Developing social care:
the current position

Chapter 4: Older people

Policy context

The context for a review of the needs of older people, the services provided and their impact is set by the 1990 NHS and Community Care Act, the guidance and directives that followed, and policy initiatives taken by the Labour government since 1997. Some key elements of these policy changes and recommendations need to be highlighted here, with further contextual material introduced as needed below.

NHS and Community Care Act 1990

The most prominent of the changes associated with the 1990 Act were:

- the massive transfer of funding from central to local government (and with it the responsibility to coordinate care purchasing);

- clarification and rebalancing of the respective roles of the NHS and local authorities;

- unprecedented rates of growth of independent sector services for older people, with local authorities given the primary role of 'enablers' (later commissioners);

- greater emphasis on - and some changes to - financial arrangements to encourage community-based care, rather than institutional care;

- more explicit emphasis on the identification of priority groups and the targeting of services;

- hence, the leveling-out and beginning of a reversal of the 50-year upward growth in care home provision;

- recognition of the often pivotal roles of unpaid carers, and of the associated need to provide them with support;

- encouragement of devolved decision-making (including care management);

- development and elaboration of regulatory and inspection procedures;

- a national debate and a Royal Commission on the financing of long-term care;

- a move away from supply-led provider-dominated hierarchies towards needs-led purchaser-dominated markets;

- the introduction and rapid development of social care markets, creating the need for local authorities to develop a whole new set of skills in the commissioning of services;

- a sea change in local authority attitudes to, and sophistication of performance in, links with independent providers.

The momentum behind those changes, and the fairly wide acceptance of many of them across professional and political spectra, has meant that the core elements of the 1990 legislation have not been abandoned (Glennerster 2000; Hudson 2000). Some have been strengthened and, of course, there have been many new developments.

Prominent among the systemic problems that prompted the 1990 legislation was expenditure. NHS and local authority budgets in the 1980s were cash limited, while social security payments were uncapped. Access to the latter for residential and nursing home care was subject to a means test, but not an assessment of need. Social security payments were also not really available to fund community-based services, which encouraged residential and nursing home care to grow rapidly at the expense of often more appropriate home care (Audit Commission 1997), and certainly faster than the rate needed to keep pace with demographic change (Wistow 1996). The gradual shift of social security funds into local authority budgets after 1993 immediately put a cap on such expenditure. At the same time, access to state-funded support (now via the local authority) was made additionally subject to a needs assessment.

The aims and detail of the 1990 legislation were heavily influenced by the need to rein in the runaway social security bill for residential and nursing home care (which had reached £2.5 billion by 1993). There were also other influences. An obvious concern was the ageing of the population, with Mrs Thatcher among those to adopt alarmist talk of a 'demographic time bomb' (reported in *The Times* 25 January 1984). Another was the untested assumption that closing hospitals would save millions of pounds of taxpayers' money (discussed in more detail in Chapter 5). A perhaps less obvious influence was the associated need to bring some structure to the concept and strategic management of 'community care'. Over the course of the 1980s, this had gradually been transformed from a loosely formulated and narrowly defined professional concern (Walker 1982; Bulmer 1987) to a higher profile and more broadly interpreted item on political, public policy and administrative agendas. A lot of media and political attention was also being focussed on what was then seen as the controversial closure of the asylums, linking it particularly to the rapidly growing numbers of homeless people on Britain's streets and (less commonly) to the growing prison population.

Another influence on the 1990 legislation was the increasing recognition of the burden carried by Britain's hidden army of unpaid family and other carers. And, of course, political ideology or preference played its part, with the Conservative government keen to reduce the provider role of local authorities (but unable to find any alternative to giving them the overall strategic, 'enabling' role) and to encourage the (further) growth of voluntary and (especially) private sector provision. We will see numerous echoes of all of these influences in the review below: evidence of the size and urgency of some of the problems that generated these pre-1990 concerns, and evidence too of the success or otherwise of the 1990 legislation to address them.

Relevant policy development since 1997

We do not attempt a comprehensive account of Labour government policy developments, but a few key components need to be mentioned. We shall return to most of these (and to others) as the chapter proceeds.

The 1998 White Paper, *Modernising Social Services*, stressed individual independence (including greater user influence), the need to give greater priority to prevention and rehabilitation, and the strengthening of statutory regulation of services in the pursuit of better standards of care. The Labour government claimed no sectoral preference: 'it is no longer who provides the social care that matters. It is the quality of care that counts' (Milburn 1999). Partnerships driven by performance (Department of Health 1997) were viewed as the 'third way', to be contrasted with the hierarchical, 'command and control' model of the 1980s and the internal market of the 1990s.

The *Health Act* 1999 introduced new 'flexibilities' to allow the NHS and local authorities to work more closely in providing integrated services by allowing transferred and pooled funds. A recurrent theme of government policy since 1997 – over many fields, not just health and social care – has been the emphasis on closer working between professionals, organisations, agencies and ministries in order to meet the needs of individual service users or citizens (with terminology and breadth of concept variously discussed in terms of 'joined-up government', 'partnership', 'integrated services', and 'whole system approaches'). Local strategic partnerships (LSPs) have provided important frameworks for setting out local intentions, for example in relation to the older people's National Service Framework (see below). *Better Government for Older People* (BGOP) is an important plank of this cross-government emphasis. Progress and achievement in relation to integrated services for older people (and whole system approaches) were reviewed by the Audit Commission (2002). In March this year, Stephen Ladyman announced the government's commitment to developing a strategy for older people that sets shared objectives across all government departments, in principle making it easier to introduce whole system approaches to the promotion of well being, independence and choice.

Also in 1999, the government announced its *National Strategy for Carers*, which included the allocation of £140 million (for England) to enable carers to take short-term breaks from caring. The earlier *Carers (Services and Recognition) Act 1995* had entitled carers to a full assessment of their needs independently of the users of services.

The Royal Commission, set up by the incoming government to look at the financing of long-term care, reported in 1999, and the government responded a year later within the context of the *NHS Plan* (Department of Health, 2000). The funding of long-term care, and particularly the contributions expected of older people with the means to pay, have obviously been prominent issues in recent years, and we discuss them in section 4.3. The *Plan* also promoted closer collaboration ('partnership' again) between health and social care agencies.

Substantial additional resources for health care were announced in the NHS Plan, to be invested over the longer term, alongside a reiteration of previously espoused objectives for older people: better partnerships between health and social services; needs-led decision making; flexible patterns of working; promotion of the independence of older people; policies to tackle ageism; an emphasis on prevention; and the development of more services to support rehabilitation (Department of Health, 2000). The National Beds Inquiry (Department of Health 2000) highlighted the inappropriate use of acute inpatient beds by many older people because of a shortage of suitable alternative services and accommodation, as well as pointing to the wide variations in service availability and utilisation across the country. It was argued that social care could contribute to the performance of the acute health sector by preventing the need for inpatient admission and by speeding up the rate of hospital discharge, effects that were later quantified by Fernandez and Forder (2002).

The Department of Health issued guidance in late 2001, *Building Capacity and Partnership*, to address the concern that restricted social care capacity was hindering the performance of the acute health care sector. The focus was particularly on relationships between public sector commissioners (of both health and social care services) and private and voluntary sector providers. A 'concordat' was established to build capacity in both home care and care homes. Additional funding would allow local authorities to set up better, longer-term commissioning arrangements and, if necessary, to raise fees to stabilise the sector (Department of Health 2001b, 2002). A later initiative was to charge local authorities if their lack of service provision delayed a person's discharge from hospital.

The National Service Framework for Older People (Department of Health 2001) now dominates the practice landscape. Eight standards were set out, related to person-centred care (tackling age discrimination; developing person-centred care); whole system working (developing intermediate care services); timely access to specialist care (providing specialist hospital care; improving stroke services; improving falls services;

improving mental health services); and promoting health and active life. Like other national service frameworks, the aim was to introduce standards that were clearly evidence-based, in this case citing 369 references in support of its recommendations. (This stands in some contrast to the majority of the reports from the Audit Commission and – especially – the Social Services Inspectorate, which appear to build their policy or practice recommendations on much narrower evidence bases. Notwithstanding some concern about the robustness of some of the evidence, many of the reports issued by the Audit Commission and the Social Services Inspectorate have proved enormously useful for this review.)

The 1992 White Paper, *The Health of the Nation,* had given little attention to the health needs of older people, which is perhaps one reason why the NSF for Older People was widely welcomed. The consultative and advisory processes employed in the development of the NSF also drew generally broad approval (e.g. see Age Concern 2001; Swift 2002). Specific initiatives set out in the NSF included reaffirmation of the single assessment process, encouragement of intermediate care and specification of defined service models for three need groups (stroke, falls, mental health). Concerns were expressed about some aspects of the NSF. Swift (2002), for example, warns of the potential burden of the single assessment process (SAP) and the lack of consensus supporting any particular assessment tool; that intermediate care may develop into a cheap and substandard diversion from hospital access; and the risk that some of the standards would merely be 'cosmetic'. Age Concern (2001) commented that housing and transport, both of which can have a great influence on health and access to health care, were not adequately addressed; that the framework relied too heavily on a medical model of healthy ageing; and that the roles of the voluntary and private sectors were not fully acknowledged. Grimley Evans and Tallis (2001) argued that the NSF was overly influenced by a political agenda, and that the single assessment process would become 'a bureaucratic nightmare' (p.331), while Ebrahim (2001) warned that the proposals for intermediate care would see the re-emergence of 'workhouse wards'. Another concern related to the financial ceiling on free nursing care (Knight 2001).

The Planning and Priorities Framework 2003-06 (Department of Health 2003) sets out detailed targets for health and social care for older people, with the aims of promoting person-centred care, independent living, healthy and active lives, user satisfaction through timely access to high-quality services, and partnerships between formal services and informal carers. The specific targets indicate the policy priorities, including to increase the proportion of people supported intensively to live at home, to reduce the rate of growth of emergency hospital admissions, to speed up assessments following first contact with social services, and to speed up the provision of community equipment. Other targets related to diabetes and stroke.

The Audit Commission (2004a) has provided a helpful overview of the current policy context (especially see chapter 3). Policies are discussed under a number of headings.

First, the NSF has helped to change the approach to older people by tackling discrimination. The EU Employment Directive will add further support, through its prohibition of age discrimination in employment and training from 2006. The NSF also requires the NHS and local authorities to involve older carers in their Local Implementation Teams. A further dimension to current policy is the effort to 'join up' services by encouraging the NHS, local authorities and other agencies to work together to promote health and active life. Linked to this objective are the new responsibilities of local authorities to assume 'community leadership', as required by the Local Government Act 2000, and their new duty to promote well being.

Local Strategic Partnerships are established to bring together agencies from across the public, voluntary and private sectors to coordinate their efforts to tackle local issues such as deprivation and social exclusion. The Audit Commission (2004a) argues that LSPs 'potentially offer an ideal forum for implementing independence and well being strategies for older people' (p.34), although their involvement thus far varies enormously across the country. Another and longer-standing policy plank for further service development is the best value review, aiming to promote the appropriateness, quality and effectiveness of local authority services (whether directly provided or commissioned). This is what the Audit Commission calls 'self-evaluation', and can go hand in hand with 'external evaluation' in the form of performance assessments, audits and inspections.

Seven key themes are identified in the Audit Commission (2004a) report as central to the promotion of independence and well-being: strategic frameworks for improving quality and choice in housing; neighbourhood renewal; opportunities for continued learning; comprehensive, integrated transport strategies; simplification of occupational and private pension schemes and the introduction of pension credit; improved information on services through, for example, Care Direct and the Third Age Service, the NSF older people; and a number of initiatives sponsored by the Department for Culture, Media and Sport. This plethora of activities is not, however, considered to be sufficient. The Audit Commission points out that 'although the direction of travel is consistent and many individual levers are in place that can be used to promote independence and well being for older people, it is up to local agencies to piece them together. Stronger leadership and coordination at national level could help to promote more integrated approaches to successful ageing locally' (p.45). Obstacles to change, particularly to the development of whole-system approaches to whole-person enhancement of well-being, include 'the consequences of reorganisation, fragmentation, poor coordination, pressure on resources and shortages of staff' (Audit Commission 2004, p.29).

These more recent policy developments and statements generally apply only to England. We have not been able to trace policy changes in Wales and Northern Ireland in the same degree of detail, although the evidence provided below is drawn from all

three countries. Broadly speaking, equivalent developments are being introduced. Last year's policy strategy for older people issued by the Welsh Assembly Government (2003) includes many recommendations that mirror what has been proposed and/or implemented in England (for example the BGOP and NSF). Its five 'key aims' are to tackle age discrimination, promote positive images of ageing and give older people more of a 'voice'; develop the capacity and ability to continue to work and to learn; to promote health and well-being through integrated frameworks; to provide high quality services and support to allow older people to live independently, while responding to their needs; and to implement the strategy as 'a catalyst for change and innovation across all sectors' (p.9).

Needs

Interpretations of need

Need is defined as the potential for improved well being along one or more of the dimensions relevant to social care (a definition consistent with, for example, the approach taken in the review by Stevens 1990 for the NHS). These dimensions tend to be discussed either in terms of well being objectives, such as independence or safety, or in terms of the services that can help achieve those objectives, such as day care or support in the home; that is, either as the potential for outcome attainment or the necessary provision of services. Another distinction would be, crudely, between the need to 'avoid the negatives' (a 'deficits' interpretation of need) versus the need to 'attain the positives' (an 'opportunities' interpretation). Over recent years, the latter has come more to the fore, as exemplified in a series of reports from the Audit Commission (2004, 2004a, 2004b, 2004c, 2004d, 2004e) and the approach implicit in the recent summary report from the SSI (2003).

The thrust of these reports was that 'older people need an environment that they can shape, thrive and live life to the full for as long as possible. A challenge for communities and councils is to be inclusive, to help older people to stay healthy and active and to encourage their contribution to the community' (Audit Commission 2004 p.2). Instead of focussing attention on needs defined in terms of deficits or shortfalls, stemming from dependency or frailty, this approach emphasises needs defined in terms of the creation of opportunities and inclusion. The report goes on to argue that there are a number of factors that contribute to 'a sense of independence and well being' including having a safe, comfortable living environment; having a safe, integrated neighbourhood; access to social activities and social networks; adequate income; information to enable people to access opportunities and services; and access to services and advice to maintain or improve health and fitness.

A number of other official documents and research reports make similar points, arguing for the re-conceptualisation of need away from the focus on deficits so prevalent 15 years ago (e.g. see Jack 1991), towards control, independence, mental health as something other than the absence of mental illness, and so on. For example, Lake (director general of Help the Aged) opines that

> the misconception of population ageing as a 'problem' continues to distract us. Population ageing gives us an opportunity to think and work differently, to engage with older people, and to design a system of support which is based on the principles of preventing avoidable disease and decline, maximising independence and promoting quality of life (p.19).

The SSI (2003) noted greater recognition in local authorities of the broad range of services and partnerships needed to support independence, although the approach in this document is much narrower than that outlined by the Audit Commission a few months later.

Hancock *et al* (2003) emphasise the importance of moving beyond disability and symptomatology, and stress that users' perspectives on their own needs should be given higher priority: 'reliance solely on assessment by staff or carers may not lead to the most equitable or appropriate use of services' (p.803). (See also Slade 1994.)

Bernard and Phillips (2000) argue 'for an integrated social policy which addresses the broad needs of an ageing society as opposed to narrow age-based interests, or the interests of specific problematised or stigmatised groups' (p.33). Consistent with this approach would be the articulation of a more explicit value base. Secker *et al* (2003) explore the meaning of independence, and how it might be promoted. They emphasise that

> while dependence equates with reliance on others, independence can be seen as subjectively self-assessed lived experience. Thus it becomes possible to combine high levels of dependence with high levels of experienced or felt independence, a particularly pertinent combination for service providers (2004 p.375).

This conceptualisation of independence is also consistent with the Audit Commission's (2004) arguments that older people need to be supported in order to be offered opportunities for enhancing their well being, even when they have (deficit-defined) needs for ongoing social care. We discuss preventive services in section 4.5 at which point some of these same issues will arise (see, for example, Godfrey 2001).

Numbers of older people

Clearly, it is difficult to find quantitative evidence on levels of, or changes in, need defined by reference to opportunities rather than deficits. (We could not structure a search for such evidence, so it is likely that there is evidence that we have not uncovered. Moreover, our search was focused on evidence in relation to the people who use care services, whereas an opportunities approach encompasses a wider group of people.) What we offer therefore follows a more conventional view of needs measurement, focusing on the impacts of disability and long-standing illness on the inability to perform the usual activities of daily living or to engage in the usual social activities. From this perspective, the past two decades have seen growth in what might

be called 'potential need': there are more older people and family structures have changed, bringing changes inand the patterns of potential informal care. Expectations among older people have also changed.

Figure 4.1 shows changes in the numbers and population proportions of older people in England, Wales and Northern Ireland. It can be seen that changes have been quite modest over the last 10 years. Of the three countries, Wales has the highest proportion of older people (around 20 per cent), followed by England (around 18 per cent). Although Northern Ireland has a younger population, with around 16 per cent aged 65 or over, figure 4.1 suggests acceleration in the ageing of the population in recent years.

Figure 4.2 illustrates the geographical variability in the proportions of people over 65 years old in England. It shows how the lowest concentrations are found in the London area, and the highest are generally situated in low-density rural areas. Melzer *et al* (1997) argue that local variations in population age structure, associated prevalence of cognitive impairment among older people and the likely need for institutionalisation are large compared to national changes over some decades. They recommend that more attention should be paid to local differences in funding levels and requirements.

Health status, disability and limiting long-standing illness

Figure 4.3 suggests a slight deterioration in health status among older people over the last 10 years, as well as an increase in the proportions of both men and women with at least one long-standing illness. This trend is probably the product of improvements in life expectancy.

Among older people in England, figure 4.4 illustrates how the prevalence of disability increases significantly with age. Among people over 80 years old, men appeared to suffer slightly higher rates of disability. Figure 4.4 also illustrates the significant differential in disability between older people living in the community and those living in care homes.

Figures 4.5 and 4.6 point to higher rates of disability or long-standing illness among females aged 75 or over in Wales and Northern Ireland (around 50 per cent and 70 per cent of females over 75 report suffering either a long-standing illness or some form of disability or infirmity, respectively), as well as a very steep age-disability gradient. (See also the review of literature considered in a Welsh context by Burholt and Windle 2001, which also includes some comparisons with England.)

In turn, figures 4.7 and 4.8 exemplify the high rates of co-morbidity associated with long-term illnesses, as well as the increased prevalence of health problems among the oldest members of the population. Again, the figures indicate how females are at higher risk of suffering from health problems, in particular from arthritis and back pain. In turn, females appear to be less likely to suffer from respiratory illnesses and heart diseases.

Figures 4.9 to 4.13 provide further quantitative evidence of the prevalence of health problems and disability among older people in England. The counter-intuitive age gradient among care home residents (in figure 4.10) is probably a combination of cohort and survival effects. People with long-standing illnesses may not survive into their 80s, and the older residents of care homes may include many who entered these facilities at a time (late 1980s and early 1990s) when there was no needs assessment prior to admission when funding came from social security budgets. In terms of the need and use of health care resources, figure 4.14 suggests significantly higher rates of usage of GP services for men aged 80 or over than for women, whether living in the community or in care homes. This will be mainly a morbidity effect. Among women, age appears to be negatively correlated with the use of GP services, again probably a combination of cohort and survival effects.

In contrast, age appears positively associated with the use of hospital services (see figure 4.15). Controlling for age, figure 4.15 suggests females tend to use hospital services less intensively. Interestingly, outpatient services seem to be used more by older people living in the community, whereas inpatient services are used more intensively by older people who are living in care homes.

Socio-economic need

In order to have a proper understanding of the need for social care services, one cannot focus solely on health and disability: an understanding is also needed of the socio-economic background of prospective users of social care services (see, for example, Davies 1968; Bebbington and Davies 1980; Grundy 1992).

Marital status is important for understanding the social networks surrounding an older person, and hence the likely availability of informal support. Figure 4.16 shows how, over the last 30 years, there has been a reduction in the proportions of older males who are married, in contrast with a sharp increase in the proportions of married females. These trends appear likely to continue in the near future. This trend explains why projections of future needs suggest that females are more likely to have (potential!) spouse carers than previously (see section 4.4). However, over the next 15 years there will be a sharp increase in the rates of divorced older people, as well as a decrease in the proportions of widowed older people and older females who never married (figure 4.16).

Looking at one point in time (the year 2001), figure 4.17 explores the relationship between age and living arrangements for older people in England and Wales. The figure demonstrates the significant decrease with age of the proportions of older people living with their spouses or cohabiting, as well as a very sharp increase in the proportions of older people living alone. Overall, among those aged 85 or over, figure 4.17 suggests that around one-third of older people lived alone in 2001 in England and Wales (around twice the rate for people aged 65 to 74 years of age).

Changes in need over time

Data from the Health Survey for England 2000, collected using an adapted version of the Abbreviated Mental Test Score (AMTS) or Hodkinson Test, suggest that among those care home residents who completed the cognitive function test, 33 per cent had severe cognitive impairment, and a further 17 per cent showed evidence of moderate impairment. These rates were significantly higher than in private households (2 per cent and 3 per cent, respectively; see figure 4.13) (Tait and Fuller 2002). Using a population-based sample (from the MRC CFAS study) rather than drawing on lists of care home residents, which they argue will provide a more truly representative picture, Mathews and Dening (2002) suggest that the prevalence of dementia in residential and nursing homes is 62 per cent. Their data were collected in 1991-93. No significant prevalence differences were found between type or sector of facility.

Evandrou and Falkingham (1987) show that nearly a third of all older people in 1980 and in 1985 saw someone every day, but only a quarter had done so in 1994/95. One in eight saw relatives and friends less often than once a week in the 1980s, whereas the proportion was one in five by 1994/95. Findlay (2003) reviews the international literature on interventions to reduce social isolation among older people. She is highly critical of many interventions that were implemented without evaluation and for which there is in fact little evidence to show that they work.. 'Of the few existing evaluations of effectiveness, many are flawed by weak methodologies. … An enormous amount of public money, time and man power may be wasted on interventions for which little evidence of the effectiveness is available' (p.655).

There is some evidence in support of the widely held view that, on average, older people using social care services today have greater needs than their counterparts ten or more years ago. Two studies can be cited as examples. Darton (1998) plots a pronounced increase in cognitive impairment (and dependency generally) in both residential and nursing home populations between 1986 and 1996. In a subsequent paper, Darton *et al* (2003) examine the cost implications of these changes. Lindesay *et al* (2003) looked at the care home populations of Leicestershire in 1990 and 1997: prevalence of self-rated moderate or severe cognitive impairment had increased from

38 per cent to 44 per cent, and the prevalence of staff-rated disturbed behaviour had decreased slightly (12 per cent to 10 per cent).

Future projections of need

In section 4.8 we present and discuss projections of need over the period to 20??.

Unmet needs of service users

Care services are provided to meet needs, but a number of studies have reported significant *unmet* needs among care populations (e.g. Nolan and Caldock 1996; Stewart *et al* 1999), and social services staff recognise the 'poor availability' of services (SSI 2003 p.41).

One unmet need described by the Department of Health (2001 p.90) as 'widespread' relates to mental health problems. Studies examining data collected prior to the 1990 Act pointed to large numbers of older people with cognitive impairment or depression who were not in contact with services or not being treated for their mental health problems (e.g. Clarke *et al* 1981; Mann *et al* 1994; Livingston *et al* 1990; Gosney *et al* 1990; Iliffe *et al* 1991; Farrow, 1992; Schneider *et al* 1993; Kavanagh *et al* 1993). But the picture has not changed: there are still large numbers of older people whose mental health needs go unrecognised and untreated (e.g. Girling *et al* 1995; Holmes *et al* 1995; Social Services Inspectorate 1997; MRC CFAS 1999). There are, of course, effective treatments available (see the Cochrane review of antidepressants by Wilson *et al* 2004). Clarification is needed of the role of social care staff in dementia assessment and support services (Manthorpe *et al* 2004). Alcohol-related problems also appear to be under-recognised (Simpson *et al* 1994).

Figure 4.14 shows rates of GP contact. People living in care homes have much higher rates of consultation than those living elsewhere. However, GPs are still not doing enough to identify the mental health needs of older people or to refer on to specialist services, thereby missing the benefits of early treatment with cholinesterase inhibitors or antidepressants (Audit Commission 2002a). The NSF advocates early detection and treatment for this reason. Concerns had earlier been expressed about pressures on primary care services as a result of changes in the balance of care for older people, particularly the decline in inpatient services (Williams *et al* 1992; Kavanagh and Knapp, 1998). It has been argued that the current public health and care policy framework does not offer any coherent overarching approach to mental health in later life (Seymour and Gale 2004).

Recognition of the mental health needs of older people from black and minority ethnic groups may be lower than in the white population (Lloyd 1993; Abas 1996). Adamson (2001) found limited knowledge of dementia among families of South Asian and African/Caribbean descent, which could cause difficulties in the planning of community-based services. On the other hand, from their study of new referrals to a psychogeriatric service Odutoye and Shah (1999) could find no support for 'the traditional view that [Indian subcontinent] ethnic elders do not adequately access psychogeriatric and social services and that they are primarily cared for by extended families' (p.446). Similarly, Livingston *et al* (2002) found no differences in accessing either health or social services between immigrant older people or their indigenous counterparts. Nevertheless, gaining a better understanding of the mental health needs of minority ethnic communities is a policy aim (e.g. Welsh Assembly Government 2003, p.28; SSI 2003).

It is particularly worrying that older people in receipt of home care services or living in care homes have unrecognised and unmet mental and other health needs. Gosney *et al* (1990) had reported unmet psychiatric and non-psychiatric health needs among local authority residential home residents in the 1980s, and Pearson *et al* (1990) similarly in a private nursing home. The situation may not have improved greatly since implementation of the 1990 legislation. Evidence comes from quite a number of 'post-1990 studies', only a few of which are mentioned here. Evans and Wilkinson (1995) found low levels of influenza immunisation in 75 residential and nursing homes in South Glamorgan. From their community survey of older people receiving home care in Lewisham, Banerjee and MacDonald (1996) found a high level of depressive disorder with little treatment from either primary or secondary health care services. Older people in sheltered housing seemed to be particularly at risk. Barodawala *et al* (2001) found that few residents of nursing homes received psychotherapy or occupational therapy, and concluded that many are 'particularly isolated' from NHS services. Bagley *et al* (2000) found low levels of recognition by nursing home staff of depression among residents (as low as 15-27 per cent by home). Nursing staff were no better at identifying depression than other care staff. Almost no staff had received specific in-service training on depression. See also Macdonald and Carpenter (2003).

A small study by Moxin *et al* (2001) examined whether training care home staff could improve their ability to detect depression. The training delivered by a community mental health team for older people appeared to improve the accuracy with which care staff were able to identify depression, although there was no control or comparison group, and the sample size was very small. Peet *et al* (1994) concluded that medical examination prior to admission to residential care did not influence chances of survival, changes in cognitive impairment, disability, incontinence or self-reported health, but was associated with greater improvement in morale. Macdonald *et al* (2002) found no evidence of excessive antipsychotic drug use in nursing homes.

At least 50 per cent of care home residents in the UK suffer from urinary incontinence (Durrant and Snape 2003). Edwards and Jones (2001) examined the prevalence of faecal incontinence in older people living in their own homes. Despite an understandable reluctance to report symptoms, they found significant associations between faecal incontinence and symptoms of anxiety, depression and disability. Poor awareness of this need among health and social care professions was seen as one of the contributory factors.

Martin *et al* (2002) looked at met and unmet needs of residents of nursing and residential care homes. In both settings residents' needs in relation to accommodation, food preparation and self-care were being met. Residential care residents had significantly greater unmet need for suitable daytime activities. Nursing home residents had greater levels of dependency, particularly problems with apathy and social skills.

Reed *et al* (1998) followed 46 older people through their admission to care homes and for up to six months afterwards. Sample members reported that they had been quite actively involved in the process of settling into homes and forming new friendships, but that their needs continued to change. Reed and her co-authors recommend greater flexibility in the range of services offered to older people, suggesting that services are still not being adapted to the assessed needs of individuals.

Redmond *et al* (1996) found that older people in receipt of home help in 1991 were significantly more likely to have unmet *health* needs than a randomly selected control group not in receipt of home help. Unmet health needs were often at a very high level. The single assessment process and better coordination generally between health and social care agencies are intended precisely to address this kind of problem.

Needs assessments

We discuss needs assessments under Services (section 4.5).

Funding and expenditure

In this section we focus on funding arrangements for social care services and expenditure patterns. We start with a brief description of the mixed economy of funding and expenditure trends over recent years. We then focus on two service areas – care homes and home care – and consider fee levels and user charges. (Profit margins and their consequences for behaviour and patterns of provision are discussed in section 4.5). Here we comment briefly on the evidence on direct payments. Finally, evidence is offered from studies that have calculated the costs of supporting older people, including costs associated with social care service use. Commissioning is covered in section 4.5.

We do not discuss the principles of long-term care finance or the debate that has raged for some years concerning the boundary between public and private responsibilities, the roles of long-term care insurance, the links between payments for long-term care and pensions, or the means-testing or otherwise of service receipt (see, for example, Royal Commission on Long Term Care 1999; Age Concern 2001a; Wittenberg *et al* 2002; Ikegami and Campbell 2002). Most people want the state to fund the services to meet their needs (e.g. Deeming and Keen 2003), but most are also worried that restrictions on public finance will limit the provision of long-term care (Royal Commission on Long Term Care 1999). We have not been able to look in detail at patterns of joint finance and joint funding, although some aspects of this topic were discussed in chapter 3. Neither were we able in the time available to examine the evidence on social security funding for older people (see, for example, McLaughlin and Glendinning 199?).

A mixed economy of funding

Social care for older people is characterised by a mixed economy of financing. Local authorities started the 1990s with substantial roles in social care provision, purchasing and regulation. Their purchasing powers have grown considerably, partly as a result of the transfer of what were formerly social security funds to their control (the special transitional grant and after), partly with the growth of the social care sector, and partly with the substitution of external contracting for traditional line management of in-house services. This is illustrated below by statistics on care home and home care services. Laing and Buisson figures for 1986-95 demonstrated the changing nature of the mixed economy by enumerating the numbers of residents of independent sector care homes for older people (and younger adults with physical disability in Great Britain) by funding source. The percentages for 1986 and 1995 were as follows:

	1986	1995
Private payers	52 per cent	28 per cent

Income support (social security)	44 per cent	37 per cent
Local authority	3 per cent	32 per cent
NHS	1 per cent	3 per cent

Netten *et al* (1999) calculated that about a quarter of residents in nursing homes and a third in residential homes were wholly privately funded in November 1996.

Clearly, local authorities are not the only purchasers of these (or other) social care services for older people, although their proportional contribution to the total has grown. The NHS was sometimes a substantial purchaser of nursing home provision. More generally, PCT purchasing of social care is likely to grow (whether singly or jointly with local authorities).

Estimates for 2000 by PSSRU suggest that 27 per cent of expenditure on long-term care in England was funded by the NHS, 38 per cent by local authority social services departments and 35 per cent by individual service users or their families (Comas *et al* 2004). The last of these was split fairly evenly between user charges and direct private expenditures. We return to user charges in a moment, but first look at their contributions to gross local authority expenditure.

Figure 4.18 shows the proportions of gross expenditure on local authority-brokered social services funded through sales, fees and charges for 1994/95 to 2002/03 in England. The proportion of expenditure funded through fees and charges varies considerably across services. Whereas around 26 per cent of social services expenditure on older people was recouped through sales, fees and charges in 2002/03, the equivalent figures for residential and nursing home placements were 37 per cent and 34 per cent respectively, around 5 per cent for day care and direct payments, and around 12 per cent for home care services. Perhaps not surprisingly, over two-fifths of gross expenditure on meals on wheels was funded through user charges and fees.

