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# To what degree have the British community care reforms met the pre-reform criticisms of targeting?

**Bleddyn Davies**

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The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the United Kingdom Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas—including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three sites:

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## **To What Degree Have the British Community Care Reforms Met the Pre-Reform Criticisms of Targeting**

Bleddyn Davies<sup>1</sup>

It was not until the late 1980s that there was evidence for detailed analysis of the relations between resources, needs, and outcomes: persons in what need-related circumstances obtained publicly-subsidised and/or brokered access to how much of what kind of service, with what effects on whom, and at what costs to whom. Very soon we shall comparison of resources, needs and outcomes for users recruited in 1984/5 with those recruited in 1995. In what follows, I shall risk some tentative generalisations from the half-analysed results of a before-after evaluation of the community care changes. The study was based on two cohorts of persons assessed and allocated community social services. One cohort was recruited during 1984/5 [hereafter, 1985], and was followed for at least 117 weeks. The second cohort was recruited during 1995, and is still being followed. The evidence is particularly rich about the circumstances and perceptions of field-level triads of users, principal informal caregivers, and their care managers<sup>2</sup>. Data are still being collected and analysed, making some comparisons impossible as yet. The generalisations must be tentative. The analyses for the second cohort are still in progress, and there has not been the analyses for both cohorts

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<sup>2</sup> The study focuses on who gets how much of what service and informal support at what costs to, and with what effects on, whom, and so on resources, needs, outcomes, utilization, productivities and costs; *how* the patterns of needs, resources and outcomes occur, and the influences of structures and policies, procedures, assumptive worlds, perceptions and practice; and *why* influences on patterns vary between areas and between cohorts. It has a before-after design based on cohorts of new users of community social services in 1984/5 and 1995 in 12 areas from 10 of the 103 authorities in England and Wales at its inception; and draws its areas from the same areas for each cohort. The main collections are survey interviews with matched triads consisting of 419 users receiving authority-brokered community care services and 72 persons in a care home sample; 'principal informal caregivers' named by users and giving substantial practical help with personal care and instrumental activities of daily living; and the care managers of all users, focusing on the needs, rationale of the care plan, and the description and analysis of care management and service arrangements and related issues. There were also interviews with 134 managers and other personnel, and other collections.

simultaneously to get the highest degree of precision achievable with respect to the precise question asked, the definition of variables, and model.

### **1. Have the changes reduced pre-reform weaknesses?**

The weaknesses of the pre-reform system have been thoroughly explored since the late 1970s. Some are of particular relevance to this argument.

- *Inexplicit criteria and idiosyncratic allocations.* That was argued in academic literature during the early 1980s (Goldberg and Connelly, 1981; Davies, 1981; Davies and Challis, 1986). It was adopted and demonstrated with great precision about causal process in 1987 in an impressive report from the DoH SSI, *From Home Help to Home Care* (Department of Health, 1987). Among other things, criteria were inexplicit, those undertaking assessments were not trained for the task, and procedures were not well designed to achieve good allocations. Reviews were more honoured in the breach, and service levels were rarely reduced, or services terminated. That was so, although evidence from the 1985 cohort showed substantial positive changes in functional capacity over time as well as deteriorations, and suggested that effective adjustment of the care plan in both could contribute as much to effective targeting as improving qualifying criteria for application at initial screening and assessment (Davies and Baines, 1992A, 1992). The argument remains valid. There was a substantial minority of the community sample in the 1995 cohort whose capacities to perform activities of daily living without help or supervision improved during the six months following assessment. That was so for personal care activities for 16 per cent, and 27 per cent for such 'instrumental' activities like preparing light meals and light housework, counting the five items for personal care activities and seven activities for instrumental activities used in many American studies (Davies, 1993A; Davies, Chesterman, Fernandez, and Saunders, 1997).

The study of the first cohort also suggested that consistency of allocations between like users was improvable. (A system in California starting with similar degrees of consistency managed to improve the consistency greatly; Pruger, 1987) But consistency is not synonymous with equity and efficiency. The latter requires (i) the absence of bias and (ii) responses to the marginal productivities of inputs for outcomes within the limits set by the equity criteria. The study of the 1985 cohort showed important biases, and little responsiveness to marginal productivities.

The degree of defensibility of the utilization patterns for the 1995 cohort are summarised in Appendix 1, which is based on a forthcoming book by Davies and Fernandez (1997). The patterns suggest greater consistency and lower bias than was found a decade ago (Davies et al., 1990). Consistency seems particularly to have improved for the services which were least developed by the mid1980s, and whose development most reflects the new flexibility and attention to the support of caregivers.

The appearance of consistency beyond some point in a statistical model is less important than the patterns of influence, because one would expect much unexplained variation, and because need-related circumstances are too subtle and many to be measured and fully estimated. It is more important that the pattern of variation is for all variables dominated by need-related circumstances, that the supply constraints were relatively unimportant in explaining the patterns, and that there are signs of new and defensible divisions of labour between services. We believe that there are now bigger differences between authorities because change has accelerated, because authorities have learned and worked through the details at different rates, and because authorities have accepted different aspects of the new policy and to different degrees. Nevertheless, we have not found big authority effects on most patterns.

Procedural inconsistency remains, though by 1996, inspections by the Social Services Inspectorate reported that it was smaller even compared with 1995 (Department of Health, 1996). We later discuss the contributions of more nationally standardised procedures, instruments, and frameworks crossing agency and sectoral boundaries. Of greater ultimate importance is the degree of unjustifiable variation in who gets how much of what and with what effect: in the equity and efficiency of the actual allocations and their outcomes. We discuss this further below.

- *Excessive share of resources consumed by persons of low potential benefit.* From the early 1980s, estimates were published suggesting that many were receiving services for tasks which they claimed to be able to undertake without difficulty: for instance, cooking, cleaning and shopping (Davies, 1981, 1994; Bebbington and Davies 1983; 1993). The proportion of recipients finding difficulty with the tasks were estimated to be between 51 and 70 per cent, depending on definition, though with variations outside that range for types of household and area. These figures are probably biased downwards because, on average, people tend to underestimate or understate their difficulties, and because many must have given answers based on their physical ability, taking no account of psychological states making the performance less likely. (Periodic confusion is one such factor, depression another, and both are common in the recipient population.) None of the studies have produced national estimates designed to correct for the understatement. But one can assume that there must have been many for whom the performance of the services they were receiving could not be justified on the grounds that they had great difficulties in undertaking them themselves.

Post-reform patterns suggest that a reduced share of resources are consumed by low need recipients. That is suggested by the before-after study. Table 1 compares estimates of package costs at the beginning of the period following the initial implementation of the first care plan - the beginning of the COCA

period, defined below - by social support and interval need for the 1995 cohort with service costs for the 1985 cohort (Isaacs and Neville, 1976). 'Whether supported' denotes whether there is a principal informal caregiver putting in substantial face-to-face care inputs at least weekly. By critical interval need means circumstances requiring frequent intervention at irregular intervals during the day. By short interval need is meant a need for help with tasks requiring inputs at least once a day. By long interval need is the incapacity to undertake tasks of daily living requiring inputs at least once a week. The costs are for interval need categories formed on the basis of description of users needs provided in the care manager interviews<sup>3</sup>.

The table suggests

- (i) Lower proportions of users in the two long interval need categories.
- (ii) Larger increases in the proportion of users with critical interval need but with substantial informal support.
- (iii) The increase in the ratios of median costs in the critical interval groups to the corresponding long interval groups.

