BRIEFING PAPER

All things come (to those who wait?)

Causes and consequences of the community care delays

Melanie Henwood
Tessa Jowell
Gerald Wistow

King's Fund Institute

JR JOSEPH ROWNTREE FOUNDATION

UNIVERSITY OF LEEDS
THE
Nuffield Institute
For Health Services Studies

ISBN 1 870607 22 8

Published by the King's Fund Institute
126 Albert Street, London NW1 7NF

Design & print by Intertype

No. 12 in a series of briefing papers on current health policy issues

All things come (to those who wait?)

Causes and consequences of the community care delays

Melanie Henwood
Tessa Jowell
Gerald Wistow

The authors

Melanie Henwood is a Fellow in Health Policy Analysis at the King's Fund Institute.

Tessa Jowell is the Director of the Joseph Rowntree Foundation's Community Care Programme.

Gerald Wistow is a Senior Lecturer in Health and Social Care Management at the Nuffield Institute for Health Services Studies, University of Leeds. He is also Director of the Institute's Community Care Unit.

Acknowledgements

This briefing paper is the product of collaboration between the King's Fund Institute, the Nuffield Institute for Health Services Studies, and the Joseph Rowntree Foundation.

Thanks are due to our colleagues who encouraged this joint venture, and who commented on an initial draft. Thanks especially to Charlotte Armour, Joy Cordwell and Karen Ho who prepared the manuscript for publication.

Thanks also to Martyn Partridge and Intertype for design and production.

Contents

Summary

In July 1990 the then health secretary, Kenneth Clarke, announced a delay in the full implementation of the Government's policies for community care. At a time when opposition to the community charge was running high the health Secretary was concerned over the likely consequences of the community care changes and emphasised the need to keep additional burdens on local government "to an absolute minimum".

The news of the delay was met with much disappointment. In the immediate aftermath there were indications that other factors were also significant in explaining the delay. In particular it seemed that central Government was not ready for implementation, and had not resolved critical issues concerning resource transfers from the Department of Social Security to local authorities.

The phasing in of the reforms over two years, from April 1991 to 1993, has a number of implications. The uncertain climate which has long surrounded community care will be protracted, and financial pressures will increase as the demand driven social security budget continues to rise. It is unlikely that this budget will be left unchecked and a number of approaches to controlling costs might be expected to develop.

What will happen in 1993 is subject to political uncertainties given the possibility of a change of government before that date. Changes are also likely in the structure and functions of local government, which could also raise questions about future responsibilities for community care. Speculation about the future might however deflect attention from the important task of maintaining momentum for change.

Recent political events, culminating in the departure of Mrs Thatcher as the Prime Minister, also create a potentially new context. One of the first actions of John Major was to ask his newly appointed Environment Secretary to review the community charge system. At the very least a statement on the funding and, perhaps, structure of local government can be expected to emerge during 1991. The implications for community care of such events are potentially very significant, as are more immediate decisions about expenditure for next year.

Throughout the delay period Ministers have continued to express their commitment to community care. Recent events provide an opportunity to demonstrate that commitment by implementing the changes ahead of 1993. Bringing forward the social security changes to April 1992 in conjunction with the new organisational infrastructure which is to be in place by that date has a clear appeal. It would remove the uncertainty about the longer term future, and provide a real opportunity for central and local agencies to break out of the stop-go cycle into which community care has been locked for too long.

Background and context

Introduction

On 18 July 1990 the then health Secretary, Kenneth Clarke, made a statement to the House of Commons "about the Government's policies for improving care in the community for elderly, disabled, mentally ill and mentally handicapped people." The statement announced a delay, or phasing in, of the community care reforms, originally scheduled for April 1991. This was by no means unexpected, and the detail was largely consistent with well sourced leaks trailed in the quality press earlier in the month, (for example, Timmins 1990). Delay has, indeed, been an endemic feature of the recent handling of community care. The Government's response to the 1988 Griffiths report was repeatedly delayed, with an eventual statement made well over a year later in July 1989. This briefing paper examines this latest change in timing, together with the apparent reasons for the change and its likely implications for implementation.

Fundamental problems

Community care has been a national policy objective for at least the last thirty years. Its meaning has developed during that time, and has encompassed in the health service both a programme of hospital closure and resettlement, especially for those with mental illness and mental handicap, and alongside that a switch in the balance of residential and home based care, provided by local authorities (especially for elderly people). It now has a larger meaning defined in the White Paper, *Caring for People*, as:

> *... providing the services and support which people who are affected by problems of ageing, mental illness, mental handicap or physical or sensory disability need to be able to live as independently as possible in their own homes, or in "homely" settings in the community. The Government is firmly committed to a policy of community care which enables such people to achieve their full potential.* (1989, para. 1.1).

In general terms it has enjoyed all party support but progress has been fitful. However, the policy framework outlined in the White Paper, *Caring for People* (Cm 849, 1989), has more immediate roots, dating especially from 1986. In December of that year the Audit Commission's report, *Making a reality of Community Care*, provided a damning analysis of "slow and uneven progress" towards community care, reflecting "fundamental underlying problems". These problems related to a number of areas, but in particular concerned:

- **Mismatched resources**

  The separation of health and social service budgets had hampered the desired shift in resources from health to Social Services.

- **Lack of bridging finance**

  The lack of resources to support transitional costs had slowed down any shift from institutional to community care.

- **Perverse effects of social security policies**

  The ready availability of Income Support for residential provision but not for community care was such that "social security policies appear to be working in a way directly opposing community care policies".

- **Organisational fragmentation and confusion**

  The division of responsibilities between different departments of central government and different local agencies, had resulted in conflicting and fragmented policy and practice.

- **Inadequate staffing arrangements**

  Manpower planning and effective training of staff were both "conspicuous by their absence as far as community care is concerned."

Together these problems constituted "a formidable barrier to be overcome". They resulted "in waste, inefficiency and less effective care than should be available to many people." Concluding that "if nothing changes, the outlook is bleak", the Audit Commission warned that the one option "which is not tenable is to do nothing."

The Griffiths review

In the wake of reaction to the Audit Commission report, the Government announced the appointment of Sir Roy Griffiths to review the use of public funds in supporting community care, and to advise "on the options for action that would improve the use of these funds as a contribution to more effective care."

The Griffiths review did not take formal evidence. Sir Roy accepted that previous reports from the Audit Commission, the National Audit Office, and the Social Services Select Committee contained "the essential facts". In particular, he

emphasised the problems of fragmentation and divided responsibilities — "a feeling that community care is a poor relation; everybody's distant relative but nobody's baby." The Griffiths' *Agenda for Action* (1988) was grounded on principles of responsibility and accountability, with implications for change at both local and central levels. While the report did not specifically address the adequacy of resources, it nonetheless stated it was "self-evident that resources must be consistent with the agreed responsibilities and objectives to be achieved." (For a discussion of the Griffiths report see Hunter and Judge, 1988).