Figure 4.18 also shows that user charges and fees for personal social services for older people are significantly higher than for the rest of the social care field. The proportion of gross expenditure funded via user charges now appears to be decreasing slightly for most services, after a period (from 1994/95 to 1999/2000) of significant increases.

The equivalent picture for Wales is given in figure 4.19. With the exception of day care services, which in recent years appear to have been funded to a greater extent than in England via sales, fees and charges, the Welsh picture mirrors that described for England.

Gross expenditure on social services for older people

Figures 4.20, 4.21 and 4.22 show substantial growth in gross expenditure on social services for older people in England and Wales, but not in Northern Ireland. (Current plans for England are for continued growth to 2008; Department of Health 2002c.) The charts show actual expenditure levels; an indication of increases in real terms can be seen by comparing the height of the expenditure columns to the price index series plotted on the same graphs (the retail index and the social services pay and prices index). (Note that most authorities have historically spent *below* their funding allocation on older people (and above it on services for children), although rebasing of the Formula Spending Share in 2001/02 in recognition of this historical pattern has changed the picture now.) Whereas in England there have been significant increases in levels of expenditure in real terms throughout the period 1994/95 to 2002/03, significant real increases in expenditure in Wales occurred only in the last two years. Expenditure on elderly programmes of care has been stable in Northern Ireland over the period 1998/99 to 2000/01, where around 55 percent of social services expenditure is destined to elderly programmes of care.

Figures 4.23 to 4.26 illustrate the proportional breakdown of gross expenditure for older people in England and Wales, for the earliest and last years available. Whereas figure 4.20 suggested increases in actual levels of expenditure for most items, figures 4.23 and 4.24 reveal that the proportional levels of expenditure in England have remained fairly constant since 1994/95. However, the proportional expenditure on nursing home placements doubled from 11 per cent in 1994-95 to 22 per cent in 2002/03, while the proportional expenditure on home care decreased from 27 per cent to 20 per cent. Overall, the main items of expenditure in England over the period are residential and nursing care and home care, followed at a distance by expenditure on assessment and care management services. It is interesting that expenditure on home care was a *smaller* proportion of the total in 2002/03 than in 1994/95 despite the policy emphasis on community-based alternatives to care homes. The gradual transfers of funding from social security to local authority budgets for care home residents will have dominated other trends over the period.

As in England, the proportional expenditure on nursing placements in Wales increased significantly between 1997/98 and 2002/03 (from 13 per cent to 21 per cent of gross expenditure). Overall, England and Wales show similar patterns of proportional expenditure in 2002/03.

Care home fee levels

Figures 4.27 and 4.28 show the recent changes in the unit costs of residential and nursing home care for older people. They indicate significant increases in care home

prices across England and Wales, and also a marked price differential between London and elsewhere. Nevertheless, Darton *et al* (2003) concluded that price changes between 1986 and 1996 (in each of which years they conducted cross-sectional surveys of residential and nursing homes) have not kept pace with cost-raising changes in resident dependency and required standards of provision. Nursing home prices had increased more slowly than residential home prices even though resident dependency levels had grown differentially. Care home prices are also influenced by contract type (Forder and Netten 2000; Kendall *et al* 2002; and see section 4.5). Local authority commissioners have successfully negotiated down the fees paid to private and voluntary sector care home providers, with home closures proving to be one of the consequences (see below).

Figure 4.27 suggests a slight deterioration in the performance of councils in the management of their unit costs of residential and nursing care, with a drop of over 10 percentage points down to 68 per cent in the numbers of councils rated as 3* by the Department of Health between 2001/02 and 2002/03. Figure 4.28 also indicates lower unit costs of residential and nursing care in Wales.

The 2004 edition of Laing and Buisson's annual review of the care sector argued that care home owners should be paid £420 to £497 (£543 to £620 in London and more expensive South East) for nursing care. (These arguments build in part on Laing's earlier Rowntree-funded research; see Laing 1998, 2002). The position within the range would depend on whether homes were meeting national minimum standards. Lower fees should be paid for personal care. Laing and Buisson suggested that local authorities are currently paying on average £358, leaving owners short of revenue, and contributing to the decline in new care home registrations.

Care homes – charges to residents

Contrary to the Royal Commission's recommendations that all of the costs of nursing and personal care in care homes and personal home care should be met by the state out of general taxation, with only 'hotel' costs subject to a means test, service users are liable to pay for their personal care if their income and assets exceed a certain amount (currently residents of care homes with assets worth £20,000 or more receive no local authority funding for their personal care; if they have assets below this amount they will receive some support). Nursing care is provided free. The National Assembly for Wales and the Northern Ireland Assembly, along with the Department of Health for England, have therefore not introduced free personal care as is now provided in Scotland. The charging regime is set nationally, in contrast to the locally determined charging regime for home care (see below).

Hancock (1998) used FES data for 1992/93 and 1993/94 to explore the wealth holdings and income levels of older people, concluding that low-income individuals could convert

some housing wealth into income to meet some current material needs, but that rarely would this income stream be sufficient to pay for long-term residential care. In other words 'it would be wrong to think that home ownership alone can solve the problems of income poverty in old age either now or in the near future' (p.29).

Wright (1998) explored the effects on carers of the admission of a frail older person to a care home, casting interesting light on the poor understanding of the financial implications of admission in those pre-Royal Commission years. Her study also pointed to the difficulties that family caregivers experienced in the process of choosing a care home. Information and advice were noticeably scarce. Hancock and Wright (1999) examined the financial implications for older couples of one individual entering a care home.

The Malcolm Pointon case, recently reviewed by the health ombudsman, suggests that PCTs and strategic health authorities will need to reconsider their eligibility criteria for funding 'to ensure that the criteria for funding care at home and the recognition of patients' psychological as well as physical needs are clearly defined' (quoting from the Ombudsman's Ruling, November 2003, as reported in *Community Care*, 12-18 February, 2004). Malcolm Pointon's needs had earlier been assessed as 'social', and not nursing, so his care was not funded by the NHS. Eligibility criteria for NHS funding may need to be reviewed. People with dementia may now be more likely to qualify for NHS funding for their continuing care, although the DH has apparently been slow to compensate people who were previously denied fully-funded continuing care (BBC News website 22 June 2004). There might also at last be greater uniformity across the country: two years ago the Audit Commission (2002a) described wide variations in the extent of NHS funding of continuing care for older people with mental health problems. (See also Means and Langan 1996.)

Home care – charges to users

Figures 4.18 and 4.19 above illustrated the proportions of gross expenditure on home care financed through sales, fees and use of charges. Figures 4.29 and 4.30 show changes in unit costs of home care for adults and older people between 1997/98 and 2002/03 in England and Wales. Just as for residential and nursing home unit costs, the costs of home care for adults and older people have increased significantly in the last few years. The average gross hourly cost for England rose by more than a third between 1997/98 and 2002/03, up to around £12 per hour. The London differential appears to be much less marked than for residential care, with metropolitan districts showing the lowest unit costs in England. Contrary to what was found for residential and nursing home services, unit costs for home care for adults and older people in Wales are higher than those in England.

Figure 4.31 compares the relative increase in prices in home care and residential and nursing home care between 1997/98 and 2002/03. It shows the relative increases in the two sectors to be almost identical, except in the last year, when residential and nursing home unit costs grew more rapidly than those for home care.

The most extensive evidence on charging for home care services is offered by the Audit Commission (2000). Four problem areas were identified:

> There is not a consistent approach to the funding of long-term care. … Some unacceptable variations in charges. … Few councils are clear about why they charge what they do. … Local management of charges needs improvement (p.58).

One consequence is that some older people choose not to use community-based care services, because they are unwilling or unable to pay the fees charged (see for example Baldwin and Lunt, 1996; Chetwynd *et al* 1997; Deeming and Keen 2002). We are not aware of any estimates of the price elasticity of demand to give any precise indication of the likely effects of further price increases or extensions. However, where service users are consulted over charges, the majority tend to regard them as fair (SSI 2003).

The absence of national guidance has contributed to these difficulties. Action is promised (e.g. Welsh Assembly Government 2003), and progress is being made; – in particular, most English authorities had reviewed charging as required by guidance issued in 2001 (SSI 2003). What is disappointing is that none of these problems is new. All were known about in the 1970s and 1980s, even if fewer local authorities were then charging for home care services (the Audit Commission report notes that 94 per cent of local authorities were charging in (presumably) 2001, compared to 72 per cent in 1992/93) and the real value of the fees charged was also lower. For instance, Judge and Matthews (1980) identified a very similar set of problems with user charges for social care a quarter of a century ago.

Direct payments

Direct payments were introduced in England and Wales under the Community Care (Direct Payments) Act 1996, coming into effect in 1997, and extended to older people in February 2000. Direct payments must now be offered to everyone assessed as needing social care, but take-up by older people has been very slow. DH community care statistics for 2002/03 indicate that only 2700 older people had taken up the option of direct payments. The main barriers to greater uptake were poorly informed care managers, lack of direct payments support services, lack of enthusiasm among local authorities (Clark *et al* 2003), the design of schemes for working age people but not older people and poor public information (SSI 2003). Another barrier for authorities is the support (transaction) costs of operating a direct payments system. Clarke's study

found that older people in receipt of direct payments reported a number of benefits, but they also experienced difficulties in coping with the audit and administrative demands of handling their own funding. Another barrier to take-up by older people, according to the National Centre for Independent Living, is that local authorities set an upper limit to the payment level that does not necessarily allow users to purchase services to meet all of their needs.

The SSI (2003) strongly urges local authorities to offer direct payments to all users, reporting 'considerable unfulfilled potential. … On current performance, social services will need to significantly improve procedures to ensure that users are given every chance to benefit from direct payments' (p.6).

Ungerson (2004) compares schemes that provide direct payments (or similar) in five European countries. Her analysis is unable to identify clear advantages associated with particular schemes, since the contexts in which payments are made and the regulatory frameworks governing payments exert such major influences on empowerment and independence.

Costs of supporting older people

Figure 4.32 illustrates changes in the average gross weekly expenditure per person on supporting adults and older people in residential and nursing care and providing intensive home care, one of the performance indicators used by the Department of Health in England. It shows that average gross weekly expenditure per person has increased very significantly since 1998/99 (an increase of over £100 in England). The main reason will have been the rebalancing of support between care homes and community settings: as the shift occurs, the average dependency and average cost in both settings will have increased (a recurrent but sometimes disconcerting feature in many areas; Knapp 1984). The figure also reveals large variability in the cost of providing services between types of local authorities: the average gross weekly expenditure per person in London authorities is more than £100 higher than elsewhere. Overall, the star ratings show a small decline in the performance of local authorities with respect to the cost of intensive support, with around 66 per cent of local authorities considered as performing up to 3* standards in the period 2002/03.

A number of studies – only some of which are summarised here – have calculated the agency-specific or societal costs of supporting older people. The best of these studies will have measured costs comprehensively across all relevant services and agencies, and explored the associations between these costs and the needs and other characteristics of older people.

Using national (GB) household survey data from the 1980s, Kavanagh and Knapp (1998) found that disabled elderly people with greater cognitive disability used more services, more intensely and consequently had higher care costs. The percentage contributions to the total costs of support, by severity of cognitive disability, for older people living in private households were:

	None	Mild/moderate	Severe
Individual and family	80 per cent	70 per cent	65 per cent
NHS	11 per cent	16 per cent	20 per cent
Local authority	9 per cent	14 per cent	15 per cent
Total cost (1994/95 prices)	£165	£187	£205

For elderly disabled people in voluntary sector communal establishments, the fees charged for placement were higher for people with more severe cognitive disability. This result was not found among residents of private sector homes. At higher levels of cognitive disability, there were higher proportions of people resident in communal establishments rather than households, and higher cost facilities, consistent with evidence that cognitive decline is a key precipitating factor in admission into institutional care (Opit and Pahl 1993; Davies *et al* 2000).

Only a minority of people in households with mild, moderate or even severe cognitive disability were in contact with specialist services at the time of the surveys – a deficiency that has been documented with more recent data (Cooper and Fearn, 1998) – and many people with severe disability in communal establishments were resident in non-specialist accommodation. As we discuss in sections 4.5 and 4.6, models of care management that co-ordinate community resources and target them on the individual needs of elderly people with cognitive disabilities could also bring cost-effectiveness improvements (Challis *et al* 1997).

The impressive MRC-CFAS study found that, within its longitudinal design and focusing on older people with dementia, disease progression was associated with increasing costs. In an Oxford study, Wolstenholme *et al* (2002) retrospectively analysed longitudinal data for 100 people diagnosed with Alzheimer's disease or vascular dementia between 1998 and 1999. They found that cognitive change (measured by the MMSE) was an important predictor of institutionalisation and cost of care, but that Barthel scores (measuring physical disability) were independently predictive of time to institutionalisation and cost. This mirrors in the longitudinal domain the cross-sectional conclusions by Kavanagh and Knapp (2002).

Schneider *et al* (2003) looked at a comprehensive set of costs, covering both formal and informal care services, again associated with the support of older people with dementia. They found that residential care was less costly than care in domestic settings, because of the high care costs falling to families and others. Over time, the burden of costs shifted from the NHS to social services as more people moved into care homes.

Informal care was found to account for up to 40 per cent of the total costs of supporting people with dementia. The authors concluded that informal care was being *supplemented* by formal care services in the early stages of care, but later *substituted* by formal care as older people entered care homes (a topic to which we return in the next section). Severity of dementia was positively linked to the quantity of informal care provided. On the other hand, physical frailty was associated with less informal care but more formal care. One hesitation about these findings is that the authors appear not to have addressed the problem of endogenity in that formal and informal service levels (and their associated costs) are causally interdependent in complex ways.

Resource inputs

The resource inputs to social care are the staff, family and other carers, capital resources and consumables that are combined together to make up the services that people use. In this section, we first look at informal care, although we cannot delve far into the impressive and detailed literature on the topic, and then at paid staff. We should stress immediately that our discussion of carers here is not intended to suggest that they should be viewed merely as inputs to the process of improving the quality of life of older people. The promotion of quality of life for carers is an outcome in its own right; we discuss the evidence on the effectiveness and cost-effectiveness of supporting carers in section 4.6. We do not discuss volunteer inputs, having found little evidence from our search (Thornton 1991; Knapp *et al* 1996; Seymour and Gale 2004).

Informal care – the numbers

The extent to which the health and social care systems rely on carers can be seen from reanalysis of data from the General Household Survey 1998/99 by Pickard *et al* (2001). They estimated that 53 per cent of people aged 65 or over with dependency problems received informal care only, 34 per cent received both informal and formal care, 9 per cent received formal care only and 3 per cent were unsupported. The financial implications are considerable, although somewhat wild estimates have been made by other authors on the basis of unrealistic figures for the opportunity costs of carer time. (McDaid 2001 reviews the challenges of assessing the cost of informal care of supporting older people (with dementia), although the cost is undoubtedly substantial, both to individuals and to society.)

The Audit Commission (2004c) recently reviewed the circumstances and supports of carers. They estimated that there are four million carers in England currently, about one million of whom provide more than fifty hours a week of care. Most are of working age (figures derived from the 2001 Census). The challenge for the future, of course, is that the growing numbers of older people needing care might be accompanied by a fall in the pool of potential carers, particularly given that the majority of carers are family members, usually children (Wittenberg *et al* 1998; Bond *et al* 1999). Legislation and guidance over the last two decades has considerably improved the (potential) support for carers (Secretary of State for Health 2000a; National Assembly for Wales 2000; Audit Commission 2004e).

Based on figures from the UK Census 2001, figure 4.33 shows the proportions of the population in England and Wales providing unpaid care, as well as the breakdown of the levels of support provided. Slightly higher proportions of the population provide unpaid care in Wales than in England (12 per cent versus 10 per cent). In addition,

those providing informal care in Wales provide a higher intensity of support: 26 per cent and 39 per cent of Welsh carers provide at least 50 and 20 hours per week of support respectively, versus 21 and 32 percent of English carers.

Figure 4.34 shows the types of support provided by unpaid carers. Overall, most carers provide practical help, companionship, assist the person cared for in going out and provide general supervision. Whereas female carers are more likely than men to undertake most tasks, male carers are more likely to provide physical help and to take out the person cared for (cf. Arber and Ginn 1995).

Figure 4.35 presents the proportion of older people being assessed for services in Wales who benefited from informal support. There does not appear to be much of a gradient in the probability of receipt of informal support by the age of the older person receiving social services. Overall, around 35 per cent of older people being assessed by social services receive informal care support.

Figures 4.36 and 4.37 describe the nature of the relationship between the older person receiving services and their carer.

The future supply of informal care has long been expected to fall, because of the changing age structure of the population, increases in divorce rates, decline in family size, rising childlessness, growing employment rates among married women, changing household composition of older people, changing care preferences of older people and the nature of kinship obligations (Pickard *et al* 2000). However, projections from the PSSRU model indicate that a fall in the number of widows and a rise in the number of elderly women with partners will alter the supply of potential carers. Their model also projects that 'carer-blind' policies – i.e., making services available to older people regardless of whether they have family or other carers already in place (modelling a policy option discussed by the Royal Commission) – will not substantially increase the future costs of long term care, contrary to some concerns.

Informal care – impacts on carers

The effects on carers of the support they provide their relatives, friends or neighbours can be considerable. On the positive side, the great majority will gain satisfaction from their enormous contribution to maintaining and improving the quality of life of the person cared for. However, most attention focuses on the negative aspects of informal care. Not surprisingly, supporting carers continues to be a policy priority (e.g. Department of Health 2001; Welsh Assembly Government 2003). But

> The government's aspiration for carers of older people are not being realised
> in practice for the majority of them. A clearly articulated and coordinated

approach is needed from all concerned if this is to change. This must be deliverable within the resources available (Audit Commission 2004e, p.62).

Carer well being (including health status and coping skills) is a key influence on the decision to admit an older person to a care home (e.g. Brooks *et al* 1990; Williams and Fitton 1991; Levin *et al* 1994; Warburton 1994; Bannister *et al* 199?; Ryan and Scullion 2000). The MRC-CFAS study, with its large sample and longitudinal design, found some support for the hypothesis of substitution between informal and formal care (and see Andrew *et al* 2000; Schneider *et al* 2003).

Failings identified by the Audit Commission (2004e) include poor early identification of carers, and failure to refer them to social services or the voluntary sector for support and guidance; unsystematic approaches to the provision of information and advice, and a lack of clear points of contact for carers in need of urgent help or advice; poor availability of appropriate support services at crucial times (such as at night or at weekends) or when the person being cared for is being discharged from hospital; many carers receiving very little service (those known the social services are receiving 'fairly good support', but others get little or none); defensive and lack of sensitivity displayed by some care managers in relation to the needs of carers.

Assessment of needs

The *Carers (Services and Recognition) Act 1995* entitled carers to a full assessment of their needs independently of the users of services; previously very few had been assessed and some that had were not shown a written account. Although some progress has been made, a number of problems remain (Briggs and Askham 1999; Hardy *et al* 1999; Audit Commission 2000a; Seddon and Robinson 2001; and many of the annual reports of the joint SSI/Audit Commission reviews). Principal among those problems is the simple fact that the numbers of carers being assessed were still too low in most authorities (SSI 2003). We discuss the statistical data in section 4.5.

Health and well being

Informal care responsibilities can lead to poor caregiver health (Schneider *et al* 1999; Evandrou 1996; Taylor *et al* 1995; Banks and Cheeseman 1999), including injuries (Brown and Mulley 1997). Bauld *et al* (2000) found that carers of people with cognitive impairment were more likely to report stress than carers of older people without cognitive impairment. The MRC-CFAS study found that carers were more likely to report poorer levels of well being (measured by the GHQ) if the person they cared for had three or more behavioural problems. In fact, the evidence on the impaired health and well being of carers is vast.

Schneider *et al* (1999) point to the 'high level of burden and mental distress in spouse carers for people with Alzheimer's disease' (p.652). They make recommendations for better primary and secondary prevention of this burden by addressing the clinical needs of people with AD, changes in public attitudes and education to reduce the negative social reactions to the illness, better economic support for informal carers, and recognition of the particular needs of higher risk groups, such as younger spouse carers. Livingston *et al* (1996) report a high prevalence of depression among the carers of older people with depression, dementia or psychical disability living in community settings. MRC CFAS (2002) found that caregivers' psychological well being did not deteriorate over a two year period, in the cases of informal carers of older people with mental health problems. See also Donaldson *et al* (1998).

Buck *et al* (1997) investigated the extent and correlates of psychological distress among informal carers: stress was higher when the older person being cared for had more problem behaviours, when carers had to alter their working hours and when the carer was female. Other studies have found that emotional or psychological distress is associated with the degree of difficulty in the caring role (e.g. Malfullul and Morriss 2000).

Employment

Evandrou (1995) found that men and women who provide twenty or more hours per week of informal care have earnings from employment that are 25 per cent lower than the earnings of employed non-carers. Caring has a lifetime impact on earnings and other income (Evandrou and Falkingham 1995).

Glendinning's (1992) work concluded that the health status of the care recipient was the most important influence on decisions over changes in labour force participation by the informal carer. Carmichael and Charles (1998) carried out searching analyses of General Household Survey data for 1985, looking at the relationship between informal care responsibilities and labour supply by women. Informal carers providing less than twenty hours of care each week were more likely to participate in the labour market, but to work for fewer hours per week, when compared to women who do not have care responsibilities but were in all other respects identical. Informal carers who provide twenty or more hours of care per week were less likely to participate in the labour market than women without informal care responsibilities, although the difference was quite small. However, those informal carers with paid employment earned less per hour and worked for fewer hours per week than women without such responsibilities. It should be noted that this evidence applies to 1985 data. The MRC-CFAS study found that 15 per cent of informal carers had altered their employment arrangements: 9 per cent of them had reduced their hours of work and 6 per cent had changed their hours of work without reducing them. One fifth of carers of pre-statutory retirement age had

given up work altogether. Half of those of pre-statutory retirement age who were not working claimed that caring was the main reason for not seeking paid employment.

An excellent review of the literature on the effects of caring on employment is provided by Pickard (2004), which paints a bleak picture of the efforts made by (primarily public sector) employers to support family and other carers.

Out-of-pocket costs

Glendinning (1992) reported how carers incurred substantial out-of-pocket expenses. The MRC-CFAS study provides further UK support for the argument that informal carers carry financial caring costs (out-of-pocket) although these tend not to be substantial. Twenty-five percent of carers in the ECCEP study reported incurring out-of-pocket expenses (Bauld *et al* 2000). Of course, the impact of caring responsibilities on the ability to continue in paid work can substantially increase this economic burden (Philp *et al* 1995).

Information

Many carers complain of a lack of information about the prognosis for the cared-for person, the availability of respite and other services, their eligibility for support, and their own roles generally (Caldock and Nolan 1994; Hanson *et al* 1999; Johnson and Abbott 1999; Banks and Cheeseman 1999; Audit Commission 2002a; Pickard and Glendinning 2002). Gillies (2000) argued that the Carers Act 1995 and the subsequent National Carers Strategy, *Caring about Carers*, 'have thrown the role of carers into some confusion and ambiguity their conflicting needs as carer and recipient impact upon their status as an "expert" carer and further complicate how they relate to the formal carers with whom they would seek to work in partnership' (p.442). A similar conclusion was reached by Hoad (2002) about the unclear boundaries between volunteering, professional care, paid manual work and informal care. As the NSF commented, 'good information is also essential for carers' (DH 2001 p.28). Unpublished evidence cited in the review by Burholt and Windle (2001) suggests that providing better information on caring reduces carer stress, and that provision of 'concise, up-to-date information … is consistently rated as among their greatest need' (p.72).

Empowerment

Information contributes to empowerment, although the two are most certainly not one and the same (Clarke 2001). Lack of empowerment of carers is frequently cited as

another failing of current arrangements (e.g. Braye and Preston-Shoot 1995; Tanner 1998).

Medication management

One particular challenge is medication management as part of the informal caring role (Smith *et al* 2003). Carers reporting a greater frequency of medication-related problems were also more likely to report higher levels of carer strain and poorer mental health. Smith *et al* recommend better support for carers in the management of medication. See also Schweiizer and Hughes (2001).

Access to support and respite care

In the 1999 *National Strategy for Carers*, £140 million was allocated to enable carers to take short-term breaks from caring. Buck *et al* (1997) found that carers' psychological stress levels were lower when the older person being cared could be left all day. Respite care is the service for which most carers express a need, as many studies have shown (e.g. Banks and Cheeseman 1999), but few have access to it (Audit Commission 2002; Koffman and Higginson 2003; Longshaw and Perks 2000; SSI 2003) or find the proffered services to be acceptable (Levin *et al* 1994; Moriarty 1999).

Kirk and Glendinning (1998) highlight the complex interface between formal and informal care giving. They caution that 'in the drive for greater efficiency and cost containment, the increased involvement of the informal carers is not matched by ideological commitments to greater choice, empowerment and the provision of appropriate support' (p.378).

Simon *et al* (2002) report the views of district nurses that lack of resources and access mean that they are not as active as they wish in supporting informal carers. Nurses felt that GPs were better placed to provide such support. Other studies have reported carers' views of lack of support (e.g. Ryan and Scullion 2000).

In their literature review, Burholt and Windle (2001 pp.77-81) emphasise the importance of support networks. Different network types have different implications for the support of older people and for carer burdens (Wenger *et al* 1998; Wenger and Burholt 2001).

Paid employment and volunteering

Volunteers

The human resources relevant for meeting social care needs include family and other carers, as mentioned earlier; volunteersing linked to formal organisations; and paid employees. Although the point is rarely made, the heavy reliance on volunteering, particularly outside mainstream residential and domiciliary care, represents a key contrast with other public services, such as education and health care. This is perhaps because research in volunteering has tended to proceed separately from research on the paid labour force. However, we can look at the two together. It has been estimated that, in 1995, the millions of people volunteering in social care voluntary organisations (typically for a few hours a week) were contributing the equivalent time of 221,000 full time employees, compared to 185,000 social care paid voluntary sector employees in social care (Kendall 2003 p.23). If we take the most recent total (all organisations) paid employment estimate of paid employees in social care of 929,000 in 2001/02 (Eborall 2004 p.1), and assume that social care volunteering has remained reasonably stable, this would mean that volunteers working for voluntary organisations accounted for one in every 5 hours of formal caring input. This understates total volunteering, of course, because it does not include volunteers mobilised by social service departments.

The rarity with which volunteers are compared with paid workers in social care does not mean that they have not received their own separate policy recognition: the Seebohm (1968) and Barclay (1982) reports gave considerable attention to this topic. Moreover, their general importance has been at least symbolically flagged by some external commentaries (ADSS and NCV 2001; Henwood 2001), although they have arguably been given less attention as an overarching (cross-client group) issue in the white papers, plans, and reviews of the 1990s.

Most Government recognition of volunteering in social care has been client group-specific. In particular, there has been some emphasis on the value of volunteering amongst people nearing 65 (see the Cabinet Office's *Winning the Generation Game* agenda; Performance and Innovation Unit 2000) or for people over that threshold (see the *Better Government for Older People* programme: BGOP Steering Group 2000; Hayden and Boaz 2000). In fact, more is probably known about volunteering by this client group, and concomitant links to services, than any other. Volunteering can be especially important in providing companionship, contact, and fostering respect amongst older people not in receipt of social care services. This 'expressive' function can develop more easily outside the prescriptive environment of SSD-funded and nationally regulated service interventions. The absence of payment can foster emotional investment, because both parties understand that the worker is not being financially rewarded, and is more likely to be there for intrinsic reasons. Empathy may be easier to

achieve where volunteers are themselves over 65, serving as 'chronological peers', and seen to be more likely to bring relevant experience than younger support workers (see literature discussed in Kendall 2003 pp.172-173).

Paid employment overview

Official data on paid employment has traditionally addressed the situation of those employed by local authorities; the public sector still has the only reasonable time series data (see below). The qualitative experiences of these employees was explored in some detail by NISW research over the period 1992 to 1997 (eg Balloch and Maclean 2000). Over recent years, however, knowledge about the characteristics of the paid workforce has gradually caught up with the reality of the dominance of independent provision. This includes the Local Government Management Board's *ad hoc* surveys of particular service areas (in collaboration with ADSS and CCETSW; see LGMB 1997, 1998); the PSSRU's workforce mappings and analyses in 1999-2001, using secondary analysis of the Quarterly Labour Force Survey and other sources (Kendall and Almond 1999; Almond and Kendall 2000, 2001; Comas *et al* 2001); and the TOPPS Workforce Intelligence Unit's reports (Eborall 2004). Although the situation is improving, there are still both uncertainties and significant margins of error in relation to global figures (which conservatively suggest a paid workforce of just under 1 million) because of definitional confusions, measurement problems and data gaps (Comas *et al* 2001 pp.162-164; Eborall 2004 p.1).

Some of they key findings to emerge from these sources (across client groups, but concentrated in older people's care because of their disproportionate economic size are:

- Around half of paid employees are to be found in care homes; around one fifth are in domiciliary care, with the remainder in day care and all other forms of social care, including non mainstream support.

- The private sector is the largest employer of paid workers, ranked ahead of the public sector (around one quarter of workers), and with the voluntary sector in third place (as noted, detailed information is available only on trends within the public sector, and are discussed below).

- Care assistants, employed across both these settings and sectors, account for approximately half of all paid social care employment.

- The social care paid workforce also :

  > is dominated by women;

> includes a relatively high proportion of people over 50;
> includes a high proportion of 'non standard' positions, including part time work. (For over three quarters of employees, this option was freely chosen, and did not reflect an inability to find full time work. See Comas et al 2001 p.180);
> involves concentrations of some minority ethnic groups, in the case of domiciliary care (across sectors), and of local authority employment (across forms of care); in the latter case, black people (particularly black Caribbean people) are particularly prominent.

(Precise figures are deliberately not given, to avoid giving a false sense of accuracy to estimates which need considerable refinement.)

Paid staff directly employed by local government – numbers

We noted above that robust information on trends is available only for public sector employees, and we report here some information on SSDs, still the most significant single public sector employers of social care staff. Figure 4.38 illustrates how there has been a significant decline in the numbers of paid staff working for social services departments in England in the last ten years. This reduction is primarily due to the decrease in the numbers of local authority employed residential care staff, a process linked to the expansion of private and voluntary sector provision. Figure 4.39 indicates that the greatest reduction in the numbers of residential care staff has occurred among those working in the elderly care sector. A very similar picture can be painted of the changes in the numbers of area office and fieldwork staff. As depicted in figure 4.40, between 1994 and 2003 the numbers of whole time equivalent domiciliary care staff fell from around 60,000 to around 35,000. This reduction was partly offset by an increase in the number of staff working in services for children.

Coinciding with the expansion of the mixed economy of care, the last ten years have seen a significant increase in the numbers of central and strategic staff (see figure 4.41). Interestingly, the increase in the number of social workers depicted in figure 4.42 over the last ten years is associated with more social workers for children and more social workers located in health settings or within specialist teams, a response to the further integration/collaboration between health and social care systems. These shifts clearly can present exciting opportunities for new collaborative approaches, but working at the health and social care interface also exposes employees to a wide range of cultural, professional and micro-political tensions and challenges (see chapter 3).

Adjusting to increased 'partnership' working is not the only transformation in working circumstances faced by many SSD-employed staff. Care management models, demanding new skills and techniques, also have clear implications for the *modus*

operandi of a significant number. Around one out of every ten social workers today is employed as a care manager, with many implications for professional roles and responsibilities (Lymbery 1998). The SSI (2003) summary of inspections noted that some authorities were planning to increase this number in order to promote person-centred planning within the new single assessment process. They also reported, however, that there was evidence of poor workforce planning within care management teams, with some authorities relying unnecessarily on qualified staff to undertake tasks that could be done by unqualified staff. We discuss care management in section 4.5.

Figures 4.43, 4.44 and 4.45 depict respectively the numbers of day care staff, occupational therapists and assistant occupational therapists in England over the period 1993 to 2003.

