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**'RHETORIC OR REALITY?
- A critical investigation of the market model for Community
Care.'**

**A thesis submitted to Middlesex University in partial fulfilment of the
requirements for the degree of Doctor of Philosophy.**

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ABSTRACT

In the 1950s the term community care was associated with the movement of people with mental health problems from longstay institutions into the community. More recently, however, the term has applied to services to a much wider range of groups including older people. The thesis is concerned with community care services for this group and in particular, domiciliary care. It seeks to evaluate claims made in the White Paper: 'Caring for People' that its preferred model of community care can provide both increased service effectiveness for consumers **and** cost control.

The thesis argues that community care policy was shaped by 'managerialist' assumptions and that improved performance could be delivered by organisational change, in particular the quasi-market and the use of managerialist techniques. Thus, the two phenomena of 'managerialism' and 'quasi markets' are conjoined, the latter offering to the former the possibility of competition between providers, which in turn is seen to provide greater user choice and value for money.

Two key reports from the Audit Commission are analysed as exemplars of managerialism and community care. The connection between the reports and government policy is discussed and the evidence presented in them for community care, as a cost containment policy, is scrutinised. The consumer effectiveness argument for community care is examined by considering, in particular, the relationship between consumer choice and the market model of community care advocated in the Griffiths report: 'Community Care: Agenda for Action' (1988) and the White Paper: Caring for People (1989). It is argued

that both the government proposals and much of the critical academic commentary fail to examine various underlying premises, in particular, the salience of 'choice' as a universally desirable objective.

The themes outlined above are explored in empirical work undertaken in the case study local authority. The consumer effectiveness issue is analysed with reference to a survey of users of domiciliary care services. The survey is used to examine how far the assumptions made by both government and many academic commentators, with regard to user satisfaction, correspond to those of users. The analysis questions these assumptions showing that 'consumerist' notions of choice of service are much less significant than personal aspects of the service such as 'caring manner' and continuity of relation with carer. Cost control issues are examined by considering an example of 'value for money' auditing in the authority. Analysis of this project suggests the difficulties which such exercises have in generating appropriate norms for service provision in domiciliary care. The thesis concludes by relating the themes explored to current problems in community care policy, in particular the increasing significance of rationing and eligibility criteria.

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PREFACE

'To the politician, community care is a useful piece of rhetoric; to the sociologist, it is a stick to beat institutional care with; to the civil servant, it is a cheap alternative to institutional care which can be passed to local authorities for action - or inaction; to the visionary, it is a dream of a new society in which people really do care; to social service departments, it is a nightmare of heightened public expectations and inadequate resources to meet them.' (Jones 1978).

The 1980s and 90s have witnessed major changes with respect to community care policy.

As the above quotation suggests, the task of assessing the policy is a complex one.

Assessment presupposes a knowledge of the objectives of policy and, in the case of community care, such objectives can vary with the way the policy is framed and defined.

The language of the recent NHS and Community Care Act, with its emphasis on choice and value for money, is exemplified in the following statement in the Community Care White Paper (1989), which explains the expected consequences of operating a market for care services:

'Stimulating the development of non-statutory service providers will result in a range of benefits for the consumer, in particular: a wider range of services; services which meet individual needs in a more flexible and innovative way; competition between providers, resulting in better value for money and a more cost-effective service.' (Department of Health 1989, para. 3.4.3).

Such a plethora of claims naturally leads the enquirer to question whether the 'reality' of service recipients will match up to the 'rhetoric' of the market language that underpins community care policy, or whether there are problems in the transfer of an essentially private sector market concept to the area of publicly funded social care.

Whilst the area of community care is clearly a vast area for study, this thesis confines itself to investigating problems within the application of managerialist techniques to the field of community care. Implementing policy for community care, however, requires structural re-organisation of social service departments and the development of a 'purchaser'/'provider' split. The latter creates a quasi-market for care services, which in turn offers managerialism the possibility of competition, which is seen to lead to greater service effectiveness and value for money. Investigating problems in the application of the managerialist framework to quasi-markets for care services thus enables an assessment to be made of the 'reality gap' between the rhetoric of policy and the capacity of the market model to deliver the benefits of choice and value for money claimed by the reforms.

Before examining further the conceptual problems of the market model for community care, it is necessary to explain why 'community care', as a policy, was chosen for investigation. Four features can be identified here that make 'community care' an interesting area for critical investigation. These are: i) the emergence of a community care 'consensus', ii) the opportunities afforded by the author's work environment, iii) the area of service provision for older people and iv) the relevance of community care to general social policy issues.

Community Care, as a policy, has long been embraced. For instance, in the field of mental health, community care had been advocated since the late 1950s, but seemingly became a practical policy following the 1990 Act. Given the substantial history of the term and the range of services to which it is applied, there are a number of difficulties over the precise meaning of the word 'community'. Such difficulties appear to relate to the presence of widely differing professional viewpoints. For instance, the term 'community' - to NHS staff - began to refer to anywhere other than hospital and therefore included both publicly funded and private residential care. (Maclean, 1989, p28). This however, ran contrary to the perspective of local authority social service departments who, with responsibility for providing residential accommodation to the elderly, tended to confine the term:

'community' to people's own homes. (Acheson 1985, p3). Furthermore, it appears from the community care legislation and preceding Audit Commission reports that even the latter definition can be expanded to include facilities such as 'day care' which, it will be argued in chapters 3 and 4, challenge the original notion of 'alternatives' to institutional care.

Maclean (1989, p29) considers that the first official use of the phrase 'community care' was in 'The Report of the Royal Commission on Mental Illness and Mental Deficiency' (1957), which referred to arrangements under the 1946 National Health Service Act for the care and aftercare of people with mental 'illness' and 'deficiency'. The general assumption, prior to the 1957 report, was that statutory authorities should concentrate their efforts on providing hospitals. In 1961, however, Powell, then Minister of Health,

proposed the running down and closing of the majority of long-stay mental hospitals. Such a development was connected with plans to develop district general hospitals, on a nation wide basis, to provide treatment for acute illness for 'defined' populations. The term 'Community Care' was subsequently referred to in the 1961 'Hospital Plan' (cited in Allen, 1962) and more explicitly in 'Health and Welfare: the Development of Community Care' (1963). The responsibility, however, for practical arrangements outside the long stay institutions rested with local authorities.

A shift, therefore, had already begun which had effectively moved the concept of community care away from long-stay institutions and hospitals to predominantly people's homes. Such a move, according to Maclean, combined the anti-institutional ideals of sociologists with the prospect of saving public money (Maclean 1989, p30). The public 'conscience' also, however, played a significant role in the 'de-institutionalised' understanding of community care in response to numerous reported media 'scandals' prompting public enquires. This was further supported though claims by psychiatrists that new 'superior' drug treatments would provide more practical ways of controlling mental health disorders outside the main institutions.

A further reason for selecting community care as a field for study stems from opportunities provided by the author's work environment. In particular, at the time of the study, the author was Planning and Commissioning Manager of a Social Services Department in an Outer London Borough. Such a position afforded various opportunities for direct day to day contact with policy issues. In particular, the implementation of

community care, post-1993, provided an opportunity for strategic involvement in the development of domiciliary care services. The latter, in particular, formed the context for in-depth empirical research through the opportunity they provided for observing the impact of community care on user satisfaction. Thus, in March 1995, the author carried out a research project to investigate the efficacy of the market model in delivering the benefits claimed by the community care legislation as a consequence of enabling independent sources of provision.

The area chosen of domiciliary care was of particular interest, because at the time of the empirical research (March 1995) such services were split between two structurally distinct parts of the organisation. These were: i) the in-house home care service, which at this point had not effected the 'purchaser/provider' split advised by the legislation and ii) the care management service which had participated in structural re-organisation, involving a division between 'purchasers' and 'providers'. In this respect, the latter service was demarcated as a 'purchaser'. On the other hand, the former service operated, essentially, as a pre-community care service in that aspects of assessment and commissioning were carried out alongside the provision of services. This, consequently, provided a unique opportunity to compare the levels of user satisfaction between a quasi-market service and a 'pre-reform' community care 'control' in the case study borough.

The area of community care, however, whilst having its own specific characteristics, in addition reflects developments which are relevant to social policy generally. In particular, there has been a commitment by the Conservative governments, since the 1979 election, to

tackle what were seen as 'inefficiencies' in public sector services. The remedy, prescribed by Government, across a range of public service contexts has been the introduction of private sector concepts of management, referred to as 'public sector managerialism'. The essential feature of public sector managerialism is that it views problems in management terms and assumes service improvements can be achieved **within** existing resources. This suggests that the primary 'problem' of the public sector is its lack of effective management, thus its failure to use resources appropriately. Given such a problem definition, management expertise was not expected to come, at least initially, from within the organisation but from the private sector (Cutler and Waine, 1994, p5). An investigation into the 'efficacy' of the market model for community care is therefore an opportunity to highlight changes that connect with a broader theme of public sector managerialism.

Clearly, community care is a policy which has implications for a wide range of groups (older people, physical disability, mental health, learning disabilities etc.), however the focus in this study is the impact of the policy on **older people**. The choice of older people is significant for a number of reasons: i) because historically, the contribution of older people as a group in relation to service planning has been marginalised; ii) because the needs of older people form a major challenge to current policy; iii) because of related financial considerations.

The 'voices' of older people who use or need community care are rarely heard directly. In this respect there are very few mechanisms for capturing the views of older people who

need or currently use community care services. This, however is in contrast, to some extent, to younger physically disabled people who appear more politically effective in getting their views across to policy makers (Thornton and Tozer 1995, p4). Certain exceptions apply however. For instance, day centre users may be offered a say in how their service is organised or be asked to comment on local community care plans. However, this still excludes the majority of older users who may be forced to stay at home, yet have an equal right alongside other groups to be heard.

Providing older people with a 'voice', in relation to services they may be receiving, strengthens reasons for the inclusion of this group in the research.

The research, however, acknowledges that inviting 'older' people, as part of a survey of domiciliary care, will need to address historic problems through their exclusion. In particular, this relates to a degree of 'passivity' which may be present for a number of reasons: a) because as a group they have rarely been consulted, b) they may have fears of having a service they have grown dependent upon being withdrawn, c) the impact of social 'stereotyping' may reinforce their sense of social exclusion and disempower them.

The needs of older people are by no means trivial in policy terms. Whilst historically, the attention of policy makers has tended to focus on specific disability groups, the area of the elderly is now receiving attention through the NHS and Community Care Act 1990.

Whilst the incentive for such policy changes is mainly financial, due to the need to reduce the high level of public expenditure on private residential placements, it is also necessary to understand the needs of older people per se and how these will change over a period of

time. Such an approach is adopted, at least initially, by the Audit Commission, which on the first page of the 1985 report ('Managing Social Services for the Elderly More Effectively') indicates a rise of 15% in people aged 75 and over by 1991 compared to 1981 and 30% more people aged 85 and over. Such statistical data on demographic changes for older people clearly provides a challenge to the community care model to develop sufficient home based services to meet current as well as future anticipated levels of need.

The area of 'older people', thus, through an analysis of changing population patterns and services that will be required to meet those needs, represents the most resource intensive group. Furthermore, demographic trend predictions suggest the over 85s, in particular, will increase at a disproportionately higher rate than other groups. This is particularly significant at a local level in the case study borough. The proportion of older people in the borough is higher than the Greater London average. This, in turn, impacts on service provision, in that over half of the borough's home care clients are in the over 85 group. Further increases in the over-85s are therefore likely to present a significant challenge to the 'managerialist' framework, which assumes further growth will arise out of efficiency savings within existing budgets.

One important aspect of managerialism is the way it connects developments in community care with general trends in contemporary social policy. Three key themes can be identified here: i) a role for private sector corporate executives ii) the creation of management bodies and iii) structural organisational changes.

A feature of 'reforms' of the welfare state has been the role played by senior private sector corporate executives. Examples of this include: Griffiths, in general management in the health service and in community care; Dearing in secondary and now higher education. Whereas Griffiths and Dearing produced statements of management practice for the NHS and higher education, the Audit Commission played a similar role with respect to services provided by local government. The requirement for management expertise in each sector, however, can be seen to arise out of a common 'problem' definition..

This was initially exemplified by the Griffiths Report (1983), leading to the introduction of general management into the NHS. In line with the view that management 'solutions' could only be found outside the public sector, Griffiths and the other three members of his team were senior private sector corporate managers (Harrison, 1988, p60). Not surprisingly, their backgrounds in the private sector influenced their assessment of problems within the health service, which are seen in terms of 'deficiencies' in management that require the application of private sector management 'models'. Griffiths' later report in 1988, in the field of personal social services, similarly ignores specifics of service context and reinforces managerialist recommendations from the earlier 1985 and 1986 Audit Commission reports, by identifying the need for change in organisation and management.

The creation of management bodies such as the Audit Commission, which embodies management consulting, accountancy and 'benchmarking' techniques, illustrates a further aspect of the way in which developments in community care, such as 'managerialism',

reflect general trends in social policy. The Audit Commission was established under the Local Government Finance Act 1982 to oversee the external audit of local authorities in England and Wales, by the appointment of auditors to carry out 'value for money' studies. The Commission, in carrying out its studies with local authorities, developed a range of accountancy techniques to assess the 'economy', 'efficiency' and 'effectiveness' of organisations. The consensus of commentators, however, is that whilst the Commission was sometimes critical of government policy, it nevertheless operated within a set of a priori assumptions which were generally consistent with those of central government..

With respect to this 'bias', Hazell (1995, p1) views the introduction of management bodies, such as the Audit Commission, as part of a significant role in securing greater Government control over the public sector. Furthermore, Hazel supports McSweeney's (1988, p40) view that the Commission, through its relationship with the public sector, deliberately contrives a 'climate of crisis' in order to execute a change in management culture. Such an analysis suggests that changes occurring in the public sector are being imposed through the agency of management bodies operating within an a priori set of assumptions that disregard particular service contexts.

A further aspect of these changes is the way in which professionally dominated cultures are being challenged by management re-organisation (Hazel, 1995, p3). Such changes can equally be seen across the public sector, in areas of Health and Education, where through the introduction of performance measures, 'power' is increasingly being transferred away from professionals, such as doctors and teachers, to managers. One of the irresistible

forces, as part of this change, is the degree to which accounting is seen by Government as possessing a high level of 'rationality'. Consequently this makes it difficult to argue or indeed to be seen to argue against such assumed 'objectivity' (Ibid.).

In conjunction with the introduction of management techniques from the private sector came a requirement for organisational change. To date, organisational changes in the public sector have been designed to turn it into a set of service enterprises. Such changes include: Local Management of schools, Grant Maintained Schools, NHS Trusts and the introduction of various forms of 'purchaser/provider' splits within local authorities. The rationale behind these organisational changes, appears linked, as with the introduction of management techniques, to a view by private sector analysts that management in the public sector is **deficient** in so far that it lacks a clear chain of structural command, such as is present in the multi-divisional organisational form or 'M-form' (Cutler and Waine 1995, p1).

Such arguments naturally give way to prescriptions for organisational change involving the importation of 'M-form' into public sector organisations, thus establishing a chain of command between the organisation's strategic centre and the operational divisions. The advantages of this, to the managerialist agenda, are that it devolves certain operational decisions to divisional level whilst retaining central control over individual divisions' performance. Such approaches have been mirrored, through Griffiths, both in the Health Service, through the link between District Health Authorities and NHS Trusts, as well as more recently in social service departments in the establishment of 'purchaser/provider'

splits. Thus, whilst in principle, operational decisions are left to devolved units, this is ceded only on the basis of greater accountability to the centre.

All these changes are inter-related, thus, the division of units has (accompanied by obligations to collect and publish information) allowed for comparison of performance and the application of 'benchmarking', value for money audits and the diffusion of 'best' practice, while senior private sector corporate managers are effectively seen as possessing the managerial expertise to introduce such changes.

The strategic role of managerialism has, arguably, created an increased willingness to accept welfare state 'reforms', in part, because the promise is one which can appeal to different constituencies. As was illustrated via the quotation from 'Caring for People' (see pviii), the reforms make cost control and service effectiveness claims. Thus they can appeal to managers and politicians concerned with staying within budgets and professionals and advocacy groups interested in better quality services. The aim of the thesis is to critically evaluate such claims.

The Plan of the Thesis

The thesis is divided into ten chapters and a conclusion. In chapter one, community care policy is situated in terms of a brief history of the development of community care policy from the late 1950s to the 1980's. In chapter 2 the concept of managerialism, central to the thesis, is introduced and its relationship with 'quasi markets' outlined. In chapter three, the role of the managerialist 'problem definition' with respect to community care is traced.

This is done by examining two reports produced by the Audit Commission, 'Managing Social Services for the Elderly More Effectively' (1985) and 'Making a Reality of Community Care' (1986). The chapter seeks to demonstrate the links between the agenda established in these texts, the Griffiths report and the subsequent White Paper and community care legislation. Thus, it seeks to show how managerialist assumptions shaped the legislation.

In chapter four, the two Audit Commission texts are subject to a critical analysis. This is done via a close textual analysis of the documents which investigates the evidence presented regarding cost control and effectiveness of community care as an alternative to, in particular, residential and nursing home care. It concludes that the documents are flawed in terms of the limited range of cases on which they draw, internal inconsistencies and highly restrictive assumptions regarding the kinds of packages which would be needed for effective community care. In this sense, the texts serve to exemplify the weaknesses of value for money auditing techniques in the area of community care.

In chapter five the other side of the case for community care is considered, namely, service effectiveness and improved provision for users. This examines the case for the reforms on 'consumerist' grounds. The analysis examines how far the reforms are likely to increase choice and whether such goals clash with other objectives such as equity in service provision. The chapter also argues that the debate on choice has been quite limited and, in particular, has concentrated on the unquestioned but debatable assumption that extending

choice is always desirable. The first five chapters make up the first part of the thesis in which the general theoretical issues which the thesis addresses are explored.

Chapters six to eleven make up the second part of the thesis in which the issues raised in the first part are considered in the context of the case study borough. To enable the context for empirical study to be understood, chapter six gives the background to the case study borough in terms of demographic factors and shows how home care services are organised. Chapter seven outlines the methods used in carrying out the research and chapter eight sets out the results of a survey of users of home care services in the case study borough. Chapter nine analyses the results of the survey and, in particular, connects the results to the arguments on the significance of user choice discussed at the theoretical level in chapter five. Chapter ten discusses a value for money audit undertaken in the case study borough. This was undertaken as part of a CIPFA (Chartered Institute of Public Finance and Accountancy) project but was also designed to provide advice on how management control of the home care service could be improved and productivity increased. Criticism of this approach is directed not at the author of the study (McCarthy, 1995) but at the way it reflects conventions commonly associated with VFM auditing at the local level. The critical analysis of the project in this chapter connects to the criticism of national level value for money audits discussed in the critique of the Audit Commission texts in chapter four. Finally, the conclusion (chapter 11) seeks to bring these strands together in an overall evaluation of the claims of managerialism with respect to community care and makes a connection to current policy concerns in the field.

Note. Where reference is made in the text to the 'government', it refers to the Conservative administration.

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ABBREVIATIONS

AHA	Area Health Authority
BDO	Borough Development Officer
CICS	Client Integrated Computer System
CIPFA	Chartered Institute of Public Finance and Accountancy
CSC	Central Support Costs
DHSS	Department of Health and Social Security
DOH	Department of Health
DSC	Departmental Support Costs
DSS	Department of Social Security
'Es'	Economy, efficiency and effectiveness
FTE	Full Time Equivalent
GP	General Practitioner
GREAs	General Rate Expenditure Accounts
HCS	Home Care Service
HMSO	Her Majesty's Stationery Office
HPSD	High Public Sector Dependency
HSS	Housing and Social Services
ID	Identification Document
IT	Information Technology
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
LA	Local Authority
LASSL	Local Authorities Social Services Letter
LBS	London Borough of Sutton
LPSD	Low Public Sector Dependency
NPM	New Public Management
NR	No Reply
PSS	Personal Social Services
SAE	Stamped Addressed Envelope
SSA	Standard Spending Assessment
STG	Special Transitional Grant
UKHCA	United Kingdom Home Care Association
VFM	Value For Money

CHAPTER 1 HISTORY OF THE DEVELOPMENT OF COMMUNITY CARE

The purpose of this chapter is to outline government policies on community care in the post war period, in particular, from the late 1950s to the early 1980s. The dates are of significance; although the idea of community care for vulnerable groups was established in the 1930s (Webster 1996, p109). It was not until the 1950s that governments began to articulate specific policies in this area. As will be argued in this chapter, such policies were developed within a broad political consensus: a desire to run down institutional provision; the assumption that the family was the main provider of community care and, where this was not the case, that statutory authorities (health and local authorities) would play a leading role; finally, this was a policy developed in the absence of strategic planning (Webster 1996, p110).

Despite the election of the first Thatcher administration in 1979, which sought to distance itself from the post-war political consensus in all areas of policy, the two key documents on community care in the early 1980s - 'Growing Older' and 'Care in Action', both published in 1981 (DHSS 1981b; DHSS 1981c) - demonstrated significant continuities with their predecessors. This chapter will outline the policies pursued by successive governments from the 1950s to the first Thatcher administration. It will provide a background for the transition in community care policies from the mid 1980s, which will be traced in Chapter 3.

Community Care: an Emergent Policy

As Webster has suggested '*...the slow and intangible changes in practice and thinking among those responsible for serving and representing various clients groups found expression in a*

plethora of official reports.' (Webster, 1996, p112). With respect to community care the key report was that of the Royal Commission on the law relating to mental illness and mental deficiency (1957). Chapter 10 of the report recommended that local authorities as well as hospitals should provide residential care for patients not in need of medical or nursing services and that local authority occupational and training centres should be developed for those client groups. Such community services, it was argued, would both speed early discharge from hospital and prevent admission. A further recommendation was that a special exchequer contribution should apply to all local authority capital expenditure on mental health services for a limited period. In view of the scale of the mental hospital population, such an investment in local authority institutional provision would have represented a sizeable capital commitment. It also highlighted a significant and new role for local authority health and welfare authorities in the development of alternative forms of provision for these client groups. The Ministry of Health supported the Royal Commission's proposal on the special exchequer grant and argued that there should be a £40m capital expenditure programme over 10 years, for the development of residential homes, hostels, training and occupational centres. The Royal Commission also proposed that NHS surplus property should be transferred to local authorities and used to provide community facilities and residential accommodation for the mentally ill. However, the proposals met objections from the Treasury, which wished to dispose of such surplus property, not merely transfer it. After lengthy negotiations the proposal was eventually abandoned in 1965 (Webster 1996, pp. 119-20).

Webster (1996, p120), argues that given the failure to obtain more than minimal resources for expansion of community care, the Ministry of Health resorted to 'exhortation'. In particular,

this involved the circulation of advice on co-ordination between hospital and local authorities. Such advice, however, was not new, but built on a previous report by the Mental Health Standing Advisory Committee in 1956, which collated the latest available information on joint ventures. This culminated in the production of a circular (Ministry of Health, 1959), based on the 1956 report, but Webster (1996, p120) argues that this was a public relations exercise attempting to demonstrate that there was a continuing commitment to community care. Whilst, with respect to local authorities, the changes associated with the Mental Health Act 1959 did clarify certain ambiguities regarding their powers and duties to provide services, overall, further developments in community care services were insubstantial. In particular, this is illustrated by the situation of local authorities, in that whilst under the 1959 Act they had duties to provide services and were directed to draw up plans for their development, there was no compulsion to act on these plans in the absence of resources being made available.

Such a failure to develop community care policy was in stark contrast to expenditure in other areas (e.g. £10 m for developing intercontinental ballistic missile systems) and was criticised by Titmuss (Webster, 1996, p122), who pointed out that, in real terms, there had been a decline in the level of resources available to community care since the beginning of the NHS. Similarly Townsend considered that attempts to implement community care policy would be seen by future historians as '*...the most striking failure of social policy in the last decade*' (Townsend, 1962, p399). Nevertheless, despite restrictions imposed by the Treasury, local authority health and welfare capital spending reached £7.25m in 1960/61 (Webster, 1996, p122). On account of the newly imposed duties under the 1959 Mental Health Act, the health departments made an effort to obtain a more realistic level of future resources. Consequently, in 1961/62, Walker-

Smith, the Minister of Health, supported a bid for £16m, on the basis of making up for past deficiencies (Ibid.). However, the conflict between the Ministry of Health and the Treasury continued, and the Treasury, supported by the Prime Minister, offered £10m (Webster, 1996, p123). This was later increased on appeal from Walker-Smith to £11.25m, who argued that that cuts in capital expenditure placed a real threat to community care services (Ibid.). To put these improvements in context they must be seen in relation to two features: a characteristic of the National Health Service in the 40s and 50s was the very low level of capital spending, thus, for example, Abel-Smith and Titmuss (1956, Appendix G) estimated that, in real terms, capital expenditure was running at roughly one third the level of pre-war services; equally out of this constrained budget the major share went to hospitals which regularly took in excess of eighty per cent of spending on new fixed assets in the service (Abel-Smith and Titmuss, 1956, p. 50).

In parallel with the long-term programme for hospitals, the Ministry of Health argued that local authorities should be allowed to plan capital development on the same basis as hospitals (Webster 1996, p123). One of the advantages of this proposal was that additional expenditure on care within the community could be argued to be the most obvious way of guarding against excessive cost of hospital expansion. Furthermore, the health departments recognised that if the basis of local authority planning for capital expenditure could be converted from the existing short-term system into a longer term planning framework, then, in line with the timescale adopted for the Hospital Plan, this would make it difficult for the Treasury to resist longer term expansion of community care. Thus, in 1961 the health departments presented plans for local authority expenditure up to 1966 (Ibid.).

Enoch Powell, as Minister of Health, similarly recognised the need for integrated planning of community care and hospital services. At one level, such arguments were attractive if only for economic reasons, in that they held out hope of preventing further escalation of costs within the hospital service. Powell subsequently called for a radical re-think about the role of mental hospitals: *'We have to strive to alter our whole mentality about hospitals, and about mental hospitals especially. Hospital building is not like pyramid building, the erection of memorials to endure for remote posterity....'* (cited in Webster 1996, p124). To facilitate the shift in emphasis away from institutional care, Powell called for a 50% or greater reduction in beds in mental hospitals. Such a process would need to take into account the required future expansion of local authority services to the old, sick, mentally ill and mentally subnormal and be considered in the context of joint planning arrangements between hospitals and local authorities (Ibid).

The tight timetable for the 1961 Hospital Plan, however, was an obstacle to the development of community care, in that it precluded meaningful discussions between hospital authorities and local authorities about the integration of their services. Thus, the Hospital White Paper signalled the importance of community care in that it pointed out that local authorities and executive councils (at that time responsible for the administration of primary health care services) would be required to prepare long term plans for services. The White Paper, however, operated as a 'signpost' to local authorities, rather than a prescriptive 'map' for the implementation of services (Ibid., p125). More prescriptive guidance for local authorities, in terms of their long term planning requirements, followed a year later in January 1962 with the

publication of the community care White Paper delayed until April 1963 (Ministry of Health 1963).

The 1963 Community Care White Paper envisaged Local Authority Health and Welfare spending as £31m, but Powell in 1962, despite earlier commitments to community care, restrained local authority health and welfare capital spending for 1963/64 to the 1962/63 level of £21.5m (Webster, 1996, p126). The emergent policy on community care in the 1950s and 1960s was one which was influenced by the desire to contain expenditure on hospitals. At the same time it was characterised by a laissez faire approach at the centre e.g. encouragement and exhortation to develop alternative forms of provision in the community. Thus the commitment to community care was not matched by powers to transfer resources from health to local authorities which might have made savings possible and led to the development of a viable community care policy.

Community Care Policy in the 1970s: More of the Same?

In the 1970s and early 1980s, the development of policy on community care was continued via White Papers (there were three setting out policies for priority groups: *Better Services for the Mentally Handicapped* (1971), *Better Services for the Mentally Ill* (1975) and *Growing Older* (1981). In addition, the Chronically Sick and Disabled Persons Act 1970 strengthened community care arrangements for physically and sensorily handicapped people. A further development in the 1970s came by way of a formal mechanism to encourage community care - joint planning and joint financial arrangements.

'Better Services for the Mentally Handicapped' outlined principles to underpin community care services for this group and provided guidance to local authorities and health authorities on the lines on which Government wished their services to develop. In the White Paper, the Government identified '*...a serious shortage of adult training centres, gross shortage of residential accommodation, and great need for more trained staff*' (Audit Commission 1986, Table A-1). In part it acknowledged the disappointing progress by local authorities in the provision of community services for mentally handicapped people. By 1974, it became clear that implementation of the 1971 White Paper was failing. As a result, Barbara Castle, as Secretary of State for Health and Social Security, introduced three initiatives: the establishment of the National Development Group for mentally handicapped people; the establishment of a Committee of Enquiry into mental handicap nursing and care, and a proposal to establish a National Development Team to offer advice and assistance to health and local authorities in the planning and operation of services to mentally handicapped people. The National Development Team proposed the introduction of community mental handicap teams, community units and a more prescriptive role for residual hospital facilities. Later the Jay Committee made recommendations in respect of staff and training arrangements together with proposals for a model of care based on small units of accommodation (Audit Commission 1986, p87).

The 1975 White Paper *'Better Services for the Mentally Ill'* similarly proposed a new model for service provision for the mental health field and set out four broad policy objectives: i) the expansion of local authority personal social services to provide residential, domiciliary, day care and social work support, ii) the relocation of specialist services in local settings, iii) the

establishment of appropriate organisational links and iv) associated improvements in staffing. At the centre of the new model of services, to a district, was the psychiatric unit, normally based at the district general hospital. An important aspect of the psychiatric unit was the development of day care activities. In practice, in addition to working at district general hospitals, psychiatrists and other health care staff were to become increasingly involved with primary health care teams working in the patient's home setting or health centres. Thus, as part of the Government's response to the Select Committee's report, it was acknowledged that day care provision was in many cases better sited away from the District General Hospital, in a location more central and accessible to the community.

In the area of services for older people, the White Paper: '*Growing Older*' (1981) gave little lead in terms of future developments in services for this client group. Instead, the objectives for health authorities and local government were more comprehensively set out in a handbook: '*Care in Action*' (1981), in which the Government outlined policies and priorities for health and personal social services, in England, for all the main client groups. Specific objectives, relating to older people included: strengthening the primary and community care services; encouraging an active 'preventative' approach via treatment and rehabilitation; maintaining capacity in the acute sector; and maintaining adequate provision for the minority of elderly people needing long-term hospital or residential care.

Central to the priorities documents of the mid 1970s was the need to adjust the balance of care to enable groups requiring continuing care to live within the community, wherever possible (Hunter and Wistow 1987, p86). Such a policy was premised on the assumption that

community care would both produce an enhanced quality of life for the priority groups and be cheaper for the public sector. Indeed, arguments for community care on both 'humanitarian and economic' grounds had been made as early as 1956 in the Guillebaud Report (Ministry of Health 1956, para 647). However, as resource constraints became tighter in the mid 1970s, a somewhat different balance between Guillebaud's 'humanitarian and economic' factors was being sought. Thus, in the 1976 consultative document: *'Priorities for the Health and Personal Social Services'* (DHSS 1976b), community care took its place alongside the pursuit of other 'low cost' alternatives such as reducing average lengths of hospital stay. Nevertheless, evidence that community care is cheaper was not 'clear cut', as revealed by a DHSS study in 1981: *'...for some people community-based packages of care may not always be a less expensive or more effective alternative to residential or hospital provision, particularly for those living alone'* (DHSS 1981d, para 3.27). Equally embarrassing, for the DHSS, was the finding by the study that : *'...the cost effectiveness of these packages often depends on not putting a financial value on the contribution of informal carers'* (Ibid, para 1.6).

In addition to problems in demonstrating cost effectiveness were problems in what precisely the policy of 'community care' meant. In this respect, it appeared to have different implications for the overall balance of services depending on whether it was viewed from a perspective located in the NHS or in the personal social services. In the former, it had traditionally meant shifting the centre of gravity from hospital to predominantly local authority residential services; in the latter it had been increasingly associated with shifting the centre of gravity from residential to domiciliary and day care (Webb and Wistow 1982). In addition to different professional perspectives, there have also been differences in emphasis that have changed over time. In

particular, the emphasis on care *in* the community as an alternative to hospital care had, by the 1980s, been overlain by a greater emphasis on care *by* the community

'...the primary sources of support and care for elderly people are informal and voluntary.It is the role of public authorities to sustain and, where necessary, develop - but never to displace - such support and care. Care in the Community must increasingly mean care by the community.' (DHSS, 1981b, My emphasis).

Since the early 1980s, and parallel to changes in policy emphasis relating to community based services, there have been changes in policies affecting long-stay hospitals. Whilst the emphasis in the second half of the 1970s was on preventing admission of new mentally handicapped or mentally ill long-stay patients, the emphasis later switched to the transfer of patients from long-stay hospitals to the community. Such a change in emphasis came as a result of a disappointing reduction in hospital places under the 'Care in the Community' initiative (DHSS 1981a; DHSS 1983) and was developed in order to facilitate early rundown and closure of mental health institutions. Such an approach, however, was sternly criticised by the House of Commons Social Services Committee (1985) which stated: *'...the almost obsessive concentration in public policy on getting people out of hospital has sometimes obscured the basic fact that most mentally ill or handicapped people already live in the community...'* Overall, whilst some commentators, such as Klein (1983), point to partial success in switching priorities from the acute to the community sector, the general view is that the shift has either been marginal or has not occurred at all (Hunter and Wistow 1987, p90).

Community Care: a Change in Policy?

The 1986 Audit Commission report: *'Making a Reality of Community Care'* provides an insightful analysis of the reasons for the failure to implement community care policies in the preceding decades. In particular, the Commission cites the slow progress in the build up of community-based services to match the run-down of long-stay NHS institutions as being a key factor: *'In relation to mentally ill people, there are over 25,000 fewer hospital beds than there were ten years ago, but community facilities have not kept pace with only an additional 9,000 day care places for example'* (Audit Commission 1986, p2). In relation to the distribution of community based provision, the Commission observed that a very uneven pattern of local authority services had developed, and that prospects for making a significant shift from institutional to community based provision were unattractive in that over 300,000 people were still in residential settings (Ibid.). A particular disincentive to making this shift, according to the Commission, was the growth in private residential homes funded largely through (what was then) supplementary benefits - between 1984 and the time of writing the 1986 report, the Commission estimated that the cost of supporting residents through supplementary benefits had risen from £200 million to £500 million (Ibid.). Hence, according to the Commission: *'At best there has been a shift from one form of institutional care to another, paid for in many cases through supplementary benefits, and missing out more flexible community care altogether'* (Ibid.).

However, attempts had been made in the 1970s to overcome problems of lack of collaboration with the introduction of Joint Care Planning and Joint Finance arrangements. In 1976, the

DHSS issued guidance which stated that: '*...effective joint planning is vital to the Government's overall strategy of developing community-based services to the fullest extent practicable so that people are kept out of hospitals and other institutions and supported within the community..*' (DHSS 1976b).

The primary mechanism to carry out this process was an arrangement whereby '*..each authority contributes to all stages of the others' planning*' (ibid). This involved the formation of a range of multi-disciplinary planning teams. At the centre of the arrangements, according to the Audit Commission (1986, para 117), was the joint consultative committee (JCC), made up of members of the health authority and social services committee with representatives from housing, education, family practitioner committees and the voluntary sector. In general the committee was served by an officer group called the Joint Care Planning Team (JCPT), which in turn was served by a network of sub-committees usually concerned with planning services for individual clients groups (Ibid.).

The continued emphasis by the DHSS on the need for joint planning to implement the Care in the Community Strategy (DHSS 1981a, DHSS 1983) was undermined by the decision of the first Thatcher administration to abolish area health authorities (AHAs), the tier of NHS administration coterminous with local social services authorities (DHSS and Welsh Office 1979). Such a proposal, as the DHSS (1981a) ultimately accepted, would make local collaborative planning more difficult to achieve. From 1982, one-to-one co-terminosity, previously the basic building block of the structures introduced eight years previously, no longer existed in most (54%) localities (Hunter and Wistow 1987, p113). At the same time, it

was widely accepted that JCC's and JCPT's had failed to fulfill their aims. Thus, for example, Hunter and Wistow argue that JCC's tended to be 'talking shops' and JCPT's were preoccupied with joint finance and other issues which fell short of strategic client group planning (Hunter and Wistow, 1987, p113). According to the Commission (1986, para 118), problems lay in differences in organisational structure, style and cooperation: *'If one of the agencies involved does not (or cannot) co-operate, at best any subsequent action will be delayed or distorted with key elements missing; at worst there will be no action at all'* (Ibid.). Thus, in 1984 a joint working party, established by the DHSS together with the health and local authority associations, reviewed arrangements for joint planning and joint finance. In its report, 'Progress in Partnership' it was noted, *'...behind the proposal (to establish the review) was a widespread sense of frustration that more had not been achieved through joint planning.'* (DHSS 1985, para 1.2,).

In 1976, the DHSS introduced joint finance as a financial incentive for promoting community care in England. The initiative reflected a keen ministerial commitment to promote collaboration and reduce the scale of long-stay hospital provision (Castle 1975). The resources for joint finance were created through 'top slicing' the NHS budget and were to provide health authorities with earmarked funds to support selected personal social services capital and revenue expenditure. The funds were allocated to regional health authorities, and then to the district health authorities, in accordance with various demographic formulae. The sums involved were relatively small, building up from 1% of NHS and 3% of personal social services planned spending in 1975/6. In allocating these funds the criterion, applied by health authorities, was that their expenditure *'...could be expected to make a better contribution in*

terms of total care than would deployment of equivalent resources directly on health services' (DHSS 1976b). However, such sums could be used to support social services schemes for only limited periods (a maximum of five years, initially) on a tapering basis. Subsequently, this criterion was relaxed to support certain primary and community health services, but on the same 'pump priming' basis as for social service authorities.

Community Care: A Policy that Failed

The development of community care from the late 1950s to the early 1980s was problematic. As Walker suggests, it was a policy where '*...the words succeeded magnificently but the policy failed miserably*' (Walker 1993, p. 205). Among the many reasons which can be argued to account for this failure, three are of major significance. These are: the pursuit of a laissez faire/exhortatory policy by the centre; the attempt to develop policy around an ambiguous concept and a general failure of collaboration.

These features can be illustrated by looking at the Priorities documents of 1976 and 1977. Following the consultation period on the 1976 priorities document, revised guidance was issued in 1977 (DHSS, 1977), which attempted to respond to the main criticisms of the earlier document. Sharp differences emerged in the approach and style of the two priorities documents. In particular, the specificity of the 1976 document with regard to service norms and targets gave way in the 1977 document to a less prescriptive, more flexible approach. Thus, whilst the 1976 document conceded that the adoption of national norms would not proceed uninfluenced by local factors, the 1977 guidance went further and made it clear that the expenditure objectives '*...were not specific targets to be reached by declared days in any*

locality.' (DHSS, 1977). Such a 'laissez-faire' approach in the 1977 guidance on priorities and plans was repeated in the DHSS's 1981 handbook of policies and priorities (DHSS 1981a). Hunter and Wistow (1987, p74) have argued that the 1981 document reflected a move away from 'dirigiste' planning towards an exhortatory approach. However, as the argument developed above indicates, with respect to community care, a reliance on exhortation was already well established, particularly because more imperative approaches would bring demands for increased provision of resources.

In addition to the adoption by Government of a 'laissez-faire' approach, there was little agreement on the concept of community care and hence the fact that it could be pursued for different reasons. In this respect, community care could be pursued, as has been argued above, for reasons of perceived cheapness or for exercise of client choice. In addition, and prominent within policy documents from the late 1950's and 60's, there is a strong and evolving commitment to de-institutionalisation and a sense that alternative community provision is preferred over the Victorian legacy of, in particular, mental health institutions. However, as has also been noted, a commitment to community alternatives can also be perceived as a reduction on statutory support to informal carers. Thus the different perspectives on community care have led to different approaches in the field of policy and in this respect have undermined the ability to reach agreement on the emphasis and direction of implementation. As Hunter and Wistow have suggested '*community care can mean anything and nothing...*' (Hunter and Wistow, 1987 p. 90).

As well as problems with the concept of community care, further difficulties arose in collaboration between authorities. In this respect, Wistow outlines a number of key characteristics that contributed to the problems experienced in joint planning. These included: an over-emphasis on 'structure' at the expense of 'process' or 'outcomes'; insufficient awareness training to foster the acquisition of 'political' skills (e.g. bargaining and negotiation) needed to sustain cross boundary processes of planning and development; emphasis on intermediate outputs rather than need or user outcomes; and an over emphasis on marginal planning activity, partly as a consequence of joint finance. Further problems, according to Wistow, stemmed from a lack of accountability, of health and local authorities to the centre, for progress in joint planning. Under such circumstances the ability to share good practice or learn from mistakes was reduced. Such a situation tended towards the promotion of unilateralist/separatist planning and development activities.

In addition to these difficulties, joint finance was in itself problematic. In particular, the allocation rules for joint finance were slackened with the result, in some localities, that instead of pump priming local authority services, substantial sums of money had been devoted to health services. Similarly, the care in the community arrangements failed to take adequate account of the need for 'bridging funds' (Wistow 1987). Overall, financial constraints affected the level of collaborative planning that could be achieved. Thus, a lack of congruence between resource and service objectives impeded the effective vertical and horizontal relationships necessary to achieve successful collaboration (Ibid.). This in turn impacted on the ability to implement effective community care policy.

By the time of the second Thatcher administration (1983-1987), the agenda in community care policy was changing and the basis was laid for a much more pro-active policy. In the light of the arguments presented in this chapter this might appear paradoxical. A continual feature of complaints by advocates of the policy across different ideological positions was that government was never willing to adequately resource the policy. The Thatcher administrations were, however, strongly identified with an economic liberalism which sought to exert rigorous controls on public expenditure. There are, arguably, two basic reasons why a pro-active community care policy could go along with such an ideological position: the first was that community care was seen as a cheaper alternative to the growth of residential care funded via social security; the second, and related feature was that this perception of the cost-effectiveness of community care was crucially shaped by the growing importance of public sector managerialism and, in particular, the work of the Audit Commission.

This change in the agenda of the second Thatcher administration led, in turn, to the reforms of community care in the third Thatcher administration, which involved the introduction of quasi-market mechanisms. The combination of managerialism and markets was of central importance because it suggested that the key to community care policy was not the supply of resources but rather how they were used. Chapter 2 discusses the basis for this commitment to managerialism and quasi-markets and forms the foundation for the discussion of the specific role of the Audit Commission which is pursued in Chapters 3 and 4.

CHAPTER 2 MANAGERIALISM AND MARKETS

It is a central part of the argument of the thesis that community care policy in the 1980s and 90s has been characterised by the importance attributed to the linked phenomena of managerialism on one hand and quasi-markets on the other. The role of managerialism in setting the agenda for *community care* in this period is explored in detail in Chapter 3 which discusses the role of the Audit Commission and this work is critically analysed in Chapter 4. Without pre-empting discussion of this part of the argument, an example of the importance of managerialist approaches is shown by the fact that a central element in Audit Commission arguments in texts like '*Making a Reality of Community Care*' (Audit Commission, 1986) was that limited public sector resources were being mis-used by inappropriate placements of less dependent elderly people in residential accommodation. Consequently, the Audit Commission was questioning how far public expenditure was being effectively managed to deliver services to elderly people.