Of course, the interval need categorisation is highly general, and other indicators might show differences in the detailed pattern. Also there are big variations in targeting between authorities, some retaining patterns more like those of the mid-1980s. The 1995 cohort study showed that at the initial assessment, targeting was more focused on those of higher interval needs in the shire counties, though the shire counties included one with a tradition of spreading resources to maximise cover. In the shire counties, 44.7 per cent of the sample were of critical interval need when the classification is based on data from the interview with care managers; in the other authorities, only 30.5 per cent. In contrast, only 27.6 per cent of the shire county cases had long interval needs, whereas that was so for 42.8 per cent of the other sample

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<sup>3</sup> The proportions of users in each category has been based on data from the user interview, partly in order to achieve comparability with the published analyses of the number of users by category in 1985. The distributions differ partly because workers tend to report more user needs than do users themselves. Davies, Chesterman, Fernandez and Saunders present comparisons based on alternative bases for classification (1997).

(Davies et al, 1997). Slightly earlier, a study concluded that authorities tended to spread their resources thinly, finding it difficult to refuse services (Association of Metropolitan Authorities, 1995). Nevertheless, these results give quantitative estimates of what all have alleged: a redistribution towards those of higher dependency.

- *Neglect of principal informal caregivers.* Table 1 also suggests a switch of resources to those with substantial informal care. (i) Four out of five users have substantial inputs from a principal informal caregiver in 1995/6, compared with three out five in 1985. There have been increases in the proportions with a principal informal caregiver in the critical and short interval need categories, and falls in the proportions without a principal informal caregiver. (ii) The post-1995 phase of the cohort study investigated the rationale and assumptions underlying the assessments and care plans with care managers for a subsample of 198 cases. The interviews showed that for 57 per cent of the cases, the carer was expected by the care manager to be a beneficiary of the plan, the carer being the sole beneficiary in 12 per cent of cases.

The patterns of caregiver inputs has been extensively analysed. The burden is clearly established. The most dramatic evidence is the pattern of distribution of indicators of stress feelings and symptoms. Column 2 of Table 2 shows the distribution of Rutter Malaise scores for principal informal caregivers shortly after assessment for the 1985 and 1995 cohorts. The inventory was developed to screen in persons for face-to-face psychological assessment. Rutter described a score of 5 or 6 as indicating stress. Rutter describes a score in excess of 6 as 'severely' stressed. Of the caregivers, 55.5 per cent were 'stressed' and 36.5 per cent were 'severely' stressed. Not all of the circumstance-induced stress was due to caregiving, and the perception of stress is influenced by personality and other factors as well as external stressors. Nevertheless, the distribution is powerful evidence that post-reform

targeting provides help for many principal informal caregivers suffering great stress.

- *Low impact of community-based services on unwanted and inappropriate admission to institutions for long-term care.* The scepticism about the effects of home care on admissions to home care was taken up by the Audit Commission (1986).

One reason for the scepticism was that the amount and nature of the services were unlikely to affect a high proportion of those at high risk of admission to institutions. That was strongly suggested in studies of the pathways, processes, and assumptions which influence who gets what, when and where (Davies et al, 1990; Hunter, McKeganey and MacPherson, 1988; Sinclair and Williams, 1990). Probably less than one half of persons admitted to residential care had not previously been recipients of community social services in the mid1980s. The probability of a person receiving community social services being admitted might have been less than 10 per cent over the subsequent 2.5 years (Davies and Baines, 1994).

That in part reflects the low probability of those targeted being at high risk of admission to homes, irrespective of whether they received services. But it also reflects the impact of community services on that probability. The first cohort study found that substantial proportions of recipients stated that but for the services they would probably have had to enter a home (Davies et al., 1990). But such statements are not necessarily correlated with actual risk of admission; and the study showed few effects of variations in inputs on, for instance, capacity to perform acts of daily living.

It also reflects that amounts provided were inadequate for many at high risk of entry. The criticisms were many. They have also been made about the service agencies in other countries in which home care services have grown without constant monitoring to direct effort at priority tasks; for instance,



France (Commissariat générale du plan, 1991). Services tended to be available only during office hours. Only from the mid-1980s did they increasingly undertake personal care tasks of particular importance to persons at higher risk of admission to residential care. Inputs were not fitted around the time structures of informal caregivers, and what they could and would do. The user had too little influence. Most received little service. Too few recipients were receiving packages whose costs were a substantial proportion of costs in residential care. There was a large gap between the costs of what persons at high risk of admission to homes would receive at home, and costs in residential care. For the users in the 1985 cohort study with critical interval needs and principal informal caregivers putting in substantial inputs at initial assessment, the probability of admission to institutions for long-term care over the subsequent 2.5 years was 28.0 per cent. But even in this group at high risk of admission to institutions for long-term care, only 10 per cent had a package of community social and health services whose combined costs were in excess of 50 per cent of the costs of residential care (Davies et al., 1990, Diagram 14.2). The gap remained after the cost figures were adjusted to compare the costs of the alternative modes more precisely.

The situation is now very different. That is illustrated by the results of the second phase of the before-after cohort study. The distribution of package costs at the beginning of the Continuing Care Period following initial assessment, care planning and care arrangement, is even over the entire range of cases up to and beyond the costs of residential care (Davies and Fernandez, 1997). Almost 20 per cent of cases had package costs in excess of 60 per cent of residential care costs. There is other evidence that richer and more flexible packaging is offering the opportunity to receive adequate care outside homes for those previously greatly at risk (Audit Commission, 1996; Department of Health, 1996). The second stage of the before-after cohort-based evaluation found that the effects of the packages were strongest in those authorities where managers judged that the most important priority among seven in their authority during the early phase of the reform had been

offering more users the chance to stay at home (Davies, Fernandez and Warburton, 1996).

An important reason was that there were periods during which the growth in expenditure on home care was taken up mainly in increasing unit costs, with 'intensity', costs per head, if anything falling, and 'cover', the proportions of those at risk receiving service, at best remaining constant (Davies, 1993A). The rise in unit costs was shown to be general to a wide range of community care services during the 1980s (Bebbington and Kelly, 1995). The progressive fall in intensity actually started during the 1950s. This is a problem frequently encountered in other countries. It has been shown for Massachusetts home care and for France, where the Schopflin Report likewise complains of 'saupoudrage'; the light 'sprinkling' of services with doubtful outcomes (Commissariat générale du plan, 1991).

Figure 1 graphs the change in Cover, Intensity, and Unit Costs for home care brokered by the social services departments from 1985/6. They are based on CIPFA data, and reflect the lack of standardisation and other problems of the returns to the CIPFA. So the graphs and rates of change are only approximate. But some trends are clear.

Intensity, the number of hours received per client, is the indicator of the concentration of resources on fewer persons. The increase in intensity suggested by Diagram 2.1. of *Resources Needs and Outcomes* for 1982 to 1984 continued for another year, but then virtually stopped until the end of the decade. Intensity increased during the first two years of the reform, from 1990 to 1992, at a much faster rate than during the early 1980s. The rate of increase doubled during the first two years after the Appointed Day.

Unit costs at constant prices - that is, deflated by the Blue Book's index of total home costs - escalated rapidly during the second half of the decade. The rate of increase of 10.7 per cent per annum was greatly in excess of the rate in

the previous two years (1982/3-1984/5), approximately 2.9 per cent. So, even with a substantial rise in gross expenditure, Cover fell rapidly. When the rate of increase in Unit Costs eased, the rate of decline of Cover fell, but the rapid fall continued during the two years after April 1993, when the new legislation took full effect. In effect, the rise in expenditure (net of charge in come) and the decline in Cover paid for the increases in Intensity and Unit Costs. However, both Intensity and Unit Costs could rise fast simultaneously only during the last two years, when expenditure was rising fastest. So the reforms were accompanied by increasing intensity at an accelerating rate.

