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A Journey through the Years: Ageing and Social Care

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Abstract

The paper analyses the history of English social care philosophy, policy, and institutions since the late seventies, and the challenges of today which they have helped to shape. Guiding principles changed in fundamental ways requiring and causing profound cultural and structural changes, not always with the intended mix of consequences. Changes in practice philosophy complemented changes in the philosophical bases of policy. They moved along a continuum of doing 'to' people (containing and controlling as well as caring), to doing 'for' (paternalistic but often also patronisingly assuming 'cosiness' in looking after people), to doing 'with' (partnership and participation), to offering more independence choice and control and doing 'by' themselves but with 'assistance' when needed. Since 1989, policy and institutions have been adapted to reduce the dependence on institutions, better match responses to individual circumstances and increase control and choice by shifting the balance of roles of authorities from direct provision to planning and purchasing more diverse services and supporting the development of a succession of new models for securing their fit to user wishes and circumstances. From 1998, policy was designed to accelerate and secure greater consistency in development based on the national policy principles through performance management including rewards and incentives. From 2005, the challenge was defined more in terms of improving the broad wellbeing of older people and finding new ways of contributing to it, particularly in ways which would reduce the subsequent need for services. Pressures on public budgets have throughout been and continue to be a major concern of field agencies.

It continues to be topical and timely although it also continues to be addressed with a degree of timidity reflecting the tensions it encapsulates. So, how should assistance be provided for people as they age with an increasing likelihood of detiorating physical and cognitive capacity and with an increased potential for mental ill health, especially depression (see, for example, National Centre for Social Research, 2000)? With current and projected demography showing an overall significant ageing of the population, and with the balance across age groups skewing towards a higher proportion of much older people, social policy and social care practice has often adjusted itself to survive, rather than to support and sustain, an ageing population.

Setting the changing scene

A long-term perspective shows a move away from institutional care in the 1940s (in large geriatric hospitals and mental health asylums, often having been reincarnated from former Poor Law workhouses), to the advent of smaller residential care and nursing homes from the 1960s, and with a greater emphasis on community care assisting people within their own homes from the 1980s, to a current policy to support people to live independently. The practice philosophy running alongside the policy changes has seen a move along a continuum of doing '*to*' people (which was as much about containment and control as about care), to doing *'for'* (with its paternalistic but also often patronising 'cosiness' of looking after people), and then doing '*with*' (in partnership and with participation by older people), to an intention now that people should have more choice and control and be 'in charge' doing '*by*' themselves but with 'assistance' rather than 'care'.

The change in practice philosophy is illustrated by changing terminology. Government initiatives about 'community care' have been replaced by initiatives about 'supporting people' and 'promoting independence'. But as well as reflecting positive changes in philosophy, with a movement away from segregation, institutional isolation, containment and negative discrimination, many older people experience benign neglect, with families having fragmented, been reconstituted and geographically more dispersed, and with the state rationing services more heavily.

There is also a two-tier experience of ageing. Those in good health and those with cash and resources within their own control (and they are likely to be the same people) have longer lives and continuing opportunity, and when they need assistance they can buy it (although its quality may still be limited). These are the older people with significant occupational pensions, available equity through home ownership and inherited wealth from a previous generation, all of which is increasing for the 'new elderly'. But for older people who need state support with income maintenance, housing and the provision of social care assistance there are more heavily rationed and reducing services, often purchased by the state more cheaply and of a lower specification and quality, and with waiting lists and delays before any help is provided. For some older people this means very damaging, unnecessary and too long hospitals admissions, with the risks of secondary infections, deteriorating muscle tone, and reducing confidence, capacity and competence.

The danger of increased rationing of services, and a continuing heavy dependence on institutional services, was noted by the Audit Commission twenty years ago:

> 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 the more flexible and cost-effective forms of community care altogether. At worse, the shortfall in services will grow, with more vulnerable and disabled people left without care and at serious personal risk.
>
> Audit Commission, 1986, p.2

The framework which has resulted is still overall one of 'less eligibility', a residue of the Poor Law, with bureaucratic procedures having been installed nationally to determine who will not be assisted as much as who should be helped. This is a residue which results from limitations in resources leading to an emphasis on rationing. But it also reflects the limited value which has been given to older people, who have been seen as a drain and strain and a cost for communities rather than as active participants and contributing citizens (see Office of the Deputy Prime Minister, 2006).