In terms of the development of markets, '*Making a Reality of Community Care*' was an important influence on the Griffiths report (Griffiths, 1988, piii) and the latter, in turn, argued that community care policy would be facilitated by introducing a 'quasi-market' in community care, with the role of local authorities being primarily as 'enablers' i.e. assessing needs and purchasing services, rather than providing them. Given the importance of both 'managerialism' and 'quasi-markets' in community care policy in the 1980s and 90s, the role of this chapter is to explore the debate around these two linked concepts.

MANAGERIALISM

Managerialism presupposes that there is scope for productivity/efficiency improvements. This is made clear in an analysis by Pollitt of the specific beliefs routinely found in managerialist analyses. Pollitt argues that they assume that *'The main route to social progress now lies through the achievement of continuing increases in economically defined productivity.'* (Pollitt, 1993 p.2). In such productivity/efficiency improvements, management has a key role: *"Management" is a separate and distinct organisational function and one that plays the crucial role in planning, implementing and measuring the necessary improvements in productivity'* (ibid.) Taken together, Pollitt considers these beliefs envisage sometimes an almost 'apocalyptic' role for management (Ibid., p3).

As these claims are pitched at a high level of generality, it follows that there is no necessary limit to the scope for the application of management, i.e. it can be applied across public and private sectors and is thus not dependent, for example, on the organisation concerned being profit-making. Such a claim is clear in a speech by Heseltine, made in 1980 when he was Secretary of State for the Environment: *'Efficient management is a key to the [national] revival.... And the management ethos must run right through our national life - private and public companies, civil service, nationalised industries, Local Government, the National Health Service'* (cited in Pollitt, 1993, p3). This brings out an important characteristic of managerialism: that it is not seen as bounded by particular spheres of application, but capable of universal application.

Public sector managerialism

Public sector managerialism is, thus, a variant of managerialism per se, but it is distinctive in that it involves bringing a managerialist approach to areas where it had been developed to only a relatively limited degree, if at all. Thus, public sector managerialism involved introducing a process of change into the public sector which meant redefining problems and occupational identities. This also involved a process of attacking current practices on grounds that existing institutions e.g. public bureaucracies were obstacles to efficiency improvements. Such a position is exemplified in the civil service 'Next Steps' reforms which advocated the break-up of the civil service into separate devolved units or agencies. Each was to be accountable for their performance to the relevant ministries. This was justified in part on the grounds that: *'While the introduction of management systems has helped make civil servants cost conscious, there is less consciousness about results.....[many people] felt that the emphasis was on inputs, not outputs or value for money.'* (Jenkins et al. 1988). Further grounds for attacking existing practices stemmed from a view of public sector professionals, that suggested they did not critically examine their practices, but simply defended their own territory. Such an anti-professional view was, for example, expressed in the mid-1980s Jarratt report on the universities which argued that they: *'.....include large and powerful academic departments together with individual academics who sometimes see their academic discipline as more important than the long-term benefit of the university which houses them'* (Committee of Vice Chancellors and Principals, 1985, p22).

A common theme running through arguments of this kind is that managerialism is a means of resolving what are seen as the problematic practices of public sector bureaucrats and

professionals. Thus whereas traditional administrative or professional practice is seen as self-serving and uncritical, managers work in structures where they are called to account for performance. However, it is also important to stress that managerialism comes in a number of variants.

Variants of Managerialism

So far the argument has discussed managerialism as a unity, but it is important to stress that, within any such broad framework there are important variants and the social science literature on public sector managerialism has attempted to characterise these variants.

Pollitt, for example, has argued that the form of managerialism initially introduced in Britain and the USA, under the Thatcher and Reagan governments, was what he calls 'neo-Taylorian' in character. The 'Taylorian' aspect derives from the idea that such public sector applications had affinities with Frederick Taylor's ideas of 'scientific management'. In this respect Pollitt stresses Taylor's stress on determining effort levels: Taylorism was centrally concerned with *'the processes of determining and fixing effort levels and can be seen as the bureaucratisation of the structure of control but not the employment relationship'* (Littler cited in Pollitt 1993, p16). Thus, for example, public sector performance targets can be seen as, in some respects, analogous to expected output levels in work study. Equally, the attempt to achieve cost reductions has been associated with policies of contracting out and competitive tendering. However there are also differences, thus the 'neo' part of the definition relates to the fact that Taylor had initially applied such ideas to manual workers in setting productivity norms. In contrast the predominant forms

of application in the public sector are to non-manual or, in some cases, professional jobs. The measurement of performance in the public sector, however, is not a new concept. For example, the Guillebaud Committee published a 'performance league table' comparing health authorities in terms of indicators such as length of patient stay and bed turnover (Klein 1982, p389). Nevertheless, such instances of performance measurement were isolated and it wasn't until the 1980s that they became widespread in the public sector as a means of generating norms that could lead to comparisons of performance (Cutler and Waine, 1994, ch 2).

The use of such quantitative norms for evaluating public sector performance has been central to the work of the Audit Commission and is integral to value for money (VFM) audit. The role of VFM in community care policy is discussed, at a macro level in chapters 3 and 4 and, at a micro level in chapter 10. Such practices have strong neo-Taylorian features, since they tend to operate in a 'top-down' fashion and have a disciplinary effect on the public sector workforce (administrative and professional), which is held to account via a series of performance norms. However, both managerialism in general, and public sector managerialism in particular, have taken quite different forms.

Arguably the most significant are forms which Pollitt has termed cultural analysis and Wood 'new wave management'. A central difference between this form and 'Taylorism' is the emphasis on shaping an 'organisational culture' rather than putting primary emphasis on quantitative targets of performance. A central text in this approach was that of Peters and Waterman (1982) 'In Search of Excellence'. This represents a different approach in that (i) it is

hostile to the use of quantitative targets e.g. they argue from their analysis of comparative private sector corporate performance that '*..the companies that seemed the most focused - those with most quantified statements of mission, with the most precise financial targets had done less well financially than those with broader, less precise, more qualitative statements of corporate purpose*' (Peters and Waterman 1982, p281). This is consistent with other key injunctions in the text, where they stress eight features of 'excellent' organisations, amongst which is the idea of 'tight-loose' organisation i.e. where staff are expected to conform to corporate values but are otherwise given considerable autonomy (in contrast to tight 'neo-Taylorian' controls). There is also an emphasis on empowerment which is not present in the neo-Taylorian variant, thus another of the Peters and Waterman principles is '*productivity through people*' and '*excellent companies treat their rank and file as the root source of quality and productivity gains*' (Peters and Waterman 1982, p14). Finally, and of very considerable importance with respect to public sector managerialism is the emphasis on customers. Thus another of the eight principles is to be 'close to the customer' and the successful business is seen as discovering and satisfying customer needs (Ibid.).

However, while 'new wave management' is distinct from the neo-Taylorian variant, it still can be seen as a form of managerialism. Thus it shares the emphasis on the significance of the manager. For example, notwithstanding the claims on 'empowerment', Carroll (1983), in a review of 'In Search of Excellence', points to the extent to which Peters and Waterman rely on statements by senior corporate executives to characterise the organisational culture of the companies being studied. The senior manager is thus seen as having a privileged understanding of this culture and shaping it. Where this approach differs is in respect to the approach which

managers are supposed to take. Furthermore, Peters and Waterman retain quite orthodox measures of corporate financial performance as indicators of success, thus 'excellent' companies are expected (by virtue of their organisational qualities) to perform well financially, in relation to six measures of financial performance (these are outlined in Peters and Waterman, 1982, p 22-3). Equally, features like 'tight-loose' organisation do involve a commitment to the corporate culture, thus it is not a culture which, in this sense, is genuinely pluralist. This is, of course, consistent with the key role of the manager discussed above.

The fact that managerialism takes variant forms is important in relation to its acceptability, thus while neo-Taylorian forms could be seen as closely identified with cost control objectives of the Conservative governments of particularly the 80s, this can be seen as less the case with new wave/cultural forms. Making the distinction between these two variants, Pollitt suggests:

'Cultural approaches are generally more tender to the interests of the employees/providers than neo-Taylorism, presumably because the basic commitment to such an approach involves acceptance of the importance of subjective perceptions and beliefs, whether economically 'rational' or not' (Pollitt 1993, p172).

While this might take claims to emphasise empowerment too uncritically, it suggests that there is the possibility of creating bi-partisan support. These issues will be explored below, but it is now necessary to turn to the second key feature of change in the public sector: quasi-markets.

QUASI-MARKETS

Quasi-markets have been a key feature of the reforms of the British welfare state in the late 1980s and early 1990s. In addition to the community care reforms, they have figured in changes in primary, secondary and higher education (e.g. via the Education Reform Act 1988) and health (NHS and Community Care Act 1990). As Le Grand points out, quasi-markets are markets, since they involve competition between providers in place of monopoly provision (Le Grand 1990, p5), but are 'quasi' markets for the following reasons: the majority of the suppliers will be non-profit organisations (e.g. NHS Trusts, Universities, Schools); on the demand side, services are not paid for directly by the consumer, but derived from a public sector budget and, with the exception of secondary and higher education, purchasing decisions are made purely by proxies e.g. GP fundholders, health authorities, care managers (ibid.). They are also managed markets, in the sense that the public authority has imperative powers which can be exercised to achieve its goals, often resulting in the short-circuiting of market mechanisms. Thus, while quasi-markets do involve the importation of private sector features, the retention of public funding goes hand in hand with a crucial role for regulation (Cutler and Waine 1994, Ch. 3). Problems of the tension between regulation and market pressures relate to the fact that: *'...markets exist within a political environment. If the market fails to find solutions acceptable to the dominant interest groups, political pressure for change is brought to bear and governments frequently act'* (Hughes 1993, p108).

As Le Grand (1990, p2) points out, the key shift involved in quasi-markets is the separation of financing from provision, thus while the services remained publicly financed, this does not mean

that the funds are allocated via direct funding. On the contrary the mechanism for funding in social care is via a third party agent. In this respect, Le Grand (Ibid., p5) indicates that: '*...the immediate consumer may not be the one who exercises the choices concerning purchasing decisions; instead, these may be delegated to a third party, such as a care manager*'.

Quasi-markets have been justified in a number of ways, but of particular salience have been: efficiency and cost control objectives, thus competition is assumed to force providers to exert greater control over costs; choice, thus competition is seen as forcing providers to provide variety in services to meet the needs of purchasers; quality, thus competition is expected to force providers to enhance the standard of their service. (for a review of such objectives in the field of health see Robinson and Le Grand 1994).

The combination of an emphasis on cost control, but also choice and quality objectives, means that quasi-markets have the potential for bi-partisan support. Thus, though they were introduced by Conservative governments in the 1980s/1990s, they were also supported by centre and left figures on the grounds that they enhanced choice and accountability. In this respect, Le Grand (1990, p5) argues '*...an important aspect of the quasi market phenomenon is that proposals of this kind are not confined to the Conservative end of the political spectrum*'. By way of examples, Le Grand cites proposals, from the left, for voucher schemes for GPs and education for under-fives published in the centre-left publication 'Samizdat' (Le Grand, 1990, p6). Thus, aspects of accountability and choice, operating in Le Grand's examples through the agency of voucher schemes, indicate a degree in convergence of ideas around quasi markets that links both right and centre left.

THE RELATIONSHIP BETWEEN MANAGERIALISM AND QUASI-MARKETS

Managerialism and quasi-markets are analytically distinct and in the British context the former preceded the latter. Important manifestations of the spread of managerialism in the UK public sector were the spread of performance measurement in the public sector (Cutler and Waine, 1994, ch 2); the creation of the Audit Commission under the terms of the 1982 Local Government Finance Act; and the introduction of general management into the National Health Service following the 1983 Griffiths report (Griffiths 1983). In contrast to such developments in the early and mid 1980s, quasi-markets came into operation in the late 1980s and early 1990s. However, there are important inter-relationships between them.

In this respect, there is a necessary interaction in their assumed operations, thus, while the market is designed to operate as a 'discipline' and a means of allocating resources to the 'successful' providers, the whole mechanism assumes the efficacy of managerialism. Thus, it is presupposed that there is the possibility of more successful provision, in terms of improved efficiency, choice and quality and this stems from the idea that management can achieve significant improvements in organisational performance. For example, the way in which managerialism, as a mechanism for cost control, is linked to quasi-markets is made clear in Griffiths:

'...the responsibility of the social service authorities is to ensure thatservices are provided within the appropriate budgets by the public or private sector according to where they can be provided most economically and efficiently. The onus in all cases should be on the social services authorities to show that the private sector is being fully stimulated and encouraged

and that competitive tenders or other means of testing the market, are taken' (Griffiths, 1988, pvii) .

In terms of the public sector, both the concepts of managerialism and quasi-markets operate on the necessary assumption that the past 'classic' welfare state was a failure. In relation to 'managerialism', failure is linked to the stagnation of bureaucracy. According to Maile:

'Change is used [in local government] to invite officers to recreate work identities and to move away from the negative images that have been directed at bureaucrats. In turn, anyone resisting such a 'calling' is implied to have a traditional or subservient mentality, or to be unwilling to meet the exciting changes offered by shifts in local authority administration' (Maile cited in Clarke and Newman, 1997, p53).

In relation to 'quasi-markets', failure is linked to the monopoly state provision. Pollitt develops this point by reference to the assumed ideal of 'perfect' competition: *'For conventional markets to operate efficiently, perfect competition requires that there should be neither a monopoly (one or few suppliers) nor a monopsony (one or few purchasers) situation'* (Hoyes and Le Grand, 1991, p6). The importance of the avoidance of monopoly in provision, is also made clear in Griffiths: *'It is vital that social services authorities should see themselves as the arrangers and purchasers of care services - not as monopolistic providers'* (Griffiths, 1988, para 3.4).

Finally, as was indicated, there is the possibility of bi-partisan support for both managerialism and quasi-markets in that, for example, both can be justified not just on cost control but on choice and quality grounds:

The Critical Discussion of Managerialism and Quasi-Markets

It is intended in this final section of the chapter to link a critical discussion of managerialism and quasi-markets with the argument in subsequent chapters of the thesis. The first key point, which emerges from the social scientific discussion, is that managerialism comes with its own set of assumptions and, in particular, in its public sector managerialist form, this involves seeking to displace 'classic' welfare state forms of practice. What this means is that there is a strong impetus both to represent current (non-managerialist) practice as unsatisfactory and, arguably, to present the managerialist alternative in a highly favourable light. The discussion in chapters 3 and 4 seeks to illustrate an example of this problem with managerialism in our chosen sphere of community care, by examining both the way in which two Audit Commission reports made an important contribution to setting the agenda for the community care reforms and the weaknesses of these reports in terms of the evidence they present for, in particular, the likely costs of community care.

A second problem, which is an important focus, is that both managerialism and quasi-markets are often justified in relation to meeting the needs of the consumer and increasing choice. Furthermore these two features are frequently conflated so that, for example, increasing choice and meeting user needs is seen as the same thing. However, this fails to take into account the different dimensions of service provision: some of which may involve an important role for

choice; others may not. This relates to a feature of both managerialism and quasi-markets outlined above, namely their abstraction. Thus, in the case of the former, the chosen managerial approach (whether neo-Taylorian or cultural/new wave) is seen as applicable across organisations and sectors and in the latter, competition is seen as playing a similarly beneficial role. However, it can be argued that such approaches fail to grasp the specificity of service and sector. In Chapter 5, the theoretical problems relating to issues of choice are addressed and this is then related to the empirical research on domiciliary care services in chapters 8 and 9. In both cases, the argument suggests that both managerialist and pro-quasi-market arguments suffer from the effects of simplistic abstractions.

As Pollitt argues, neo-Taylorian approaches involve an emphasis on quantifying norms for work performance and this has been particularly salient in the key strand of public sector managerialism embodied in performance measurement. It has also involved the phenomenon of value for money audit (McSweeney, 1988), where auditing is extended to provide a set of judgements on service performance. However, just as the implication of managerialism in the management of change, seeking to shift perceptions and occupational identities, can be argued to lead to distorted accounts, so the search for norms can have similar effects. This is illustrated in Chapter 10 of the thesis, which involves a critical discussion of a value for money audit carried out in the case study borough. The object of this chapter will be to explore the potential for arbitrary norms in such forms of audit.

The introduction of quasi-markets has (see above) worked on the assumption that monopoly state provision inevitably involves higher costs as a function of the lack of market disciplines.

Commentators on quasi-markets have, however, raised doubts regarding the link between quasi-markets and cost control. Le Grand cites three reasons why such links are problematic.

'First, there are costs involved in setting up the infrastructure for markets to operate efficiently. ...Second, competing institutions will use resources for advertising and other ways of trying to increase their market share. ...Third, the switch from monopolistic providers to competitive ones may bring about a rise in labour and other input costs' (Le Grand 1990, p10).

The recent situation of the NHS illustrates these points. Thus, the creation of an internal market within the NHS increases infrastructure costs in the setting up of independent Trusts. In turn, such Trusts are in competition with each other to capture a share of the market, resulting in higher expenditure commitments on marketing. Also, by virtue of their independent status, each Trust, through their ability to determine pay and conditions for their staff, arguably reduces the former ability of the NHS, as a monopoly employer, to control and hold pay down (Ibid.).

In chapter 10, a further potential for higher costs is examined, namely, the terms under which purchasers and providers contract. Thus, using cost data derived from the value for money study in the case study borough, it is shown that, while terms and conditions of employment in the in-house provider were substantially better than in external contractors, costs per case were higher in the latter, because spot purchases and the practices of the provider reduced productivity.

The above chapter has therefore sought to examine the parameters of managerialism and quasi-markets - two phenomena which have been of central importance in the community care reforms - and suggest some of the reasons for doubts on the efficacy of both. This argument is now developed by examining the role of managerialism in influencing the community care reforms. This is pursued via a discussion of the role of the Audit Commission in the genesis of these reforms.

CHAPTER 3 THE CONCEPTS BEHIND COMMUNITY CARE: THE KEY AUDIT COMMISSION REPORTS

The Audit Commission was created under the Local Government Finance Act 1982 and came into operation in 1983. An important feature of its work has been the regular publication of reports which seek to both evaluate and influence the organisation of public sector service provision. A characteristic feature of such work has been the use of comparative studies. Where local authorities are concerned this has meant that studies of particular services have been across a range of authorities. These are then used as the empirical basis for drawing prescriptive policy conclusions and these have often been accompanied by presentation of comparative data in 'league table' form. This aspect of the Commission's work has affinities with management accounting, in that it seeks to underpin organisational norms with quantitative comparisons. For example, cost comparisons can be used to suggest that a given service can be delivered at a particular unit cost, thus what one authority has achieved is now used as a standard for others. However, as a managerial body, the Audit Commission has always given prominence to prescriptive advice, thus it assumed that the achievement of the normative standard is related to various features which some organisations do better than others. This aspect of the Commission's work is closer to management consultancy.

In relation to community care both these aspects are illustrated in two reports which are analysed in this and the subsequent chapter. One of these reports is well known and has a justified (see below) status as one of the 'founding documents' of community care policy in the 1980s and 90s: *Making a Reality of Community Care* (Audit Commission, 1986). The focus of this document is predominantly prescriptive. As the title suggests, the aim is to outline

the organisational changes which are in the Commission's view necessary to effect a policy of community care. In presenting evidence for the apparent superiority of community care, the Audit Commission usually assumes the validity of the latter. This is why it is important to examine an earlier report: *'Managing Social Services for the Elderly More Effectively'* (Audit Commission, 1985), since this less celebrated report often provides the empirical underpinning, which allows for the assumed superiority of community care, which is evident in the later document.

Having outlined the claims of these two documents, their relationship to the report on community care policy by Sir Roy Griffiths ('Community Care: Agenda for Action' 1988), which was crucial to the policy proposals contained in the 1989 White Paper: 'Caring for People', is analysed.

'MANAGING SOCIAL SERVICES FOR THE ELDERLY MORE EFFECTIVELY.'

The 1985 Audit Commission Report: 'Managing Social Services for the Elderly More Efficiently' summarises the findings of a two year study of local authority services for the elderly. Its appearance comes after a number of previous reports (viz. 'vehicle fleet management', 'council house management' and 'non-teaching costs in secondary schools'), in areas which were designed to show local authorities how better value for money could be obtained.

'Managing Social Services for the Elderly More Efficiently' asks three questions of local authorities: i) how much residential care and community services should be provided locally, in view of the likely demographic changes, and the expansion of private services? ii) are clients receiving the most appropriate care, in particular, are clients in residential care when it would be 'better' and cheaper to have them supported in the community? and iii) are existing services being managed as economically, efficiently, and effectively and as possible? (Audit Commission 1985, Foreword)

The 1985 report claims not to be prescriptive with respect to the overall level of provision and use of services in any particular local authority (Ibid., Appendix C). Nevertheless, the 'centralist' role of the Audit Commission makes it hard to interpret the report as anything less than directive, especially in its suggestion that Directors be asked to explain to their social service committees why particular standards of management practice, for individual authorities, differ from a nationally constructed 'norm'. (Ibid., para. 101.)

However, before identifying particular managerialist strands, it is necessary to characterise the Commissions' methodological approach.

Methodological approach

The report brings together and summarises findings from two studies. (Ibid., para. 9.) The first, arranged by the former Audit Inspectorate of the DOE covered two metropolitan boroughs and two inner London Boroughs, resulting in a report entitled '*Social Services: Provision of Care to the Elderly*' (Audit Inspectorate 1983). The second study carried out

on behalf of the Audit Commission, by the same team of management consultants, extended the coverage of the earlier study to include three shire counties. The original two metropolitan boroughs and two inner London Boroughs were selected to cover different approaches to care for elderly people and different expenditures on the various types of service. The additional three shire counties were selected to include both 'high' and 'low' spenders on community care, as well as authorities making extensive use of potential alternatives to residential accommodation.

Before carrying out visits to the seven authorities, national data was reviewed to:

'...determine the extent to which factors outside the control of social services departments might affect the level of services provided' (Audit Commission 1985, para. 12).

According to Appendix C of the 1985 report, a range of methodologies is employed in relation to national data, in order to find a basis for adjusting local data collected from the sample authorities. These included: i. adjusting local data to allow for variations in unit costs, age structure, and proportion of pensioners living alone, and ii. deriving national average estimates for the sizes of various defined groups of elderly e.g. 'very severe', 'severe', 'moderate' and 'no specific disability' (Ibid., Appendix C. Table C-1/C-2). The source for the data in i. came from CIPFA Personal Social Services Statistics (1982-83 actuals); the data in ii. made use of previous work carried out by a management consultant (Arthur Andersen & Co) using an approach termed the 'Balance of Care' approach (Borley, Taylor and West 1981, p493-499). In addition, data was used from a survey by Hunt (1978) and from information collected by the study team. However, we are told that the 'Balance of care' study and Hunt's study were used in preference to the study team's

survey on the basis that these studies surveyed a much larger group of elderly clients. A further ten authorities were surveyed to supplement the data from the seven authorities studied in detail. (Audit Commission 1985, para. 9.). In addition, data was collected from a questionnaire sent to a further twenty five authorities (Ibid., para.13.), however, it is not always clear in the text, when the wider sample is being used, and whether it refers to the additional ten or twenty five authorities.

According to the report, both the early and later extended study sought:

'...to identify the factors underlying differences in patterns of care provided to elderly people by social services departments in different local authorities and to review the impact these factors have on the costs of care provided and the value for money obtained; they also sought to identify good practice in managing services for the elderly whose adoption by other authorities might improve their value for money.' (Ibid., para. 10.).

In conducting the studies in this way, the Commission made the assumption that the chosen authorities, in particular the sample of seven, were representative of the country at large; that differences in patterns of provision could be adequately standardised for variations in local demography; and that 'good practice', which was seen mainly in terms of areas which they identified as contributing to value for money, had the capacity for transference to other local authorities, in different parts of the country.

Against this background of comparative study methods, utilising both local and the national data, three main initiatives emerge as key strands of the report, which characterise the Audit Commission's approach as 'managerialist'. These are: i. categorisation of need as a means of de-limiting the target group for intervention; ii. a policy of minimising the need for residential care leading to the development of expenditure control through the establishment of norms for community based provision; and iii. the improvement of value for money in existing services.

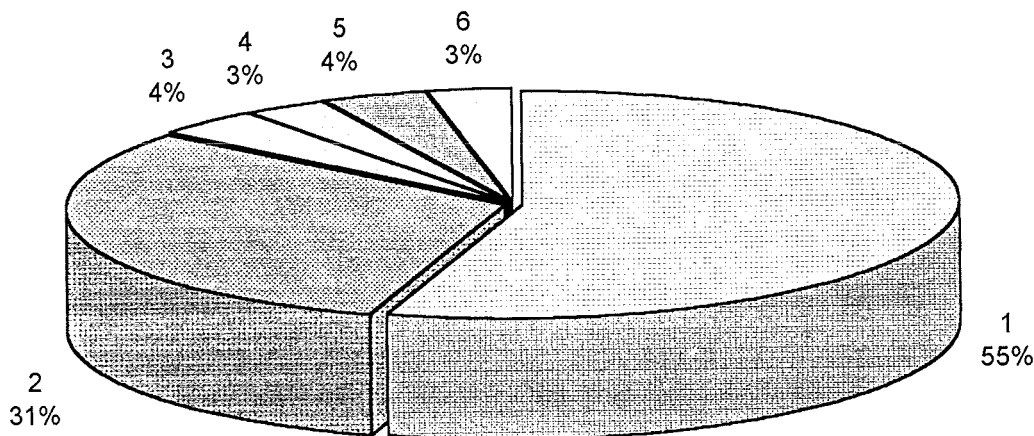
Categorisation of need.

Underlying the 'categorisation of need' approach is a desire to reduce expenditure on services for the elderly. Therefore, in establishing a basis for this approach, the Commission begins by highlighting local authority expenditure on residential care and community support services. This was derived from CIPFA 1982-83 actual net expenditure on the elderly (Audit Commission 1985, p14). See Table 3.1 below:

Table 3.1 Breakdown by Service % Direct Net Costs

100% = over £1 billion

Note 1 = Residential care
2 = Home Help
3 = Day Care
4 = Meals on wheels
5 = Sheltered Housing
6 = Other



Source: Audit Commission 1985, Exhibit 3, p14. Social Services Expenditure on the Elderly - 1983 (CIPFA 1982-83 Actuals)

The cost data, the Commission argued, indicates that 55% of total net social services expenditure on the elderly was on residential care, thereby establishing the latter as the most significant item of expenditure (Audit Commission 1985, para. 21.). With additional reference to 'study team estimates' (1982-3) on '*net estimates for a typical authority*' (Ibid., Table 2, para. 21.), which reported residential LA accommodation as costing 33% higher than an equivalent intensive community care package, the deduction was made, that: '*...the decision on how much residential accommodation to provide is therefore critical.*' (Ibid., para. 22) In contrast to such a confident assertion, however, we are later

told that these figures are 'purely illustrative' (Ibid., para 54) and based on weekly costs for a typical metropolitan district, with an elderly population of 45,000 and a county with 112,000 aged 65 or over. Nevertheless, despite the figures being described as 'purely illustrative'(see also below), the Commission in the same section claims that: '*...they suggest the scale of the resource implications for a typical authority.*' (Ibid.). This raises significant problems over the validity and application of costing methods used by the Commission, which whilst beyond the scope of this section is critically explored in chapter 4.

Having based its argument on the assumed lower costs of community care settings as against residential provision, the Commission proceeds to set out a basis for categorising different levels of need. As a first step in this approach, local authorities were asked to assess the characteristics of the elderly, outside hospitals, who 'really need' residential home places. (Ibid., para. 24.). This group was referred to as the 'core group'. Secondly, authorities were asked to identify the characteristics of the elderly outside hospital who could manage either in residential care or with alternative community support. This group was defined as the 'optional group' (Ibid., para. 24.). Finally, authorities were asked to calculate how many people had the 'core group' or 'optional group' characteristics, at the time of the study, and how these numbers would change over the next five years. From investigating the above three areas, and from an awareness of how many of these people would be cared for in hospitals, and private and voluntary homes, Local Authorities were expected to be able to arrive at the number of residential places which should be provided. (Ibid., para. 24.).

As a means of identifying needs, suggestions were given for categorising people according to three levels of disability, 'very severe', 'severe', and 'moderate' (Ibid., para. 27).

Individual cases were placed, via assessment and categorisation, into one of these three bands of dependency. In relation to the 'very severe' physical disability category, most of the professionals contacted, felt that the majority of this group required 24 hour nursing care and should be looked after in hospital, but that even amongst this group: '*...some could manage in the community with the support of friends or relatives and appropriate community services*' (Ibid., para. 28). The Commission responded to this, however, by querying whether more of this group could be looked after in residential homes with 'appropriate levels of nursing support'; whether those living in the community were receiving an 'adequate level of care'; and whether their relatives were receiving 'proper support' (Ibid.).

In relation to the 'severe' physical disability group, particularly those with little or no support from friends and relatives, the Commission quotes the professional view that '*...many required residential care*' (Ibid., para. 33). As a suggestion for consideration, the Audit Commission asked authorities to ensure that their residential premises were adapted for use by people with severe physical disability by means of: '*...a relatively small extra investment in lifts and bathing facilities etc.*' (Ibid., para. 34). In addition, as with the 'very severe' category above, the Commission suggested the need to ensure that, as an alternative to residential care, for some in this category, an 'adequate' package of community care was provided (Ibid.). The prevalent use of the word 'adequate', in

relation to 'package' or 'level' of community based care, together with its attendant financial implications, is discussed in chapter 4.

In relation to the 'moderate' physical disability category, however, the Commission maintained:

'It was generally agreed by professionals in the authorities studied that nearly all those in this group with support from friends or relatives do not require residential care, community care being cheaper and usually better for the elderly person.' (Ibid., para. 37).

As with the assessment of the other two categories 'very severely disabled' and severely disabled', no specific data is given in support of this assertion other than claims of professionals.

The overall picture, therefore, that is built up from such a limited assessment of categories of need amongst the seven sample authorities, suggests that the Commission sees the greater majority of the 'optional group', who can manage either in a residential home or with alternative community support (Ibid. para. 24), as coming from the 'moderate' category. Yet, the problems of identifying this group are complex, as will be seen from a more detailed discussion of the Audit Commission's approach to categorising need in chapter 4. Despite such complexities, however, the overall significance of the

'categorisation of need' approach can be seen in terms of its potential to **de-limit** a target group for intervention, and thereby **minimise** need for residential care.

Minimising residential care

The policy incentive for minimising places in residential homes is provided by assumptions of higher costs of residential care compared with alternative community provision. It was pointed out earlier that the report presented 'illustrative' cost figures (Ibid., para 54) claiming that residential provision was 33% more expensive than an intensive community care package. The source of these figures is given in Table 3.2 below, with the service provision assumptions of each package given in the footnotes:

Table 3.2 cost per week - net estimates for a typical authority 1982-3

	£
Residential LA accommodation	60
Intensive community care*	45
Limited community care**	15

* 9 home help hours, 5 meals on wheels and 2 day care attendances per week. (Note that more intensive packages could cost as much or more than residential care)

** 4 home help hours, 2 meals-on-wheels per week.

Source: Audit Commission 1985, para. 21, table 2 (study team estimates)

The vulnerability of these assumptions is illustrated in a footnote at the bottom of the table, where the Commission recognises that a more intensive package '*...could cost as much or more than residential care*'. (Ibid. My emphasis) [See chapter 4 for detailed

discussion on this point]. A further source of cost evidence, for the Commission, arises from a particular interpretation of CIPFA statistics: '*...2% of the elderly (those in residential care) account for well over half social services' expenditure on services for the elderly with a further 13% (in receipt of community care) accounting for the balance.*' (Ibid., para. 4.). The latter evidence suggested to the Commission, that since expenditure on community care services was less than expenditure on residential care, for a given proportion of elderly population, then provision of further community care services, as an alternative to residential care, would reduce overall costs. In addition, the Commission further emphasised the need for diversionary community care services by reference to data on demographic trend projections, that indicated potential further resource pressures on residential care budgets from the over 75 and 85 group: '*By 1991 there will be 15% more people aged 75 and older than there were in 1981 and 30% more people aged 85 and over.*' (Ibid., Summary p1.).

The Commission, therefore, expressed concern that, given the '*...very large sums of public money*' (between £1,400 million and £1,700 million p.a. in 1982-83) that were targeted on '*a small minority of the elderly*' (Ibid., para. 5), coupled with the likelihood of further demographic increases in the elderly population, means should be found to reduce the level of overall expenditure on services for this group. Such a view, however, rested on a number of assumptions: i) that alternative community support for people on the threshold of residential admission would be cheaper to provide, ii) that this group could be unproblematically circumscribed iii) that many placements to residential and nursing homes had been made inappropriately and iv) that, for the target group for intervention, an

alternative programme of care services provided in the community, at the level illustrated for an intensive package (Ibid., para. 21, table 2), would be sufficient to meet their needs. (See chapter 4 for a critical investigation of these assumptions). Furthermore, the Commission anticipated that such reductions in expenditure would also enable some social service departments to meet further levels of demand, within existing resources, at the same time as improving the quality of service given to clients (Ibid., summary, p3.). No evidence, however, was provided to support this assumption.

The Commission, persistent in its claim that alternative community provision was cheaper than residential care, sought to identify scope for diversionary capacity, within the area of 'gatekeeping' admissions to residential homes. According to the Commission, too many people with 'optional' characteristics, who could manage with community care (Ibid., para. 24), were inappropriately referred to residential homes. In the Commission's view, such a situation would have serious financial consequences for authorities, since spending on residential homes represented the highest item of expenditure on personal social services. The solution advocated was, therefore, to minimise the need for residential care by providing more 'adequate' support in the community: *'Unless there is adequate support available in the community, the number of elderly people requiring residential accommodation is likely to increase, with serious financial consequences for local authorities'* (Ibid., para. 54).

As a 'proxy' for assessing whether community provision was 'adequate' to prevent unnecessary residential provision, the Commission compared the amount of expenditure

per elderly person on community support services between the seven sample authorities. In assessing levels of expenditure for the sample authorities, the Commission identified two pre-defined dependency groups: high public sector dependency (HPSD) and low public sector dependency (LPSD). HPSD was defined as older people with very severe or severe physical disability, or moderate disability, with little or no support from friends or relatives. LPSD was simply defined as the remaining group. (Ibid., para. 58. table 8).

The Commission estimated that only 9% of the elderly population were in the HPSD group, whilst 91% were in the LPSD group (Ibid). By examining national levels of provision of community support services, the Commission calculated an average level of expenditure, or expenditure norm, which it termed, the 'low reference point'. In relation to the sample authorities, the Commission identified an expenditure level of 25% above the 'low reference point' as separating out between 'high spending' and 'low spending' authorities (Ibid., para. 72). In justification, of selecting the 25% level, above the sample authority low expenditure reference point, the 1985 report simply stated, albeit in parenthesis: *'25% is convenient because it separates out those authorities who are above from those who are below the national average provision'* (Ibid.). What is unclear, however, from the report, is the status of the sample group, other than as case study material, since the 'adjusted' low expenditure reference point, that was used, was derived from the average expenditure, on community support services, of local authorities nationally, rather than from the sample material.

Authorities, in the sample group, with relatively low levels of community care expenditure (those with expenditure below the adjusted low reference point), were consequently urged to take steps to ensure that the levels of community care provision were 'adequate' to support clients who might otherwise be admitted to residential care (Ibid., para. 62). In addition to authorities identified as having relatively low levels of community care expenditure for the HPSD group, were authorities with relatively high levels of expenditure on this group. In the view of the Commission, expenditure in these sample authorities on community support services for the HPSD group, could be separated into two parts: *'...the first is on services which are worthwhile almost irrespective of cost. The second is additional expenditure where the value for money is not so clear, and depends on the local views of what constitutes 'value'* (Ibid., para. 63). There therefore existed, for the Commission, a very delicate balance to be achieved between high or low spending on HPSD services, which highlighted the problem of identifying the 'optional' group and quantifying the degree of expenditure required to 'adequately' support it (see chapter 4), through community alternatives to residential care.

In relation to the national data on expenditure levels for the HPSD and LPSD groups, individual social services departments were encouraged, by the Commission, to calculate their own level of expenditure on community support services to these groups and deduce whether it was above or below the nationally adjusted low reference point:

The framework ...is designed to help members and officers identify the relevant questions to be asked about overall expenditure on community services for the elderly. To provide a

scale, figures which are 25% above the low community expenditure reference point for each group have been used to distinguish 'high' expenditure from 'low' (Ibid., para. 72).

Authorities spending above this norm on the HPSD group were encouraged to focus a reduced amount of community services so that additional support from friends and relatives could be mobilised. Conversely, some authorities, in terms of the Commission's comparative studies had relatively low levels of expenditure on the HPSD group. Such authorities were advised to *'...review what steps are taken to avoid high risk situations occurring in the community and, where appropriate, further develop contacts with other organisations'* (Ibid., para. 62). Overall, the Commission's intention was to minimise entry to residential care by ensuring that expenditure would be targeted on people, in the community, whom the local authority considered were entitled to have a priority call on its resources. In this way, the Commission assumed that overall expenditure on personal care could be reduced and that a target group for intervention in the community could be identified.

In relation to the LPSD group, the Commission reported that much of the expenditure on this group was justified by authorities on the grounds that it added to the quality of the elderly person's life. The report indicated that wide variation on provision for the LPSD group had been found and suggested this placed an onus on authorities to:

'..be clear about their objectives in providing community support services for those elderly people less dependent on the public sector and thus by definition able to look after themselves unaided or with help from friends and/or relatives' (Ibid., para. 70).

The Commission claimed that in many authorities substantial expenditure on community based services is spent on the LPSD group and placed a responsibility on these authorities:

'...to justify that expenditure on this group was preventing or delaying a sufficient number of people from needing more intensive services. (Ibid., para. 70. My emphasis).

The Commission did not, however, provide guidance, in this context, on what might be described as a 'sufficient' number of people.

Improving value for money.

In addition to looking for ways of reducing expenditure, through minimising the need for residential care, the 1985 report explored further opportunities for securing better 'value for money' in existing services, through improvements in operational 'effectiveness'. Such opportunities for improvement, are described by the Commission, as:

'...making better use of available home help hours; using day care more effectively; ensuring meals on wheels meet their real client service objectives; improving co-ordination with housing authorities over sheltered housing; reviewing staffing in residential accommodation, in the light of dependency and occupancy levels' (Ibid., para. 95).

The Commission sets the context for such improvements by describing the level of expenditure and demand for the largest of the community support services: the 'home help' service:

'30% of total social services expenditure on the elderly is on home help and about 65% of the elderly in receipt of social services receive home help. The home help service accounts for about two thirds of social services net expenditure on community services' (Ibid., para. 96).

In relation to home help hours, the Commission reported that *'On average, in the sample authorities, something over 50% of home help hours are provided to members of the high public sector dependency group.'* (Ibid., para. 97). The remaining hours according to the Commission were provided to the LPSD group. For the LPSD group, the Commission recognised the significance of home help in this area: *'For these people, home help will often be the only social service they receive'* (Ibid., para. 97). Of importance to the Commission was the finding that the level of support to the LPSD group varied considerably from one hour per week for some clients to more than 20 hours per week for others (Ibid., para. 97). Equally, in relation to HPSD clients who were receiving more than 6 hours of home help per week, variations in contact hours ranged between 5 hours and 50 hours per week (Ibid., exhibit 11). Of concern to the Audit Commission was that such differences, for both HPSD and LPSD groups, did not appear obviously related to differences in stated policies, nor to different levels of provision and commented that: *'it seems that they may just have happened'* (Ibid., para. 98). The Commission suggested

that what was needed in every authority was: *'A systematic process of planning and controlling the level and nature of home help to the different groups of the elderly...'*

(Ibid., para. 99). This led to a suggestion that: *'Authorities should ensure that appropriate systems are in place to support the most effective use of available home help hours.'*

(Ibid., para. 99). Such a response characterises the 'managerialist' approach taken earlier in the report, namely, that by defining different levels of need, it is possible to target more of the resources on those cases, which without intervention, could lead to more costly placements.

'MAKING A REALITY OF COMMUNITY CARE'

The 1986 report, as its title suggests, sets out the organisational changes required to make community care a 'reality', and provides an analysis of the obstacles to achieving community care for the elderly, mentally ill and physically disabled. The report was prompted by the view that policies encouraging the development of community care were being hindered by the mushrooming growth of private residential homes in which social security payments played a key role. (Maclean 1989, p.44)

While, as argued above, the main focus of the 1986 report is prescriptive, like the earlier report it does use quantitative evidence to generate norms. Equally, like the earlier report, norms are used as mechanism of cost control but footnotes to the main argument involve important caveats. Present, in the report, is the categorisation of the population into different groups according to level of disability; an analysis of a community support package; and the comparison of the costs of institutional forms of care with alternative

community based packages. It is, however, worth reflecting on two issues where assumptions made in the report are analysed. The first concerns the treatment of demand. In both the 1985 and 1986 documents, demand is discussed predominantly in relation to demographic trends and the construction of measures of 'need'. However, as Schorr points out community care has the potential to generate a demand of itself: *'...potential cost is compounded by the so-called 'Pandora effect'. That is, expansion of home-based services would lead to expanded demand for them'* (Schorr, 1992, p35). In part, of course, this derives from the very claims made by the Audit Commission that, in addition to cost control, community care represents a qualitative step forward in standards of provision.

The 1986 report also raises an instance of an issue which has regularly been debated with respect to community care, namely, what precisely is the distinction between 'residential' and 'non-residential'? This arises because (see below) in its prescriptive recommendations, the Commission constructs packages which make heavy reliance on day care. Yet, of course, such provision, particularly when used on an extensive scale, has the effect of providing an 'institutional' alternative (see chapter 4).

Whilst much of the body of the 1986 report, as has been discussed, is concerned with the organisational changes required in 'making a reality of community care', it necessarily works within the assumption that this is a desirable policy. Furthermore, like the 1985 report, there is a general assumption that the quality of provision in community settings is superior and that it can be provided at a lower cost. Thus, on the first page of the report a

range of 'typical' public sector cost figures for individuals with learning disabilities for a range of different types of accommodation is presented:

Table 3.3. Spectrum of care settings

Own Home Alone	Group Home (Unstaffed)	Sheltered Lodgings	Residential Home	Hospital
£133 pw	£119 pw	£133 pw	£210 pw	£255 pw
<-----Increasing Independence----->				

(Audit Commission 1986, exhibit 1, summary)

The choice of an illustration of different care costs for learning disabled people is an unusual one, as we are told that out of the 1.5 million adults in England and Wales who receive some form of care, 1 million of these are elderly (aged over 65) (Audit Commission 1986, summary, p1). On this basis, it would have seemed more logical to have chosen an illustration of care costs for the majority group: elderly people. The Commission's primary aim, however, was to illustrate the lower costs of supporting people at home. What is perhaps interesting, nevertheless, about the example quoted for learning disabled people is that the group home (unstaffed) is cheaper than care in 'own home', and that sheltered lodgings, which might appear to provide a more ideal mix between 'control' and 'independence', is costed at the same price as living in one's own home. These figures, as they stand, therefore cast further doubts as to the validity of the assumption that institutional placements are more costly than care in one's own home. Such problems, however, are not examined in the report, which instead warns of the

'perverse incentives' in favour of what is *assumed* to be more expensive institutional forms of care.