But the increasing intensity was not accompanied by a reduction in admissions to residential care during the period for which the DoH returns provide information about admissions to all homes, not just to authorities' own homes. The number of admissions increased during each of the three years from 1994 to 1996, the same period during which the intensity of home care provision increased most. In relation to the population aged 75 and over, the increase was lower (5 per cent) between 1995 and 1996 than between 1994 and 1995 (9 per cent). Overall, the increase in admissions between 1994 and 1996 was 17 per cent. Likewise, although the total number of residents remained virtually the same between 1991 and 1993, there was a net increase by 2 per cent between 1993 and 1996. The increased intensity of home care may have had an immediate effect on shortening length of stays in homes, but not, it seems, on reducing the number of admissions.

And in real terms, weekly unit costs for supported elderly residents continued to rise from 1990/1 to 1994/5, though at a lower rate than during the 1980s. The pattern of geographical variation suggests that the trend may be reducible. There were wide differences in the percentage change in unit costs between authorities, the authorities having the highest initial unit costs appearing to have higher increases in unit costs than authorities average lower initial unit costs (Department of Health, 1997, Figures 10, 24, and 25).

Some of the policy questions raised by these findings must be faced (Davies, 1993B; Davies et al., 1990; Bebbington and Kelly, 1995).

- *Generally low marginal productivities of services.* The escalation of unit costs and falling ratios of quantities of service actually received by users per unit of input discussed immediately above should be distinguished from the effects of the services users receive on outcomes of evaluative importance; the productivities of service inputs in relation to 'final outputs', outcomes of value in their own right. The first of the cohort evaluations showed that marginal productivities of services for such outcomes were not high enough to seem large, given the measurement and specification problems inherent in the estimation of productivities with respect to final outputs in all the human services (Davies et al. 1990)<sup>4</sup>. But productivity issues are vital, it was argued. First, the logic of the 1989 white paper was based partly on using more of the resources to create more expensive packages for those in most need; particularly, by implication, those for whom the expensive packages would reduce the probability of using homes. The opportunity cost of one package costing the same as residential care was estimated to be seven persons obtaining the standard input then consumed by most. So the low marginal productivities of services threatened the viability of the policy. Secondly, raising probabilities is more difficult than improving targeting. The improvement of productivities would require changes in micro-structures and procedures, such aspects of the technology of care as information and quality control devices, assumptive worlds, values and skills.

Preliminary results of modelling for the 1995 cohort suggests some substantial marginal productivities. In particular, there is preliminary evidence that some of the services have substantial marginal productivities for the number of days adequately maintained in the community and for the reduction of caregiver stress. There is important process evidence showing

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<sup>4</sup> Only preliminary estimates of marginal productivities have been computed for the 1995 cohort, so that an exact comparison cannot yet be made with marginal productivities for the 1984/85 cohort.

why there should have been increases in the marginal productivities of services. One is the strength of the consensus about what had been the most important outcome aimed at in the authority shown by interviews with 134 managers in the ten departments. The consensus was across authorities and at all levels for the period preceding the recruitment of the 1995 cohort. Providing 'a real chance for more users to stay at home rather than enter a care home' was rated first. 'Empowerment, choice and control over their own lives' and 'Support for family carers to enable them to have respite' were ranked next. This consensus around goals directly relevant to the outcome indicators provided the goals. The most important mechanism for making those goals affect outcomes were the new arrangements for performing the core tasks of care management and assessment. The Chief Social Services Inspector describes what a major task authorities faced in developing them as 'the cornerstone of high quality care', and how authorities are increasingly effective in the as they learn from experience (Laming, 1997, paras. 3.1.-3.7.). Many authorities were indeed slow to start developing them before 1993 (Glennerster and Lewis, 1996; Gostick et al., 1997). But there has been great and continuous effort over the period as a whole, and in many authorities real change for a high proportion of users. These results of exploratory production function modelling also fits with other evidence from the study of the 1995 cohort. But the results are certainly not yet firm.

Together with targeting issues, the handling of the dilemmas in the steering of community care should critically depend on the evidence about what productivities are and could be. That can be seen from a consideration of some of those dilemmas.

## **2. Key dilemmas**

### **2.1. Dilemma 1: Prioritising goals and users**

The prioritisation of groups of users is one aspect of the prioritisation of potential benefits.

One perspective on the dilemma is prioritising

- the provision of a greater number of persons with the opportunity to be helped to be well cared for at home rather than having to enter residential or nursing home: the '*adequate care at home, not care in a home*' criterion.

**versus**

- the response to a high degree of what the Audit Commission called 'high public sector dependency': a high degree of incapacity to perform acts of daily living without help or supervision in the absence of an informal support network who could (or could be expected to) cope with it without social services help: the '*palliative help*' criterion

**versus**

- the response to the high public sector dependency of some while maximising user and caregiver gain from the public budget for others: a mixed '*palliative help and investment for later gain*' criterion.

The first and third are investment-focused criteria: front-ended effort and resources are often required in order to achieve better welfare outcomes and lower costs to public funds later, and so over the lifetime. The second is an immediate consumption criterion.

Empirical analysis of the patterning of needs, resources and outcomes in pre-reform community care showed these criteria to imply the prioritisation of the needs of three different, albeit overlapping, groups (Davies et al., 1990; Davies and Baines, 1997B).

*Investment for later gain.* It was clear from experimental evidence about care-managed community care that palliative support and the provision of good care at home not in homes are far from the only gains from community care inputs. There can be gains to the user in the form of improved morale, an extension of time with good care in the community, and other effects. Similarly there can be gains for informal caregivers. Analyses of pre-reform programmes of case-managed care shows that the highest ratio of such gains to costs are often obtained from low expenditures on persons who are not heavily disabled (Davies and Chesterman, 1995). One strategy compatible with the results would be operating to combine a stringent ADL criterion in the absence of other expected gains with the freedom of teams to recruit users on the basis of anticipated gain/cost ratios, subject to regular retrospective accountability for the gain/cost ratios achieved.

For some cases, the investments required to achieve the gains require only social services inputs: activity to improve the morale of users who are not clinically depressed, to support the informal network and provide reassurance that their liability is limited as the user's disabling disease progresses are examples. Others depend on a degree of jointness of care planning with professionals from other agencies, particularly the health services. The networks of contacts during the Set-Up phase<sup>5</sup> of the care managers of users in the second cohort, and their goals and expectations about the care plan, may well reflect a handicapping vagueness about possibilities for investments involving collaboration between health and social care which is found at every

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<sup>5</sup> The Kent Community Care Project and its replications showed; (i) the relations between resources, needs and outcomes to be very different between the Set-Up phase [SUP] and the ensuing period of Continuing Care [COCA]; (ii) a higher proportion of costs to be due to care management during SUP, much of the care management activity being undertaken to achieve a stream of benefits during COCA, and (iii) relations between resources, needs and outcomes varied with need-related circumstances. The evaluation of SUP care management inputs must be looked upon substantially as investment appraisal. The yield from the front-ended investments depend in part on the gains during each week of the subsequent COCA period, but mainly on the duration of the COCA period, that being more variable between cases. The Kent Community Care Project and its evaluated replications in Gateshead, Sheppey and Tonbridge showed big changes in client costs in one direction or another during the COCA period, so complicating the analyses (Davies and Chesterman, 1997).

level in the community care policy system. The care managers' contacts with the health professionals are those with narrow care functions. Direct contacts with physicians, even general practitioners, are notable for their rarity. Their expectations about the degree and manner of the impact of the care plan on users' independence do not suggest an investment approach based on jointly coordinated investment for all the cases for which that would be appropriate. For 77 per cent of cases, the care managers expected the planned intervention to impact on independence, but only by preventing further deterioration or in other ways suggesting palliation rather than substantial improvement. For only 7.7 per cent of cases was full recovery of independence expected. Working from multi-disciplinary teams with health workers was a rarity (Davies, Fernandez, Milne and Saunders, 1997).