At the national level, the Griffiths framework recommended a Minister being "clearly and publicly identified" as responsible for the policy. The Minister would set out the Government's community care objectives and priorities, and specify standards in particular areas of service delivery. Central government would also provide a ring fenced grant of 40 to 50 per cent of the total expenditure estimated to be necessary to meet these national objectives.

At the local level, social services authorities would be responsible for:

- assessing local community care needs; setting priorities and objectives and developing plans in consultation with health authorities and other bodies;
- identifying and assessing individuals needs, and designing packages of care to enable people "to live as normal a life as possible."
- arranging the delivery of packages of care.

In carrying out these functions, local authorities would act

> *... as the designers, organisers and purchasers of non-health care services, and not primarily as direct providers, making the maximum use of voluntary and private sector bodies to widen consumer choice, stimulate innovation and encourage efficiency.*

The role of the Social Services Department (SSD) was therefore to be an enabling one — promoting the further development of a mixed economy of care. Such departments, it was argued, "should see themselves as the arrangers and purchasers of care services — not as monopolistic providers."
This view of the SSD was a further development of ideas expressed by Seebohm (1968), which had emphasised the 'one door' approach to organising social care, and Barclay (1982), which stressed the importance of social care planning. Its most recent antecedent was a speech made in 1984 by the then Secretary of State, Norman Fowler, to the joint Social Services conference in Buxton. The role of the SSD was seen as one of strategic planning and the co-ordination of wider community resources, rather than as predominantly one of service provision.

The Griffiths proposals focused on managerial and systems reform as means to achieving specific practical outcomes in community care. Sir Roy was convinced that "merely to tinker with the present system would not address the central issues", and the framework he proposed was intended to:

- **Improve targeting**

  ensuring that the right services are provided in good time to the people who most need them;
- **Increase choice**

  the people receiving help would have a greater say in what was being done, and a wider choice of services;
- **Achieve community care**

  people would be helped to remain in their own homes, or in a similar domestic environment, for as long as possible.

Caring for people

The Government's proposals for community care set out in the White Paper *Caring for People* followed the main thrust of the Griffiths' model. The central objective was to enable people to be cared for and remain in their own homes aided and supported in individually appropriate ways. New financial arrangements would be introduced to "secure better value for taxpayers' money" and to remove the perverse incentive towards residential or nursing home care. Responsibilities would be clarified, and local authorities were to be the lead agency in "assessing individual need, designing care arrangements and securing their delivery within available resources". The enabling role of the local authority was also endorsed, and specifically defined as maximising the use made of the independent sector. The lead role for local authorities, however, had been reluctantly accepted only when all other options (such as giving responsibility for community care to health authorities) had been rejected as impractical.

The impetus for the community care reforms came from a number of sources including the lack of policy coherence discussed by the Audit Commission and others, and from the unplanned diversification of social care provision. These were accompanied by the twin influences of normalisation and social care consumerism. The proposals were also a reflection of developments at the local level which, as Wistow has observed:

> *... reflected the dissatisfaction of professionals and users with the appropriateness and quality of much of the community care available. Three related themes have been particularly influential: the notion that*

community care should be "value driven" and oriented to outcomes for users; the related requirement that care packages be closely related to the properly assessed needs of individuals; and the importance of user involvement in identifying need and selecting services to meet them.

Consistent with these origins, 'Caring for People' contains two distinct elements. First, it specifies the outcomes for users which Government policies are intended to promote. In this regard, the White Paper's underlying purpose is described as that of promoting choice and independence, with a consequential emphasis on home-based care, personal development and a greater consumer voice. Second, it outlines a new framework for organising and delivering care in ways intended to maximise those outcomes for users. (Wistow, 1990).

The major differences between the Government proposals and those of Sir Roy concerned finance and the role of central government. The Government rejected the case for ear-marked resources (other than, in the first instance, a relatively modest specific grant for mental illness services). Instead, resources would be channelled through the general Revenue Support Grant.

The long delay between the report from Sir Roy Griffiths and the Government response and subsequent White Paper in 1989, was in sharp contrast to the pace of events which then ensued. The White Paper was followed within days by the NHS and Community Care Bill (published on 22 November 1989). The second reading, committee and report stages followed in rapid succession. The Bill received Royal Assent on June 29th 1990 and was intended to be implemented in full on April 1st 1991. There was considerable disquiet at this rate of progress, in view of the enormity of consequential changes for health and local authorities. The House of Commons Social Services Committee also had misgivings:

We are concerned that the attempt to introduce at the same time as the NHS reforms, a whole new structure for services provided by local authorities and health authorities and very different sets of relationship between the many different units involved may not have been sufficiently thought through. The Government may simply be demanding more of managers in the health and Social Services than they can deliver within the tight timetable set for implementation of the two policies. (Social Services Committee, Eighth Report, 1990, para 85).

Alongside the legislative process, the Department of Health was undertaking a programme of development work designed to provide health and local authorities with detailed guidance on various aspects of the White Paper proposals. Much of this work was led by the Social Services Inspectorate (SSI), in conjunction with managers from Social Services and, to a considerably lesser extent, from the health service. Details of the programme were announced in a letter to Directors of Social Services from the Chief Inspector of the SSI in January 1990.

Development projects were set up in relation to: assessment and case management; inspection and quality assurance; purchasing and budgeting; community care plans; monitoring the mental illness grant, and training for social services staff. The role of these projects was initially to inform the production of draft guidance, which the Department of Health issued for consultation in June 1990.

In the next sections we examine the details of the revised timetable. We also consider whether the announcement of the delayed implementation was a recognition that the previous timetable was simply unrealistic, and that a new structure for community care could not be operable within eighteen months of the legislation being introduced into the House of Commons, or whether other factors were also significant.

Kenneth Clarke ended his statement by expressing the hope "that everyone will take advantage of the extra time to ensure that they will be even better prepared for successful implementation over the next three years." We suggest below that the new timetable for implementation may re-open issues which the White Paper had closed. For example, resources and resource allocation mechanisms may once again be under review. The Social Services Committee has called on the Government to "reconsider the manner in which resources are to be allocated, including our recommendation that this should be by means of a specific grant covering all community care." How local authorities measure up to the challenge of the local leadership role, which the Government had conceded with such apparent reluctance, will be the focus of much attention. For local authorities, the stakes are potentially very high.

2 Delayed implementation

The new timetable

Under the revised timetable announced by the Secretary of State in July 1990, implementation will now be phased over two years and will take place in three stages from April 1991 (see Box 1). However, as indicated previously, preparation for the reforms is already in progress, and will continue. In November 1990, the Department of Health issued final guidance based on the drafts put out for consultation in June 1990. The development projects led by the Social Services Inspectorate will also continue, and information on these will be included in newsletters from the Department of Health. A series of five regional seminars on the guidance will take place in early 1991.