'Perverse incentives'

The critical feature of the market for independent residential homes was that the social security system was a third party payer for a large number of users, by providing indefinite payments at set rates, for those who obtained a place and were eligible on account of low income. (Wagner Report 1988). According to Maclean (1989 p.44), this group of people was, on average, less disabled than those admitted to local authority homes. The effect of the relatively straightforward access to social security benefits, for those on low income seeking residential care, was thus to reduce the price of private residential care, compared to alternative community forms of support. For those eligible for Supplementary Benefit, this created a 'perverse incentive', which encouraged residential placements at the cost of community based care. This prompted the Audit Commission, in their 1986 Report, to write:

'At best, there seems to be a shift from one pattern of residential care based on hospitals to an alternative supported in many cases by Supplementary Benefit payments - missing out more flexible and cost-effective forms of community care altogether' (Audit Commission 1986, p.2).

The 1986 report went further to suggest the expansion of private facilities had occurred in a totally unplanned fashion in response to market forces and had led to an inequitable

distribution of residential and nursing home provision around the country, with the densest provision being in the south (Ibid., para. 92).

Whilst the Commission is careful to suggest that: *'It is not about imposing a community solution as the only option.....'* (Ibid., p.2), it nevertheless works within the assumption, that a policy of providing community based care is desirable. Such an assumption is reinforced by evidence pointing to an unprecedented boom in the provision of private residential accommodation as a result of the 'perverse' incentive provided under the supplementary benefit system. In particular, the Commission illustrates this, by citing statistics: *'In 1984 some 40,000 residents were receiving such help [with residential fees from Supplementary Benefits] at a cost of some £200 million; but the Commission estimates that the costs is now £500 million a year and growing rapidly'* (Ibid., summary p2).

As a response to the perceived 'perverse incentive' (Ibid., para. 96), and unplanned market expansion, the 1986 report calls for an early independent review of the entire Community Care and inter-related fields (Ibid., para. 174). The purpose of the review is to focus on a number of areas designed to make the implementation of community care more effective by the removal of barriers. The 'perverse incentive' for residential care is thus cited as a key barrier to effective implementation (Ibid., para. 177). As an overall response, the Commission, fearing that the pattern of private care might become entrenched considers that: *'...what is not tenable is to do nothing'* (Ibid).

Having described the problem of the 'perverse incentive' to the effective implementation of community care, the 1986 report takes up the following themes which characterise the report as 'managerialist': the construction of norms; assumptions of lower costs outside institutions; and the search for organisational change. These themes, together with the reasons for their introduction are detailed below:

Construction of norms

In the context of the Audit Commission reports, the establishment of norms involves the identification of performance for a particular authority, which represents a standard by which other authorities performance can be measured against. Its usefulness to the Commission is in identifying authorities where expenditure varies significantly above or below the chosen norm.

As part of a process of defining norms, the 1986 report develops the approach of the 1985 report, which identified taxonomies of need, a stage further by standardising packages of care, in terms of their content and cost, compared to institutional forms of placement. In this respect, as with the previous 1985 report, day care is included as part of an intensive package (Audit Commission 1986, table 4, p11). It is not, however, explained how day care functions as a form of community provision, despite its function appearing more akin to an institutional setting (See also chapter 4).

In addition to identifying standardised care packages, the Audit Commission uses examples of 'best practice' to suggest actions required for 'effective' community care

implementation. '*...in spite of the many obstacles, effective community care is being promoted in a number of authorities*' (Ibid., p3). Central to the Commission's argument with respect to 'successful' community care implementation is the identification of a number of local schemes, which according to the Commission, evidences the feasibility of achieving the benefits of community care in terms of quality of life and value for money. According to the Commission: '*These successes point the way ahead*' (Ibid.).

Consequently, in chapter 3 of the 1986 report, a range of 'successful' schemes is discussed, which includes examples of practice from Plymouth, Torbay, Hastings, Hillingdon, Wigan, and Hampshire.

The examples of 'success', in addition to issues of representativeness and consequent transferability, also raise further issues with regard to arguments about relative costs. The first example, Plymouth, illustrates this point. According to the report, the discharge of 144 learning disabled people from hospital was to be managed through the provision of a range of accommodation types, including: staffed and unstaffed homes, a treatment unit and a short stay facility. At odds with an emphasis on lower costs outside institutions, the overall cost of the service is reported as '*comparable to the cost of the previous hospital-based service*', (Ibid., para. 153) with the consequence that all that has been achieved in cost terms is a transfer of expenditure away from hospitals to social services budgets without any overall reduction in expenditure. Furthermore, the report is silent on whether such transfer of responsibility from the Health to the Local Authority is followed by a parallel transfer of funds. The overall impression gained is therefore **less** of a radical policy

involving cost reduction and **more** of a policy of 'cost shunting' between the health and local authority.

The second example, Torbay makes a similar case on costs, suggesting: '*Analysis of the costs of the service shows that a service can be provided within current financial provisions*' (Ibid., para. 155). As with the previous example, the balance of care together with responsibility for expenditure appears shifted from the acute hospital to the community, with a larger role envisaged for social services departments and primary care professionals. In the next example from Hastings, however, the transfer of funds, as a result of hospital closure, is explicitly cited as being transferred from the hospital to the Social Services Department to fund the new development (Ibid., para. 157). It would therefore appear that the primary function of the examples of best practice is a commitment, a priori, to a transfer of responsibilities from hospitals to local authorities, on the assumption of superiority of community care. Such an assumption, however, works in the absence of specific outcome evidence from users of the particular schemes and suggests the transfer of funds is an indicator of the desirability of the policy per se. Furthermore, as in the Hastings example above, the overall cost in transferring patients from hospital wards into the community, appears not to have been reduced. In this respect, in para. 158, it is made clear that within the re-housing of mental health patients, any savings made are to be re-deployed to develop a more 'preventative' approach. (Ibid., para. 158). Thus, earlier arguments about lower costs outside institutions appear to be **modified** and to have become subsequently replaced by a need to contain expenditure

within existing budgets. It is therefore necessary to re-consider the relative costs and advantages claimed for community based provision as an alternative to residential care.

Assumptions of lower costs outside institutions

From the examples given in the report on the '*...perverse effects of social security policies*' (Ibid., para. 87), it is clear that the demonstration of lower costs outside institutions is a primary intention of the Commission. What is less clear, however, is why the Commission, in responding to the mushrooming growth in private residential care, chose as its primary strategy the development of alternative community based services, rather than simply to have introduced tighter controls on entitlement to supplementary benefits for residential accommodation. Whilst such a possible solution was allowed for, to some extent, through the 'gatekeeping' role of the local authority, the primary emphasis of the policy was the promotion of community based services:

'The policy of successive governments has been to promote community based services allowing the reduction of long-stay hospital provision. This is generally considered better in most situations. It is also more economical in many cases' (Ibid., summary. p1).

This, therefore, further illustrates the assumed desirability and primacy of the 'community' based solution over alternative policies to contain costs.

The case for community forms of support costing less than residential care, however, as previously discussed is not compelling. Furthermore, such claims are modified, even at the

beginning of the 1986 report: *'While the total cost of community care may be comparable with the cost of institutional care, different individual placements have markedly different cost implications...'* (Ibid., para. 13). The above quotation, is in fact cited in relation to a table of *'costs of care in different settings'*, in which it is evident that an intensive community care package, as defined by the 1986 report as involving domiciliary and day care (Ibid., table 4. para. 13), exceeds, by £2 per week, the cost quoted for a local authority Part III residential home.

A further example of qualification is provided in para.14 of the 1986 report:

'Moreover, even where there are no cost advantages because of the level of domiciliary support required, there is general agreement that for most people a higher quality of life can be realised in the community if proper community services are available.' (Ibid., para.14. My emphasis).

In addition, no detail is provided in the text to explain what is meant by 'proper' in relation to levels of provision, or its likely impact on costs. Thus, the reference in the text to 'quality of life' benefits, in relation to pursuing a policy of community care, again suggests that a policy of community care is to some extent being pursued as a desirable policy, independent of arguments on costs. What is significant here is a **shift** in the basis for support for community care policy. As was indicated in chapter 2, a distinctive feature of the managerialist approach to community care was the claim that both cost control **and**

superior outcomes could be achieved. Here, the Commission is raising doubts over the viability of the cost control objective per se.

The search for organisational change

Despite problems in demonstrating lower costs, the 1986 report maintains the managerialist approach of the 1985 report, in advocating organisational change. Thus, in relation to the actions required by local authorities for successful implementation, the Commission recommends: *'The organisational structures of the different agencies need to be aligned and greater managerial authority delegated to the local level'* (Audit Commission 1986, summary p4). According to the Commission, the context for the changes that it seeks to make is one of organisational change: *'Such changes will require some adjustment to the organisational framework for community care'* (Ibid., summary p4).

Problems around the failure of community care are thus seen in terms of organisational 'fragmentation': *'Unfortunately the present management arrangements do not promote the essential integrated service and operational planning'* (Ibid., para. 98). This appears to be in contrast to residential care:

'Residential care usually involves only one agency - either health (hospital or nursing home), or the private or voluntary sectors (nursing or residential homes). Most services are provided under one roof and are co-ordinated by the person in charge, simplifying administrative arrangements.' (Ibid., para. 97).

This, therefore raises, as before, the question as to why the Commission advocates a switch away from institutional to community care forms of provision, when the very merits that they are exhorting, of better co-ordination of care and planning, are **pre-existent** in arrangements for residential care. The 1986 report, therefore, raises two key problems within the operation of the model for community care that contradict managerialist claims, namely: i) a lack of evidence to unambiguously demonstrate lower costs outside institutions and ii) problems of fragmentation in the managerial and organisational arrangements proposed for community care that undermine the development of satisfactory outcomes. Both problems also cast doubt on the sustainability of the desired policy changes, as well as their introduction per se (see chapter 4).

GRIFFITHS REPORT 1988
(*'Community Care: Agenda for Action'*)

As soon as the 1986 report was available, the Government asked Sir Roy Griffiths to undertake a review of community care policy, in line with the Audit Commission report's recommendations (Audit Commission 1986, para. 177). Griffiths consequently undertook his assignment and published what became known as the 'Griffiths' Report in March 1988. In it he proposed solutions to many of the strategic areas identified in the 1986 report (Ibid., para. 177).

When Griffiths accepted the assignment, it was with the recognition that community care had been talked about for thirty years and that '*...in few areas [could] the gap between political rhetoric and policy on the one hand, or between policy and reality in the field on the other hand have been so great*' (Griffiths Report 1988, para. 9, piv. My emphasis).

Furthermore, the 1986 report had warned that: '*...the one option that is not tenable is to do nothing*' (Audit Commission 1986, para. 177). Consequently, Griffiths saw himself as debarred from exercising the 'safest option' (Griffiths Report 1988, para. 19) and instead resolved '*...to be even more radical*' (Ibid., para. 20) than those whom he describes as having implied that he should '*...tear up the present organisational structures and start afresh*' (Ibid.).

The Griffiths version of 'radicalism', however, is entirely consistent with the broad managerialist framework of the 1985 and 1986 Audit Commission reports, as illustrated by its call to: '*... spell out responsibilities, insist on performance and accountability and to evidence that action is being taken;... to match policy with appropriate resources and agreed timescales*' (Ibid., para. 20). In the matter of 'appropriate' resources, however, Griffiths, whilst accepting that it was not his remit to comment on the level of resources which should be available, strongly commends a ring-fenced specific grant for community care: '*Funding of social services authorities should be by way of specific grant amounting to say 50% of the costs of an approved programme*' (Ibid., para. 22). This was not a policy, however, which was at first palatable to Government: '*The Government gave careful consideration to Sir Roy Griffiths' case for a specific grant but concluded that a large scale specific grant is not necessary to secure community care objectives*' (Department of Health 1989b, para. 8.25). In its place, the White Paper advocates continued use of the Revenue Support Grant as a means of supporting necessary community care expenditure (Ibid.). Such a decision, however, was later reversed in time for the delayed community care implementation in 1993, whereupon a ring-fenced

community care grant (Special Transitional Grant or STG) was paid to local authority social service departments to develop the necessary infra-structure to support implementation and to purchase care from the independent sector.

A further feature of the Griffiths report is the identification of a Minister who will have accountability for Community Care: *'...a new focus for community care should be provided with a Minister clearly and publicly identified as responsible for community care'* (Griffiths Report 1988, para. 22). At the local level, however, Griffiths counterbalances this with a requirement for social service departments to:

'... be re-orientated towards ensuring that the needs of individuals within the specified groups are identified, packages of care are devised and services co-ordinated; and where appropriate a specific care manager is assigned' (Ibid., para. 24. pvii).

In this way Griffiths, whilst concurring with the 1986 report in relation to accountability to the **centre**, argues a stronger case for **local** determination of individual needs:

'If community care means anything, it is that responsibility is placed as near to the individual and his carers as possible. I also believe that where the priorities between different groups may differ widely according to local needs, the right and indeed obligation to determine that should be as local as possible and with the locally elected authority' (Ibid., para. 30).

Overall, the nature of Griffiths' remit, compared to previous assignments, was considerably more complex, in lieu of the different accountability structures that shaped the field of personal social services:

'...the responsibility for inputs to community care at the centre being divided between two arms of the DHSS, the Social Security and the Health and Personal Social Service sides, and the Department of the Environment - a feeling that community care is a poor relation; everybody's distant relative but nobody's baby' (Ibid., para. 9. piv).

Relationship with earlier reports

In relation to earlier reports, Griffiths saw his role as strongly influenced by the recommendations of the Audit Commission 1985 and 1986 reports. Moreover, whilst the organisational prescriptions of the Griffiths report do not simply mirror those of the Audit Commission, there is no question of the crucial role of the latter in setting the policy agenda. Thus, in para 2.8 of the report, Griffiths refers to the 1986 report as '*a valuable description and analysis of current problems*' (Ibid., para. 2.8. My emphasis).

Furthermore, in Para. 4, Griffiths explicitly cites the 1986 report as one of the documents containing: '*... the essential facts on which this review is based*' (Ibid., para. 4).

In outlining his task, Griffiths makes an implicit reference to the 1986 report by way of its role in establishing issues on which his report is established: '*...the facts have already been well documented in the publications and the issues have been well identified*' (Ibid., para. 2.9. My emphasis). According to Griffiths, his role in contrast to earlier studies is

'pragmatic': *My job has been to produce proposals for action, and the report sets out not to add to the volume of information about community care, but to explain the proposals*' (Ibid.). This, therefore clarifies Griffiths' position as one which, rather than challenging former approaches (viz. Audit Commission 1985/1986), sets them within an implementation framework. Thus, the two central premises of the 1985 and 1986 reports, that community care is a **desirable** policy from both an effectiveness and a cost control standpoint and that the creation of community care policy involves significant **organisational and managerial changes**, enters unproblematically into the formulations of the Griffiths proposals and thence into the NHS and Community Care Act 1990.

Despite such a 'managerialist' alignment between the Griffiths report and the preceding Audit Commission reports (1985/6), Griffiths nevertheless manages a small degree of divergence. Thus, in his letter to the Secretary of State, Griffiths mentions that he has 'side-stepped' certain of the Commission's recommendations, namely the consideration of a lead authority for the mentally ill, elderly and mentally and physically handicapped. This, Griffiths defends, on the basis that he recognises '*...the starting point has to be to identify and respond reasonably and appropriately to the needs of individuals in their particular circumstances*' (Griffiths 1988, para. 32). In clarifying further the importance of a 'user-led' response, Griffiths suggests: '*If community care means anything, it is that responsibility is placed as near to the individual and his carers as possible*' (Ibid., para. 30). In this regard, Griffiths echoes the Commission's earlier recommendations '*....the creation of a new occupation of 'community carer' to undertake the front line personal and social support of dependent people*' (Audit Commission 1986, para. 176).

Overall, despite certain differences in emphasis with the earlier Audit Commission reports, Griffiths openly acknowledges the strong links between his investigation and preceding reports from the Audit Commission (1985/6): *'I believe that the recommendations contained in this review should answer most of the points made by the Audit Commission....'* (Griffiths 1988, para. 39). In particular, Griffiths' approach is characterised not so much by the addition of 'new' policy, but by an attempt to clarify existing policy and identify the steps required in making it a 'reality.' In this context, Griffiths makes recommendations on the 'enabling role' of local authorities in the development of markets for care services.

Enabling the market

In relation to the wider 'market' context for community care, Griffiths places an onus on social services to demonstrate that *'...the private sector is being fully stimulated and encouraged'* through use of competitive tendering or other means of testing the market (Ibid., para. 24) and challenges social service departments to break with their historic role as *'...monopolistic suppliers of residential and non-acute nursing home care'* (Ibid., para. 6.49). In this respect, as 'market enabler', Griffiths reflects the 1986 report which characterises community care policy as involving: *'The development of a wide range of services in a variety of settings providing a wide range of options'* (Audit Commission 1986, para. 10). The same principle of 'enabling markets' is later endorsed by the White Paper, *Caring for People* (Department of Health 1989b, para. 3.1.3). Thus, prescriptions for the development of a mixed economy can be traced from the Audit Commission report

1986, through the agency of the Griffiths report to the Government White Paper: *Caring for People* (Department of Health 1989b).

Within his proposals for developing a mixed economy, Griffiths recognises the value that stems from providing a range of services: *'There is value in a multiplicity of provision, not least from the consumer's point of view, because of the widening of choice, flexibility, innovation and competition it should stimulate'*. (Griffiths 1988, para. 3.4). This, again, echoes the preceding 1986 report, which makes reference to the range of partners and services required to contribute to a single community care package (Audit Commission 1986, para. 97). Similarly, this area is endorsed by the White Paper:

'Stimulating the development of non-statutory service providers will result in a range of benefits for the consumer, in particular: a wider range of services; services which meet individual needs in a more flexible and innovative way; competition between providers, resulting in better value for money and a more cost-effective service.' (Department of Health 1989b, para. 3.4.3).

In section 25, Griffiths clarifies the public sector role as being *'...to ensure that care is provided'* but considers *'How it is provided'* (scope clearly for the independent sector) *is an important, but secondary consideration'* (Griffiths 1988, para. 25).

Such a development of policy in relation to the 'enabling' of markets offers the possibility of competition between providers and its attendant disciplines; this in turn is seen to

provide greater user choice and value for money. The attainment of these benefits, however, are seen to be dependent on a particular approach to organisational and managerial change, which links Griffiths to the earlier Audit Commission reports.

Organisational and managerial change

In relation to his approach to organisational structures, Griffiths does not consider a fundamental re-organisation of the responsibilities between levels of Government would be practical or desirable. Instead, he recognises that restructuring could be disruptive and time consuming and the initial approach with regard to structure must be:

'...to see why at present care is not being delivered effectively..... and before it [restructuring] is contemplated it has to be shown that the existing authorities are incapable of delivering; in short, we have to be satisfied that it is not the roadblocks to achievement which are the major problems, but the vehicles themselves (Ibid., para. 12).

Thus, in his report, Griffiths, instead of proposing widespread change in structural organisation, attempts first to clarify the responsibilities and accountabilities of existing health and social authorities in respect of community care.

Whilst the Minister of State's role is, as we have seen, to monitor the implementation of community care plans, the local authorities' role is to have primary responsibility for community care, making use of a specific grant for that purpose (Ibid.). As part of these proposals, authorities are to submit annual plans for the provision of community care

services, including how they are to support informal carers, in partnership with voluntary groups, housing and health authorities. 'Partnership' is the key to Griffiths, who expresses concerns that however much we restructure: *'...we simply move the interface between responsible authorities. Collaboration is vital, whether in planning, financing or implementation'* (Ibid., para. 13) This is directly echoed in the White Paper: 'Caring for People': *'To achieve success, local government, the National Health service and the independent sectors must work in an effective partnership and pay close attention to the views of those in need of help'* (Department of Health 1989b, foreword). Griffiths, therefore, envisages that Social Services and Health Authorities would submit joint plans on the basis that they have the support of local voluntary organisations. Such a suggestion is taken up in the White Paper Caring for People:

'... local authorities will be expected to produce and publish clear plans for the development of community care services, consistent with the plans of health authorities and other interested agencies. The Government will take new powers to ensure that plans are open to inspection, and to call for reports from social services authorities' (Ibid., para. 1.12).

Thus, Griffiths, in his emphasis on partnership, links the Audit Commission prescriptions on joint working to the policy, set out in the White Paper, on the responsibility of local authorities to produce joint plans.

In addition to partnership considerations, Griffiths recognises that the way community care is funded is vital to its success, in providing incentives for effective management.

Whilst his brief prohibits him from commenting on levels of funding, he nevertheless recommends that the sources of funding received by social service authorities are secure, enabling them: *'...to plan to develop their community care service in a coherent way*

(Griffiths 1988, para. 5.10). In this context, Griffiths sees the move to a specific grant as important for both local authorities and central government: *'It should be seen as liberating to local authorities to have more certainty. It will provide an instrument of central control, but it should not be seen as an instrument of constraint'* (Ibid., para. 31).

In relation to central control, Griffiths sees the payment of specific grant as: *'...conditional on central government being satisfied that local social services authorities have adequate management systems.....'* (Ibid., para. 1.5.3). Nevertheless, in relation to management practice, Griffiths asserts he has no wish to be 'over-prescriptive' (Ibid., para. 5.6).

However, no sooner than this is raised, he suggests: *'Some things are fundamental and in particular the creation of a budgetary approach, centrally and locally, which aligns responsibility for achieving objectives with control over the resources needed to achieve them..'* (Ibid). In para. 8, Griffiths makes a clear link between his concept of management and methods for controlling the use of resources: *'Cost improvement, by which I mean the more efficient use of resources, is at the heart of any management process and should be characteristic of the use of whatever money is available'* (Ibid., para. 8)

Thus, in emphasising the need for efficient use of resources, Griffiths is seen to reinforce the 'value for money' ethos of the earlier Audit Commission reports, in advocating

impartial commissioning on the basis of which provider offers the best 'value': *'The role of the public sector is essentially to ensure that care is provided. How it is provided is an important, but secondary consideration and local authorities must show that they are getting and providing real value'* (Ibid., para. 25). In para. 24, Griffiths further emphasises the importance of a strong budgetary management response from social service departments in obtaining economy and efficiency:

'...the responsibility of the social services authorities is to ensure that these services are provided within the appropriate budgets by the public or private sector according to where they can be provided most economically and efficiently' (Ibid., para. 24)

Again, here, the pursuit of 'value for money' is linked to 'competition' between providers as part of a market for care services:

The onus in all cases should be on the social services authorities to show that the private sector is being fully stimulated and encouraged and that competitive tenders or other means of testing the market, are being taken. (Ibid.)

The above, therefore, suggests a close correlation between the Griffiths' and 1985 and 1986 reports in the emphasis on management approaches, in the context of developing markets on the basis of attaining value for money. Indeed, the Audit Commission (1988a), in a later response to the Griffith's report, lends support to the latter's recommendations, and further suggests that grants to local authorities should be conditional on further

progress towards a 'mixed economy' model of provision, which is viewed, by both the Commission and Griffiths, as a vehicle for the attainment of value for money.

Funding issues

Echoing the managerialist emphasis of the Audit Commission, Griffiths describes his remit, received from the then Secretary of State Norman Fowler, as to find a 'better' way of managing existing resources:

'To review the way in which public funds are used to support community care policy and to advise me [Secretary of State] on the options for action that would improve the use of these funds as a contribution to more effective community care' (Ibid., para. 2).

In section 7, Griffiths more simply states this as: *'... to suggest how resources, whatever the level, may better be directed'* (Ibid., para. 7) According to Kubisa (1990), in this respect, Griffiths' brief was too restrictive. In focusing Griffiths' task on issues related to the management and organisation of services, rather than the adequacy of resources required for implementation, Kubisa considers the key question is ignored, namely: *'Do Social Service agencies have the capacity to deliver?'* (Ibid.). Such capacity would also need to be seen in the context of the skills to be acquired by social workers in carrying out their new roles, yet the report is framed in a way that such issues are avoided (Kubisa 1990, King 1991a, p15-17).

Despite such a restrictive remit, Griffiths, nevertheless, manages to provide two warning messages, which are clearly intended to be understood in the context of the level of resources available for community care:

'On many counts poorly implemented programmes for change are very often worse than the status quo. Even with the improved machinery of handling and funding which are recommended, if we try to pursue unrealistic policies the resources will be spread transparently thin' (Griffiths Report 1988, para. 38).

Whilst not seeing his role as commentator on the level of resource for community care, Griffiths nevertheless provides a salient warning, over the dangers of using community care resources to pursue unrealistic policies, which may yet prove to be 'prophetic'.

Overall, Griffiths' influence can be seen as 'pragmatist' and 'moderating', in clarifying and defining the steps required to bring community care to the level of implementation. In so doing, Griffiths **fails** to challenge the assumptions of the 'managerialist' framework characterised by the preceding Audit Commission reports, which suggest that the application of certain approaches to management will unproblematically deliver both quality outcomes to users and cost control. Community Care, as a policy, can therefore be seen to be built up from the Audit Commission 1985 and 1986 reports, which exert a key influence on the Griffiths report (1988), which in turn leads to the development of the community care legislation.

CHAPTER 4 CRITIQUE OF MANAGERIALIST ASSUMPTIONS

The discussion so far, has argued that the 1985 and 1986 Audit Commission reports contributed to a particular way of defining the problem of community care policy, which centred on the role of management. This chapter investigates the coherence and rigour of this argument. However, before examining the problem, it is necessary to examine another feature of the Commission's arguments. This consists of seeking to establish the conditions in which the need for **change** will be seen as necessary, by the creation of an atmosphere of 'crisis'.

THE CONCEPT OF 'CRISIS' SCENARIOS

Both the 1985 and 1986 reports are full of examples of how existing service provision is seen in 'crisis' terms and thereby in need of urgent change. Thus, the 1986 report points to claimed sharp differences in costs of provision: *'.....a frail elderly person living in their own home with day and domiciliary support would typically cost public funds some £135 per week; the same person would cost about £295 per week in a NHS geriatric ward'* (Audit Commission 1986, summary, p1). Furthermore, reference is made to the spiralling cost of private residential homes through Supplementary Benefits: *'In 1984 some 40,000 residents were receiving such help at a cost of some £200 million; but the Commission estimates that the cost is now £500 million a year and growing rapidly'* (Ibid., summary p2).

Further elements of crisis are evident within the way the Commission characterises the progress of 'care in the community' to date: *'At best, there seems to be a shift from one form of residential care based on hospitals to an alternative supported in many cases by Supplementary Benefit'* (Ibid.). In similar terms the Commission predicts: *'At worst, the shortfall in services will grow, with many vulnerable and disabled people left without care and at serious personal risk'* (Ibid.).

Other illustrations of crisis scenarios arise out of the use of demographic trend predictions: *'The number of very elderly (aged 75 and over) has increased over the last ten years by 27%; and the number of people aged 85 and over will increase by an estimated 37% over the next ten years'* (Ibid., para. 6). A discussion of demographic trends is then linked to a discussion about the total money required for the care of all client groups. Calculated at out-turn prices for 1984/5, a total of £5.29 billion is arrived at across the National Health Service, Personal Social Services and Social Security (Ibid., para. 7. Table 3). However, of the four client groups it includes (elderly, mentally handicapped, mentally ill and younger disabled), expenditure on the elderly accounts for around 60% of total expenditure. (Ibid.). Such information, as before, operates by way of a pre-text to advocating alternative community methods of support, which are presumed to provide greater value for money: *'Any failure to meet the challenge of community care will result in a lower quality service and reduced value for money'* (Ibid., para. 13).

Having painted a picture of crisis, the Audit Commission then moves towards an argument for radical change: *'Radical steps will be necessary if the underlying problems are to be*

solved'; and in para 149, the Commission concludes that '*...radical changes need urgent consideration*' (Ibid., para. 149). In order to provide examples of how such radical changes could be approached, a number of 'successful' schemes are studied in detail by the Commission: '*... one lesson is clear. In their different ways, all three successful schemes known to the Commission involve a radical departure from the generally accepted ways of doing things*' (Ibid., para. 163). An awareness of 'crisis', is therefore used as a 'vehicle' by the Commission to legitimise a requirement for a 'radical' policy solution, based on copying an example of 'best' practice, without adequately questioning the latter's transferability to the new context.

Overall, then, the managerialist approach to community care rests on the assumption that efficiency and quality improvements can be achieved, through more effective management of existing resources. In turn, this, of course, means that, in line with the assumption of 'crisis', current practices are 'inefficient'. More specifically, this argument can be broken down into a number of related sub-arguments. The first is that relatively large numbers of people in institutional care do not need this provision and thus, that inappropriate placement on a large scale has occurred. This would be consistent with the supposed effects of 'perverse incentives' discussed, in particular, in the 1986 report. The second related assumption is that community care packages for groups, either in or at risk of admission to residential provision, are likely to be cheaper or at least no more expensive, than institutional provision. In addition to these claims there is a wider aspect to the Audit Commission arguments, namely that demand for community care is broadly speaking finite, or at least is likely to shift only in relation to demographic changes. Thus, the

managerial decision concerns how best to meet such finite demand. Each of these arguments will be examined in turn.

THE RATIONALE FOR CHANGE - DIVERTING PEOPLE FROM RESIDENTIAL HOMES TO CARE IN THE COMMUNITY

The issue of 'diversionary' capability is first addressed in the 1985 report, where it is argued: *'Some of the professionals interviewed felt that almost all of the people in this group (older people with moderate physical disability) could be adequately cared for in the community, given the provision of suitable alternatives'* (Audit Commission 1985, para. 38). Specific evidence for diversionary capability is provided by information relating to the categories of need in the sample seven authorities, together with unspecified conversations with officers. However, from the evidence provided in the report, doubt must be expressed as to the reliability of this finding. Indeed, there are a number of problems in this area. The first relates to the fact that, while the professional opinion expressed above suggested that inappropriate placement was common, it was only in three out of the seven sample authorities studied that a significant number of residents were found, who *'...might be expected to be able to be supported in the community'* (Ibid., summary, p2). This casts doubt on why under 50% of such a small sample could describe behaviour which could be used to define a national 'norm'. However, other evidence given in the text suggests that the status of inappropriate placements in these three authorities may also have been tenuous.

There are a number of problems involved here. The first is that inappropriate placements claims depend on arguments that individuals with 'moderate' disability characteristics are being placed in residential care. In turn, however, this depends on confidence as to estimates of the numbers in the various categories concerned. Secondly, such categorisations are not 'facts' but depend on the judgements of professionals who make the assessments and, in turn, given such a small sample, this raises questions about how far such assessments are representative. Thirdly, even if the validity of assessments is assumed, assessments in residential settings will not necessarily reflect need at admission. The latter could have been higher or lower than that discerned when the assessment was undertaken. Finally, the use of the categories of need at all suggests the necessity that they be defined coherently, i.e. with all the difficulties involved, the Commission still claims to be able to group people together in homogenous categories. Thus, there are difficulties with the Audit Commission arguments on all these points. The following section examines the problems of categorisation in greater detail.

THE CATEGORISATION OF NEED

As part of an approach towards categorising different levels of need, the Commission advised local authorities to discover the characteristics of the elderly outside the hospitals who 'really need' residential home places. (Ibid., para. 21). It was assumed that those who really needed residential places, referred to as the 'core group' (Ibid., para. 24), were mainly those with 'severe' or 'very severe' physical disability '*...who have little or no support from friends or relatives....*' (Ibid., para. 33). With regard to the 'moderate' disability category however, it was assumed that: '*...almost all of the people in this group*

could be adequately cared for in the community, given the provision of suitable alternatives' (Ibid., para. 38). Such assumptions, however, we are told were based merely on 'professional opinion' at the sample authorities (Ibid., para. 33). Thus, in the absence of systematic research, there is a problem with the validity of these findings, yet they are central to the notion of a policy of 'diversion'.

Further problems arise with the definition of the 'moderate' physical disability category. Namely, in table 3 of the 1985 report, the 'moderate' category is cited as having both 'practical' and 'personal' care elements: *'Unable to perform some important domestic tasks unaided or unable to wash all over without help'* (Ibid., para. 27, table 3). Such a definition, however, is very unclear, since the same group that contains people who have a need for certain practical care tasks also appears to include those who require substantial personal care. This, again appears similarly muddled in a later section (Ibid., para. 37), where the 'moderate' category is defined as people who need: *'...assistance with household tasks such as shopping and cleaning, but who do not require personal care'* (Ibid.). The only concession that the Commission makes to this confusion, is in a footnote to page 16: *'For example, someone with moderate physical disability and many other problems may have a definite requirement for residential care; someone else with moderate physical disability and very few other problems may only require a low level of community support'* (Ibid., p16. footnote). This may be a reasonable recognition of the difficulties with categories of need. However, it sits uneasily with an implicit notion that such categories are a reliable basis for classifying individuals and consequently can serve as the basis for determining the appropriate care package for them.

Complexities within the definition of the 'moderate' disability category emerge again in para. 50, where the Commission recognises a second sub-division ('more dependent' moderately physically disabled) within the moderate category: *'..the type of more dependent moderately physically disabled now in residential care would require community-based alternatives to residential care if they are to be cared for without undue risk'* (Ibid., para. 50). Such a description, however, appears more in accordance with the second characteristic listed in table 3, namely: *'...unable to wash all over without help'* (Ibid., para. 27). Thus, in the absence of a clear definition of the 'moderate' physically disabled category, doubts must be cast on estimates of the numbers in this group, who could be supported through alternative services in the community, which forms the basis of the policy for diverting more resources into the community.

THE CASE FOR 'INAPPROPRIATE' PLACEMENTS

A policy of re-direction or diversion of resources from institutional to community forms of care is reliant, as we have seen, on a clear definition of 'moderate' disability, which itself exerts an influence on the number of existing placements to residential and nursing homes that can be identified as being made 'inappropriately'. Attempts, nevertheless, to provide evidence of 'inappropriate' admission are provided by the 1986 report, which interprets the earlier study of seven sample authorities published in the 1985 report (Ibid., exhibit 4) and identifies the characteristics of elderly people in local authority, as well as private and voluntary sector homes: *'...in three authorities studied in detail about half of the residents in the authorities' homes could have been supported in the community had the necessary resources been available.'* (Audit Commission 1986, para. 89). The case for

inappropriate placements is, therefore, linked by means of Exhibit 4 (Audit Commission 1985, p22), to problems in identifying categories of need.

Thus, in Exhibit 4, three out of the seven authorities are shown to have a level of 'moderate' disability significantly above the other four authorities studied. However, what the 1985 report fails to tackle is a problem with the estimation of the 'core group', referred to in Exhibit 4 as 'More Physically disabled' (Ibid.). Such a problem is only mentioned in a footnote to Exhibit 4 (Ibid.). This states: *'Surveys at 'A' and 'D' used different methods which may have underestimated the number in residential care having more than moderate physical disability.'* (Ibid.). The implications of this caveat are damaging to the arguments of both reports. Inappropriate placement, as has already been argued, could only be claimed in three out of the seven authorities. The caveat suggests that in two out of these three authorities, the size of the 'moderate' group may have been exaggerated and that the 'core' group underestimated. If this is so, then, in the Commission's own terms, a claim for inappropriate placement is reduced to one out of the seven authorities. Nevertheless, the unsound claim, referring to three authorities, remains as a conclusion in the 1985 report and this spurious 'finding' is carried though into the 1986 report.

THE QUESTION OF 'ADEQUATE' OR 'SUFFICIENT' PROVISION

A broader assumption, particularly in the 1985 report, is that in the context of community care, statutory provision confronts a **finite** demand. Thus, over the long term, as has been indicated earlier in the chapter, demographic change is assumed to have the impact of

increasing demand. However, in the short to medium term, a broadly finite level of demand is assumed. For example, in the discussion of levels of local authority spending on community care in the seven sample authorities (1985 report), the Commission identifies two authorities 'D' and 'G' as low spending' on community support services to the HPSD group. A suggestion by the Commission to each of these authorities is: *'Is the authority satisfied that its services to the more highly dependent elderly are sufficient to avoid high-risk situations occurring?'* (Ibid., para. 60) On the other hand, a further two of the seven sample authorities (A and C) are identified as spending a high level of expenditure on the HPSD group. A suggestion made by the Commission to these authorities was: *'Is the extra expenditure generating sufficient benefits, given the possible alternative uses for some of this money?'* (Ibid., para. 60). Furthermore, the Commission charges local authorities who spent above the calculated norm, with the need to demonstrate how such increases in expenditure for groups of lower dependency would result in prevention of admission. *'...If the preventative value of such care is a major factor, the authority should satisfy itself that community expenditure is preventing or delaying a sufficient number of people from needing more intensive services in the longer term'* (Ibid., para 70).

This argument suggests that there is a circumscribed group which should constitute the demand for statutory community care services, namely those at risk of admission to residential care. This is indicated in the implicit norms set out in the 1985 report, that 'low' spenders may be failing to meet needs, by not catering for those at risk, and that 'high' spenders may be over-supplying services by providing them to some not at risk.

Yet, as, for example Schorr has trenchantly shown, (Schorr 1992, p35), community care does not operate in a context where demand is given independent of policy. On the contrary, the very promulgation of the virtues of community care policy, with its emphasis on improved services, is likely to generate substantial increase for demands on services. The Commission is aware that use of statutory services is relatively limited and that: *'By far the majority of elderly people fend for themselves or are looked after adequately by relatives, friends or the voluntary sector without turning to the local authority social services for support* (Audit Commission 1985, p1, summary). However, what is not catered for is the potential impact of community care policy in creating a context in which *'... this situation changes materially, and considerably more elderly people seek assistance from their local authority'* (Ibid). Given such a scenario, we are told: *'... the authorities would be unable to cope within the scope of their existing resources'* (Ibid). Cohen (1991) suggests, that in addition to such external demands, changes within existing care packages would be equally difficult to predict: *'..care packages can be very expensive and it is often difficult to foresee sudden crises in a household.'* (1991, p15-17).

This, however, raises another tension in the Commission's arguments, that 'managerialism' suggests that community care policy will be able to meet **more** from limited resources, by better 'management'. In contrast, if policy confronts the unleashing of 'hidden' needs, then what becomes crucial is the **rationing** of services. In this case this is illustrated in the Commission argument, in the 1985 report, that *'..resources are*

deployed so that those with moderate disability and without support from friends and relatives are given the necessary support' (Audit Commission 1985, para. 61).

THE COST OF PACKAGES OF CARE

As has been indicated, the Commission's arguments suggest that community care provision could be significantly cheaper than residential provision, for individuals with 'moderate disability'. Evaluation of this claim is rendered more problematic because of the indeterminate character of the latter category. However, there are a number of interesting features which emerge, if the basis on which the Commission costs community care packages is examined.

In examining the evidence for community care packages being at a lower cost than residential or nursing home placements, problems are first encountered in the description of an 'intensive' package of care. According to a footnote to table 2 (of the 1985 report, reproduced as Table 3.2 in the previous chapter), the components that are described as comprising the intensive community care package are: *'9 home help hours, 5 meals on wheels and 2 day care weekly attendances'* (Ibid. para. 21, table 2). What the reader however is not told is how an older person, who could, given the broad category of 'moderate disability' have considerable personal care needs, might cope by way of an alternative community package that simply comprises just over 1 hour per day of home help, 1 meal on wheels per day for 5 days out of 7, and 2 days day care attendance.

For instance, in relation to the home care component, doubts emerge as to the adequacy of 1 hour of home care per day, which, along with small amounts of day care and meals on wheels, is supposed to function as an appropriate alternative to the care and support available at a residential home. Indeed, such a position would appear irreconcilable with the extensive list of tasks reported to be within the home helps remit and described later in the report:

'...shopping, collecting pensions, paying rent and bills, writing letters, heavy and light household cleaning, washing and ironing (including dealing with the results of incontinence), making beds, preparing meals, washing dishes, and monitoring a client's condition. Their tasks sometimes extend to assisting with personal tasks such as assisting a client to eat and drink, getting client up, dressing, putting to bed, washing and bathing' (Ibid. para. 96).

Furthermore, we are told that even clients of the LPSD (Low Public Sector Dependency) group, from the sample seven authorities, may receive support varying from one hour per week up to 20 hours per week home support (around 3 hours per day) (Ibid., para. 97). Clearly, from this illustration, there is considerable variation in professional opinion as to the adequacy of home care support, even for the lower dependency group, which must cast further doubt on how such a categorical judgement can be made, that only just over 1 hour per day (9 hours per week viz. chapter 3, Table 3.2) for the HPSD group can be justified.

Such a discussion on variations in support, however, is side-stepped by a statement indicating that: *'These differences were not obviously related to differences in stated policies nor to different levels of provision. It seems that they may just have happened'* (Ibid., para. 98) Also absent is any information on the methods used for determining whether such relationships between levels of provision and local policy did exist. In this respect it is worth relating to the assumption of 'crisis' discussed earlier in the chapter. Thus, as was argued there, this approach works on the assumption of deficiencies in current practice as the basis for managerialist interventions. Such deficiencies are, thus, either not demonstrated or have been argued in relation to other points in the chapter, which are based on questionable data. Overall, the reader is left without an explanation as to why the Commission chose to standardise the amount of daily home help, for the HPSD group (approx. 1 hour home help per day), to a level that was on the 'low side' even for the LPSD group, which according to the Commission's own evidence could receive as much as 20 hours of home care support, in some authorities. Such a problem, of unsupported cost figures, used to illustrate a typical community care package, further highlights the commitment of the Commission to community care as a 'desirable' policy, rather than one based on an investigation of the full cost of providing alternative community support.

Further problems in relation to costing emerge in relation to the understanding of 'intensive', in relation to the day care element of the illustrative package. (Ibid. para. 21. table 2. footnote). Whilst, in the footnote to table 2, the Day Care element of an intensive community care package is interpreted as 2 days per week, this appears at variance with

para 106 of the same report, which cites an example of 'intensive' day care, in relation to four or five day attendances a week: *'It [Day Care] can be provided to an individual for several different reasons, for example: personal care, such as bathing, for more dependent old people on an intensive four or five days a week basis'* (Ibid., para. 106). Thus, from the above, even if such an extensive range of day care tasks could be interpreted in an 'minimalist' way, it would be hard to see how such provision could be presumed to function as a satisfactory alternative to the 24 hour care and support available in a residential home. The term 'intensive', therefore, does not appear adequately reflected in the composition of an intensive community care package as set out in the 1985 report. (Ibid., para. 21, table 2.).

Further problems with the costing methodology emerge on recourse to the footnote under table 2 which indicates a 'disclaimer': *'Note that more intensive packages could cost as much or more than residential care'* (Ibid. footnote). Such a note, therefore, throws into doubt a key assumption of the Commission, that residential accommodation is: *'...almost invariably more expensive on a per client basis than supporting an elderly person in the community'*. (Ibid., para. 21). In addition, we are told that the costing methodology contains certain exclusions to the cost data presented, which if added to the gross cost of a community care package, would further increase the expenditure on community care in relation to residential provision. The exclusions identified by the Commission are *'...fieldwork, administration costs and certain items of expenditure e.g. telephones'* (Ibid., Appendix B, p. 63). Yet, such items, which are not quantified in the report are likely to be more significant items of expenditure for clients supported in the community, due to the

need for social work teams and other care professionals to keep very frail older people (HPSD group) in their homes, under regular review. Indeed, such a situation is advised by the Commission, under a previous section (Ibid., para. 61), as part of checking the 'adequacy' of provision. In addition, the planning, execution and recording of these reviews would attract further administration costs, including greater use of the telephone, which are also absent from the standardised costing for a community care package. Such ancillary costs, however, would further inflate the overall cost of community support, in relation to the cost of residential care. The premise, therefore, that a local authority must seek to reduce expenditure on residential care, on the basis that an equivalent community package is almost invariably cheaper, is **flawed**.