*Joint health and social care production and investment.* This fits badly with the increased potential for medico-social investments. Cases selected for social services concentrate populations presenting opportunities for medical investment. Recipients of community social services have high probabilities of presenting opportunities to secure timely interventions (Banerjee, 1993a; Banerjee and MacDonald, 1996; Bond et al., 1993; Clossie et al., 1995; Iliffe et al., 1993; Lindesay, 1990; Saltz, 1992). For instance, the argument has been put for some persons with clinical depression, for persons with incontinence, stroke victims, and persons with fragile care networks. They are also conditions for which there is evidence of a wide gap between the most appropriate treatment and what is now obtained by many.

Likewise, many of those on whom the health services have made a potentially productive investment depend on the adjustment of the nature and timing of the social service input for the investments to pay off.

For some users, missed opportunities for timely medical treatment are lost for ever. The window of opportunity in some conditions can be counted in hours and days rather than weeks and months. Timely contact is much more likely



if there are daily observers sensitised to crucial signs and symptoms. Secondly, for some users, missed opportunities for timely medical treatment cause heavy demands for chronic health and social care. Much of the functional incapacity which contributes to the need for publicly-subsidised community care is due either to missed opportunities for timely and cost-effective interventions or to failures of adjust the temporary or permanent after-care in such a way as to permit the gains from the investments to be made. Thirdly, the success of outcomes from treatments can be jeopardised by inadequate or inappropriate social care. Despite major improvements during the last decade, there is evidence that the content and nature of the social services insufficiently complement the medical plan for rehabilitation. Fourthly, changes have created opportunities for new field delivery models. For instance, the field organisation of geriatric practice is uncertain and changing fast. Changes in primary and community health are creating new opportunities. There are interesting examples abroad; for instance the PACE experiments based on On Lok (Ansak et al 1989; Branch, Coulam and Zimmerman, 1995; Zawadski and Eng, 1988; Zawadski et al, 1984; Eng, Pedulla and Eleazer, 1997)<sup>6</sup>.

Around the world, there are projects exemplifying models providing a range of variation from negligible coordination, through collaboration, to a high degree of field integration. The higher the degree of coordination/collaboration/integration, the higher the investment cost of changing attitudes, procedures and practices everywhere, as is abundantly clear from the evaluation evidence. Models in which physicians are proactive hands-on leaders of small teams are necessarily expensive if the teams provide long-term managed care intensively and continuously. Such models would require larger numbers of physicians with the appropriate professional backgrounds and commitments

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<sup>6</sup> The model is a 'carve-out' managed care model financed largely by capitation payments from public funds, filling financing gaps in a way which provides constructive incentives for those for most affected by the divisions of labour between acute and long-term, health and social care. It reorganises the division of labour in a way which is more cost-effective for the group at which it is targeted. See Davies (1994A).

than would now be available given other demands for their services. The British Geriatrics Society has only 1800 members in all. Some American models also have features which suggest high recurrent costs; for instance, the staff:user ratios in PACE projects are approximately 1:2 (Eng et al., 1997). And models providing more rather than less integration require particularly costly investments in the British context, where the divisions of labour between health and social care are so long-standing, and have created larger areas for independent action by social care personnel at all levels.

Fortunately, users actually require widely varying degree of coordination/collaboration/integration. The circumstances can be crudely ranked in ascending order of coordinative/collaborative input.

For some cases, the required investments at the individual level can be carried out with great success by the social services departments themselves; for instance for many cases with fragile care networks (Davies and Challis, 1986; Challis et al., 1989). For such cases, intensive care-managed care has been shown to have great potential in British experiments. For a second group, the investments can be undertaken by the health services, but cases tend to present themselves in a timely way, and the social services after-care required can be handled effectively given clear inter-agency agreements and the detailed local protocols for which the DoH has been pressing.

For a third group, the investments depend on timely medical and health-related interventions, but require little coordination with social services beyond the recognition of signs by the personnel in day-to-day contact with the persons at risk, and appropriate referral through well-oiled machinery to a part of the health system which reacts appropriately and in good time. Success in this requires clear policies and protocols, and good working relationships with social service personnel at the field level. The long history of mixed success suggests that perfection is unlikely to be attainable. But much lower investments in improving them are as likely to pay off well than are

required to create new team structures for the higher level, and the closer coordination/integration described below<sup>7</sup>.

But for a fourth group, there must be more than coordination within short response times. Often the users will suffer from unstable medical conditions, or vulnerable to sudden changes which if not reversed immediately do irreparable damage. The timing and nature of the social services intervention must be fitted into the timing and nature of the health system intervention. In these circumstances, the distinction between coordination and collaboration breaks down with respect to some activities. Tasks can so overlap as to require redefinitions of the division of labour. It is arguable from the literature that the highest degree, and most immediate responsiveness, of coordination and collaboration requires the internalisation of the coordinative/collaborative processes within teams with a high degree of interaction and systematised and time-consuming means for sharing and interpreting information. There are descriptions of expensive multi-disciplinary teams providing time-consuming systems with frequent multi-disciplinary review of each case. It would be wasteful for these overhead costs to be faced for those not needing such close and immediate collaboration.

Selective development of field models for handling the fourth group is an important priority for the UK. The models would have a large physician input, if not be physician led. The whole point is that there is the range of skills available for hands-on work operating in harness around the case at the field

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<sup>7</sup> Examples of such investments are training in assessment applying tools and protocols developed by national initiatives, embodying triggers and agreed procedures for the involvement of other professions and agencies within a national framework of policy for the divisions of labour. Most Australian multidisciplinary Age Care Assessment Teams [ACATs] stop far short of covering the whole range of care management tasks and providing continuity in the care management function, but they cover all users facing certain risks and transitions. Such a model might not be sensible for all users in the UK, given the history of our development; for instance, 92 per cent of the ACATs in one study were hospital-based (Kung, 1996). But more than one half of persons commencing an episode of care at home or in homes brokered and subsidised by the social services are being discharged from hospitals, a higher proportion if those being discharged to nhs-financed continuing care are included. It is important to learn from such models because of the risk of investment opportunities and the prevalence currently of misplacement in inappropriate and needlessly expensive settings.

level. The models should ensure continuity and incentives to balance costs and benefits across the whole span of acute and community, health and social care. The development of such models would require large investments. They would distract from worth-while development more consonant with existing structures. We should carefully distinguish the markers for each group, and target carefully at them. They should be carefully piloted and evaluated before authorities are pressed to apply them to large populations. Were they to be developed too quickly, without careful description and evaluation, without the use of prototypes as teaching and learning centres (like the Long-Term Care Gerontology Centres and their successors in the USA), there will be an even larger gap between achievement and potential than exists with our current structures.

*Care management arrangements and investment for gain.* That investment opportunities have not been appreciated is reflected in the new structures for care management.