This contrasts with some other cultures known to the author, such as in The Gambia, where older people are seen to have experience and wisdom and the elders have status as advisors and decision-makers. It also contrasts with the very real position in the UK where it is often older people who are leading and sustaining community and voluntary organisations as well as being a resource as carers and confidants within their own families and neighbourhoods.

Our concept of 'being old' is also changing. No longer, in some respects, are women aged 60 and men aged 65 seen as 'elderly'. The age of admission to residential care is now in the high 80s rather than the mid 70s, and more people are maintaining active and independent lives well into their 90s. The special and unusual significance of reaching 100 is less now that more people are becoming centenarians. Service performance measures which used to focus on how many people aged over 65 years are receiving assistance have been replaced over time by measures of over 75s and then over 85s.

However, conversely, people aged 50 plus are being drawn into the concept of 'being elderly' as, very positively, they are encouraged to plan for their own ageing, and in particular about money, housing, health and activity. They are also, more generally, being engaged in planning the shape of future services, which is especially relevant as services being commissioned and designed now, and especially where they require a return on capital investment, are still likely to be what is available in twenty or thirty years time.

And the aspirations of someone who is now aged eighty, who would have been born in the mid 1920s, and would have grown up under the Poor Law, the depression of the 1930s and the post-war rationing in the late 1940s and early 1950s are likely to be quite different to someone who was born in 1950 (and who will be aged eighty in 2030) with an experience of the MacMillan 'never had it so good' 1950s, with an adolescence in the freedom decade of the 1960s, and with much of their adulthood amidst the consumerism and individualism of the Thatcher years, and all within the framework of the post 1946/1948 welfare state.

The accepting, largely undemanding and grateful (see Help the Aged, 2006) current older generation (who regularly rate services as good or better) will be replaced by a consumer-orientated, choice-expecting and quality-conscious generation who are likely to be more demanding and less acquiescent. For an increasing number they will have control of their lives as they use their own wealth to determine how they want to live. For a smaller number with no or limited financial resources, they could be, and are being, left stranded by a state which only sees the improvements within a majority who are more visible than an isolated, excluded and ghettoised minority.

Policy and practice: shaping or responding?

So, within this changing scenario of ageing and of older people what has happened within social policy and social care practice? To what extent has it shaped the context for older people and to what extent has it responded to changing contexts? The answer, of course, is that it is both. Policy and practice has an impact on experience and shapes expectations, but it also is a creature of its times, reflecting contemporary values and realities. And policy and practice are often rational responses to current and future issues, but there are also times when they generate their own unanticipated and unintended consequences. One such dynamic was a major driver in promoting the social care changes of the 1980s.

The growth of residential care

In the late 1970s, despite the national community care policy intention that more disabled and older people should be assisted to remain in their homes, a possibility was spotted of using the income support system to meet the majority of people's costs if they moved into residential or nursing home care:

> . . .in contrast to Attendance Allowance and Invalid Care Allowance no test of disability is required for Supplementary Benefits payment for board and lodging unless the special rate for 'very dependent elderly' is claimed. Thus, anybody fulfilling the Supplementary Benefits rules (irrespective of extent of disability) who chooses to live in a residential home is entitled to allowances meeting their fees up to £125 or more a week . . . in these circumstances the temptation must be strong for anyone trying to look after a relative at home to make use of the more generous, and far less stringent payments for board and lodgings, by placing them in residential care . . . in short, the more residential the care, the easier it is to obtain benefits, and the greater the size of the payment. And Supplementary Benefit funding cannot be targeted towards those most in need of residential care. Nor are homes judged on whether they are giving value

> for money within the care for which they are registered.
> Audit Commission, 1986, p.44

This manoeuvre was not only followed up by disabled and older people themselves as an alternative to waiting for local authority funding to allow them to move to independent private and voluntary sector care homes, but was also encouraged (albeit often surreptiously) by local councils as a means at a time of tight budget restrictions to shunt costs from local authorities to the Department for Social Security:

> Local authorities are becoming increasingly aware that board and lodging payments can often meet the accommodation and care costs of those in independent homes who might previously have been sponsored by the local authority. In at least two of the authorities visited, a 'gain' of £1 million a year (each) had been received by transferring to Supplementary Benefits responsibility for people placed in voluntary sector residential accommodation.
> Audit Commission, 1986, p.45

The consequences were an escalation in the social security spend on residential care from £10m in 1974 to £1bn by 1989 (Evandrou, Falkingham, and Glennester, 1991), the move into residential care of older people for whom there was (at least within local authority threshold judgements) no need for residential care, and a burgeoning private sector expansion of care homes, often run as small businesses. It was not at all unusual to find, for example, a local builder adapting properties to become care homes which were then managed by his wife and staffed by other family members or local doctors owning care and nursing homes. But at the same time that this unintended consequence of social policy (the opening up of the social security system to pay care home fees) was taking place, another counter initiative was being implemented.

Care management

The advent of 'care management' is a fascinating example of how national policy can grow from local initiatives (a further example below is about 'direct payments'). Indeed what is about to be illustrated here is how there is often a time-lag between a successful and well promoted local model and its adoption within national policy and legislation.

'Care (or case) management' in the UK was heavily promoted in Kent, starting with the Kent Community Care Project in Thanet in April 1976. Kent County Council took up, shaped and promoted a model designed at the Personal Social Services Research Unit (PSSRU) at the University of Kent at the end of 1974. PSSRU then evaluated its implementation and impact. In this well-structured evaluative study of care management with older people (and one of those too rare occasions where research can be seen to have influenced policy development) it was found that care management led to lower rates of admission to institutions, there were gains in cost-efficiency, there was a closer match between resources used and the needs of the older people, and older people and their carers appeared to benefit more from the (care management) scheme than from the usual range of services, and "the reduction in admission to institutional care did not appear to be achieved at the expense of quality of life" (Challis and Davies, 1986).

Professionally and, especially, politically 'care management' found its moment in time, although in its wider roll-out some of the focus, professional social work skills base and sophistication of the initial model were lost. Professionally, the emphasis on care managers being beside disabled and older people helping them to choose how they wanted their needs to be met, and then making the arrangements on behalf of the disabled or older person, fitted well with a professional orientation focussed on assisting but not controlling or dominating people. Politically, care management fitted well with the Thatcherism philosophy of a mixed economy of care which would alter the balance away from a heavy reliance on local authority provided and managed services, with the market to drive the three 'Es' of greater economy, efficiency and effectiveness (but often forgetting a concern for 'equity' and a fairness between people and between areas), and where consumer choice would drive the re-shaping of services and promote quality.

Griffiths and the reform of community care

This was all then picked up by Sir Roy Griffiths in his report on the care of disabled and older people, with Griffiths noting the gap between policy rhetoric and reality:

> 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 other hand have been so great. To talk of policy in matters of care except in the context of available resources and timescales for action owes more to theology than to the purposeful delivery of a caring service.
> Griffiths, 1988, p.iv

Griffiths noted the perverse incentive resulting from social security payments being available to fund a person's residential care but not their care at home, and saw the solution as making local authorities responsible for assessing whether someone needed residential care and what was a reasonable rate to pay for that care. But Griffiths also saw that giving local authorities this responsibility, and the control of the money for care services, would allow the ambitions of national policy care for more people in their own homes to be more easily attained:

> The aim would be first, to preserve entitlements whilst putting the social services authority in a position of financial neutrality in deciding what form of care would be in the best interest of the individual and secondly to ensure that individuals are not placed in residential accommodation, when it is not in their best interest.
> Griffiths, 1988, p. vii

The actions proposed in the Griffiths Report were that local councils should assess the community care needs of their area, set priorities and service plans, assess individual needs within this framework "taking full account of personal preferences" and "design packages of care best suited to enabling the consumer to live as normal a life as possible", and then to arrange the delivery of the package of care, acting as "the designers, organisers and purchasers of non-health services, and not primarily as direct providers".