Overall, the agenda of management of change, which the Commission sought to establish in the 1985 and 1986 report, has been shown to be problematic. Existing practice was claimed to be deficient, yet the evidence presented on this front was insubstantial. Evidence from the 1985 report (cited as a key source in the 1986 report) was based on a small sample. However, even here, when the two authorities where the findings are unclear are excluded, only one of the seven sample authorities showed a combination of high levels of residential provision and a small core group. The problems in this respect are further magnified when the heterogeneous character of the 'moderately' disabled group is recognised. Yet, the ability to clearly identify this group is crucial for the Commission's normative argument. Finally, there is confusion over what an 'intensive' package should include and even, in some places, whether it will be cheaper, yet this argument is crucial for the 'cost control' case for diversion.

CHAPTER 5 CONSUMERISM

In the White Paper 'Caring for people' (1989b) the community care approach is understood in terms of a range of changes to service provision and delivery (Department of Health 1989b, para. 1.11). These include moving from a provider dominated to a needs-led approach; providing care in community rather than institutional settings; moving from a claimed state-led monopoly on care provision towards the development of a 'market model' for community care, involving a partnership between voluntary, private and statutory providers; and, to carry out the above changes, a transfer of finance from social security and health authority budgets to local authorities. This chapter will focus on the third change, namely the development of a 'market model' for community care.

The concept of a 'market model' for community care is based on assumptions that a market for services can be created in the social care field through the development of competition between providers. (Department of Health 1989b, para. 3.4.3). The consequences of such an approach are expected to lead to greater value for money and wider benefits for consumers. (Ibid.) The background to the idea that better management in community care could lead to improved value for money has already been discussed in earlier chapters. The market model is related to this concept. Thus the separation of purchaser and provider is designed to effectively enable the purchaser to select between competitors in the management of such resources. The market, therefore, is designed to act as a 'discipline' to ensure that better management, which is assumed to be possible, will actually be delivered. In the second part of the thesis, some further difficulties with

respect to 'value for money' will be discussed in relation to empirical work carried out in the case study borough.

However, the role of the market in community care is not limited to the function of cost control. In addition, the market is argued to deliver a series of **consumer benefits**. For example, in para. 1.8, the Government details the outcomes intended as a result of the changes outlined in the White Paper. These are to:

- enable people to live as normal life as possible in their own homes or in a homely environment in the local community;
- provide the right amount of care and support to help people achieve maximum possible independence and, by acquiring or reacquiring basic living skills, help them to achieve their full potential;
- give people a greater individual say in how they live their lives and the services they need to help them do so.

(Department of Health 1989b para. 1.8).

In summarising the above points, the White Paper adds: *'Promoting choice and independence underlies all the Government's proposals'*. (Ibid.)

The provision of such benefits, according to para 1.11, is related to the assessment process:

- ii. to ensure that service providers make practical support for carers a high priority. Assessment of care needs should always take account of the needs of caring family, friends and neighbours;
- iii. to make proper assessment of need and good case management the cornerstone of high quality care. Packages of care should then be designed in line with individual needs and preferences;

(White Paper 1989b para. 1.11 [extract]. My emphasis)

Objectives (ii), and (iii) highlight the importance attached, in the legislation, to the assessment process in providing support to both users and carers, in meeting their particular care needs. Both objectives also reflect the emphasis in the Griffiths Report (1988, para 3.8), on needs based assessment and service provision that is tailored to individual users.

In para 3.4.3, the White Paper connects the outcomes for individual users with the 'enabling role', given to local authorities, in developing services with the independent sector:

- a wider range of services
 - services which meet individual needs in a more flexible and innovative way
- Department of Health 1989b. para. 3.4.3. (extract)

The discussion in the earlier chapters raised questions on the cost control rationale for the community care reforms. In this chapter, the aim will be to explore some of the difficulties

with the other central rationale for the reforms, that they will deliver benefits to consumers and that this objective should be central to community care policy. In considering the capacity of the reforms to generate benefits for consumers, it is necessary to investigate a number of assumptions about the market model for community care. In investigating these assumptions, the following areas will be investigated: the nature of the quasi market, the identity of the consumer, the aspect of consumer choice, approaches to quality, and user consultation.

Nature of the quasi market

First, it is important to understand the nature of the theoretical framework in which consumerism is expected to operate. The context for this, according to the reforms, is the 'quasi-market'. Such a concept is problematic, as will be discussed later, in considering taxonomies of markets. Nevertheless, certain features can be identified. As was argued in chapter 2, the quasi market must face the dual tension of market 'discipline' and 'regulation'. The former stems from the element of competition, that is created through the contract tendering process and requires, on the basis of a 'level playing field', that social service in-house providers compete with the independent sector for contracts. The latter arises out of central Government objectives, in relation to the way social service departments are to manage the mixed economy of care, as well as stipulations by the local authority, on the level, type and quality of services to be commissioned.

Assumptions behind the market model are, as we have seen, that a competitive market in community care services will provide both qualitative and quantitative benefits. The notion

of the market model is based on the government's perception of how the private sector operates. The perception commonly held by Government of the private sector is that it represents a model of 'excellence' embodying characteristics of 'open' competition, resulting in a broader range of goods offering increased choice and lower prices. The quasi market is therefore derivative of a particular perception by Government of how the private sector operates and of a commitment to this approach, a priori, as a more effective way of working.

In transferring such concepts of how private sector markets work to the public sector, certain changes are required under community care legislation. In particular, Local Authorities are required to undergo modifications to organisational structure, to reflect a separation between aspects of the organisation that are concerned with purchasing and those concerned with provision - the 'purchaser/provider' split (Department of Health 1990b para 4.5). The rationale behind the structural changes is that decisions about assessment and purchasing can be taken more objectively by parts of the organisation not involved in direct service provision (Ibid.). Problems with this rationale, however, lie in the tensions such a structural division might cause to the consumerist framework for community care. In particular, the emphasis by professionals on assessment and defining levels of dependency (chapter 3) may conflict with the user's perception of the services they need. Whitfield and Stewart (1993, p1-2) argue that potential conflicts are made more likely because the present arrangements, in transferring assessment responsibilities to purchasers, minimises the previous experience and knowledge of assessment built up by providers. Such tensions, between different groups of professionals and users, have

implications for the continuity and quality of service received by the consumer. This area will be taken up in the empirical results and analysis in chapters 8 and 9.

In principle, however, the spirit of the market reforms is explicitly 'consumerist' - users will be empowered to express their needs, and exercise choice, whilst suppliers compete to obtain their custom in a mixed economy of care (Department of Health 1989b, para. 3.4.3). As with other aspects of community care, discussed in earlier chapters, the fact that a concern with consumers derives from a variety of sources of different political hues is probably contributory to the whole acceptance of community care policy. However, whilst a growing emphasis on the consumer may have contributed to the broad acceptability of community care there are important conceptual difficulties with such a policy.

The identity of the consumer

Much of the current argument about consumers reduces the question to one of the current service consumer, but this omits a) the current carer and b) the potential user or what is often termed 'unmet' need. Thus, while the official community care literature assumes that the interests of current users and current carers are broadly compatible, this is clearly dubious. For instance, in the case of a disabled person, who wishes independence from carers and families, the notion that the interest of users and carers are the same is clearly unfounded. There are also clear potential contradictions between actual and potential users. Thus, providing more resource intensive services to current users could result in the absence of service provision for potential users with lower dependency needs.

The potential tension between current and potential users is given added force by a key structural feature of the community care reforms and the financial framework within which such reforms have operated. In this connection, it is important to re-iterate, that the claimed benefits for consumers are to be delivered by a 'quasi-market' in community care. A central characteristic of such a market is that it remains predominantly publicly funded. Thus, whilst charging policies will account for a small portion of the income raised, the vast majority of funding is from the 'public purse'. For the remaining expenditure, the authority is mainly reliant on funding from Central Government, through the Standard Spending Assessment (SSA). This, therefore, raises an important question about equity concerns in a publicly funded service, in that parity of access to services may be threatened by the funding levels required to support care packages. The latter issue has already been discussed earlier in the thesis, when it was pointed out that Audit Commission evidence (Audit Commission 1985 para. 21, table 2.) on the capacity to contain the costs of community care policy was seriously flawed.

Further evidence on this issue is presented by the Audit Commission in a recent publication: 'Balancing the Care Equation' (1996, para. 19-32), which, in acknowledging the high cost of intensive care packages compared to residential alternatives, advocates the use of eligibility criteria as a means of financial control to further target services. The consequence of such a policy is to deprive users, other than those who are assessed as 'highly' dependent, from access to these services. Similar issues are raised by a study by the London Research Centre, which indicates: *'Financial constraints... [are] beginning to exert considerable pressure on social service departments, with increased targeting of*

resources on those people requiring intensive services' (London Research Centre 1996, p1). Further evidence on issues of equity, in relation to tensions between overall funding and the demands for care packages, will be presented in the background to the case study borough in chapter 6.

This new emphasis on service rationing contrasts markedly with Audit Commission publications of a decade earlier, where management of resources was argued to deliver 'more for less'. Such rationing, as well as pointing to equity issues between current and potential users, also raises equity issues with respect to the position of the informal carer. Thus, where resources are constrained, this may lead to users with informal carers being prioritised lower for services than users living on their own. Issues of equity also impact on users as a result of differences in the way local authorities apply discretionary charging policies (Audit Commission 1996, para.68). In their report, the Commission found widespread variation in the percentage of income recovered between different local authority areas. Questions of equity therefore raise fundamental issues concerning the appropriateness of consumerism in a publicly funded service with heavily constrained resources. However, it can be maintained that, even if equity is sacrificed, it is still possible to argue that genuine and significant benefits can accrue to current service users. To analyse this question, it is necessary to look at another feature of consumerism: the claim that it enhances choice. In discussing this issue, a number of commentators have accepted the premises of this argument, but questioned whether the quasi-market is able to deliver this result, particularly in the financial context in which it operates.

Consumer choice

A key assumption of the White Paper is that the development of 'alternative' markets for care services will lead to greater choice for consumers. (Department of Health 1989b, para. 3.4.3). Research carried out by Lart and Taylor (1993, p25), however, suggests that whilst the enhancement of consumer choice is seen as a key aspect of the reforms, consumers express fears that choice will be limited by scarcity of resources. The latter, as discussed earlier, leads to financial control measures such as eligibility criteria and charging, which constrain the level of user choice available. Concerns around the impact of resource levels on user choice are given further credence as a result of the 'Gloucester' judgement, in June 1996. The latter allowed local authorities to take service resources into account when deciding the level of appropriate care to provide. Other financial controls, relating to user income, are provided by differences in the charging system operated by local authorities in financial assessments for residential and home care. In the former, a client's capital may be taken into account. In the latter capital is ignored. Thus, as a result of differential arrangements for charging, a 'perverse' incentive is constructed in favour of residential care.

Such a limitation on consumer choice, in favour of previous patterns of residential provision, as outlined above, runs contrary to the rationale of the community care reforms. The latter explicitly emphasises the development of non-institutional services and the enhancement of choice through the promotion of a competitive market for care services (Department of Health 1989b, paras. 1.8; 3.4.3). Facilitating the development of competitive markets is the contracting process, whereby contracts for care services are

awarded under competitive tender to alternative providers (Ibid. para. 3.4.7). Evidence, however, supporting the increase in user choice as a result of these arrangements is thin. Research by Common and Flynn (1992, p36) into contracting arrangements with twelve local authorities around the country found no evidence to suggest that consumers perceive more 'choice' as a result of the contracting process:

'Either contracts replicated existing services, or established a new service which then became the only one on offer. In cases where there was a variety of services available for an individual or a group, there was, according to their research, no greater choice at the point when services were offered due to the existence of independent providers'.

(Ibid.).

Similarly, Walker (1989) and Clapton (1992, p12-13) found that for many consumers choice is 'illusory' due to the absence of real alternatives to choose between.

A further area that affects user choice, in relation to contracting arrangements, is the particular type of contract that is arranged between the purchaser and provider. Two broad choices of contract that are available to social services commissioners are what are commonly referred to as 'block' or 'spot contracts'. In a 'block contract' situation, a purchaser typically buys a specific volume of service at an agreed price for a fixed period of time. In a 'spot contract' situation, a purchaser only buys the level of service required for a specific client (or clients) as the need arises and usually selects the particular

contractor from a 'approved list' of providers. Either choice of contract can be seen to have particular advantages and disadvantages for purchaser, providers and consumers.

For instance, if a commissioner purchases a service through a 'block contract', the provider organisation derives benefits from having guaranteed funding 'up front' to plan services and recruit staff; for the commissioner however this may provide less flexibility, that is, if the needs of a population change the contract that was originally negotiated at a fixed volume of work, cannot change with it. The converse is true of a 'spot contract'. As a result, 'spot' contracts have been generally favoured by care managers, over 'block' purchasing, in order to maintain flexibility in community care purchasing (Marchant 1993 p14-15). According to Marchant (Ibid.), this is tantamount to passing the greater share of the risk to the provider. Such a situation, however, could change as local authorities gain more information on levels of demand and begin to recognise greater benefits in 'block' contracting from 'economies in scale'. (Ibid).

Obtaining choice in services is therefore significantly affected by whether Social Service Departments purchase a 'block' contract with a single supplier, or whether they 'spot' purchase services for individual users from a range of 'approved' providers. Such a tension between 'block' contracting and 'spot' purchases serves to underline the conflict in interest, not just between commissioner and providers, but also between providers and users, in that whilst the 'spot' contract system is more likely to be responsive to individual user needs, providers may not have sufficient financial incentive to maintain such services. (Francis 1993, p25).

Decisions in relation to 'spot' or 'block' contracts, as well as leading to differential benefits for purchasers, provider and consumers, also serves to illustrate the 'power' of purchasers over consumers in decisions affecting social care arrangements. For Hoyes and Le Grand (1991, p2.) and Knapp (1993, p32), the presence of a 'proxy' social care purchaser is significant, in that it prevents the consumer from being in a position to make appropriate choices in relation to community care purchases. Knapp, in particular, cites the position of a proxy purchaser as being a key difference between the operation of social care and commercial markets. Moreover, Knapp sees the presence of a proxy purchaser, who makes decisions on behalf of consumers, as a 'distortion' element, that effectively limits consumer choice. (Ibid.). Knapp's arguments, however, appear somewhat 'simplistic' since the ability to make comparisons between different types of markets relies on all markets other than public sector quasi-markets operating on a similar way. This, however, is unlikely to be the case since most markets, outside economist's 'constructs', are likely to display varying degrees of 'imperfection'. Moreover the absence of a direct relationship between provider and consumer is not unique to community care, since financial brokerage services from mortgage or insurance agents in the commercial sector operate in a similar way.

Despite limitations in the classification of different markets, certain features of the 'proxy' role for purchasers remain. Namely, that users, within a publicly funded 'quasi' market for community care are not in a position to directly switch between providers themselves. This gives added emphasis to the monitoring of service standards by purchasers. In turn, if current users are to be given a voice, then this suggests that purchasers must be aware of

user dissatisfaction with providers and be willing to act on it. In this respect, the White Paper does make certain requirements of social service departments, in regard to the management and monitoring of contracted-out services: *'The authority should be clear in advance how it will deal with a situation where a contractor is not providing an acceptable service.'* (Department of Health 1989b, para. 3.4.9). Where arrangements are not already in existence, authorities are responsible for establishing procedures for receiving comments and complaints from customers. In addition to complaints about service provision, a user may also request that a particular assessment decision be reviewed (Department of Health 1990b, para. 3.54; 6.29). In a number of authorities this has led to a judicial review. Progress, however, in developing complaints and appeal procedures in response to the reforms has been slow, and those that are in existence are at risk of being driven by a preoccupation with financial performance, rather than a motivation to redress individual grievances (Downey 1990, p15; Dean and Hartley 1995, p22-23).

Approaches to quality

Responsibilities in the White Paper (Department of Health 1989b: paras 5.1-5.31) for achieving quality, are seen in terms of accountability relationships. Two key levels of accountability are identified. Firstly, a responsibility for quality is indicated at the consumer level, in terms of contractual responsibility for maintaining standards of care. Secondly, at the strategic level, accountability to the Secretary of State is emphasised through the publishing of annual community care plans, which must include measures of performance by which progress in achieving strategic objectives can be assessed. (Ibid.

para. 5.6). In relation to contractual accountability, only broad responsibilities are indicated: *'As purchasers, arrangers and providers of care services local authorities must be responsible for ensuring adequate systems are in place for securing the necessary quality of services, and monitoring it over time'* (Ibid. 5.14). Brevity of guidance, however, within the area of safeguarding standards of contracted-out services to consumers, is counterbalanced by greater detail in relation to the role of social services departments in the compiling of plans at the strategic level. Such an emphasis suggests that the aspect of protecting service standards to consumers plays a less significant role, within the reforms, than the organisational changes required in making a strategic shift from 'provider' to 'enabler' of services (Ibid. para. 5.6). Thus, issues of quality in service provision, through being expressed in terms of a set of accountability relationships are overtaken by an agenda of central control which emphasises organisational change.

User empowerment

As part of the organisational change agenda, social service departments are required to move away from a position of 'direct' provider to 'enabler' of services. As discussed previously, this involves a greater role for a 'proxy' purchaser, who must purchase services from independent providers, on behalf of users, in response to assessed need.

Proxy purchasing, however, as identified earlier raises a problem with user 'empowerment', because it involves a crucial role for professionals in the assessment of need. Thus, Common and Flynn, indicate that: *'The people assessing need and allocating resources still exercised control over the choices available rather than by the service users or their carers.'* (Common and Flynn 1992, p36). Such a professionally dominated

position is confirmed too in studies by King (1991b, 15-18) and Ellis (1993, p3), who discover real doubts on the part of service consumers as to whether equal 'power' can be achieved with professionals. Such a view is linked to a perception that power lies with those who are holding on to the 'purse strings'. This suggests to King, that despite the emphasis in the reforms on consumer 'empowerment', in practice, community care staff tend to dominate decision making. (Ibid.). Such concerns appear echoed in a report of the House of Commons Social Services Committee (1990), which concludes that a fundamental cultural change is needed, since the involvement of consumers and carers will challenge deep seated professional attitudes and practices (Ibid.).

Mirroring problems with the involvement and empowerment of consumers at the individual level of assessment, arrangements for consulting with local populations at the strategic level through the production of annual Community Care Plans (CCPs) appear similarly inadequate. In particular, the NHS and Community Act 1990 requires local authorities, to consult with:

'... such voluntary organisations as appear to the authority to represent the interests of persons who use or are likely to use any community care services within the area of the authority or the interests of private carers who, within that area, provide care to persons for whom, in the exercise of their social services functions, the local authority have a power or a duty to provide a service'.

(NHS and Community Care Act 1990, para. 46.)

From the above, problems are raised of how 'representative' voluntary organisations are of broad consumer views. Indeed, it would seem unlikely, in relation to consumers, that i)

their individual voices will be represented adequately by voluntary organisations; ii) the voluntary organisations are representative of a broad range of views; iii) the views of the voluntary organisations will hold equal weight with other partners being consulted and iv) the voluntary organisations have the capacity to represent 'unmet' need, in terms of the views of consumers who have not yet used services.

These types of argument, therefore, effectively accept the premises of the **desirability** of consumerism, but raise doubts about how far it has been attained, or is attainable, in the quasi market as currently constituted. Thus, problems are seen to arise from proxy purchasing per se, that is, from the supposedly disempowering role of professionals in an assessment based system, a top-down driven monitoring process and inadequate arrangements for consultation. The logic of such a position, however, is that if these problems could be corrected, then even if the benefits could be available to a minority under the current funding regime, it would mark a significant advance in provision for them. In this final part of the chapter, the aim will be to raise various questions regarding the assumptions behind this position. This will provide a conceptual background to the issues raised in the empirical investigation in chapters 8 and 9.

Assumptions of the consumerist framework

As was argued earlier, central to the government's claims was the idea that the community care reforms would extend consumer 'choice'. The general lack of discussion of this concept goes along with a notion that extending choice is unproblematically desirable and thus, for example, that the extension of choice and the promotion of welfare are

synonymous. However, if the concept is examined more carefully, various problems with this equation can be seen to arise. A framework for such an investigation is provided by Dowding's discussion of the issue.

In this respect, Dowding suggests that advocating markets on the basis that they increase consumer's choice is doubly wrong: '*...firstly, because choice is not necessarily something to be valued and, secondly, because increased choice itself is not what is valuable about markets*' (Dowding 1992, p312). In relation to the first point, Dowding, suggests the key question for customers is not the aspect of whether choice is provided, but: '*...whether the market provides the best educational or health system or whatever*'. (Ibid.). As part of that judgement, Dowding suggests that the underlying issue, in any area where a range of alternatives are provided, is not the provision of choice per se, but whether the alternatives genuinely lead to greater control. In relation to the second point, Dowding points out that the most common context in which the idea of extension of choice is raised is with respect to what he calls the 'choice set' (Ibid. p303). Thus, if the individual is faced with a choice between a) or b), then an extension of choice will occur when the choice set also includes c). However, as Dowding indicates, this is not equivalent to an increase in individual welfare: '*...why should we want a larger number of alternatives to choose from, if the most preferred alternative remains the same.*' (Ibid., p305). Furthermore, as Dowding indicates, more often in areas of public policy, choice is reduced to the replacement of one alternative by another. Such a situation, of providing choice by 'default', is an area taken up in the empirical research in chapters 8 and 9.

Providing choice in terms of a range of positive alternatives that can be seen to connect with individual welfare is therefore problematic. In particular, for Dowding, the exercise of such choice is dependent upon, for example, the ease of shifting from one alternative to another. In turn, this may be influenced by a further set of underlying conditions, namely: *'... the costs of making decisions and the ability of individuals to have clearly defined preference schedules'* (Ibid., p314). Thus, the significance accorded to choice in government documents assumes that choice is not important for its intrinsic virtues (the act of choosing) but because it yields material benefits. In turn, however, this suggests that individuals have a clear defined set of preferences and that the extension of the choice set allows a preference nearer the top of the schedule to be realised.

Much of the argument about consumers, and in particular the issue of choice, assumes that they are broadly homogenous. In this respect, community care policy assumes that consumers have a 'template' of the service they want, by which they judge what is provided. Furthermore, much of the theoretical policy framework assumes consumer choice is unproblematically transferable from 'product' based areas to the field of social care. This premise is implicit in critical work by social economists, such as Knapp (discussed above), who links restriction on consumer choice to the existence of a 'quasi market', but pre-supposes that choice is a universal aspect of consumer satisfaction. This therefore raises the issue of how far actual user behaviour compares with the theoretical framework.

According to Baldock and Ungerson (1994a, p26-27), whilst aspects of the market, such as choice, appear dominant themes within the legislation, they are largely irrelevant to consumers. Indeed, studies by Baldock and Ungerson confirm that consumers often care little about whether services provided to them are public or private, provided they continue to receive them (Ibid., 1994b, p49). Furthermore, their previous experiences as consumers do not appear to inform their behaviour within the present system of managed care. (Ibid., p44). Such a situation, therefore, appears contrary to the reforms, which assume that consumers, rather than behaving according to the 'status quo', interact dynamically with the market.

Thus, a problem of the debate on the consumer benefits of community care is that it is focused on the obstacles to the operation of consumerism, without questioning how far users might vary in their desire to operate as consumers. This is not to deny the possibility that increased choice might increase utility, but it is to question whether it invariably has this result. In turn, it also means that in looking at this question, we should focus not on arguably spurious universal conceptions of the consumer, but rather the differences between groups and services, which mean that current users will vary in the extent to which choice is significant to them. The significance of this issue will be taken up in the empirical research in chapters 8 and 9.

CHAPTER 6 BACKGROUND TO CASE STUDY BOROUGH

This chapter sets the scene for the empirical research and includes information on characteristics of the elderly population, together with information on the services provided in the case study borough. The first part sets out demographic information. The second part, divided between external and in-house services, investigates, for each service in turn, eligibility criteria, services provided, service users and financial information. At the end of the chapter, principles of community care service provision clarify the local context for implementation of community care.

DEMOGRAPHIC INFORMATION - CASE STUDY BOROUGH.

The case study borough is an outer London borough, situated at the South West edge of Greater London, covering an area of approximately 17 square miles. At the time of the research, the borough had a population of 174,000 (Source: Case Study Borough/Health Authority 1995/6). Table 6.1 below, compares the profile of the borough's population of older people for different age bands with the average profiles for Greater London:

Table 6.1: Analysis of current users and pensionable population

Category	Case Study Borough	Greater London	No. of users *
Residents of pensionable age as % of the population	18.4%	16.8%	
% of population aged between: pensionable age and 74	10.7%	10.2%	268
75-84	5.9%	5.2%	331
85+	1.8%	1.4%	729
		Total	1328

* Home Care Users: Case Study Borough

Source: HSS report 1st July 1995 and Age Concern 1995 ('Older People in London: some basic facts').

According to the above table, compiled by Age Concern, in each of the three age categories, the percentage of the population of these groups in the borough is higher than the greater London average. This may contribute to the current pressures experienced by the in-house home care service to meet levels of demand, particularly in the more resource intensive over 85s group, which accounts for more than 50% of the total Home Care clients. Table 6.2 below, indicates how the size of population, for each of the different age bands, has been calculated to change between 1993 and 2016.

Table 6.2. Population trends for older people in Case Study Borough

	1993	1996	2001	2006	2011	2016
65-74	14039	13246	12582	12296	12661	14390
75-84	9447	9007	8470	8294	7974	7862
85+	3685	3996	4196	4002	4046	4055
All ages	173309	174492	176405	178197	189728	184030

Source: Population Assessment Data - Case Study Borough Health Authority. 1995/6.

From the above table, it is evident that the population of over 85s has increased by around 8% since 1993 and is likely to increase by a further 5% between 1996 and 2001. This is contrary to the trend for people between the ages of 65 - 74 and 75 -84, whose numbers, over the same period, are likely to fall by 7% and 5% respectively. However, it is the increasing trend for over 85s that is most significant for planning considerations, as it is this group that is likely to require more costly intervention to enable people to stay in their own homes (see chapter 3). Furthermore, such a continuing trend upwards in the over 85s is compounded by the fact that 60% of pensioners of this age, in the case study borough, live alone and are thus more likely to have a need for domiciliary care.

In relation to elderly people living in the Borough, there are two types of domiciliary services provided. These are a) the 'external' service, provided by external agencies, for users whose needs are at the 'high' dependency level and require a 'complex' package of services to sustain them in the community b) the in-house service, which services clients at i) the 'high' dependency level, requiring intensive provision, comparable to that provided by external agencies, and ii) a 'moderate' dependency level where a lower level of service is required to maintain independence.

THE EXTERNAL SERVICE

The external service, which forms the **experimental group** for the research provides a range of domiciliary care services, commissioned by Care Management, from agencies external to the case study authority. Care Management, as operated in the case study borough, represents the process of assessing, monitoring and reviewing the needs of

users/carers and arranging services to meet those needs. The needs identified by the care manager, with the user, are recorded in a care plan (see below). If the user's needs are such that they can be met in the community, rather than a residential or nursing home care, then a package of care is purchased by care managers on a 'spot' contract basis from one of 18 external agencies on the approved list of providers.

The provision of care, from providers on the approved list, is in accordance with a service specification and contract conditions. Contract conditions require compliance to a range of departmental policies, including quality assurance, confidentiality, equal opportunities, complaints, health and safety, hygiene. The service specification outlines the standards required by the provider for a range of personal and practical care tasks around the home e.g. mobility and 'transfers', washing, dressing, eating/drinking, continence. In addition, the specification requires the provider to tailor the specific care it provides to the needs of individual clients, as specified in the care plan. Adherence to the contract conditions is monitored by the contracts and complaints sections.

The case study borough has fourteen Care Managers who are responsible for purchasing services for their particular user group. Six of the Care Managers purchase domiciliary care for Older People. The remaining eight care managers are divided equally between hospitals, where they operate on a generic basis and locality bases where they purchase services for other specialised client groups e.g. mental health, learning disability and physical/sensory disability. The process of care management, given the emphasis on developing a mixed economy, leads often to the purchase of an external domiciliary

package, but can also result in a placement to a residential or nursing home. In the case study borough, the process of receiving an external domiciliary service consists of three stages: assessment, care plan and review.

Assessment

The Council has a legal responsibility to assess the need for community care of anyone who may require services and to arrange for appropriate services to be provided (NHS and Community Care Act 1990. s.46). The assessment is carried out by a member of the social work team on behalf of care management. At the time of the research, the structure of the assessment in the case study borough was unique, in that care managers sub-contracted assessments to social workers, confining themselves to the arrangement of services to meet the needs identified in the assessment. In this respect a further 'purchaser/provider' split operated at the 'micro' level, thereby separating out those who assessed needs (social workers) from those who purchased services (care managers) to meet those needs out of given resources (devolved care management budgets).

An assessment, in the case study borough, is offered to people:

- who may be at serious risk of neglect or abuse
- where the existing care arrangements are breaking down or may break down in the near future
- who believe they require help because they cannot manage personal care tasks
- who are substantially and permanently disabled
- who need help in looking after someone who is dependent on them
- with chronic illness who are likely to have health and social care needs
- with support needs following discharge from hospital

Users with a range of high level needs will receive a detailed assessment, which may involve additional specialist advice from other professionals e.g. Occupational Therapist, GP etc. Provided they can be appropriately maintained in the community, users, following an assessment, will be in receipt of a care package from an external domiciliary agency, in accordance with the agreed requirements as set out in the care plan.

Care Plan

A Care Plan lists the agreed needs and describes the identified services which will be provided to meet those needs. The Care Plan, in the case study borough:

- covers all services, even if more than one agency is involved
- states which services are to be provided, by whom, where and when, and the objectives of these services
- includes details of when the assessment and care plan will be reviewed to ensure that they are still appropriate and how the review process can be started
- provides details of a named key worker if the user has intensive support needs requiring health and social care
- provides a contact telephone number where help may be obtained in the event of problems or a need to change services urgently or temporarily
- is in writing and a copy provided to care management users

Case Study Borough: Care Plan requirements.

Review

Care Plans are reviewed once every three months. However, if there are specific concerns by a particular party, a review or case discussion may be requested at any time. In most cases, the review is completed by the care manager who organises the initial assessment. The user will be fully involved in such reviews and will receive a copy of the Care Plan.

The reviews are usually convened in the user's home, but may be held in a day centre if this is more appropriate. All care providers are invited and involved in the review and other professionals may be called upon as appropriate e.g. GP, District Nurse etc. The care providers may be asked to produce a report prior to the review and would be expected to take an active part in its execution. In addition to professional involvement in the assessment, the participation of users and carers is positively encouraged.

Eligibility criteria

In order for a user to be in receipt of an external domiciliary service, a person must first be eligible, under the following criteria:

- be resident in the case study borough, and
- either want to stay in their own home, but have needs which could otherwise be met in residential care, or
- wish to be placed in residential or nursing home, being eligible under funding rules for assistance with fees from Social Services and
- be in need of several co-ordinated services and
- have severe mobility problems, or have difficulties carrying out normal daily living functions (e.g. washing, dressing, toileting, food preparation or getting in and out of bed), so help is needed or received from a paid carer, and/or
- be at high levels of risk in their own home or present a danger to others and/or
- as carers be experiencing serious physical and/or psychological stress due to the service user, and/or functional problems which will probably cause the carer's situation to break down.

Services provided

Following an assessment of need, and subject to being eligible for the service, a user will receive domiciliary care from one of the 18 external agencies on the council's approved list for domiciliary providers. The choice of agency, however, is made by the care

manager, according to the expressed need, type and cost of service provided. The services provided by external agencies consist of 'personal' and 'practical' support to users and carers. Services are available seven days a week and are not restricted, as with the in-house service, to particular hours of operation. The service is, however, financially assessed, as with the in-house service, and a maximum payment of £5.40 per hour is payable by the user according to individual means.

Service users

At the time of the research, the Care Management service had 200 users who were in receipt of care packages from external domiciliary agencies. Each of these users were in receipt of intensive care packages, consisting of 3 or more inputs per day, from an external domiciliary agency.

Financial information

The budget for the External Service in 1994/5 was £900,000. This represented just over 3% of the total Social Services budget for 1994/5, which was £27.7 million.

Each Care Manager had a budget of £40,000, to be spent in the Independent Sector, to purchase services for users, most of whom are maintained in the community, as opposed to a residential or nursing home. Care Managers, in their purchases, were to ensure that care packages did not exceed the equivalent residential or nursing home cost, applicable to the relevant user group, as outlined in the annual Community Care Plan (1994/5). If a package in the community is more expensive than the equivalent residential or nursing home cost, but is the choice of the user and/or carer, the latter are asked to pay the

difference, if they wish to receive that particular package. Table 6.3, below, indicates the price levels for 1994/5 of payments made by care management to residential and nursing homes for older people.

Table 6.3. 1994/5 prices of residential and nursing home placements.

Residential Care Homes

Registration category	Price Level (per week) £
Elderly	220
Very Dependent or Blind Elderly	272

Nursing Homes

Registration category	Price Level £
Elderly (incl. physically disabled over pensionable age)	329

Source: Case Study Borough 1994/5 Community Care Plan.

Making a cost comparison between residential placements and care packages, however, is problematic, since the placement figures represent 'prices' rather than 'costs' (see also chapter 10). In particular, the price of an external placement would exclude the cost of assessment, monitoring and review carried out by care management. Whilst comprehensive unit cost information on alternative care packages was not available in the case study borough, certain broad estimations can be made. For instance, domiciliary care is likely to form the largest component of an intensive care package and, from estimates of average weekly care programmes from care management and home care, an average user will be in receipt of 20 hours of care per week. If the unit costs for the respective services

(see chapter 10) are used of £7.39 (External Service) and £12.55 (In-house Service), then this would generate average weekly costs of £147.80 and £251 respectively. On this basis, the cost of purchasing care from the in-house service would be more expensive than the cost of a residential placement for the elderly (see table above), even excluding other areas of provision such as day care and meals on wheels. However, a more detailed discussion, on methods of unit costing, is taken up in chapter 10.

In addition to understanding the cost implications of different packages of care, Care Managers are encouraged to make 'creative' use of resources in purchasing care packages for individual users. They cannot, however, give money to the user to purchase their own care, neither can they pay individuals who are informal carers directly, because of current legislative restrictions. [This situation was current at the time of the research, but in 1997/8, under the Community Care (Direct Payments) Act (1996), certain categories of disabled people will be eligible to purchase their own care, under a new Personal Assistance Scheme, according to criteria being agreed in the case study borough]. The purchase and provision of domiciliary care, by care management, is restricted to independent agencies, selected from the department's approved list of providers, of which only nine of the eighteen were 'active', at the time of the research, in providing services to care management users.

IN-HOUSE SERVICE

The in-house Home Care service, which forms the **control group** for the research, provides 'personal' and 'practical care' support, to currently around 1300 people living in their own homes. Since April 1993, the Home Care service has been increasingly targeted on people with high level needs, who, without such services, would be likely to enter residential care. Home Care at the time of the research was provided through three district offices, backed up by management and administrative support teams, based within the council's main civic offices.

The Home Care Service offers a range of personal and practical care services to users who are eligible for the service. Users are presently **assessed** by home care organisers, who manage teams of carers that provide the service in accordance with that assessment. The empirical research confines itself to elderly users in receipt of 'intensive' services, whose needs are recorded, as with care management, on a **care plan**. An 'intensive' service, for the purposes of the research is one in which users receive three or more daily care inputs, to enable them to remain independent in the community. **Reviews** of care plans, by the in-house service, although less frequent than reviews of the external service, are carried out, as a minimum, once a year.

Eligibility criteria

To be referred to the Home Care Service, users must be:

- resident in the case study borough; and
- require help with basic needs on a seven day a week basis; and
- housebound or post retirement age, and who, without support from a paid or unpaid carer would otherwise have to consider admission into residential care; and
- in need of assistance with most of the following tasks:
 - a) Personal hygiene
 - b) Toileting/emptying commodes/lack of continence
 - c) Food preparation
 - d) Assistance with feeding
 - e) Getting out of bed
 - f) Dressing/undressing
 - g) Shopping
 - h) Laundry
 - i) Housework tasks
 - j) Dealing with bills/finances
 - k) Pension collecting
 - l) Preparing for bed
 - m) Medication

and /or be a carer who needs support

Case Study Borough. Eligibility criteria for Home Care.

Eligibility of users for the home care service since 1993 has been tightened. As a result, each current service user has had their service reviewed, resulting in a contraction of support to those assessed as having 'lower' dependency needs, together with an expansion of support to those assessed as having 'higher' dependency needs. Lower dependency needs are defined as where the service user simply requires assistance with housework and/or cleaning. Higher dependency needs are defined as where the user requires a 'mixed' package, comprising both practical (e.g. housework, cleaning, laundry, shopping etc.) and personal care elements (e.g. washing, dressing, toileting etc.). In addition to a shift in the

distribution of care hours towards those with higher dependency needs, there has been a contraction in the number of hours of care provided overall.

Services provided

The in-house service provides a seven day a week service offering personal and practical support to dependent adults and their carers. It also provides a practical care service for elderly people, younger people and families who need care to help them to remain in their own homes. The practical service, however, has been reduced and new entrants to the service, from April 1995, are no longer eligible to receive housework or cleaning as a 'stand alone' service, although they may still receive assistance with laundry and shopping. These services are financially assessed, with a maximum payment, from the user, of £5.40 per hour. Services are available seven days a week, between the hours of 7 am and 11 p.m., according to assessed need.

Service users

As at 1st January 1995, the number of older people receiving Home Care was 1328. Table 6.4, below, indicates the proportion of these users receiving different durations of home care.

Table 6.4. Proportion of users receiving different durations of care episode.

TIME Hours per week	NO. OF USERS	%
0 - 1 hour (incl.)	346	26%
>1 - 2 hours (incl.)	370	28%
>2 - 5 hours (incl.)	402	30%
>5 - 20 hours (incl.)	210	16%
TOTAL	1328	100%

Source: Home Care Report. January 1995. Case Study Borough.

The users, for the purposes of my research, included older people who received more than three care inputs per day (to enable a 'matched' comparison with the external service) and were drawn from the shaded category in table 6.4 above. Within this category, users selected for the 'control' sample received up to 20 hours of care each, which allowed comparability with the external service.

Financial Information

Table 6.5, below, analyses the expenditure on the in-house home care service from 1992/3 up to 1995/6. The £2,756,269 spent on the Home Care Service in 1994/5, represented 10% of the total Social Services budget for 1994/5, which was £27.7 million.

Table 6.5 Analysis of Home Care Service expenditure 1992/93 - 1994/5 and estimate for 1995/6.

	Actual 1992-93	Actual 1993-94	Original estimate 1994-95	Actual 1994-95	Estimate 1995-6
Net expenditure	£2,081,873	£2,041,956	£2,120,000	£2,756,269	£2,291,900

Source: Case Study Borough. General Ledger.

From the above table, it is evident that actual expenditure increased in real terms by £634,033 (excluding inflation of 3%) between 1993/94 and 1994/95 and that this had not been anticipated in the original 1994/95 budget. This corresponds to an increase in demand for the service in 1994/5 of around 31%. Since trends in user demand for the service are rising, it would appear that the estimate for 1995/96 was unrealistic.

A recent financial appraisal of the service (see chapter 10) linked the overspend in 1994/5 to inadequate management information and budgetary control. Given that demand for the service is increasing, the report indicated that managers needed to operate strict budgetary measures to keep the service within budget. Such measures included rationing resources for home care, on the basis that corporate or departmental contingency funds were not likely to be available to subsidise future overspends, as had previously been the case. Thus, the implications for service users are that they are prioritised on the basis of assessed need, resulting in those who are eligible, but with lower dependency needs, being transferred to a waiting list. However, prior to the report, rationalisation of home care resources had already been begun and had minimal effect on reducing the overall level of hours. Moreover, such measures risked compromising levels of user satisfaction by reducing perceived equity of provision between service users (see chapters 9 and 10). A further option, available to the department, of increasing income through raising charges for the home care service was rejected by social services committee, on the basis that it was deemed politically undesirable to raise charges above the current levels.

Overall, the area of rising in-house home care expenditure has been the source of some considerable departmental concern. Reasons for such increase in demand are likely to have arisen from a) an increasing awareness from users as to the range of services available under community care [see discussion on Schorr (1992, p35) in chapter 3], b) increasing demographic demand (8.4% increase in over 85s between 1993 and 1996 (Table 6.2) c) the impact of more 'efficient' hospital discharges by the Health Authority. Other sources of difficulty relate to control exercised by Government, through the administration of the

annual financial settlement to local authority social services departments: the Standard Spending Assessment (SSA). The latter is received by councils at the start of each new financial year and is increasingly being constrained to the point that growth in services is not allowed for, except on the basis of 'efficiency' savings. The effectiveness of the 'managerialist' model, in meeting new levels of demand within existing or lower levels of resources, is therefore at stake here.

Principles of Community Care Service Provision

The services provided by external agencies and the in-house service are required to operate within the objectives of community care provision, as set out in the White Paper (Department of Health 1989b, para 1.11). However, because of local political and demographic differences between authorities, each interprets these objectives for community care in a different way. The principles for the delivery of community care services, below, indicate the approach taken by the case study borough, for the implementation of community care:

- *Partnership.* A partnership in the planning and delivery of services should be created between service providers, consumers, carers and other collaborating agencies. This should involve not only jointly agreed policy frameworks but also the involvement of consumers and carers in decision making wherever possible.
- *Range of services.* A range of services should be planned, co-ordinated and provided by statutory, voluntary and independent agencies, which respond to the health and social care needs of consumers and carers.
- *Flexibility and choice.* Services should be responsive to the agreed needs of consumers and carers and to changes in them, to give real choice about the way they live and to gain or retain independence, within available resources.
- *Fairness.* Services should be provided equitably and on a non-discriminatory basis to meet the differing needs of individuals, taking into account their gender, disability, sexual orientation, ethnic, social, cultural and linguistic background.
- *Easy Access.* Services should be provided locally wherever possible, in accessible locations, with good publicity and information available in a range of languages including interpreting and signing and tapes for visually impaired people.
- *Consistency and reliability.* Efficient services should be provided by trained and reliable staff to consistently high and measurable standards at times agreed.
- *Respect for people.* Service providers should ensure that the worth of service consumers and carers is acknowledged and respected and their dignity enhanced.
- *Assessment.* The needs and potential of people with complex needs and their carers should be comprehensively and regularly reviewed by care managers/other professionals to take into account changing needs so that appropriate services and support can be provided.
- *Confidentiality.* The rights of service consumers and carers to confidentiality is of the utmost importance and must be respected.
- *Sharing the care.* Where a carer is involved, services should be sensitive to the relationship between the carer and the cared-for person.
- *Accountability.* Service providers should be accountable for the services they provide through opportunities for service consumers and carers to feedback comments and through publicity for complaints procedures and named people responsible for a service.
- *Respect for the environment.* The development of efficient services should simultaneously take into account their environmental consequences.

(Source: Community Care Plan. Case Study Authority. 1995/6)

From the above set of principles for community care service provision, in the case study borough, it is evident that they contain a number of tensions. Firstly, there is a pre-community care strand, in relation to 'fairness', 'respect' and 'sharing the care'. In relation to 'fairness' this describes the importance of distributing services in an equitable manner, which is likely to be in tension with the consumerist emphasis of community care, which in the context of current resource constraints, necessitates targeting services on those with highest needs. In relation to more 'personal' aspects of caring, such as 'respect' for people and 'sharing the care', these may prove difficult to sustain, given the greater emphasis of community care policy on external aspects of the market e.g. 'efficiency'. Secondly, there is a 'market' strand which includes more 'technical' features such as 'choice', 'flexibility', 'assessment' and 'accountability' which appear aligned to the objectives of the market model for community care set out in the White Paper (Department of Health 1989b, para. 3.4.3). (see also chapter 7).