One aspect is that an unnecessarily crude logic has been applied in the local design of care management principles. The thrust has been the creation of straightforward service with the requisite performance of core cm tasks for the majority of users; the equivalent of primary care. The DoH guide encouraged authorities to recognise secondary care in the form of intensive and complex care management and the Department of Health has repeatedly pressed the concentration of complex assessment on fewer cases (Department of Health, 1993; 1994; 1995; 1996A and B). However, it did not press the argument made in *Matching Resources to Needs* for specialised teams centred on the care management functions targeted at persons in different circumstances; an argument later elaborated into a logic for matching care management arrangements to the varying needs of subgroups of users passing through key junctions in their journey through the care systems (Davies and Challis, 1986; Davies et al., 1990; Davies, 1992). There is some evidence which suggests that for some, there might be benefits in having more specialised

secondary, even tertiary, level teams. A wide range of care management arrangements and parameters' would differ between the teams; including skill mixes, budget limits, average service budgets, organisational locus and auspices, and caseloads. The international literature shows that the choice of setting on each dimension has its own impact, and each dimension complements, or is an alternative to, the others (Davies, 1992). The fitting of these dimensions to local priorities, user circumstances and local situations was a main principle in the design of the PSSRU's experimental programme on care management. What has been implemented is crude: the triaging of users into simple and 'complex' cases, sent for one of two levels of assessment. In practice, British practice has reduced the dimensionality excessively. Presumably, this reflects the slow absorption of what are still new logics, although logics which have been made available in forms intended to be accessible to policy-makers.

A second aspect is that the focus of the changes to care management arrangements have been those for the Set-Up period: from screening through to the establishment of the first complete care plan expected to be of indefinite duration. However, the circumstances of substantial proportions of users are expected to continue to be volatile. There are users for whom the care management investment is not just needed initially, but repeatedly, and by persons who have followed the case through time. Care management inputs made specifically in response to volatility and change were shown to be productive in British care management experiments (Davies and Chesterman, 1997). Research evidence is accumulating that in most authorities, few users receive intensive, skilled and continuous care management. In the authorities studied by the second cohort study, the proportion is lower than would be expected to have changes requiring intensive care management activity<sup>8</sup>. It is

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<sup>8</sup> But it is also the case that there is great variance in what care managers report to be the amount of time they devoted to each case for care management purposes at the beginning of the COCA period with a coefficient of variation of 2.37; larger than the big relative variance in care management costs during SUP with a coefficient of 1.00 (Davies, 1997).

not that nearly all of the users are expected to receive home care for only a short period. In fact, the proportion still receiving home care after 97 weeks is 39 per cent. That is lower than the 53 per cent for the 1985 cohort, but not a small minority.

Thirdly, authorities have failed to see the wood for the trees in the implementation of care management argument. The essential prerequisites for care management to have the greatest impact had long been established before the reforms were designed. Examples are due weight to the effective performance of the core tasks of care management for everyone to the requisite degree given the resources available - that is, inputting care management only to the extent that the ratio of marginal benefits to marginal costs suggests; triaging of those for whom the productivities of care management would be particularly high to care management arrangements appropriate to them applying grounded risk markers and/or the insights of those with close contact with existing cases; routines for the review of the performance of teams involving senior care managers from elsewhere, and procedures for the insights from senior field care managers to be fed into the development of authority-wide care management policy, including targeting; knowledge about local costs and resources; methodologies for allocating the service and care management budgets between teams in ways which took account of the implications of continuing caseloads; argument about the design of care management arrangements for user subgroups in the context of priorities and local systems. Being developed in evaluated practice, there was a great deal of detailed empirical knowledge about what these meant in practice. This was not systematically followed through in the implementation process, so leaving more gains still to be made by investing in systems.

*Setting the parameters of users' choice of care at home.* The evidence clearly indicates the dangers of over-commitment to the 'adequate care at home not care in a home' criterion. One reason is that the reasons for its selection have usually been more that they would gain the support of policy constituencies

than they reflect the patternings of needs, resources and outcomes, and their causes: reducing the dependence on the dreaded nursing home and promising a slower escalation of costs to public funds in the United States; perhaps an appeal to social service constituencies consonant with the broader rhetoric of independence in the UK.

Over-commitment to this criterion has slowed analytic and policy progress in the United States. The exciting history of American long-term care argument is packed with experiments which seem to have failed. The reason is their choice of criterion for evaluating whether case-managed home care would be worth while. The criterion has been whether it so reduces the probability of admission to nursing homes as to reduce spending from the relevant public budget (Davies, 1986A, 1986B, 1989; 1992; Davies et al., 1990; Kemper, Applebaum and Harrigan, 1987; Weissert, 1987). For many of the projects for which data and their analysis allowed the adoption of other perspectives, there was substantial evidence of success by alternative criteria (Davies, 1992; Greene et al, 1993; Rabina, Mutran and Stearns, 1994; Rabina, Stearns and Mutran, 1992; Weissert, Cready and Pawelak, 1988). At least, the British evaluations used criteria which provided a more balanced basis for assessing the potential of the new care-managed community care.

Hopefully, the heavy emphasis on the 'adequate care at home, not in homes' criterion will not trap policy development in the U.K. Authorities have adopted this criterion. It was one of the most important promises of the policy of 1989. Evidence from interviews with 132 managers for the second phase of the before-after evaluation showed that of seven goals presented, managers on average rated 'choice for service users to stay at home rather than enter a care home' the most highly rated priority for their authority during the early period of the reform immediately prior to the recruitment of the 1995 cohort. It was thought to have been the authority's most important priority among managers at all levels: senior, middle, and field. It came a close second for the second phase, also; and was interpreted to be at the top of their authority's priorities

among field managers. Local priorities impact outcomes: variations in the strength of the consensus about the importance of that priority was among the significant predictors of the post-assessment triaging of persons to homes or to care at home (Davies and Fernandez, 1997).

One well-explored reason to avoid entrapment by the care at home, not in a home priority is to avoid inequitable burdens on caregivers. The third column of Table 2 shows substantial proportions of principal informal caregivers to be predicted to suffer severe stress six months after assessment. The proportion had not been reduced. In the evaluation based on the 1995 cohort, care managers thought that the interests of caregivers and users were in conflict in 21 per cent of the cases with principal informal caregivers making at least substantial weekly contributions. The probability of admission to residential care is one outcome affected by the conflicting interests of users and caregivers. We find that where the care manager describes the consequence of caring to be engulfment, there is a higher probability of admission to residential care at the end of the Set-Up period of assessment and care planning (Twigg and Atkin, 1994). Again, we find that at higher levels, variations in the Kosberg carer burden scale affect the probability.

Changes of the last decade have also has sharpened the need to prioritise the criteria, two in particular: adequate care at home not in homes, and palliative care with investment in welfare gain.

First, services are more tightly targeted now. The danger of failing to serve those who would qualify by any reasonable weighting of criteria has grown. The danger of serving persons who would not has diminished. Those submitting evidence to the 1996 report of the House of Commons Social Services Committee on long-term care expressed anxiety that those who should qualify for subsidised service had a much lower probability of getting it (House of Commons 1996A, 1996B). Some may have understood this to mean that those being deprived were those who a decade ago would have had a



standard allocation for the performance of tasks which the user judged themselves capable of performing, although the providers did not think there to be a high probability of dire consequences if the services were not performed. Such cases obtain service in fewer authorities<sup>9</sup>. Those now with diminished probabilities of allocation are cases with much greater public sector dependency.

Secondly, the upward drift in the unit costs of care inputs have made it more important not to lose economies of scale and concentration for fear of facing the dilemmas of providing choice to users. So the dilemma posed in *Resources Needs and Outcomes* remains the same, though improved marginal productivities may have changed the relative importance of the reasons for it. The upward drift may have been approximately 3 per cent per annum (Bebbington and Kelly, 1996). To countervail this with rising service productivities over a long period is a formidable challenge. Again, slack has been reduced in residential care. The expensive care in long-stay wards has almost disappeared. The valid cost comparison is no longer with them, or with the Department of Health's high cost nursing home experiment as it was for the Darlington experiment, but with independently-provided nursing homes. Though due to an unestimated extent to lower wage levels in the private sector, the Department of Health suggested a fall in prices in independent homes in the early 1990s (Department of Health, 1996). The break-even level which equalises care costs to public funds in homes and at home is likely now to correspond to a smaller number of care hours. Depending on the level set, the introduction of a minimum wage might further shift the break-even point. On the other hand, the reintroduction of employment generation, and the net increase in tax yield caused by it, to define a more stakeholder-based set of appraisal criteria, would shift the break-even levels in the opposite direction.