Figure 4.46 suggests that part-time staff numbers have fallen whereas full-time staff numbers have stayed more or less unchanged. Consequently, greater proportions of staff in 2003 work for local authority social services departments as full-time employees than in the period 1994 to 1999.

In contrast with the English picture, the overall numbers of staff working for social services departments in Wales and Northern Ireland have increased over the last ten years (see figures 4.47 and 4.48 respectively). Figure 4.49 illustrates how the majority of the workforce employed by social services in Northern Ireland is constituted of females, mostly working full-time, with almost no male part-time workers.

Staff recruitment and retention

There are obviously many staffing issues that could be discussed, and here we focus on two: (a) recruitment and retention, and (b) training. Both are presenting challenges for the social care sector (Mathew 2000; Audit Commission 2000a; Henwood 2001), and especially in relation to services for older people (e.g. Litwin 1994; Peach and Pathy 1982; Department of Health 2001 p.140; SSI 2003 p.64; Francis and Netten, 2003). As the SSI and Audit Commission (2004) note 'Workforce pressures and gaps are causing problems in allocating work and providing continuity of care' (p.3). Figure 3.1: Social care supply in context Grants targeted on staff recruitment and retention problems have recently been made available by the Department of Health, to be used across all provider sectors.

One hurdle in recruiting staff is the need for clearance from the Criminal Records Bureau (there is currently an average wait of three months). The Department of Health announced in March 2004 that it proposed to allow new home care, nursing agency and care home staff to begin work prior to completion of a CRB check, provided they had completed three days' training.

A number of studies have reported high levels of staff stress or dissatisfaction. 'Partnership' working often seems to be experienced as a mixed blessing (see chapter 3), but more generally research has pointed to difficulties across a range of workplace situations. The TOPSS Workforce Intelligence Unit summary report has pointed out that satisfaction in the social care workplace seems to require that a range of demanding conditions be met for workers to be satisfied. Thus, *inter alia*, without appropriate human resource and line management, work/life balance, training and qualification opportunities, limits to bureaucratic intrusion, protection from violence and abuse, a supportive inter-personal and career environment, and sufficient rates of pay, workers are likely to feel short changed (Eborall 2004 pp.4-7).

Many of these conditions would apply in other fields of public service too. Again, the detailed research has been undertaken specifically in relation to SSD employees as part of the NISW workforce programme mentioned earlier is relevant here, and brings in to focus more clearly some of the particularities of social care. Pahl's (1999) study as part of that programme pointed particularly to the dangerous character of some of this work, and the problem of racism flagged by these and other studies implies that workers of black and minority ethnic groups (who we noted are disproportionately present in this domain) bear additional burdens. But the researchers in this programme also offered a list of problems which draws attention to the specific experiences of workers operating in a difficult resource-constrained and political environment. In their study, four out of five managers and field social work staff and about two thirds of residential workers experienced stress:

> Major sources of stress were the inability to provide service users with what they needed, having accountability or responsibility without power, and feeling out of sympathy with the way the service was run, frustration at game playing and office politics and uncertainty about the future (Balloch and Maclean 2000 p.90).

One Welsh study suggested higher levels of stress since implementation of the 1990 Act, particularly attributed to the introduction of care management, although a number of possible influences other than the reorganisation of care could not be controlled for (Parry-Jones *et al* 1998). From a study carried out in the early 1990s, Moniz-Cook *et al (*1997) found that local authority residential home staff experienced stress levels equivalent to those found in professional nurses in an NHS setting, adding to previous reports of relatively high levels of sickness and absenteeism, as well as burn-out and staff turnover. They cautioned that increasing levels of dependency in care homes, particularly associated with cognitive impairment, may push stress levels higher. Ryan *et al* (2003) explored the sources of job satisfaction and reward among staff working in community settings with older people with dementia and their carers. Given the high rate of turnover in some social care professions, related in part to low morale, their findings are insightful.

> Organisationally, the study suggests that the availability of good support structures characterised by open channels of communication, the ready availability of senior colleagues, and a clear sense of organisational purpose and value, all promote feelings of genuine collegiality despite the potentially isolating and intensive one-to-one nature of support workers' daily work (p.116).

Autonomy was also valued, but needs to be 'supported by close attention to support workers' own needs'. The pivotal influences on expressed satisfaction, however, related to the ability of staff 'to forge and maintain good relationships with the people with dementia and their families, and to believe that what they were doing genuinely made a difference to their quality of life'. In other words, the study emphasises the fundamental relational nature of social care, and the importance of good, two-way trust in promoting outcomes.

Twigg (1997) also reminds us of the intimacy and relational nature of much social care. She also discusses what she calls 'the principal fault line of community care: that between the medical and the social' (p.229). In a later paper she emphasises the 'bodywork' nature of social care activities, accounting in part for the low occupational esteem (Twigg 2000). Ungerson (2000) forcibly argues that gender still matters in relation to the delivery of social care services, both when looking at informal care and at formal care with paid staff.

Other studies that have examined staff stress and its determinants include those by Bradley and Sutherland (1995), Baillon *et al* (1996), Jenkins and Allen (1998), Moniz-Cook *et al* (1997; 2000) and Margallo-Lane *et al* (2001).

Young and Wistow (1996), in work for the UKHCA, reported that three-quarters of their sample of independent sector home care providers felt that wages were 'too low' in the sector, erecting a sizeable barrier in the way of recruitment. The introduction of the national minimum wage ought to have eased recruitment into social care jobs (although we have not seen any evidence), but will have further squeezed the finances of independent sector providers facing fixed fees for their services. The NMW increases from £4.50 to £4.85 in October 2004 (as announced in the March 2004 budget).

Social care pay

Social care employers, particularly in the private sector, have traditionally paid low (and sometimes *very* low) wages and offered poor conditions for many, and so have been significantly affected by New Labour's minimum wage legislation (Kendall and Almond 2000; Almond and Kendall 2001). Comas *et al* (2001, p.209) systematically compared the remuneration of the most notoriously underpaid category – care assistants – and

show that they were typically earning similar rates of pay to shelf fillers, domestic servants, cooks, packers and farm workers. (See too Almond and Kendall 2000, 2001 for wider comparisons, setting social care-relevant activities and occupations in the context of the economy as a whole, and distinguishing within them between sectors of ownership.) However, these comparisons were undertaken using data from six years ago, and clearly conditions have now changed significantly. The introduction of the national minimum wage ought to have eased recruitment into social care jobs (although we have not seen any evidence) but will have further squeezed the finances of independent sector providers facing fixed fees for their services.

Staff training

Staff training levels are widely recognised to be inadequate (e.g. Department of Health 2001; Henwood 2001; Local Government Management Board 1997; Audit Commission 2002a; Nazarko 1996). Baldwin *et al* (2003) examined the roles of support workers in nursing homes. A lack of role clarification was evident from their review, and there also appeared to be inadequate preparation and subsequent supervision of these staff. Training also appeared to be inadequate. Aoki and Davies (2002) describe the barriers to accessing training experienced by nursing home staff.

Training of health service staff was boosted by the *Agenda for Change* programme, but social services' training activities appear not to have received the same resource encouragement. The training support programme grant was worth £56.5 million in 2003/04, and there are other smaller grants made available by TOPSS. The recommendation from TOPSS in 2000 was that 3 per cent of social services expenditure should be on training, compared to as little as half that proportion in many local authorities. However, expenditure per head on staff training is actually lower in voluntary sector organisations (*Community Care*, 12-18 February 2004).

The NSF recommended 'additional training and support for staff at all levels to build their knowledge base and foster more positive attitudes towards ageing and older people' (Department of Health 2000 p.21), and set out a number of other workforce requirements stemming from the set of care standards (pp.138-141). The SSI (2003) summary of inspections found a strong commitment to training in authorities, although some weaknesses, including 'programmes disconnected from modernisation' (whatever that means!) (p.40).

All in all, this seems to be a deeply problematic area. The National Vocational Qualifications related to social care – the main instrument for driving up skills, in the sense that these are built in to new regulations at the provider level – are seen by many as inadequate. Moreover, little seems to be known about where or how resources ring-

fenced by central government for training are being used – let alone whether they are being used cost effectively (Netten *et al*, 2004).

Services

There have been a great many service changes since 1990, and here we attempt to cover the most significant. As ever, the volume of evidence is far greater than we can cover in such a short-term review. We discuss developments under the following headings:

- care management

- needs assessment

- commissioning

- targeting

- care homes

- housing services

- home care

- other community-based services

- hospital-community balance

- delayed discharges from hospital

- intermediate care

- prevention

- whole system approaches

Care management

Care management is 'the process of tailoring services to individual needs. Assessment is an integral part of care management but it is only one of seven core tasks that make up the whole process' (Social Services Inspectorate, 1991, p.11). We discuss them separately here.

Care management was obviously a fundamental element of the community care reforms. The *core tasks* of care management include: case finding and referral; assessment and selection; care planning and service packaging; monitoring and re-assessment; and case closure (Davies and Challis 1986). The *core skills and knowledge* required of care managers, as set out by Challis (1999), include well developed skills in listening, interpersonal relations, collaborative working, communication, thinking outside the professional box, understanding of needs, awareness of local resources, assessment skills, and ability to work across a range of agencies. Care management was highlighted in the 1989 White Paper and its importance has been reiterated more recently (in, for example, *Modernising Social Services*, 1998). The broad definition of care management allowed considerable local flexibility in the interpretation of the tasks and the organisation of services.

Care managers should be well placed to identify and assess needs and preferences, and to respond to them through their (co-ordinated) purchasing of services. Care managers can help users and carers gain more influence over services. Care management was expected to improve choice and market responsiveness to needs and preferences so long as some purchasing powers were devolved, in turn requiring better information and financial monitoring systems (Audit Commission 1997).

The cornerstone of community care?

Has care management therefore proved to be the 'cornerstone of community care' (Secretaries of State 1989)? It has certainly changed the nature of much social work. As we saw earlier, one in ten local authority social workers is today employed as a care manager. But the ways that care managers work vary a lot across the country, as revealed by the survey by Challis *et al* (2001) in English local authorities in 1997/98, and by audits and inspections (e.g. Audit Commission 1997; SSI 2003).

Challis and colleagues were interested to know whether the original care management model ('a mechanism predominately concerned with coordinating and managing care for specific groups of vulnerable people with long-term care needs') had evolved into a broader mechanism for delivering care to the full range of social care users, as well as a vehicle for pursuing other objectives such as developing a mixed economy of care. Their survey uncovered wide variation between authorities in terms of care management arrangements for older people, often characterised by an internal lack of coherence. The study was not able to explore connections between arrangements and service user outcomes.

It was also unusual to find authorities with small care manager caseloads or clear eligibility criteria, both ingredients of a good intensive care management structure. Using data from the same survey, Weiner *et al* (2003) argued that arrangements for

health care staff to act as care managers have not been widely taken up in England. Where such care manager arrangements have been used, they tend to be focused on supporting older people with mental health problems and on assessment rather than the longer-term management of individuals. The single assessment process (SAP) may engender change. (The PSSRU survey also looked at the relationship between care management and the 'care programme approach' for older people with mental health problems. See Hughes *et al* 2001. We discuss the findings in chapter 5.)

Devolved budgets

One central recommendation of the 1989 White Paper was the devolution of financial responsibility to care managers. A longitudinal study of the developing mixed economy of care in 25 areas found considerable reluctance among local authorities to devolve budgets, with concerns about 'field social workers running around with cheque books' (Wistow *et al* 1994 p.76). Inadequate information and monitoring systems were the most common reason given for this reluctance, although as Harbert (1994) argues, many elected members might fear that devolution would marginalize them by shifting considerable power to field-level staff. (See Dant and Gearing 1990 for some earlier concerns about care management and devolved budgets.) By 1993 there was evidence of budgets being devolved to team managers but rarely to individual care managers, with directors of social services expressing concerns about lack of consistency, ongoing information system inadequacies and the high transactions costs when commissioning is not centralised (Wistow *et al* 1996 pp.147-149). Nonetheless, there was 'some decision-making flexibility and responsibility for care managers. On the whole, authorities had been relatively cautious in the implementation of … devolved purchasing (p.75).

There had been little change by the mid 1990s: in only three out of 18 sample authorities were care managers either sole budget holders or part of a combined team for purchasing external services (unpublished findings from the PSSRU/Nuffield Institute 'Mixed Economy of Care' project). Often, care managers' purchasing powers applied only to external and not to in-house services. Another study, based in 10 English and Welsh authorities, found that the level of authority to spend awarded to frontline staff tended to be concentrated on home help organisers, i.e. on staff in charge of arranging low intensity and inexpensive care packages (Bauld *et al* 2000). Numerous other studies confirm that budgetary devolution to care managers remains uncommon (e.g. Baldwin and Lunt 1996; Audit Commission 1997; Filinson 1997; Challis *et al* 2001).

Significant, continuing shortfalls

More generally, there has been disappointing progress with the implementation of care management services. The 1997 Audit Commission report, *The Coming of Age*, described a number of constraints on care managers, including restrictions on choice or provider – with 'in-house first' policies still prevalent, lack of influence over what was provided (particularly by the in-house providers), lack of skills and confidence in some tasks, poor information on unit costs, and of course lack of budgetary control (Audit Commission 1997 pp.32-35). More recent, and no less stinging, criticism comes from the SSI (2003):

> Like our previous reports we have identified significant, continuing shortfalls in the efficient operation of care management. In many councils this undermined the delivery of good outcomes for users, jeopardised staff morale, and reflected organisational inefficiencies (p.5).

> In most councils care management was not fully effective and systems needed improvement. Bureaucratic processes and a lack of adequate IT support undermined many councils' efforts. In councils inspected care plans were mostly basic or unsatisfactory. Improved care plans are a key feature in preventing users from experiencing delays (p.33).

It is also interesting to hear Bleddyn Davies' (2004) reflections on the 1990 community care reforms, comparing the subsequent implementation with the findings from the Kent community care project (Davies and Challis 1996) which had greatly influenced thinking around care management.

One must remember that some of the key KCCP mechanisms were never implemented in full, and rarely even in part. Above all, it has been the devices which the KCCP logic argued would create the beneficial incentives and help them to work which had been neglected. Budgets were never devolved to a low enough level and without excessive strings, so members of care management teams never saw their users facing the opportunity costs of their own care managers' inefficient allocations. The incentives in information and review have been late and inadequate. There has been little investment in the topping up of human capital. Just before the implementation of the reforms, *Resources, Needs and Outcomes* (Davies et al 1990) called for raising the ratio of investment to consumption now to prepare us for the baby boomers, because radical reform of decentralisation systems takes a long time. It has not happened. In some respects, preserve incentives have been created. Until recently, resourcing has always reflected the particularly high pressure on the balance between resources and needs in

social care, inhibiting investment and forcing more attention to economy than to effectiveness or efficiency in field practice.

> Being a cornerstone of the reforms, attempts are being made to improve care management through the Single Assessment Process. It is hoped that this will have big effects, but much more effort should have been made earlier to prepare workers for new roles and *modus operandi*. For too long there was little investment in information field use and for equity and efficiency control through retrospective review. Routine data still leave almost all field managers and local policy-makers almost as ignorant as in the late eighties about the detail of who gets how much of what, with what effect on whom. The … logic of matching care management arrangements … to the needs of subgroups … is only now beginning to be implemented, and that in a round about way (p.283).

It could reasonably be argued, therefore, that the model of care management seen in most parts of the UK today – undeveloped, unsupported by information systems, without devolved budgets, overly bureaucratic, unresponsive to users' preferences – is of unproven effectiveness and cost-effectiveness (Lewis and Glennerster 1996; Gostick *et al* 1997; Lymbery 1998; Sinclair *et al* 2000). Fidelity to the evidence-based model of Davies and Challis (1986) has been very poor. Nevertheless, support for care management is unlikely to lessen (Audit Commission 2002a p.38).

Intensive care management

The NSF recommended that more intensive forms of care management should be concentrated on the most vulnerable older people.

From their postal survey of all English social services departments in 1997/98, Challis *et al* (2001) found that 97 per cent 'had a goal of providing a community-based alternative to residential and nursing home care' (p.409), but that only 5 per cent had established *intensive care management* services for older people. They define intensive care management as involving 'a multidisciplinary assessment, a coordination of substantial health and social care inputs in a flexible fashion within a care plan, and frequent adjustment of provision (as needs often fluctuate due to illness and disability)' (p.409).

A successful model of intensive case management will improve outcomes for individual older people, as well delaying or removing the need for admission to a care home or hospital (Jones *et al* 2003; Bernabei *et al* 1998), as Challis *et al* (2002) found from their evaluation of an intensive care management model for people with dementia, compared with what was then (late 1980s) standard care without care management. There were no differences in destinational outcomes until after 18 months, when the group receiving

intensive care management were less likely to be admitted to institutional care. Quality of life comparisons showed advantages for the care-managed group in some domains, although the only significant difference at 12 months was in relation to social contacts. The study found a significant reduction in the total number of informal carer hours and in carers' felt burden for the care management group but not for the standard care group, and carer stress was lower. The needs of the people with dementia were lower in the care management group. However, these outcome advantages were achieved at significantly higher costs to the social services department (and almost significantly different for society as a whole: the small sample size and probably skewed cost distribution undoubtedly complicated this test). Costs to carers were slightly lower for the care-managed group. However, whether the positive user and carer outcomes from intensive care management are worth the higher cost of implementing such an arrangement needs to be considered very carefully.

The Audit Commission (2004c) discusses approaches to intensive case management, aiming 'to develop more effective ways to support frailer older people' (p.15). Central to this approach is an increasingly central role to be played by social care services to encourage a whole-systems approach to the promotion of well-being. 'The approach identifies and targets people who already receive a large amount of support from health and social care services' (Audit Commission 2004c p.16). Examples of such approaches in the UK include individual case managers, jointly co-located teams and 'virtual teams'.

In the increasingly prevalent EverCare system, health professionals and social care staff work together within an individualised, whole-person approach. Evidence from the US is apparently encouraging, but there are as yet no evaluative findings in the UK. A primary care team leads the EverCare to older people living in the community, with social care services obviously very closely involved. Nine PCTs are participating in an evaluation to report in 2004. Another American import is Pursuing Perfection, which places 'a strong emphasis on working in partnership with service users and, in the UK, is based on cross-organisation working within whole health and social care communities' (Audit Commission 2004c p.18). Pilot sites in the UK are presumably being evaluated, although we could find no details. Another model described by the Audit Commission (2004c) is the London Older People's Development Programme, bringing together health, social care and other agencies across twenty-five borough-based project teams. Again, the emphasis is on the promotion of a whole-systems approach. Evaluation of the programme by Jones *et al* (2003) reported significant reductions in hospital stays and A&E attendances, leading to cost savings. Intensive case management was an important component of this development programme.

Needs assessment

Assessment rates and performance indicators

Needs-led care was a fundamental aim of the 1990 legislation, and good needs assessment was obviously a key ingredient (SSI and SWSG 1991). How has the social care system responded?

One important development has been the greater transparency of eligibility criteria in the pursuit of greater equity, as set out, for example, in *Fair Access to Care Services*. There are now four eligibility bands: critical, substantial, moderate and low (Department of Health 2002b).

Over time, there has been growth in the proportion of service users receiving written statements of their needs and how they will be met: by 2002/03 reaching 86 per cent in England, 8 percentage points higher than in 1999/2000 (figure 4.50). The percentage is almost identical in Wales (figure 4.51). Inner London authorities appear to be the best performers in England, although across the country fewer than half of all authorities received a 3* or better rating on this performance assessment framework indicator. (The bands are: 1* = investigate urgently; 2* = ask questions about performance; 3* = acceptable but possible room for improvement; 4* = good; 5* = very good.) Despite this growth, the conclusion from the latest round of inspection reports was of variable quality, with one quarter of cases examined having 'mostly unsatisfactory assessments' (SSI 2003 p.35).

One group of older people who are less likely to be assessed are those who, if admitted to a care home, would be self-funders. Wright (2003) looked at people who are paying the full cost of their long-term residential or nursing home. She found that 'it is a common policy to encourage older people in this situation to admit themselves directly to care homes without a needs assessment' (p.603). Little professional advice is given about placements or alternatives to residential or nursing home care, with the result that significant numbers of self-funding residents are 'inappropriately' being admitted to long-term care. A study of 308 older people entering long-term care (residential or nursing homes) by Challis *et al* (2000) found that many of the new admissions to nursing homes with rather low levels of dependency were self-funded. As Netten and Darton (2003) argue, local authorities 'deploy a number of tactics to avoid carrying out needs assessments of people with assets above the capital limit'. In other words, perverse incentives continue to operate in England's long-term care system.

DH community care statistics (2002/03) indicate that only about 20 per cent of assessments of older people were completed within 48 hours of first contact, about 50 per cent completed within two weeks, and just over 70 per cent completed within six

weeks. The public service agreement (PSA) target – to be achieved by the end of 2004 – is that all assessments should begin within 48 hours and be completed within four weeks, with 70 per cent completed within two weeks. 'Deficiencies in referral and initial response systems … hampered effective assessments' (SSI 2003 p.35).

Figures 4.52 and 4.53 show the estimated length of time from first contact to first service and to full package for new clients aged over 65 years. There appears to have been some slight deterioration in performance over recent years in these two indicators. For example, whereas around 49 per cent of new clients received their first service within two weeks of their first contact with social services in 2000/01, only 44 per cent did so in 2002/03. Similarly, 47 per cent of new clients in 2000/01 received all services in the care plan within two weeks of their first contact with social services, 13 per cent more than in 2002/03.

However, the picture changes if one measures the proportions receiving their first service six weeks rather than two weeks after assessment. (The Department of Health uses the longer period to define their performance indicator.) As figure 4.54 illustrates, in the last two years there has been a considerable reduction in the proportion of new adult and other clients who receive their first service more than six weeks after their first contact with social services. This pattern, particularly noticeable for metropolitan districts, resulted in a higher number of local authorities achieving a performance rating of 3* or better.

There has also been a noticeable improvement in the speed with which equipment and adaptations costing less than £1000 are delivered (figure 4.55). In England in 2002/03, 93 per cent of such equipment was delivered within three weeks of the assessment, compared to 86 per cent in 1997/98. Whereas in 1998/99 only 60 per cent of councils were rated as 3* or better by the Department of Health with respect to this performance indicator, the corresponding figure was 89 per cent by 2002/03.

Recent years have also seen improvement in the rate of assessments of older people in Wales (figures 4.56 and 4.57). In 2002/03 an average of 145 people per 1000 population aged over 64 received a needs assessment. Assessment rates in the NHS also appear to have improved. Paterson *et al* (2001) surveyed most NHS trusts in the UK, concluding that 'pre-discharge home assessment visits are increasing in number, complexity and involvement of professional time despite little evidence for their effectiveness' (p.291).

Carer assessments

Until recently, little attention has been paid to the assessment of carers' needs. Figure 4.58 shows a substantial increase between 2000/01 and 2002/03 (the only period over

which statistics are available) in the number of caregivers identified during the assessment process, as well as the number of carer assessments carried out (separately or jointly with the service user). Although the number of carers assessed separately during the period remains low, by 2002/03 the great majority of carers identified during the assessment process received a needs assessment of some kind. However, the SSI (2003) remains unimpressed: 'Most councils were performing poorly in assessing carers' needs' (p.33).

Figure 4.59 illustrates how the number of informal carers receiving an assessment has increased (across all types of authority, but particularly in unitary authorities, with Inner and Outer London authorities lagging behind). By 2002/03 fewer than 60 per cent of authorities were performing up to 3* standards.

In Wales, around 55 per cent of carers caring for adults were offered first assessments in 2002 (see figure 4.60). The likelihood of an assessment offer did not vary with the age of the service user. Of those offered, only about one-third of carers of older people accepted to receive a separate assessment of their needs (see figure 4.61). This figure was significantly lower than for carers of younger clients.

In Wales, the chances of being offered a separate assessment of needs appear to increase significantly with the age of the carer, but there is no difference by carer gender (figure 4.62). Whereas the acceptance rate of separate assessments by adult carers did not change with the age of the carer, a greater proportion of female carers accepted to have a separate assessment of their needs (figure 4.63).

Assessing the needs of black and minority ethnic groups

There is considerable emphasis today on targeting black and minority ethnic (BME) groups, who are perceived to be under-utilising services given their needs (e.g. SSI 1998a). Cultural biases in assessment tools may be a contributory factor (Department of Health 2001; Silveira and Ebrahim 1998). The DH performance assessment framework now monitors the percentage of older service users from BME groups receiving services following assessment. Figure 4.64 indicates a recent slight improvement in local authority performance in this regard, although less than 40 per cent of councils in 2002/03 were rated 3* or better by the DH on this indicator. Performance is better when looking at provision of services for those whose needs are assessed (figure 4.65).

Assessments leading to services

In terms of the overall volume of contacts in England, figure 4.66 suggests little change in the last three years, remaining at around 3.3 million contacts. Equally, the proportion

of such contacts requiring further assessment has remained stable at around 51 per cent. There is variation across the country in the percentage of assessments for older people and adults leading to the provision of services (figure 4.67). In England, 69 per cent of assessments in 2002/03 led to the provision of services, a very slight improvement relative to the previous two years. Inner and Outer London authorities perform worse in this area than metropolitan districts and unitary authorities. Overall, the DH rated over 90 per cent of authorities as performing at 3* standard or better on this indicator. Care planning was commonly not satisfactory (SSI 2003 p.36), and many older people were still experiencing long delays for their services (p.37).

A study based on semi-structured interviews with social and health care personnel in North Wales gathered data in 1994/95 and 1998/99. Comparing the two periods, the researchers observed a shift of focus from the assessment of individual needs to rationing, suggesting (in their view) a tension: 'on the one hand, [practitioners] are to assess needs irrespective of service implications and on the other they are to reconcile service users' wishes with available resources' (Parry-Jones and Soulsby 2001 p.415-6). The authors argue that this threatens to undermine holistic approaches to needs assessment. It also appears to have led to reluctance on the part of staff to discuss needs with users and carers because of the fear of raising false expectations (cf. Hardy *et al* 1999). They recommend that structures within organisations that support assessment and care managers should be strengthened, including providing care managers with greater information and better management systems. Devolving budgets would also contribute, although, as discussed earlier, few authorities have moved very far in this direction. Social care practitioners 'will need to come to terms with the reality that their role to ration scarce resources is as important as assessing needs, which is likely to grate against the traditional ethics for social care practice' (Parry Jones and Soulsby 2001 p.426), although it is fair to say that this interpretation of role is hardly new.

Reviews

One of the pillars of a good case management system is the provision of timely and frequent reviews (Davies 1992). Figure 4.68 illustrates the steady increase in the number of adult and older service users receiving a review as a percentage of all those receiving services in England over a three-year period, although from a low base. However, levels of reviews remain low (at around 51 per cent; SSI 2003 p.38), and fewer than 60 per cent of councils were rated as performing up to 3* standard in 2002/03. Heavy assessment workloads are often used to explain why workers do not manage to find the time to undertake reviews (Audit Commission 1997). The summary of inspections found numerous shortfalls in review procedures, leading to both under- and over-provision of services (SSI 2003 p.38).

Single assessment process

The Single Assessment Process (SAP) for older people was proposed in the NHS Plan, further justified in the NSF, set out as a more detailed proposal by the Department of Health (2001a), and introduced in April 2004. Inspections of local authorities from 2005 could include reviews of the implementation of the single assessment process to be jointly carried out by the Commission for Social Care Inspection and the Healthcare Commission. In Wales, Unified Assessment procedures have been introduced 'to take a holistic approach to assessment with benefits form people who use services, for agencies and for professionals' (Welsh Assembly Government 2003 p.27).

Concern had long been expressed about the quality and poor coordination of assessment, including disagreements (and resultant duplication of effort) between the NHS and social services authorities, and particularly for people moved into care homes or awaiting discharge from hospital (e.g.Higginson and Victor 1994; Nolan and Caldock 1996; Department of Health 1997a; Audit Commission 1997, 2000a; SSI 1998; Clinical Standards Advisory Group 1998; Worth 1998; Martin *et al* 1999; Stewart *et al* 1999). Social services departments' assessment procedures for older people with mental health problems were highly variable in coverage, quality and speed of response to urgent requests, leading to 'marked inequalities' in services made available (Martin *et al* 1999). User and carer involvement in the assessment process was also low (Ellis 1993; Thornton and Tozer 1994). The NSF set out nine assessment domains: user perspective, clinical background, disease prevention, personal care and physical well-being, senses, mental health, relationships, safety, and immediate environment and resources. The SAP emphasises the specification of intended outcomes in care plans.

Not all authorities were able to implement the SAP by the April deadline, not surprising given that a quarter of authorities inspected in 2003 had made little progress towards the new arrangements (SSI 2003). Doubts had earlier been expressed about the preparedness of local authorities (e.g. District Audit 2002), with three of the main difficulties being lack of resourcing by central government, lack of investment in the information systems necessary to share data across agency boundaries, and the choice taken by some authorities to develop their own systems rather than applying the national standard system. Qureshi (2002) argues that 'Tools suggested to assist assessment are … designed, in my view, with more of an eye to consistent measurement than as basis for consequent action' (p.709). On the other hand, worries have been expressed about the quality of the information that will be generated by the stand-alone local systems (*Community Care*, 18-24 March 2004 p. 16-17). (McCormack and Slater 2002 describe existing assessment tools and make suggestions for a new instrument. There have been many other suggestions for new tools; see, for example, Anderson and Bungay 2004.)

For the SAP to work there must be

effective information sharing between health and social care practitioners. …
However, auditors found that shared case files, or easy access to each
other's files, only existed in a tenth of areas, and partly so in a further third
(Audit Commission 2002a p.40).

Areas without specialist multidisciplinary teams 'will struggle to implement a single
assessment process for older people with mental health problems' (p.24).

Commissioning

The simplest interpretation of commissioning is the funding link between purchasers
and providers, but it is more helpful to see the tasks of commissioning as comprising a
range of tasks (Knapp *et al* 1992; Wistow *et al* 1996):

- clarification of organisational mission as it relates to purchasing and provision,

- definition of need,

- identification and assessment of need,

- clarification of the services necessary to meet those needs (i.e. service
  specification),

- negotiation of contracts with providers to deliver those services,

- monitoring of contracts, and especially of performance, and

- re-negotiation, termination or extension of contracts.

It is also possible to identify the key strategic commissioning *options*, ranging from the
broad choice of hierarchy versus market as the principal means by which services are
organised and delivered, through finer details such as contract type and mode of
reimbursement, to more general (and longer-term) concerns about the balance between
adversarial and 'obligational' purchaser-provider relations. The choices made between
these options will have implications for the shape, functioning and performance of the
social care system, as well as for the success or otherwise of markets through their
effects on information, risk, incentives, relationships and level of competition.

Broadly interpreted in this way, commissioning was clearly the pivotal responsibility
passed to local authorities by the 1990 Act. This key position has been reinforced by, for
example, the Audit Commission's (1997a) review of progress, and the more recent
concordat (Department of Health, 2001b). In the early 1990s, even as the balance of

care was demonstrably beginning to change, there was marked resistance, sometimes even hostility, towards market commissioning as a mechanism for securing services (Wistow *et al* 1994). Some of this resistance simply reflected more general institutional inertia and a desire to defend the home power base (interpreting direct services as a natural corollary of local democratic control, at a time when local government in general felt under siege from the centre). There were also ideological objections from traditional 'statist' authorities. But some of these sentiments were specific to social care, and based on principled objection. Foremost among the rationales for this hostility or reluctance were perceived incompatibility between markets and social care from across the political divide, because of the vulnerable situation of many social care users; and perceptions that for-profit provision in particular involved making profit inappropriately from the suffering of the disadvantaged, buoyed by anecdotal evidence – later shown to be largely myths (Forder 1997; Forder and Netten 2000; Forder *et al* 2004) – about widespread making of 'excessive' profit.