Having established the context for empirical study, chapter 7 outlines the research methodology, chapter 8 sets out the survey results and chapter 9 analyses the data generated. The empirical chapters build on the first part of the thesis, which considers issues relating to the managerialist framework for community care and, in particular, problems within the 'market' model in the delivery of both qualitative and quantitative aspects of community care policy. In addition, a further issue raised in chapter 5 is considered, namely, whether users accept the consumerist premises of community care policy, which assumes that 'technical' aspects of the market, such as consumer choice, are desirable per se.

CHAPTER 7. EMPIRICAL INVESTIGATION: METHODOLOGY

The first part of the thesis argued that the application of market principles to welfare systems introduces problems within the 'market' model for community care in the delivery of community care outcomes. In particular, tensions exist between the attainment of effective outcomes for users and the requirement to provide value for money for social services departments. Furthermore, the managerialist framework, outlined in the Audit Commission 1985 and 1986 reports, assumes that such tensions can be resolved by the application of particular approaches to managerial and organisational change. Whilst much of the existing literature acknowledges such tensions may exist, it tends to focus on shortfalls in the attainment of community care outcomes, rather than to challenge broader assumptions relating to the sustainability of the managerialist framework. The empirical investigation below, in addition to demonstrating tensions within the community care model between the generation of qualitative and quantitative outcomes, seeks to identify features outside the market model that impact upon user satisfaction.

THE RESEARCH PROBLEM

In the case study borough, problems within the 'market' model are investigated in relation to the capacity of a 'contracted-out' care service to deliver the outcomes claimed in the community care legislation (Department of Health 1989b, para 3.4.3). The research focuses on domiciliary care provision, which in the case study borough is split between in-house service provision provided by home care teams and external provision provided by independent agencies. The 'problem' for empirical investigation is whether there are

differences in outcomes perceived by recipients of externally purchased care and users of the in-house service. Such differences might be expected in terms of the managerialist claims made by 'Caring For People' (Department of Health 1989b, s.3.4.3), which advocates greater choice and value for money in services as a result of contracting out. The purpose of the research is to investigate, for the case study borough, whether such benefits, from contracting out services, are evident. The qualitative material from the survey results (chapter 8) is further augmented by micro-illustrative cost data in chapter 10.

The questions raised in the survey of domiciliary users also provide an opportunity to assess and compare the 'technical' aspects of the market, emphasised by the community care reforms over the more traditional 'personal' aspects of service provision. Thus, an opportunity is created to investigate which of these features drives overall user satisfaction. For the purposes of this research, 'technical' aspects of the market model include factors such as 'choice' and 'flexibility' which are seen as accessible to external verification and contract specification. 'Personal' features, for the purposes of this research, include caring attributes and user feelings and as such represent more subjective outcomes. The former arguably relies on an 'arms length' contract enforcement model (see chapter 5); the latter appears more 'trust' based. Thus, the case study research seeks to investigate the efficacy of the market model in generating qualitative (e.g. choice) and quantitative outcomes (e.g. value for money). It also seeks to identify whether it is the technical aspects of the market model or the personal features of the pre-community care service that contribute to overall satisfaction.

PROBLEMS IN CARRYING OUT CONSUMER SATISFACTION RESEARCH

Donabedian, an acknowledged 'guru' of quality assurance, views consumer satisfaction surveys as of fundamental importance in measuring the quality of care, by giving information on the provider's access to meeting client values and expectations, which are matters on which the client is the ultimate authority (Donabedian 1980, p25). Donabedian consequently sees consumer satisfaction questionnaires as important 'tools' for research, administration and planning (Ibid.). Whilst Donabedian does not advocate the uncritical use of surveys of consumer opinion, such a view, according to Williams (1994, p511) contains a number of assumptions about the way in which consumers evaluate. Namely, that i) consumer opinion exists; ii) consumers have belief in the legitimacy of their opinions and iii) consumers have a willingness to engage in an expression of that opinion. Williams, consequently, whilst acknowledging the importance attached to consumer satisfaction, as an outcome measure of care services, is concerned that more work should be carried out to identify the ways in which consumers perceive and evaluate services. Whilst it is acknowledged that the use of a consumer satisfaction survey in the case study borough also makes certain assumptions, in line with Williams' observations, about the way consumers evaluate services, it was not practicable, working within the limitations of resources available for research, for the author to carry out a prior investigation into the way consumers perceive and evaluate services.

A further area relating to consumer satisfaction, which the literature is in general agreement on, is that the aspect of satisfaction often reflects a judgement of either context or personal relation, rather than simply 'objective' service characteristics. This would

appear to be the case in the empirical research. Moreover, whilst this argument is often used for complex professional services, such as acute hospital care, Shaw suggests it is applicable also in the area of social care: '*Client evaluations are...relative to context, to knowledge of services, to expectations,... to perceptions of the 'pleasantness' of the social worker*' (Shaw 1984, p.280). In relation to consumer 'expectations', whilst the recentness of the community care market reforms would suggest there is no reason to expect the 'experimental' and 'control' groups to differ in this respect, no objective test was possible in this area.

A further aspect of consumer satisfaction surveys is the communication between interviewer and respondent, in relation to the quality of 'rapport' that develops between them. According to feminist researchers, Bowles and Klein (1983, p150), traditional methodologies that rely on questionnaires, tend to strip respondents of their context, whilst interview situations are more likely to develop a 'rapport' between interviewer and respondent, which in turn is likely to have positive benefits in terms of the quality of information collected (see also later discussion under 'alternative empirical approaches').

In relation to the domestic circumstances of many women, Finch (1985, p74) considers such conditions are more likely to make them open to intrusions, such as letting an interviewer into the home, than men. In turn, the nature too, of such a contact, is more likely to take on an 'intimate' character (than with men), with consequent greater benefits in terms of the quality of information that can be collected in this way (Ibid.). Nevertheless

it could also be argued that such a situation, if handled inappropriately, might be exploitive of the circumstances that many women find themselves in.

Such a feminist critique of social research, as briefly explored above, is of relevance also to those carrying out research with older people, in that the majority of older people are women (80% in the case study sample). However, whilst the aspect of gender relationships to the research of older people would have been an interesting additional area to study, it was not possible, due to constraints imposed by the work environment, to investigate this area. Nevertheless, in view of the issues raised above, the choice of interviewers selected was predominantly female (5 female: 1 male).

ALTERNATIVE EMPIRICAL APPROACHES.

In tackling some of the potential problems of carrying out user satisfaction research introduced above, a range of approaches were open to the author. These included: 'focus groups', 'telephone surveys', 'self-completion questionnaires', and 'interviews'. Each particular method has its particular advantages and disadvantages which will be briefly discussed below.

'Focus groups', whereby a particular group of people (e.g. older people at a day centre) are brought together to seek their views on a particular subject, form a popular method for local authorities interested in consulting with particular groups of people. However, in the author's experience of consulting on local community care plans, such methods necessarily

tend to emphasise dominant themes of a group of people, rather than obtain in depth individual perceptions of services.

Telephone surveys, on the other hand, whilst seeking the views of individual people and providing a fast and low cost way of obtaining data, tend to limit the observations of context open to the researcher and constrain questions to a more 'mechanistic' format. A further method, self-completion questionnaires, which have formed a common approach in the past to consumer satisfaction surveys, share some of the advantages of the telephone methods in terms of the relative ease and low cost of data collection. A particular constraint, however, of such a method, is that it does not appear to address the potential 'passivity' of older people to consumer satisfaction surveys, in that it tends to diminish the value of users' own experiences, which may be important in their evaluation of services (Oakley 1990, p32). According to Williams, problems around the 'passivity' of consumers, in relation to aspects of service provision, may contribute to generally high overall satisfaction ratings, especially amongst older people (Williams 1994, p513). Such factors were of concern to the author in view of the age, frailty and 'house-bound' nature of the samples of domiciliary users to be investigated and suggested use of alternative methods.

One such alternative to the self-completion questionnaire, in view of the problems discussed of 'passivity' in relation to older people, is the 'interview' approach. According to McIver (1991, p17), such an approach may enable older people, in particular, greater ease of communication in relation to sharing 'experiences'. Kellaher (1991, p25) and

Willcocks (1991) similarly recognise the constraints of alternative methods, such as self-completion questionnaires, and argue positively for the adoption of interview methods with older people, on the basis that this facilitates more of a self-advocacy approach in which the user is encouraged to 'speak out' (Ibid.).

The case study survey, in recognising some of the problems of the different methods, discussed above, adopted a 'semi-structured' interview approach to the survey. Such a choice of methods was also suggested by previous consideration, by the author, of the appropriateness of different techniques to a range of research contexts (Winsor 1994, p13 - see appendix III). Thus, whilst a questionnaire was used, it operated, not as a 'tool' for respondent completion, but by way of a facilitator's 'brief', to indicate the questions that should be raised by the interviewer, without being over-prescriptive of the way in which individual questions were asked. Nevertheless the use of a questionnaire, within an interview context, provided a consistent framework for different interviewers to operate within, by listing questions in a systematic way. The recording of questions, however, was not intended to detract from the building of a 'rapport' with the respondent. In this respect interviewers were urged to develop a positive relationship with the respondent, maintaining as much eye contact as possible, whilst maintaining an adequate record of user responses.

In order to further address potential problems of passivity discussed above, the questionnaire made use of 'open-ended' as well as 'close-ended' questions. The former enabled interviewers to explore the context of the question, by obtaining further

information from respondents in support of their answers, thus augmenting information on levels of respondent satisfaction collected by the latter. Furthermore, on the basis that respondent passivity might be caused by concerns around withdrawal of service, researchers were advised to assure users that participation in the survey would not endanger their continuing receipt of services.

Overall, therefore, there is no one correct method. However, on weighing potential advantages and disadvantages, the semi-structured interview approach, incorporating a user satisfaction questionnaire, was favoured, for the above reasons, over alternative empirical approaches.

THE PROCESS OF EMPIRICAL INVESTIGATION

(Incl. problems encountered and possible limitations of data and methods of analysis)

The research 'problem', as has already been discussed, was to investigate whether there were differences in perceived outcomes by recipients of externally purchased domiciliary care and users of in-house home care services. The first part of the research involved assessing consumer satisfaction for different aspects of the process of providing domiciliary care. The second part of the research involved a critical review of a recent value for money audit carried out in the case study borough. The methods used for review of the local VFM audit are set out in chapter 10. This chapter focuses on the methods used to carry out the investigation of consumer satisfaction.

The research into consumer satisfaction levels, for both in-house and externally purchased domiciliary services, was carried out in March 1995. The method used (see also above)

involved an interview, making use of a semi-structured questionnaire, which raised questions on different aspects of the process of service provision, namely: 'access to service', 'assessment', 'characteristics of service', 'characteristics of carer', 'feelings of user' and other areas (see also chapter 8). Thus, an assessment was enabled of the different levels of user satisfaction operating between in-house and external recipients of care services, for different parts of the process of care delivery. In addition, and where appropriate, qualitative data arising from discussions with care managers and care staff were included, as a means of triangulating the survey data.

The remainder of the chapter describes different aspects of the methodological approach to the empirical research. These include: *the use of the in-house service as 'control', construction of the sample, 'matching' process, service participants, questionnaire design, pilot stage, data collection and data analysis*. Each of these is discussed in turn and associated conceptual and practical difficulties considered together with possible limitations of data and methods of analysis.

The use of the In-House Service as 'control'

In relation to research design, the external service, for the purposes of this research, operates as the 'experimental' group, whilst the in-house service serves as a pre-community care 'control'. Both samples are matched according to four demographic factors (see below). The significance of the in-house home care provider as a 'control' is reinforced by the fact that it has not yet undergone an organisational re-structuring between 'purchaser' and 'provider' (see chapter 6), as described in the policy guidance to

the Community Care Act. (viz. Department of Health 1990b, para. 4.5). Consequently, whilst the in-house service combines roles of both ‘assessor’ and ‘provider’, the external service operates exclusively as a service provider, commissioned by care management. Such a situation provides an opportunity to assess the benefits claimed by the reforms (Department of Health 1989b, para 3.4.3) in contracting-out domiciliary services to the external sector (the ‘experimental’ group), by comparing them with an equivalent portion of retained in-house provision (the ‘control’). The role of the in-house service, however, as ‘control’ is not exacting. In this respect, whilst the latter had not, at the time of the research, undergone re-structuring to differentiate between ‘purchaser’ and ‘provider’, it could be argued, to some extent, that it operated within the changed context provided by the introduction of recent community care legislation. Nevertheless, whilst acknowledging certain limitations of the method, the importance of the ‘control’, to the case study research, lay in its continuity with pre-community care methods of providing services in-house.

The sample

The user group investigated in the research is **older people**. The significance of using this group for the research was that it represented the largest group in receipt of community care services (see also preface) and would therefore have the most significant implication for resources (see chapter 6). In constructing the research samples, 40 users from the external service (‘experimental group’) were matched against 40 users of the in-house service (‘control’). The two samples were then matched according to four demographic characteristics (see below):

- Age - 65/74; 75/84; over 85
- Gender - male/female
- Ethnicity
- Service input (More than three care inputs per day was selected as a 'proxy' for 'disability')

The use of 'age', 'gender' and 'ethnicity' is standard for much empirical research. The inclusion of a measure of 'service input', rather than a measure of 'disability', is discussed below.

Matching process

Table 7.1 'matching' characteristics

USER NO.	AGE BAND	GENDER	ETHNICITY	SERVICE INPUT
1	2	m	W/E	3+
2	2	m	W/E	3+
3	2	f	W/E	3+
4	3	f	W/E	3+
5	2	m	W/E	3+
6	3	f	W/E	3+
7	3	m	W/E	3+
8	3	f	A	3+
9	3	m	W/E	3+
10	1	f	W/E	3+
11	3	f	W/E	3+
12	2	f	W/E	3+
13	3	f	W/E	3+
14	3	f	W/E	3+
15	3	f	W/E	3+
16	3	f	W/E	3+
17	3	f	W/E	3+
18	2	f	W/E	3+
19	1	f	W/E	3+
20	2	f	W/E	3+
21	3	f	W/E	3+
22	2	f	W/E	3+
23	2	f	W/E	3+

24	2	m	W/E	3+
25	2	f	W/E	3+
26	3	f	W/E	3+
27	2	f	W/E	3+
28	3	f	W/E	3+
29	3	f	W/E	3+
30	3	m	W/E	3+
31	3	m	W/E	3+
32	3	f	W/E	3+
33	3	m	W/E	3+
34	3	f	W/E	3+
35	3	f	W/E	3+
36	3	f	W/E	3+
37	1	f	W/E	3+
38	1	f	W/E	3+
39	1	f	W/E	3+
40	2	f	W/E	3+
P1	2	f	W/E	3+
P2	3	f	W/E	3+
P3	1	f	W/E	3+
P4	3	f	W/E	3+
P5	2	f	W/E	3+

Key:

<i>user no.</i>		<i>age bands</i>	
P	= Pilot	1	= 65 - 74
		2	= 75 - 84
		3	= 85 and above
<i>gender</i>		<i>ethnicity</i>	
m	= male	E	= White European
f	= female	A	= Asian
<i>care inputs</i>			
3+	= More than 3 care inputs per day		

Table 7.1, above, records the profile of the research sample in relation to the 'matching' characteristics used. The sample size of 40 users, generated by the matching process, represented 50% of the total care management population in receipt of domiciliary services (80 users) at the time of the research. Information was received on all 80 users of

the external service together with 91 users of 'intensive' in-house home care services. The number of in-house service users, for which information was available, exceeded the number of care management users, in order to ensure that sufficient matches could be found for the empirical sample. 'Drop-out' from both samples was due to user levels of frailty (1 for in-house service; 3 for external service), user or carer refusal to participate (14 for in-house service; 16 for external service), or no match being available between the two groups (36 for in-house service; 21 for external service).

Age

In relation to age, the samples contained users in three separate bands from 65 years of age upwards (see Table 7.1 above). Of these, 12.5% were 65-74, 32.5% were 75-84 years and 55% were in the over 85 age group. Such percentages, rather than reflecting the proportion of such age groups within the case study borough overall, reflected instead the service criteria for in-house and external services, which were targeted on people with higher levels of need, who predominantly came from the higher age bands.

Gender

In relation to gender, 8 of the 40 users (20%) in each sample were male (cf. Borough average over 65 years: 38%). A likely reason for the lower percentage of males in the research sample compared with the Borough average is that a large proportion (55%) of the sample group is over 85 years. At this age it is likely that more women would be surviving than men. If, on that basis, the comparison for males in the sample population is made with the Borough average for the over 85 group, then the percentage is comparable:

sample average 20% cf. Borough average (over 85s) 22.4%. In view of the high percentage of women in the sample the choice of interviewers was predominantly female (see earlier discussion).

Ethnicity

In relation to ethnicity, the sample population, containing one Asian person out of 40 users (2.5%), was comparable with the Borough population average of 2% Asian origin. Whilst it is accepted that the category of 'Asian' is problematic, in that it is open to broad interpretation, the survey made use of ethnic monitoring data from social work assessment forms, which adopted this particular category. The decision to use assessment forms, as primary sources of data on ethnicity, was based on the fact that asking such questions during an interview might appear 'invasive' and threaten the quality of the rapport between interviewer and respondent. Whilst it is accepted that some of the categories used by social work teams were open to confusion, the alternative more direct means of obtaining such data was rejected for the above reason.

Service input

At the time of the research, no scale of disability was used by professionals. Instead, social work assessors categorised users in terms of three levels of dependency: 'high', 'medium' and 'low'. Arising from discussions with assessment professionals, a 'high' level of dependency was equated to a 'high' level of disability. In turn, a level of three or more service inputs per day was agreed as being a proxy indicator of a 'high' level of disability. In this respect, the level of inputs was not an exacting indicator, but represented a

practical solution to the problem of measuring disability and enabling sufficient 'matches' to be constructed between the two samples.

Service Participants

The service participants comprised nine external domiciliary agencies ('experimental' group), from the 'approved' list of providers (see chapter 6), who were 'active' at the time of the research and the three locality teams of the in-house home care service (the 'control'):

External Service:

- Agency A
- Agency B
- Agency C
- Agency D
- Agency E
- Agency F
- Agency G
- Agency H
- Agency I

In-House Service:

- Home Care Team 1
- Home Care Team 2
- Home Care Team 3

In comparing the performance of the external service to the in-house service, it is acknowledged that the external service is not one service, since it includes services from a range of domiciliary agencies (nine are included, on the basis that they were 'active' providers at the time of the research) from the Borough's approved list of care providers.

To be admitted to the list, agencies were required to satisfy a range of requirements in relation to cost and quality. Since no one agency had a significant monopoly of users and this is a deliberate feature of the 'spot' purchasing system operated by care management, it was not possible to compare the in-house service with a sole external provider. On the other hand, it may be argued too, that the in-house service, operating from a range of geographic bases (three at the time of the survey), did not possess total consistency in all perceived areas of operation. Thus, 'distortions' should be acknowledged for both external and in-house services.

Questionnaire design

The questions used in the survey were selected from a range of sources, which included the external domiciliary service specification, standards published by UKHCA (United Kingdom Homecare Association) for domiciliary care providers and a range of discussions with care management and home care staff. Although the initial questionnaire design was drawn up on the basis of a range of professional perspectives, the pilot stage enabled the questions to be tested with users in the field.

The chosen structure for the questions, as discussed above, reflected the different 'technical' and 'personal' aspects of the process of providing domiciliary care. Questions were designed in mainly 'multiple-choice' format to facilitate ease of answering and data analysis. Each question had additional scope to collect further comments from users or qualify answers already given. In this way it was considered the user would be enabled to contribute additional perspectives and insights into the service, without being constrained

through an over prescriptive questionnaire format. A copy of the questionnaire can be found in Appendix II.

Pilot stage

Following the design stage, the questionnaire was piloted on 10 users, divided equally between in-house and external samples. Where problems were encountered in communicating survey questions, during the pilot stage, these were later examined and the questionnaire design appropriately revised. As a result, a number of questions (relating to 'information' and 'assessment') found to be duplicative or ambiguous were removed, language was further simplified and a range of interview prompts developed (see Appendix). Questionnaires used in the pilot were clearly marked to distinguish them from the rest of the interviews and excluded from the main sample.

Data collection

In-depth interviews with both samples of users were carried out by a research team over a period of three weeks: 20th March to 10th April 1995. The research team comprised the author, as Project Manager, and six field interviewers (five female/one male) from Alpha Research, an external agency, selected because of experience in collecting consumer satisfaction surveys with frail older people. Before interviews were arranged, permission was sought from users from both samples by means of a letter of introduction. (see Appendix I). This was an important 'ethical' consideration within the research, in order that no user experienced coercion in taking part in the survey. Users were also made

aware, through this process, that all information would be treated as anonymous and confidential.

Overall responsibility for the survey was assigned to the author, who designed the questionnaire and 'briefed' the research team. 'Briefing' of the team consisted of reviewing each of the questions in turn with the field researchers, in order to ensure that each interviewer had a common understanding of the questions being asked and the concepts that lay behind them. As part of the briefing it was also explained to interviewers that clients often feel 'vulnerable' as recipients of council services and as a consequence tend towards complimenting a service too readily, for fear of having that service withdrawn. In order to make some allowance for this, interviewers were instructed to give users verbal reassurances, where appropriate, that taking part in a survey would not lead to withdrawal of the service. In addition users taking part in the survey were again reminded that anonymity would be preserved and any information given would be treated in confidence. Each interview lasted one hour and answers were recorded on the questionnaire by the interviewer. The period of one hour was felt to be appropriate, in view of the need to allow time to gain the confidence of the user and to explain any difficult concepts involved.

At the end of the first day of interviewing a 'de-briefing' session was held with the team of interviewers to discuss various difficulties or issues encountered during the field research. Such an opportunity enabled a common experience base to be developed, which could be re-invested in further interviews and contribute to a better understanding of any

issues and problems involved (see next section). The team consisted of mainly female interviewers, and this was considered important on the basis that the majority of respondents were female (see earlier discussion). All other aspects of the research, including the analysis of research data, were undertaken by the author, who also participated in a series of interviews.

De-briefing sessions

During the course of the research a range of de-briefing sessions were held in order to share experiences of carrying out the research, as well as to identify and resolve any problems encountered. In most cases, the experience of interviewers was that they were warmly invited into respondents homes and, in many ways, their arrival seemed to relieve a sense of loneliness, a theme also reflected in answers to the question on 'feelings on arrival of carer'.

Because the respondents in many cases enjoyed the opportunity for conversation, the interviewers had to work hard to prevent respondents from digressing too much from the questions. In such circumstances, interviewers were briefed to lead respondents back to the interview, by reinforcing the question being asked. In other instances some of the digressions proved valuable, in providing additional information in support of a particular question. In such cases the information was recorded alongside the question it referred to.

A further perception of interviewers, in carrying out the research, was the high level of frailty of respondents. Such problems were to be expected, in view of the fact that 55% of

respondents surveyed were in the over 85 age group. One person contacted appeared to have difficulties in breathing and had to use a nebuliser during the course of the questions. Although the particular interviewer recommended that the interview be suspended, the respondent asked that the interview continue, but at a slower pace. One person had recently suffered a mild stroke and the interviewer had to concentrate hard on recording responses to questions, often checking answers back with the respondent to ensure accuracy. During the de-briefing session, the alternative option of providing pen and paper to the respondent was discussed.

In addition a number of respondents appeared to have degrees of 'confusion', and in such instances, where a carer was able to be present, their assistance was occasionally invited to assist in the answering of questions. However, during the de-briefing, interviewers were reminded that the needs of users and carers may be conflicting, and that they should be alert to any tendency for the carer to want to 'take over' from the user under such circumstances. In the small number of instances where a carer helped facilitate the interview, this was clearly marked on the questionnaire.

Data analysis

The user satisfaction survey represented a small scale piece of research on two samples of 40 users, drawn from the external and in-house domiciliary services respectively. The research involved qualitative and quantitative elements. The qualitative side involved the detailed analysis of user comments to identify particular themes in relation to respondent

perception of services and related satisfaction. The quantitative side of the research involved the assessment and comparison of levels of respondent satisfaction between external and in-house services. Such a combination of approaches, together with relatively small sample sizes, presented problems in the application of statistical tests of correlation. In particular, the Chi2 test was rejected on the basis that the sample sizes were small and that a 'control' was already built into the research design (see earlier discussion). Under such circumstances, the use of a statistical test of correlation, such as the Chi2 test, appeared inappropriate.

In relation to user comments, these were grouped together in response categories which were chosen to illustrate 'common' themes. In some cases where a comment might have fitted in more than one category, a decision was made to select a category that fitted the 'dominant' theme. If there was no clear dominant theme, the comment would be listed in the separate categories to which it applied and cross referred. Whilst the process of sorting comments into categories can introduce a degree of simplification, this method was used on the basis that it broke down a larger group of comments into a range of smaller identifiable themes, which were more accessible to investigation.

A further area of data analysis involved a calculation of 'net' satisfaction. In examining levels of satisfaction, particular categories of satisfaction were often identified e.g. the 'very satisfied' response. Whilst, this was useful in terms of identifying perceived levels of service 'excellence', it was also important to place this within a broader context for understanding satisfaction, namely 'net' satisfaction. The calculation of net satisfaction,

used in chapter 8, involved the summation of the different levels of satisfaction e.g. 'very', 'fairly', 'partly' followed by subtraction of the negative response i.e. 'not satisfied'. Such a method of calculation was chosen on the basis that an individual level of satisfaction e.g. 'very satisfied', could appear misleading, particularly where there were further substantial levels of satisfaction at lower levels e.g. 'fairly satisfied' or where there were high levels of respondents who indicated they were 'not satisfied'. Although, as was acknowledged earlier, there are possible problems with 'passivity' of older people in general, which may lead to inflated levels of recorded satisfaction, the process of combining categories (including negative scores), notwithstanding the above effect, is defended on the basis that such a process provides a more 'complete' perspective on the spectrum of satisfaction perceived by respondents in the survey.

An additional area of difficulty for the analysis of data arose from the high use of 'don't know' and 'other' categories in questions relating to 'information' and 'assessment'.

Whilst it is acknowledged, in chapter 8, that such responses often confuse interpretation of data, exclusion of these categories would have affected the precise 'matching' between 'empirical' and 'control' groups. If such categories had been removed for both groups, the corresponding 'matches' would also have had to have been excluded. This would have left a much reduced sample size, which would have made the comparison between the two groups further problematic.

ASPECTS OF SUBJECT EXCLUDED FROM THE EMPIRICAL INVESTIGATION

Certain areas have been excluded from the empirical research for reasons related to constraints within the author's work environment. These include an investigation into contracts with independent sector providers and the implications of the market model for employment in the social care sector. Whilst these would have been potential areas for investigation, the author was prevented from empirically investigating these areas because of restrictions in the work environment. Namely, that working in the case study authority, as Planning and Commissioning Manager, required the author to justify levels of time spent on empirical research. This had the effect of limiting the empirical work, in the case study borough, to a user satisfaction survey of domiciliary care and an investigation of micro-illustrative cost data for the home care service. Nevertheless, some of the theoretical themes from chapter 5, in relation to the impact of the market model on the operation of domiciliary care services, are further investigated in chapter 10. The latter, in investigating the difficulties associated with generating cost norms, considers the potential negative effect of the market model on employment conditions, which in turn are likely to impact on user satisfaction levels. However, for the reasons set out above, a more detailed study of this area was precluded.

The above chapter discussed the methodology used for carrying out the user satisfaction research. In addition, it investigated problems in the research design and limitations of data and methods of analysis. The following chapter (chapter 8) sets out the survey results which are subject to a detailed analysis in chapter 9.

**CHAPTER 8 EMPIRICAL INVESTIGATION:
SURVEY RESULTS**

The following chapter sets out the empirical data generated from the user satisfaction survey carried out by the author, in the case study borough, in March 1995. The data is presented in tabulated form, for both external and in-house users, and relates to six different aspects of service delivery which correspond to the six sections of the questionnaire (see Appendix II).

Table 8.1: The different aspects of service delivery (relating to sections of the questionnaire)

SECTION	ASPECT OF SERVICE DELIVERY
(1)	ACCESS TO SERVICE
(2)	ASSESSMENT
(3)	CHARACTERISTICS OF SERVICE
(4)	CHARACTERISTICS OF CARER
(5)	FEELINGS OF USER
(6)	OTHER AREAS

In each of these areas, users are invited to provide a satisfaction rating on different aspects of the service. The results are compared between the external service, as 'experimental' group, and the in-house service as 'control'. Thus an assessment is enabled of the relative benefits of contracting out a domiciliary service, as promoted by the reforms, compared to a pre-community care control. In addition, through cross-tabulations, an investigation is made of the impact on overall satisfaction of a range of 'technical' and 'personal' factors within the process of providing care.

1. Access to service

The initial access point to a service is via information. Information can be communicated verbally e.g. through professionals such as doctors or social workers or in printed form.

Even before a user can be assessed for a particular service, such as domiciliary care, information must first be available in an 'accessible' form.

The following questions were asked to identify the extent to which information about the respective services was available, the ease of obtaining that information, and its comprehensiveness in describing different aspects of the service.

Table 8.2: Finding out about the service.

(Q. How you found about the service?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
From a leaflet	0	0	2	5
From Social Services	17	43	4	10
From a friend or relative	3	7	9	23
Other	20	50	25	62
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 1a: *How did you find out about the service?*)

* *The other category includes Hospital and GP*

External service users were much more likely to find out about the service through the 'formal' channel of social services (43% as against 10% for the in-house service).

Conversely, 'informal' sources such as friends and relatives were much more important for

in-house users (23% as against 7% for the external service). Hospitals and GPs, however, which formed the major part of the 'other' category, were the largest source of information on services, outside the main response categories, for both services. Within the hospitals, this was provided mainly by the social work teams.

Table 8.3. Ease of getting information
(*Q. How easy was it getting the information*)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Very easy	15	38	10	25
Fairly easy	12	31	8	20
Very difficult	3	8	2	5
Don't remember	4	10	15	37
Other	5	13	5	13
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 1b: *How easy was it getting the information?*)

* *The other category includes: arrangements made by someone else; visited by worker.*

From the above table, a higher proportion of external service respondents found it 'easy' to obtain service information, compared to the in-house service. If the 'very easy' and 'fairly easy' categories are combined, less the 'very difficult' category, 21% more respondents from the external service (61%) found it easy to get information, compared to the in-house service (40%). Furthermore, nearly four times the number of in-house service respondents reported they 'didn't remember' whether it was 'easy' or not to obtain service information. This may be due in part to the fact that in-house home care users had

been on average with the service for a longer period than external service users. The service manager estimated that users of the in-house service had been with the service on average for around 3-5 years. By contrast care management records indicated that, on average, external service users had been with the service for under a year. Such a difference between the two samples was unavoidable, due to the fact that the external service commissioned by care management had only been in existence since April 1994, whereupon it was set up specifically in response to requirements of the community care reforms, which required that 85% of special transitional grant monies, for community care, were spent in the external sector. The significant proportion of 'don't remembers', particularly for the in-house service, makes the analysis problematic.

From investigating the 'other' category responses, users from both services reported arrangements being made on their behalf, implying that in such circumstances information on services had not been an issue for them.

Table 8.4. Comprehensiveness of information

(Q. Did the information tell you everything you needed to know?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Yes	25	63	17	42
No	6	15	4	10
Don't know	7	17	16	40
Other	2	5	3	8
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 1c: *Did the information tell you everything you needed to know?*)

* *The other category includes arrangements made by someone else*

From the above table if the 'No' replies are deducted from the 'Yes' replies, the external service has 16% more respondents, who indicate they have comprehensive information about the service, than the in-house service. (External Service 48% c.f. In-house Service 32%.)

The larger percentage of 'don't knows' (40% in-house service), compared to the external service (17%), may, as with previous questions be due to the longer average period that users of the in-house service have been with that service. (See comments under table 8.3).

2. Assessment

Assessment represents a key initial stage in the process of receiving a service and a pre-condition of it. In carrying out an assessment, a range of questions in relation to the dependency of the user, and eligibility for particular services, is raised by the assessor.

Assessments have the potential to leave significant impressions with the user, as they often involve quite lengthy (a typical initial assessment interview lasts an hour) personal and searching questions e.g. on aspects of personal care and finance. The different arrangements for assessment, between external and in-house services, are described in chapter 6.

The following questions were raised to identify the ease of obtaining an assessment, the degree of consultation with the user and the degree of satisfaction with the assessment.

Table 8.5. Ease of receiving an assessment
(*Q. How easy was it getting an assessment?*)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Very easy	15	37	13	32
Fairly easy	18	45	11	28
Very difficult	2	5	2	5
Don't remember	4	10	10	25
Other	1	3	4	10
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 2a: *How easy was it getting an assessment?*)

* *The other category includes: 'everything organised for the user'.*

From the above table, on combining the 'very easy' and 'fairly easy' categories, 22% more external service respondents report greater ease of access to the assessment process than the in-house service. However it should be taken into account that a comparable proportion of respondents (25%) of the in-house service reported that they 'don't remember'. As before, this may again be due to the longer period of time the in-house service users had been with the service, compared to users of the external service. (See again comments under Table 8.3).

Table 8.6. Consulting with user over assessment (statistical data)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Fully	23	58	14	40
A little	8	20	8	15
Not at all	4	7	2	5
Don't know	5	10	12	33
Other	0	5	4	7
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 2b)

From table 8.6, above, in relation to the 'fully consulted' category, the external service (58 %) reported a higher proportion of respondents perceiving consultation over assessment, compared with the in-house service (40%). A similar displacement is evident if the calculation includes the 'consulted a little' and 'not at all' categories.

As in the previous two questions on assessment, a higher proportion of 'don't knows' were recorded for the in-house service. (See under Table 8.3). In the 'other' category responses, respondents from both service reported that they had reached 'mutual' agreement over the assessments arrangements, indicating a degree of consultation had taken place.

Table 8.7. Consulting with user over assessment (user comments)

(Q. Were you consulted in your assessment?)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
USERS INVOLVED/ MADE AWARE IN CONSULTATION	<ul style="list-style-type: none"> • <i>Talked to me about everything</i> • <i>Went through the forms and asked what [user] could do</i> • <i>They came to see me and we discussed it</i> • <i>Yes, they asked exactly what was wanted</i> 	<ul style="list-style-type: none"> • <i>I felt involved in the arrangements if that is what you mean</i> • <i>I was aware of all the options</i>
FAMILY INVOLVEMENT	<ul style="list-style-type: none"> • <i>Family was consulted</i> • <i>They decided with my niece I could manage at home</i> • <i>Yes. I think so. With my wife, they all seemed to know what help I needed (see also * below)</i> 	<ul style="list-style-type: none"> • <i>I left most of the decision to my family</i> • <i>A little, bit my daughter was in attendance</i>

ARRANGEMENTS /ASSUMPTIONS MADE BY PROFESSIONALS	<ul style="list-style-type: none"> • <i>I shouldn't think so. It was automatic.</i> • <i>They told me what they would be able to do</i> • <i>Spoke above me</i> • <i>Not initially. Discussions over short period of time resolved availability etc. of various services</i> • <i>A little. I wasn't asked. It was assumed what I would need</i> • <i>Yes. I think so. With my wife, they all seemed to know what help I needed (see also * above)</i> 	<ul style="list-style-type: none"> • <i>My doctor arranged everything</i> • <i>The lady came to see me.....She made the arrangements. Said she'd put me down for the 'Put to Bed Service'</i> • <i>They came to see me. They told me</i> • <i>The doctor put things in and told me what they had arranged</i> • <i>They suggested everything. It was all cut and dry. The only thing I asked for was a chair. [Which they arranged]</i> • <i>Was told what would be done....given a timetable</i>
NO ASSESSMENT		<ul style="list-style-type: none"> • <i>Don't think I've been assessed</i> • <i>No one had ever been, unless they informed them from the Hospital....but they didn't inform me.</i>
FINANCIAL EMPHASIS BY ASSESSOR	<ul style="list-style-type: none"> • <i>You were just told how much it would cost</i> • <i>They told me I would have to pay from my pension</i> 	<ul style="list-style-type: none"> • <i>We spoke about it....what I get as regards my pension.</i>
RESPONDENT INCAPABLE OF TAKING PART	<ul style="list-style-type: none"> • <i>Respondent was incapable of taking part</i> 	<ul style="list-style-type: none"> • <i>On behalf of my wife - she wasn't capable of seeing anybody</i>

(Source: user satisfaction questionnaire. Question 2b)

Despite a greater perception of consultation over assessment arrangements from external respondents in Table 8.6, the user comments for both groups in table 8.7 suggest a similar picture of arrangements being made for the user, rather than with the user:

'They told me what they would be able to do' (External service)
'My doctor arranged everything' (In-house service).

Table 8.8. Satisfaction with assessment
(Q. Were you satisfied with your assessment?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Very satisfied	17	44	25	63
Fairly satisfied	13	33	4	10
Not satisfied	3	8	1	3
Don't remember	6	15	7	18
Other	0	0	3	8
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 2c)

** The other category includes no one came to assess me; service seemed expensive*

From the above table, at the 'very satisfied' response level 19% more in-house service respondents indicated they were satisfied with their assessment. This result is interesting, because in the context of table 8.6 (see above), this may suggest that consumer satisfaction with the assessment process, at the 'very satisfied' level, is not directly linked to the degree of consultation (which is higher for external service respondents), yet such a factor is emphasised by the reforms. (Department of Health 1989b. s.1.11)

In combining the 'very satisfied' and 'fairly satisfied' response categories and deducting the 'not satisfied' responses to arrive at a 'net' level of overall satisfaction, the picture modifies. In this situation, the respondent satisfaction for both samples is comparable.

(69% External; 70% In-House).

3. Characteristics of service

A key benefit, according to the community care reforms, is in the element of 'choice' that is provided to service users or consumers, arising out of the contracting out of services to

the independent sector (Department of Health 1989b, para. 3.4.3). The theme of 'choice' in this section is distinguished between choice in carer, choice in time of receiving care and choice of task completed by carer.

Table 8.9. Choice in carer (statistical data)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Yes	5	13	2	5
No	29	72	35	87
Other	6	15	3	8
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 3a)

* *The other category includes user perception that carers frequently changed.*

From table 8.9 above, although only a low proportion of users from both services indicate a choice in carer, the percentage of users for the external service (13%) recognising a choice in carer, is nearly three times the percentage of users of the in-house service (5%). Nevertheless the findings are problematic, since the actual number of respondents who replied 'yes' are low and are comparable also to the number of respondents who selected the 'other' category.

However, from experience of 'probing' users at interviews for further information, it appears that more external service users had been initially dissatisfied with the carer they received initially and consequently requested a replacement. In the light of this, the higher perception of choice by external service users may have been attributable, in certain

circumstances, to the breakdown of initial carer arrangements, necessitating a carer replacement, rather than by the direct application of choice per se.

More significant, however, for both external and in-house respondents is the proportion of recipients recognising 'no choice' in carer, which is high for both sets of respondents.

This may suggest, as above, on evidence provided particularly by the external service respondents, that, unless carer arrangements breakdown, users have no involvement in the selection of their carer.

Table 8.10. Choice in carer (User comments)

(Q. Were you able to choose the home carer you wanted?)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
HIGH STAFF TURNOVER/LACK OF CONTINUITY	<ul style="list-style-type: none"> • <i>They had quite a high turnover of staff</i> • <i>I had a lot of different carers originally, but now its settled down</i> • <i>Have to have who turns up</i> • <i>Agency P never sent the same two twice</i> • <i>Had a girl for first three sessions then changed</i> • <i>Too many different carers</i> • <i>Had different people - if not happy would tell</i> 	
ABSENCE OF CLEAR CHOICE		<ul style="list-style-type: none"> • <i>They didn't ask me</i> • <i>There was never any question of choice</i> • <i>Carers are just given to you. Suppose you could ask to change one if you didn't like one.</i> • <i>They just send somebody. I can't choose</i>

<p>PREFERENCE FOR PARTICULAR CARERS NOT OTHERS</p>		<ul style="list-style-type: none"> • <i>Didn't like the younger ladies, preferred the older ones, so they said they would find someone compatible</i> • <i>They appointed them after a while. I said I preferred Mrs M.</i> • <i>Preferred the older staff. They seem to be more sympathetic</i>
<p>LACK OF CHOICE BUT USER DOES NOT MIND</p>		<ul style="list-style-type: none"> • <i>No, but I like the ones who come to me</i> • <i>I'm not bothered. It wasn't necessary. different people come.</i> • <i>No, you just have what they send. They're pretty good - they send me the same ones as much as they can, except for holidays</i> • <i>No, but they're all lovely ladies, very cheerful and kind.</i> • <i>I just leave it to them - whoever is available. They're all very nice</i> • <i>No, but they're all nice</i> • <i>They just sent somebody, but I'm well satisfied with the carers I have.</i>
<p>CHOICE MADE BY OTHER</p>		<ul style="list-style-type: none"> • <i>Came to see my wife (implication: arrangements made for user by wife)</i>

(Source: user satisfaction questionnaire. Question 3a)

From table 8.10 above, it appears that there is a perception, particularly by users of the external service, that agencies keep changing their carers:

*'Agency P never sent the same two twice'
 'Have to have who turns up'*

This may suggest that carer continuity, particularly for users of the external service, is more important than receiving a choice in carer. From responses from in-house service users however, whilst it is generally acknowledged there is no choice of carer, this does not appear to be an issue for them and mostly their carers are rated highly by them.

Overall, the issue of concern to users appears to be more about carer compatibility and continuity, rather than simply matters of carer choice.

Table 8.11. Choice in times of receiving home care

(Q. Were you able to choose the times you wanted home care?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Yes	22	55	9	22
No	13	32	23	57
Don't know	2	5	3	8
Other	3	8	5	13
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 3b)

* *The other category includes time arranged for user; time agreed mutually.*

From table 8.11 above, the proportion of external service respondents (55%) perceiving a choice in time of carer was more than twice the level reported by users of the in-house service (22%). Such a high proportion of respondents from the external service perceiving choice is further reinforced if the 'No' responses are taken away from the 'Yes' responses.

Table 8.12. Choice of jobs (tasks) - whether user's experience a choice.
(Q. Were you able to choose which jobs you wanted doing?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Yes	19	47	17	42
No	12	30	16	40
Don't know	2	5	2	5
Other	7	18	5	13
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 3.c)

** The other category includes certain jobs not done e.g. housework, schedule of work arranged for user; staff are experienced so choice not required.*

From the table 8.12 above, if the 'No' responses are netted off the 'Yes' responses, the external service shows a 15% higher proportion of respondents who perceive a choice in jobs. In the in-house service, the proportion of users perceiving a choice in jobs is only slightly higher than the percentage who recognise no choice in jobs.

The 'other' category responses indicate that in both services, there is a perception that the care plan is arranged and that it tightly prescribes the jobs that take place. Additionally, in both services, there is an awareness that staff already know or have experience of what tasks are needed. From probing during interviews, it further became evident that users of both services are aware of restrictions in carrying out certain non-personal care tasks, such as housework.

4. Characteristics of carer (home or agency)

Questions on the 'characteristics' or 'attributes' of the carer form a part of the overall experience of care by the service user. In view of the recent emphasis in the community

care reforms on aspects such as choice within service provision, it was considered important also to see how other aspects of caring contributed to service satisfaction.