At the time Griffiths was not totally 'on message' politically (see Baldock,1994; Jones, 1994). Thatcher was uneasy about handing more money over to the control of local government whereas Griffiths' view was that "to prescribe from the centre will be to shrivel the varied pattern of local activity". But Griffiths did argue that there needed to be stronger national incentives and sanctions noting that "nothing could be more radical in the public sector than to spell out responsibilities, insist on performance and accountability and to evidence what action is being taken". This is a message which was heard and then reflected in the increased management from the political centre introduced by New Labour in the late 1990s. Griffiths also went on to say that it would be "even more radical to match policy with appropriate resources and agreed timescales", but even now twenty years on this can be seen to be a message which has still to be heard and continues to be debated, especially in terms of how much should people pay towards their own care (Royal Commission, 1999; Wanless and Forder, 2006).

It was by and large the recommendations of the Griffiths Report which were picked up in the 1990 NHS and Community Care Act (see also Department of Health, 1990). This legislation, which followed the 'Caring for People'(1989) white paper, gave the framework within which local authorities were to assume the responsibility for public funding of residential and nursing home care, with the government to transfer to local authorities during a transitional period of several years the social security spend which had seeped into funding care services. But through this manoeuvre the Government also intended to cap the public spend on care services (with social security spend being uncapped and rights-based whereas local authority budgets are cash-limited and discretionary), and to re-direct expenditure away from residential services to more investment to assist people in their own homes and in their own communities. How the government came to create further levers to promote and deliver this change is discussed below.

The Griffiths Report and the 'Caring for People' white paper also resulted in a flurry of reorganisation within local authority social services departments, with new organisational arrangements being established to separate care management and the purchasing of services from the provision and management of direct care services. There was also the requirement that "local authorities should set up independent inspection units, under the Director of Social Services, charged with inspecting and reporting on both local authority and registerable independent residential care homes" to ensure that "common standards should apply across all sectors" (Caring for People, 1989). This inspection and regulation function was further expanded and shaped in the mid 1990s and with the inspection and regulation functions being taken outside of local councils to an independent inspectorate (see Burgner, 1996).

There was also a flurry of activity to create specialists and separate divisions within social services departments for the management of children's services discrete from the management of social care services for disabled and older adults, and this partly reflected the increasingly separating legal frameworks for children's services, through the 1989 Children Act and also the 1991 Criminal Justice Act, and for adult and disability services, through the 1990 NHS and Community Care Act. This is a separation which has now reached its conclusion in the mid 2000s with the requirement in England (but not in the three other UK administrations) that there be directors of children's services separate from directors of adult social services (see Department of Health, 2005b) whereas previously every local authority with social services responsibilities had to have in post a director of social services. My own senior management career between 1987 and 2006 mirrors these changes where I went from being a divisional director of social services, to deputy director of social services, to senior assistant director (purchasing), to director of social services and then to director of adult and community services, and en route also had a year as chief executive setting up one of the new national organisations spawned in the early 2000s to promote the performance agenda.

The consequence of the community care changes heralded by the Griffiths Report, shaped by the 'Caring for People' white paper and encapsulated in the 1990 NHS and Community Care and the associated statutory regulations and guidance (see, for example, Caring for People, 1990) was that there was a levelling off and then a reduction in the numbers of older people moving into residential and nursing homes, and an increasing number of older people who were assisted, primarily through receiving home care services (see, for example, Audit Commission, 1996) but also day care, respite care and home meals services, to live in their own or family homes and this followed an existing trend:

> There has been a gradual shift away in the balance of care from hospitals to the community. The numbers of people in long stay hospitals (whether elderly, mentally ill or disabled in some way) have been declining with the community expected to take the strain. People are discharged earlier from acute hospitals with average stays in geriatric beds halving over ten years. And with the increase in day treatments they may no longer even stay overnight. There are increasing demands for alternative options from childbirth to hospice at home; and many conditions such as asthma and diabetes are managed in the community where hospital would once have been the automatic focus.
>
> Audit Commission, 1992

The most up-to-date picture of the re-patterning of community care services, which it was noted in 2004-2005 were provided to 1.7 million adults in England, is within the annual report of the Commission for Social Care Inspection which commented that:

> There have been further increases in the number and proportion of people using intensive home care (households using more than 10 contact hours and 6 or more visits per week); in 2005, 98,240 households received intensive home care (an increase of 6% from 2004) . Admissions to nursing and care homes have continued to decline reflecting government policy to support more people to live independently in their own homes. The number of people supported by councils to live in residential care decreased from 277,950 in 2003-04, to 267,240 in 2004-05.
>
> Commission for Social Care Inspection, 2006

