes to dominate the nature of the work produced.

## The PSSRU and 'science-push'

The PSSRU has always played a big part in science-push. The impacts in this country have been clear enough not to require illustration. There have been documented results in many other countries too.

Having a mission around the development and application of a Unit paradigm, our POW approach has helped greatly. It provides an intellectual framework and body of logic, a repertoire of tools for collecting and analysing data, a set of priorities for guiding the design and selection of new work. Its logics have guided those of our policy and practice models; for instance, budget-devolved care management of the Kent Community Care project and its successors, and our work on needs compensation in grant systems. The impact of POW has occurred partly because its foci — equity and efficiency, needs resources and outcomes and their interrelationships — have become the foci of policy and practice concerns. Regardless of changes in funding structures, it will be the responsibility of units like the PSSRU to ensure that the needs both of science and of policy continue to be linked together in this way.

## Adapting the PSSRU

So much for the great issue of DH research of our day. There is the more local task: to recognise our strengths and weaknesses; to take steps to build on the former, and to remove the latter. We shall be using the changes to try to do both.

\* Department of Health (1992) *Review of the Role of DH-Funded Research Units*, report to the Director of Research and Development of a review team chaired by Dr P.O. Williams, HMSO, London.



Established in 1974 at the University of Kent at Canterbury, the Personal Social Services Research Unit is now the largest social care research unit in the UK, with some 40 staff members. Its work is funded by the Department of Health, and other government departments, the Economic and Social Research Council, charitable trusts and international social welfare organisations.

PSSRU research focuses on needs, resources and outcomes in social care: its concerns are resourcing, equity, and efficiency from the perspective of users, agencies and others. A distinctive analytical framework called the 'production of welfare approach' has been developed by the Unit to illuminate such research.

The PSSRU applies the approach in studies of a wide range of areas. Most of its work has been on what is loosely described as 'community care', but it has also worked on other areas such as health care, housing, income maintenance and criminal justice services.

## ***The PSSRU Bulletin***

The aim of this Bulletin, number 9 in a continuing series, is to give a taste of the Unit's work, and show whom to contact to find out more about the research. The Bulletin is distributed free of charge to all local authorities, health authorities, relevant voluntary organisations, and to others on request. If you would like to be put on the circulation list, please complete and return the form on page 4.