Table 8.13. Caring manner of carers (statistical data)

(Q. Would you say that your that your carers have a caring manner?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
All of the time	19	47	29	72
Most of the time	14	35	6	15
Some of the time	5	12	5	13
Never	1	3	0	0
Don't know	1	3	0	0
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 4a)

From table 8.13 above, the in-house service had a higher proportion of respondents who perceived their carers had a caring manner 'all of the time' (72% in-house service compared with 47% external service). If 'all' and 'most' of the time responses are combined, then the difference between the two groups reduces (external service 82%; in-house service 88%). (See also cross-tabulations, where a correlation is evident, between caring manner and overall satisfaction levels).

Table 8.14. Caring manner of carers (User comments)

(Q. Would you say that your carers have a caring manner?)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
CARING MANNER	<ul style="list-style-type: none"> • <i>They're very helpful and very kind</i> 	<ul style="list-style-type: none"> • <i>They're great you become friends</i> • <i>I'm very happy with them, they are wonderful.</i> • <i>Yes they are always very kind and do what their limited time allows</i> • <i>You can't fault them</i> • <i>We are blessed with nice ladies</i>

CARING MANNER (CONTD.)		<ul style="list-style-type: none"> • <i>They're gentle in their treatment. Always bright and happy</i> • <i>Yes, very, very. They couldn't be better. They're marvellous.</i> • <i>They're all very caring. I've nothing against the carers at all</i>
DEPENDS ON WHICH CARER COMES	<ul style="list-style-type: none"> • <i>They're very good - some are more sympathetic towards the elderly</i> • <i>It depends who comes. Our regular one is marvellous. others I have had to lay off because they were clock watchers ore just unkind to my mother</i> • <i>As far as this weeks carer goes, yes.</i> • <i>Not all of them.</i> • <i>Odd one or two [are caring]</i> • <i>Some do [weekdays]. Weekends don't.</i> • <i>Mrs P or Mrs C are. Relief carers - a little concerned about.</i> • <i>The guy who comes in the morning does.</i> • <i>Except on relief</i> • <i>The one before was a bit superior.</i> 	<ul style="list-style-type: none"> • <i>Some have a little chat and a tea with me. Some are rude and in a hurry.</i> • <i>They change so often that it is difficult to assess how caring they are. They are efficient, but the evening girl is very caring</i> • <i>Yes, some more than others.</i> • <i>The older ones are better</i> • <i>Depends on the individual carers. they seem to be rushed all the time.</i>
BUSY/LIMITED TIME	<ul style="list-style-type: none"> • <i>They are very busy</i> 	
NOT CARING	<ul style="list-style-type: none"> • <i>They're not the right sort of people - they're basically just home helps. They don't have a caring attitude</i> • <i>Some of them are a bit rude and not caring</i> • <i>She seems inexperienced. Not a caring way with her</i> 	

(Source: user satisfaction questionnaire. Question 4a)

From table 8.14 above, there was a larger acknowledgement of personal characteristics attributed to caring manner, on the part of in-house service respondents:

'They're all very caring' (In-house service)
'I'm very happy with them, they are wonderful' (In-house service)

compared to external service respondents:

'They're not the right sort of people - they're basically just home helps. They don't have a caring attitude' (External service)
'Some of them are a bit rude and not caring' (External service)

Respondents from both services considered there were differences between who came, and this, in part, was attributed to age and life experience:

'It depends who comes. Our regular one is marvellous. Others I have had to lay off because they were 'clock watchers' or just unkind to my mother' (External service)
'The older ones are better' (In-house service)

Table 8.15. Degree of 'Rush' to finish work (Statistical data)
(Q. Are they ever in a rush to finish their work?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
All of the time	2	5	4	10
Most of the time	2	5	3	7
Some of the time	10	25	18	45
None of the time	23	57	14	35
Don't know	1	3	0	0
Other	2	5	1	3
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 4b)

* *The other category includes recognition of time pressure on carers.*

From table 8.15 above, if the 'All' 'Most' and 'Some' categories are combined, the proportion of respondents perceiving their carer to be in a 'rush' is approximately twice as high for the In-House Service, compared to the External Service. (In-House Service 62% cf. External Service 35%). In addition, nearly two-thirds of external service respondents indicate their carers are 'in a rush none of the time', compared to just over a third of in-house service respondents.

Table 8.16. Degree of 'Rush' to finish work (user comments)

(Q. Are they ever in a rush to finish their work?)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
CARER IS RUSHED (FOR VARIOUS REASONS)	<ul style="list-style-type: none"> • <i>Most of the time yes, because they are short staffed</i> • <i>Some of the time - have other others to go to</i> • <i>Some of the time - she's got two children to get to school</i> • <i>Some of the time in a rush, especially weekends and nights</i> 	<ul style="list-style-type: none"> • <i>Some of the time - they've got a lot to do</i> • <i>Sometimes they're held up because of certain things, i.e. a lady fell out of bed which took time to sort her out. So they have less time to spare.</i> • <i>Just occasionally, just one of them seems in a rush and hurries me too much. I feel times often being rushed</i> • <i>They've got another job to go to, so yes</i> • <i>Only if they have to help with a hospital case or if the office delays them</i> • <i>Sometimes they are in a rush - I comment on that</i> • <i>Sometimes they're a bit pushed. Often dash off to meet a nurse - help with a hoist. They give us as much time as they can</i>

DEPENDS ON WHICH CARER COMES	<ul style="list-style-type: none"> • <i>It depends, some are some aren't</i> • <i>Some [are] a bit fast</i> 	<ul style="list-style-type: none"> • <i>Mrs M never is, but sometimes one or two say they have to rush off</i> • <i>Most of them watch the clock all the time. I can tell the ones who are just in it for the money</i>
CARERS USE TIME EFFICIENTLY	<ul style="list-style-type: none"> • <i>No, she just gets on with it. Doesn't waste time. She doesn't have time to spare</i> 	<ul style="list-style-type: none"> • <i>They don't waste time. They are going from here to there.</i> • <i>They do what has to be done. Never rush away but they don't hang about</i>
TIME IS TOO SHORT	<ul style="list-style-type: none"> • <i>Yes, they need to have more time - they need another 1/4 hour in morning</i> 	<ul style="list-style-type: none"> • <i>They try not to show it, but we know they have such a short time</i> • <i>If they've got another job waiting yes. Not always. They don't always have time to do what is necessary. If they cut down on anything, it's the housework</i> • <i>They're not given enough time. Can't even have a cup of tea</i> • <i>Some times the 45 minutes they given them here is too short. they all say they need one hour</i> <p><i>They never seem to have time to stay for the end of the meal to clear things away</i></p>
CARER NOT RUSHED	<ul style="list-style-type: none"> • <i>The agency people have more time to chat and be with you</i> • <i>Not as a rule, unless they've got a date or something. Very rare.</i> 	<ul style="list-style-type: none"> • <i>No, they tell me how long they've got. They give me an hour in the morning</i>
DON'T KNOW	<ul style="list-style-type: none"> • <i>They just go onto another room. I don't know when they've started or finished</i> 	

(Source: user satisfaction questionnaire. Question 4b)

From table 8.16 above, it appears that whilst respondents from both services cite instances of carers being in a 'rush', there are many more examples of this situation provided by in-house service users:

'Sometimes they are in a rush - I comment on that'
'Sometimes they're a bit pushed. Often dash off to meet a nurse....'

Common reasons given for this sense of 'rush', by in-house service respondents, relate to the shortness of time allocated and the need to leave to provide care to another:

'They're not given enough time. Can't even have a cup of tea'
'They've got another job to go to...'

In both services the incidence of 'rush factor' appears related to which carer attends:

'It depends, some are some aren't' (External service)
'Mrs M never is, but sometimes one or two say they have to rush off' (In-house service)

From information received from the home care service manager, it is likely that the higher 'rush factor' perceived by in-house respondents is related to recent reviews carried out on home care clients, in which contact hours were been reduced, particularly in relation to practical work, as a means of reducing costs and managing higher levels of demand for the service.

Table 8.17. Punctuality of carer
(Q. Are they always punctual?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
All of the time	15	37	14	35
Most of the time	16	40	21	52
Some of the time	3	7	4	10
None of the time	1	3	0	0
Don't know	2	5	1	3
Other	3	8	0	0
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 4c)

The other category includes perception that carers may get held up at other users' homes.

From table 8.17 above, the proportion of users from both services who consider the carer punctual is comparable for the 'all of the time' category responses, but 10% higher for In-house service respondents if the 'most of the time' responses are included.

Table 8.18. Clean and tidy appearance of carers
(*Do your carers have a clean and tidy appearance?*)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
All of the time	30	74	33	82
Most of the time	6	15	5	12
Some of the time	3	8	1	3
Don't know	1	3	1	3
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 4d)

A comparably high proportion of respondents, from both groups, considered their carers had a clean and tidy appearance.

Table 8.19. Degree to which more help given when needed. (Statistical data)
(*Q. Do they give you more help when you need it?*)

	EXT. SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
All of the time	13	32	15	37
Most of the time	7	17	5	12
Some of the time	8	20	4	10
None of the time	1	3	6	15
Don't know	6	15	5	13
Other	5	13	5	13
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 4e)

* *The other category includes perception that more help is given even when carer is running late.*

From table 8.19 above, on combining 'all', 'most' and 'some' and subtracting 'none' categories, a higher proportion of respondents from the external service (66% External cf. 44% In-house) consider they are given 'more help when needed'. The greater flexibility enjoyed by external respondents may be due to the less rigid regulations on what a carer can or cannot do, in addition to the longer time interval per user visit (external service: 1 hour per user visit cf. in-house service: average of 24 minutes per user visit) [see also chapter 10].

Table 8.20. Degree to which more help given when needed. (User comments)
(Q. Do they give you more help when you need it?)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
MORE HELP PROVIDED	<ul style="list-style-type: none"> • They will do any little job that might be needed • We get as much as we need • All my needs are taken care of • Yes they have done 	<ul style="list-style-type: none"> • They will do everything for me • Yes. They have helped with lunch time help when asked • Yes...they make me a flask of tea if I ask them • Yes, I mentioned I had to go to town to buy some pants but she went for me • Yes, but they know if they spend an extra few minutes they will be late for the next person (see also* below)
TOO RUSHED/NOT ENOUGH TIME		<ul style="list-style-type: none"> • They often seem to be running over time • If they have time but I know they are very busy
DEPENDS ON WHICH CARER COMES	<ul style="list-style-type: none"> • Depends on the person 	<ul style="list-style-type: none"> • The regular one will do more

PROVISION OF EXTRA HELP DEPENDS ON OTHER FACTORS	<ul style="list-style-type: none"> • <i>She gets my prescription sometimes if its urgent</i> 	<ul style="list-style-type: none"> • <i>If we ask, but they're not allowed to do housework</i> • <i>Most would help if asked, but I know someone else is waiting for them</i> • <i>...they do it if they can</i> • <i>It's not always possible</i> • <i>Yes, but they know if they spend an extra few minutes they will be late for the next person (see also* below)</i>
MORE HELP NOT PROVIDED	<ul style="list-style-type: none"> • <i>They have too much to do. Have to get on to the next person</i> • <i>Its difficult to get anyone to do cleaning</i> 	<ul style="list-style-type: none"> • <i>Sometimes I would like to go outside. I have to be pushed, and sometimes they won't</i> • <i>They've just cut down the time. They can't give me more help</i>
NOT ASKED	<ul style="list-style-type: none"> • <i>Wouldn't dare ask them</i> • <i>Not asked them to do more. Must see office or care manager</i> 	<ul style="list-style-type: none"> • <i>Never asked. Just pleased they come</i>
THINK IT MAY BE POSSIBLE	<ul style="list-style-type: none"> • <i>I think that's possible. I can call them up - they have mobile phones</i> • <i>She always says: 'if you need me ring'</i> • <i>I would say yes. She is very conscientious</i> 	<ul style="list-style-type: none"> • <i>If I wanted it I think they would</i> • <i>I have never asked them but I am sure they would</i> • <i>If I asked for it I'm sure I would</i>
HELP NOT NEEDED		<ul style="list-style-type: none"> • <i>Yes I'm sure they would but so far I haven't needed it</i> • <i>Never needed to ask for anything</i> • <i>It's sufficient what they do</i>
NOT SURE	<ul style="list-style-type: none"> • <i>Not sure. Will try to get more practical help</i> 	

(Source: user satisfaction questionnaire. Question 4e)

From table 8.20 above, problems of time constraint emerge, which are particularly pronounced in the In-House service:

*'They often seem to be running over time'
'Yes, but they know if they spend an extra few minutes they will be late for the next person'*

However, both groups contain users who had never asked for 'more help',

*'Wouldn't dare ask them' (External service)
'Never asked. Just pleased they come' (In-house service)*

Some of those who had not asked assumed that more time would not be available or that additional tasks would take time away from another person's care arrangements:

*'They have too much to do. Have to get on to the next person' (External service)
'Yes, but they know if they spend an extra few minutes they will be late for the next person' (In-house service)*

The latter response suggests that users (from both services) understood the limitations of the care resources supplied and in that sense recognised the 'public' context for service provision, despite the broader aspect of a market for care services. Other respondents from both services assumed 'more help' would be given if needed, but had not yet asked:

*'She always says: 'if you need me ring' (External service)
'I have never asked them but I am sure they would' (In-house service)*

In addition, it appears as though some users, from both groups, were aware that certain jobs are not considered appropriate by the department for carers to do. Such tasks appear to be related to practical care tasks such as housework and cleaning:

*'Its difficult to get anyone to do cleaning' (External service)
'If we ask, but they're not allowed to do housework' (In-house service)*

Table 8.21. Starting work by asking users what they need
(Q. Do they start by asking you what you need?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
All of the time	6	15	13	32
Most of the time	9	22	4	10
Some of the time	5	13	5	13
Never	7	17	13	32
Don't know	5	13	1	3
Other	8	20	4	10
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 4f)

** The other category includes carer's knowledge of routine*

From the above table a complex picture of responses emerges. In relation to the 'all of the time category' over twice the proportion of in-house respondents report carers start work by asking them what they need. However, when 'all of the time' and 'most of the time' responses are taken together, In-House and External Service respondents report a comparable level of response. (External Service 37%; In-House Service 42%). However, 15% more respondents from the In-House Service perceive that their carer never starts work by asking them what they need.

From examining the 'other' category replies, respondents from both services indicate the worker knows the routine, suggesting that for these people there is no expectation of being asked. Additionally where the user has a 'confusional' state e.g. dementia, there is often no expectation of consultation.

Table 8.22. Satisfaction with work carried out by home carer
(Q. Are you satisfied with the work carried out by your carers?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Very satisfied	27	67	31	77
Partly satisfied	10	25	6	15
Not satisfied	0	0	1	3
Don't know	1	3	0	0
Other	2	5	2	5
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 4g)

* *The other category includes perception of shortage of time; criticism of staff.*

From the above table, the in-house service has a 10% higher proportion of respondent satisfaction (77%) with the carers' work at the 'very' satisfied level, compared to the external service (67%). However, on combining 'very' and 'partly satisfied' categories, the proportion of respondent satisfaction is the same for both services (92%).

5. Feelings of user

Very often, in the assessment of a service, it is the 'technical' aspects that are given particular emphasis by professionals. This is probably attributable to the fact that they relate more to aspects of financial control (e.g. VFM - see chapter 10) and, as such, have greater capability of measurement. For this reason a number of questions on 'feelings' was introduced into the questionnaire, to enable a more qualitative assessment of factors important to the service users.

The questions on 'feelings' (see Appendix II), relate to the arrival (Q.5a) and departure (Q.5b) of carer, as well as overall satisfaction with the service (Q.5c). 'Arrival' and 'departure' of carer were assumed to be significant moments of feeling by service recipients, that would reflect on their satisfaction with the service. The question on 'overall' satisfaction with the service was chosen to enable cross tabulations with other aspects of the service, in order to identify which factors contributed most to user satisfaction. In this respect, it was important to see whether 'technical' aspects of the market reforms such as 'choice' were more or less significant in driving user satisfaction, than 'personal' aspects such a 'caring manner' and user 'feelings'.

Table 8.23. Arrival of carer. (Statistical data).
(Q. How do you feel when your home carer arrives?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Very happy	18	45	29	72
Fairly happy	7	17	7	17
Not happy	1	3	0	0
Not sure	9	22	1	3
Other	4	13	3	8
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 5a)

* *Other category responses include: Depends on who is coming; relieved; prepared for it.*

From table 8.23 above, the proportion of in-house respondents who perceive themselves being 'very happy' on the arrival of the carer (72%) is just over 50% higher than the proportion of external service respondents (45%). An equal proportion of respondents

from both services indicate they are 'fairly satisfied' on the arrival of the carer. In addition, nearly 20% more respondents of the External service, compared to In-house respondents, indicate they are not sure about their feelings on the arrival of the carer (22% External; 3% In-House). This may be affected by the degree to which satisfaction with the external service is dependent on who comes, perhaps, again highlighting the problem of carer continuity in the external service.

Table 8.24. Arrival of carer. (User comments).
(Q. How do you feel when your home carer arrives?)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
HAPPY ON ARRIVAL	<ul style="list-style-type: none"> • <i>Pleased when they arrive. Get on well with them</i> • <i>I'm pleased to get up. I like to see them</i> • <i>Always pleasant, chatty</i> • <i>Lovely. I don't know how many there are but each one is good. They'll do anything for you</i> • <i>Look forward to seeing carer</i> 	<ul style="list-style-type: none"> • <i>Bloody happy</i> • <i>Very happy. Nothing's too much trouble for her</i> • <i>Always pleased to see them. Have a laugh with them!</i> • <i>Always glad to see them, to have a chat</i> • <i>They make tea first thing and I'm very pleased to see them</i> • <i>She's so jolly</i> • <i>I'm delighted to see her</i> • <i>Happy to see them especially Mrs D - very efficient and helpful</i>
RELIEVES LONELINESS/ MONOTONY	<ul style="list-style-type: none"> • <i>Relieved</i> • <i>I'm happy because I'm glad there's someone there</i> • <i>I'm glad I've got somebody here at night</i> 	<ul style="list-style-type: none"> • <i>I get lonely and when they come I think "goodness" there's someone at the door. I tell them personal things (like finances)</i> • <i>I am pleased when they arrive - it breaks the monotony</i> • <i>Very happy because I'm on my own otherwise</i> • <i>Pleased to see anybody</i>

RELIEVES LONELINESS/ MONOTONY (CONTD.)		<ul style="list-style-type: none"> • <i>Nice to see someone during the day</i> • <i>Always relieved to see them</i> • <i>Pleased always happy to see someone</i>
CARER BECOMES A FRIEND	<ul style="list-style-type: none"> • <i>We are friends</i> 	<ul style="list-style-type: none"> • <i>They are like friends now</i>
DEPENDS ON USER FEELINGS/ HEALTH	<ul style="list-style-type: none"> • <i>Depends on whether I am well</i> 	<ul style="list-style-type: none"> • <i>All right, depending on how I feel</i>
DEPENDS ON WHICH CARER COMES	<ul style="list-style-type: none"> • <i>Some have been friendly, others less so</i> • <i>Depends who it is. Some are good. Some are not</i> 	
HAPPINESS DEPENDS ON OTHER FACTORS	<ul style="list-style-type: none"> • <i>Very happy because I get same carer</i> 	<ul style="list-style-type: none"> • <i>Very glad to see her but a bit nervous when we have a new one</i> • <i>First of all I used to find it very difficult to accept someone washing me. I've always been independent. Once I've accepted it I didn't mind at all.</i>
USER IMPARTIAL TO CARER		<ul style="list-style-type: none"> • <i>A bit blasé about it now. Felt very happy when they first came</i> • <i>Just say good morning and that's it</i>

(Source: user satisfaction questionnaire. Question 5a)

From table 8.24 above, the text responses, particularly for the in-house service, suggest that the carer's arrival, to some extent, relieves a sense of loneliness:

'I get lonely and when they come I think "goodness" there's someone at the door'

'Very happy because I'm on my own otherwise'

This would suggest the importance of the carer's personal skills of empathy and befriending, rather more than 'technical' aspects of the market reforms. As in a number of previous questions, the response, particularly from external service users, appears dependent on which carer attends.

'Some have been friendly, others less so'
'Depends who it is. Some are good. Some are not'

Table 8.25. Departure of carer (Statistical data).

(Q. How do you feel when your home carer has finished)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Very happy	7	18	7	18
Fairly happy	9	22	11	28
Not happy	2	5	10	25
Not sure	8	20	3	8
Other	14	35	9	23
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 5b)

** Other category includes sad, sorry, lonely on departure; used to carer's departure; feeling of satisfaction with work; concerns that work too rushed or carer left too soon.*

From table 8.25 above, an equal proportion of respondents from both services report they feel 'very happy' on departure of the carer. However if the 'very happy' and 'fairly happy' response are combined, and the 'not happy' response excluded, 14% more external respondents perceive they are 'happy' on the departure of the carer. (External Service 35%; In-house service 21%). As with the last question a similar proportion of external respondents are not sure about their feelings on departure of carer (viz. 20% External Service; 8% In-house Service), which may, as before, in part be related to the degree to

which an external respondent's satisfaction with the service is dependent on which carer comes, itself an aspect of carer continuity (see under Table 8.23).

Table 8.26. Departure of carer (User comments)
(Q. How do you feel when your home carer has finished)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
SAD/LONELY/UNHAPPY ON DEPARTURE	<ul style="list-style-type: none"> • <i>Sad. All back on me</i> • <i>Sorry. I feel lonely again after she has gone</i> • <i>Sad but I much prefer it to a home</i> 	<ul style="list-style-type: none"> • <i>A little bit sad when they go</i> • <i>Not happy. I don't see anyone until the evening</i> • <i>I'm sorry they've gone invariably and then I feel lonely again</i> • <i>I'm sorry to see them go</i> • <i>I miss their company. Living alone its nice to have company</i> • <i>Not happy, but I know she is coming again</i> • <i>Out on a limb. Lonely. Didn't worry me before, but since my last illness, not at all happy on my own</i> • <i>Sad that they are leaving. Would like them to stay longer</i> • <i>I feel sad but she has her family. It is nice when they tell you about their family</i> • <i>I sometimes feel I'm a little bit lonely. This winter has been treacherous and I've had flu. When it comes to Saturday or Sunday evening I wish someone could pop in and have a few words with me. Do they have a service like that?</i>

DEPENDS ON WHICH CARER COMES	<ul style="list-style-type: none"> • <i>Depends on the carer. Whether she is sympathetic and trustworthy</i> 	
OK ABOUT DEPARTURE/ACCEPTS CARER HAS TO GO	<ul style="list-style-type: none"> • <i>Normal parting</i> • <i>That's OK. It's quite a regular thing now</i> • <i>Quite relaxed knowing some essential chores have been carried out</i> 	<ul style="list-style-type: none"> • <i>I say 'bye bye'. I wish you safe on the road</i> • <i>I just put up with it. No good being unhappy</i> • <i>I like the company [but] they've got to go some where else</i> • <i>I know they have other people to see</i> • <i>Not upset. Take things as they come</i> • <i>I know they've got to go</i> • <i>I know they have got to go because someone else is waiting</i> • <i>I go three days a week to the day centre. I have to put up with being on my own. I'm used to it now anyway</i> • <i>I know I'm set up to the next visit</i> • <i>Reasonably satisfied. Their tasks are usually completed</i> • <i>Oh quite relaxed and then I think what's the next thing on the agenda</i>
HAPPY ON DEPARTURE	<ul style="list-style-type: none"> • <i>With the good ones I'm very satisfied Some leave a bit of a mess after them</i> • <i>I feel I can relax when she's gone</i> • <i>Appreciative</i> • <i>Happy we get on very well</i> 	<ul style="list-style-type: none"> • <i>Very comfortable</i> • <i>I am content. They do their job and go</i> • <i>Well in a way I'm glad they've done the work</i> • <i>Quite comfortable</i>
USER IMPARTIAL TO CARER	<ul style="list-style-type: none"> • <i>Fine its just routine</i> • <i>They do their time</i> • <i>They come and go</i> 	

USER HAS OTHER COMPANY/ ASSISTANCE ON CARER'S DEPARTURE	<ul style="list-style-type: none"> • <i>Appreciate them when they are here but have a friend to help when the home carers aren't</i> • <i>I've got a little dog to talk to. I don't mind it when they go</i> • <i>Daughter is home when the carers go</i> • <i>OK when they go. Has radio</i> 	<ul style="list-style-type: none"> • <i>I share a flat so I do not get lonely as if I were on my own</i> • <i>There are two of us so it is not so bad, but people on their own must feel 'oh dear, I am on my own again'</i> • <i>I'm not nervous. No. I've got the pager and then my son comes in to give me lunch and i always wear my emergency pendant - it gives me confidence - I wear it day and night</i>
OTHER FACTORS		<ul style="list-style-type: none"> • <i>Sometimes they're in and gone before you realise</i>
LOOK FORWARD TO SEE CARER AGAIN	<ul style="list-style-type: none"> • <i>Look forward to seeing them again</i> • <i>I know I'm going to see her the next day so I'm not unhappy</i> 	<ul style="list-style-type: none"> • <i>I feel secure - I know they'll come back</i>

(Source: user satisfaction questionnaire. Question 5b)

From table 8.26 above, there appears to be a theme of 'sadness' in relation to the carer's departure. Such an emphasis is strongest in the in-house service:

*'Not happy. I don't see anyone until the evening'
 'I'm sorry they've gone invariably and then I feel lonely again'*

By way of contrast, in the external service, there is a tendency for respondents to see the service more in terms of a series of routines:

*'Fine its just routine'
 'They do their time'*

The latter may, in part, be due to a lack of staff continuity in the external group, which tends to de-personalise the service. Similarly, and related to continuity of service, the feelings of external respondents may depend, in part, on which carer turns up:

'Depends on the carer. Whether she is sympathetic and trustworthy'

Some respondents from both services appear to accept that the carer must go and are more stoical about this, secure in the knowledge that they will return:

'I know I'm going to see her the next day so I'm not unhappy' (External service)
'I feel secure - I know they'll come back' (In-house service)

Overall, the respondent's feelings on the departure of the carer appears influenced by a number of factors including: degree of bonding with care worker, presence of other company, ability to rationalise departure and general sense of loneliness/isolation.

Table 8.27. How the user feels about the service overall.

(Q. How do you feel about the service overall?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Very satisfied	20	50	29	73
Fairly satisfied	13	32	9	23
Not satisfied	3	7	1	3
Don't know	3	8	0	0
Other	1	3	1	3
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 5c)

* *The other category includes poor standard of cleaning; gratitude for the service.*

From table 8.27 above, the proportion of respondents who are 'very satisfied' is 23% higher for the in-house service (73%), compared with the external service (50%). In taking into account the 'very' and 'fairly' satisfied responses and deducting the 'not satisfied' category, the difference is 18% (75% External; 93% In-House). This suggests a higher level of satisfaction perceived by in-house respondents than external respondents of the service overall.

The levels of overall satisfaction are important as they enable cross-tabulations (see tables 8.30 - 8.37) to be constructed, which investigate features of service provision within both groups, to determine which features, 'technical' or 'personal' aspects, drive user satisfaction.

6. Other areas

Table 8.28. Areas not previously covered (Statistical data)

(Q. Is there anything that we haven't covered that you would like to mention?)

	EXTERNAL SERVICE		IN-HOUSE SERVICE	
	NO.	%	NO.	%
Time is being reduced	0	0	1	3
Minimal housework done/would like more	1	3	1	3
Would like other specified services	1	3	1	3
Negative comment	3	9	3	9
No response	35	85	34	82
TOTAL	40	100	40	100

(Source: user satisfaction questionnaire. Question 6)

* *Negative comments include:* concerns over communication with the home care or agency office (including after hours), poor carer continuity, different priorities in relation to tasks and time for carrying them out.

From table 8.28. above, only in-house respondents perceive time is being reduced. A similar number of respondents from both services perceive support with housework is minimal and would like other specified services, including more housework.

Table 8.29. Areas not previously covered (User comments)

(Q. Is there anything that we haven't covered that you would like to mention?)

RESPONSE CATEGORY	EXTERNAL SERVICE	IN-HOUSE SERVICE
PROBLEM WITH COMMUNICATION WITH OFFICE	<ul style="list-style-type: none"> • <i>'We would like to know if they're going to be late. About 4 times no carer turned up</i> • <i>'[Sometimes] office pulls out of commitment'</i> 	<ul style="list-style-type: none"> • <i>'Problem of communication between home care office and myself.'</i> • <i>'We have no way of contacting anyone outside office hours. If we had a crisis over the weekend we could not contact anyone.'</i>
PROBLEM WITH CONTINUITY	<ul style="list-style-type: none"> • <i>'No continuity'</i> 	<ul style="list-style-type: none"> • <i>'We would prefer the same person all the time'</i>
NOT GETTING BENEFIT OF CARING RELATIONSHIP	<ul style="list-style-type: none"> • <i>'I would like them to stay and sit some time: that's what I call caring'(see also below*)</i> 	<ul style="list-style-type: none"> • <i>'It would be nice if one person came so I could get fond of one person. There are days when they are rushed and don't have time to be really caring.'</i>
PREFERENCE FOR PARTICULAR TASKS NOT CURRENTLY PROVIDED	<ul style="list-style-type: none"> • <i>'They go upstairs, never sit with me'</i> • <i>'I would like them to stay and sit some time: that's what I call caring' (see also above*)</i> 	<ul style="list-style-type: none"> • <i>'Would like to go on walks. One of my carers used to take me, and I would like to get a list of who's coming' [also an issue about communication]</i>

PREFERENCE FOR PARTICULAR TASKS NOT CURRENTLY PROVIDED (CONTD.)		<ul style="list-style-type: none"> • <i>'[Would like carers to] spend more time caring, more time on general care like washing hair and washing generally'</i> • <i>'Because they thought I was capable of getting my own meal, they stopped the home care person doing it. I can have meals on wheels but don't like them.'</i>
--	--	--

(Source: user satisfaction questionnaire. Question 6)

From table 8.29 above, respondents from both samples indicate problems in communication with the head office:

'We would like to know if they're going to be late. About 4 times no carer turned up' (External service)

'Problem of communication between home care office and myself.' (In-house service)

staff continuity:

'No continuity' (External service)

'We would prefer the same person all the time' (In-house service)

and capacity to respond to particular user preferences.

'They go upstairs, never sit with me' (External service)

'Would like to go on walks' (In-house service)

CROSS-TABULATIONS

A series of cross-tabulations were carried out to investigate the relationship between overall satisfaction (Q5c - see Appendix II) and certain 'technical' and 'personal' characteristics of both services. The objective of the exercise was to see which factors drive overall satisfaction. The cross-tabulations combine the responses for both services.

The areas selected were as follows:

1. consultation in the assessment process (Q2b)
2. choice of carer (Q3a)
3. choice in times of receiving care (Q3b)
4. the caring manner of workers (Q4a)
5. the degree to which carers 'rush' to complete work (Q4b)
6. the degree to which more help is given when needed (Q4e)
7. the work carried out by the carer (Q4g)
8. how the user feels on arrival of carer (Q5a)

Note:

The figures in brackets refer to numbered questions from the survey questionnaire (Appendix II).

1. Consultation/participation in the assessment process

Table 8.30. Comparison of overall service satisfaction with level of consultation in assessment process.

5c	2b						
	Total	Fully	A little	Not at all	Don't know	Other	NR
Total	80	37	16	6	17	4	0
Very satisfied	49	23	10	0	13	3	0
Fairly satisfied	22	11	4	4	3	0	0
Not satisfied	4	1	1	1	1	0	0
Don't know	3	1	1	1	0	0	0
Other	1	0	0	0	0	1	0
NR	1	1	0	0	0	0	0

Key: 5c = overall satisfaction

2b = consultation in the assessment process

From the above cross-tabulations, there appears to be no marked relationship between the level of consultation in the assessment process and overall service satisfaction. This result is interesting given the emphasis in the reforms on the 'proper assessment of need' and the design of packages of care 'in line with individual needs and preferences' (Department of Health 1989b, para. 1.11).

2. Choice of carer

Table 8.31 Comparison of overall service satisfaction with choice of carer.

5c	3a					
	Total	Yes	No	Don't know	Other	NR
Total	80	7	64	0	9	0
Very satisfied	49	3	41	0	5	0
Fairly satisfied	22	3	16	0	3	0
Not satisfied	4	0	4	0	0	0
Don't know	3	0	2	0	1	0
Other	1	1	0	0	0	0
NR	1	0	1	0	0	0

Key: 5c = overall satisfaction

3a = choice of carer

From the above cross-tabulation, the levels of overall service satisfaction, at both the 'very satisfied' and 'fairly satisfied' levels, appear unaffected by the low reported levels of choice of carer. On the contrary the numbers of users who are 'very' or 'fairly' satisfied with the service are similar to the numbers of users reporting no choice in carer. The aspect of choice of carer, therefore, does not appear to drive overall satisfaction.

3. Choice in times of receiving care

Table 8.32. Comparison of overall service satisfaction with choice in times of receiving care.

5c	3b					
	Total	Yes	No	Don't know	Other	NR
Total	80	31	36	5	8	0
Very satisfied	49	17	25	3	4	0
Fairly satisfied	22	10	8	1	3	0
Not satisfied	4	1	2	0	1	0
Don't know	3	2	1	0	0	0
Other	1	0	0	1	0	0
NR	1	1	0	0	0	0

Key: 5c = overall satisfaction

3b = choice in time of receiving care

From the above cross-tabulation, a similar picture emerges as in 8.31 above, namely that levels of satisfaction are not in a direct relationship with levels of reported choice in times of receiving care. The aspect of choice in times of receiving care, therefore, does not appear to drive overall satisfaction.

4. The caring manner of workers

Table 8.33. Comparison of overall service satisfaction with caring manner

5c		4a						
	Total	All of the...	Most of the...	Some of the...	Never	Don't know	Other	NR
Total	80	48	20	10	1	1	0	0
Very satisfied	49	41	7	1	0	0	0	0
Fairly satisfied	22	3	13	6	0	0	0	0
Not satisfied	4	0	0	3	1	0	0	0
Don't know	3	2	0	0	0	1	0	0
Other	1	1	0	0	0	0	0	0
NR	1	1	0	0	0	0	0	0

Key: 5c = overall satisfaction

4a = caring manner

From the above cross-tabulation, the degree of overall satisfaction perceived by respondents appears closely related to the level of satisfaction with the caring manner of workers. In making the comparison, it has been assumed that 'all' and 'most of the time' categories for 'caring manner' can be combined to compare with the 'very' satisfied level for overall satisfaction, where the relationship between the two is most striking.

5. The degree to which carers 'rush' to complete work

Table 8.34. Comparison of overall service satisfaction with carer 'rush' factor

5c		4b						
	Total	All of the...	Most of the...	Some of the...	None of the time	Don't know	Other	NR
Total	80	6	5	28	37	1	3	0
Very satisfied	49	2	2	15	29	0	1	0
Fairly satisfied	22	3	3	10	5	0	1	0
Not satisfied	4	1	0	2	0	1	0	0
Don't know	3	0	0	1	1	0	1	0
Other	1	0	0	0	1	0	0	0
NR	1	0	0	0	1	0	0	0

Key: 5c = overall satisfaction
4b = carer 'rush' factor

From the above cross-tabulation, the degree of 'rush' factor experienced by respondents, does not appear to directly contribute to the overall level of service satisfaction. Such a position is reinforced by table 8.15 earlier, where the 'rush' factor for the external service was lower, yet it was the in-house service which reported the higher overall level of service satisfaction.

6. The degree to which more help is given when needed

Table 8.35. Comparison of overall service satisfaction with the degree to which more help is given when needed

5c		4e						
	Total	All of the...	Most of the...	Some of the...	None of the...	Don't know	Other	NR
Total	80	28	12	12	7	11	10	0
Very satisfied	49	26	5	3	6	4	5	0
Fairly satisfied	22	1	7	7	0	3	4	0
Not satisfied	4	0	0	2	1	1	0	0
Don't know	3	0	0	0	0	2	1	0
Other	1	0	0	0	0	1	0	0
NR	1	1	0	0	0	0	0	0

Key: 5c = overall satisfaction

4e = degree to which more help given when needed.

From the above cross-tabulation, whilst there is some relationship between the provision of 'more help' and overall satisfaction, it is not marked. Such a position is reinforced by table 8.19 earlier, where the net perception of 'more help given when needed' was higher for the external service, yet it was the in-house service which reported the higher overall level of service satisfaction. This suggests that the aspect of service flexibility (exemplified by 'more help is given when needed') does not drive overall satisfaction.

7. The work carried out by the carer

Table 8.36. Comparison of overall service satisfaction with work carried out by carer

5c	4g						
	Total	Very satisfied	Partly satisfied	Not satisfied	Don't know	Other	NR
Total	80	58	16	1	1	4	0
Very satisfied	49	47	1	0	0	1	0
Fairly satisfied	22	8	12	0	0	2	0
Not satisfied	4	0	2	1	0	1	0
Don't know	3	1	1	0	1	0	0
Other	1	1	0	0	0	0	0
NR	1	1	0	0	0	0	0

Key: 5c = overall satisfaction

4g = work carried out by carer

From the above cross-tabulation, there appears to be a correlation between overall satisfaction and the degree of satisfaction with the work carried out by carer. This is most striking at the 'very satisfied' level. This result is interesting, since in terms of satisfaction with 'work carried out by carer', there appears to be no clear assessment as to whether such an aspect represents a 'technical' or 'personal' feature of the service. On the basis that satisfaction with work carried out by carer has been a familiar feature of consumer surveys prior to the reforms, it will be argued here that it represents a more 'traditional' aspect of service provision, independent of the market model.

8. How the user feels on arrival of carer

Table 8.37. Comparison of overall service satisfaction with feelings on arrival of carer

5c	5a						
	Total	Very happy	Fairly happy	Not happy	Not sure	Other	NR
Total	80	47	14	1	10	7	1
Very satisfied	49	40	6	0	0	3	0
Fairly satisfied	22	7	7	1	4	3	0
Not satisfied	4	0	1	0	3	0	0
Don't know	3	0	0	0	3	0	0
Other	1	0	0	0	0	1	0
NR	1	0	0	0	0	0	1

Key: 5c = overall satisfaction

5a = feelings on arrival of carer

From the above cross-tabulation, the degree of overall satisfaction perceived by respondents appears related to the feelings on the arrival of the carer, particularly at the 'very satisfied' level of overall satisfaction. This suggests that the aspect of 'feelings' on arrival of carer is a factor that contributes to overall satisfaction

Overall, in terms of tables 8.30 - 8.37 above, the overall satisfaction of respondents from both services appears more directly related to their satisfaction with 'personal' aspects of the service, namely, the caring manner of workers and the feelings on carer's arrival. In other more 'technical' areas, namely: consultation in assessment, choice of carer/times of receiving care, 'rush' factor, and service flexibility, there appears to be no direct correlation between satisfaction ratings and overall satisfaction. In the area of 'work

carried out by carer', whilst satisfaction in this area appears related to overall satisfaction, it has been argued that it represents a more 'traditional' aspect of service provision independent of the market model, which falls outside the analysis applied here in relation to 'technical' or 'personal' features of the service

In relation to 'technical' aspects of the service, the lower proportion of in-house respondents perceiving satisfaction in these areas does not appear to directly affect their overall level of satisfaction with the service. In fact, the converse appears true, in that a higher level of overall satisfaction is recorded for the in-house service, despite relative shortfalls in areas relating to 'technical' aspects of the service, as emphasised by the market reforms. This suggests that 'personal' aspects of the service, such as caring manner and 'feel good' factors, are more valued by consumers in the case study borough than aspects of 'choice' and 'flexibility' emphasised in the community care reforms. It is recognised, however, that the research carried out in the case study borough, though detailed, represents a particular approach to evaluating user satisfaction. In order to test the transferability of these findings to other parts of the country, it would be necessary to carry out further research on a larger scale which is beyond the scope of this study.

A detailed analysis of the case study data, including both 'technical' and 'personal' aspects is carried out in chapter 9, which considers the implications of the empirical findings to both consumer satisfaction and the market model for community care.

CHAPTER 9. EMPIRICAL INVESTIGATION: ANALYSIS OF DATA

From examining the data in chapter 8, the most striking findings are the connection between satisfaction rankings and 'personal' features e.g. caring manner of worker (Tables 8.36-8.37) and the lack of connection with external service features, e.g. assessment participation and choice (8.30-8.31, and 8.32-8.35). In addition, the user's satisfaction with the work carried out by the carer (Tables 8.40-8.41), a further traditional and largely pre-market aspect of service provision, appears strongly linked to overall satisfaction. Other areas of the survey evidence similarly reinforce the argument on features that are independent of the market reforms, e.g. satisfaction with the assessment (Table 8.8), did not appear to be connected with user consultation in the assessment process (Table 8.6), a feature emphasised in the reforms (Department of Health 1989b, para 1.11). Equally, there are other instances, where the external service appeared better on objective service features e.g. 'rush factor' (Table 8.15) and 'more help when needed' (Table 8.19). Whilst the aspect of personal relations appears linked to the overall level of consumer satisfaction, other aspects, such as external service features, appear less relevant to consumers, although arguably relevant to the theoretical model for community care. This chapter will, therefore, consider the implications of the empirical findings to both consumer satisfaction and the market model for community care.

IMPLICATIONS OF SURVEY FINDINGS

Two particularly interesting implications of the survey findings can be identified: i) most commentators have assumed (viz. chapter 5) that the debate ought to be about whether

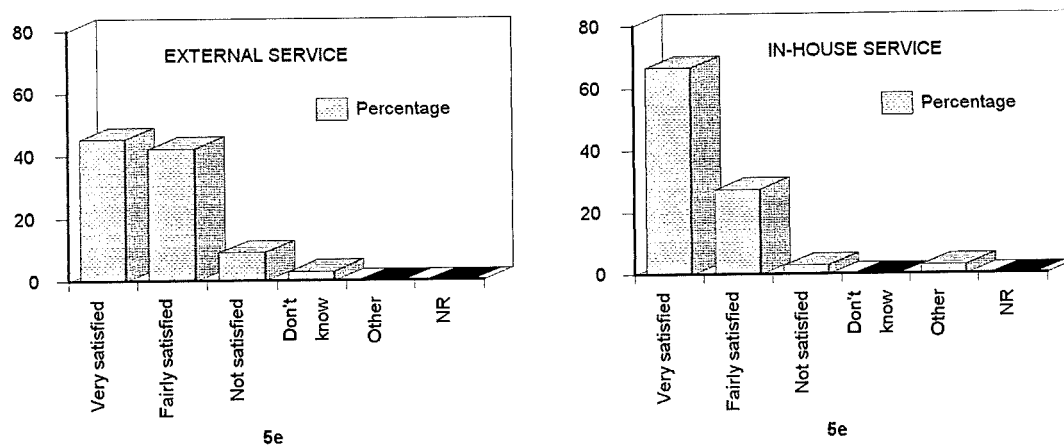
choice is being delivered. Whilst in this argument the implicit assumption is that all consumers want choice, the evidence from the case study illustrates the point that such arguments are questionable, since, although choice may well be important to some individuals and with respect to some services, it is not universal; ii) conversely the findings show that it may be less important to give choice than provide continuity in the caring relationship. The latter was illustrated by questions relating to 'choice of carer' and 'caring manner' which users used to feed back to interviewers problems in the quality of care attributed to breaks in staff continuity. Such a pattern of responses underlined the importance to users of the personal relationship they developed with their carer(s). Thus the critical issue to users was not the ability to switch between providers on an 'approved' list, but the ability of any one provider to maintain quality of service through staff continuity. The latter would have potential implications for the market model. For example, the emphasis on tight contract specifications, competition and a rigorous 'purchaser/provider' split all suggest the use of an 'arms length' relationship between purchasers and providers and this would fit with the 'disciplining' role of the market (see chapter 5). However, such a pattern might suggest that to operate in this way would risk changing providers and hence disrupt continuity valued by users in the empirical research.