In essence, the changes reflected the community care policy intentions and the Association of Directors of Social Services commented one year after the implementation of the community care changes that:

> It is clear that Social Services have delivered the objectives set for them in this first year. Assessment processes have been established, negotiations undertaken with the National Health Service, and arrangements made with the independent sector which – with very few exceptions – have proved to be effective and have considerably improved the pre-1993 situation.
>
> ADSS, 1994

However, this 1994 ADSS report (with a foreword by Denise Platt, the then president of ADSS but later to become the chief inspector for social services in the Department of Health) also flagged up concerns about the uncertainty of roles and responsibilities across the NHS/ Social Services interface, the 'planning blight' resulting from the uncertainties of local government reorganization, the lack of clarity for engaging with housing authorities and providers and, in particular, about the resources which would be required to continue to successfully implement the community care reforms.

This concern about resources was emphasized in a number of reports at and around the time of the early 1990s community care reforms and was seen as a major threat to achieving the aspirations of the reforms:

> The rate of growth allowed to social services by the government between 1978/79 and 1988/89 was 22.3% in real terms – an average annual increase of 2.3%,which is intended to allow for 'demographic and other changes' . . . Local authorities have been spending considerably more on social services than the figure the government thought necessary. Overall, their spending exceeded the government's figure by 4.3% in 1987/88, rising to 13.9% in 1990/91. The difference was made up from local taxation. However, charge-capping has now forced spending down and more into line with government figures . . . In 1990/91, thirty two local authorities had reduced budgets for social services, and many more had standstill budgets or reduced growth. This year the trend is even sharper, with half of all local authorities having reduced or standstill budgets to bring them closer to government figures. Government controls on local authority spending mean that the option of raising more money locally is no longer viable.
>
> Harding, 1992

This scenario is echoed in a further report five years later:

> Funding was transferred (from the social security budget to local authorities) in the form of a Special Transitional Grant (STG) which has increased Government funding on social services by 63% over the five years from 1992/93 to 1997/98. During this same period the basic Standard Spending Assessment (the amount the government thinks needs to be spent and on which it bases its formulae for giving money to local councils), without any additions for the STG, increased by only 8.5% in cash terms. Taking inflation into account, the basic amounts of Personal Social Services SSA have actually decreased by over six per cent in real terms . . . A number of authorities have introduced stringent limits on the number of placements they will make and the services they will provide. These have been introduced as emergency measures in response to budget shortfalls. A result is users waiting in hospital beds for placements which, due to their greater costs in comparison to residential care or nursing home beds, is not a cost effective use of resources. Such a policy also has implications for the choices available to users.
>
> Edwards ands Kenny, 1997

This financial scenario could be seen as another example of an unanticipated effect of policy (this time the trickle policy effect following the introduction of the "poll tax", which was so unpopular that it became an overriding government concern, regardless of other social costs, to keep it low with minimal yearly increases), and it was a continuing concern four years later when the Audit Commission (1996) noted that in 1995/96 local councils were still spending on average 7% more on social services than the national government considered appropriate and that:

> Overall, most authorities have given priority to community care with steadily increasing sums made available to deal with increased responsibilities. But whatever the framework set by central government or the budgets set by local government, financial commitments must be kept within these budgets. This calls for a number of measures starting with the careful management of the numbers receiving care.
>
> Audit Commission, 1996

From provision to planning and purchasing

A further government policy intention at this time was to discourage local authorities from being direct providers of services. For residential care for older people there was a danger that by transferring the social security spend on care into local social services budgets that local councils would then use this money to spend on their own in-house

care homes. This national government unwanted policy outcome was avoided by restricting local authority capital expenditure on building and maintaining care homes, by still making available through the national social security system a 'residential care allowance' which could only be claimed by disabled and older people on low incomes who moved in to independent private and voluntary sector care homes (but not local authority homes), and through the 'choice directive', which was a statutory regulation enshrining the right of a person to choose which care home they entered (albeit if funded by the local authority within a price envelope set by the local council).