Transformation of commissioning attitudes and behaviour

Cultural and political shifts during the 1990s brought changes. Ideological objections gave way to more pragmatic concerns about 'what works'. More generally, local authorities increasingly realised that some orientation towards profit did not typically mean crude profiteering, but generally a richer combination of empathetic, professional and financial motives (Kendall 2001; Kendall *et al* 2003). Encouraged by the Best Value regime, authorities could also see that there were savings to be achieved by externalising at least some of their services (SSI 2003). It seems probable that the major and rapid shifts in home care market share have been greatly influenced in this way. It is true that the cost comparisons made were often based upon fairly crude calculations of hourly costs, but there were nevertheless wide disparities between in-house and some external service costs (see below).

Three factors may have contributed to the softening of opposition to the 1990 Act commissioning proposals. First, many policy scientists have argued that it takes a decade or more for a 'policy community' to 'mature' in terms of the durability of its institutions, and the mutual recognition of its actors' beliefs and motivations (Sabatier and Jenkins-Smith 1993). There should now be relatively little reason for significant persistence in basic misunderstandings of motivations of the kind mentioned earlier, with growth in both goodwill trust and competence trust, to use Sako's (1992) terminology. Nevertheless, a significant proportion of independent sector providers do not experience their relationships as unambiguously supportive, not least because of the continuing low fees paid by authorities and the perception of preferential treatment of in-house services. Second, the (albeit slow) establishment of national regulatory standards provides some assurance concerning minimum quality standards. Third,

relationships between central and local government may generally now be more comfortable (but see Hudson 2000).

Commissioning challenges today

Commissioning has moved a huge distance since the early 1990s. The summary of joint reviews noted:

> The best councils now concentrate more on arranging services and less on directly providing them. New skills of commissioning, market management and procurement have been used to good effect in getting more choice and better value from services provided across public, private and voluntary sectors. Poorer councils can find themselves defending higher in-house costs without being able to demonstrate added service quality (SSI and Audit Commission 2004 p.4).

Nevertheless, a number of problems remain. There are still sizeable differences in some areas in commissioning procedures for in-house and external services (levelling of the playing field is taking longer than many would wish). Independent sector providers were not as fully involved in strategic discussions as they might be: 'Although there was some encouraging progress in engaging independent sector providers as partners, they still need to be more closely involved in planning' (SSI 2003 p.51). Independent providers report poor relations with purchasers, complaining of late payments, poor review and follow-up of clients, low prices and a systematic purchasing bias towards in-house providers (Hardy *et al* 1999a; Matosevic *et al* 2000).

Choice of contract type can create inappropriate incentives and can load too much of the market risk on already vulnerable providers. Relatively few contracts include contingency clauses related to changes in input prices or service user needs (Forder *et al* 2003, 2004), and none reward on the basis of service user outcomes. However, while they share the risk more equitably, cost-contingent contracts are open to moral hazard problems. Forder and Netten (2000) analysed variations in placement prices in residential and nursing home care using data collected in 1996. Resident characteristics were influencing price, with higher dependency residents attracting higher fees, but contract type was also a cost-influencing factor. Block contracts appeared to encourage discounted prices, because of the risk reduction for providers, although only about 10 per cent of residents at the time were covered by block contracts. Another 12 per cent of placements were covered under cost-contingent contracts, for which Forder and Netten found that the moral hazard disadvantages outweighed the risk-smoothing advantages, giving weight to arguments 'against the further use of contingent contracts of this type' (p.656). Mark-up rates at no more than 10 per cent of the weekly charge were found.

Forder *et al* (2004) describe the contract arrangements for independent sector home care services across 11 English authorities. As Forder and Netten (2000) had found for care homes, cost-contingent contracts were, other things being equal, associated with higher prices. Grant funding also meant higher prices. On the other hand, quality-contingent contracts led to lower prices compared to the average. Contracts that 'create relatively high prices can be inferred as reducing efficiency and value for money' (p.218). Potential mark-up rates were modest at an average of 13 per cent of hourly prices; *actual* mark-up rates depend on how providers use their market power, and this varies with motivation.

In home care markets, the most common contract type is the call-off contract without any contingency conditions for either cost or quality. Over half of providers in a study of 155 home care providers in 1999 were entirely dependent on this type of contract and over 80 per cent had a contract of that type with at least one authority (Forder *et al* 2004). Providers would have preferred block or cost-and-volume contracts. Mark-up rates were about 12 per cent, or possibly as low as 4 per cent (Fernandez and Forder, 2002).

Contract arrangements and commissioning more generally were considerably under-developed in the mid 1990s (Audit Commission 1997). By 2003, however, there was some improvement. The SSI observed that 'many councils were moving away from unhelpful spot purchasing. However, weaknesses in contract monitoring continued to undermine quality and sustainability' (2003 p.51). Principal among those weaknesses were 'limited management capacity, … uncertain progress in forging partnerships with independent providers and in managing the market' (p.6). On the positive side, authorities had made 'commendable progress' in mapping supply and demand, developing market intelligence, projecting future needs, developing market management strategies, using Best Value reviews to get a better understanding of service costs, scooping provision, engaging better with independent sector providers, closer work with the NHS, and recognising 'provider-market fragility in some localities' leading to increased fees (p.7). Block and cost-and-volume contracts were being more widely used in preference to spot contracts, and there was a more even-handed (but by no means balanced) treatment of in-house and external providers. As noted earlier, there was insufficient commitment to devolved decision making and devolved budgets.

Another problem – to which we return later – is that many authorities have successfully 'managed down' their local care homes market, using their commissioning powers to reduce overall capacity and to ease out poorer quality facilities. But it is not clear whether the process is now under control, since there appears to be a shortage of suitable beds in some localities and concerns have been expressed that smaller, 'homely' facilities have been disproportionately affected. Whether current commissioning arrangements and skills will allow local authorities to 'manage up' provision remains to be seen. As the SSI (2003) review of older people's services

concluded: 'Limited management capacity and difficulties managing tensions in the market sometimes undermined commissioning. … Most councils inspected were not effectively using a commissioning strategy to drive change' (p.51).

Another challenge is the extent of variation in commissioning styles and practices across the country. A PSSRU survey of English local authorities in 2001 focused on a number of commissioning dimensions, including pricing strategies, devolution of budgets, arrangements for selecting and involving providers and contract types. Marked variations were found, quite possibly reflecting or creating differences in commissioning competence (Forder *et al* 2003). Of course, local social care markets are also very diverse, initially a major cause of commissioning variations but increasingly a consequence of them.

Markets for social care services differ greatly, not just across the country but by service type and user group. We describe these differences more precisely later in this section, but they include the degree of 'externalization' and the rate of change in the balance between sectors, the relative importance of private rather than voluntary sector providers, and the market share of corporate private sector providers.

Ware *et al* (2003) describe a number of issues at the micro level. One challenge is fragmentation of the care management process, with different staff responsible for different elements (initial screening and assessment, devising and arranging care services, actual service provision, and review). There has been an over-emphasis on bureaucracy in procedure maintenance and short-term task management overload, driving out the ability of care managers to foster longer-term relationships and holistic approaches to need. Choice was predictably limited where users' preferences were not aligned with systemic priorities (see section 4.7 below). For example, some users who would have preferred a significant practical care element to their package have not received it, because local policy practices are increasingly geared towards delivering personal care. Finally, despite the reticence of this client group to complain and their tendency to have low expectations of service delivery, a significant number of service users articulated clear concerns about quality. Echoing other research (Social Services Inspectorate 2001), prominent worries reported by users often revolved around problematic relationships with home care workers, including difficulties in assuring valued continuity, and problems with reliability, attitudes and timeliness.

New commissioning challenges are already emerging, most noticeably in two areas where progress in meeting the needs of older people remains quite slow: joint commissioning between health and social care agencies services (Hudson *et al* 2002; Davey *et al* 2004; and see chapter 3) and direct payments (see section 4.3).

Targeting

In the care system prior to 1990, the targeting of resources on needs was poor (Bebbington and Davies 1983; Audit Commission 1986; Bebbington and Charnley 1990; Bowling *et al* 1991; Davies 1994; Bowling and Grundy 1995). Poor targeting is both inequitable and inefficient.

Improving the targeting of services on needs is fully consistent with a 'new manageralist' approach to social care, as urged by the Audit Commission in the 1980s for example (Davies 1994). Davies argues that targeting should mean 'allocating resources at the margin to those for whom the value of benefits are greatest, and that this is not necessarily synonymous with allocating resources proportionally to the diswelfares of the state' (p.896). This is like the economists' interpretation of need as a cost-benefit concept (Culyer *et al* 1971). The targeting criterion then effectively becomes an investment appraisal.

Improvements in targeting have been achieved since 1990, including a general commitment to needs-led decision-making, clearer eligibility criteria, and a higher frequency of carer assessments. Much of the evidence presented in other sections of this chapter indicates such targeting improvements.

Nevertheless, concerns continue to be voiced, not least by the SSI (2003), one of whose recent conclusions was that there is 'an increasing disconnection between actual performance and the targets that councils have set' (p.17). Targeting remains unsatisfactory for a number of reasons (SSI 2003; Edwards and Jones 1998; Audit Commission 2004d). Although a key one is a substantial volume of unmet needs (as discussed in section 4.2), we focus here on other areas where the targeting of services has been found to be inadequate or inappropriate.

Age discrimination

One persistent problem is age discrimination in relation to access to both health and social care. Evidence is helpfully summarised in the NSF report (Department of Health 2001 p.2):

> There have been reports of poor, unresponsive, insensitive, and in the worse cases, discriminatory, services. Instances of adverse discrimination have usually been inadvertent, a result of the survival of old systems and practices that have failed to keep pace with changing attitudes or advances in the capacity of professionals to intervene successfully. This has been shown in specific problems such as the lack of rehabilitation, inadequate dementia services and inconsistencies in stroke care.'

Authorities may also be discriminating against older people (relative to younger groups) by adopting commissioning strategies that fail to recognise individual needs and preferences (Wistow *et al* 1996; Audit Commission 1997, 1997a).

Black and minority ethnic older people

A second concern is that people from black and minority ethnic populations are less well served than people of white ethnicity. Three conclusions in the SSI (2003) summary of inspections relate directly to this issue:

There were major gaps in [almost all] councils' provision for older people with sensory impairments and for elders from black and minority ethnic groups (p.17).

Most councils had published race equality schemes and also recognised the need to improve services to minority groups. Only half of councils inspected monitored ethnicity and outcomes; this poor performance undermined plans for improvement (p.45).

Only a minority of councils inspected had sound public information systems, although there were good examples of developing practice. Information served black and minority ethnic groups less well (p.45).

The NSF had also noted that older people from BME groups 'can be particularly disadvantaged…. and are likely to suffer more discrimination in accessing services' (Department of Health 2001 p.17). Nelson *et al* (2004) found that people from BME groups in their household sample from north London received significantly fewer services.

Older people with mental health problems

Targeting of services is often considered to be poor for older people with mental health problems, and we have already noted the extent of unmet need (section 4.2). The Audit Commission (2000b) report on mental health services for older people, *Forget Me Not,* was followed up two years later. There were still many areas without specialist teams for older people with mental health problems (and see Mitchell 2001), and many teams did not have all the recommended core professions represented. Respite care was still hard to access, and day hospital services were also not available in more than half the areas surveyed. Only one third of the areas had jointly agreed assessment and care management procedures. Almost a quarter of all areas studied had no clear service goals or plans (Audit Commission 2002a; see also Moriarty and Webb 2000). The distribution of mental health professionals working within primary care was very uneven

at the start of the 1990s (Kendrick *et al* 1993) and has probably not changed much since.

Women with cognitive impairment were found in one study to be less likely to receive home care services than women with physical impairment but otherwise equivalent dependency (Ely *et al* 1997). However, a later study reached a different conclusion, perhaps indicating some improvement in service targeting (although a host of differences in study design suggests caution in making such an interpretation). Nelson *et al* (2004) found that care packages for older people with dementia were significantly more costly than those for people with physical dependency or depression.

The SSI summary of inspections concluded: 'Older people with mental health difficulties were often poorly served. There were major gaps in provision and few specialist intermediate care services' (SSI 2003 p.17 and see pp.25-26). One problem, perhaps, is poor coordination between the mental health and older people's NSFs (Seymour and Gale 2004). Guidance was issued by the Department of Health in January 2004 on protocols for the care of older people with mental health problems.

Older people with visual and sensory impairment

Another area highlighted by the SSI summary of last year's inspections concerned older people with visual and sensory impairment. A few authorities had developed 'excellent specialist services' and specialist staff were singled out for their dedication and skill, but elsewhere there was low commitment of resources to meeting the needs of this group, poor strategic vision, inadequate planning and inadequate consultation (SSI 2003 pp.26-27).

Economic status

We have already noted some of the perverse incentives in the social care system. Almond *et al* (1999) found that, after adjusting for personal characteristics (including age and gender) and needs-related circumstances (including ADL, cognitive impairment and self-rated health), the frequency and volume of use of community-based services was not related to whether an older person was in receipt of income support, but income support recipients were more likely to be admitted to publicly-funded care homes. Challis *et al* (2000) found that self-funded residents of care homes had lower dependency levels than publicly-supported residents. Potentially self-funding residents are less likely to have their needs assessed (Wright 2003; Netten and Darton 2003).

Household arrangements

A number of studies have pointed to differences in the probability and intensity of service receipt according to living circumstances. As we saw in the discussion of carers, there is some degree of substitution between formal and informal care; that is, service allocations are *not* 'carer-blind' (Royal Commission 1999).

Calculations by Evandrou and Falkingham (1997) show that older people living alone were twice as likely to use a local authority home help or private domestic help as those living with other household members. Utilisation was also linked to socio-economic status and income. Based on analyses of GHS data for 1980, 1985 and 1994/95, they found that home help services in the early 1990s were 'used more intensively by people at the lower end of the income distribution and by those in the manual social classes' (p.249). In 1994/95, older people in the top income quintile were nine times more likely to be using *private* home help services than those in the bottom quintile. The targeting of home help on the lower end of the income distribution had become weaker over time. (See also the evidence presented by Bebbington and Davies 1983; Bowling *et al* 1991; Almond *et al* 1999; Andrew *et al* 2000.)

Rural areas

The SSI summary of inspections concluded: 'Most councils with rural areas were finding it difficult to ensure equitable access to services. Transport and service costs were frequent issues' (2003, p.45). See also Bowling and Farquhar (1991).

Health or social care?

A further targeting issue highlighted by recent evidence is the problem that the services someone receives (or indeed whether anything is received at all) depends in part on whether referral is to a health or social care agency. An interesting study by Healy *et al* (2002) compared the services that older people received after discharge from hospital according to the multidisciplinary team that supervised the discharge. Controlling for user characteristics, they found that

> the nurse-led team was least likely to refer patients for care assessment and these patients received the least post-hospital services. The occupational therapy-led team arranged the most occupational therapy services and equipment and their patients received the most home care. The social work-led team referred the most patients for care assessment and their patients received the greatest range but not the greatest amount of services (p.19).

Thus, while multidisciplinary assessment and coordination was common practice in this locality at least, the consequences for individual older people were dependent on the lead profession in the multidisciplinary team. Some years after the 1990 Act, therefore, service decisions still appeared to be influenced by professional predilections or resource availability rather than individually assessed needs. Similar problems beset service access for working age adults with mental health problems, as discussed in the following chapter.

More generally, as we noted in chapter 3, there has been ongoing confusion about the division between health and social care responsibilities, the respective roles of the various agencies involved, and differences in eligibility criteria for continuing care.

Residential or nursing home?

Although the question is no longer relevant, there is evidence of wide differences across the country in the facility-type destination for older people. Netten *et al* (2001) studied the placements of 2544 older people supported by local authorities, in particular the differences between those admitted to residential and nursing homes in 1995. There were marked variations between authorities in the proportion of local authority-supported residents placed in nursing homes rather than residential care homes, which they attributed to local differences in policy and practice in relation to maintaining people in private households. The choice between nursing home and residential home was heavily influenced by the dependency characteristics of the individuals. Authorities that placed higher proportions of people in nursing homes appeared to be maintaining people in private households at higher levels of dependency (?). Lack of carer support was found to be associated with residential care admission (Warburton 1994). Once other factors were taken into account, dementia was not an influence on the direction of placement; this result applies to these publicly supported residents, but in other work has been found not to be the case for privately funded residents (Netten *et al* 2001b).

Dependency, rehabilitation and prevention

The final issue is a combination of three interlinked matters, each of which will be discussed in more detail later. The first concerns the targeting of home care services (indeed a range of community-based services) on those older people with higher dependency levels, which has been an explicit policy aim (successfully implemented) since the early 1990s (Warburton and McCracken 1999). A few years ago, only one fifth of dependent people living in the community were receiving home care (Wittenberg *et al* 1998), although within this average the proportion is much higher for those living alone. Older people with lower dependency are thus no longer eligible for local authority support: the advisability of closing off these potential preventive services has been

widely debated (e.g. Ellis 1993; Quilgars *et al* 1997; Clarke *et al* 1998; Rummery and Glendinning 1999; Bartlett 1999; Lewis 2001). *Fair Access to Care Services* made absolutely explicit the policy of targeting services 'on those in greatest immediate or longer-term need'. Although it has been suggested that unplanned admissions to hospital and to care homes might result, it is difficult to find much evidence on the longer-term consequences. It is also not clear how many people who need support are not getting it (horizontal target inefficiency) or how many people who get services do not really need them by current eligibility criteria (vertical target inefficiency) (Baldock 1997). The ECCEP (Evaluating community care for elderly people) study by PSSRU sheds light on this targeting issue, and we discuss the findings in section 4.6.

A second concern is the under-development (and associated poor targeting) of rehabilitative services, creating the vicious circle found in many social and health care fields of people being admitted unnecessarily to institutional settings, but then being discharged (if at all) to insufficiently supportive settings (District Audit 2002).

Third and more generally, too few resources are targeted on preventive action (Audit Commission 1997; Godfrey 2001); we return to this topic later in this chapter.

Care homes

Laing and Buisson (2004) suggest that the number of care home beds in England was just over 400,000 in 2003/4 (compared to a peak in 1996 of 460,000) and occupancy levels remain steady at about 90 per cent of capacity. The last 25 years or so have seen some sizeable changes in care home provision. Indeed, as Cotter et al (1998 p.54) colourfully describe it, 'between the 1980s and the 1990s the field of long-term institutional care for older people has been ploughed up and replanted'. The extent of change must be almost unprecedented in social and health care: wholesale closure of hospitals, rapid growth of private sector care facilities, decimation of in-house provision, emergence of intermediate care and other new models of support, the development of extra care housing. For the moment, we concentrate on care homes. This new term replaced residential care and nursing homes in 2002 to describe settings that provide accommodation and either personal care and/or nursing care; as defined by the Care Standards Act 2000. However, much of the evidence relates to the pre-2002 arrangement, and the distinction between the two types is arguably still relevant, given significant differences in the dependency characteristics of residents, the levels of fees and the market share of larger providers (Netten et al 2004b).

Our discussion of care homes is arranged under six headings:

- scale and patterns of provision

- home closures

- sectoral balance

- provider motivation and behaviour

- quality of care, and

- regulation of standards.

- scale and patterns of provision.

Residential care services for older people grew rapidly during the 1980s for a number of reasons: demographic change, the liberal social security environment (with no needs assessment of residents), the general business-supporting climate engendered by the Thatcher government, and the boom in the property market making investment in physical capital a sound one. These growth years have been extensively discussed (e.g. see Audit Commission 1986, 1997; Holden 2002; Evandrou and Falkingham 1997; Oldman and Quilgars 1999; Netten *et al* 2004b). It is unnecessary to go into further detail here.

Figures 4.69, 4.70 and 4.71 present respectively the number of residential and nursing care homes, places and supported residents by type of accommodation in England. Figures 4.72, 4.73 and 4.74 paint the equivalent picture for Wales, and figures 4.75, 4.76 and 4.77 for Northern Ireland. Of the three countries, England experienced the greatest fall in the number of care homes since 1996, and particularly in the number of private residential homes, although it is interesting that the immediate years after the 1990 Act saw a slowing, but not a reversal, in the rate of growth of care home provision. During this period many local authorities were looking to close some of their in-house provision, but in fact many facilities were transferred to the private and voluntary sectors (Wistow *et al* 1994 chapter 7; Kendall *et al* 2002). There was also a difficulty of countering the strong influences of the inherited patterns of (supply-induced) demand (Audit Commission 1997 p.47). Today, as a result of a faster rate of home closure than anticipated, some areas face shortages of care home accommodation (SSI 2003; and see discussion of home closures below).

The decrease in residential and nursing care provision in England was much smaller in relative terms when measured in terms of care places (figure 4.70) because proportionately more of the smaller homes have closed. Interestingly, this trend is reversed in Wales, where since 1997 there has been a larger proportional fall in the number of places than in the number of homes. There has been an *increase* in the number of local authority-supported residents in England (figure 4.71), with the increase between 2002 and 2003 partly explained by the transfer of all remaining 'preserved

rights' residents from the social security system to local authority control. There was a very significant increase in the levels of supported residents in Northern Ireland between 1994/95 and 2002/03 (figure 4.72). In Wales, after a period of some decline in the number of older people in residential homes, numbers may have started to rise again in recent years (figures 4.74 and 4.78).

By dividing the number of places by the number of homes, it is possible to estimate the average size of residential and nursing homes (figures 4.79, 4.80 and 4.81 for England, Wales and Northern Ireland respectively). There has been a clear increase in the average size of nursing homes in England in recent years. (A little caution is needed when interpreting these results, as nursing home figures refer to all user groups and not just people aged 65 and over.) Across all three countries, local authority homes tended to be larger than homes in other sectors. In England over the last few years, the average size of local authority and voluntary homes seems to have converged to around 34 beds per home, at least partly because of the closure of smaller homes (see below).

Figure 4.82 shows the number of older people admitted to care homes in England during the period 1998 to 2003. The majority are temporary admissions. The figure indicates a slight decline in the number of temporary admissions after 2000. After declining between 1998 and 2002, the number of permanent admissions rose again in 2003. The rate of temporary admissions increased rapidly in local authority homes but remained stable in independent sector and nursing homes (figure 4.83). Millard *et al* (2001) used 'flow modelling' methods on data for one health district in 1990 to show that, 'in both sexes, the older a patient/resident, the longer the time they occupied short-stay beds and the shorter the time they occupied long-stay beds' (p.57).

Figure 4.84 illustrates changes in the number of admissions in residential and nursing care in Wales in the period 1994 to 2001. After a period of stability between 1994 and 1996, there was very fast growth in the number of admissions to 1999, mostly into independent sector residential care. Since 1999, there has been a significant fall in the number of admissions, again mostly occurring in the independent residential care sector. The SSI (2003) reports local authorities' expectations that admission rates will continue to fall. The Welsh Assembly Government (2003) wants 'sustainable growth of a confident, flexible and viable care home sector for the future, to ensure that services are in place to support older vulnerable people' (p.28).

There was a fall in the number of older people admitted to residential care homes in Northern Ireland between 1998/99 and 2001/02 (figure 4.85).

There have always been marked variations within the three countries in relation to many of these charted features of care homes. For example, the Audit Commission (1986) noted that there were heavier concentrations of private sector care homes in the south

of England and in larger conurbations, particularly on the coast, where there already existed suitable housing stock for conversion. Much of the work of Warnes has examined the geography of care home provision. The SSI (2003 p.31) point to marked regional variations in admissions, for example. We have not had time to describe these differences, although some of the evidence discussed below is built on econometric and statistical analyses of such patterns (e.g. see Fernandez and Forder 2002). Smith and Ford (1998) mapped the spatial pattern of residential care between 1988 and 1993, describing differences between regions and between the provider sectors.

Home closures

As we have just seen, there has been a very noticeable drop in the number of care home places since the mid 1990s. Although most providers interviewed in the PSSRU/Nuffield Institute study expressed neutral or slightly positive views about relations with purchasers, a sizeable minority were clearly in difficulty. A fifth of residential care providers in 1997 said that they were seriously considering leaving the market, many had already been forced into reducing costs (with predictable implications for services), and more than half claimed that the prices paid by local authorities did not cover their costs (Hardy *et al* 1999; Kendall *et al* 2002). Discussions of care home markets in recent years have consequently been dominated by the question of closure: which facilities are closing, why, and with what consequences?

Which homes have closed? Generally, it is the smaller homes that are closing. Darton (2004) compares care homes that closed between 1996 and 2001 with those that remained open, based on a large nationwide survey of homes. Those that closed tended to be

> smaller; to have had lower occupancy levels in 1996; to be the only home run by the organisation; to occupy converted buildings; to occupy multi-storey buildings, and if so to have no lift; to have more shared bedrooms; and to have en suite facilities in none or only some of the bedrooms (p.254).

The study also found that homes that closed were more likely to have a positive social environment than those that had remained open. Darton's analysis therefore questions whether the growth in corporate sector facilities at the expense of single-owner-managed homes (a topic to which we return) is consistent with the promotion of choice for potential residents and with improvement of care home standards. The introduction of national minimum standards could be at odds with the maintenance of smaller, owner-managed facilities which Peace (2003) for example suggests offer more 'homely environments' (and see Centre for Policy on Ageing 1996; Department of Health 2001d).

Why have homes closed? Many forces are at work to bring about care home closures, including the policy of encouraging community-based care (Netten *et al* 2004b). One central factor has been the long-standing problem that the fees paid by local authorities do not cover the costs of providing support in some homes, particularly in smaller facilities, and providers' own reserves can be drawn on only for so long. Average mark-up or profit levels in the care homes market are very low (Forder and Netten 2000; Fernandez and Forder 2002), and especially for smaller homes (Andrews and Phillips 1998). A further concern voiced by providers is fluctuations in net income and excessive risk (Hardy *et al* 1999), due in no small measure to uncertainties over future levels of demand and the highly competitive nature of most local markets (Fernandez and Forder 2002). Shortages of nursing staff were seen as contributing to the closure of nursing homes, and generally staff recruitment has been difficult (Netten *et al* 2002).

Cost inflation has also added to the pressures on care homes, due to the rising dependency of residents (a consequence of the changing balance of care, although probably not the most important cost-raising factor, it would have increased managerial demands; Netten *et al* 2004b), the introduction of the national minimum wage and the European working time directive, a substantial pay award to nurses, and of course the cost of improving homes so as to meet the new national minimum standards. The macroeconomic climate, and general economic policies (over and above the employment and social policies referred to above) that contribute towards that climate, have been two critical factors. Interest rate decisions by the Bank of England are relevant for those providers financing their businesses through borrowing. Smaller providers face higher financial barriers to entry into the market, linked to the reluctance among lending institutions to invest in this market (Holden 2002). Developments in the property market, which are highly sensitive to macroeconomic factors, affect the value of the alternative uses to which facilities can be put (the opportunity costs), especially bearing in mind that most are not purpose built. (Netten *et al* 1996 report that 50 per cent of private sector homes were formerly private residences and 16 per cent formerly hotels.) Faced with so many other pressures, rising property prices gave many owners the opportunity to leave the market for which they had been waiting for some time.

What are the consequences of closure? Ministers have long feared seeing older residents of care homes dumped on the pavement as a result of home closure. Of course, nothing quite so dramatic is likely, but the consequences of closure can still be very damaging. Williams *et al* (2003) describe the experiences of relatives, informal carers and residents. Closure periods varied, with some residents and relatives given only three weeks' notice. Many respondents described the difficulties of telling residents of the closure decision. After closure, a number of people moved to temporary placements and a few left residential care altogether. Many were not offered a choice, and less than half had their needs reassessed by a care manager. A number of relatives and residents described deteriorating care standards during the closure period, with falling staffing levels and growing use of agency staff. Hallewell *et al* (1994) looked

at two local authority homes in Manchester identified for closure in 1991. The 59 residents moved to a total of 19 different establishments. The study revealed an increase in restlessness over a one-year period, but no other differences in behaviour or dependency (when comparing people who moved and a control group of people who remained in another local authority home). Health service involvement in the move was described as 'minimal', and indeed delays and other communication difficulties with GPs were reported. Recently, new procedures have been put in place to manage the closure process, including a need for proprietors to apply to the National Care Standards Commission to cancel their registration three months ahead of the closure, although whether such a requirement is enforceable is debatable. It is also unclear whether more can be done to improve resident control and widen choice.

Another consequence of home closures has been to leave some areas with under-capacity, particularly in nursing homes and other facilities offering specialist care for older people with mental health problems (SSI 2003; Netten *et al* 2002). The availability of care home places has demonstrably important impacts on delayed discharges from hospital (Fernandez and Forder 2002).

Sectoral balance

Over the course of the 1990s, many local authorities closed some in-house provision and sold or transferred much (sometimes all) of the remainder to the independent sectors. The '85 per cent rule' governing the special transitional grant contributed to the decline of in-house provision and the relative growth of particularly private sector provision. Whether such 'externalisation' of services expands user choice needs to be examined, but it obviously generated short-term, lump-sum resources for authorities, potentially reduced longer-term placement costs, and shifted responsibility for achieving externally set standards of care onto the new owners. These changes in the sectoral balance of care were important, but they were in fact just a continuation of the much bigger changes in market shares that had already happened in the 1980s.

Where local authorities have retained some in-house provision, a number of rationales are offered (Forder *et al* 2003). First, they have concerns about alternative provision: that it is unavailable, does not cater for some user groups, provides insufficient 'insurance', and offers inferior employment rights and payment rates. Second, there is considerable pride in public services, partly as a mirror image of the aforementioned concerns, but also motivated by an ethos associated with the ownership (rather than indirect control) of physical assets, and adherence to a traditional model of public accountability. Third is the argument that in-house provision maintains a greater range of choice for users. Another factor has been democratic support from local citizens. Finally, in-house provision offers a benchmark against which to compare the independent sector in terms of costs, quality and innovation.

From the accumulated evidence, there are perhaps four main topics to be addressed concerning the sectoral balance: the experiences of private sector providers over the period, the growth of corporate provision, differences between the sectors, and shaping the market.

Private sector providers' experiences. Andrews and Phillips (2000) compared residential care for older people in Devon in 1994/5 and 1997, particularly looking at the private sector. A subgroup of homes studied in the earlier year were followed up in the later year. Empirical findings from the study illustrate vividly the consequences for private care home owners of the changes introduced by the 1990 Act, particularly the change in funding routes, the emphasis on community-based care, the greater emphasis on needs assessment and the encouragement of social care markets. For example, vacancy rates were reported to be higher by quite a number of the homes, and proprietors claimed that it had become harder to fill bed spaces. There was a trend towards lower profits, obviously linked to the growing vacancy rate (although more recent evidence from Laing and Buisson suggests that vacancy rates are falling). Before April 1993, 4 per cent of proprietors claimed that they were making a loss or breaking even, compared to 24 per cent in 1994, 18 per cent in 1995 and 25 per cent in 1997.

We know from later research that low profit margins have been important factors in the closure of homes. In this Devon study the authors found 'a steady trickle of business failures, with concomitant problems for residents, their families and social services' (p.215). Over time, more proprietors were less secure about the future of their businesses, and business confidence was generally falling. Proprietors also were more likely to report personal stress in the later survey. At the time – and this situation changed in the late 1990s and has continued to change – home owners felt unable to sell their businesses as going concerns, and were not generally selling the capital for alternative uses. As we know, this picture changed after this study was completed. On a more positive note, proprietors were more likely to be considering diversification of their business interests into, for example, home care or meal services. Nevertheless, many facilities were simply not of a size or design to allow such diversification. Andrews and Phillips argue that this evidence points to market imperfections, and some of it may well do so, but some of the observed consequences of policy changes are fully consistent with what a market would predict. The residential care market in Devon was probably similar to that in many other localities, with an over-supply of residential care beds. The 1990 Act changes included a responsibility for local authorities to 'manage down' residential provision, and many of these observed impacts would appear to reflect just such a process.