'TECHNICAL' AND 'PERSONAL' STRANDS

In analysing the empirical findings, two key strands can be identified. The first strand relates to the 'technical' aspects of the market reforms such as consultation in assessment, choice and flexibility. The second strand relates to the 'personal' aspects such as 'caring manner' and feelings associated with the carers arrival. Aspects from both strands are

considered by way of a comparison of respondent data between the external and in-house services. In highlighting the nature of the comparison, statistical data from chapter 8 is represented below by histograms for the external and in-house service respectively. In addition, reference is made to the cross tabulations (chapter 8), to identify which factors drive overall service satisfaction ratings. The table below indicates the overall level of satisfaction from respondents of the external and in-house service.

Table 9.1 Overall level of satisfaction with the domiciliary care service:



From the above table, the proportion of respondents who feel they are satisfied with the service overall is higher for the in-house service than the external service, particularly at the 'very' satisfied level. Such an overall level of satisfaction provides for each service an important 'baseline' for cross-tabulations, in determining which particular aspects of the service drive overall satisfaction. Thus, the two areas of 'technical' and 'personal' aspects of service provision can be investigated in terms of which factors drive overall satisfaction.

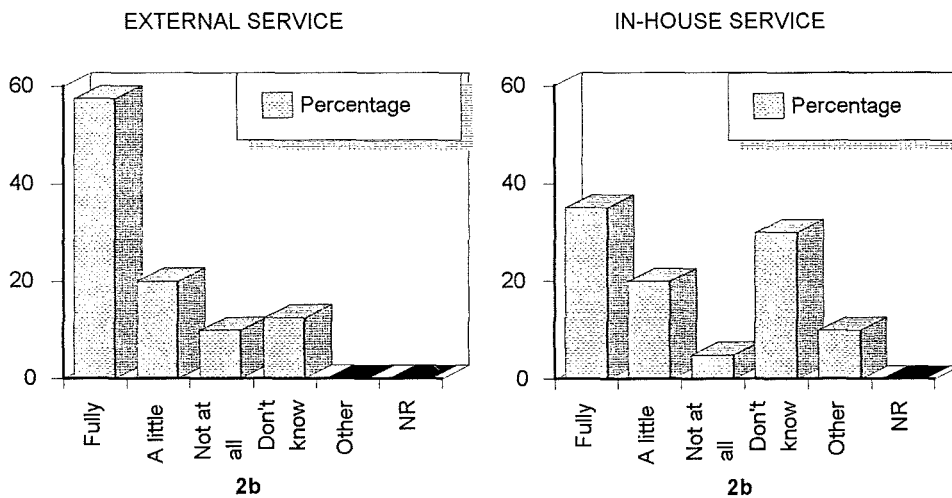
i). 'Technical' aspects

The following 'technical' aspects refer to non-personal features, promulgated by the community care reforms. These include assessment, choice and flexibility:

a. Assessment

The table below indicates the level of consultation in the assessment process perceived by respondents of the external and in-house service.

Table 9.2 Consultation in assessment



From the above table it is evident that a higher proportion of external respondents indicate they are consulted in the process of assessment. According to the reforms (Department of Health 1989b. s.1.11), participation in the assessment process is an important aspect of the market model for community care. However, despite a higher reported level of consultation in the assessment process by external service respondents, this is not a factor that drives overall satisfaction (Table 8.30/8.31). Thus, from comparing Table 9.2 (above) with Table 9.3 (below), a different picture emerges.

Table 9.3 Satisfaction with assessment

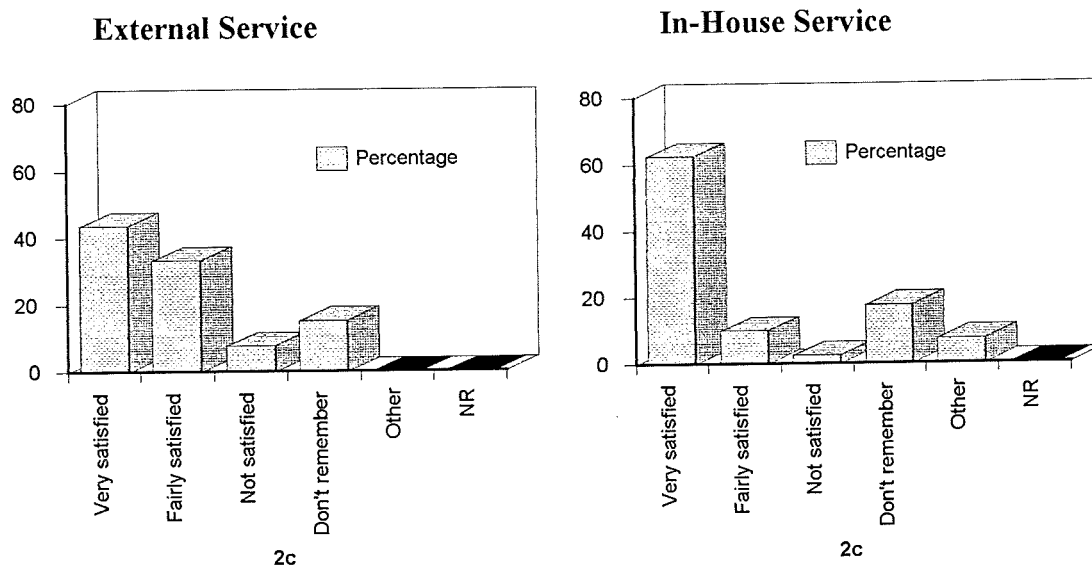


Table 9.3 above indicates a higher proportion of respondents from the in-house service are satisfied with the assessment at the 'very satisfied' response level. Such a position suggests that the level of satisfaction with the assessment process is not directly linked to the degree of consultation in the assessment, despite the latter's emphasis in the community care reforms.

b. Choice

The following two tables represent 'choice of carer' and 'choice in times of receiving care'. In both tables the proportion of external service respondents perceiving choice was higher compared to the in-house service.

Table 9.4 Choice of carer

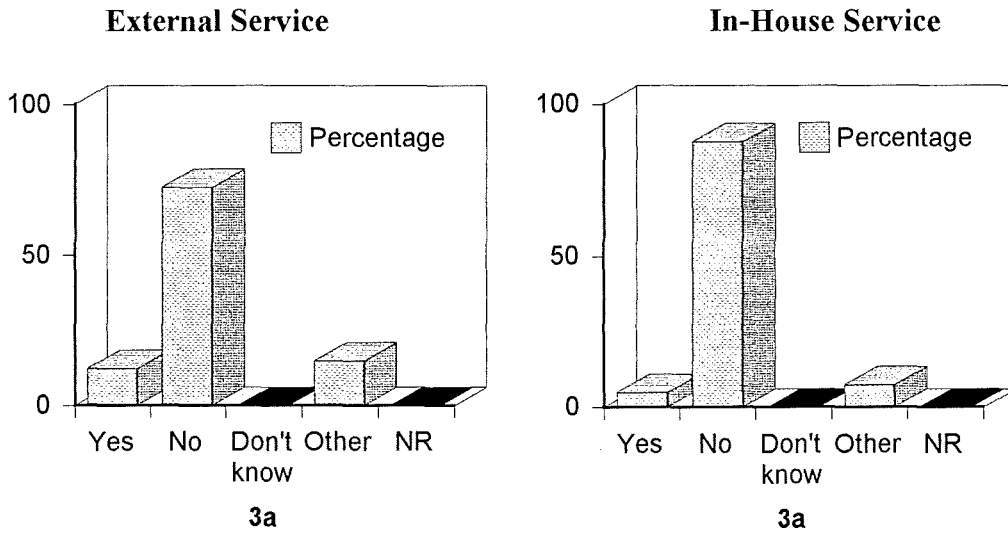
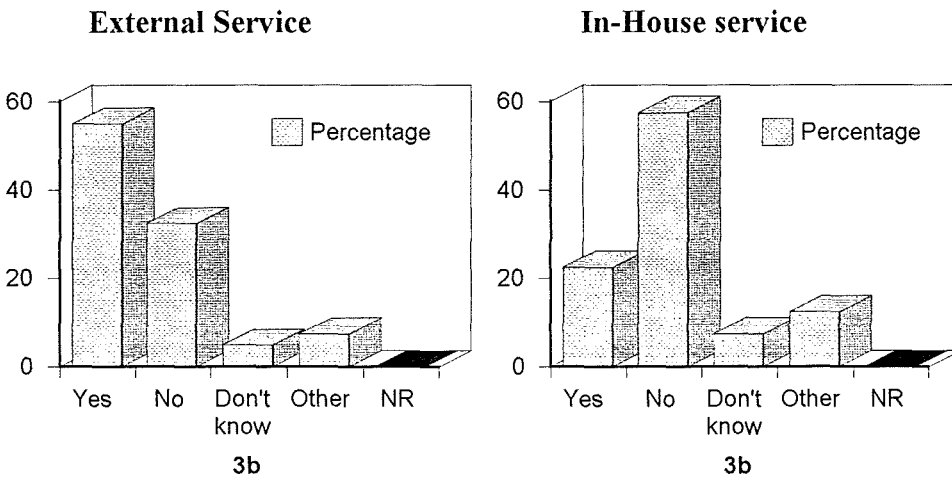


Table 9.5 Choice in times of receiving care

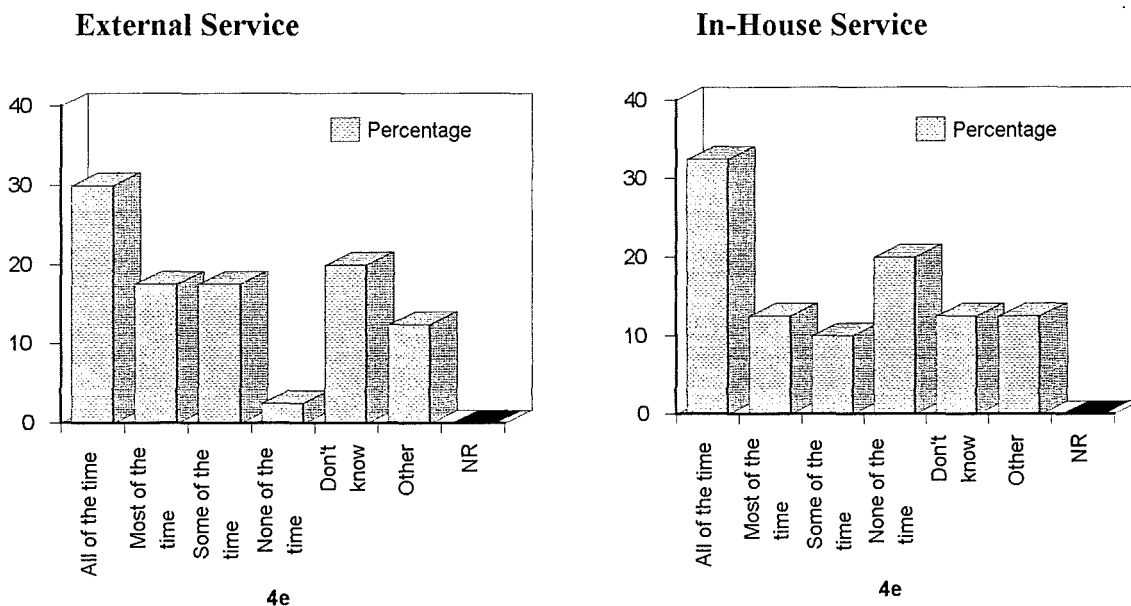


The perception of more choice by external service respondents is particularly striking in table 9.5 above, representing choice in times of receiving care. However, from the cross-tabulations (Tables 8.32-8.34), neither choice factors appear to be linked to overall satisfaction. Consequently, whilst it could be argued that the market model, proposed by the reforms, can lead to greater choice for the consumer, such a factor appears less relevant to consumers than personal characteristics of caring.

c. Flexibility

Flexibility is a characteristic that bears some relationship with choice. For example, it might be considered that as the external service provides greater choice in times of delivery, that it is therefore a more 'flexible' service, responding to the needs of individual consumers. However, a more specific question (Q4e) on flexibility is included in the survey (Appendix II): *'Do they (carers) give you more help when you need it?'*

Table 9.6 Degree to which more help is given when needed



From the above table, the impression given is at first complex. Whilst the proportion of respondents who indicate 'more help is given when needed', for the 'all of the time' category, is slightly higher for the in-house service, this trend is reversed on combining 'all', 'most' and 'none of the time' responses. Again, the above represents a technical aspect of community care provision, and as in questions about choice, it is the external service that most reflects these aspects. However, from the cross-tabulations in Tables

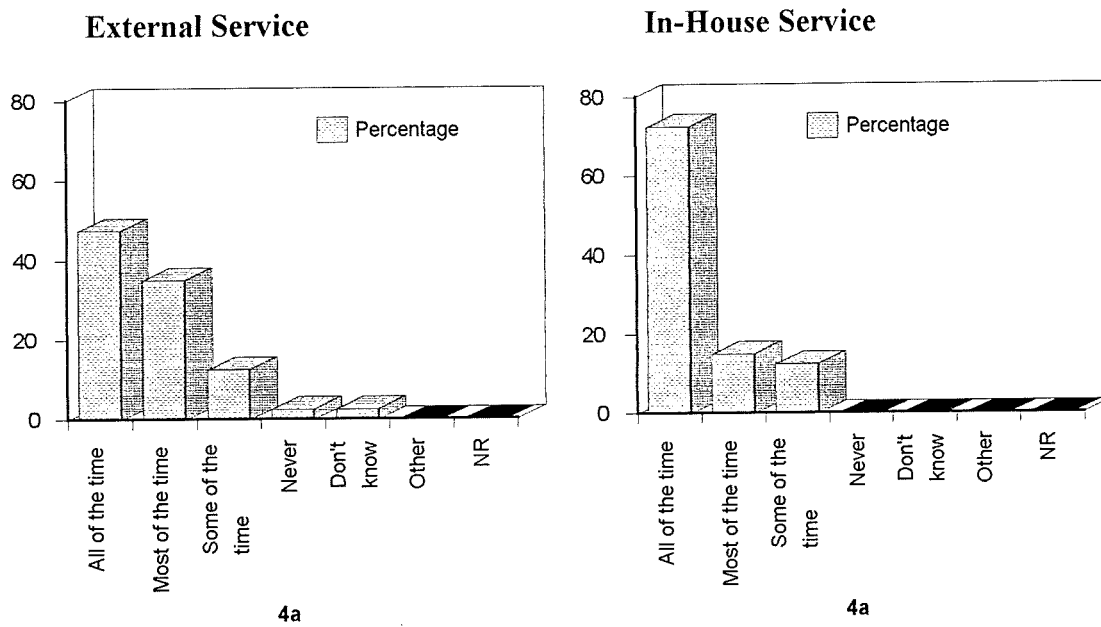
8.42/8.43 it is evident that the factor of ‘flexibility’ (as exemplified by the question: ‘more help when needed?’) does not drive the overall level of satisfaction.

ii. ‘Personal’ aspects

The following tables relate to ‘personal’ aspects of the service which reflect the interaction between care worker and client..

a. Caring manner of worker

Table 9.7 Caring manner of worker



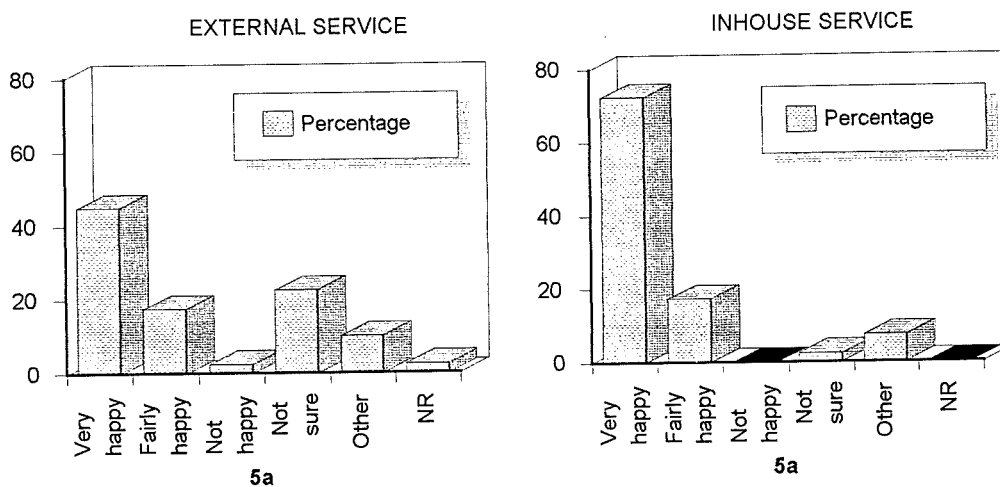
From table 9.7 above, there is an overall higher proportion of respondents from the in-house service who perceive a ‘caring manner’ from their carer. This is most striking at the ‘all of the time’ level. In investigating the cross-tabulations in Table 8.36-8.37, there appears a link between overall satisfaction and caring manner. This suggests that despite the emphasis on the reforms on ‘technical’ aspects of the market model, it is the more

personal aspects of the service, in this case, attributed to the carer, that drive overall satisfaction.

b. Feelings (arrival of carer)

The following table illustrates the degree of 'happiness' on arrival of the carer.

Table 9.8. Feelings on carers arrival



From the above table, there is a higher overall proportion of respondents from the in-house service who are 'happy' on arrival of carer (this is most striking at the 'very happy level'. From considering the cross-tabulations (see Tables 8.44-8.45), there appears to be a relationship between personal 'feelings' on the arrival of carer and overall satisfaction at the 'very satisfied' level.

OVERVIEW OF SURVEY FINDINGS

From the comparative research on domiciliary services a complex rather than simple pattern emerges. Whilst 'Caring for people' (Department of Health 1989b) claims stronger

benefits for the community care approach, in terms of 'technical' aspects of service provision, these are not aspects of the service, within the research undertaken, that appear related to consumer satisfaction. Moreover, the overall satisfaction of respondents appears linked to non-technical aspects of service provision. Such aspects relate to personal characteristics of the carer and caring relationship, rather than external market features, emphasised in the reforms. In these former areas, it is the in-house service respondents who experience a higher level of satisfaction.

Whilst the 'personal' aspects of service provision appear more important to respondents, it is, nevertheless, useful to see how choice operates within the market model. Although the aspect of choice may appear initially straightforward, it operates, not at one level, but within a 'hierarchy' of levels (viz. Common and Flynn 1992, p35). Within the empirical investigation four different levels of choice can be identified. These are: 'choice of agency', 'choice of carer', 'choice of times for receiving care' and 'choice of tasks' performed by carer. This suggests, that to examine the effectiveness of the reforms in relation to choice, it is necessary to assess the experience of users in relation to these different contexts. In addition, as discussed earlier, it is necessary to test the assumption, implicit in the reforms, that the feature of choice is of universal importance to users.

Whilst, in theory, the Borough has, at its disposal, a range of agencies from which care may be purchased, in practice, access to decisions in relation to choice of agency are blocked by the presence of an intermediary agent: care management. (viz. Knapp and Wistow 1991, p18-19). Although, as argued in chapter 5, this is not of itself a feature

unique to community care, it does run counter to the claims of increased choice for users. Furthermore, selection of agencies by care managers is not cost neutral, but constrained by care managers budgets.

In addition to 'choice of agency', further problems exist in relation to 'choice of carer'. In particular, the exercise of carer choice for many consumers within the case study borough depends on the previous breakdown in the user-carer relationship. In such circumstances the consumer is offered an alternative carer. Thus the process of providing choice of agency is by 'default' rather than as a direct right of the consumer. In addition, it would appear that *which* carer the user receives by way of a replacement is in some senses a 'lottery', since the carers of independent agencies are not necessarily foreknown to either the purchasing authority or the consumer. This raises the further risk that the replacement carer might not be appropriate to the particular needs and preferences of the user. Thus there is a further related problem of regulation of standards, in that certain aspects of the quality of service provision, are, through the contract process, delegated to the external agency. Accordingly the ability to regulate certain aspects of quality for externally purchased care is weakened. This therefore further undermines the value of consumer choice and suggests that in relation to 'choice of carer', it is no more than an undertaking by the agency to provide a replacement carer on a 'hit' and 'miss' basis.

In relation to choice of times of receiving care, it is the external respondents who perceive more choice in the arrangements than in-house recipients. The ability to provide such choice, however, needs to be considered in relation to the types of contracts that staff are

employed on. According to the in-house service manager, in-house staff contracts are less flexible in terms of hours and employment conditions than staffing contracts with external agencies. It would therefore seem likely that such inflexibility within the in-house staffing structure contributes to a reduction in overall choice in times of care. However, whilst this may count against the technical progress of the in-house service, in adapting to the new reforms, it does not, according to the empirical findings, appear to influence overall satisfaction. Moreover, the employment conditions of the in-house service, whilst these may inhibit certain technical aspects of service provision, may equally contribute to higher staff morale and lower staff turnover. Both these features are likely to have a positive effect on carer continuity and user satisfaction.

In relation to choice of tasks performed by the carer, respondents of both services perceive certain restrictions. Again, in this area, it is the care manager or home care manager, who appears to exercise most control. Thus, if a particular task is not congruent with the care plan, then, according to replies from respondents, such a choice is often denied. A particular area that exemplifies this aspect is housework and cleaning, which, whilst frequently valued by respondents, is less of a priority for purchasers and providers. Such a reduction of support in this area reflects a re-targeting of service criteria for domiciliary care on higher dependency groups where the key needs are related to personal care tasks (see chapter 6). Such restrictions operate for both external and in-house services.

A further area, from the findings, that appears more valued by consumers than choice, is continuity of service. The ability of providers to provide continuity, however, is likely to depend on a number of factors, which include size of organisation, organisational policy, and the number of carers employed. All of these factors, also, depend to some extent on economic viability, which may be influenced by the type of contract the provider enjoys with the purchasing authority (see chapter 6). In this respect, problems of continuity may arise out of the 'spot' contract mode of purchasing currently used by the case study borough (see chapter 6) for purchasing domiciliary services from the independent sector. Such a method of purchasing, in contracting only for services to individual users as and when required, may not invest sufficiently within the long term viability of independent providers. Whilst it is hard to predict the effect that an alternative 'block' purchase system might have on independent agencies, such a system is likely to provide more opportunities for investment in staff training, quality issues and staff retention, which in turn are likely to have an impact on service continuity. Thus continuity may be affected both by internal factors within the external agency and by the type of contract it enjoys with social services departments.

Overall, it would appear that whilst there are certain benefits to be gained from both in-house and externally purchased services in relation to consumer satisfaction, the emphasis under community care policy has shifted the focus away from traditional more personal aspects of the caring relationship, which may be highly valued by consumers, to the more technical aspects of caring. Thus, social service managers are left with a judgement as to whether to heed the user emphasis on personal aspects of the service, which appear more

strongly represented by the in-house service, or to consider a managerialist perspective which emphasises technical aspects of service delivery, in line with the market reforms. Furthermore, in view of the complex nature of assessing quality, consideration must be given to the importance of the difference between 'very satisfied' and 'fairly satisfied' outcomes, and whether a 'reasonable' rather than 'excellent' level of performance could be tolerated in the pursuit of lower costs (see chapter 10).

Thus, the degree to which a service is judged more 'effective' depends on whether more emphasis is placed on the user or purchaser perspective - the inherent problematic within the market model for community care. From the rhetoric in the reforms, however, it would appear that the greater emphasis has gone to the aspect least relevant to consumers.

Namely, the dominant emphasis in the market model proposed by the reforms is a 'managerialist' perspective which, whilst employing the rhetoric of consumerism, places greater emphasis on the technical aspects of service provision, as opposed to the personal aspects valued by users in the case study borough.

CHAPTER 10. A VALUE FOR MONEY AUDIT IN THE CASE STUDY AUTHORITY

Chapters two to five were concerned with the framework within which community care has been conceptualised in the 1980s and 90s. In that analysis the central role of the Audit Commission was stressed. The Audit Commission is identified with value for money (VFM) Audits. In this chapter, the issues relating to VFM which were addressed in general terms in the first part of the thesis are examined in the context of financial data generated within the case study authority. The financial data that will be used also serves to compliment the qualitative data from the empirical study. The object is to reinforce the argument in the first part with the use of this 'micro' illustrative data. In carrying out the review of cost data, I shall highlight a range of areas in a financial appraisal of the Home Care Service (McCarthy, 1995), contemporaneous with my own empirical study (chapters 7-9).

First, however it is necessary to review a number of areas surrounding the introduction of VFM: the nature of VFM and its relation to the prevailing political climate. The nature of VFM will be further sub-divided to consider: i. the private sector model, ii. the assumption of 'visibility', and iii. the problems of measurement.

THE NATURE OF VFM

For local government, the introduction of Value for Money (VFM) auditing can be seen as concomitant with the work of the Audit Commission, set up under the Local Government Finance Act 1982. The role of the Audit Commission was to undertake or

promote '*....comparative and other studies designed to enable it to make recommendations for improving the economy, efficiency and effectiveness in the provision of local authority services*'. (Local Government Finance Act 1982, s. 26.) The specific role of the Commission in relation to the management of personal social services has already been analysed in chapters 3 and 4. This part of the argument will therefore concern itself with the nature of VFM, as part of the managerialist approach of the Commission already described.

To understand VFM, it is important to grasp its component elements. According to Willis (1993, p2), VFM is a hybrid of conventional auditing and management consultancy. VFM is distinct from 'regulatory' audit because it involves judgements which relate to standards of service provision, many of which have a professional component. In contrast, regulatory audit is concerned with the accuracy of recording of transactions and their legality. Thus, VFM can be seen to involve two components: a management accounting component, whose object is to establish cost based performance norms, which involve the undertaking of cost calculations and relating them to standards of service performance; and a related management consultancy aspect which makes recommendations with regard to changes in practice required to achieve VFM. The stated benefits of such a dual aspect approach, is that it supplies the independence, objectivity and reporting skills of auditors, whilst complementing it with the specialised analytical systems and implementation skills that may be available from management consultants (Ibid.).

In relation to the first of these components, VFM involves judging service provision in terms of three elements: 'economy', 'efficiency' and 'effectiveness'. Basic definitions of these are provided by Butt and Palmer:

Economy - An economical operation acquires resources in appropriate quality and quantity at the lowest cost.

Efficiency - Making sure ...that only the minimum level of resources are devoted to achieving a given level of output.

Effectiveness - Ensuring that the output from any given activity (or the impact that services have on a community) is achieving the desired results. (Butt and Palmer 1985, Ch. 2)

The above definitions suggest important differences between economy on the one hand and effectiveness on the other. Whilst, as will be argued later in the chapter, economy and efficiency measures are not unproblematic, they do lend themselves to quantitative measures. For instance, efficiency is often measured via throughput, where service use is related to a physical or financial measure of inputs. Thus, an example of a financial efficiency measure would be unit costs in a day centre; and of a physical measure, the ratio of care staff to centre attendees. However, effectiveness is much more obviously contentious. For example, there is clear potential for disagreement over what the object of the activity should be and to whom (e.g. the user, the informal carer or the community more generally) it is aimed. This clearly raises concerns that economy and efficiency will be assessed at the expense of effectiveness and such issues will be taken up under iii. problems of measurement.

Despite the potential of VFM, through its management accountancy component, to provide some measure of objectivity, McSweeney (1988) considers that the effect of the

complementary management consultancy component is to take a more narrow view of the options for change, through advocating a 'one best way' approach for local authorities to provide their services. Such an approach, according to McSweeney, outlines *'the characteristics, structures, approaches and decision making procedures to which local authorities should adhere and with which each authority's actual arrangements, as perceived by the auditors, are compared'*. (Ibid.).

i. The private sector model

McSweeney identifies a number of problems within VFM, as arising from assumptions that private sector organisations provide a particular model of economic management, with capability of transference to the public sector. Problems with this assumption relate to the fact that the private sector is not in itself homogeneous, but a collection of different sized companies and interests. This would therefore make it difficult to make a meaningful assessment both on the range of audits that existed and more particularly to hold it up as a meaningful 'role model' to the public sector.

Nevertheless, certain perceptions of private sector behaviour appear to characterise the approach of the Audit Commission to VFM auditing. In particular, a private sector approach is identified with a set of accountability relationships between individual line managers and managers placed more strategically in the organisation. The approach of the Audit Commission, in this respect, was *'...to strengthen financial control by involving line managers more, and making them more accountable'* (Audit Commission 1987, para 49). Thus, central to the Audit Commission's approach, in conducting VFM audits, was the

recommendation of decentralising of operations and aligning financial responsibilities with individual managers. Changing the character of the relationship, between those managers responsible for strategy and those responsible for operations, was seen as a crucial means of achieving improvements in overall service performance, in terms of the three 'E's. Such improvements in performance relied on a number of associated aspects of devolved management, namely that, i) it improved the standard of 'strategic' decisions by reducing the time which, in this case, councillors would be spending on operational matters, ii) it improved the standard of operational decisions, because service managers would have freedom over the methods used to achieve policy objectives and iii) the distinction between strategic and operational functions would not lead to a loss of management control, since the performance of service managers would be judged by reference to performance norms established by the management accounting side of VFM.

Whilst VFM is seen by the Audit Commission as a 'tool' which can be used within local authorities, it is also consistent with precepts of central government. Thus, the assumption underlying VFM is that efficiency and effectiveness improvements can be achieved by utilising appropriate managerial approaches. What is interesting, however, about the VFM measures is that they are being applied to non-commercial entities, on the assumption that they can and will function more efficiently and effectively, by the application of what are claimed to be disciplines which operate in the private sector. In the public sector however, concerns for outcomes have tended to be placed over and above outputs - an ethos which may be challenged by VFM, but which would need proper attention in the setting up of appropriate role models for the public sector to follow.

ii. The assumption of visibility

McSweeney (1988) in common with Flynn (1986) [- see below], considers that the character of VFM embodies the new 'managerialism', in that, whilst being delivered on the basis of providing greater local accountability, it is really about providing greater accountability to the centre. McSweeney, in substantiating this claim, points to the centralisation in local authorities as a result of reductions in discretion and financial autonomy together with the creation of 'central purpose' bodies (McSweeney 1988). VFM can be seen as an aspect of this centralisation, in comparing performance between authorities and thus establishing a series of national norms to which local authorities would be expected to conform. In this way, the establishment of VFM norms could be seen as an intellectual/political justification for expenditure controls, such as Standard Spending Assessments (SSAs), which determine the level of expenditure locally, by reference to a number of nationally defined levels related to demography and economic performance.

The ability to establish norms, however, which in turn is central to the model of devolved management, espoused by the Audit Commission, rests on the assumption of 'visibility'. In this respect, the retention of management control, without direct instructions to service managers, depends on the effectiveness of performance measures, as indicators, which reliably measure differences between authorities, or units, and form the basis for norms.

iii. Problems of measurement

Management performance in public services, aimed at producing social outcomes, produces a range of difficulties for measurement. Whilst certain elements of the process may be influenced by setting targets on a managers performance, control in other areas appears less clear. On the onehand, in relation to 'economy' and 'efficiency', both these components show measurement capability, which can be seen respectively in relation to the cost of the materials and services brought in and the relation of outputs to inputs. On the other hand, control over 'effectiveness', by an approach linked to outcomes, appears less than straight forward both in definition and measurement. The logical conclusion to this is that data on effectiveness is likely to be 'thin', which suggests that the key emphasis of the VFM approach in practice will be towards the more measurable characteristics of economy and efficiency, which, in addition, appear more relevant within a climate of cost constraint.

As a result of such difficulty in obtaining clear and objective measurement of effectiveness, it is not difficult to see how it becomes the poor relation of the other two 'E's.

Furthermore, such a problem might easily be overlooked by accountants carrying out audits, being more inclined towards concerns of cost per unit of service provision. The problems of measurement are therefore a reflection of the different areas being assessed.

In the area of social care, this might suggest we are to measure the social impact of services upon a community. Quantifying the social impact in scientific terms, however, would pose considerably greater problems than measuring the 'efficiency' of a given process.

Additional problems arise from the ranking of the three 'E's. Although, it is difficult to identify a standard pattern for dealing with the three 'E's, the tendency has been for economy and efficiency to be given a higher priority. The reasons for this may be the relative ease of measurement of the first two 'E's, but equally it could be related to the political agenda behind VFM constraining local managers to cut costs. McSweeney suggests:

'Its [VFM's] neglect of effectiveness is caused not merely by the undoubted technical and political difficulties of identifying and determining the impact of some local authority outputs, but also more fundamentally that a greater focus on effectiveness could weaken the Commission's attempt to change local authorities' (Ibid.).

Efficiency measures, because they emphasise 'throughput', easily lend themselves to the use of the lowest cost providers as the 'norm'. This naturally is consistent with an emphasis on expenditure control, suggesting that more can be done within existing resources, or that existing service provision can be achieved with fewer resources. In this respect, McSweeney characterises the role of the Audit Commission as an agent of organisational change. Central to this is an emphasis on the role of management, hence the Commission's emphasis on the local authority operating on the expectation of no increase in funding. This is made explicit in 'The Competitive Council' (1988): *'Plans for expanded service in one area will not be realised unless funds can be found by economies of improved value for money elsewhere. (Audit Commission 1988b, p6). If, on the other*

hand it could be demonstrated that effectiveness was compromised by lack of resources, this would weaken the organisational change programme.

THE POLITICAL CLIMATE

In examining the 3 'E's, I have demonstrated that a strict apolitical reading of VFM is not adequate, as it does not explain the imbalance in practice between concerns for effectiveness and those for economy and efficiency. Inherent contradictions, as well as difficulties in comparability, suggest that VFM is not a neutral measure and should be seen against a political background that stresses the need for measurable characteristics as part of central control. 'Effectiveness', being the most difficult to measure, is consequently the greatest casualty of the central discipline, which perceives it as a potential threat in terms of its capability of revealing unmet needs that would otherwise increase spending.

Furthermore in the application of VFM, we have seen the linkage of incentives to managerial performance as the 'carrot' and 'stick' of this centralising discipline. In the drive towards efficiency targets, the special nature of a particular organisation's context, in particular the complexities of the field of personal social services, appears to have been overlooked (Knapp 1984, p14-16). The effect of this has done much to impose upon local government a greater constraint on service spending. This in turn has tended to reduce the outcome, in terms of effectiveness to the customer, whilst increasing managerial accountability to the centre.

Overall, the establishment of the Commission, and the setting up of Value for Money audits, is to be seen against a period of significant change in the government's handling of

local government and the public sector at large. A number of distinctive elements in the political climate can be seen to have influenced the use to which VFM has been put. These include: *'...financial incentives, the admiration of the private sector, the desire to cut public expenditure, and a desire of central government to control local services ...'*

(Flynn 1986, p390). Consequently, whilst the rhetoric of government has emphasised local accountability, the effect of VFM has been to bring LAs more under the political control of the centre. The intention of greater visibility of process has therefore brought with it the assumption of organisational certainty. Yet, in the area of social services, which has historically delivered a plethora of services to the community, with inherent complexities of organisation, outcome and measurement, such clarity of process clearly does not exist. Choosing to narrow the scope more on the side of economy and efficiency has therefore had a reductionist effect upon the nature of services offered. Furthermore, the assumption of near perfect visibility and organisational certainty has been matched by a further assumption, that the private sector offers the 'one best way' and that the ethos of commercial organisations is transferable to public services.

In the context of a more detailed understanding of the nature of VFM and the political climate that prescribed its use, it is now necessary to investigate certain micro-illustrative data from the case study authority. The purpose of such data is to reinforce earlier more general arguments relating to the role of the Audit Commission and its identification with VFM.

MICRO-ILLUSTRATIVE DATA - CASE STUDY AUTHORITY.

The micro-illustrative data, below, arises from a financial appraisal of the Home Care Service (McCarthy, 1995), carried out using guidelines from CIPFA (Chartered Institute of Public Finance and Accountancy). The study took place at a time for the Home Care Service when demand for the service was on an upward spiral, resulting in an overspend of £636,300 (30% higher than the original budget) at the close of 1994/5. Furthermore, the Home Care Service was operating within a political context which prevented it from raising further income through its charging policy. Further details, relating to the financial and social context of the case study borough, are set out in chapter 6.

For ease of identification, I shall refer to the CIPFA financial appraisal, throughout, as the 'appraisal'. The timing of the appraisal is broadly contemporaneous with my own empirical study. The approach in this chapter involves reproducing a range of sections from the appraisal report and then examining them, as a means of illustrating particular problems within the application of VFM in the case study borough. My investigation of the micro-illustrative data highlights a number of important aspects that reinforce arguments in chapters 3 and 4. These comprise: i. methods of costing services (including the allocation of overheads), ii. the use of norms, and iii. tensions between efficiency and effectiveness.

i. Methods of costing services

As was indicated above, one crucial element of VFM is the construction of quantitative norms of service performance which, in turn, involve cost comparisons. Thus a pre-

condition is the assessment of service costs. It is customary to divide these into costs of two kinds: 'direct' and 'indirect' costs. Within the Home Care Service (HCS), the direct costs refer to the wage/salary costs of staff involved in service provision; 'indirect' costs, on the other hand, are incurred in other parts of the organisation and can be seen as providing support of various kinds to service provision e.g. the work of the central finance department in setting revenue estimates. For the purposes of the appraisal, an estimate of 'direct costs' was made. This covered the following elements: cost of employees (salaried and waged, including oncost for superannuation and national insurance), transport expenses, supplies and services. These direct cost figures are given in Table 10.1 below. Additionally, income received through charges was netted off against the gross cost.

The division into four organisational categories relates to a planned service re-organisation. A report was received by Housing and Social Services Committee (Case Study Borough, June 1995), recommending that the service be restructured and rationalised. The service had been operating from three district offices, each of which provided a full range of services. These comprised a practical service (assisting clients with laundry, shopping and house cleaning etc.) and a personal service (assisting clients with personal daily routines, getting into/ out of bed). The report, which was accepted, recommended ending this structure and proposed, instead, two area offices (East and West) specialising in the provision of personal and practical care on a boroughwide basis. The fourth category: BDO, refers to the post of 'Borough Development Officer', which contributes to service development for the entire Home Care Service i.e. East, West and

Boroughwide. Table 10.1, below, shows the summary of the budgets for the East, West and Boroughwide services and the BDO.

Table 10.1 - Budgets for the re-structured home care service

	EAST	WEST	BOROUGHWIDE	BDO
Employees	1,067,800	1,069,200	629,900	27,500
Transport	75,600	75,600	50,700	1,500
Supplies & Services	3,900	4,100	2,300	200
Total Expend.	1,147,300	1,148,900	682,900	29,200
Income	246,700 (cr)	246,700 (cr)	135,300 (cr)	0
Net Expend.	£900,600	£902,200	£547,600	£29,200

(Source: Financial Appraisal, 1995, table 7)

In this part the full cost is constructed by allocating various 'indirect' costs to the home care service.

A central objective of the financial appraisal was to provide an estimate of the 'full cost' of the Home Care Service. The cost estimates, in the appraisal, involve a combination of 'direct' service costs (net expenditure) and allocation of 'indirect' or 'overhead' costs.

Such overheads operate at two levels: firstly, with respect to functions provided by 'Central Support Services' (CSC), represented by an allocation of overhead costs from corporate services and secondly, from Departmental Support Services (DSC), which relate to support services provided at a Departmental level e.g. Finance, Personnel, and Information Technology. What is crucial to such costing practice is that it depends on the use of rules to allocate indirect costs to the services concerned. In the financial appraisal such rules were described as the 'overhead allocation model'. An example of the overhead

allocation model with respect to CSC is the charge made for corporate Human Resource Management Services. Thus, in the appraisal, the basis of allocating CSC to Departmental Support Services is argued using the CSC charge for Human Resources as an example:

'CSC are allocated directly to the departmental/divisional support services and frontline services. Taking the Human Resources charge to Personnel as an example (based on the number of FTE posts), the calculations are performed in the following way. The CSC charge for Human Resources is £65,977. Personnel has 5.28 FTE posts of the total SS [Social Services] 972 FTE posts. The Human Resources Charge to Personnel is therefore £358. This equates to $5.28/972 \times £65,977$ ' (McCarthy 1995, para. 3.3.3).

Thus, the allocation of CSC to recipient departmental services is pro-rata to the number of full time equivalent posts, for a given service, expressed as a ratio of the total number of FTE posts in the department. The next stage of the calculation, although not shown in this particular extract, would be the allocation of the resultant charge, operating as a DSC, to the Home Care Service. In this particular example, the CSC represents services provided by Corporate Personnel (Human Resources) to the Departmental Personnel. Such services include advice, support and training. The DSC, on the other hand, relates to support given to the Home Care Service in relation to recruitment and selection. The amount of £65,977 for CSC, which is used in the calculation, represents the total cost of providing corporate personnel services to the Social Services Department.

The underlying justification for the methods, like the overhead allocation model used in the appraisal, is to provide a realistic idea of the full cost of service provision. This is given added relevance in the context of the market model of community care, since such costings play a crucial role in decisions over whether services should be retained in-house or contracted out. For example, in the financial appraisal, what is termed the 'equitable charging of overheads' is justified on the grounds that if such an analysis were not undertaken, then:

'...the charge from departmental support services to front-line services would be less than the full cost of providing that support service. CSC would be charged only to front-line services thus inflating the HCS charge. It would reduce information on the cost of providing departmental support services, limiting the services' future ability to compare the cost of receiving this service 'in-house' rather than going to an external provider for the same service' (Ibid. para. 3.3.4).

However, the claims that such charging is 'equitable' needs to be examined in the light of the way in which such rules operate. The personnel charge is small, but the way in which it is calculated is significant as an illustration of the problem of overhead allocation. The basis of the recharge, as we have seen, is pro-rata to the number of FTE posts in the recipient service, supported by Human Resources, compared to the total number of FTE posts it supports in the department overall. This clearly raises difficulties, in that the number of posts in the recipient service (e.g. departmental support service or direct front-line service), pro-rata to the total number of departmental FTE posts supported, may not

reflect adequately the degree of support it receives. For example, the FTE posts in a service like the Home Care Service could remain unchanged, but an increase in labour turnover would increase the demands for human resource support, via for example recruitment. Clearly, in such a case, the model would keep the charge constant, while actual support costs were increasing. This would suggest that the normative allocation model for Central Support Costs makes broad assumptions about services, which ignore their particular service context. Furthermore, Central Support Costs represent a secondary level of support, in addition to the support, also recharged to the front line service, from departmental personnel. It is therefore apparent that in the allocation of indirect overheads, individual front-line services are receiving a recharge from both central (CSC) as well as departmental support costs (DSC). Whilst in the extract, from the appraisal below, this approach is commended as 'equitable', it does not appear to challenge why such a level of organisational complexity is required to support a basic front-line service increasingly operating in a competitive market:

'Calculating the full cost of the service will be done by developing a financial model which will allocate all the indirect costs to the service. Costs will be allocated on a number of different bases which will all be outlined; all costs allocated to the service will be done so on an equitable basis so that they will bear close scrutiny from HCS [Home Care Service] managers and other SS [Social Services] managers' (Ibid. para. 3.1.2 - my emphasis)

This issue provides an interesting example of the organisational assumptions implicit in cost calculations. In this case, what is assumed is that the provision of CSC and DSC services is a 'given' for the front-line service. Of course, this is not just an issue for the calculation of overall costs, but means that, insofar as cost savings are considered, they effectively exclude the possibility of the front-line service contracting for its own support services. Such complexity of organisation, in possessing both central as well as departmental support costs, in addition to support functions carried out by the front-line service itself, might suggest a substantial cost disadvantage for the Home Care Service in competing with individual domiciliary agencies. One possible explanation, of why such a rationalisation of complex corporate structures has not occurred, is because re-organisations within the case study borough are not impacting on corporate structures, but rather on each department and sub-section in isolation. In this regard, the sections of the NHS and Community Care Act (1990) directed primarily at social services authorities are silent.