Local councils (see Edwards and Kenny, 1997) indeed increasingly transferred their existing care homes to the independent sectors (and often spawned local not-for-profit organisations, what might now be called 'social enterprises', to take on the care homes) as a means of being able to attain for the homes the capital investment they required. This was not only to cover general maintenance and refurbishment costs but also to meet the enhance standards now being set nationally before a home could be registered and operated. By transferring the homes local authorities also reduced their net revenue commitment to the homes as residents with limited income could claim the 'residential care allowance' to subsidise the costs of their placements and there was also an opportunity for increased cross-subsidy from full fee payers (who received no state support) as the fabric and environment of the homes was enhanced making the homes more attractive to self-funders. The new providers of the former local authority homes also reduced the unit costs of running the homes by reducing terms and conditions of employment (and especially pension entitlement) and management and staffing structures, and by focussed management often leading to higher occupancy rates and fewer voids (i.e. vacant beds).

At the same time, within the established independent care home sector there was considerable turbulence. The new registration standards (influenced by Avebury, 1984 and which continued to be enhanced; see Department of Health, 2000) meant the closure of some previously adapted small care homes, rising property prices meant it was possible in many areas for care home owners to cash in on a capital gain by selling the home (for conversion into apartments, private dwellings or guest houses and hotels), and the unit costs of, in particular, smaller care homes were higher than the weekly fee rates local authorities were willing or able to pay making the homes unviable, especially as the expanding flow of potential residents was curtailed by the shift to assisting more older people to remain, with support, in their own homes.

A consequence of all of this was a re-shaping of the care home market, which has become much more dominated by a smaller number of large national and international companies (which are often traded on) running larger homes. Whether this market-driven re-shaping will meet the expectations of the forthcoming generation of older people is still to be seen as 80-100 place care homes are bound to be somewhat institutional.

An alternative has been, especially within the private sector, the growth of supported accommodation, through 'retirement apartments' and indeed 'retirement villages', where a whole range of activities and care is provided on-site to be bought off a menu of options as and when needed. At the same time, however, much 1960s and 1970s built local authority 'sheltered accommodation' for older people has become dated and poorly maintained and is difficult to let.

But overall the 1990s community care changes achieved the government's aspirations, which were largely shared by older people, social care workers and local councils, to stem the public spend on residential and nursing home care, to repattern services to support more disabled and older people within their own homes, to turn the focus of local authorities to strategic planning, commissioning and service purchasing rather than the direct management of service provision, and to stimulate choice for service users within a mixed economy of services. However, for those requiring public funding for their services their choice was increasingly limited by tight local authority budgets, which led to a heightening in the thresholds of need which had to be met before local authorities would fund a service.

This is a concern which is very current. The Commission for Social Care Inspection (CSCI) has noted that fifteen years ago councils provided home care to over 500,000 households (with each household on average having just over three hours of home care a week). Despite the growing and ageing population, and the policy of assisting more older people to live within their own homes, only 395,000 households were receiving a local authority funded home care service (albeit with an average of 10.1 hours per week) in 2004-2005. Some people may now be using their own resources to buy the services they want without seeking help from the local authority, but CSCI comments:

> The continued increased intensity suggests that provision is actually focusing on people with the greatest need, providing a narrow range of people with a deep level of service. Whilst this is important, it poses questions about what happens to those people with considerable needs and those who may be prevented or delayed from seeking more expensive services by some timely, simple help.
>
> Commission for Social Care Inspection, 2006

Direct payments and choice and control

For younger disabled people in particular, however, being a recipient of what were still local authority determined and arranged services was experienced as restrictive, limiting and intrusive. This was especially so when local authorities, especially as they continued to ration services heavily, continued to spend most of their social care budgets on residential care leaving limited choice for people with impairments with the options of little or no service or residential care. The residential care itself was experienced as

engulfing, leaving little space for individual life-style decision making, little privacy and little opportunity for any personal progress or change in the future.

It was disabled people themselves (see Morris, 1993; Campbell and Oliver, 1996; Oliver and Barnes, 1998; Barnes and Mercer, 2004)) who developed and led the move towards more independent living in the community, with the disabled person in charge of the resources to acquire whatever assistance they needed when and how they wanted it. The then existing social care legislation did not give powers to local authorities to hand over money to disabled people so that they could purchase their own services (although social security disability benefits, such as attendance and mobility allowances, did to some extent provide this opportunity). Griffiths (1987) only dipped a toe into the water of direct cash payments suggesting that "there is no reason why, on a controlled basis, social services authorities should not experiment with vouchers or credits for particular levels of community care, allowing individuals to spend them on particular forms of domiciliary care and to choose between particular suppliers as they wish".