Growth of corporate provision. Many small independent providers remain, but recently the market has attracted more corporate and large-scale providers. According

to Laing & Buisson (2003), 10 per cent of residential homes and 37 per cent of nursing homes are run by organisations operating three or more homes, an increase over recent years (Holden 2002; Netten *et al* 2004). In view of concerns expressed by some purchasers that larger homes are associated with poorer quality care, it is interesting to note that mean home size for these 'corporate' providers was 54 beds, substantially larger than elsewhere. Netten *et al* (1999) found mean sizes in November 1996 of 35 beds in local authority homes, 20 in private residential homes, 30 in voluntary residential homes, 39 in dual registered homes and 38 in nursing homes.

Corporate providers have been more likely to buy up smaller providers that are facing financial difficulties in the market, rather than to build new facilities, although the new care standards might make this a less attractive option for the future (Holden 2002). There might also be growth in mergers between large providers to improve their ability to exploit economies of scale in the face of falling profits.

Differences between the sectors. Differences between the sectors appear to be narrowing in terms of the characteristics of residents. Studies from the early 1990s and earlier tend to show quite marked differences (especially if one goes back to the much older studies of Townsend 1962, Williams 1967). For example, Campbell *et al* (1990) found lower dependency levels in private and voluntary sector residential care homes in Northern Ireland, when compared to public sector facilities. By 1990, there was already some suggestion of a narrowing of differences in England, as shown for example by the comparison of homes in Leicestershire in 1979 and 1990 (Campbell Stern *et al* 1993). Jagger and Lindesay (1997) report that residents in local authority residential homes in Leicestershire had significantly higher odds of demonstrating offensive behaviour than those in private and voluntary sector homes. Most of the residents with behavioural problems were cognitively impaired, with obviously implications for staff training. Wood and Castledon (1993) compared five private residential homes, five local authority homes, five private nursing homes and five NHS long-term care wards in Leicestershire. Public sector residents were more dependent (in terms of mental confusion, incontinence and social disengagement) than those in the private sector, although staff-resident ratios were no different. A measure of quality of care (covering general care policies, residential activities and therapy, administrative philosophy, physical environment and overall 'homeliness') revealed no inter-sectoral differences. Challiner *et al* (1996) found that a number of aspects of quality of care were better in local authority care homes than in private residential or nursing homes and in NHS wards, and that private residential and nursing homes also achieved better quality scores than NHS wards. The NHS provision was generally not found to be resident-oriented. Dissatisfaction expressed by residents with staff was significantly higher in NHS wards and nursing homes than in private residential homes, where the small scale and intensive involvement of owners may improve staff-resident relations.

Shaping the market. The Government remains committed to the *market* determination of long-term care fees, sectoral balance and, indeed, closures and openings (e.g. Stephen Ladyman's speech to the Laing and Buisson annual long-term care conference, March 2004). However, the rapidly changing shape of the care home market will surely need some attention beyond the kinds of measure encouraged by the 'concordat'. Local provider monopolies or cartels could emerge (Holden 2002). However, while unexploited economies of scale will doubtless encourage market concentration, there are still today very large numbers of providers in most local markets, and there is the strong counterbalancing market power of local authority purchasers.

Nevertheless, there are dangers. Holden points to three areas of 'concern associated with this process of concentration: the effects of increased ownership transfer [potentially disruptive for staff and residents]; the implications of standardisation [and reduced choice]; and the possibility of decline in the quality of care if local monopolies emerge' (2002 p.88). On this last point, Holden points to evidence from the US that stricter standards concerning the physical environment of nursing homes in the US 'hastened concentration within the industry' (p.90), because large companies found it easier to meet the standards by building large homes that exploited economies of scale (Braithwaite 1993). Larger homes and externally set regulatory procedures encouraged 'ritualism among providers, fulfilling the formal requirements specified by the regulatory system but not attending to the well-being of individual residents'. Weisbrod and Schlesinger (1986) pointed to exactly this phenomenon in their earlier work on US nursing homes, contrasting for-profit and non-profit facilities. The former were more likely to conform to contractual requirements (governing room size, the provision of lifts, etc), but had higher levels of complaints from residents, which Weisbrod and Schlesinger interpreted as indicating poorer quality personal care. In the UK, Tune and Bowie (2000) found that private sector homes were in better physical condition, but public sector homes provided significantly more recreational facilities. (See also the arguments about the monitoring of quality of care versus quality of life in Davies and Knapp 1981 ch.7.)

Provider motivation and behaviour

Some words are appropriate here on provider motivation and associated behaviour. Understanding provider motivation for being in business is clearly important in trying to fashion incentives to promote quality, user choice, user welfare and best value.

The expansion of independent care home provision in the 1970s and 1980s was achieved mainly by entry into the market of many small family-run businesses, catering for large proportions of privately funded residents. Providers' future revenue streams were reasonably predictable, as were (modest) profits, whilst capital appreciated.

Alongside these small businesses were voluntary sector providers, again rarely grouped into larger organisations, many with close affiliations to religious, cultural, ethnic or professional groups. An increasingly important source of funding for independent providers was the non-cash limited social security budget. The 1990 Act sought to control public expenditure on placements by passing funding responsibility to local authorities. One of the effects has been to undermine providers' fairly secure fiscal environments.

Findings from our own research clearly question the profit-maximising model of 'introductory textbook discussions' of market competition, and which appeared to underpin many local authorities' fears about social care markets in 1990. In fact, a complex mix of motivations was found to be at play in the care home sector: professional, empathetic, autonomy-oriented and financial priorities (Kendall 2000). Those providers who do prioritise income or profit, which understandably - given their responsibilities in respect of shareholders - includes corporate providers, have higher price-cost mark-ups (Forder *et al* 2000).

Quality of care

Quality of care in residential and nursing homes has been a concern for many decades, with Townsend's (1962) classic study being among the best-known descriptions of the parlous state of much accommodation only half a century ago. Numerous subsequent studies have described the low standards of care offered in many homes (e.g. see Davies and Knapp 1981; Booth 1985; Willcocks *et al* 1986; Gibbs and Bradshaw 1990; Gibbs and Sinclair 1992.)

Standards have improved, of course, in response to inspection and contractual requirements as well as competition, although there are few routinely collected data to illustrate trends over time. Figure 4.86 shows the availability of single rooms in residential and nursing homes in England for the period 1997-98 to 2002-03. Overall, around 92 per cent of single adults and older people going into permanent residential and nursing care were allocated single rooms in the period 2002-03. New residents in the inner London area were the most likely to have been allocated a single room. In terms of local authority performance, there has been a gradual increase in the proportion of councils rated as 3*or more by the Department of Health since the period 1999-00, so that by 2002-03, around 90 per cent of English councils were rated 3*or more with respect to this performance indicator.

However, the general feeling is that physical and social environments need to improve. A number of studies and official reports have pointed to poor standards, and we summarise just a few here. A local study in Blackpool and Stockport concluded that 'funding problems have resulted in shabby environments, low pay, poor training and

high staff turnover' (Chambers and Tyrer 2002, p.29). The NSF noted that 'Quality of care has … been affected by negative staff attitudes in a number of settings' (Department of Health 2001 p.16). The Audit Commission (20002a) found that the physical environments in which respite and hospital services were provided were unsuitable for older people with mental health problems in over a third of the areas examined in the course of their audit, and that specialist settings – where they were available – had 'consistently good quality physical environments' in only half the areas (p.32). Georgiou *et al* (2001) found marked variations in the achievement of quality standards for urinary continence care in a sample of residential homes, nursing homes and long-stay hospital wards. Fahey *et al* (2003) noted that quality of care was markedly worse for older people living in nursing homes than for those living at home. Peace *et al* (1997) summarise much of the evidence, and Oldman and Quilgars (1999) offer a 'structured dependency' critique (with an added humanist perspective) of residential care.

The expectation that care homes can achieve 'homely' environments for their residents has long been abandoned, at least for large facilities (Willcocks *et al* 1987), but smaller homes (with less than four places) continue to be regarded as 'homely and domestic settings' by residents, relatives and staff (Peace and Holland 2001 p.407). However, this 'homeliness' is threatened by pressures to formalise care arrangements, particularly within the increasingly performance-driven social care system. Darton *et al* (2004) found that homes with 'positive social climates' (based on measures taken with the Moos Sheltered Care Environment Scale) were more likely to be smaller, converted premises, accommodating mainly long-stay, less dependent residents and with lower occupancy levels – almost precisely the characteristics of the care homes that are today most likely to be closing, as we saw earlier (Darton 2004).

Regulation of standards

Since 1990, a number of initiatives have been taken to improve care home standards, working through a number of interlinked channels: purchaser-provider contracts and monitoring, performance reviews, inspections, audits, Best Value reviews and, of course, national regulatory standards. The Registered Homes (Amendment) Act came into force in 1993 and required all small homes (with fewer than four residents) to register. Robinson and Simons (1995) reported wide variations in the approaches to such registration. Day *et al* (1996) examined the regulatory framework for care homes. Their interviews with social services directors and heads of inspection units in eleven areas, together with an analysis of two hundred inspection reports on individual homes, suggested that both regulators and providers agreed that care home standards had improved since the mid 1980s. The reasons for this included more stringent standards, competition between providers within developing social care markets, and pressure from commissioners. However, the research was not able to establish which were the

'active ingredients' in the rising standards. Concern among regulators was expressed about a minority (estimated at about 10 per cent of homes providing persistently poor quality, many of which were in the local authority sector).

Most of the excitement, however, has been since 1997. In *Modernising Social Services* (Secretary of State for Health 1998) the Government emphasised its commitment to raising standards, and has been much more interventionist than previous administrations. The National Care Standards Commission (NCSC) came into being in April 2002 to take over the roles of the local and health authority arm's-length inspection units around the country. NCSC's remit covered home care as well as care home services, although it was soon to be replaced (April 2004) by the Commission for Social Care Inspection (CSCI), which also assumed the roles of the Social Services Inspectorate and the joint review team of the SSI and Audit Commission. A new regulatory regime is also being introduced in Wales, its implementation to be assured by the Care Standards Inspectorate for Wales (Welsh Assembly Government 2003).

The national minimum standards for care homes were launched for consultation in 1999 (Department of Health, 1999a) and subsequently revised a number of times. There was a 'U-turn…on some of those standards before the ink was fully dry' (Henwood 2002 p.26) when the Secretary of State announced (July 2002) that the new regulatory framework introduced by the Care Standards Act 2000 would be revised and postponed, presumably to stem the tide of home closures.

The standards focus on physical environments (home size, room sharing, lifts, etc), staff qualifications and ratios, and managerial competence (Department of Health, 2003a). In their current form the standards indicate good practice, but are not requirements for homes in operation prior to April 2002. The standards are likely to have a sizeable impact on individual homes, aggregate provision and overall market shape (see the discussion in Netten et al 2004). The demands on inspectors or regulators will also increase. Netten et al (2004a) found inspectors were now spending more time directly on inspection and registration than in the past. The time taken to inspect care homes had grown significantly from an average of 16 hours for health authority inspection units and 19 hours for local authority units in 1998 to 33 hours (over both groups) in 2002/03.

Extra care housing

A significant change in the service portfolio for older people over recent years has been the development of 'extra care housing as an alternative to long-term care and as a community focus for intermediate care schemes' (SSI 2003 p.7). Earlier manifestations of these services were called 'very sheltered housing' and 'housing and care' schemes.

Retirement communities can come within this category. (Croucher *et al* (2003) looked at Hartrigg Oaks in York, opened as a retirement community in 1998. Satisfaction levels were high and the pooled financial model appealed to many residents. However, it is difficult to know how to assess these findings, given that there appears to be no comparator.) Most extra care housing is provided by the social rented sector (local authorities or registered social landlords).

Although more needs to be done, authorities are comfortably on course to reach the national target of an additional 6900 places by 2006. (There are parallels elsewhere. One of the strategic objectives of the Welsh Assembly Government 2003 is to 'promote an adequate supply of special forms of housing which meet the varying and changing needs of older people and ensure that they can remain independent as long as possible' (p.25).) Many local initiatives in England are linked to the Supporting People programme, which replaced the previously fragmented funding arrangements for housing and care arrangements and was intended to overcome legal restrictions on the use of housing benefit for care services. The underlying aim was the promotion of independence through unregistered rather than registered accommodation, in a consistent and fair manner. There has been mixed success (Griffiths 2000).

Oldman (2000) compared residential care and these newer forms of provision (which she called 'enhanced sheltered housing'). Although the two services accommodated people with similar levels of frailty, 'tenants in the enhanced sheltered schemes generally had higher disposable incomes and rather more choice and control over their lives than their residential care counterparts. Schemes, however, were not generally cheaper than residential care' (p.1). The relatives of sheltered housing tenants also had greater involvement than the relatives of people in residential care. Independence was more likely to be promoted, and the housing schemes sought 'to create an active community'. Despite these advantages, Oldman saw obstacles to the replacement of residential care with very sheltered housing, and urged the 'decoupling' of registration and funding to allow residents to continue to receive housing benefit even if their scheme was registered. Older people would achieve greater choice and control if they were charged individually for their services.

In this review, it has not been possible to explore what remains a rather small but increasingly relevant field of provision in any detail. Netten *et al* (2004) offer a short account of the development of extra care housing, ownership and tenure, supply, funding, demand and future potential. As Netten *et al* conclude:

> At present, extra care housing represents a small, and rather ill-defined, aspect of overall social care provision, and one where there is generally a lack of detailed evidence. However, it is a rapidly developing area that has considerable government backing, and early indications from our investigations suggest that it is a welcome development from the perspective

of service users. Unlike home care and care homes, it is currently dominated by public and voluntary provision. Potentially, there is considerable scope for much larger private sector involvement. Barriers to expansion include the cost of the initial capital investment required and shortage of capital funding in the public sector. This type of development also demands land, with shortages in many areas and planning restrictions also potentially acting as barriers to new developments.

Stephen Ladyman, in his speech to the Laing and Buisson annual long-term care conference (March 2004), encouraged the growth of extra-care housing, predicting that it would be quantitatively the most important form of care in twenty years time.

Home care

One reason for the recent reversal of 50 years of per capita and then absolute growth of residential, nursing home and long-stay hospital provision was the growing provision of community-based support. However, as we saw earlier, rather bigger influences on the scale of care home provision came from outside the social care system. SSI's (2003, p.17) recent overview of performance of older people's services concluded: 'Rates of admission to long-term care were falling, but increases in the provision of intensive community care were only modest'. Preliminary analyses of data on home care provision and supported admissions to care homes did not show any relationship, nor that there was 'increased investment in community services in individual councils where admissions were falling' (p.32). Less than a year later the SSI was in rather more bullish mood, asserting that:

By 2002/3, the gradual increase in numbers of older people receiving intensive home care was beginning to show results in the reducing number of new admissions into residential or nursing home settings (SSI and Audit Commission 2004 p.28).

The summary report of seven years of joint reviews – which departs somewhat from the usual reports from audit and inspection bodies in being rather self-congratulatory – provides no substantiation for the assertion, and we assume it is therefore either based on impressions gained from the fieldwork that is needed for the joint reviews or on the interpretation of a simple correlation as an indication of causality.

PSA targets suggest that authorities intend to reduce care home placements, but not to increase the provision of intensive home care.

The most marked change in community-based care has been the growth and re-targeting ('intensification') of home care (formerly home help and domiciliary care). There are no statistics on the overall size of the home care market, and the (potentially

large) privately funded sector is currently neither registered nor regulated. Most of the evidence that follows therefore concentrates on local authority-funded services. We organise the discussion under four headings:

- growth and intensification

- sectoral balance

- provider characteristics and motivation

- quality and regulation.

Growth and intensification

Figure 4.87 shows the very significant increase in the volume of home care hours purchased by local authorities in England between 1993 and 2003. Particularly striking is the very rapid growth of the market share of the independent sector, leaping from 2 per cent in 1992 and 5 per cent in 1993 to 68 per cent in 2003.

In contrast to the growth in number of hours of home care purchased, figure 4.88 shows how the number of households benefiting from home care decreased substantially from around 540,000 in 1994 to 380,000 in 2003. Evandrou and Falkingham (1997) report how the proportion of older people in receipt of home care rose from 6.6 per cent in 1974 to 8.8 per cent in 1980 and then remained around 9 per cent throughout the 1980s. Since then it has fallen considerably.

The consequence of the growth in total hours and fall in service users is illustrated by figures 4.89 and 4.90: the intensity of provision of home care services has risen significantly in the last ten years. The average number of contact hours per household per week rose from 3.4 in 1993 to 8.6 hours in 2003. In other words, many fewer households are now receiving home care services, but those that do are receiving a much more intensive package of support. Generally, these are the people with greater needs (Bauld *et al* 2000; and see section on ECCEP below). In 1993 38 per cent of households in receipt of home care had only one visit of two hours or less in duration, compared to 15 per cent in 2003 (Department of Health, 2004). Many of these people will now be purchasing home care services privately: the proportion has increased considerably (Pickard *et al.*, 2001).

In contrast with these trends in England, the number of home care contact hours for older people in Wales has decreased in recent years, as has the number of people aged 65 or over receiving home care in Northern Ireland (see figures 4.91 and 4.92 respectively). The independent sector also appears to provide a much lower proportion

of home care in Wales than in England. In terms of the intensity of home care provision, figure 4.93 indicates broadly similar proportions of home care recipients receiving over 10 hours per week of care in Wales and England.

The SSI (2003) overview of inspections concluded that

> although there was a small increase in the proportion of older people helped to live at home in 2002-03, there has been no overall increase in this indicator during the last three years. The national average out-turn for 2002-03, at 85 older persons per 1000 aged 65 and over, represented 'acceptable' performance, but there were distinct regional variations both in levels and in trends. East and South East regions have relatively low average levels and plans to indicate this will continue, whilst the North East and London regions has the highest levels. Nationally, planned targets for 2003/04 appear ambitious in view of the last three years' performance (p.19).

While many services were appreciated by users, in many places the quality of domiciliary care remained variable. Although many councils reported complaints, few had robust means of learning from them and of adding value to practice as a result (p.33).

There have been many changes in service range and orientation. For example, the percentages of short-duration, weekend, out-of-hours and dependency-contingent packages has increased (Hardy and Wistow 1999; Ware *et al* 2001). Such changes appear not to have gone far enough. The NHS Plan put great emphasis on the development of flexible services to prevent older people being admitted unnecessarily to hospital, and to receive high quality care on the basis of need when they are admitted. But the SSI concluded last year that '[t]here was widespread interest in extending service responses into evenings, nights and weekends. However there was considerable scope for progress and some councils were not yet planning for this' (SSI 2003 p.45).

Sinclair *et al* (2000) describe the responses by local authorities to the excess demand for home care services, including re-negotiating contracts to provide services at different times; developing routine services that can reap economies of scale: using user charges to ration and limit services; referring clients to private domestic care services; exporting difficulties to independent sector providers through the contractual arrangement; developing new styles of care management to develop more effective and cost-effective care packages; and tightening of controls on resource use. To address concerns about the competence of independent providers, authorities were offering training, introducing quality assurance and control mechanisms, and also developing preferred provider arrangements.

Sectoral balance

The independent sector's share of the home care market has grown much faster than the expectations of local authority directors in the early 1990s (Wistow *et al* 1996). As Laing and Saper (1999, p.97) commented, the 1990 'community care reforms can be credited with kick-starting independent sector supply of home care services for state-funded clients'. In fact, it was not really the legislation itself but the 85 per cent rule governing spending of the special transitional grant that provided such impetus, followed over recent years by the irresistible influence of Best Value reviews, which brought home to a number of authorities the cost difference between in-house and externally provided services. Today most independent providers are in the private sector.

Independent sector market shares – and home care arrangements generally – vary enormously across the country (Wistow and Hardy, 1999), while commissioning arrangements generally remain rather simple, heavily reliant on spot contracts. For example, London authorities rely more on independent sector provision. However, Ungerson (2000) hypothesises that markets for home care may be less spatially diverse than those for care homes, because of the lesser reliance on suitable capital stock. It would be possible to examine changes over time in the spatial concentrations of market share, and one might hypothesise that Labour-controlled authorities would have been more reluctant to shift home care services from the local authority to the independent sectors. Regrettably, such a study has not been undertaken.

What was behind these changes in market share? Local authorities came to recognise the high relative cost of some in-house services and sought economies by contracting out. The SSI (2003) reports how some inspected authorities had concluded from their best value reviews that it was most effective to switch more of their purchasing to independent sector services, leaving only a specialist and short-term function for in-house services (see Patmore 2003). A major influence in the early part of the decade was the requirement attached to the redirection of public money from the DSS to social services departments that 85 per cent of the grant revenue be spent outside the public sector.

Home care provision has been less concentrated in larger organisations than has the care homes market. There is a multiplicity of small providers in most local markets, but here, too, there are signs of market consolidation through mergers and acquisition (Hardy and Wistow 1999; Laing & Buisson 2003; Netten *et al* 2004).

Provider characteristics and motivation

Ware *et al* (2001) report on the changing characteristics of independent sector home care providers between 1995 and 1999, based upon two cross-sectional surveys in 11 English authorities. In 1999, most providers were still relatively new to the field, with two-thirds having been established since 1993. Most were small enterprises covering quite a modest geographical span. Over a quarter of the sample in 1999 provided 250 hours or less per week, equivalent to about seven full-time care staff. Another quarter provided over 1000 hours per week, higher than in 1995 (14 per cent). Local authorities were encouraging consolidation, preferring to contract with larger providers. Larger providers were also better at competing on price for the new block contracts that some authorities were beginning to offer. Smaller providers also struggled with meeting some of the standards and quality requirements set by purchasers. It was clear that there was some consolidation of the provider side of the home care market in the second half of the 1990s, with the growth of more large organisations with individual branches operating across a number of different localities. Influences on this consolidation were local authority market management strategies, staff recruitment difficulties, the squeezing of prices and profit margins, and the anticipated introduction of new and tougher quality standards. Economies of scale were likely to be reaped in many of these dimensions.

More than half of the providers in the 1999 sample had more than three-quarters of their clients funded by local authorities, an increase in the proportion four years earlier who were so heavily reliant on public funding. There was growing concern about local authority dominance of the market, squeezing prices and making demands that some providers found hard to meet.

In both years, around two-thirds of the providers believed that their local authority operated a policy that favoured in-house services. Evidence from local authorities in 1999 confirmed that the playing field was still not level. Two purchasers admitted, for example, that there was an unwritten in-house first policy.

Over time, attitudes to the private sector appeared to have changed a little, with providers less likely to report what they saw as prejudiced views among purchasers. Nevertheless, a number of providers felt that their purchasers did not fully appreciate the constraints under which they operated, the bureaucratic burden of some contractual links, the impact of delayed payments (which were still quite substantial in some localities) and a general reluctance to share the market risk. Voluntary sector providers were treated differently, sometimes on the basis of long historical links.

Considerable pressure on prices was a constant theme in both 1995 and 1999. One in five home care providers in 1999 reported being forced to reduce costs in response to local authority pricing policies, one in eight said that prices failed to cover costs, and 11

per cent were seriously considering leaving the market. This had led to cutbacks in staff, pay cuts for some staff, and neglect of some of the administrative aspects of the business.

An improvement over time was in the sharing of information, with more providers in 1999 feeling that they had information on local authority intentions and plans than was the case in 1995. Trust appeared to be developing.

In relation to contracts, in 1995 three-quarters of the sample only had spot or call-off contracts, compared to 50 per cent in 1999. In the later year, there was also wider use of a range of different contract types. There was clearly some distance to go to share the risk more equitably between purchasers and providers, but the direction of travel was generally seen to be appropriate.

This PSSRU/Nuffield Institute research also underlines the extent to which the motivations of providers need to be understood not just in terms of financial or monetary reward, but also in terms of respect for their autonomy as independent operators, and recognition of their competence and professional achievements. There need to be better opportunities for communication and feedback between purchasers and providers. The institutional arrangements set in place by local purchasers – forums, review and planning processes, and contractual design – have failed to create such supportive conditions (Kendall *et al* 2003).

Quality and regulation

There is very little evidence on the quality of home care services. The SSI (2003) noted 'growing recognition that poor-quality services are ineffective and therefore inefficient in achieving non-residential outcomes' (p.28). Greater flexibility, particularly to make services available when people need them, is urged, and generally many of the authorities inspected

> had problems with the quality of domiciliary care and/or with delays in accessing services. Services that were unreliable or lacked continuity in staffing failed to give users the confidence and practical assistance they needed to continue living independently (SSI 2003 p.28)

User satisfaction levels are often rather low (Netten *et al.*, 2004). Underlying problems include staff recruitment and retention difficulties, under-developed relationships with providers (see above), a poorly trained workforce, and a recent tendency to keep prices low, thereby threatening quality.

There have been moves towards registration and national regulation of care standards only quite recently. One of the new standards is that by April 2008 50 per cent of direct home care workers will need to have an NVQ level 2 qualification or higher (Department of Health, 2003b). The Welsh Assembly Government (2003) proposes to introduce new regulations and national minimum standards for home care, and to ensure 'Charging policies for home care are designed to be fair and operated consistently between different services' (p.27).

Other community-based services

Figure 4.94 shows the number of clients in England receiving community-based services other than home care in the period 2000/01 to 2002/03. There was a significant increase in the numbers receiving professional support and a small increase in the numbers attending day care centres. Other widely used services include equipment and adaptations and the provision of meals. Local authorities are giving day care a wider role and many are also redesigning such services following best value or other reviews (SSI 2003). Day care places grew by 69 per cent from 15,300 in 1977 to 25,900 in 1992, but the proportion of older people using them fell from 5 per cent in 1985 to 3 per cent in 1994 (Evandrou and Falkingham 1997).

Figures 4.95, 4.96 and 4.97 show a reduction in the number of day care sessions, meals and nights of respite care provided to older people in Wales between 2001/02 and 2002/03 (figure 4.98 shows the number of nights of respite care provided or funded by authorities for all adults). There was a very small level of involvement of the independent sector in providing these services. In contrast, figure 4.99 indicates a slight increase in the number of users receiving personal equipment and adaptations.

Figures 4.100 and 4.101 depict the level of provision of meals on wheels and statutory respite care, day care and residential accommodation in Northern Ireland.

The hospital-community balance

Policy intentions in 1990 in relation to community care were to alter two balances: between hospital and other forms of care, and – within the 'other' category – between care homes and support in older people's own homes. Slightly confusingly, both have been called *community care*. We have already discussed how the balance between care homes and home care (another example of poor terminological imagination) has shifted over the course of the last two decades. We turn now to the hospital-community balance, the challenge of delayed discharges and responses to it, such as the encouragement of intermediate care.

Falling hospital utilisation

The position of hospital in-patient care within the full spectrum of support for older people has changed, although not as much or as fast as many people in 1990 may have expected or hoped. The number of geriatric beds in England fell progressively from around 53,000 in 1987/88 to 46,000 in 1990/91 to 28,000 in 2002/03 (figure 4.102). Over recent years, the bed occupancy rate has grown (from 87 per cent in 1996/97 to 91 per cent in 2002/03), indeed to such an extent that some doctors are now (1 July) blaming the quest for 100 per cent occupancy as partly to blame for worryingly high rates of hospital-acquired infection. Older people occupy many other beds than those in geriatric wards. The *Health Service Journal* (12 February 2004, p.13) reported that two-thirds of acute in-patient days are used by people aged over 65, and admission rates for those over 65 are three times higher than for people aged 16-64. The provision of acute beds has also declined over recent years.

The downward trend in hospital beds had started somewhat earlier, and the emphasis on community-based care goes back some years. In 1966, for example, the Ministry of Health published *The Development of Community Care: Revision to 1975-6* which emphasised the importance of providing care in people's own homes. A consultative document issued in 1981 argued 'Most people who need long-term care can and should be looked after in the community. This is what most of them want for themselves and what those responsible for their care believe to be best' (DHSS 1981, paragraph 1.1). During the 1980s, community care for people with chronic health problems or other long-term needs was regularly discussed, and the rundown and closure of many long-stay hospitals was a notable and sometimes controversial feature of the changing practice landscape.

There was a marked reduction in the average length of stay in geriatric beds over the 1980s. That period also saw some experimentation with new forms of community-based services and the coordinating functions of case management, although 'structured dependency' was still generally the order of the day and care home destinations for former hospital residents tended to be accepted without much question as to appropriateness or quality. (Most were, after all, marked improvements on the 'back wards' they replaced.) But it is debateable to what extent the shifting balance between hospital and other forms of care can be ascribed to a firm policy commitment. The key ingredient was surely (and opportunistically) the funding environment:

> The availability of social security monies in the 1980s enabled many health authorities to reduce their own provision for long-term care, closing old, outdated geriatric and psychogeriatric wards, and freeing the revenue for use elsewhere. Between 1983 and 1996, there was a 38 per cent reduction in acute and long-stay beds for older people and an almost nine fold increase in nursing home beds (Audit Commission 1997, p.12).

Hospital closure also generated sometimes considerable capital sums at a time when NHS finances were much less healthy than today. Effectively, for unplanned reasons, it might therefore be argued, the kinds of provision that policy makers most wanted to close (the decrepit, remote, neglected asylums and back wards) were actually closing.

One of the consequences was a shifting expenditure balance. Over the ten-year period between 1979/80 and 1989/90, expenditure on hospital services in England grew from £8.8 billion to £10.7 billion (at 1989/90 prices), representing a 22 per cent increase. Over the same period, however, total expenditure on community-based care grew by 69 per cent from £8.5 billion to £14.3 billion. The social services contribution to this latter figure grew a little, but most of the change was due to increases in primary care and social security expenditure (Audit Commission 1992).

The initially slow implementation of the 1990 Act may therefore have been symptomatic (centrally and locally) of the hesitancy and uncertainty about turning the principles of non-hospital care (in an almost residual sense) into positively enhancing community-based care. The Secretary of State of the time blamed the decision to phase in implementation of the legislation on a lack of preparedness among local authorities, while many people in local government blamed the Secretary of State's anxiety about the consequences of community care reorganisation and funding for the poll tax. Nevertheless, after 1990 and for perhaps the first time, 'community care' as a policy was taking some shape. The proposals to plan and tailor packages of services, provided by a multiplicity of agencies, delivered to people whose needs had been consistently assessed, in cognisance of their preferences, and coordinated by care managers, were central to this new shape.

Delayed discharge

'Delayed discharge is seen as a litmus test for the way in which the whole health and social care system is working' (Robinson 2002, p.22). Whether the system is getting more acidic or more basic is not entirely clear, but there are certainly changes afoot. Figures 4.103 and 4.104 illustrate the recent falls in the rates of delayed discharges of older people from hospital in England and Wales. Figures 4.103 also reveals wide variations in the rate of delay between local authorities, with metropolitan districts performing better than the rest. There are also broad variations hidden within these regional averages. Warnes (1997), for example, reported widely varying admission rates within London, with rates being 15 per cent lower in deprived parts of inner London compared to similar areas in the rest of the country. Older residents occupied fewer beds in inner London than did older people in other parts of the country. He argued that older people with complex needs were falling between agency responsibilities, suggesting that the lower rate of inpatient service utilisation was not due to better community-based services.

Figure 4.105 reveals almost no changes in the per capita rates of emergency admissions to hospital between 2001 and 2002. However, it shows again considerable variations in performance across local authorities in England. Figure 4.106 reports the rates of hospital admissions of people aged 75 or over due to avoidable harm (falls and hypothermia). Outer London authorities perform better than the rest. In terms of star ratings, around four-fifths of all authorities have been granted 3* status or better in recent years.

Why are delayed discharges a problem?

Many commentators refer to vicious circles. Older people, although ready for discharge from hospital following acute treatment, find themselves unable to cope unassisted in the community, thus find themselves trapped in a hospital awaiting the availability of a community care package or a residential or nursing home placement. In the meantime, hospital throughputs are reduced and waiting lists and waiting times increased. But the high expenditure on inpatient services reduces the resources to develop community-based alternatives. This 'delayed discharge vicious circle' has a long history (Brooks *et al* 1990; Jenkinson *et al* 1992). It is a classic case of poor targeting of services on needs.