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<sup>9</sup> Nor should they, given existing pressures. The Audit Commission argued that case to be untenable a decade ago, and there was little firm research evidence to suggest that an investment appraisal of that input would in general have been favourable (Audit Commission, 1985; Davies et al., 1990). The task must be to see whether there are risk factors which will allow targeting on those for whom the investment will be worth the opportunity cost of care foregone by others.

The inputs of caregiving hours in home care studied for the second cohort of the evaluation study suggests that employment effects could be highly sensitive to changes in the balance of care. If there is a sector in which we should think laterally about how to make a virtue out of post-modernist ideas and opportunities, it is in the encouragement of care in the community<sup>10</sup>. What is less clear is that those brought into employment would be those whose employment is the highest national priority. The French experience has been disappointing, though recent changes condemned there as inadequate may actually have created stronger incentives to combine care inputs more innovatively than the more ambitious plans which their commitment to joining the single European currency had forced them to abandon (Davies, Fernandez and Saunders, 1997).

It will be important not to fudge the comparison between costs at home and in homes, and not to avoid the difficult questions which the comparisons raise. Research has shown authorities increasingly applying cost caps to their subsidisation of home care, but considerable variety in how the cost caps compare with the price of the marginal unit of residential care in their areas (Audit Commission, 1996, Exhibit 7). Research has shown that supply curves both for residential and home care slope upwards, and have different shapes and levels between authorities (Audit Commission, 1996; Davies et al., 1990). The variation is likely to be very local. A logic for computing guideline budget caps for budget-devolved care management taking local supply curves into

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<sup>10</sup> The service organisation set in the public bureaucracy increasingly dominated by new managerialism is not the most promising environment for post-modernist flexibility. This was illustrated by the fate of some of the communitarian developments of the 1960s. It is also illustrated by the history of the descendants of the Kent Community Care Project. The Kent Community Care Project was managed by those with a fierce determination to encourage the care managers to procure care from whatever sources were most effective and efficient, subject to equity. That was less true of its descendants. Each generation became more orthodox in the range of sources tapped. Whereas learning was continuous in the Kent Community Care Project, the relations between resources and outcomes being much more favourable at the end of the experiment than at the beginning, the best of the replications (the Gateshead scheme), whose members served their apprenticeship in the Kent project at the end of the experimental period, and so when it was most efficient, managed to achieve only the mid-term efficiency of the Kent Project. The Sheppey and Tonbridge projects did worse. (Davies and Chesterman, 1996).

account has been worked through (Davies, 1990). But local cost and price information is patchy. An inspection concluded: 'direct provision of information for staff use was ... limited. Arrangements for ensuring that service option information was available to staff in a form which was useful, complete, accurate and up to date, were limited.' (Department of Health, 1997, para 3.14). Some forms of investment are prerequisites for the logics to be applied in practice: detailed accountancy, better information systems, the devolution of budgets with arrangement in which the care management team faces the opportunity costs and benefits of its allocation behaviour, within budget ceilings and other arrangements (like the rigorous review of targeting) designed to prevent the decisions from being primarily cost-driven. Fudge tastes good to local managers. But it is costly in lost welfare.

*Guidance about targeting.* Clear guidance is not provided about the prioritisation of users of varying need-related circumstances in the community care plans, statements of eligibility criteria, manuals for care managers, or other sources of guidance to which care managers and their managers can turn (Davies, Chesterman, Fernandez, and Milne, 1997). (Indeed, departments' eligibility criteria quite frequently juxtapose completely opposing principles, supporting both with apparently equal commitment.) Such statements often float at a higher level than the competing goals embodied in the formulation of the dilemma. Statements at that higher level are not without an at least implicit rationale. It is that human needs are too complex to reduce to formulae without the risk of decreasing, not improving, equity and efficiency; and that the emphasis should therefore be on the instruments of control associated with professional service organisations. As a senior manager wrote:

'I am, in general, not in favour of tightly drawn criteria for services as no detailed criteria can cover the range and complexity of most individual situations. This Department has ... focused on training and managerial support which encourages improved judgements by

prioritising as to how services can best be utilised to meet assessed needs to ensure reasonably consistent and effective interpretation of the Departmental principles and priorities.'

This argument fits well with the traditions of the British social services department. It is powerful as long as the training, monitoring, and support is of the requisite thoroughness, and as long they are consistent with other features of values, policies and procedures. What is not so clear that is that it sufficiently succeeds in reducing unjustifiable variations in who gets how much of what. It is more likely that the eligibility criteria now current in the U.K. standardise too little than they lead to inequity and inefficiency through over-standardisation. For instance, only 50 per cent of the care managers of the cases in our 1995 cohort study claimed that the problems addressed by the plans for the case under discussion fitted the authority's eligibility criteria to a 'very considerable extent'; 85 per cent to at least a considerable extent. The greatest departure from conformity appears to be for those with short interval needs - understandably, because they are not necessarily the persons who have great functional handicap, but are often complex cases.

The more careful attempts to increase the standardisation of assessment and care planning decisions in home care illustrate both that the eligibility criteria must be more complicated than some of the simpler scoring or categorisation devices, and that workers require training in their use (Austin, 1995; Charles, 1992; Coopers and Lybrands Consulting Group, 1994). Functional incapacity is overemphasised in assessment documentation compared with other factors, researchers and the SSI argue (Challis et al., 1996; DoHSSI 1995, 1996). Research has demonstrated that during early stages of the attempts to achieve greater standardisation of allocation, this has been a problem in other countries also: for instance, the USA, and France with its national AGIR *grille de dépendence* (Decker, 1982; Jourdain et al., 1996).

## **2.2. Dilemma 2: Balancing direct provision and cash for care**

There is a division of policy responsibility, and so the lack of coordination of policy means, between some social security benefits whose purpose is to meet community care needs, and the brokerage- and supply-dominated economy centred on the social services department. Replicated data bases have been used to estimate the effects of the British attendance allowance and the French *Allocation ompensatrice pour tierce personne*, the ACTP. The ACTP is much more part of the armoury of financing mechanisms for community care (Davies, Fernandez, and Saunders, 1997). We argue that it has worked better in one important respect: combined with optional brokerage help, it has more successfully contributed to reducing the probability of admission to French institutions for long-term care. The British local authorities used the attendance allowance to merely shift the burden of finance. The ACTP had real consequences on community care.

Many of the dilemmas of British Direct Payments, which should have been recognised as potential dilemmas for an extended attendance allowance, will be those of the discussion of the French ACTP, and the PSD which is to replace it for elderly beneficiaries. ACTP and Direct Payment models share their well-known dilemmas with the American development of so called consumer-directed programmes: the central trade-off between user security and user autonomy; the trade-off between more formal employment and the sponsorship of quasi-informal paid activity; the trade-off assumed in France and the USA between lower costs of care and more predictably adequate standards; the dilemmas of defining who should be eligible, indeed be required, to be served by what assessment and care management arrangement.

As in all things, the potential as well as devil will be in the detail. The task is so to develop the arrangements and the technology as to make the choices less stark, to get a bit more of the better of both worlds. As ever, the

Americans lead in generating a literature (Cameron, 1995; Clark et al, 1991; Doty, Kasper and Litwak, 1996; Flanagan, Green, and Eustis, 1996; Lewis-Idema, Falik and Ginsburg, 1991). Of particular interest will be American Intermediate Service Models, because they help to avoid the creation of gaps into which cases can fall. Particularly, the spectrum variety offers powerful advantages, it now seems from research on the experiences of State officials (Flanagan, Green and Eustis, 1996).