Stage one, April 1991

Development work will continue on the new planning arrangements, assessment and case management procedures, and on the separation of purchaser and provider functions within Social Services Departments.

The new inspection units within local authorities — separate from operational management but directly accountable to the Director of Social Services — will be introduced. The remit of the inspection units will extend to voluntary, private and the local authority's own residential homes. All homes will be expected to meet consistent standards. A new complaints procedure will also be introduced.

A new specific grant for services for people with severe mental illnesses (including those with dementia) will also be introduced from April 1991. Its objective is to bring about significant improvement in the social care services local authorities provide to those people. The allocation of the grant to local authorities will be calculated against their standard spending assessments, but its payment will not be 'triggered' until plans are approved by District Health Authorities. The grant is to support total expenditure of £30 million, with central government providing 70 per cent of that total. In addition, a new specific grant for funding of voluntary organisations providing services for drugs and alcohol misusers will become available. This will be paid on the same basis as the mental illness grant to support total spending of £2 million.

Finally, the existing training support grant is to be increased by £7.5 million to support the total expenditure of £35.5 million in 1991-92. The

1

PHASED IMPLEMENTATION

Stage 1: April 1991

Financial

- new Specific Grant for Mental Illness
- new Specific Grant for Drugs and Alcohol

Implementation

- setting up inspection units
- setting up complaints procedures
- work to develop and implement the "purchaser/provider" split

Developmental

- work on local authority and health authority plans
- continue with general development projects

Stage 2: April 1992

Implementation

- local authority and health authority plans

Developmental

- test out proposals on assessment/case management in preparation for the transfer of the care element of social security funding

Stage 3: April 1993

Financial

- transfer of social security for new cases after April 1993
- introduction of assessment and case management procedures

Source: Letter to Regional Health Authority Chairmen and Local Authority Social Services Committee Chairmen from the Minister for Health, Virginia Bottomley.

additional sum is to extend training support to staff working with mentally ill, mentally handicapped and physically disabled people, and to increase support for post-qualification training.

Stage two, April 1992
New planning arrangements for local authorities and health authorities will be implemented, and development work begun in Phase One will continue.

In the first year of the new arrangements the Social Services Inspectorate will examine all local authority community care plans.

Stage three, April 1993
The new system is to be fully implemented from April 1993 when the social security transfers begin. Local authorities will then be responsible for assessing individuals' needs, and funding care appropriate to those needs whether in residential settings or wherever possible in the person's own home.

Why the delay?

The Secretary of State's statement to the House of Commons on the 18th July set out a revised timetable for the implementation of the community care reforms, and at the same time reaffirmed the mission of the Government's community care policies as "improving social care services by ensuring that they are properly tailored to the needs of individual people". To achieve this "the Government recognise that the local authorities will need adequate resources to help them to discharge their new responsibilities". The debate about the definition of adequacy will no doubt be a source of continuing debate both inside and outside parliament over the months ahead. The local authority associations had costed the full implementation of the reforms for 1991-2 at £829 million, including the costs of transferred financial responsibility for existing services, new services and additional management and support services (see Box). The Government's own cost estimates have not been made known. However, the Government statement also made it clear that the pace of implementing improvement in social care services would be determined by the consequences for community charge levels. The AMA priced the community charge consequences of full implementation at £15.00 per community charge payer.

The Government's main explanation for the delay was its lack of confidence in local authorities' capacity to carry out the reforms within reasonable cost boundaries:

> *... It has become overwhelmingly clear that many local authorities are not managing their services and*

2

LOCAL AUTHORITIES' ESTIMATES OF THE COSTS OF IMPLEMENTING CARING FOR PEOPLE

	£m
(a) Existing services: transfer of financial responsibility	
From Social Security	
1 Transfer of DSS PES provision	372
From clients, relatives and charities etc	
2 Toping up for younger people in nursing homes	26
3 Shortfall in Income Support	114
4 Protection of Personal Allowances	16
5 Alignment of Charging rules (for LA Part III accommodation)	29
6 Discretion over charging for short term admissions	11
	568
b) New services	
1 Provision of Home Care (including additional management)	50
2 Mental illness (supported by specific grant)	24
	74
c) Additional Management and Support Services	
1 Information technology (start-up)	36
2 Information technology (running costs)	13
3 Preparation and maintenance of Community Care plans	8
4 Needs assessment and case management	61
5 Business management, quality assurance, complaints and public information	53
6 Arm's length inspection service	12
7 Training	4
	187
TOTAL COMMUNITY CARE	**£829.0m**

Source: figures supplied by the Association of County Councils

> *their spending so that they deliver good quality services effectively within reasonable spending limits.* (Hansard 18 July 1990, col.1000).

Under such circumstances, the Health Secretary argued:

> *... it is only sensible for any additional new burdens on local Government in 1991/92 to be kept to an absolute minimum. Local authorities have made it clear that the changes that we propose in community care would lead to many authorities increasing their expenditure and their levels of community charge. This would place a further unacceptable burden on charge payers.* (Ibid).

In introducing a phased timetable, therefore, it was argued that local authorities would "have longer to come to terms with the need to discharge their duties efficiently and at a cost which their community charge payers can afford". The extra time would also ensure better preparation for successful implementation.

Following oral evidence by Ministers, the House of Commons Social Services Select Committee concluded that there were two main reasons why the reform might be delayed. In addition to concerns over levels of community charge, were factors:

> *... related to the lack of agreement between Departments about the method of calculating the amounts to be transferred from the Department of Social Security Votes to local authorities.* (Social Services Committee, Eighth Report, para 101).

Moreover, Peter Westland, Under Secretary for Personal Social Services with the Association of Metropolitan Authorities, claimed immediately after the announcement that the Government had not reached agreement on implementation costs:

> *... This question arose this morning with Kenneth Clarke, and I pointed out to him that his civil servants had never provided us with estimates of their own.*
>
> *I asked him: 'what are your figures?' He replied that he didn't have any and that he didn't think our estimate was unreasonable.* (Insight, August 1 1990).

The importance of such factors in the decision to delay implementation appeared to be confirmed by Junior Health Minister Stephen Dorrell who told the Health Service Journal:

> *It's precisely because we didn't have a specific figure we argued that there is concern about the level of community charge. There wasn't reasonable assurance about what the extra cost would be.* (Davies, 1990).

Therefore it would seem that central government too should be included in the Secretary of State's hope that "everyone will take advantage of the extra time" to be better prepared for successful implementation.