Another vicious circle sees hospital beds under pressure, leading to earlier discharge but without adequate rehabilitation services, leading to increasing use of care home beds by people who cannot cope in their own homes, leaving less money available for preventive services, leading finally back to increases in hospital admissions (Audit Commission 1997). Although there have been encouraging results from a few pilot initiatives, there has not been a great deal of replication on the wider canvas. For example, in relation to the support of people who have had a stroke, there is good evidence of improved effectiveness and cost-effectiveness from early discharge to community rehabilitation (Beech *et al* 1999), early liaison between NHS and social care staff (Hakim and Bakheit 1998) and the training of informal carers (Kalra *et al* 2004; Patel *et al* 2004). But it is not clear how far these (usually) medical school initiatives are rolled out more widely, or how willing local managers are to extrapolate from one clinical area to others.

Lewis (2001) points to half a century of

> failure to develop services for the intermediate group [people in need of nursing and medical attention on a very regular but not constant basis] – in the hospitals as well as in the community … a result of the tussle over the respective responsibilities of health and social services, which have in turn been at the heart of central policy making' (p.355).

Contributing to the difficulties is what the AMA and ACC (1995) called the 'gearing effect' (cited in Audit Commission 1997 p.50). Supporting one older person with high-level need can cost as much as supporting half a dozen people with less but quite still substantial need. The concentrated targeting of community-based services on older people with the greatest needs has consequently had a sizeable impact on the availability of the less intensive, preventive forms of home care, which could in turn increase the risk of admission for some people, particularly those unable to afford to purchase private domestic help, not to mention the negative impact on quality of life for those people who place particular store by domestic order and appearance (Quilgars *et al* 1997; Clark *et al* 1998; Lewis 2001).

In resource management terms, delayed discharges are therefore problematic to policy makers because they waste resources – they are both inefficient and inequitable; at the same time, they are problematic to individual older people because they confine them to longer stays in hospital than they or their families would wish, with generally adverse implications for quality of life and the risk of infection. The pressures on resources and time may also rule out the proper involvement of service users in the choice of placement destination. Reed and Morgan (1999), for instance, report that few older people being discharged from hospital to residential or nursing homes had been offered opportunities to discuss their move with nursing staff, and hospital and care home staff were unclear as to their roles in initiating such discussions.

Central government's response to the delayed discharge pressures was to announce the National Beds Inquiry (NBI) in 1998. The aim was to 'review assumptions about growth in the volume of general and acute hospital services and their implications for health services and hospital bed numbers looking 10 to 20 years ahead'. The Department of Health believed that the long-term reduction in hospital capacity had gone too far, with hospitals ill-prepared for dealing with increasing waiting lists and the recurrent winter pressures on emergency beds. At the same time, it was of the opinion that there was significant inappropriate and avoidable use of hospital resources.

Inadequate service provision

The Audit Commission was already warning in 1992 of the potential difficulties of discharging people from hospital to community settings, generated by the curtailment of access to social security funds to support people in independent sector residential and nursing homes. Initially at least, there appeared not to be a problem. Two early studies found no impact of the 1990 Act on length of hospital stay (Junaid *et al* 1996; Lewis *et al* 1994). A third study by Shah (1996) could find no impact on length of hospital stay or destination following discharge. The first few years after implementation of the 1990 legislation did not reveal the expected widespread difficulties in discharging older people from hospital into residential or nursing homes (Wistow 1997).

However, subsequent studies have pointed to the scale of the challenge (e.g. Vaughan and Withers 2002) and linked it to the changes in community health and social care arrangements. In North Essex, for example, it was reported that 10 per cent of the entire bed stock in 2000 was occupied by older patients delayed in hospital, a situation described by Pascoe (2001) as 'gridlock'. She went on to set out the initiatives taken locally to improve information flows, ensure better accountability across all organisations, speed up assessments, work closely with patients and families to change expectations (particularly to emphasise the risks of continued residence in hospital, while getting a better understanding of patients' concerns and longer-term wishes), find funding for minor 'home-fixing schemes', block-purchase care home beds (replacing spot purchasing), and ring-fencing the older person's purchasing budget to protect resources in the future. The result was to reduce the number of older people awaiting discharge from 280 to 60. Similar initiatives have been launched in a number of other localities.

A literature review commissioned by the NBI concluded that 20 per cent of inpatient bed days accounted for by older people were probably inappropriate due to the absence of alternative service arrangements (Goddard *et al* 2000). (The Audit Commission 1997 had earlier suggested that 50 per cent of older people in hospital needed rehabilitation.) The NBI report stressed how hospital services should be considered in a wider context, including other parts of health and social care systems such as primary, community, rehabilitative and long-term care. In particular, the report collected circumstantial evidence for England suggesting that the need for hospital services and beds was influenced by the availability of these other services, which 'can help prevent the need for acute interventions, can enable safe discharge to community or home-based care and can act as either substitutes for or complements to hospital services'.

A summary District Audit report (2002) on rehabilitation suggests that dislocation between hospital and community settings can occur for at least three reasons.

> Community therapy services are generally not geared up to deal with people discharged from hospital … Social services often have long waiting lists to fit aids and adaptations in the home … Information about a patient may not be passed on from the acute hospital to rehabilitation teams working in the community or in day hospitals (p.2).

Shah *et al* (2001) found similar reasons for delays in discharge from the audit and quality assurance exercise undertaken in their trust. Placement difficulties led the trust to conduct an experiment involving the appointment of a dedicated specialist social worker (with a dedicated budget for purchasing home care services) to work exclusively with psychogeriatric in-patients to facilitate moves to the community. The evaluation compared two 7-month periods, before and after appointment of the social worker (but without a control/comparison area, which is a weakness of the study). There was a

reduction in bed usage in both the local hospital and extra contractual referrals (which existed at the time) between the two time periods. There was also a reduction in costs very similar in size to the cost of employing the dedicated social worker. There was an association between increased length of stay and discharge from hospital to an institutional setting, indicating 'placement difficulties'. The sample size for the study was too small to show a significant difference in either length of stay or costs between the two years. No data were collected on the clinical or quality of life outcomes for individual older people.

Victor *et al* (2000) carried out a retrospective case note review in three English hospitals, looking at 456 patients aged 75 or over who were admitted from their own homes and subsequently discharged from specialist elderly care wards. They sought to identify through statistical analysis the factors that influenced delayed discharge. Three predictors were identified: absence of a family carer, entry to a nursing or residential home (associated with delayed discharge because of the need to carry out a range of assessment and other procedures), and discharge assessment team staffing (late referrals and less emphasis upon multidisciplinary working may delay discharge). Delayed discharge was not related to the dependency or morbidity characteristics of older people, nor to their age or whether they previously lived alone, but was 'compounded by social services resource constraints'.

Social care and delayed discharge

The most searching examination of the scale of this 'compounding' problem has been carried out with English national data by Fernandez and Forder (2002). They used two perspectives to explore the interaction between social care and delayed discharge rates, one mapping the relationship between social care and health services and rates of delay, the other describing the relationship between aggregate resources, input costs and delay.

The analyses corroborated the view held by the National Beds Inquiry and by others that provision of social care services (both community- and institution-based) significantly reduced delayed discharge rates. Local resource levels and input prices matter significantly. Other things being equal, richer authorities and those facing lower input prices (property prices and wages) enjoyed significantly lower delayed discharge rates. The wage effect was particularly strong, so that a fall of £26 in average gross weekly earnings was associated with an improvement in delay by around 1 per cent in the average local authority. Much of the variation in delay rates is linked to factors outside local authority control.

The costs of reducing delayed discharge levels were shown to depend critically on which and how extra services were distributed, the share taken up by the different

services and the time frame considered. Overall, targeting extra resources on home care services was most cost-effective, closely followed by providing supported residential/nursing care beds. Simply increasing local authorities' budgets for older people's services appeared to be more than twice as expensive as restricting investments to only one of the two service types. Although district nursing inputs were also found to reduce delay rates, they appeared a much more expensive alternative.

Because higher rises in service prices would be required, the short-term costs of reducing delay rates by increasing social care provision were more than double those in the long term. Moreover, 'ring-fencing' extra resources for cases awaiting discharge would very significantly reduce the costs of reducing delays.

Inadequate discharge planning

In work carried out prior to implementation of the 1990 legislation, Victor *et al* (1993) had looked at hospital use by older people in one London area, revealing poor liaison between health and social care services at both the admission and discharge points. In fact, poor discharge planning is a recurrent theme in the literature, as we illustrate below with a few examples. It also figures prominently in the SSI (2003) review of inspections: 'Hospital discharge systems were poorly coordinated in the councils inspected that had the highest delayed discharge transfers of care'. Of course, as lengths of hospital stay get shorter and the pressure on beds (occupancy) intensifies, it becomes harder to implement good discharge planning.

A systematic review by Parkes and Shepperd (2000) concluded that good discharge planning can reduce length of hospital stay, reduce readmission rates and increase patient satisfaction (and see Bull 2000; Rosswurm and Lanham 1998). Unfortunately, discharge planning often does not start early enough, if at all (Hallet 2001; McKenna *et al* 2000), and protocols are not always followed (Parry-Jones and Soulsby 1999). Multidisciplinary inputs to discharge planning are often missing (Lundh and Williams 1997). Readmission rates are particularly high for people aged 85 or over (Harding 1998). Other factors inhibiting good discharge practices include under-funding and non-availability of services (Henwood *et al* 1996). Pre-discharge home assessment visits are not necessarily effective (Patterson and Mulley 1999).

Roberts (2001) explored how older people may assume active roles when accessing health and social care services. Based on evidence gathered from semi-structured interviews with thirty service users soon after they returned home from hospital, she found interesting differences between health and social care. She urged greater uniformity across the whole system in information about access to contact points. Direct purchasing of services would be an advantage. Roberts (2002) also carried out a small sample study of user participation among older people facing discharge from hospital.

She concluded that most 'respondents felt that they had been involved in decisions regarding their discharge from hospital' (p.413). Waters *et al* (2001) compared two non-random samples, drawn ten years apart, of older people who were being discharged from hospital. The study has certain limitations, but points to continuing problems with the planning and coordination of services to allow people to be discharged from hospital settings.

Payne *et al* (2002) conducted a systematic review of strategies for the transfer of information between hospital and community services for older people with physical illness. They uncovered the expected information problems. From their analysis of the qualitative and quantitative studies, they concluded that 'the most effective strategy for transferring information is the appointment of a key worker, who can provide a point of contact for workers from hospital and community' (p.116). Although the focus was primarily on health services, there are clear lessons for social care as it seeks to implement the recommendations of the NSF to transfer information more effectively across professional and service boundaries.

The policy response

Since the National Beds Inquiry, a number of initiatives have been taken to tackle delayed discharges, including encouragement of intermediate care (helped by an initial additional £300 million announced in October 2001), establishment of the 'change agent' team at the DH, and – since January 2004 – cross-charging of local authorities by the NHS for avoidable delays. Henwood (2002) describes how the Commons health select committee looked closely at the number of available beds lost to the system, estimating the figure at 34,200 net lost places between 1997 and 2001 (House of Commons Health Committee 2002). Whether the figure is accurate is unclear, but the DH itself agreed that there had been a net reduction in overall capacity in the care home sector (their estimate was 19,000 places). The select committee called for 'dynamic alternatives to the options of residential care, nursing care or care at home', and Henwood (2002) cites Hartrigg Oaks as an example (see Croucher *et al* 2003), better housing options and telecare solutions. More attention is now being given to telematics and 'smart' technology and their potential to improve the quality of life of older people living independently (Hanson and Clarke 2000; May *et al* 2003), although the scale of the investment to date looks extremely modest.

Intermediate care

The NHS Plan (Department of Health, 2000a) announced a very significant expansion of intermediate care services, pledging funds were in addition to the £200 million already allocated to Health Act schemes promoting partnership working (Department of

Health, 1999). Through investment in intermediate care, the government expected to be able to achieve a significant reduction in the average rate of delayed discharge from hospital for people aged 75 and over (Department of Health, 2001b).

The NHS Plan had argued

A new tier of services – intermediate care – will give more people the help they need to remain independent at home, immediately after or even through a period of acute illness. … [There would be new service options] including housing developments with immediate care and support available close by, as well as adaptations and care in people's own homes. The aim must always be to help people do things for themselves, not to do things to them … Whatever the model and whatever the focus on rehabilitation, intermediate care will require all parts of the health and social care system to work better together, ensuring the right emphasis at each level of care.

The Plan also urged further research on the cost-effectiveness of rehabilitation, 'although the absence of research should not prevent the development of a national strategy' (Secretary of State for Health 2000). The policy emphasis is similar in Wales. One of the strategic objectives of the Welsh Assembly Government (2003) is 'To develop the provision of intermediate care services to meet the need for short and long-term care of older people close to their homes whenever appropriate' (p.25).

What is intermediate care?

Standard Three of the NSF is 'to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living' (p.41), that is to give older people access to a new range of intermediate care services. This arose because of inadequate attention paid to both prevention and rehabilitation, as revealed by the Audit Commission (1997, 2000c), the National Beds Inquiry, and other reports and studies. Intermediate care guidance was actually issued ahead of the NSF (Department of Health 2001e). The key to the development of intermediate care is 'integrated and shared care, including primary and secondary health care, social care and involving the statutory and independent sectors' (p.42).

The NHS Plan set targets for expanding intermediate care, projecting that by 2004 there should be 5000 extra intermediate care places and 1700 supported intermediate care places; rapid response teams and other avoidable admission prevention schemes; 50,000 more people enabled to live at home through additional home care and other support; development of respite care services for carers.

According to the NSF 'Intermediate care services should:

- Be targeted at people who would otherwise face unnecessary prolonged hospital stays or avoidable admission to acute in-patient care, long term residential care or continuing NHS in-patient care.

- Be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation.

- Be designed to maximise independence and to enable patients/users to remain or resume living at home.

- Involve short-term interventions, typically lasting no longer than six weeks and frequently as little as 1-2 weeks or less.

- Involve cross-professional working, within the framework of the single assessment process, a single professional record and shared protocols' (p.43).

It is probably more helpful to conceptualise intermediate care not as a collection of services but as the 'function to facilitate transfers from medical dependence to day-to-day independence' (Lewis 2001 p.355; following the work of Steiner and Vaughan 1997). In similar vein, Herbert and Lake (2004) discuss what they call the *intermediate tier*:

> Our thesis is that intermediate care is only effective if developed and used as part of a whole system of care. It is through developing better understanding of the nature of care provided, the process involved, and new ways of working, that we can achieve the objectives of intermediate care policy… In effect intermediate care is a function of some services within a wider system (pp. i and 7).

Progress with developing intermediate care

Carne *et al* (2002) describe a joint initiative between an NHS trust and a housing association to develop purpose-built accommodation to provide continuing care services. Residents remain fully under the control of the NHS, with two of the 30 beds allocated for respite admissions. Other places in the facility are occupied by people who are clients of the housing association. Although not formally evaluated, Carne and colleagues describe the service as a great success in terms of the positive attitudes, resident satisfaction, and absence of complaints.

In fact, every couple of weeks there is an article in the *Health Service Journal* or in *Community Care* magazine reporting a new intermediate care development, usually describing the organisational cooperation that made the service possible, the resource barriers that had to be surmounted, the reduction in inpatient bed usage that has resulted and plans for the future. Positive quotes from people who have used the service are usually included in each article. This is not robust evaluative evidence, but it *is* an indication that local authorities, the NHS and independent sector partners are working together to put new service models in place.

More formal evidence of practice developments comes from the SSI (2003), whose last round of inspections found that many local authorities were developing intermediate care, and many were delivering excellent results. Nevertheless, they were often disjointed pilot projects that needed to be integrated better with mainstream activities. The summary of inspections therefore concluded that 'intermediate care now plays a central part in the aspirations of most health and social care partners to promote independence' (p.22). The one unacceptable common shortfall identified was the exclusion of older people with mental health problems from intermediate care services (p.24).

The link with the promotion of independence obviously suggests broadening the aperture to look at the kind of needs definition discussed earlier, one that promotes control and choice as well as addressing the 'deficits' that sometimes accompany ageing. We have also noted frequently how the concentration of services on people in greatest need has removed the potential preventive function of low-level support for other older people, many of whom have 'substantial' needs (Lewis 2001). Those with the resources to do so may be purchasing private domestic help, others may be relying more and more on the unpaid help of family and other carers. But for many older people, the likelihood is that their circumstances will deteriorate without low-level home help with domestic tasks.

Steiner (2001) reviewed some of the early experience with intermediate care. She highlighted the need to balance the risks associated with, for example, iatrogenic illness in the inpatient setting against the risk of falls, neglect and general deterioration in a community setting. Jacobs and Rummery (2002) explored the ability of nursing homes to provide intermediate care. Based on a national cross-sectional telephone survey in 1999/2000, owners, managers or matrons of 570 care homes provided information on access to a range of health services. The survey was followed by interviews in a sub-sample of homes. Obviously the quality of nursing care offered by homes will influence the success of intermediate care functions, but this paper raises questions about the ability of homes to access supporting NHS services, in particular rehabilitation, physiotherapy, speech and language therapy and occupational therapy. The study also found delays and difficulties in obtaining expensive items of medical equipment. The

burden falling on GPs was thereby increased (cf. Kavanagh and Knapp 1998) and the successes of intermediate care may have been fundamentally compromised.

What, then, are the factors that limit the supply of intermediate care? A number of hurdles can be identified from the experience to date (see Robinson 2002 for an insightful account):

- Local authorities facing difficulties finding and paying for care home places.

- Shortages of care home places following the large numbers of closures in some areas, or decisions by providers not to take local authority business.

- Local authorities not able to increase the fees they pay because of their own financial constraints.

- The fact that some of new money announced by the government (£900 million in 2002 over a three year period) 'is being used for other purposes, such as meeting increased salary and prescribing costs, or long-term care' (Robinson 2002 p.22).

- Generally, the financing of intermediate care remains unclear, with different agencies and budgets to be tapped (Steiner 2001). Capital funding is a particular problem in some areas.

- Discharge planning for people in hospital is often started only when they are ready to leave hospital, not any earlier.

- In some areas the NHS and local authorities have not been enthusiastic about working together (e.g. see Davey et al 2004 and chapter 3 above).

- Public-private partnerships have sometimes proved problematic, with a reluctance to commission private nursing homes because of concerns about quality or competence.

- 'Authorities have found it difficult to take a whole systems approach to intermediate care that would prevent gaps, duplications and discontinuities' (Robinson 2002 p.23). The lack of a strategic framework is a constraint (Herbert and Lake 2004).

- Insufficient efforts to reduce hospital admissions in the first place, with few early intervention schemes targeted on people most at risk of emergency admissions (for example, during the winter months). (But see Roe et al 2003.)

- The cross-charging of local authorities for avoidable delays is a blunt instrument that does not create the right incentives.

- Lack of advice. There is a need for 'better support for health and social care agencies for the strategic development of intermediate care, in the form of guidance on whole-systems planning and educational programmes for managers charged with that responsibility' (Robinson 2002 p.24).

- Insufficient investment in preventive health measures to improve the management of chronic conditions.

- Inadequate structuring of the processes of care management.

- An understandable reluctance – although overcome in some areas – to close respite care beds to make way for intermediate care.

Three years ago Lewis (2001) made the following argument, but it is still pertinent today:

> It is encouraging that the gap in services for the intermediate group has at last been put on the policy agenda and explicitly recognised, but more is required in terms of thinking about the nature of the services that are required. It is also uncertain whether the measures proposed to tackle the financial, administrative and professional divisions that remain are adequate.

Here, as elsewhere, whole system approaches are flavour of the month. Noting that in some areas, community hospitals were providing an intermediate care function, Henwood offers a warning:

> But if the current emphasis on developing 'whole systems' solutions to care needs is to have meaning in long-term care, the focus should be on approaches that maximise the skills, knowledge and experience across health and social care and which fully integrate the independent sector as partners. Criticisms of 're-badging' of NHS services as intermediate care are an indication of what can occur without such partnership and provide few grounds for optimism in recommending a narrow NHS model for long-term care provision more broadly (p.27).

Prevention

'Prevention has emerged as a key theme in social policy discourse and a central thrust of national policy within and across health and social care' (Godfrey 2001 p.89). The NHS Plan was strongly committed to preventive interventions, and the DH announced a targeted prevention grant in the late 1990s. Examples of preventive schemes include respite care, telecare and other smart technology, energy efficiency projects, home

security projects, befriending schemes, and day care. There is also, of course, the low-intensity provision of home care services, which might prevent the need for more intensive services later on, or the need for admission into a care home or hospital.

A systematic mapping of the literature by Godfrey (1999) revealed that the evidence base on social care prevention was not very extensive, and much of it was rated as quite weak. Godfrey (2001) presents some of the main findings, linking the evidence to the changes in social care for older people over the last decade or so. (We summarise her findings in section 4.6.) She argues that the 1989 White Paper and 1990 Act focused on tertiary prevention, putting services in place to reduce disability or dependency, and so prevent the need for admission to care homes or hospital. She also suggests that some of the higher intensity home care services may actually be creating dependency by taking on specific tasks for older people, rather than helping them to do things for themselves (Godfrey *et al* 2000). It may well be that the more recent focus on the maintenance and promotion of independence will counteract such tendencies, but in any case it is not clear if there evidence in support of this assertion.

The 1998 White Paper, *Modernising Social Services* (Department of Health 1998a) expanded the interpretation of prevention from tertiary to secondary and primary, putting emphasis on the need to support people at risk of losing their independence (and see Wistow and Lewis 1997). Godfrey (2001) nevertheless points to some underlying ambiguity in the shift from tertiary to secondary and primary preventive strategies, in that the practical consequences of government policies imply a continuation of the decade-long concentration of community-based services on people with the greatest needs. Subsequent policy documents that have contributed to the discussion of, and emphasis on, prevention include the 1999 health White Paper (Department of Health 1999b) and the Better Government for Older People initiative (see Hayden and Boaz 2000a).

The evidence, however, clearly points to the under- and uneven provision of preventive services. The Audit Commission (1997) noted that too little investment was being made in preventative or rehabilitative services, and that this resulted in unnecessarily high numbers of admissions (unplanned) for older people to acute hospital services and premature admission to long-term residential care. This was one of the vicious circles noted earlier. Clark *et al* (1998) interviewed 51 older people living in their own homes, as well as some staff of public and independent sector services, to examine whether 'low-level' services (such as 'help with housework, gardening, laundry, and home maintenance and repairs') help older people to maintain their independence to achieve better quality of life. Consistent with the approach recommended by others (including the Audit Commission 2004), older people emphasised their ability to exercise control and choice. For these respondents, help with housework and other 'low-level' needs were viewed as instrumental in maintaining independence. A similar emphasis on the need to keep the home clean and presentable was reported by Raynes *et al* (2001)

from interviews with 143 older people living in Manchester. Again, respondents stressed the maintenance of independence, the need for company and trust built up with regular home carers. Older people from black and minority ethnic groups reported a need for culturally specific support (for example in relation to food and activities). Bird and Parslow (2002) review the potential of community-based initiatives to prevent depression among older people.

Not surprisingly, there are marked variations across the country. For example, a number of authorities studied by Lewis *et al* (1999) had not yet considered how to implement national guidance, while others had invested significantly in preventive approaches, often by grant-funding voluntary organisations. Senior managers reported difficulties in justifying expenditure on preventive services, given the difficulties on demonstrating effectiveness. It was always thus. There was also greater attention paid to short term objectives, and less attention on long-term promotion of quality of life of older people. A few years later there appears not to have been any marked improvement. The SSI (2003) review report concluded that:

> A majority of councils included prevention in their plans to promote independence. These included developing day services, luncheon clubs and befriending services, as well as increasing low-level practical support such as care and repair, shopping and handy-persons' schemes. However most councils inspected had made little investment in, and had no strategy for developing low-level prevention and support services. Usually the voluntary sector was providing an uncoordinated patchwork of services (p.19).

Whole systems approaches

We noted at the beginning of the chapter the growing commitment to developing whole system approaches to the identification of needs and particularly to meeting them, involving active participation of all statutory and independent agencies. The SSI (2003) noted, for example, that some local authorities were using their best value reviews to help to develop such approaches.

In emphasising the need for a whole-systems approach to the promotion of independence and well being, the Audit Commission (2004) expressed surprise that 'comprehensive, systematic approaches to older people are still relatively rare. In future, local councils and their partners should expect to be judged on their ability to build communities that support older people to live active, fulfilling lives' (p.3). Nevertheless, initiatives were said to be in place in a few localities, aimed at adopting a whole person approach and a whole system response to the needs and preferences of individual older people. The Audit Commission's argument, which seems utterly plausible but for which the evidence base is uncertain, is that such approaches deliver 'fewer hospital

admissions; shorter average lengths of stay; reduced A&E attendances; and less use of GP services. Proactive approaches can bring enormous benefits to older people, as well to the wider NHS and social care system' (p.17). In support of this assertion, the Commission points to some pilot schemes, some adopting the approaches of Kaiser Permanente or EverCare, others trying various approaches to integrated care pathways and such like.

We have not searched for UK research evidence on integrated care pathways, although we are aware of one study in the stroke area. Sulch *et al* (2002) found that integrated care pathways, when compared to conventional multidisciplinary care, resulted in higher frequency of assessments, provision of better information to patients and carers, and earlier notification of discharge to GPs. A review of integrated care experiments by Johri *et al* (2003) would appear relevant, although the only UK study covered is the Darlington care management evaluation (Challis *et al* 1991, 1991a) discussed elsewhere in this chapter. More generally, experiences with intensive and standard care management in social care, and with the care programme approach in the mental health field, would presumably be relevant to the introduction of such whole system models.

Outcomes and cost-effectiveness

And so at last we arrive at the discussion of outcomes – for users, their carers and the wider community. We first need to discuss what is meant by outcome in relation to the social care of older people, and so the first subsection considers the dimensionality of outcomes. We then look at changes aimed at improving the balance of care, particularly the achievement of better 'destinational outcomes'. A lot of attention is now being focussed on measures of service user satisfaction, particularly through regular surveys by local authorities and various auditing and inspection bodies, and we present some of the findings (and note some of the limitations with these kind of data). The longest subsection attempts to summarise the evidence on effectiveness and cost-effectiveness. Even by focusing our attention on those interventions or policy objectives emphasised in the 1989 White Paper and subsequent policy initiatives, this is an enormous task. Finally, we describe the results from the Evaluating Community Care for Elderly People (ECCEP) study, the most ambitious evaluation of the effectiveness and cost-effectiveness of the post-1990 Act community care system.

On the whole, we have little to say about performance indicators in this section. With very few exceptions, the measures employed in, for example, the Department of Health's performance assessment framework are indicators of input, process and service volume. They do not measure the impact of services on the users of services. Indeed, it has been argued that they do relate very obviously to performance (Qureshi 2002), and some indicators can change managerial behaviour in ways that are not generally desirable (Goddard *et al* 2000). A further drawback is that these indicators are often employed without adjustment (statistical or otherwise) for context.

Outcomes

The government promoted its new performance management framework five years ago (Department of Health 1999). The proposals face familiar barriers: ideally performance would be measured by the impacts of social care on the lives and well-being of service users and their families, the costs of achieving them, and the match between the distributions of impacts and needs. But the impacts (or outcomes) of social care are notoriously difficult to measure for a host of familiar reasons (e.g. Knapp 1984; Nocon and Quereshi 1996; see also the brief discussion in chapter 2 above).

Challenges and expectations

For a start, outcome measurement requires assessment of change over time, which is why cross-sectional surveys of user satisfaction can be so unsatisfactory. Second,

changes in quality of life or well being for some social care users may take some time to be achieved or observed, so that short-term evaluations could miss the true impact of an intervention. Another challenge is that effectiveness could mean slowing down a deteriorative trend (perhaps in cognitive ability or physical mobility), rather than seeing an improvement in ability, making it essential to compare the experiences of one group of service users with another, or with some population norms. Fourth, effectiveness cannot be assessed without understanding the (subjective) experiences of the service user, since social care is clearly a very personal service. Difficulties arise if we do not use approaches that allow service users to express their views. Quality of life is an inherently multidimensional concept, and social care services do not simply focus on one dimension such as mobility or social integration. Many interventions also have multiple clients, particularly the older person and their carers, so that we will want to get multiple perspectives on what a service achieves.

In other words, a fully satisfactory outcome assessment – whether it is based on quantitative measures built up from standardized questionnaires or qualitative research methods – needs to be dynamic, long-term, comparative, experiential, multidimensional and multi-perspective. On top of all these requirements, the assessments made along any one dimension need to be valid and reliable in the sense that they reflect what they purport to be assessing and that the methods used to gather the information would, if reproduced, generate identical data (and again these requirements apply whether the underlying approach is quantitative or qualitative). This, in itself, is a challenging requirement. Finally, if the results from one study are to be useful, we would want to be reassured that it is possible to generalise from the evidence collected to the wider context.

Disappointingly, a great deal of the evidence generated for or about social care for older people simply does not achieve these standards. Much of the quantitative or qualitative evidence that we have reviewed is embarrassingly poor (cf. Sheldon and Macdonald 1999).

Outcome dimensions

Many outcome dimensions are relevant when considering care for older people, although it is not always straightforward to separate those outcomes domains that are primarily the responsibility of social care agencies from those that are primarily within the purview of other agencies, such as housing, social security or the NHS. (This is equally the case with other user groups.) In principle, social care needs can be defined across a very wider spectrum, and certainly the evidence reviewed tends not to focus narrowly on a particular core of outcome domains. For example, examination of the roles of care homes and their implications for residents inevitably brings in discussions of the accommodation needs of individuals. Studies which look at services aimed at

compensating for the physical disabilities that can accompany ageing will usually also look at some of the interventions offered by health care professionals to slow down the rate of deterioration in abilities.

A helpful approach was followed in the OPUS study (Netten *et al.*, 2002a), which in identifying a core set of dimensions that constitute the outcome domains of social care for older people and used a discrete choice experimental approach to construct a profile measure. 'Social care is concerned with managing or reducing the effect of impairment of people's daily lives. Outcomes should reflect the primary objectives of social care services, which are to meet needs created by impairment by helping people with personal care tasks or providing company for those who might otherwise be socially isolated' (p.5). After extensive fieldwork with older people and with social care providers, five key domains were chosen for the outcome measure:

- **food and nutrition** (including nutritional value, timeliness, and cultural appropriateness);

- **personal care**, which was stressed by respondents in the consultation exercise to be a key aspect of social care provision (cf. our earlier discussion of the cessation of local authority-supported low-level home care support);

- social participation and involvement*;*

- **safety**, including 'reducing the probability of occurrence of specific events (such as falls); reducing the level of harm resulting from the occurrence (such as being left after a fall for a long time or suffering serious injury); and increasing an individual's sense of being safe and secure. In addition there are the concerns of others' (Netten et al 2002 p.7). 'Elder abuse' would also be relevant under this head (Penhale and Kingston 1995a; Action on Elder Abuse 1995); and

- **control over daily life**, including 'level of control over the way care is provided, maximising autonomy and independence'. Choice (in the sense of diversity, information and empowerment) is central to this domain. (See Bamford and Bruce 2002 on autonomy.)

This dimensionality gives us a good idea of what we should be looking for by way of evidence on the outcome impacts of the developing social care system. (Other discussions of outcome domains arrive at equivalent dimensions. For example, Challis 1981 identified seven: nurturance, compensation for disability, independence, morale, social integration, family relationships and community development. Davies and Knapp 1981 emphasised the centrality of psychological well being and generally found Maslow's 1970 typology of need to be a useful starting point.) We cannot look at every piece of evidence to see what it tells us about each of these dimensions, but it is worth having them in mind when assessing the usefulness of what has been shown.