### **2.3. Dilemma 3: Filling gaps in national 'trade-and-industry' policies versus relying on the new local 'self-inventing' community care authorities**

Trade and industry policies for a stakeholder society may require different emphases. The 1997 white paper proposed minimalist regulation (Department of Health, 1997). A new approach might be less dominated by new managerialist philosophy than the white paper. Directors agree that the incrementalist mould has been replaced more successfully than could have been envisaged without the new proactivity of the DoH and national quangos during the last decade. Most authorities would have been unable to achieve nearly as much without the DoH activity. But at no level of government has policy implementation achieved internal consistency across all sections and through time (Gostick et al, 1997). The absorption of new logics has been patchy. There have been the inevitable mistakes.

There there are some obvious lacunae in trade-and-industry policy. Investment in several would yield high dividends, and the need for them is widely recognised, not least in the government service. One detects less consciousness about one. For almost three post-War decades, arguably more, an important part of the trade and industry policy role of the central government was to attempt to extend the vision of providers, planners and others in individual types of service. In fact, the range was disappointingly narrow, and the impact clearly less effective than the interventions of the last

decade (Davies, 1997). During this decade, the focus has been more to make the community care authorities 'self-inventing'. There has been little emphasis on extending service visions as such. This can be seen at all levels in community services. It is even more striking in new concepts of shelter-with-care. In particular, there is none of the radical thought about new service concepts that one sees, for instance, in such creative American states as Oregon and elsewhere during the last decade. The importance of this vision is that it could contribute greater variety at a time when there must be greater attention to the development of shelter-with-care as budget caps press increasingly on levels of home care.

### **3. Conclusions**

Progress has been truly remarkable in many respects during the lifetime of *Policy and Politics*. International comparisons show that we have a good record in engaging the issues of ensuring community care for a post-modern global society and economy. There have been mistakes and distortions, but it is not too late to correct most of them. Now is a good time for a policy review as we collect and analyse evidence whose periods of gestation differ (Davies, 1994B). A review of policy directions is certainly needed. The paper has attempted to pick out some about which the argument is still rudimentary. Most of the issues are dilemmas, not problems. Their precise definition, and research effort to understand and describe what they mean, will add greatly to our capacity to handle them. But of course, like all the countries who take community care seriously, and who are in the middle range of OECD spenders in relation to the population at risk, we shall have the sense of living at the edge of policy failure however well we do so: the failures of being excessively resource-driven, and of under-investing in human and other capital in order to cope with immediate needs.

## Appendix 1

### **Need-related circumstances, care-manager-recognised supply constraints and the defensibility of influences on who gets how much of what in post-reform community care of elderly users of SSD-subsidised care management and services**

The analysis is based on the argument that influences on who gets what can have varying degrees of political legitimacy and paradigmatic defensibility. For instance, the literature allows the easiest defence of need-related circumstances **[NRCs]** central to argument about causes of welfare shortfalls in the 'ological and care professional literatures are most defensible. Avoidable constraints **[SCs]** on the quantity of resources which prevent the performance of statutory responsibilities and demonstrable causes of inefficiency are among the least defensible. Between them lie influences of debateable legitimacy and defensibility. Examples are deviations in the priorities of local councils from the national policy paradigm, and mediating variables with unclear normative interpretability.

The analysis evaluates the influence of indicators of varying levels of paradigmatic defensibility on who gets what in post-reform community care.

The data are for a subset of 196 users. The methods used are stage-wise ols, logistic, and tobit regression analysis. Indicators were entered in stages by domain, the domains broadly reflecting the degree of defensibility of the indicators. In one sequence, the order was from the most to the least defensible, the modelling tactics seeking to maintain the influence of the indicators from the earlier domains admitted. In the other, the sequence was reversed, and the tactics attempted to maintain the influence of the least defensible indicators. It was intended thereby to suggest the range of influence of domains whose influence is more and less defensible.

The results relating to three analytic foci are the most relevant to the paper's argument.

+ *Whether admission to residential care at the end of the SUP stage.* (i) The models suggest more ological defensibility than models predicting admissions after initial receipt of community services in the cohort studied a decade ago (Davies and Baines, 1994). (There is no comparable direct evidence for pre-reform care in the UK for persons admitted to residential care directly after assessment.) (ii) The only supply constraint to compete successfully reflected restriction of care managers opportunities to using few service sources. That occurred particularly in areas in which the authority discouraged the development of independent provision. (ii) NRCs are the most important influences. The influences include ADLs, IADLs, health problems, behavioural problems due to cognitive impairment, caregiver presence and user-caregiver relationships. They suggest that user and caregiver welfare are interdependent, partially incompatible, and traded against one another. (iii) As well as outcomes depending on aspects of the quality of the work of the care manager, as suggested by the DoH SSI (1995, 1996) inspections, the results suggest that care management arrangements may be influential. (iv) Scales based on managers' interpretations of local priorities and their achievement are also influential.

+ *Total weekly cost at the beginning of the Continuing Care Phase.* (i) NRCs account for a substantial proportion of the variance, nine indicators having effects significant at the 5 per cent, five at the .01 per cent level. One model set suggests that two SC indicators may increase the probability of entry to homes, being almost 5 per cent significant. Another variable which may reflect supply constraints has a highly significant effect. (ii) 'Care manager' background may be of influence.

+ *Who gets how much of what type of community service at the beginning of the COCA phase.* (i) The NRCs which dominate the pattern differ between types of service. A comparison of the



results of earlier analyses (but not yet the reanalysis) of the comparable study of a decade ago, suggest an increasingly clear and defensible division of labour between service types. User assertiveness is suggested to have an effect. (ii) One model suggests that the quantity of home care utilised reflects variations at the higher levels of carer stress (Kosberg score squared), and a clear negative correlation with the overall time input of the principal informal caregiver, but the other main NRCs relate to the user. More subtle caregiver NRCs and caregiver-user relationships affect the utilisation of day care and respite care. (iii) SC indicators have a small influence for some services. The stagewise models illustrate the importance of combining outcomes analysis with process evaluation, since reliance on the former could overestimate the influence of supply constraints, as care managers describe their frustration and anguish about the consequences of the constraints on what they can do for their clients.

*Source: Davies and Fernandez (1997) Who gets What in Post-Reform Community Care: Who Gets What in Post-Reform Community Care, PSSRU at the LSE and the universities of Kent and Manchester.*

## Appendix 2

### **Does stringent ADL targeting deliver the most equitable and efficient use of resources?**

The critique of the 1980s heavily emphasised the vagueness of local authorities' means and ends. Post-reform, local authorities' assessments have a heavy emphasis on abilities to perform personal care and instrumental activities of daily living, ADLs and IADLs (Department of Health, 1994; Challis et al., 1996). Insurance firms use these as the signs for entitlement to benefit. However, research has shown responsiveness of the allocations by social services departments to a much wider range of criteria. It has also shown that social services can create a range of benefits, including longer stays in the community with adequate care, judgements that shortfall in needs for help are reduced, reduced problems in the lifestyle of principal informal caregivers, and improved user morale (Davies and Challis, 1986; Davies and Chesterman, 1997).

The analysis examines three criteria for targeting given the size of the budget: the maximisation of welfare gain; the maximisation of the ratio welfare gain to cost; and the greatest reduction of unmet ADL and IADL need. The data are for 192 cases from the experimental groups of the Kent Community Care Project and its closest replications, the Gateshead, Sheppey and Tonbridge programmes.