Reaction and implications

Reaction to the delay

The initial parliamentary reaction to the Secretary of State's announcement of delay was generally one of infuriated dismay. In the House of Commons the Opposition condemned the statement as "shameful" and "disingenuous". Much of the reaction 'on the ground' was one of considerable disappointment. While the original timetable was extremely tight, most authorities were making efforts to meet it. A survey carried out by the Association of Directors of Social Services (ADSS) prior to the announcement concluded that almost all authorities expected to implement the reforms on schedule (95 of the 96 who replied said they would be ready). The then President of ADSS John Rea Price expressed the "greatest regret" at the prospect of delay and commented that:

> *Local authorities, almost without exception, are geared up to at least deliver the basic minimum that will be required next April.* (Insight, July 18, 1990).

Nonetheless most authorities felt that they had not been given sufficient time to make those changes. A survey of Social Services Departments (SSDs) by the journal *Community Care*, before the delay announcement, found almost 80 per cent believing the lead-in was not long enough (see Box). As the survey also indicated, the greatest obstacle to local authorities preparing for the reforms was shortage of money.

The reforms create powerful financial disincentives to local authorities to continue providing residential care. The parliamentary rejection of the local authorities' case for "a level playing field" means that residents of local authority homes will not be eligible for receipt of housing benefit. This places local authorities in an unfavourable position, since residents of all other homes will qualify for such benefit. In addition, all residential homes, whether run by the local authority, voluntary or private sector, will be required to meet consistent standards monitored by the new inspection units. The current physical disrepair of many local authority homes means that they are unlikely to meet those requirements. These two factors have combined to prompt substantial interest in the transfer of local authority homes to other forms of management, e.g. housing associations, private sector or voluntary organisations. As the *Community Care* survey indicates, more than 40 per cent of SSDs had plans to reduce their direct provision of residential services. A more recent survey by the Association of Metropolitan Authorities found all responding member authorities (66%) were considering the issue of transferring residential care facilities into the independent sector (October, 1990).

The Association of Metropolitan Authorities (AMA) and the Association of County Councils (ACC) had both urged the Health Secretary not to delay implementation, and expressed their bitter disappointment with the announcement. The Social Services Committee voiced additional concerns that some local authorities would have developed projects and contracts with the independent sector, which might now "face financial disaster". (Eighth Report, 1990).

3

Do you think, that in setting an April 1991 deadline the Government has given you long enough to implement the community care reforms?

Yes 21% No 79%

What were your main problems in meeting the deadline?

Lack of political motivation	9%
Lack of financial resources	60%
Shortage of experienced staff	27%
Insufficient staff training	38%

Have you any plans to cease directly providing residential care?

Yes 41% No 59%

Will the reforms, overall, have a good effect on residential care?

Yes 69% No 27% Don't know 4%

Do you think that arm's length inspection units are a good idea?

Yes 97% No 3%

Source: 'Ready and Waiting', Community Care, 26 July 1990.

Table 1 Supplementary Benefit (Income Support from April 1988) to people in independent Residential Care Homes (RCH) and Nursing Homes (NH).

		Expenditure, £ million (current prices)	Expenditure, £ million (May 1988 prices[1])	Number of claimants (000s)	Numbers in RCH (000s)	Numbers in NH (000s)
Dec	1979	10	18	12	—	—
Dec	1980	18	27	13	—	—
Dec	1981	23	31	13	—	—
Dec	1982	39	50	16	—	—
Dec	1983	104	127	26	—	—
Dec	1984	200	234	42	—	—
Dec	1985	348	385	70	55	15
Feb	1986	459	505	90	70	20
May	1987	671	699	117	85	32
May	1988	878	878	147	103	44

Notes
1 Estimated only
2 Where — appears, figures are not available
Source Social Services Committee, Second Report, 1990, Table 1).

Implications of delay

The delay in the community care timetable arguably adds to the general uncertainty about the practical implementation of the various features of *Caring for People*. The momentum for change will, in many respects, proceed regardless of the delay but with greater uncertainty. Assessment holds the key to achieving the better outcomes on which *Caring for People* is based. Assessment of need, not just assessment for service, is the critical shift local authorities must achieve. Needs assessment also implies that local authorities have an enhanced capacity to devise a range of support, some drawn from existing services, some from new "locally contracted" arrangements with friends, neighbours or services of private and voluntary organisations.

Without the flexibility provided by additional funding, needs are likely to be met by old service solutions rather than more imaginative new combinations. Local authorities have been given great latitude in determining types of assessment procedures, including eligibility. How far case management will become combined with assessment is unclear as is the extent to which assessors will also be purchasers or budget holders.

The most obvious consequence of delay, however, concerns the continued use of social security funds to finance residential care. The first implication is that resources will not be transferred to support the White Paper's central objective of extending care at home. Second, the charge on the social security budget is certain to rise, which is ironic since it was concern about the rise of Income Support expenditure on residential home fees which prompted the Government to commission the Griffiths report in the first place.

Social security costs

The need to control the growth in social security spending on residential and nursing homes was a principal target of the community care legislation. Having increased from £10m to £878m between December 1979 and May 1988 (see Table), the most recent official estimates suggest an outturn figure for such payments of £1,200m to £1,300m for the year to March 1991 (Minutes of evidence, 1990, Q.174). As the Audit Commission noted in 1986, the availability of such funds from a central government budget which is not cash limited encourages health and local authorities to develop community care programmes which are "social security efficient". That is, those which maximise contributions from central government while minimising costs to local agencies. The perversity of these incentive structures in relation to home-based care has also been much criticised, although, as Wistow has argued, social security payments have also had a less-recognised role supporting housing based community living schemes as well as more traditional forms of institutional care. The announcement that the current social security arrangements would terminate in April 1991 had two consequences. First, it reinforced the immediate incentives for health and local authorities to shift costs to the social security system. Second, it provided them with a specifically circumscribed window of opportunity within which to effect such savings. The original timetable for implementing the community care legislation was criticised for allowing local authorities inadequate time to prepare for their new role. However, as a way of saving money, it had the clear advantage of restricting sharply the

period within which local statutory authorities could continue to transfer costs to the social security budget. Even so, social services departments have moved rapidly to explore opportunities for transferring responsibility for significant elements of their residential services into the non-statutory sector (as the *Community Care* survey of SSDs illustrates). The possibilities identified have included sale to the private sector, transfers to trusts or consortia and the creation of employee co-operatives.

The incentives for health authorities to beat the April 1991 deadline were, if anything, even stronger than those for social services departments. As, for example, the Audit Commission's (1989) report on mental handicap has demonstrated, the social security system has been utilised to fund the transfer of a significant proportion of long stay patients into private and voluntary homes. Howard Glennerster and Nancy Korman's study of the closure of Darenth Park Hospital similarly found that the high proportion of costs (25 per cent) falling on the Department of Social Security provided the explanation for "how the enterprise can be afforded", and underlined how important social security resources had been in facilitating hospital discharges (1990). The same study also demonstrated that the local authority financial contribution to the care of patients discharged from hospital was 3 per cent, compared with the NHS contribution of 63 per cent. Such figures help to explain why health authorities sometimes feel that it is they rather than local authorities which have taken the lead in implementing care in the community policies.