It is also important to avoid focusing exclusively on dependency and deficit, and to pay attention to opportunity, inclusion, independence and broader concepts of well being (cf. Audit Commission 2004; Better Government for Older People). This broader approach will influence the comprehensive performance assessment for 2005, assessing the progress made by local authorities in these domains. 'The focus is moving from prevention of illness or the need for intensive support, towards a more positive emphasis on well being and engagement with the wider community' (Audit Commission, 2004, p.7). Good performance will therefore be gauged in terms of adherence to such core principles as 'increasing choice and control, … proactively promoting health, … adopting a whole-person approach, … and building a whole-system response' (p.17).

Changes in the balance of care

Because it may not be appropriate for all older people to remain in the community, and because some older people may actually wish to move into residential care settings, reductions in institutionalisation rates are not always a good indicator of outcome of care. Nevertheless, given that it is the wish of the vast majority of older people to remain in their homes for as long as possible, it is useful to examine at the aggregate level the extent to which social care services are able to help greater proportions of older people to live independently in the community. (It is also a government preference. In an interview with the *Health Service Journal* February 2004, Steven Ladyman asserted 'I think a very limited number of people would choose a care home as their primary choice'.) Of course, there are many confounding factors to take into account here, not least the supply-side influences. Other influences on destinations include the availability of supportive informal care, and the preferences of older people.

Statistical data give us an indication of the trends in such 'destinational' outcomes, obviously linked closely to some of the data on care homes and home care we discussed in section 4.5. But before we show developments since the early 1990s, it is interesting to reflect on the findings of an earlier study by Grundy and Glaser (1997) which compared the rates of transition from private households to any type of institution (including hospitals, care homes, nursing homes, hostels etc) in two ten-year time periods: 1971-81 and 1981-91. They carefully adjusted for socio-demographic characteristics. They found a 50 per cent higher risk of moving from a private household to institutional living (a 'non-private household') in the 1980s, despite the policy emphasis on community-based care. The effect of the liberal social security funding policy is very clear from this careful analysis.

The picture was different during the 1990s. Figure 4.107 examines the per capita rate of supported admissions of older people to permanent residential and nursing care. It reveals substantial reductions in the rates of supported admissions across local authorities in England, and so substantial increases in the proportions of councils rated

as 3* or better with respect to this performance indicator. Equivalently, figure 4.108 shows significant increases in the per capita rates of households receiving intensive home care. Significantly greater proportions of households receive intensive home care in inner London authorities, probably linked in part to the prohibitively high costs of providing residential care. Between 1998/99 and 2002/03, the proportion of local authorities rated as 3*or more by the Department of Health grew from 50 per cent to 75 per cent. Given the evidence in figures 4.107 and 4.108, it is not surprising that over the last few years there has been a very significant increase in the rate of intensive home care as a proportion of intensive home and residential care in England (shown in figure 4.109).

Figures 4.110 and 4.111 show the per capita rates of older people helped to live at home in England and Wales, respectively. Although the English picture overall does not show significant change over time, it does reveal interesting geographical differences. Hence, whereas the rates for London authorities (both inner London and outer London) have decreased over the last five years, they have increased in shire counties and unitary authorities. Overall, 63 per cent of English authorities were assessed as performing up to 3* standards or more in 2002/03. After a significant fall in the rates of older people supported at home in Wales between 1996/97 and 1998/99, figure 4.111 suggests small but significant improvements between 1998/99 and 2002/03.

Figures 4.112, 4.113 (repeating what was shown in a previous section) and 4.114 provide an overall picture of the balance of care in the three countries. Figure 4.112 suggests no change in the proportions of older people supported in the community in England, which remained at around 75 per cent between 2001 and 2003. In Wales, there has been a slight decrease in the proportions of community care packages in the period 1999 to 2001 (no further data are available). Overall, around 85 per cent of packages of care were located in the community. There was a marked deterioration in the balance of care in Northern Ireland between 1994/95 and 2002/03, with the proportion of home care packages in the total falling from 89 per cent to 74 per cent.

When reviewing the evidence on targeting earlier in the chapter we noted a number of factors associated with the admission of older people to care homes or hospital. Interventions which can address some of those underlying causes, such as providing more effective support to carers (which we discuss below) will clearly be beneficial in delaying institutional admission, and therefore contributing to the achievement of a better balance of care.

User satisfaction

The NSF noted 'For social care services, Social Services Inspectorate inspections of services for older people regularly show user satisfaction rates of around 80 per cent'

(Department of Health 2001 p.2). Do these data mean anything? The joint reviews report tells us that rates of 'excellent or good' satisfaction levels have remained steady at around 70 per cent. How are we to interpret these two statements? Do they mean the same thing? Do they actually mean *anything*?

User satisfaction surveys are notorious for generating poor quality data, or at least data that are very difficult to interpret. Low response rates from probably unrepresentative samples are common (Qureshi 2002). Satisfaction surveys suffer from the reluctance of most older people to voice criticisms of the services on which they rely or the staff who provide them (as found by Henwood *et al* 1997; Hardy *et al* 1999; Chesterman *et al* 2000; Ware *et al* 2003; and many others). The most recent summary of SSI inspections notes that 'users were generally positive about services and were grateful for what was available' (p.40), but adds that these positive responses generally did not tally with external judgments about performance. Reluctance to criticise may be stronger when service users feel there are no alternatives (Baldock and Ungerson 1994). The SSI and Audit Commission (2004) report offers satisfaction ratings over time on one page, but, when their statistics show no improvement in ratings from year to year, then urge us to be cautious before interpreting them as indicating that local authorities have failed to improve their services. Although Evandrou and Falkingham (1997 p.251) suggest that using consumer (user) satisfaction as an outcome measure would indicate 'whether the political market has met rising expectations', we are decidedly dubious about the relevance, robustness and meaning of such measures.

Notwithstanding these difficulties of interpretation, what do studies of user satisfaction tell us about the quality and effectiveness of social care?

In 2002/03, the Department of Health commissioned the first national survey of user satisfaction with home care services for older people. Figures 4.115 to 4.118 summarise the main results for England as a whole. Figure 4.115 explores whether care workers come at times that suit the recipients of care. Around 45 per cent of respondents stated that care workers arrived always at suitable times, and around 88 per cent that care workers arrived either always or usually at suitable times. Higher proportions of black and ethnic minority groups reported dissatisfaction with the times that care workers arrived. Henwood *et al* (1997) recorded a number of user criticisms of home care, particularly about frequent changes of carer and general lack of continuity, service inflexibility and the attitudes of some staff.

Overall, 65 per cent of respondents noted that social services always implemented the changes in their care they requested (figure 4.166) and 43 per cent had never asked for changes to be made. Again, there were higher rates of dissatisfaction among black and ethnic minority groups. Between 51 per cent and 56 per cent of clients, depending on their characteristics, reported that somebody had contacted them from the social services department to check that they were satisfied with the home care they were

receiving (the average figure for England was 55 per cent; see figure 4.117). Figure 4.118 reports the overall picture of user satisfaction with home help. Around 25 per cent of clients reported being extremely satisfied with the home care they received, and 88 per cent of clients reported being at least quite satisfied. Significantly smaller proportions of black and ethnic minority older people reported being extremely or very satisfied.

Netten *et al* (2004) collected additional data from over 20,000 older people, who between them used services from almost 700 different home care providers, spread across 34 English local authorities. Almost 60 per cent of respondents were 'very' or 'extremely' satisfied with their social care support; 64 per cent felt that requested changes to services were always made (a flexibility measure) and 90 per cent felt that they received a sufficient number of visits. Satisfaction levels were lower with regard to their relationship with the care worker: more than half thought their care worker was in a rush, a fifth complained of workers arriving late, and a third felt that less time was sometimes spent on them than the amount to which they were entitled. When Netten and colleagues examined links between service user experiences and area-level characteristics, some counter-intuitive results emerged (although the small number of localities and the inability to control for some likely influences such as need and the availability of informal care limited the analysis). Better experiences were associated with lower average per person weekly expenditure for home care, higher hourly cost of home care, lower employment rates and lower local wage rates. Black and minority ethnic service users' lower satisfaction ratings were linked to carer quality and not service quality, which the researchers interpreted as possibly indicating cultural clashes or expectations about care worker behaviour rather than delivery of poorer services to this group (p.X). The impact of labour market factors on quality may be indicative of recruitment difficulties. People receiving more intensive home care tended to be least satisfied.

Higgs *et al* (1998) found very few differences between nursing home residents and residents of long-stay geriatric wards when asked for their level of satisfaction in five domains: in relation to the staff, autonomy, amenities, privacy and social environment. They concluded that hospital wards are not as 'profound' in their 'institutionalising capacities' as some policy makers appear to believe. The authors argue that 'the practicalities of being physically dependent circumscribe most of their assessments' of satisfaction, with both groups reporting very high levels of satisfaction with their care. Moreover, if indeed it is the 'practicalities of physical dependency' that are heavily conditioning responses, the case for a broad interpretation of need is reinforced. The evidence from this study is interesting, but it would not appear to be a particularly robust basis for arguing against more 'homely' settings.

Outcome and cost-effectiveness evaluations

The typical systematic review commissioned by the Health Technology Assessment programme a few years ago used to take a year and require more than one researcher year. There was therefore not the faintest chance that we could review the evidence base on effectiveness for every area of social care in three months, especially given the task of also reviewing evidence on needs, resources, services and care processes. This preface is necessary in order to understand what we seek to do in this section.

Because we could not cover all of the evaluative evidence on the effectiveness and cost effectiveness of interventions, there is every chance that relevant studies have been overlooked. We also had to be quite derivative, using reviews conducted by other people, where the exist. Unfortunately, as the discipline of systematic reviewing has not been applied very often in social care, there are few such reviews. One reason for this might be that interventions are sometimes difficult to characterise or group: some are rather amorphous, and certainly highly variable from place to place. Another difficulty is that the variety of evaluative techniques employed in social care research makes systematic reviewing less straightforward than, say, in health services research where there is a clearly dominant research methodology. Fourth, the electronic retrieval of empirical research in the social care field is still quite primitive compared to what is possible in the health care field. Electronic databases are less informative, and tend to exclude books and chapters where quite a lot of social care evidence gets published. A final difficulty, and one that crops up a lot in this report, is to distinguish the social care 'active ingredient' within multi-professional responses to needs. The move to seamless or integrated care is to be applauded, but it creates research challenges for those seeking to identify the specific contributions of social care.

These and doubtless other considerations probably explain the very limited progress made by the Campbell Collaboration in the social care field. The Campbell Collaboration website (last accessed 2 July 2004) lists 25 reviews in the social welfare field, but none of them relate to older people. The Cochrane Collaboration is obviously focused on health and medical interventions, but it does include reviews of interventions for older people that span the health/social care boundary. Here too, however, some of the reviews found disappointingly few studies of sufficient quality robustness to be relied upon. We describe the review findings below.

We have tried to focus on evaluative evidence that relates fairly closely to service models or changes in service arrangements prompted or encouraged by the 1990 Act and subsequent policy changes. We therefore organise the review under the following six headings, roughly in the order we discussed these topics earlier:

- Support for informal carers

- Care management

- Care homes

- Home care

- Intermediate care

- Prevention

We do not review evidence that is primarily health care-related, such as support and treatment interventions for people who have had a stroke, even though there will be social care inputs to many of the community-based care arrangements studied, unless those social care contributions can be identified. Many of these medical areas are well served by easily accessed Cochrane reviews.

Support for carers

The recent Audit Commission (2004e) report on support for carers of older people reviews experience and evaluative evidence from across the country. Parts of it drew heavily on two joint Audit Commission/PSSRU reviews by Pickard (2004, 2004a). Our own electronic and hand searches of the literature generated more than fifty papers that included evaluative evidence on the effectiveness of services to support carers of older people. A small number also had cost-effectiveness evidence. Because of the excellence of Pickard's reviews, and given the time constraint for our own review, we have not attempted our own interpretation of this evidence, but instead summarise Pickard's findings.

Pickard (2004a) reviewed the literature on a number of support and service types: day care, in-home respite care, institutionalised respite care, carer support groups, social work and counselling, home care services, and multidimensional approaches. The focus of the review was on recent studies of the effectiveness and cost effectiveness of services for carers in England and Wales, although findings from other countries are also mentioned. The review drew on other recent systematic literature reviews in the field (Arksey et al 2002, 2003). She organises her summary of the evidence in terms of the dimension of effectiveness and the strength of the evidence.

Her synthesis of the evidence suggested that day care, home care, institutional respite care and social work/counselling can all be effective in improving outcomes for carers, including reducing the negative psychological effects of caring. In terms of delaying admissions to institutional care, three support interventions were found to be effective: day care, home care and institutional respite care, although for the last of these the

evidence is not universally supportive of effectiveness. The ECCEP evaluation (see below) found that institutional respite care decreased the length of time spent in the community by some older people, particularly where the relationship between the older person and their carer was poor.

In terms of the impacts of services on older people themselves, both day care and institutional respite care were found to generate ambivalent feelings among older people. For example, day care that was received quite frequently (beyond about two days a week or more) appeared to be associated with reductions in user satisfaction with services, and many older people did not want institutional respite care, because they simply did not wish to be admitted to an institution, even temporarily.

There was insufficient evidence to evaluate whether in-home respite care was effective, even though a number of older people and their carers expressed positive views about such a service. There was also no evidence to say whether carer support groups were or were not effective.

Turning to cost-effectiveness, Pickard's review found that day care, institutional respite care and social work/counselling could all be cost-effective in reducing the negative psychological effects of caring experienced by carers. Day care, home care and institutional respite care could all be cost-effective in delaying admissions to institutional services.

The review also examined 'whether access to effective services has increased since the introduction of the community care reforms' (Pickard 2004a p.59). In two respects Pickard believes that access has improved: day care is now targeted more on frail older people with carers, and access to institutional respite care for carers of frail older people has also improved. On the other hand, there have either been no changes or reductions in access to some services since the early 1990s. The intensity of day care received by frail older people, including those with carers, appears to have lessened. There has, of course, also been a shift of home care resources away from dependent older people with carers. Access to institutional respite care has not changed. Temporary admissions of local authority-supported residents to care homes have declined since 2000 (and this might reflect the re-designation of some respite beds as intermediate care beds, as noted earlier). Indeed, institutional respite care continues to be underprovided. Finally, it is still the case that 'only a small proportion of carers have access to therapeutic social work' (p.60).

Care management

The original Kent experiment with what was then called case management produced strong results that greatly influenced Roy Griffiths. When social workers were given

greater budgetary flexibility and carried out the various core tasks of care management, they were able to respond more effectively than is the case in standard care, providing individually varied care packages. The need for admission to institutional care was reduced significantly, satisfaction and well being were greater for both the individual older people and their carers, and there was no increase in costs to social services, the NHS or society as a whole (Challis and Davies 1986; Davies and Challis 1986). In the Gateshead evaluation, which had a multidisciplinary team, but in many other respects adopted a similar care management approach, there was again a marked improvement in destinational outcomes for the care-managed group. There were no significant differences in costs. Other outcomes were not evaluated.

A third English care management experiment was conducted in Darlington (Challis *et al* 1991, 1991a) as part of the 28-project Care in the Community demonstration programme. Again, this was carried out prior to 1990. It explored whether care-managed care at home was superior to long-stay hospital care for frail older people. The community-based service was found to cost less than hospital care, both for the health service and for society as a whole, and user outcomes were better (in terms of quality of life). Carers did not report greater stress with the community model.

We have already described a fourth study by Challis *et al* (2002) in the earlier section on care management. The focus here was older people with dementia, and an intensive form of care management was compared against standard care. The study started in the late 1980s. No differences were found in rates of admission to care homes or hospital in the first 18 months, but thereafter the group receiving intensive care management were less likely to be admitted. There were some quality of life advantages for the care-managed group and more needs were met. There was also a significant comparative reduction in informal carer hours and carers' burden. These outcome advantages for care management need to be set against significantly higher social care and (probably) societal costs. Costs to carers were slightly lower.

In each of these four pilot studies, the care management was carefully targeted on older people with considerable needs, each facing a high probability of being admitted to a care home or hospital (Challis 1992, 1999).

London and Craig (2002) describe a pilot scheme in London to help older people with mental health problems overcome their reluctance to use day care facilities during the winter. The scheme offered assertive outreach, engaged with the full range of community services to promote well being, offered home and group-based assessment and therapy to improve engagement with resources, forged relationships with local services and developed the community multidisciplinary team. The evaluation was very modest but suggested health improvements over a six-month period, presumably also easing winter pressures.

A systematic review by Godfrey *et al* (2000) of home care included care-managed programmes where domiciliary (home) care is the main component. Five studies were identified in that review, one in the US and the other four being the four English studies by Challis, Davies and colleagues just mentioned.

Care homes

Two Cochrane reviews are relevant here, concerning the broad place of care homes within the spectrum of care, but neither could uncover robust evidence. The review by Ward *et al* (2004) sought 'to compare the effects of care home environments (e.g. nursing home, residential care home and nursing facilities) versus hospital environments and own home environments in the rehabilitation of older people'. The review was last updated in February 2003. The reviewers were looking for evidence on functional outcomes using ADL measures, subjective health status, quality of life, return to usual place of residence, mortality, adverse effects, readmission, user and carer satisfaction, number of days in the facility and the number of days receiving rehabilitation. None of the studies uncovered by the search met the inclusion criteria.

The review by Mottram *et al* (2004) looked at 'the effects of institutional versus at-home long-term care for functionally dependent older people on outcomes, satisfaction, quality of care and costs'. The review was last updated in November 2001. Only one study met the inclusion criteria. This compared a community-based foster care programme to nursing home care in the US. The study was described as 'small and of poor methodological quality', and found no outcome differences between the two services. This review also extended its search beyond randomised controlled trials.

There have also been Cochrane reviews of at least three psychosocial interventions for older people with dementia, one looking at reality orientation and the other at reminiscence therapy (Spector *et al* 2004, 2004a). Both reviews were last updated in May 2000. Reality orientation appears to have benefits both for cognition and behaviour, but there was no evidence in the review of cost-effectiveness. No robust evidence could be found in support of reminiscence therapy, so that the review could draw no conclusions regarding its effectiveness from the accumulated literature. Validation therapy is similar to reality orientation. A review of this third approach found insufficient evidence from randomised trials (it did not include other research designs) to draw conclusions concerning effectiveness (Neal and Briggs 2004).

There are a few other UK interventions not covered by the above reviews. Cognitive stimulation therapy for older people with dementia (not covered by these three Cochrane reviews), delivered in care homes or day centres, has been found to be effective in an English study (Spector *et al* 2004b) and it also looks cost-effective (Knapp *et al* forthcoming paper). Proctor *et al* (1999) compared behavioural

management (a training and education intervention) in nursing and residential care homes with usual care. Residents receiving the intervention had significantly improved scores for depression and cognitive impairment, but there was no difference in behaviour or disability. GP visits per resident were significantly lower in the intervention group. Moxon *et al* (2001) describe the positive benefits of psychosocial interventions for depression for care home residents. The interventions were supported by a community mental health team, and generated encouraging results.

Skea and Lindesay (1996) compared a long-stay mental hospital ward for people with dementia with two new forms of residential unit: a community hospital ward and a scheme developed in a partnership between the NHS and a charity which explicitly emphasised resident choice. Both the new units offered better quality of life than the hospital ward they were aiming to replace. The partnership scheme had a more explicit philosophy of social care, which led to better user outcomes than the community hospital ward with its more traditional nursing approach. The 'independence orientation' of the partnership scheme could be contrasted with the 'disability orientation' of the community hospital ward, and clearly encouraged resident choice and a wider interpretation of independence. This is a modest evaluation in that it covers just three settings, but it offers encouraging results.

Davies *et al* (1999) found a positive relationship between the educational preparation of staff employed in nursing homes and a measure of resident autonomy. Better preparation was associated with greater autonomy.

Home care

There is surprisingly little evaluative research on home care. Two reviews survey the field, and both clearly had the same difficulties we encountered in finding relevant studies in a poorly defined field. As Godfrey notes, research that has looked at outcomes rather than needs is very scarce in the UK, and not exactly plentiful in the US or elsewhere. Both reviews cover non-UK as well as UK literature, but only those published in English. Both purport to focus on evidence since 1990 but also mention important earlier studies.

The first review was commissioned by the Centre for Evidence-Based Social Services (CEBSS) from Godfrey *et al* (2000). It covered three areas: homemaker/home care programmes, short-term home care programmes, and care managed programmes where domiciliary care is the main component. From our point of view, the third of these is more appropriately covered under care management. The review is a little uneven in its coverage and especially in its assessment of studies, and appears to miss some relevant evaluations for 'non-older' people that would appear to meet their inclusion criteria (see other chapters of this report).

The second review is more recent (it was published by the WHO Health Evidence Network at the end of June 2004) and covers home visiting and home-based support (Elkan and Kendrick 2004). It differs from Godfrey's review in looking at health-dominated interventions, and in focusing exclusively on older people. It categorises home care services as follows: preventive-promotive, therapeutic, rehabilitative, long-term maintenance and palliative. The HEN review is also different in that it is a review of reviews (systematic, meta-analyses and meta-regressions). Four such reviews are covered (Stuck *et al* 1993; Van Haastregt *et al* 2000; Elkan *et al* 2001; Stuck *et al* 2002).

The two reviews do not cover overlapping literature, which is perhaps a surprise in that the boundaries between health and social care interventions are not so clear in practice as these reviews imply by their inclusion strategies, and anyway many older people will be receiving both home (social) care and home nursing, so that interpretations of the evidence ought to be factoring in the complexity of welfare production processes. However, the Godfrey *et al* decision to concentrate on social care and the Elkan and Kendrick decision to concentrate on 'community health nursing' are both understandable.

Godfrey *et al* (2000) identified four studies of homemaker/home care services that met their inclusion criteria, all carried out in the US, and therefore not relevant to our purpose. The definition of services in this category was where there was a major emphasis on providing housework, chore, home help and personal care services on an ongoing basis. It might therefore have been expected that the review would have covered two UK studies: the Domiciliary Care Project (Davies *et al* 1990) and the Evaluating Community Care for Elderly People (ECCEP) study (Davies *et al* 2000). We discuss the results of these studies below.

In Godfrey's second category are services that offer practical support to older people in the home, often following discharge from hospital, with an emphasis on users achieving independence. These are much shorter-term interventions. Only three studies were found to meet the inclusion criteria, two of them carried out in England (Townsend *et al* 1988; Waddington and Henwood 1996) and one in Wales (Victor *et al* 1986). None are very helpful to us. Two pre-date the 1990 Act (despite the intention of Godfrey and colleagues to concentrate on post-1990 literature) and we say no more about them here. The third is a study of a voluntary sector service (delivered under contract by the British Red Cross) that did not evaluate outcomes or costs. Interviews were conducted with 33 people (mean age 73) to ascertain users' satisfaction with services and perceptions of met needs; there was no comparison group or observation of change over time. Volunteers did not provide any personal care tasks. Again, therefore, the Waddington and Henwood study is not very helpful to the present review.

Elkan and Kendrick's (2004) review is health-focused, most of the included studies were conducted in the US, and any social care component to the interventions is not separately identified. The review is therefore not especially helpful to us here. It is worth mentioning that the evidence base is clearly far stronger in relation to community nursing than for home (social) care. For completeness, we should also mention the main conclusion:

> There is consistent evidence that home visits could reduce mortality and nursing home admissions. There is some evidence that the reduction in mortality may be greater among the younger elderly, and that nursing home admissions may be reduced to a greater extent with a greater number of visits. Home visiting has not been shown to reduce functional decline, except amongst those with a low mortality rate and in programmes providing multi-dimensional geriatric assessment and follow up. Home visiting programmes have the potential to be cost-effective due to their low cost compared to long-term institutional care (Elkan and Kendrick 2004 p.4).

The depressing bottom line from this review of reviews of reviews is that, apart from the evidence coming from the ECCEP study described below, we know nothing about the effectiveness of home care in England, Wales or Northern Ireland in the post-1990 period.

Intermediate care

According to the NSF, 'Intermediate care services should focus on three key points in the pathway of care: responding to or averting a crisis, active rehabilitation following an acute hospital stay, and where long-term care is being considered'. The report cites research evidence in support of these recommendations the report.

On hospital at home schemes the evidence is not plentiful, but there are some British studies (Hughes *et al* 1997; Coast *et al* 1998; Jones *et al* 1999; Wilson *et al* 1999; York Health Economics Consortium 1999; Parker undated). A Cochrane review has been conducted, comparing hospital at home with acute inpatient care for people aged 18 and over (Shepperd and Iliffe 2004, last updated February 2001). Such schemes do not appear to be cost saving, but early discharge schemes for older people can reduce pressure on acute inpatient beds, but carers' views must be taken into account.

British evidence is scarce on rehabilitation services, and some of it is of doubtful quality, but the NSF authors argued that it suggests that rehabilitation reduces the risk of hospital readmission or admission into long-stay care homes, improves survival rates and physical and cognitive functioning (Evans *et al* 1995; Werner *et al* 1996; NHS Executive 1996; Audit Commission 1998; Herbert and Townsend 1999). Townsend *et al*

(1992) found that a very modest care attendant support scheme reduced emergency readmission and multiple readmission rates, compared to standard hospital discharge procedures for people aged over 75. A very recent evaluation offers further supportive evidence on how a care home rehabilitation service can divert older people from hospital (Fleming *et al* 2004). See also Dean and Briggs (1993) and Beecham *et al* (1993) on domus care; and Knapp *et al* (1992, 1994) on care home placements for former long-stay hospital residents. Evidence apparently is strongest for specialist projects (such as those for stroke patients mentioned earlier). There was also evidence that early discharge schemes can have significant benefits for older people and possibly cost savings for the NHS (Martin *et al* 1994). A Cochrane review on discharge planning for hospital inpatients of all ages (Shepperd *et al* 2004, last updated September 2003) found studies that met the inclusion criteria. The impact of discharge planning on readmission rates, hospital length of stay, health outcomes and cost was said to be 'uncertain', although small sample sizes constrained the ability to reach firm conclusions.

Griffiths *et al* (2000) carried out a randomised controlled trial to compare usual care in an inpatient setting with a nursing-led inpatient unit. They were surprised to find that intermediate care in the nursing-led unit led to 'dramatically increased hospital stay when compared to usual care in a hospital'. Previous intermediate care studies, and their own pilot, had suggested the opposite result might be obtained. In a second paper Griffiths and Wilson-Barnett (2000) tried to unpick this finding. It appeared that the performance of the intermediate care unit declined, but that usual care had improved dramatically. The greater length of stay in the intermediate care unit was attributed at least in part to its location on a satellite site.

Burch and Borland (2001) compared two rehabilitation settings: a day hospital and a social services day centre augmented by visiting therapists within a randomised controlled trial. The day centre model had a number of positive aspects, including successful rehabilitation, shared skills, knowledge and resources but suffered from problems in relation to discharge policy, acceptability of service to users, attitudes of staff and inappropriate rehabilitation facilities (not surprisingly). The researchers recommend that health care staff should maintain a permanent presence in social services rehabilitation settings. They also suggest that the acceptability of care to users might be improved by allowing them a greater degree of choice of facility.

Henwood (2002) points to the three pilot nurse-managed NHS nursing homes of some years past as good models for intermediate care today. The evaluation had pointed to positive outcomes: the NHS nursing homes performed well in terms of the level and type of activities undertaken by residents, and the degree of resident engagement and meal time interactions. Residents and their relatives were also more likely to express positive views about staff and their environment (Bond and Bond 1990). The costs of these nursing homes were quite high compared to the private sector, but resident

dependency levels were higher (Donaldson and Bond 1991). Another study of a NHS nursing home compared to hospital settings (Bowling *et al* 1991) found that the mental and functional ability of nursing home residents deteriorated more rapidly, and they had a higher accident rate, although quality of life was superior. Philp *et al* (1991) also point to higher levels of user satisfaction in nursing homes than in geriatric hospital wards.

Turrell (2001) questions whether nursing homes can provide an alternative to hospital care for older people. In a short paper that nevertheless reviews an enormous swathe of UK literature, Turrell compares nursing home and hospital care (for example in terms of their physical environments, the characteristics of residents, quality of care, prescribing practices, access to medical care, access to nursing care, access to rehabilitation therapists and equipment, patient documentation and assessment). The quality of the available evidence is obviously variable, and a number of key areas (including cost-effectiveness) have been almost completely ignored by previous researchers. Overall, the review points to opportunities for nursing homes to provide (intermediate care-like) alternatives to hospital care for older people, but that many challenges remain, particularly related to the narrow range of skilled staff being employed in nursing homes. Most of Turrell's evidence, of course, came from 1980s and 1980s.

Steiner *et al* (2001) carried out a randomised controlled trial (six month follow up) of post-acute intermediate care in two settings: an inpatient nurse-led unit and a general medical ward of an acute hospital. Inpatient length of stay was significantly longer in the nurse-led unit, although the difference was difficult to interpret given the complication of how to judge transfers to community hospitals. There were no differences between the two settings in mortality, functional status or living arrangements. The nurse-led unit appeared to offer "a safe alternative to conventional management", although no economic evaluation was conducted.

Prevention

As we noted earlier, Godfrey (1999, 2001) conducted a systematic mapping of the literature on social care prevention, which she described as rather modest in volume and rather weak in quality. She points to the difficulties of defining prevention in a social care context, particularly if it relates to the promotion of independence for older people. Independence has a range of meanings, it is bound up with reciprocity in personal relationships, and – as noted in the discussion of the re-conceptualisation of need – it needs to encompass objectives such as control and choice rather than simply competence in the activities of daily living.

Most of the literature covered by Godfrey relates to prevention in the health field, rather than in social care. 'In the main, preventive strategies aim to reduce or delay the onset of impairments that tend to accompany ageing; they involve primarily health, socio-

economic and environmental interventions as opposed to social care activities' (2001 p.93). As she says, this is a 'relatively narrow conceptualisation of risk in respect of ageing'.

Turning to the wider set of preventive aims, Godfrey's review builds on the 'successful ageing' model of Baltes and Baltes (1990). With this kind of approach, she describes primary prevention strategies as including initiatives that open up opportunities for social contact, stimulate abilities, offer opportunities to pursue valued interests and facilitate participation as a full citizen. Secondary preventive strategies would help older people maintain their abilities, 'seek to maintain a familiar environment within which to negotiate increasing disabilities' (p.95), support people through bereavement and support informal care relationships. The distinction she makes between primary and secondary prevention 'reflects the nature of the balance of losses over gains. Whereas the former focuses on support in anticipation of loss, the latter is geared towards helping people manage in a situation where loss is experienced' (p.95). The policy challenge is to develop services that support 'successful ageing as losses begin to exceed gains, for whom they are most effective, in what contexts, and for what level of loss experienced'.

Three Cochrane reviews examine prevention programmes with some relevance to social care. Gillespie *et al* (2004) looked at interventions to reduce the incidence of falls by older people (living in the community, care homes or hospital). The review was last updated July 2003. A number of interventions were found that are likely to be effective, although the reviewers concluded that it was harder to draw conclusions about the effectiveness of these interventions in preventing fall-related injuries. Interventions likely to be beneficial included: multidisciplinary health/environmental risk screening interventions, either for an unselected population or for those older people with a history of falling; muscle-strengthening and balance programmes; home hazard assessment and modification; withdrawal of psychotropic medication; cardiac pacing; and a 15-week Tai Chi group exercise programme. The *Effective Health Care Bulletin* produced by the Nuffield Institute and the NHS CRD is based on the Cochrane review.

Lyons *et al* (2004) reviewed modifications to home environments to reduce injuries from physical hazards. The review was last updated in July 2003. Fifteen studies that met their inclusion criteria related to older people, but none of them 'demonstrated a reduction in injuries due to hazard reduction, although two demonstrated a reduction in falls that could be due to hazard reduction'.