But Griffiths was in danger of being behind the times. Local authorities were already using vouchers, for example, so that parents of disabled children could arrange respite care as, when and how they wanted and there was already pressure from disabled people themselves, first in Hampshire but then in a relatively small number of other areas, for disabled people to have control of the cash for the assistance they needed. Some local councils set up 'third party' schemes where a grant would be given to a another, often voluntary sector, organisation that would then, usually following still a care management assessment, make cash payments to the disabled person so that they could purchase and have more control over the assistance they needed. The popularity of these 'indirect, third party' payments was such that, with considerable canvassing from organisations of disabled people, but also with support from organisations such as the Association of Directors of Social Services, the government moved to introduce legislation, the 1996 Community Care (Direct Payments) Act.

The 1996 Act gave the power, although not initially the duty, to local authorities to give direct cash payments to disabled people who were "willing and able" to arrange and manage the assistance they required. At first this was limited to disabled adults aged between 18-64 years, but was then extended to all disabled adults aged over 18, including older people, to 16-17 year old disabled young people making the transition to adulthood and to carers. This was a win-win-win policy, supporting the aspirations of many disabled people to have more control within their lives, supporting the then Major government's interest in moving services away from local authority control (as also happened, for example, with schools becoming grant maintained rather than immediately managed by local education authorities), and the incoming New Labour government's agenda to promote consumer choice as a means of pushing forward improvements in services and to break what was seen as the lethargy of the public sector and the paralysis of public sector bureaucracies.

However, the take up of direct payments was slow (see Commission for Social Care Inspection, 2004), partly because local authorities may not have heavily promoted them (and some where openly opposed to direct payments which might threaten the viability of in-house services, a concern also shared by public sector unions) and partly because, as now, there are limited numbers of disabled and older people and carers who want to take on the responsibility, pressure, tensions and workload of making their own service arrangements. One way around this conundrum of increased choice and control being set against increased stress and work is the introduction in the mid 2000s of 'individual budgets' where a sum of money is allocated to the service user, they can choose how it is spent, but the management of the money and the arranging of services may be undertaken by someone within the local authority, usually a social worker, or by a third party, such as a family, friend or advocate. But the take-up of direct payments is increasing from 14,000 people in March 2004 to 22,000 people in March 2005 to 32,000 in March 2006 (Commission for Social Care Inspection, 2006). No doubt this increase is prompted by local authorities having 'direct payments' as one of the key performance indicators on which they are externally measured and publicly assessed, but it also reflects a continuing change in professional and agency culture, confidence and competence in promoting direct payments.

Promoting performance

By the end of the 1990s, however, despite the community care framework from 1990 having been in place for ten years there were concerns about the limited pace of change and an expressed frustration by the in-a-hurry new Labour government from 1997 to want to make a difference and to be seen to be making a difference. In particular, Blair had a concern about the inertia within public services (see Sampson, 2004; Seldon, 2005). A new, and not seen before, phase of public policy was initiated. Right across the public sector there was a government crusade focussed on performance and quality and a number of levers were constructed to drive performance and quality improvements (see O'Neill, 2002). Similar techniques to drive change were applied in widely varying public services from health to education to housing to libraries to waste management, etc. and social care for disabled and older people experienced the full range of levers within this somewhat manic and certainly managerial agenda from central government.

The levers for change (Jones, 2004) included:

- "*management by machismo*", achieving an impact through threat and intimidation (more prevalent in recent years in the NHS than social care), including being publicly "named and shamed" and "called in" to

see the chief inspector with jobs on the line;

- *"management by message",* with the clusters of performance indicators showing where the government wants attention to be given and within national policy frameworks, such as the National Service Framework for Older People (Department of Health, 2001);
- *"management by measurement",* on the basis of what gets measured gets done!
- *"management by motivation",* with rewards (stars and honours) for achievements and punishment (more inspections or on monthly report) for failures;
- *"management by money",* with specific grants from central government defining how resources can be used;
- *"management by mistake",* which is to be avoided where possible but where there is an unintended consequence of striving to hit a target and with this undermining sensible policy (as with local authorities being measured on how much service they provide or purchase but not how much they invest in building community capacity to enhance life opportunities and experience more generally for older people).