The community care legislation will not only close down the health services' direct access to social security support for such programmes, but will also leave the NHS dependent on social services departments allocating to hospital closure programmes sums transferred from the social security budget. The absence of ring-fencing for those funds together with competing social services priorities made such continuing access highly problematic and raised fears of increased bed-blocking. In such circumstances, it would be surprising if health authorities had not sought to take full advantage of the existing arrangements before April 1991. This aspect has received less public attention than parallel developments on the local authority side, though the recently publicised Ealing inquiry into the use of Income Support payments by the NHS in order to discharge patients to private care, may be the tip of an iceberg. (Hunt, 1990).

Likely consequences

Against this background, the delay in implementing the social security changes is likely to have the following consequences:

a) new monies will not be available to local authorities to support care at home and meet the needs of carers;

b) the underlying rate of increase in social security support to residents in care and nursing homes will continue;

c) health and local authorities will take advantage of the longer lead time to implement policies which shift costs to the social security system and, thereby, reinforce that underlying trend;

d) the NHS will continue to develop hospital closure programmes largely independently of Social Services;

e) transfers from the social security budget to the revenue support grant will take place from a higher baseline in 1993 than would have been the case in 1991.

The possible financial implications of such developments are not easy to quantify. The Association of County Councils has suggested that "it will cost at least as much to continue with the existing system as to move to the new community care regime" (*Hansard*, 18 July 1990, Col 1049). House of Commons library researchers have calculated that £520m will be added to social security payments in the next two years (Brindle, 1990). However, if the social security costs continue to rise at the same rate as in the recent past (an average annual increase of 30 per cent between 1985 and 1988), we might expect the budget to reach £1.5 billion in 1991, and £1.9 billion by 1992. Whether the Government could allow such increases to take place within the current public expenditure regime is extremely doubtful.

For its part, the Government has emphasised through the Secretary of State for Health that the existing social security arrangements will continue until April 1993 and that the preservation of benefit rights for people already in homes will also be implemented at that time (*Hansard*, 18 July 1990, Cols 1000-1001 and 1003).

The Secretary of State for Social Security has also accepted that the consequence of delay will be to increase the numbers receiving income support for residential and nursing home care (Social Services Committee, Minutes of evidence July 1990). However he counselled against exaggerating the extent of that increase (Q285). He was similarly cautious about the consequences of the continuing incentive for local authorities to transfer residents of their own homes into the non-statutory sector, expressing the view that he "would not expect any dramatic moves of (that) kind" (Q300). However,

when pressed to consider taking powers in the event of a more significant trend in that direction, he acknowledged that Ministers "would obviously consider where action should be taken but I would not want to go beyond that because it is speculation and I would not expect it to occur ..." (Q301).

Can the social security costs be controlled?

Hypothetical though these issues may be, whether the Government could afford to allow such a trend to emerge is a pertinent issue. Apart from the financial implications, such a development would undermine the case against overspending local authorities, especially if the final social security costs did exceed the much criticised local authority estimates of the cost of the 1991 implementation date. If the Government decided to take action to slow down social security spending in advance of the 1993 transfer date, a number of options would be open to Ministers.

i) Funding shortfalls

The gap between charges for residential care and levels of social security payments could be allowed to increase on the assumption that local authorities (where permitted), charities or families will continue to bridge the gap. However, it was the existence of such a gap, and the pressures which this creates for families, highlighted by the Parliamentary Social Services Committee (Second Report, 1990), which led to a Government defeat in the Commons earlier this year. The Social Services Committee concluded the average shortfall was £30 per week. As a result, the relevant income support limits were uprated (by £5 a week from August 1990), and following the independent study of residential and nursing home costs commissioned from consultants Price Waterhouse (as recommended by the Select Committee) further upratings were announced for 1991. Residential home limits will rise by £5 a week (£15 for people who are very dependent) and by £45 for nursing home places. The Price Waterhouse survey found mean weekly running costs of residential and nursing homes to be £166 (median £145), but with considerable variation from £104 to £246 a week (excluding capital costs). While the Government will doubtless seek to exercise downward pressures on such costs, the widening of the gap between those charges and DSS payments appears unlikely as a deliberate act of policy since it would carry with it substantial political costs.

ii) The test of care need

Eligibility for social security payments might be made dependent on local authorities conducting a prior test of the need for residential or nursing home care. This course might be presented as part of the staged implementation strategy, with assessment being phased in ahead of local authorities taking on budgetary responsibility for the care element of the current social security payments. However, local authority staff would retain an incentive to shunt costs onto the social security system.

Moreover, assessments of the need for residential care are not independent of the supply of alternative services. Without transferred funds to develop such alternatives, assessment staff would have few, if any, additional options to offer to those who might in principle be cared for at home. In any case, the Department of Social Security continues to maintain that few people are misplaced in residential care. For all these reasons, this option could be expected to make little more than a marginal difference to the take-up of DSS payments. At the very least, such a strategy could imply the need for close monitoring by DSS of local authority assessment decisions.

iii) Management executive control

NHS managers might be instructed not to participate in the establishment of trusts, consortia or private establishments and also, perhaps, not to discharge patients into private or voluntary homes. The latter course might appear to infringe existing individual entitlements for Income Support payments and would, at best, be incompatible with assurances that such entitlements will continue until 1993. At worst, it might create significant difficulties of definition and administration. On the other hand, the NHS Management Executive might "police" more rigorously health service participation in schemes designed to access social security payments. Such a course would be incompatible with the longer term objective of promoting a mixed economy.

Lastly, the financial incentives of the existing arrangements could be neutralised by withdrawing from health authority allocations sums equivalent to those saved by transfers to the independent sector. This would be the most direct and administratively most straightforward course to adopt. If appropriate monitoring mechanisms could be put in place, this option could reduce spending where social security funds were being used to substitute for long stay beds. It would not, however, deal with the social security consequences of discharges from acute beds to the independent sector.

iv) Control of off-loading

Local authorities might similarly be constrained in their capacity to transfer responsibility for funding and providing residential services. As in the NHS case, similar difficulties would arise about

restricting individual entitlement to Income Support services. The most direct and effective mechanism would be to neutralise the existing incentives by withdrawing from an authority's revenue support grant sums equivalent to savings achieved by transferring residential services into the independent sector. However, the non-hypothecated nature of the revenue support grant would mean that the relationship between gains and losses was somewhat less direct than in the NHS. An alternative and more straightforward approach might retain local authority responsibility for existing residents of any transferred residential establishments with Income Support available only for new residents. The revenue saving attractions of transfer to the non-statutory sector would thus be much curtailed. Again, this option would be contrary to the promotion of a mixed economy of care.