The third Cochrane review, last updated May 1999, looked at medical day-hospital care (geriatric day-hospitals) versus alternative forms of care (Forster *et al* 2004). The reviewers concluded that medical day-hospital care was more effective than doing nothing, but did not have obviously clear advantages over other forms of comprehensive medical services for older people.

Evaluating the 1990 changes: the ECCEP study

Davies (1994) emphasises the importance of understanding the marginal productivities of social care services. Put another way, what is the impact on the well being of service users of the delivery of one additional unit of service? Marginal productivities will vary with the mix of resource inputs employed within the care process (that is, they respond to the nature of the productive process itself), with the underlying characteristics of the individual service user (particularly their non-resource features) and, of course, with the volume of service delivered (i.e. the marginal productivity of the tenth hour of home care is likely to be smaller than that of the first hour; see Davies *et al* 1990). The targeting of resources is closely interconnected with the improvement of marginal productivities. One framework for managing this interdependence is care management, of course.
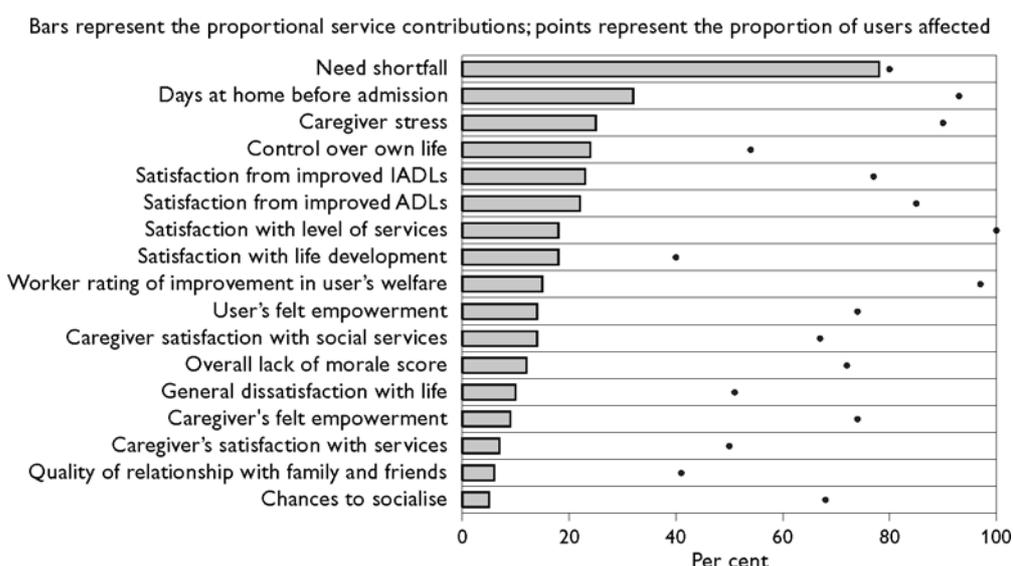
The Evaluating Community Care for Elderly People (ECCEP) study found that the question of marginal productivity is rather complex. This is the largest and most searching study of targeting and service productivities in the post-1993 community care system in England and Wales. It was, in part at least, a replication of a large pre-1990s study (the Domiciliary Care Project or DCP). ECCEP allows inferences to be made about system changes in the patterns of community care service allocation and service productivities before and after the 1990 changes. Here, we summarise some of the main implications of the study (for further details, see Bauld et al 2000; Chesterman et al 2000; Davies et al 2000; Fernandez and Davies 2000, 2003). We summarise a large body of evidence here under five headings.

Evidence of improvements in the degree of 'defensibility'

The ECCEP study investigated the extent to which the patterns of service utilisation reflected factors which are 'defensible' given policy and practice priorities, values and beliefs, or whether they responded to factors not so defensible or to the temporary lack of adjustment of resources to needs and demands. In other words, the analysis tested the extent to which targeting patterns were needs-led rather than supply-driven. Influences deemed most defensible by policy and practice criteria were needs-related circumstances of users and carers. The results from the study suggest that in the post-reform system, utilisation patterns were much more strongly associated with needs than with what care managers saw as distorting supply influences. In other words, the results suggested a substantial improvement in the defensibility of patterns, compared with results obtained from the DCP and other pre-reform studies.

Evidence of significant service productivities

In sharp contrast with the DCP findings (Davies *et al* 1990), the ECCEP study found post-reform community care services to produce significant improvements in a wide range of outcome indicators (Davies *et al* 2000). The study estimated the impact of these productivity effects in terms of both the intensity and the degree of cover of the effects. The main results are summarised in the figure reproduced below.

Bars represent the proportional service contributions; points represent the proportion of users affected

The figure illustrates how the productivity effects covered most users. For instance, approximately 93 per cent of service users were found to benefit from extra days in the community, 77 per cent and 85 per cent of users to enjoy improvements in the self-perceived ability to undertake 'instrumental activities of daily living' (IADL) such as cooking and cleaning, and activities of daily living (ADL), and 90 per cent of carers to enjoy reductions in their levels of stress due to the effect of services. Perhaps unsurprisingly, only 54 per cent of users enjoyed a significant improvement in their felt control over their lives.

Second, the results suggested that the effects of services were of considerable intensity for significant outcomes. In particular, service productivities were estimated to account for approximately one third of the number of days spent in the community after assessment for a case with average scores on risk factors. A sample of 133 ECCEP service managers defined helping users to stay at home as the primary goal of their authority (Davies *et al* 2000).

Also important is the estimated impact of services on the felt burdens of care giving and on users' felt control over their lives. (Both welfare goals had been highly rated in the ECCEP managers' rankings of local authority priorities.)

Although users with higher levels of dependency were found, other things being equal, to achieve lower overall levels of outcomes, the study found that it was for them that services yielded the greatest contributions. This finding was due to:

- the fact that so many more resources in the post-reform community care system are provided to the neediest;

- the fact that it is for the neediest that some types of services appear to yield the greatest gains per pound spent; that is, the productivity levels of some services (day care and respite care in particular) are highest for them.

- Despite the significant contribution of services to outcomes, non-service factors were shown to be responsible for the greatest proportion of the variation in outcome levels.

These findings underline the importance of controlling for case mix when, for instance, deriving measures of local performance (see our earlier comments about the naïve use of performance indicators in many contexts).

In addition to looking at final outcomes for users and carers, the ECCEP study estimated the impact of community care services on the utilisation of hospital inpatient care. Results indicated that community care services have a significant preventive impact on inpatient care. Overall, the cost-reducing effect of community-based services was estimated to account for approximately a fifth of community package costs and in excess of one half of inpatient care costs in the two years following assessment by social services. As in previous analyses, the intensity and nature of the service productivities were found to vary considerably with the characteristics of the recipients of services, the most dependent cases exhibiting the greatest potential for substitution in both absolute terms and relative terms to the cost of community care packages.

Overall, the combined effect of all services for the average case in the sample was estimated to reduce the probability of admission into hospital in the two years subsequent to assessment by over 20 per cent. Few service effects on the length of stay were identified.

The nature of service productivities in community care

The ECCEP study produced important evidence about the nature of the relationship between resources and outcomes, i.e. about the properties of productivity effects.

Returns to scale effects. For most services, the marginal effect on outcomes of marginal increases in the level of services was found to decrease with the level of services provided. In other words, most of the productivity effects estimated exhibited significant decreasing returns to scale effects.

Heterogeneity in the production of welfare. The results illustrated the significant interdependence between the productivities of services and the characteristics of individuals. For instance, day care was found to be around twice as effective in preventing institutionalisation for users with cognitive impairment than for other users. This finding is of particular relevance given the diversity in the characteristics of cases traditionally ascribed to social services. Overall, newer services (day care and respite care) tended to show higher productivities for more dependent users. Coupled with the concentration of resources on the neediest in the post-reform system, this finding explains why the analysis found the greatest service contributions for most outcome indicators for the most dependent cases.

Complementarity and substitutability of services. Whereas the results indicated high substitutability between services in the production of outcomes, there was only limited evidence to suggest significant complementarity between services. In other words, for most outcomes and most users, the effect of services on outcomes appeared not to depend on the levels allocated of other services.

Joint supply. The results of the estimation suggested that the level of gains in particular outcomes affected the additional inputs required to achieve gains in others. The most interesting examples of such 'joint supply' were between extending days in the community, user satisfaction and the relief of caregiver stress. The analysis suggested that, other things being equal, improvements in user satisfaction were associated with reductions in carer stress levels, and that reductions in carer stress were in turn associated with longer stays in the community. Overall, however, differences in the direct effect of services on outcomes meant that 'maximising' a given outcome implied losses in others.

Optimisation analysis

The ECCEP analysis illustrated how different input mixes follow from simulating the maximisation of empowerment, user satisfaction, relief of caregiver stress and providing a home and community alternative to support in care homes. The simulations

suggested that the policy choice that would yield the best balance of benefits depends greatly on the elasticity of supply of individual service inputs, i.e. on the availability of further levels of supply of services at current prices.

Overall, the results suggested that optimising input mixes with respect to most outcomes, assuming the availability of extra levels of supply at current prices, would imply reducing significantly the share of budgets spent on home care in favour of increases in respite and day care services, particularly for users with the greatest need.

Consequences of cost minimisation in allocating care

The ECCEP analysis explored the likely consequences of a policy whose only aim would be to balance the provision of community-based and residential-based services so as to minimise the cost of providing care to the public purse. The results suggested that neither cost levels nor the total number of weeks in the community achieved in reality were in most cases proportionally much different from what would be achievable given cost-minimisation.

For most users, given most of the assumptions about care home prices, optimisation to minimise overall costs was found not to cause a reduction in the number of weeks supported at home. However, differences in costs savings between users were found to be large. In particular, significant further cost savings could be achieved for the most dependent users by reducing somewhat the levels of resources currently allocated to them. However, these 'excess' budget levels could be rationalised as the implicit valuations attached to the superior benefits of care at home by care managers, particularly to those in greatest need. Overall, the results of the analysis were found to be highly dependent on the relative levels of care home prices assumed.

In terms of input mixes, a move towards cost minimisation was shown to result in a reduction in home care inputs, and an increase in the provision of day and respite care inputs.

Choice

The objective 'to give people a greater individual say in how they live their lives and the services they need to help them to do so' (Secretary of State for Health 1989 p.4) is one of the most widely quoted passages from the 1989 White Paper. Expanding user and carer choice was one of the maxims of the 1990 legislation, and has remained fundamental to social care policy since that time. It was reinforced for people facing admission to a care home by the *Direction on Choice* (Department of Health 1992). The Labour government's White Paper, *Modernising Social Services* (Secretary of State for Health 1998), emphasised the commitment to promoting choice. *Better Government for Older People* is intended to help older people become more empowered to express their views, and the evaluation of BGOP by Hayden and Boaz (2000) found that older people want public services to be more flexible, better coordinated and more focused on helping them to remain independent for as long as possible. The Welsh Assembly Government (2003) strategy for social care sees 'older people having an effective voice on a wide range of participative and planning issues (p.16). Choice should also be facilitated at the point at which older people move out of their own homes and 'accept the inevitability of long-term care' (p.28). Looking more widely, choice promotion is a core government objective in the NHS and indeed across all public programmes.

At a macro-level, we might expect choice to be broadened by, for example, stimulating new providers to enter care markets. At a micro-level, the promotion of choice might mean that older people are helped to make informed decisions about the services they receive and who provides them. Direct payments might be seen as a logical consequence, giving older people complete (or at least *more* complete) control over their lives. Expanding choice in fact requires three ingredients: (a) developing a range of alternative services, (b) making them known to users and carers in a way that is meaningful and then (c) empowering users and carers to select from the options available. We shall organise the discussion here under those three headings (diversity, information, empowerment), but also add a fourth (control). This last heading allows us better to reflect the intended situation with direct payments, and also links us back to the very early discussion about the breadth of the need definition and the promotion of independence, in terms of both the compensation for deficits and the creation of opportunities.

The building blocks for improved choice are being put into place. 'A fundamental cultural shift in social care underlies the various elements of promoting independence. The principle of person-centred needs-led planning now offers choice and empowerment' (SSI 2003 p.30). The summary of, and reflection on seven years of joint reviews noted that 'users have become more involved in decisions and plans made by councils about their care' (SSI and Audit Commission 2004 p.3). But, on the ground, progress towards

genuine, informed choice remains slow. We start with an illustration of the issues drawn from some of our own research conducted by the Nuffield Institute and PSSRU.

Views on choice

Ware *et al* (2003) looked at the choices available to 55 older people, their carers and care managers. Users and care managers were asked what choices they had of agency, service and timing. The overriding impression was of users being offered little choice in any of these three dimensions. Care managers confirmed that users were rarely offered a choice in selecting a home care agency, but argued that it made little sense to users without them having prior knowledge of what services were available. It is difficult to gain experience by 'shopping around' for a product such as personal care. Moreover, these care managers argued, users' choices would clearly be restricted by the availability of services and the nature of contractual relationships between purchasers and providers.

Block contract or cost-minimisation purchasing arrangements were restricting choices. So, too, were the 'in-house first' policies in three of the eleven localities included in the study. In a fourth area, care managers said they had a personal preference for in-house services. Most users did not mind which sector provided their care. Another restriction on choice came from tightened eligibility criteria, in that domestic tasks were increasingly being taken out of the range of services supported by local authorities. These clearly limited older people's abilities to maintain their independence.

The choice of care home is subject to the 1992 Direction on Choice, and it was not surprising that older people who had moved into care homes reported a greater degree of choice of provider. They were given more written information and could visit the homes prior to making a decision. However, some users were presented with the simple choice of staying at home or going into care, and others said that they had accepted care home admission reluctantly, feeling that they had little choice about staying in their own accommodation. There was no involvement of users or carers in two out of twelve cases. Again, choices were constrained, in this case by service costs (in relation to authorities' contractual arrangements), the availability of vacant places, and the speed with which funding could be allocated.

Information provided to users was limited, but generally appeared to be better than in the past. Care managers said that they had too little information about providers in the independent sectors, and some said that they did not have confidence in their purchasing colleagues' assurances on the quality of such services. Information on user charges was also sometimes less than complete. Satisfaction levels, as other studies have found, were generally high, but a number of difficulties with home care packages were mentioned, mainly related to having too many changes of worker, or workers

arriving late or not at all. Some users complained that their care workers came too early to put them to bed.

What were the causes of these difficulties? And what are the solutions? We now turn to other evidence on choice.

Diversity

One of the last things John Major said on social care as Prime Minister was that 'No one type of solution will or should be applicable to everyone' (Secretary of State for Health, 1996 p.3). Diversity of provision was an explicit aim and was one reason for the Conservative government's encouragement of private and voluntary sector providers. There is no doubt that service variety has increased over the past 15 years or so, but not sufficiently, as is made plain by the evidence we collated on unmet needs and service development.

> Indisputably, between 1996 and 2003, a wider range of services have been developed to support vulnerable people in the community. This has been driven, in part, by action from the Government in the form of national priorities, hypothecated investment and performance assessment. However, the impact locally varies markedly depending on the coherence of council planning, the quality of local partnerships and the extent to which that planning has sought to involve people using services (SSI and Audit Commission 2004 p.12).

Expanding choice therefore requires the commissioning framework to encourage the development of a diversity of services at an affordable cost to the state or to self-funding users. There also needs to be diversity in other dimensions. For example, for an older person about to enter a care home, there should be more than one option not just in relation to the particular home but also in relation to when to enter a home, the locality of that home, and whether to stay there once the choice and initial move have been made (see Challis and Bartlett 1998). For the majority of older people, such a move is likely to be a choice about where they will spend the rest of their lives. For older people using home care services, there might need to be the option of a choosing the provider (although most appear not so bothered about this particular choice; Hardy *et al* 1999; Ware *et al* 2003), the regularity and timing of the visits, and perhaps the tasks to be performed.

What factors limit diversity and the 'choice range'? Budgetary restrictions that constrain the development of new services obviously limit choice, as does a contractual regime that rules out diversity through the imposition of uniform standards or the block purchasing of large numbers of places from a single provider. 'In-house first' practices

are clearly likely to be damaging in this respect (Ware *et al* 2003; Audit Commission 1997a). Under-development of home care services could leave little option but for someone to go into a home (Ryan and Scullion 2000). Admissions policies operated by care homes might deny a full free choice. Fears have been expressed that the imposition of national care standards could narrow the difference between providers (Holden 2002). There might be a tension between the tendency for the standardisation of services and the individualisation of services in response to the preferences of individual people, particularly the routinisation and increasing regulation of home care services (Patmore 2001). This is the long-standing (and beautifully named) 'coercive isomorphism' thesis of DiMaggio and Powell (1983). Concentration of provision in a small number of organisations as a result of mergers and acquisitions could reduce the diversity of provision (Holden 2002), although it is not inevitable. (See our earlier discussion of concentration in care homes markets.) Another problem is the 'ratcheting up of eligibility criteria' (Ware *et al* 2003 p.422) which is denying many older people – those with 'lower-level' needs – access to publicly supported services. For these people, the range of options is limited to what they can afford or their relatives can provide informally.

Diversity, interpreted in the multidimensional sense set out here, can be seen as the *rate-limiting factor* in the choice debate. If there is no diversity, then there is little choice, but diversity is only necessary and not sufficient for choice.

Information

Inadequate information systems, particularly getting information to people who, through dint of language, culture, frailty or other reasons, may have difficulty with some forms of communication. Accounts of the limitations of available information, especially for older people from black and ethnic minority groups and for older people with mental health problems, are legion (Audit Commission 2000a; Reed *et al* 2003)

Quinn *et al* (2003) distinguished three particular barriers to accessing information, advice and advocacy: lack of awareness that information was available that could help, difficulties in gaining access to the appropriate information, and difficulties in gaining practical assistance to act on the information obtained. They find from their empirical study in Slough that no single approach to making information available would suit all older people. A study by Ware *et al* (2003) found that over-bureaucratisation and fragmentation of the care management and assessment processes were making it harder for information to flow efficiently through the system. Certainly, care management was not operating in the manner evaluated in the PSSRU projects of the 1980s or as envisaged in the 1989 White Paper. A number of other studies have pointed out that older people have better information handling abilities than has often been assumed. For instance, Godlove *et al* (1999) show that a high proportion of older

people living in care homes were able to answer questions about their quality of life, even in the presence of significant cognitive deficits.

There has been progress. Local authorities today collate and distribute information on care homes to prospective new residents and their families, but little information is usually given on the quality of providers, and authorities express hesitation about being seen to be favouring or recommending particular homes or providers (Audit Commission 1997a). Annual or more frequent sample satisfaction surveys allow information to flow in the other direction. Improving inter-agency coordination should also reduce the confusion among users and carers, although it might actually make things worse in the short run. On the other hand, many older people are still admitted to care homes with little preparation (because of unforeseen changes in their needs or in the continuing abilities of their caregivers), and when there *is* a degree of planning. the information provided to them can be limited. A few years ago, Wigley *et al* (1998), for the Office of Fair Trading (1998), found that a majority of care home residents were able to express views on the care they received, but many had been poorly informed about what admission to the home would entail or the options available to them. 'Nearly six out of ten said they had no choice about moving into a home' (p.53). People going into local authority homes received less prior information than those entering independent homes. Very few made complaints about their care, and when they did, it was usually via a third party (a relative). Wright (2003) found that people who are paying the full cost of their long-term care home are given little professional advice about placements or alternatives to care in a home. Netten *et al* (2004b) note that the situation is little different for older people moving into extra care housing (Oldman 2000) and facing health interventions (Commission for Health Improvement 2004).

Empowerment

Diversity and information are clearly necessary, but options need to be turned into genuine choices (Myers and MacDonald 1996).

Active participation of service users in decisions about their care remains elusive in many settings. In the home care context, Hardy *et al* (1999) report that no one in a sample of 24 users of local authority and independent sector home care services (sampled from four localities) had been offered a choice between sectors or providers, and few had been consulted about the composition or timing of services. Most were happy to rely on care managers' judgements (Hardy *et al* 1999).

For sheltered housing, the development of performance measurement regimes might be encouraging standardised methods of information gathering, rather than efforts to engage with residents in order to elicit a better understanding of their needs and preferences (Foord *et al* 2004). These authors could find little evidence that the

emphasis in *Quality and Choice for Older People* (DETR 2001) on gauging user quality of life was reflected in the performance measures being introduced.

The District Audit (2002) summary of their auditing of rehabilitation services found that few services had a user-centred approach or offered them much choice. Therapist shortages – particularly of speech and language therapists and physiotherapists – were contributing to these difficulties.

Bland (1999) focuses 'on the translation of the core values of independence, privacy, dignity, choice and rights into a daily reality for residents' of care homes (p.539). She traces the historical development of what she calls a 'social care' approach to residential care for older people that

> assumes responsibility for their [residents'] welfare because they are seen as no longer able to manage it for themselves. By applying for residential care or, more typically, being referred by professionals or relatives, older people become by definition, 'socially incompetent' or incapable of remaining independent (p.545).

This is consistent, of course, with Walker's (1982) thesis on the social construction of 'dependency'. Bland argues that care home staff interpret the objective of promoting independence as enabling physical activities, rather than allowing residents to exercise autonomy and self-determination. She compares this approach with what she calls the 'service approach' which emphasises autonomy and independence, gives residents greater control over their lives, ensures that they are treated as socially competent rather than as frail and vulnerable, and sees them as experts in relation to their own needs and wishes. As she notes, by returning to the original Bevanite conception of care homes as hotels, we would be paying greater attention to service user choice and control.

In contrast, Raynes (1998) describes a project to elicit user views about the quality of their care homes and to bring those views into the service contract specification. Focus groups were held with residents to gain their views about what makes for a good care home environment, and these views were fed into the service specification process. The local authority purchasing unit acted upon residents' comments in renegotiating contracts with providers. Reed and Stanley (2003) produced and evaluated a user-led daily living plan intended to facilitate communication of preferences as older people move from hospital to care home. Their small-scale action research study found that person-centred communication could be improved.

There is quite a large literature on user involvement in health and social care, much of it relevant to the discussion of empowerment for older people. We have not been able to review this evidence base, but we are aware of a wider and informative review recently

published by SCIE on this topic (Carr 2004). See also Wistow and Barnes (1993), Hoyes *et al* (1994) and Bewley and Glendinning (1994). Empowered choice requires informed user involvement.

Control

The focus group approach to feeding care home residents' views into the contract process described by Raynes (1998) still left staff in control. Empowerment was greater but incomplete. To what extent, for example, should service users be given the freedom to choose risky behaviours (Clark *et al* 1996)? Paying for their own care, an option now (slowly) being offered to older people through direct payments, obviously gives that greater degree of control, although older people will still need information and support in order to exercise their powers (Roberts 2001). As we noted earlier, there are various barriers to the wider take-up of direct payments including poor information systems.

The Office of Public Management (1995) reported significant changes in user and carer involvement across the range of community care activities in four sites (Dyfed, Hereford and Worcestershire, Sheffield and Sutton) following initiatives to improve user- and carer-centred services. Resources were allocated to individual service users to allow them to purchase some services for themselves (communication aids, respite care, travel and so on). These early explorations of direct payments for older people suggested that there were important benefits to be gained.

Choice and independence

At the heart of the Audit Commission's (2004) most recent report on services for older people lies choice.

> Older people have strong and consistent views about what helps them to stay independent. … At the heart of older people's sense of independence and well being lies their capacity to make choices and to exercise control over their lives (p.7).

Both independence and interdependence are emphasised. The work underpinning this report found that many older people had very few opportunities to express their preferences, those most disadvantaged in this respect being 'very frail or housebound older people, black and minority ethic elders or older people with mental health problems' (p.11). In their follow up, the Audit Commission (2004a) focused on choice. They argued that older people's expectations are changing, but that systems of support and care have failed to adapt. The message is not new, but has not yet worked through to influence the way that resources are allocated to support older people (Harding

1997). The Audit Commission report summarises the views of older people under seven headings, reflecting the dimensions most often emphasised by older people themselves: housing and the home; neighbourhood; social activities, social networks and keeping busy; getting out and about; income; information; and health and healthy living. Recommendations are made for ways to promote better well being in each of these dimensions, taking us back to our earlier discussion of the meaning of need, and of course linking us to wider public discussions of the meaning of citizenship.

Projections of future demand for long-term care

This section presents some demographic projections for older people in the United Kingdom, and projections of long-term care demand and expenditure for older people in England obtained using the PSSRU long-term care model. The PSSRU has developed a model that makes projection of future demand for long-term care and associated expenditure in England to 2031 under a range of scenarios (see Wittenberg *et al* 1998, 2001, 2004 and Comas-Herrera *et al* 2003 for more details).

Future numbers of older people

In the UK, the numbers of older people are projected to increase very substantially in the next fifty years. The 2002-based population projections for the UK by the Government Actuary's Department (GAD, 2003) project that, between 2001 and 2051, there will be a 81 per cent increase in the numbers of people aged 65 and over. The number of people aged 85 or more is projected to rise even faster during this period, by 255 per cent. Much of this increase is a result of a projected rise in male life expectancy. Between 2001 and 2050, the numbers of men aged 85 or more are projected to rise by 425 per cent, compared to a 191 per cent rise in the number of women in that age group.

Such demographic projections so far into the future carry a substantial degree of uncertainty. Past projections have tended to underestimate future numbers of very elderly people.

Table 1. GAD's 2002-based UK population projections for people aged 65 and over for the years 2002, 2031 and 2051 (in thousands)

	2002	2031	2051	per cent increase 2002-2031	per cent increase 2002-2051
Males					
65-69	1,237	1,955	1,764	58	43
70-74	1,054	1,641	1,504	56	43

75-79	824	1,276	1,407	55	71
80-85	452	1,078	1,306	139	189
85 & over	306	982	1,605	221	425
Females					
65-69	1,361	2,124	1,918	56	41
70-74	1,282	1,805	1,722	41	34
75-79	1,176	1,486	1,633	26	39
80-85	792	1,369	1,617	73	104
85 & over	812	1,511	2,365	86	191
All 65 & over	9,296	15,227	16,841	64	81
All 85 & over	1,118	2,493	3,970	123	255

Source: GAD 2004.

Numbers of dependent older people

It is not old age in itself that generates the need for long-term care, but dependency. The probability of being dependent (defined as having difficulties with activities of daily living, such as bathing, dressing and feeding) is much higher for older age groups and for women. Analysis carried out for the PSSRU projections model (Wittenberg *et al*, 2004) shows than in England, 7 per cent of males aged between 65 and 69 have problems with two or more activities of daily living (ADLs), whereas among women in that age group, 9 per cent have problems with two or more ADLs. Of males aged 85 and over, 28 per cent have problems with two or more activities of daily living, whereas among women in that age group, 43 per cent have problems with two or more ADLs.

Table 2 shows the percentage of the older population of England who report having problems with at least one instrumental activity of daily living (IADL), such as shopping, with one activity of daily living (1 ADL), such as bathing, and with two or more ADLs (2 + ADLs). Older people in institutional care are included among those with two or more ADLs.

Table 2. Estimated percentage of the older population of the UK with different levels of functional dependency, 2000.

| Males	None	IADL	1 ADL	2+ADL
65-69	85	4	4	7
70-74	83	4	6	7
75-79	73	9	7	11
80-84	55	13	16	17
85+	45	12	15	28
Females				
65-69	82	4	5	9
70-74	75	6	8	11
75-79	62	6	15	17
80-84	45	12	17	26
85+	25	17	15	43
All	67	8	10	15

Source: PSSRU model estimates, based on data from the General Household Survey 1998 (Bridgwood, 2000), Department of Health (2000) and Netten et al. (1998).

Future demand for long-term care in England

Projections from the PSSRU long-term care model show that future demand for long-term care is likely to increase substantially over the next three decades and beyond. The number of occupied residential places (in residential care establishments, nursing homes and hospitals) in the United Kingdom would need to expand from approximately 459,000 in 2002 to 1,130,000 in 2051, an increase of around 151 per cent, to keep pace with demographic pressures. The number of home care hours would need to increase from around 1.9 million per week in 2002 to nearly 4.8 million per week in 2051, an increase of around 137 per cent. These projections take account of demographic pressures, but not of any changes to dependency rates or any policy changes. (These projections assume that age- and gender-specific dependency rates remain constant; that the proportions of older people receiving informal care, formal community care and residential care services remain constant for each sub-group by age, dependency and other needs-related characteristics; that unit costs rise in line with historical trends in input pay and prices. For details see Wittenberg et al 2004.)

Long-term care expenditure would need to increase by 317 per cent in real terms between 2002 and 2051 to meet demographic pressures and allow for real rises in unit costs of care (of 1.5 per cent per year for health care and 1 per cent per year for social care). This would mean an overall increase in expenditure from around £12.2 billion in 2002 to approximately £53.9 billion in 2051 (Figure 4.119). Although expenditure would grow substantially by 2051, the economy is also forecast to expand. If, for example, gross domestic product (GDP) grows by 2.25 per cent per year, long-term care expenditure would increase from about 1.40 per cent of GDP in 2001 to around 1.83 per cent of GDP in 2051. (The assumption of 2.25 per cent per year growth is in line with trends over the last decade and with the assumption used by the Treasury for purposes of public finances over the next two decades. See Wittenberg *et al* 2001 footnote 31.) These figures do not comprise the total costs of long-term care to society. That would require the inclusion of the costs of a wider range of services to a wider range of public agencies and service users, and the opportunity costs of informal care.

Figure 4.119: Projected expenditure (£m) by source of funding, United Kingdom, 2002-2051, under base case assumptions
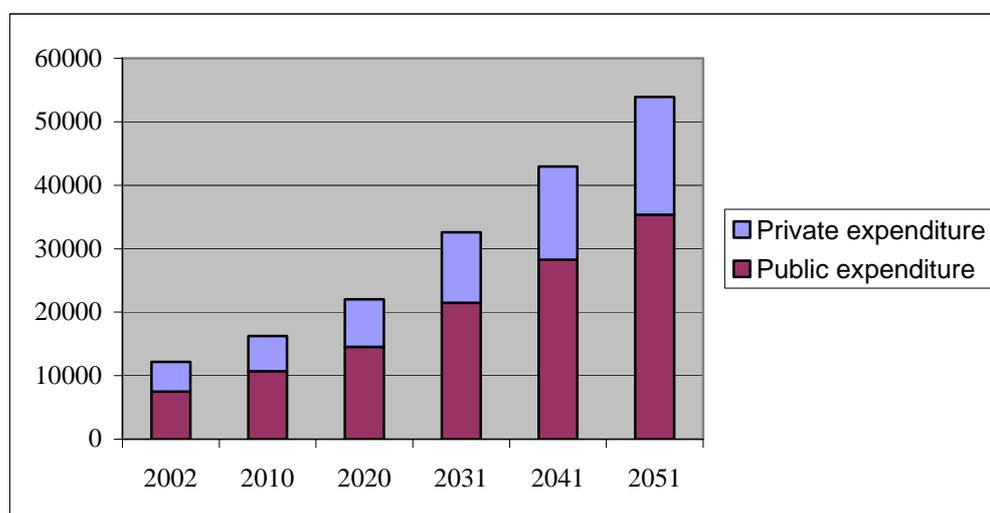
Source: PSSRU model projections (Wittenberg et al., 2004)

Sensitivity analysis both in the UK and in other countries has shown that projections of future long-term care expenditure are very sensitive to the assumptions made about three factors: trends in life expectancy, dependency and unit costs (Wittenberg *et al.* 2001, 2004 and Comas-Herrera and Wittenberg, 2003). If dependency rates are assumed to decline as mortality rates decline, this would lead to rather lower projections of future demand for long-term care. If real unit costs are assumed to rise faster than past trends in input prices, this would lead to rather higher projections of future long-term care expenditure.

These projections suggest that future demand for long-term care and associated expenditure are likely to increase substantially over the next decades. Yet, as future mortality and prevalence rates and rises in unit care costs are inevitably uncertain, there is a significant range of uncertainty about the extent of these increases. The challenge for policy-makers is that they need to plan for quite a degree of uncertainty in future demand for long-term care for dependent older people.