The analysis suggests that the stringent application of targeting criteria based on difficulty in performing ADLs and IADLs is likely to exclude from service persons for whom the ratio of gains to programme costs are high. Gain/cost ratios are not highly sensitive to the relative marginal valuations of types of gain. Gain/cost ratios are moderately predictable from information available to care managers given skilled and thorough assessments.

Perhaps a combination of eligibility for service for many could be established with a stringent ADL + IADL criterion taken with cognitive impairment and behavioural disturbance, but field teams should be able to allocate part of their budgets to others on the basis of expected gains in relation to costs.

*Source.* Davies and Chesterman, *Does Stringent ADL Targeting Deliver the Most Equitable and Efficient Use of Resources?*, PSSRU at the LSE and the universities of Kent and Manchester.

**Table 1**  
**Package costs by interval need and**  
**whether supported by a principal informal caregiver**

<b>INTERVAL NEED</b> <b>and whether supported</b>	<b>Mean</b>		<b>Median</b>	
	<b>1985</b>	<b>1995</b>	<b>1985</b>	<b>1995</b>
<b>LOW NEED</b>				
Comm. hlth & soc.s				2.8
<b>LONG INTERVAL, Supported</b>				
Comm.soc.s	9.9	42.9	8.0	30.5
Comm hlth & soc.s	12.7	51.4	9.0	33.0
<b>Unsupported</b>				
Comm soc.s	10.4	19.4	7.0	13.5
Comm hlth & soc.s	13.9	42.3	8.7	17.6
<b>SHORT INTERVAL, Supported</b>				
Comm. soc.s	17.7	80.2	13.4	58.9
Comm. hlth & soc.s	22.3	92.0	16.1	75.1
<b>Unsupported</b>				
Comm. soc.s	18.6	70.1	13.6	54.5
Comm. hlth & soc.s	26.2	101.4	17.9	82.9
<b>CRITICAL INTERVAL, Supported</b>				
Comm. soc.s	18.3	122.4	8.9	95.5
Comm hlth & soc.s	31.3	158.3	17.4	124.2
<b>Unsupported</b>				
Comm. soc.s	25.4	138.8	19.3	118.0
Comm. hlth & soc.s	46.3	162.1	32.8	138.0

**Sources:** Davies et al (1990) *Resources, Needs and Outcomes*, Avebury, Aldershot, Tables 3.1 (sample numbers) and 3.14.

Davies, Fernandez and Warburton (1996) *Evaluating community care for elderly people*, PSSRU DP1226 Inset 2.

**Table 2****Distribution of Malaise scores among principal informal caregivers of users of community social services: cohorts of users assessed in 1984/5 and 1995**

	1984/5 cohort		1995 cohort	
	Six months after assessment	At assessment	Six months after assessment	
	%	%	%	
0	15	9	10	
1-2	31	16	16	
3-4 'Stressed'	19	19	17	
5-6 'Severely stressed'	11	20	17	
7-8	10	14	14	
9-11	12	10	13	
12-	3	12	10	
Total: per cent	100	100	100	
number	210	179	134	

**Notes** 1. Rutter, Tizard and Whitmore (1970).  
 2. Thresholds seem have not to have been fully established. These are thresholds suggested by Rutter and quoted in Bebbington and Quine (1986).

**Sources:** For 1984/5 cohort, Davies et al (1990), 267.  
 For 1995 cohort, Davies, Chesterman, Fernandez and Saunders (1997, forthcoming).

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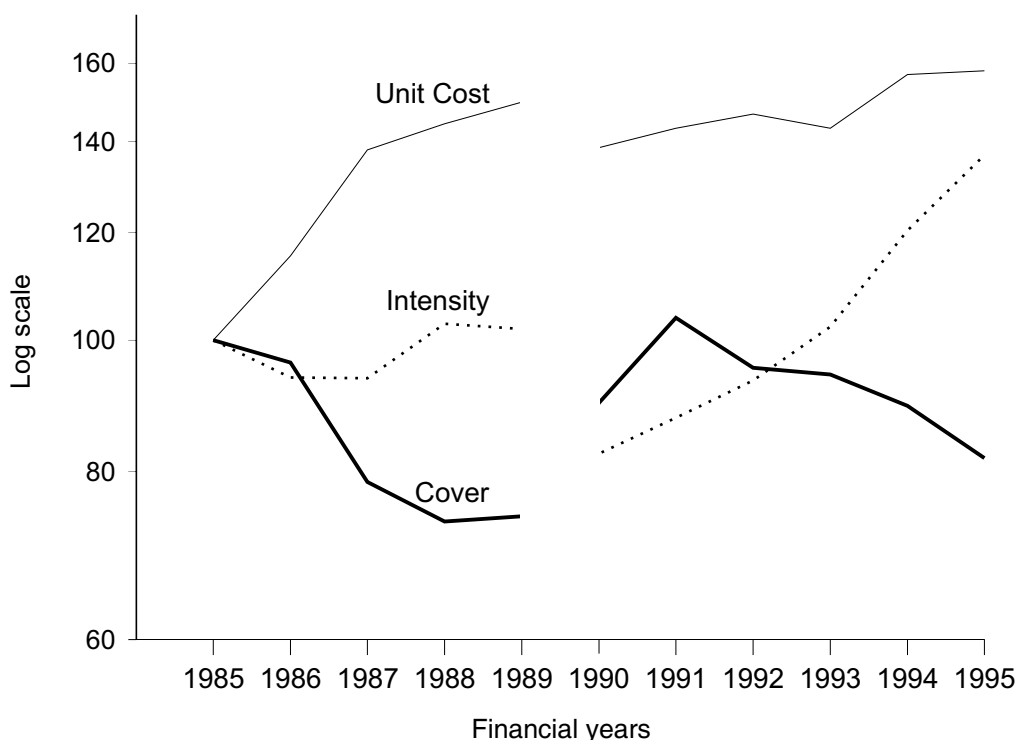
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**Figure 1**  
**Home help/care: Cover, Intensity and Unit Cost, England and Wales**  
**1983/4-1995/6; 1985=100**



**Annual rates of change (per cent)**

	Cover %	Intensity %	Unit Cost %
1985/6-1989/90	-7.8	+0.5	+10.7
1990/1-1993/4	-4.9	+7.4	+1.1
1993/4-1995/6	-7.3	+15.7	+5.0

**Notes**

1. Cover is the proportion of the population of the age group at risk receiving services, and was calculated by dividing the average number of clients receiving services divided by the estimated population aged 75 and over. Intensity is defined as the number of hours received per client, and calculated by dividing the number of hours received by clients by the number of clients. Unit costs is calculated by dividing gross expenditure by the number of hours received by clients and deflating by the Blue Book's index of total home costs published in the UK National Accounts. (The adjustment is not therefore for the prices of inputs specific to the social services, as with the PSS deflator, but to the prices all goods and services in the economy.)

The calculations are no better than the degree of standardisation, completeness, and other aspects of the reliability of the data collected by CIPFA. The main problems for time series analysis are changes in CIPFA collections and in the number of authorities not making a return. The non-response rate was typically 0, but there were years when it was as high as 7 per cent. However, the ratios are not highly sensitive to the variations in response rates. The periods for which the rates are computed were chosen partly to allow for discontinuities, partly to take into account turning points suggested by the time series.

2. There is a discontinuity in the basis for calculating the number of recipients between 1989/90 and 1991/2. Therefore, the rates have been calculated separately for the periods on each side of the discontinuity, but not across it.

3. The population estimate for 1990 is suspect. Therefore the rate for Cover in the row for 1990/1 to 1993/4 is the change between 1991/2 and 1993/4.

**Source:** CIPFA: *Social Services Statistics (Actuals)* for each of the years.