If the first two of the above options are, respectively, not politically feasible or likely to have only a marginal effect, the second two do offer some possibility of restricting the capacity of both health and local authorities to engage openly and directly in major shifts of responsibility to new non-statutory agencies. They would not affect individual entitlements and, doubtless, the growth of income support payments would continue as a result of individual decisions. However, they would restrict the capacity of statutory agencies to take advantage of the longer lead time which the phased implementation offers. Ironically, however, any such action to restrict the growth of social security payments would have the consequence of reducing the momentum towards a mixed economy. The choice for Ministers, therefore, is the relative weight they will seek to place on controlling social security spending as against diversifying responsibility for provision over the next two to three years.

4 Conclusions

In this briefing we have examined the latest delay to the community care reforms, and considered some of the implications. It is worth re-emphasising a number of key points.

1. Central government was ill-prepared

Despite the considerable time which had elapsed since the Griffiths report (1988), and since the Government outlined its own plans for community care, it appears that central government departments were ill-prepared to implement the White Paper. The Government had not published any estimates of the costs of implementing *Caring for People*, and was alarmed by the figures produced by the Local Authority Associations. The immediate consequences for community charge levels were judged unacceptable.

2. Local authorities were ready

The original timetable for implementing the reforms was generally viewed as extremely tight. Local authority social services departments were also having to deal with the changes following the Children Act, 1989 (due to come into effect in October 1991). While almost 80 per cent of social services departments believed the lead-in to be too short, most were nonetheless expecting to be ready for their new role.

3. Continued uncertainties

The revised timetable has re-opened issues that had appeared to be closed, and has led to the re-emergence of uncertainty surrounding the longer term future of community care. With the transfer of social security resources delayed until 1993, there will be a two year period during which uncertainties about the level and method of resourcing, and about the role of local authorities will continue. Many local authorities may be sceptical about the Government's commitment to full implementation but it will be vital that they take the initiative and move ahead.

4. Financial pressures will continue

If the major reason for the Government's delaying implementation of the community care reforms was its concern over the cost consequences at the local level, that course of action has nonetheless created other financial pressures. In particular, support to residential and nursing home care from the demand driven social security budget will continue to rise for a further two years. The total annual cost of such support is currently estimated at between £1.2 and £1.3 billion, with expected increases of more than £400 million per year. The Government has been forced to respond to pressures to reduce the gap between social security payments and care costs. The total cost of the consequent upratings in April 1991 will be £225 million.

It seems unlikely that such an open-ended budget will be left unchecked for another two years.

In this concluding section we address ways in which local authorities might maintain the momentum for change, and offer our views on the future of community care towards 1993, and beyond.

Maintaining momentum

The inevitable question for local authorities is how they are to maintain momentum under the new timetable. The disillusionment of staff who have been preparing for April 1991 may be mixed with relief that the timetable is now less onerous. However, there is a risk that the pressing importance given to community care before the summer of 1990 will be lost. The new Children Act for example, which is due to take effect in October 1991, may absorb much of the deferred energy and resources, and the health service also has other pressing priorities. As the MP Jack Ashley observed in the debate in the House of Commons which followed the Health Secretary's statement on phased implementation:

> *Delay is bound to mean that people in hard-pressed local authorities and the National Health Service will simply turn their attention to other matters. Like Ministers, they are busy people and delay means that they will carry out bypass operations and other projects that are dear to the hearts of voters. As a result of the Secretary of State's announcement, thousands of disabled people will be pushed aside.* (Hansard Opposition day debate on community care, 18 July 1990, col. 1032).

On the other hand, it might be argued that the revised timetable allows time for better preparation. The Health Secretary suggested that "if community care plans are ready now, there is no reason why they cannot be implemented without a statutory duty ...". However, implementation without the necessary resources will be problematic. This is one illustration of the difficulties in trying to bring in the reforms piecemeal. The components of: planning;

assessment and case management; development of purchaser and provider functions, and new financial mechanisms, need to form a coherent system. The removal of any one piece may bring down the others like a house of cards.

Moreover, there is at present little sense of partnership between the centre and localities. As discussed above, local authorities were held by the Health Minister to be responsible for the delay because of their profligate behaviour. Far from following any lead from the centre, those local authorities who are determined to push ahead see themselves as doing so despite central government.

Leadership from central government

The Griffiths *Agenda for Action* envisaged a stronger role for central government. Accepting that community care should not be managed in detail from Whitehall, Sir Roy nonetheless saw central government playing a major part. There would be controls and mechanisms to ensure local authorities took the matter seriously. Anything less, would be "inconsistent with the claim that there is a national policy" (1988, para 29). What should be the role of the centre?

Policy leadership and ownership

In rejecting the arguments for a specific grant, the Government has also rejected the Griffiths model which combined lines of accountability and responsibility. The position of Minister for Community Care within the Department of Health also differs from that envisaged by Sir Roy. The result is altogether a weaker structure which both reduces the capacity of central government to steer local developments, while also distancing its direct responsibilites for such action. In these respects *Caring for People* failed to act on two problems for community care which the Griffiths review identified. There are, however, opportunities for strengthening the role of the centre, particularly through the implementation guidance, and the continuing SSI development programme. Central government has a particularly heavy responsibility to ensure that the momentum of change is sustained in view of its responsibility for delay.

The money to make it happen

The new approach to community care which intends to match individual needs with specifically designed combinations of support may allow more efficient 'targeting', i.e. devoting the most time and effort to those people in greatest need of attention. Sir Roy Griffiths argued that policy and resources "should come into reasonable relationship". It was unacceptable "to allow ambitious policies to be embarked on without the appropriate funds". The question of 'how much is enough?' is in many ways unanswerable. However, from the outset the Government has accepted that implementation of the *Caring for People* reforms will entail additional costs to local authorities in carrying out their new responsibilities (*Hansard*, 1989). The delay was justified by the Health Secretary as an attempt to stage the costs, "to protect the charge payer against the costs of proceeding with the policy so quickly" (*Hansard*, 1990). Thus in order to sustain the momentum of change the Government has to reconcile its objective of controlling overall local government expenditure with its recognition that community care requires higher levels of spending by social services departments. With an increasing focus on needs based planning the adequacy of community care funding will be increasingly pressing.

The commitment of central government, and resource issues come together in relation to developmental or start-up costs. The need to invest properly in new information systems and in training and management development is widely recognised. However, the £2 million which the Department of Health committed in 1990-91 to such support is in marked contrast to the development investment which accompanied the NHS reforms (£85 million in 1989-90 and over £300 million in 1990-91).