Further norms, within the case study borough's accounting practice, relate to the exemption of certain support functions from the allocation model for recharging overheads to departmental services. These fall into two categories. Firstly, there are costs/services which relate to what the appraisal calls the 'Corporate and Democratic Core' of the Local Authority. In the appraisal, this is defined as:

'...all activities which local authorities engage in specifically because they are elected multi-purpose authorities. The costs are seen as being over and above those which a

single purpose authority would incur and it is therefore illogical to apportion these activities to services' (McCarthy, para. 3.2.1).

The second refers to 'overheads from which no user now benefits' and the appraisal provides two specific examples: '*...backfunding of employees' pension contributions and shares of long-term unused but realisable assets'*. (Ibid. para. 3.2.1). Whilst this may be defensible for certain cost comparisons with the independent sector, on the basis that they represent the costs of a complex multipurpose authority, it is clearly another example of the normative principles involved in allocation.

The analysis of the overhead allocation model illustrates a number of important points regarding VFM. As the personnel example (see above) shows, recharging rules are often rough and may give an inadequate idea of the real cost of service support. The significance of this point is reinforced in this case, if we examine the cost structure of the service:

Table 10.2 - Full cost budgets for the Home Care Service

	EAST	WEST	BOROUGHWIDE	BDO
NET EXPEND.	900,600	902,200	547,600	29,200
CSC	45,700	47,500	30,200	3,300
DSC	118,800	118,900	73,700	3,800
FULL COST	£1,065,100	£1,068,600	£651,500	£36,300

(Source: McCarthy 1995. table 10)

Thus, as Table 10.2 above shows, even in a highly labour intensive service like home care, indirect costs make up in excess of 15% of the 'full cost' figure. This point is reinforced if

we examine, in Table 10.3 below, the range of central and departmental services where overhead charges are made:

Table 10.3 - Bases of cost apportionment

Overhead	Bases of allocation
<i>Central Support Costs</i>	
<i>Finance and Corporate Services</i>	
Finance Services	1995-96 HSS Revenue Estimates
Building Services	No. of Full Time Equivalent (FTE) posts
Office Services	No. of FTE posts
Payroll	No. of FTE posts
Public Offices	Cost of accommodation per m ²
Central telephones	No. of telephone extensions
<i>Joint Computer Department</i>	
Computer Services	No. of connections to the mainframe
<i>Chief Executive's Department</i>	
Committee Administration	Direct costs of front line HSS services
Human Resources	1995-96 HSS Revenue Estimates
Legal Services	Actual usage 1993-94 & 1994-95
Committee Rooms	Direct costs of front line HSS services
<i>Environmental services</i>	
Construction and Property Management	Cost of accommodation per in'
<i>Departmental Support Costs</i>	
<i>Chargeable to all front-line services</i>	
Unallocated	1995-96 HSS Revenue Estimates
Training	No. of FTE posts
Finance	1995-96 HSS Revenue Estimates
Central Administration	1995-96 HSS Revenue Estimates
Management Information	No. of connections to the mainframe
Planning & Commissioning	1995-96 HSS Revenue estimates
Personnel	No. of FTE posts
Quality Assurance	1995-96 Revenue Estimates
Director	1995-96 Revenue Estimates
Complaints procedure	1995-96 Revenue Estimates
Planning and Review	1995-96 Revenue Estimates
Divisional Charges	
Divisional Admin.	1995-96 Divisional Estimates
Senior management team	1995-96 Divisional Estimates
Community Care Admin	1995-96 Divisional Estimates
Generic Team	1995-96 District Office Budgets
Area Team Support	1995-96 District Office Budgets

(Source: McCarthy 1995. table 9)

It is also worth bearing in mind, that, insofar (see above) as such calculations are used in assessing whether services are retained in-house or contracted-out, then indirect costs may assume an even greater significance in determining crucial organisational decisions.

The allocation model is also significant in illustrating how cost calculations embody political and organisational assumptions. Thus, it has already been argued that the calculation assumes that certain support service costs should be treated as 'givens' and that others, such as the 'central and democratic core', should be excluded. The point is that such assumptions cannot be avoided, but their significance is often either suppressed or not revealed at all in apparently neutral cost calculations. This reinforces the point made earlier regarding Audit Commission cost calculations, which often exclude vital information on how cost figures are arrived at.

ii. The use of norms

The financial appraisal was not just concerned with a 'full cost' calculation, but with constructing operational norms for the service and making comparisons between in-house and external provision. McSweeney (1988) has argued that the work of the Audit Commission, at a national level, has operated in a context of constraint over spending. This was also true of the financial appraisal, at the level of the case study borough. Thus, in its discussion of the 'cost effectiveness' of the home care service, the appraisal argues:

'There are..... insufficient resources to meet the current level of client demand, which had contributed to a considerable overspend in 1994-95. Any improvement in cost

effectiveness would therefore help to offset this budgetary shortfall' (McCarthy 1995, para. 5.1.1).

Tackling the budgetary shortfall then involved deciding the focus of investigation. In this respect the appraisal argued:

'Improving cost-effectiveness by increasing levels of income is not feasible.....Similarly, improvements gained by reducing the number of carer hours are not feasible as more service is required by clients, not less. As the direct costs are made up entirely of employee related expenditure, the chapter will concentrate on these costs' (Ibid. para. 5.1.2).

Such considerations meant that the financial appraisal would focus on direct costs of service provision, with the object of obtaining higher service output from a given level of resources. Two particular methods were adopted. Firstly, the study examined the issue of 'carer productivity'. Secondly, it '*...[took] into account comparisons with immediate competitors or established yardsticks of performance'* (Ibid. para 5.1.3).

With respect to the former, the Home Care Service employed a 'resource management system', which recorded all time spent by carers in clients' homes. With respect to the latter, the analysis drew on information held by the Social Services Department. The former approach was first introduced in April 1994 and is used as a basis on which to charge clients of the service. The system records how carers spend all their time, although

only time which is actually spent in a client's home (but incl. laundry/shopping) is seen as 'productive' time. All other time is regarded by the appraisal as 'unproductive'. Table 10.4 below shows the split between 'productive' and 'unproductive' time for 1994/5 and 1995/6:

Table 10.4: Productivity of the Home Care Service

	Productive	Unproductive
Year		
1994-95	52.4%	47.6%
1995-96 (April - July)	53.1%	46.9%
Variation (+/-)	+0.7%	-0.7%
Average	52.75%	47.25%

(Source: McCarthy 1995, table 13, p18)

Table 10.4 above indicates 'unproductive' time accounted for nearly a half of total carer time. Although between 1994/5 and 1995/6 there had been a slight improvement, it nevertheless suggested to the author of the appraisal that there was scope for further reduction of unproductive time.

With respect to external comparisons, the appraisal made use of a publication of the Audit Commission: 'Unit Costs of Community Care' (1994). This was used to provide a 'norm' for direct overhead costs in the case study authority, by application of a nationally derived benchmark. Table 10.5 below, shows the way in which this benchmark is used in the financial appraisal:

Table 10.5: Ratio of management to direct carer costs.

	EAST	WEST	B'WIDE
Direct (Carer) Cost	869,400	869,400	568,300
Direct overhead cost	290,800	290,800	121,300
Ratio of overheads to direct costs	0.33: 1	0.33: 1	0.21:1
Mgt. overheads at 16%	139,100	139,100	90,900
Variation from actual	£151,700	£151,700	£30,400

(Source: McCarthy 1995, table 19, p23)

For the purposes of the Audit Commission Report (Ibid.), the direct carer cost of the Home Care Service relates to the cost of employees only. The direct overhead cost includes transport, expenses, supplies and services. The Case Study Borough's overhead costs, however, represent a full cost, and, in addition to the direct overhead costs (see above) include Central Support Costs (CSC) and Departmental Support Costs (DSC), which are excluded from the Audit Commission's calculation. This creates a substantial variation from the Commission's 16% benchmark for management overheads, as a ratio of direct costs.

The following extract, from the appraisal, shows the conclusions which are derived from the external comparison:

'Given the way that the East and West budgets have been put together it is not surprising that the ratios are the same. Although the Boroughwide ratio is a lot lower, it confirms a trend in terms of management and supervision which is well in excess of the 16% benchmark. In order to reduce the level of overheads the service incurs, the service

manager should undertake a full review of all the management/ administrative posts with a view to reducing costs to the 16% level' (McCarthy, para. 5.2.2).

The context in which these comments are made relates to features of the organisational structure of services. Thus, the East and West teams represent a 50/50 split of the client case load and staffing for personal care and therefore generate the same ratio of management overheads to direct cost. The boroughwide team is a smaller and less complex service offering practical care only. It consequently generates a lower ratio of management overheads to direct cost.

There is also another significant difference between the Audit Commission cost figures and those in the case study borough. In addition, in calculating direct carer costs, the Commission's report does not take into account the cost of assessment, which in the Case Study Borough, at the time of the appraisal, was undertaken by home care 'organisers'. Both these costs would need to be excluded from the case study borough's figures, in order to carry out a meaningful comparison with the national benchmark figure.

The second basis of comparison used in the appraisal was between the in-house and external service providers. Again, however, this involved adjustments. Thus, the financial appraisal points out that:

'The HCS management and administration team assess the needs of clients, prepare care programmes, select carers to deliver the agreed programme and monitor and evaluate

the care that is given to clients. These are all activities which need to be carried out for effective management of the service and if they are not carried out by the current management they would need to be carried out by another team in their place. Agency charges do not reflect these activities' (Ibid. para. 5.2.6.- 5.2.7).

This involved various adjustments in order to allow comparability. In essence, these involved comparing costs of direct service provision, although CSC costs were included for the in-house provider. The cost comparison with external providers is given in Table 10.6 below:

Table 10.6 - Comparison of Home Care Service costs to agency costs

	Areas			Agencies
	East	West	B'wide	
Grade 6				
Monday - Friday	12.55	12.55	12.55	7.39
Saturday	18.70	18.70	18.69	8.73
Sunday	24.92	24.92	24.92	9.29
B'Holiday	24.92	24.93	24.92	13.81
Grade 5				
Monday - Friday	-	-	£12.55	£7.39

(Source: McCarthy 1995, table 21)

From table 10.6 above, it is evident that the average external agency unit cost (expressed as a cost per hour) at £7.39, is lower than the unit cost quoted for the in-house service of £12.55. However, it is also important to consider two contextual issues which will be discussed in more detail below. Firstly, services from external agencies are specified and purchased by care management staff, from Social Services, on behalf of clients and at

present the duration of care provided by agencies is limited to a **minimum of one hour**.

Secondly, the charges from agencies represent **prices** and not **costs**. The significance of the difference is brought out later in the appraisal:

'One hour's agency service will only purchase a visit to one client for one hour. In a productive hour however, a HCS carer may see between 2-3 clients. If an agency carer saw three clients the cost would be three times the hourly rate' (Ibid. 5.2.10).

Table 10.7 below, shows the effect of this difference in practice, so that recalculated for a daily rate in which the same number of clients per day are seen, the in-house service is substantially cheaper.

Table 10.7 - The daily cost of Home Care Service and agency services

	East	East £	Agency £	Variation HCS surplus/ (deficit) position
Average hours per day	7.8			
Productive hours	3.7			
Productive minutes	222			
Average time spent with clients	23			
No. of client visits	9.65			
Cost per productive hour		£12.55	£7.39	(£5.16)
Cost per day		£46.43	£71.31	£24.88

(Source: McCarthy 1995, table 22)

In particular, this is because the in-house service has no restrictions in terms of a minimum time of contact with each client. Since September 1994, it has been reviewing all of its

clients' home care requirements and as a consequence has reduced the average number of contact hours per client. It is now able to service 2 - 3 clients per hour.

Thus the in-house service, in achieving this level of productivity, challenges the assumption that the 'efficiency' of private sector providers is superior. Earlier in the chapter, it was pointed out that VFM involves two aspects: a management accounting and a management consultancy side. The discussion of the relation between 'productive' and 'unproductive' time in the financial appraisal provides an interesting example of these two aspects. Thus, the management accounting side is illustrated by the attempt to generalise operational norms for the service and compare them to current practice standards; the management consultancy side is reflected in proposals for changes in current practice. The breakdown between 'productive' and 'unproductive' time has been outlined above. In the appraisal, an analysis of unproductive time is given in Table 10.8 below:

Table 10.8 - Analysis of unproductive time (Home Care Service)

(A breakdown of average productive and unproductive time for 1994-95 and the first quarter of 1995-96.)

	Productive time	Sick leave	Annual leave	Travel	Misc hours
%	52.75	9.91	11.23	23.46	2.65

(Source: McCarthy 1995, table 23)

The appraisal goes on to distinguish areas which are seen as under potential management control and those which are not:

'Of the above categories of unproductive time, the only category which is beyond the immediate concern of the service manager is annual leave. It would be unrealistic to think that this area of unproductive time could be reduced (Ibid. para. 5.3.2).

This left two areas of particular interest: sick leave and travel time. With respect to sick leave, the 9.91% of overall time is identified as 'a very high percentage' (Ibid. para. 5.3.3) and is contrasted with a 'usual level of sickness'. However, the appraisal also notes that: *'...the work is very stressful, involving caring for clients who have very debilitating illnesses. It is physically and emotionally demanding'* (Ibid. para. 5.3.4) and it also points out that:

'There is evidence to suggest that clients are reluctant for carers to leave their homes on completion of the service, carers can provide clients with their only source of social interaction; carers also give up their own time to visit clients. This type of situation is very stressful for clients and carers alike, and carers need all the assistance that can possibly be given' (Ibid).

Having identified sick leave as one of the crucial areas of 'unproductive time', the financial appraisal goes on to recommend various management approaches to reducing sick leave. These include stress counselling; assertiveness; time management training (in the context of pressures from clients to exceed time limits spent with them); and an approachable stance from management, which encourages carers to raise problems with them before they manifest themselves in sickness absence; and close monitoring of personal absence records where appropriate.

With respect to travel time the appraisal argues:

'The high level of unproductive time due to travelling stems from the fact that carers are allowed 15 minutes to travel between clients. 23.46% equates to 14.1 minutes. This agreement has been in operation since the service was first formed and is now seen by the management as being too long (Ibid. para. 5.3.5).

The judgement that travel time is 'high' is, in turn, related to the experience of another department:

'The Refuse and Street cleansing sections of the Borough's Contract Services Department have route planning software to plan their daily trips. The use of such software had reduced the time taken to do their rounds by 16.5% when first used. It is reasonable to think that the HCS could benefit in the same way' (Ibid. para. 5.3.6).

This led to a proposal to institute a similar system in the home care service. Thus, the appraisal involves attempts to create norms of performance and to suggest means by which such performance can be attained. However, a closer examination of the material presented in the appraisal raises a number of problems relating to the way in which these norms are constructed.

The management overhead costs of the Home Care Service, illustrated in Table 10.5, are simply contrasted with what appears to be a 'national' average figure for direct

management overheads, as published by the Audit Commission, for local authorities in England and Wales. The Commission's research indicated a 'benchmark' figure of 16% for the ratio of direct management overheads to direct carer costs. However, excluded from the Commission's benchmark, are the not inconsiderable areas of Central (CSC) and Departmental Support costs (DSC), which are included in the overhead cost of the Home Care Service. This indicates that the use of the Audit Commission cost figures as a benchmark, in excluding such overheads, is problematic. A further issue is raised by methods for calculation of the national benchmark. In this respect, it would be necessary to know how adjustments were made for local variations that might have an impact on the level of overheads charged to the home care service. In the absence of a defined methodology, therefore, such a national average figure is again problematic.

In terms of 'quasi-market' comparisons there seems to be a conceptual slip, thus the 'cost' figures for external agencies cited in Table 10.6 are not 'costs' but rather 'prices'. That is, they reflect not a cost calculation, but rather the price cited by the agency. Included within the Home Care Service cost, as explained above, are both direct and indirect overheads. Such a cost comparison with the external sector is therefore problematic. Although the appraisal was not able to provide costing methodologies for how agency prices were calculated, it is nevertheless conceivable that such relatively lower hourly rates, quoted by external agencies, operated to some extent as 'loss' leaders with the intention of drawing further business away from local authorities [For an example of such practices in the NHS see Milne (1993)].

In the part of the appraisal relating to productivity of carer, the classic approach of distinguishing 'productive' and 'unproductive' time is made. This involves two features: firstly, the improvement of 'cost effectiveness' which is linked to the reduction of 'unproductive time (see iii. below), secondly, the construction of norms which justify the reduction in such time. Within the construction of such norms, various features such as annual leave and corporate and democratic core are screened out on the basis of political decisions. This treatment raises a number of issues. The logic of 'marketisation' would suggest that no aspects of local authority provision ought to be excluded for the scope of cost comparisons. Yet, in this case both particular overheads and the annual leave arrangements are effectively screened out of the comparisons. This illustrates an interesting tension in the practice of VFM. On the one hand the practice involves a search for cost norms to guide practice. On the other hand it works, as in this case, within pre-given political arguments for local authorities adopting conditions of annual leave which are superior to private sector providers or maintaining a core of services which are not subject to competition. Thus, VFM can lead to practice, as in the case study borough, in which such political assumptions structure the cost calculations, yet lack justification in terms of the rationality that such an approach requires.

The following section in the appraisal appears to present a further case of applying arbitrary norms:

5.33 **Sick Leave:** 9.9% of time is recorded as absence from work through illness: this is a very high percentage that equates to 29,611 hours (total hours grade 5 and 6 = £298,815 x 9.91%). An analysis of sick leave records in the payroll section revealed that the service had only 2 carers who had been off sick for a continuous period of 1 month (long terms illness) and only 6 carers who had been signed off as sick by their doctors for between 1-2 weeks. From this it can be

deduced that the majority of sick leave is of less than 6 days and does not require a medical certificate.

5.3.4 HSS Personnel have advised that the usual level of sickness is put at between 7-9 days per annum per person. Those involved in trading agreements in the borough also budget for this level of sickness. 9.91%, however, equates to 25 days per person per annum:

- Health checks would be given to all carers by the occupational health department, there would be no further financial cost to the service as the service is already paid for through the CSC recharge.
- Stress counselling - the work is very stressful, involving caring for clients who have very debilitating illnesses. It is physically and emotionally demanding.
- Assertiveness and Time management skills courses- stress and illness can be caused by exceeding limits for time that is supposed to be spent with clients. There is evidence to suggest that clients are reluctant for carers to leave their homes on completion of the service; carers also give up their own time to visit clients. This type of situation is very stressful for clients and carers alike and carers need all the assistance that can possibly be given.
- Management should meet face to face with carers to let them know of the problem of sick leave and that all possible support is available. Carers should be able to approach management with any concerns they have over their roles and performance.
- Management should monitor all sick-leave closely and approach individual carers if they feel the situation warrants it.

(McCarthy 1995, para. 5.3.3 - 5.3.4),

In the above extract, 9.91% is initially referred to as 'high', but it is not clear on what basis it is compared to a norm of 7-9 days per annum. Indeed the only basis given to support this norm is that this level of sickness was advised by departmental personnel and used in other areas of the council. Equally, this section points to contradictions: if the 7-9 days is an average for the department, or even the council as a whole, it arguably doesn't come to terms with the special features of the job, which are identified as high levels of

stress and demands of certain clients for more carer time in the home. On the basis of these latter features, this suggests that the application of departmental or corporate norms, might be inappropriate. Equally there are contradictions in the same section between stress and illness in a caring context and the pressure to increase productivity. Thus, increasing productivity will mean attempting to increase the number of client visits in a given time period. However, by the admission of the financial appraisal itself, such practices are likely to increase the stresses on carers, possibly leading to more 'unproductive' time through sickness. A further tension exists between disciplinary measures by management, in controlling levels of sickness, and tactics destined to make management more 'approachable' to staff, in identifying and discussing particular problems related to the job.

In a later part of the appraisal, a norm for travel time is derived from applying the % travel time in a totally different service, namely refuse and street cleansing and applying it to the Home Care Service. Again, the report is silent on why such norms should apply to home care services. Yet, given the fragility of this argument, it is simply asserted that the reduction in travel time is 'achievable'.

The normative convention in relation to unit costs is to express it as a cost of service per hour. However, as is conceded by the appraisal, if the cost of the service is expressed in a different way, namely as a cost per visit, then the nature of the comparison changes. Indeed the cost per day, calculated on this revised basis at £46.43 (Table 10.7), is 35 % lower than the agency cost per day of £71.31. This represents, in fact, a reversal of the

previous method for expressing unit costs, where the comparison of £12.55 (In-house) to £7.39 (external), suggested the external agencies cost was 41% lower. This is also a point raised by my empirical investigation (chapters 8 and 9) and illustrates an important area around the complexity of measurement of value for money, in that the methods used for calculation of unit costs have a direct bearing on the assumed degree of competitiveness. In addition, they also highlight tensions within the model between efficiency and effectiveness, in that sustained reductions in unit cost may have a detrimental affect on service effectiveness.

iii. Tensions between efficiency and effectiveness

In resolving issues of greater service efficiency, the tensions between efficiency and effectiveness appear to some extent irreconcilable. In the appraisal, it is conceded that the home care service provides a 'very important service' which is 'well received by its clients'. However, on the crucial aspect of the direct cost of carers' wages, whilst it is acknowledged that the latter (for the home care service) is higher than the private sector, we are told that: '*...working practices... make it cheaper to operate than private agencies*' (McCarthy 1995, para. 5.4.2). The basis of the 'more effective' working practices for the in-house service, contributing as outlined above to a revised unit cost, relates to the number of visits that the in-house service make per hour, which is estimated by the Service Manager at between 2 and 3. This is in contrast to external agencies who, at the time of the appraisal and my empirical study, operated a minimum duration of one hour of service per visit.

Underlying, therefore, the appraisal's approach to the in-house service is a commitment to 'managerialism', in that it aims to extract increased client contact out of a given number of paid hours. The method for progressing this, as we have seen, relies on the scrutiny of 'unproductive' time to see where improvements can be made. The problem, highlighted above, suggested that the basis for carrying out such an approach involved the adoption of norms from other service areas that ignored the different social context of personal care. Whilst it would be conceded that improvements in efficiency should be addressed, in the light of the higher levels of demand that the home care service is facing, it does introduce problems of tension between efficiency of operation as a process and effectiveness in terms of outcomes for users. An important aspect of this is the importance of maintaining an effective relationship with the service user, which as costs are further driven down, must be vulnerable to increased labour turnover and changes in contracts, both of which might threaten continuity of care.

If an organisation concedes an approach as described, based solely on driving costs down, then the logic of this approach effectively reduces the work to simply one of completing a given range of tasks, yet the evidence from my empirical study suggests that the centrality of the relationship between user and carer favours an approach based on effectiveness of outcome. This at least suggests that the model in operation here is inappropriate, which is virtually conceded in the appraisal. It would therefore be argued that the appraisal effectively operates as a search for 'bottom line' figures on a relatively arbitrary basis, which is at variance with the rationalistic assumptions of VFM promulgated by the Audit Commission. Furthermore the issue of the centrality of the personal relationship between

carer and 'cared for' raised by my empirical study (chapters 8 and 9), might, in the context of a more targeted eligibility policy towards higher dependency clients (see chapter 6) and an increasing emphasis within the department on personal care, make the VFM framework more difficult to sustain. It is therefore interesting, in such a context, that the appraisal concedes, on the issue of non-productive time, that if private agencies were required to visit more than one client per hour, in line with the in-house service, it is likely that: *'...they too would have unproductive time and their own management and supervision costs would also change accordingly'* (McCarthy 1995, para. 5.4.2). The balance between efficiency and effectiveness is therefore of a complex nature and in the context of social care, as resources become more constrained, decisions to increase productivity need to be balanced carefully against policies to target services on higher dependency clients and should take into account the higher levels of support required by staff providing intensive personal care.

This chapter began by considering broad theoretical arguments about the status of Value for Money Audit. The case study material provides interesting micro-evidence for the operation of the mechanisms identified in such theoretical work. Thus, the context of cost constraint does orientate VFM towards a central concern with 'efficiency'. This can be seen in the focus of the financial appraisal on reducing 'unproductive' time. Effectiveness issues were not ignored but were marginal, indeed they could not be otherwise, when, for example, in the case of the discussion of time lost due to sickness, concerns of effectiveness could be argued to potentially undercut a strategy of increasing productivity.

The material also provided interesting evidence on the question of 'visibility'. Thus, while the financial appraisal generated 'bottom line' figures, they were often based on crude assumptions or organisational 'givens', which included some features for consideration and excluded others. Equally, it is questionable whether VFM can operate as a decision making tool. Thus, as McSweeney (1988) argued, efficiency and effectiveness cannot be summed by being given weights in a calculation. This means that when efficiency and effectiveness come into contradiction, as in the situation where demand for a service increases during a time of financial constraint, then politicians are faced with the familiar problem of choosing between service quality and cost. VFM thus fails as a technical 'fix' for the problems of managing dwindling resources in the public sector.

CHAPTER 11 CONCLUSION

This thesis has sought to contribute to the evaluation of the claims made for the community care reforms initiated in the late 1980s. These reforms involved a departure from previous approaches because they involved both changes in the management and organisation of local authority services and the creation of quasi-markets. The aim in this conclusion is to bring together the insights gained from discussions of both the theoretical literature in this area and the findings of empirical research in the case-study borough.

THEORETICAL ARGUMENTS

In Chapter One it was argued that community care was a policy which both commanded bi-partisan political support from the late 1950s, but delivered very modest results in shifting the balance of service provision. The period of the second and third Thatcher administrations, in contrast, marked the shift to a much more pro-active policy and the development of a new structure for community care. In part this was possible because this period was characterised by the increasing importance of arguments that the problems of public sector service provision could be resolved, not by increasing the resources available, but by managing such resources more effectively. Quasi-markets were to serve as a discipline, so that the potential of better management would be realised.

In Chapter Two it was stressed that support for both managerialism and markets was based on a set of prior beliefs and attitudes. In both cases existing public sector provision was seen as problematic. The absence of management was seen as going along with

traditional professional and administrative approaches, which made little or no reference to measures of performance. The absence of competition reinforced such complacency by sheltering public sector providers. Equally, both managerialism and markets offered a diffuse range of benefits - cost control, quality and choice could, it was argued, all be delivered.

In the sphere of community care, the policy agenda was crucially influenced by the work of the Audit Commission. The two key reports, discussed in Chapters 3 and 4, worked on the assumption that community care could deliver significant benefits to users. This was, in many ways familiar and reflected the long-established consensus on the desirability of the policy. Where the reports were significant was in the claim that such gains could be achieved, whilst effecting savings in resource use. The argument in these two reports shared many key features of managerialism, including the attack on existing practice as seriously deficient. However, a potential weakness of this approach is that such reports are disproportionately concerned with shifting public sector values and attitudes and may thus be based on scanty and unsound evidence. This issue was addressed in the analysis in Chapters 3 and 4. In those chapters it was argued that throughout the 1985 and 1986 reports, evidence to support the conclusions is thin and the conceptual basis questionable. For instance, in the 1985 report, the Commission based important conclusions on levels of residential provision and categories of occupancy and on data from a limited study of local authorities. In particular, methods of research were inadequate. These included problems of using a limited sample, comprising only seven authorities, together with the use of different research methods for collecting data in two out of the seven authorities. In the

latter case, differences in data collection methods should have led to their exclusion. Had such an exclusion been properly made, this would have left only one of the seven sample authorities as showing clear evidence of inappropriate admission. Yet, claims from the study are used to support claims that inappropriate resource use occurred on a wide scale.

Further problems, within the argument, were found in the incoherence of particular categories of disability, which in turn, depended, for their establishment, on an uncritical acceptance of 'soft' data from professionals. The three categories of disability defined in the report (Audit Commission 1985, para. 27) were: 'very severe', 'severe', and 'moderate'. In particular, the 'moderate' category was identified by the Commission as an area where so called 'inappropriate' placements had been made (Ibid. p22, exhibit 4).

Such claims enabled the Commission to assert that most of the people in this group could be supported in the community, given the appropriate package of care. Chapter 4, however, showed that the definition of the 'moderate' category is problematic, in that it included people with modest practical care needs and others with extensive need for support with personal care (Ibid., para. 27, table 3). Thus, in the absence of a clear definition, the claim of inappropriate placements, on which the policy of community care depends, is problematic.

'Intensive' packages, required to support users on the margins of residential care admission (Ibid., para. 21, table 2), were also defined in an extremely minimalist way. For instance, in the footnote to table 2 of the 1985 report, we are told that an intensive package contains only 9 home help hours. This contrasts with the case study authority

where an intensive care package contains approximately 20 hours of care (see chapter 6). This, in part, betrays an attempt by the Commission to downplay the cost of a community care package as an alternative to a residential placement. Individual components of intensive packages were equally bizarre, in that they often relied extensively on services in institutional settings, such as day care. Thus, chapter 4 established that the Audit Commission reports (1985/6), which played an important role in the creation of community care policy, are flawed in relation to assumptions of lower costs outside institutional settings. Furthermore, in relation to costs, original claims of lower expenditure outside institutions (viz. Audit Commission 1985, para. 37) are later modified in the 1986 report to 'comparable costs' (Audit Commission 1986, para.13). Thus, as Chapter 4 argues, the managerialist framework for community care was problematic.

Assumptions about user choice and satisfaction

Community care policy is not just based on cost, but on assumptions that the creation of the market will extend user choice and hence user satisfaction (Department of Health 1989b, para. 3.4.3). Chapter 5 pointed out that there are problems with the desirability of such a policy since, for example, an emphasis on the current service user could be argued to be inequitable to potential users. It also examined arguments that genuine choice was difficult to sustain in a quasi-market with proxy purchasers. However, the argument also examined an issue which has received much less attention, that there is no necessary connection between increase in user choice and user satisfaction.

Dowding's analysis was used to identify some of the key problems in this respect. In particular, Dowding suggests that the underlying issue, in any area where a range of alternatives are provided, is not the provision of choice per se, but whether the alternatives genuinely lead to greater control. For Dowding, the most common context in which the idea of extension of choice is raised is with respect to what he refers to as the 'choice set' (Dowding 1992, p303). However, as Dowding indicates, the existence of an additional choice is not automatically equivalent to an increase in individual welfare, since there would be no requirement to increase the number of alternatives to choose between if the most preferred alternative remains the same (Ibid.).

Thus, part one of the thesis argued that community care policy was established on the basis of assumptions regarding cost and effectiveness (in relation to outcomes for users), which were problematic. In the second part, the aim was to illustrate these issues from empirical analysis in the case study borough.

LINK BETWEEN EMPIRICAL FINDINGS AND THEORETICAL ARGUMENTS

Case study survey on user satisfaction

As was argued in chapter 2, an assumption behind both managerialism and quasi-markets was that existing forms of provision were deficient. The user satisfaction survey, conducted in the case study borough, illustrated problems with such an assumption in investigating evidence for the supposed superiority of quasi-market or contracted out approaches. It confirmed the problems in the capacity of the market model for community care, as illustrated by the external domiciliary service, to demonstrate the qualitative

benefits claimed for users. (Ibid.). On the contrary, the survey results indicated a higher overall level of user satisfaction with the in-house service, which operated as the pre-community care 'control'.

Thus, a second phase to the investigation was developed, which was to see which factors from both services contributed to overall satisfaction. In this respect, the results indicated that, despite the emphasis in the community care legislation on 'technical' benefits (e.g. the aspect of choice) of the market for care services (Department of Health 1989b para. 3.4.3), it was the 'personal' aspects, such as 'carer manner' and 'relationship with care worker', that appeared most linked to overall levels of user satisfaction. The argument developed was that this may well have flowed from the user's situation and the nature of the service being provided. Consequently, far from a market delivering choice as a means of increasing effectiveness, this feature was largely irrelevant.

Thus, whilst most commentators have assumed (see chapter 5) that the debate ought to be about whether choice is being delivered, in the implicit belief that all consumers want choice, the evidence from the case study suggested that such arguments were questionable, since, although choice might be important to particular groups and individuals, it is not universal. In addition, the findings indicated that it might be less important to give choice than provide continuity in the caring relationship. In this respect, questions relating to 'choice of carer' were used by respondents to highlight problems in continuity which affected the quality of care provided. Thus, it appeared, the critical issue to users was not the ability to switch between providers on an 'approved' list, but the

ability of any one provider to maintain quality of service through staff continuity. The latter, it was argued, would have potential implication for the market model. Observation of actual behaviour in relation to choice, in the empirical research, therefore displaced many of the assumptions about user behaviour discussed within the theoretical chapters.

Local VFM audit

Chapter 10 complimented the findings on user satisfaction with an analysis of a VFM audit in the case study borough. Thus, it illustrated the use of a technique which the Audit Commission has sought to pioneer in the public sector. It made the point that the financial appraisal, used to illustrate the micro operation of VFM, showed how service costs had to be constructed via accounting rules and these frequently involved political assumptions about the nature of the organisation concerned. It also illustrated the problems, posed in chapter 4, regarding the construction of norms. Thus, in the aim to find a 'bottom line' standard and a set of related recommendations, the financial appraisal used various arbitrary assumptions, and favoured policies which could, arguably, have compromised policy effectiveness. The context of cost constraint led to a concern to increase productivity. However, this policy itself had contradictory aspects in that such a policy by compromising the personal relationship with the carer could increase the stress of the job. This, as the appraisal recognised, could increase sickness absence and hence increase labour costs. In addition, the chapter showed that the treatment of travelling time was arbitrary. In the search to push up 'productive time', norms were imported from other services, without any attempt to demonstrate their appropriateness to the home care service context.

Relationship with contemporary developments

It is also interesting to examine these conclusions in the light of contemporary developments. Central here and, arguably, indicative of the collapse of the managerialist problem definition is the importance of rationing/eligibility criteria. The increasing use of such techniques has been advocated by the Audit Commission in two recent publications: 'Taking Care' (1993, paras. 16-22) and 'Balancing the Care Equation' (1996, paras. 19-32). In the former, the Audit Commission urged local authorities to set eligibility criteria in such a way as to allow through **only** those people with needs which could be met within current resources. Similarly, in the latter, the Commission identified rationing and targeting measures as significant 'agents' for controlling the allocation of limited resources. A recent study by the London Research Centre and Local Government Management Board (1996) similarly reinforces observations by the Commission of a financially dominated agenda and the need for eligibility criteria to target services on those in greatest need. The introduction of such measures suggests the problem definition was breaking down and under such circumstances, more drastic financial control measures were required. Such measures also impact on issues of equity between different categories of user, resulting in those assessed with higher needs receiving services at the expense of those categorised as lower priority (Ivory 1997, pi). Furthermore, in identifying different categories of need, more emphasis tends to be put on personal care needs at the expense of practical care, such as shopping or cleaning, without adequate consideration of whether or not those needs are critical to the user's independence. Thus, the rhetoric of 'needs-led' services promotes the formalisation of hierarchies of need, which in turn legitimises not meeting lower levels of need, which are increasingly identified with non-personal care

tasks. (Lewis 1997, pii-vi). Such a position is backed up by evidence from the case study borough (see chapter 6) where, since April 1993, the Home Care Service has been increasingly targeted on people with high level needs, as a means of achieving community care policy, in respect to minimising placements to residential care. In relation to 'lower level' practical care tasks, survey results from chapter 8 indicate that some users, from both in-house and external services, were aware that certain tasks, such as housework and cleaning, were not considered appropriate by the department for carers to do.

Although rationing was not ignored in the early Audit Commission reports, there was a stronger emphasis on better management generating more return from resources - for instance, the switch to community care being both cheaper and more effective.

Thus, rationing was a relatively secondary issue, with the emphasis being on managerial techniques and market mechanisms to manage better within existing resources.

The latter has since been displaced by the dominance of rationing, which effectively operates on the assumption that resources are generally insufficient, in contrast to the earlier reports, which assumed they would be sufficient but were being used inappropriately. Chapter 10 illustrates this point in linking the overspend in 1994/5 to inadequate management information and budgetary control necessitating the adoption of rationing to keep the service within budget.

Evidence to support the argument that resources are inadequate for community care implementation is provided by the London Research Centre (1997, p5-7) in a report: '*Non-residential services in London*', in which 9 out of 21 London boroughs surveyed

(43% of sample) were spending more than £167 per week (average net cost of a residential home) per head of population over 65 on domiciliary care packages. This was also confirmed in evidence from the case study borough where intensive packages of domiciliary care were often more expensive than 'equivalent' residential places. These contemporary developments can thus be related to the argument in chapters 3 and 4, that assumptions over the cost of community packages, relative to residential provision, were flawed from the very outset.

Overall, the thesis established that community care is a complex policy field and that this has implications for the successful attainment and assessment of qualitative and quantitative outcomes. Problems of complexity in implementation related to the nature of the managerialist framework underlying the market model for community care. Such problems were attributed to the failure of the managerialist problem definition. The failure of the latter can be seen to be linked to an ideological emphasis on 'change', which meant that crude assumptions were made about deficiencies of current practice and what could be achieved by better management. In turn this led to shallow consideration of the evidence on both costs and effectiveness.

Thus, problems within the managerialist framework contributed to difficulties in the delivery of the qualitative and quantitative benefits claimed by the reforms. Such problems are confirmed in my empirical research, together with the micro-illustrative cost data, which, together, showed that the development of a market approach to domiciliary provision failed to produce enhanced outcomes (for users) and greater value for money.

Moreover, it suggested that the market model was inappropriate, in relation to the key component of user satisfaction, which related to the quality of relationship with the care worker. Thus, as resources become still further constrained, it is difficult to see how the situation described by Griffiths, in 1988, with respect to the previous 30 years, has changed:

'At the centre, community care has been talked of for thirty years and in few areas can the gap between political rhetoric and policy on the one hand, or between policy and reality in the field on the other hand have been so great' (Griffiths 1988, para. 9, piv. My emphasis).

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APPENDIX I

Social Services

your ref	Direct line
my ref	Please ask for Tony Winsor
date	March 6th 1995

Dear

Home Care Service - User Satisfaction Survey

The Department are currently looking at the quality of care provided by the Home Care Service, and will be asking users what they think about the service.

During the second half of March a team of researchers commissioned by the Borough of X will be visiting users of home care services to ask them questions about the service they receive. In the next couple of weeks you will be receiving a telephone call from one of the team of home care researchers to set up a visit at a time convenient to you. If you decide you don't wish to participate in the survey please complete the slip attached overleaf.

All interviewers will carry ID and all information from the survey will be treated as anonymous and confidential. **Your support will be of great help to us in reviewing our home care services.**

Yours sincerely

Tony Winsor
Planning and Commissioning Manager

Only if you **do not** wish to participate in the survey:

I **do not** wish to participate in the home care survey.

Signature

Date

(Please return complete letter in SAE
provided.)

**IF YOU DO WISH TO PARTICIPATE THERE IS NOTHING FURTHER THAT
YOU NEED DO.**

BEST COPY

AVAILABLE

TEXT IN ORIGINAL IS
CLOSE TO THE EDGE OF
THE PAGE

HOME CARE SERVICE USER SATISFACTION SURVEY

1. HOW YOU FOUND OUT ABOUT THE SERVICE

First of all I would like to talk to you about the service you receive. Can you remember....?

a. How you found out about the service?
(Probe: was it from a leaflet....?)

- From a leaflet
- From Social Services
- From a friend or relative
- Other

b. How easy was it getting the information?

- Very easy
- Fairly easy
- Very difficult
- Don't remember
- Other

c. Did the information tell you
everything you needed to
know?

- Yes
- No
- Don't know
- Other

d. Is there anything else you want to tell me
about how you found out about the
service?

And now can we talk about your assessment....?

When a Social Worker or someone from Home Care came round to find out what you needed.)

a. How easy was it getting an assessment?

- Very easy
- Fairly easy
- Very difficult
- Don't remember
- Other

b. Were you consulted in your assessment?

- Fully
- A little
- Not at all
- Don't know
- Other

c. Were you satisfied with your assessment?

- Very satisfied
- Fairly satisfied
- Not satisfied
- Don't remember
- Other

d. Is there anything else you want to tell me about your assessment?

B. YOUR HOME CARE SERVICE

And now I would like to ask you a few questions about the home care you receive....

a. Were you able to choose the home carer you wanted?

- Yes
- No
- Don't know
- Other

b. Were you able to choose the times you wanted home care?

- Yes
- No
- Don't know
- Other

c. Were you able to choose which jobs you wanted doing?

- Yes
- No
- Don't know
- Other

d. Do you feel you get value for money?

- Yes
- No
- Don't know
- Other

e. Is there anything more you would like to tell us about the home care you receive?

- Yes (Please explain)
- No
- Don't know
- Other (Please explain)

I. YOUR HOME CARER(S)

You may have more than one Home Carer. Generally speaking which of the following descriptions best fits your Home Carer(s).

i. Would you say that your home carers have a caring manner?
(Probe: Is that all the time....?)

- All of the time
- Most of the time
- Some of the time
- Never
- Don't know
- Other

ii. Are they ever in a rush to finish their work?
(Probe: If Yes, is that all the time....?)

- All of the time
- Most of the time
- Some of the time
- None of the time
- Don't know
- Other

iii. Are they always punctual?
(Probe: If Yes, is that all the time.....?)

- All of the time
- Most of the time
- Some of the time
- None of the time
- Don't know
- Other

iv. Do your home carers have a clean and tidy appearance?
(Probe: Is that all the time.....?)

- All of the time
- Most of the time
- Some of the time
- Never
- Don't know
- Other

e. Do they give you more help when you need it?
(Probe: Is that all the time....?)

- All of the time
- Most of the time
- Some of the time
- None of the time
- Don't know
- Other

f. Do they start by asking you what you need?
(Probe: Is that all the time.....?)

- All of the time
- Most of the time
- Some of the time
- Never
- Don't know
- Other

g. Are you satisfied with the work carried out
by your home carers?
(Probe: Is that very satisfied....?)

- Very satisfied
- Partly satisfied
- Not satisfied
- Don't know
- Other

h. Is there anything else you want to say about your home carers?

5. HOW YOU FEEL

I have asked you a number of questions about the service you receive. Now I want you to tell me a bit about how you feel yourself....

For instance.....

a. How do you feel when your home carer arrives?

[Note: Record verbatim and tick appropriate box.]

- Very happy
- Fairly happy
- Not happy
- Not sure
- Other

b. How do you feel when your home carer has finished?

[Note: Record verbatim and tick appropriate box.]

- Very happy
- Fairly happy
- Not happy
- Not sure
- Other

Note: Instead of happy might be pleased/good/OK etc

e. How do you feel about the Home Care Service overall?

[Note: Record verbatim and tick appropriate box.]

- Very satisfied
- Fairly satisfied
- Not satisfied
- Don't know
- Other

6. OVERALL

a. Is there anything that we haven't covered that you would like to mention? If Yes, what?

**Thank you for taking part in the survey.
All information will be anonymous and
confidential.**

Interviewer _____

Date _____

Respondent's name: _____

(This will be detached after being checked by office)