The relationship between central and local Government has always been recognised as a delicate one. Too much detailed prescription from the centre can stifle local initiative. On the other hand, too little guidance and direction may mean that objectives are unclear; that resources are inconsistent with the scale of the task, and that there is little opportunity for monitoring performance or achievements. In the same way that the local SSD is to operate in an 'enabling' capacity, central government needs to enable local authorities in that task (Wistow, 1990).

Will 1993 be different?

The delay in implementing parts of the community care legislation has raised questions about whether it is being phased in or phased out. Such a concern is inevitable given both the difficulty Ministers appeared to find in making the initial decision to give new responsibilities to social services departments and also their subsequent justification for delay in terms of the "unreasonable" and "excessive" levels of local authority spending (*Hansard*, 1990). It is not surprising, therefore, that the longer term commitment of the Government to implement the legislation has been questioned.

Peter Westland, of the AMA, addressed Mr Clarke specifically on this point:

> *"I asked Mr Clarke that — he will still have the poll tax and it will still have to take account of community care. All he said was, he was very glad nobody asked him that question during the Commons debate* (Insight, *1990).*

That question is, moreover, one which will not need to be addressed finally until after the general election which must be held by June 1992. The possibility of a change of government creates even more uncertainty about the consequences of delay. A number of scenarios seem possible, in part depending upon a new government's policies towards the NHS and local government, in general, and their consequences for the lead role of social services authorities, in particular.

There are some common issues which will confront any future government by 1993. For example, it will have to find a solution to the uncontrolled growth of social security support to residential and nursing care (if one has not already been put into effect), as well as responding to the increasing need for social care services of which that spending is itself a partial reflection. In those circumstances, to continue with the phased implementation timetable would remain a viable option. At the same time, however, such a scenario might be threatened by the proposed restructuring of local government in which both major parties are now expressing an interest. For instance the allocation of social services responsibilities to all-purpose district authorities might raise questions about proceeding with the community care changes in advance of that reorganisation.

On the other hand, by 1993, district health authorities and family health services authorities (FHSAs) might be thought sufficiently well established in their new purchasing roles to take on additional functions in the community care field. Options could include creating a primary and community care authority based on FHSAs or the integration of all health and social care purchasing functions within District Health Authorities (DHAs). Proposals for the merging of existing DHAs to form larger health purchasing agencies are already under consideration. In places like Leeds and North Yorkshire those proposals imply creating a purchasing agency on the boundaries of the former Area Health Authorities and, thus, coterminous with those of FHSAs and social services authorities. Such developments could lay the ground for further mergers with family health and social care purchasing functions.

The importance of linking health and social care purchasing decisions is already being given some recognition in the Department of Health's guidance on community care (1990). In the NHS, the lengths of stay and re-admission rates on which provider units' business plans are based will necessarily incorporate assumptions about the availability of social care services to facilitate and sustain discharge policies. If such services are not forthcoming, there might be pressures for the integration of those services within the NHS in order to sustain the viability of the reforms. Indeed, the "Rubber Windmill" simulation has already highlighted the vulnerability of the internal market to the absence of such integration. Against this background, a Conservative government might find adequate cause to adopt one of the health options for the community care lead role which it had previously rejected not least because the NHS was unable to sustain an additional change agenda in the run up to 1991.

The election of a Labour Government would provide a different context, including structural changes in the organisation and delivery of community care. For example, it is proposed that District Health Authorities be merged with Family Health Services Authorities confirming the existing trend towards joint purchasing. The appointment of a Minister for Community Care is also intended as a means to raise the profile of community care and improve the interdepartmental co-ordination which holds the key to greater responsiveness to individuals' needs. Other proposals include the ring fencing of central government funding of community care, with local authorities being endorsed in their lead agency role. A reviewed implementation programme would be prepared for the Disabled Persons Act, a means of providing a codified set of rights and entitlements to complement the service developments in community care. The "level playing field" would be restored by providing access to public subsidy across all residential care sectors. At the same time, however, the promised review of regional government would also, potentially, impact on the organisational framework for the management of health and personal social services.

Consideration of these scenarios can only be speculative. They provide a possible longer term context but do not in any sense remove the urgent obligation on central government and local agencies to maintain the momentum towards the community care changes. As the Government's announcement of the delayed implementation amply demonstrated, decisions about community care are subordinate to higher political and policy agendas, over which social services authorities have almost no influence. They cannot by their own actions ensure that implementation goes ahead in 1993. However, the better prepared they are for their new community care role, the more difficult it will be for central government to take it away from them. Therefore, they have every incentive not to allow concerns about the future to divert them from preparing as fully as possible for 1993.

Failure: A self-fulfilling prophecy?
Speculation about the future intentions of central government — however well grounded it appears to be — could itself be damaging, creating at best a downward spiral in the local commitment to change and at worst a self fulfilling prophecy about central government's intentions towards local government responsibilities. There are strong grounds for local authorities seeking to maintain the momentum of change and making a positive virtue of the longer lead time which the phasing of the Act now allows. Much also depends on the role of central government in its support to a development programme which promotes change and disseminates emerging ideas about good practice.

The departmental guidance (Department of Health, 1990), and the practice notes which are to follow will have a crucial contribution to that development process. Many local authorities are continuing to gear up for their new role. For example some are still intending to produce initial community care plans by April 1991, a year ahead of the new schedule. The Yorkshire Regional Health Authority is asking all of its districts to do likewise, in collaboration with matching local authorities. On the other hand it may be difficult to sustain political commitment for this level of preparatory work as the consequences of what is effectively universal charge capping penetrate the budget making system.

Even so there is much that authorities can do individually and jointly in laying the foundation stones for the new framework of service planning and delivery. In the case of community care planning, for example, the additional time can be used to ensure that the four building blocks of an outcomes and needs led planning system, are more firmly put in place (Wistow, 1990). These starting points comprise:

- determining values, principles and objectives
- identifying need
- compiling a local resource inventory and ring-fencing existing resources
- establishing joint inspection/quality assurance units

Similar starting points can be identified for the other key changes which the White Paper proposed. Assessment of need, the mechanism to drive the user orientation of *Caring for People*, implies also a broader brief than simply assessment for health or social services. Therefore the assessment process needs to recognise that community care is a corporate responsibility of the local authority. Accordingly, the process must be organised so as to secure access to sources of support and services which increase opportunities for ordinary living from agencies beyond just the Social Services Department. Such key resources will include training, employment, recreation and transport.

Consumer satisfaction?
Most importantly, it is even more in the interests of users and carers that a stable settlement should be put in place with the minimum of delay. To subject them to yet another round of speculation and uncertainty would be deeply damaging to the stated commitment to place user and carer needs at centre stage. To date, political and provider agendas have dominated the extremely long drawn out process of political debate and organisational change. Yet the justification for these changes is that they will provide better outcomes for users and carers.

The major appeal of *Caring for People* lay in its stress on meeting individual needs (including those of carers), and doing so in ways which enable people to live as independently as possible in the community. The reality of practice is still a long way short of the elegant rhetoric. Four years ago the Audit Commission argued that the one option that was not tenable was to do nothing. The latest delay in the implementation of the community care reforms, however, risks doing just that. While the extra lead time until 1993 may be productive in ensuring adequate preparation, the new resources which would have enabled local authorities to develop community based care packages are not immediately available. Many local authorities are achieving innovative and successful services, but without sufficient support there is a risk that existing — and often inappropriate — services will become ossified. In those circumstances individuals will continue to enter residential care, and the cost to central government will continue to rise.

1992: Proof of commitment

Ministers have repeatedly emphasised their continuing commitment to the policies enshrined in the NHS and Community Care Act. Mrs Bottomley, the Minister of Health, has most recently expressed this position in the following terms:

> *I want to say clearly and unequivocally that the full community care proposals will be implemented. The policy will not be abandoned and it would be wrong-headed to think so.* (Bottomley, 27 November 1990).

The change of Prime Minister has potentially created a new context for the fulfilment of that commitment. We have noted above that the principal cause of delay was the anticipated consequence for community charge levels. The Environment Secretary's review of the community charge system seems likely to create a situation

before 1993 in which that obstacle is either removed or assumes less importance.

At least a statement of intent on the funding and, perhaps, structure of local government can be expected to emerge during 1991. In these circumstances, the cost-effectiveness logic of transferring responsibilities and resources from the social security system to social services departments would re-assert itself over the narrower and financially more costly political logic of limiting charge levels which was the predominant influence in July of 1990. The implications for community care of such a turn of events would be potentially very significant since it would open the way not only to implementing the Act in full but to bringing forward the date of that full implementation.

Under the phased implementation timetable, all the elements of the new organisational infrastructure for community care (including assessment procedures and community care plans) are required to be in place by April 1992. If the social security changes were brought forward to that date, the full package could go ahead then. Such a course would remove uncertainty about the longer term future, help to maintain the momentum of change and still retain the advantage of gaining extra development time to complete preparations for implementing the Act which has been the positive consequence of the delay announcement.

It remains to be seen, of course, what will be the Major government's stance towards local government as a whole and a lead role for the health service may still seem attractive. What is clear, however, is that the consequences for local government finance of the Conservative leadership struggle are likely to be profound and to create yet another range of complexities, uncertainties and potential scenarios for the future of community care. There is a strong case, however, for using recent events more positively to create a real opportunity for combining the developmental advantages of limited delay with the financial benefits to the social security system of implementing the community care changes ahead of 1993. A highly practical and imaginative way for Ministers to demonstrate the commitment which Mrs Bottomley so powerfully expressed would be to end all further uncertainties and proceed with a 1992 implementation date. This would not only enable Ministers to back-up fine words with effective actions; it would also constitute a real opportunity for central and local agencies to break out of the stop-go cycle into which community care has been locked for too long.

References

Association of Metropolitan Authorities (1990), *Local authorities and their care homes*, 5 October.

Audit Commission (1986), *Making a reality of community care*, HMSO, London.

Audit Commission (1989), *Developing Community Care for adults with a mental handicap*, Occasional Paper No. 9, HMSO, London.

Barclay Committee (1982), *Social workers and their tasks*, Bedford Square Press, London.

David Brindle (1990), 'Care delays will cost £520m', *The Guardian*, 6 August.

Caring for People: Community care in the next decade and beyond (1989), Cm 849, HMSO, London.

Community Care: Agenda for Action (1988), a report to the Secretary of State for Social Services by Sir Roy Griffiths, HMSO, London.

Peter Davies (1990), 'Look at the figures: see the commitment', *The Health Service Journal*, 9 August, p.1170.

Department of Health (1990), *Caring for People: Community care in the next decade and beyond, Policy Guidance*. HMSO, London.

Howard Glennerster and Nancy Korman (1990), 'Success Costs Money', *Community Care*, 20 April, pp.30-31.

House of Commons *Hansard*, 1990, statement on community care, 18 July, cols. 999-1014, HMSO, London.

House of Commons *Hansard*, 1990, social security benefits uprating statement, 24 October, cols. 348-366, HMSO, London.

David Hunter and Ken Judge (1988), *Griffiths and community care: meeting the challenge*, King's Fund Institute.

Seebohm Committee (1968), *Report of the Committee on local authority and allied personal social services*, Cmnd 3703, HMSO, London.

Social Services Committee, Second Report (1990), *Community Care: Future funding of private and voluntary residential care, Session 1989-90*, HMSO, London.

Social Services Committee, Eighth Report (1990), *Community Care: Planning and co-operation*, House of Commons, Session 1989-90, HC 580-1.

Social Services Committee, *Public expenditure on social security*, Minutes of Evidence, 25 July 1990, HMSO, London.

Nicholas Timmins (1990), *The Independent*, 11 July.

'Peter Westland Answers Back' (1990), *Insight*, August 1.

Gerald Wistow (1987), 'Financing residential care: objectives and options', in E Hartley-Brewer (Ed) *The Future Funding of Residential Care*, BASW, Birmingham.

Gerald Wistow (1990), *'Implementing "Caring for People": issues and perspectives'*. Paper presented to the Association of Directors of Social Services, Blackpool Conference, 3 May 1990. To be published by ADSS.

KING'S FUND INSTITUTE

The Institute is an independent centre for health policy analysis which was established by the King's Fund in 1986. Its principal objective is to provide balanced and incisive analyses of important and persistent health policy issues and to promote informed public debate about them.

Assessing the performance of health care systems is one of the Institute's central concerns. Many of its projects focus on trying to determine whether health care systems achieve their objectives. The Institute is also concerned with health policy questions which go wider than health services proper. These centre on the scope of public health policy and on social and economic determinants of health.

The Institute's approach is based on the belief that there is a gap between those who undertake research and those responsible for making policy. We aim to bridge this by establishing good relations with the scientific community, and by gearing our work towards making the most effective use of existing data. One of our key objectives is to undertake informed analyses and channel them to politicians, civil servants, health managers and professionals, authority members and community representatives.

The Institute adopts a multidisciplinary approach and seeks to make timely and relevant contributions to policy debates. A high priority is placed on carefully researched and argued reports. These range from short policy briefings to more substantial and reflective policy analyses.

The Institute is independent of all sectional interests. Although non-partisan it is not neutral and it is prepared to launch and support controversial proposals.

The Institute publishes a range of documents which include: Occasional Papers, Briefing Papers and Research Reports. A publications list is available.

ISBN 1 870607 22 8
£5.95