The pulling of these levers had an impact. On the basis of what gets measured gets given attention, and that punishment will almost always be avoided and rewards will be chased, the performance targets set by central government did demonstrably lead to "gradual improvement and the modernisation of services" (CSCI, 2006, p.iii). Those people still seen as eligible for help received that help more quickly, the help provided was repatterned in line with national policy intentions (such as more home care and more community equipment to assist people to remain at home), and the views of samples of service users were sought each year to check on consumer satisfaction, which started relatively high and continued at similar levels but with quite considerable variation between local authorities.

But the focus on performance indicators which were largely agency and service focussed has its own limitations. Firstly, the indicators did not encourage the integration of services between, for example, health and social services, despite evidence that bringing health and social care together locally can improve access to, and speed of response of, services (see Brown, Tucker, and Domokos, 2002). Each public service sector had its own battery of indicators, focussed inwardly on its performance rating, and when the going got tough (especially about funding) would look after its own interests even if at the expense of its partners. This has been an intense experience in those areas where the NHS had set itself an unrealistic and damaging timetable to achieve financial balance after years of overspending. Secondly, for disabled and older people their quality of life is not only determined by the quality and quantity of services they receive. The services remain important but the service-focus misses the whole life-focus which is of importance to disabled and older people. The service focus primarily sees older people as service users and recipients of assistance, but not as active and contributing citizens with often unique aspirations.

The bigger and broader picture

It is this bigger and broader picture for disabled and older people which has most recently been painted by the government (see Department of Work and Pensions, 2005; Office of the Deputy Prime Minister, 2006), prompted by organisations for disabled people (see Help the Aged, 2004) and service and professional organisations (see LGA, 2004). It takes into account that older people, for example, are still citizens who within their communities are impacted by universal commercial and public services as well as specialist and secondary health and social care services. It also recognises that older people do not primarily define themselves in terms of the services they receive but still have a range of roles, and make a range of contributions, within their continuing capacity and commitment and reflecting their continuing ambitions and aspirations. For the public sector, therefore, a perspective is needed which sees older people more roundly in a bigger context which is not restrictively defined only in terms of services.

Focussing on this wider context can be a potential ally in seeking to address some of the difficulties heavily rationed public services have failed to adequately tackle. For example, high levels of depression in older people who use social care services (see, for example, Brown, Tucker, and Domokos, 2002) may be linked to a narrowing of friendship networks, to bereavement and loss of close family and friends, but also to some loss of capacity and physical and intellectual functioning. Opportunities for older people to remain socially active and engaged within their communities, with valued roles and status, and with social and intellectual stimulation, may contribute more to tackling depression than the array of health and social care services. It may also encourage continued physical activity, delaying or minimising the onset of physical deterioration and ill health.

It is local authorities (see, for example, DTLR, 2001) who have been given by central government a lead responsibility, through 'local area agreements' and 'local public service agreements', to bring together the sectors and interest groups right across communities to look to enhance the life experience and opportunities for everyone within the community. This might range from tackling crime and nuisance and the fear of crime, to the availability and access to transport, leisure and retail services, to safe and attractive environments with reasonable and appropriate housing, and with encouragement for communities to actively engage with all their citizens.

For agencies that have traditionally been service providers or, more recently service purchasers, they need to have a focus on community development as much as service development. This was a theme in the Seebohm Report (1968) on social services in England in the late 1960s, and twenty years on it was a part of the script for care managers and their organisations in the Griffiths Report in 1988 in developing more options to give more choice to disabled and

older people, and twenty years on again it has re-emerged as a major theme in social policy for older people.

Where now?

Chronology may influence but does not define or determine people and their needs. Being aged 75 does not require that someone must be in ill health and needing a range of health and social care services. Social care and health services are not provided to older people because of their age but because of their variable, but likely to be increasing, needs. And the experience of being aged 75 is not solely or, for most people, even primarily described and delimited by their health or social care status. This is the current challenge about the change in mind set which is required if people as they age are to be seen as more than dependent, and despondent, recipients of services.

There is also a challenge to move further away from the legacy of the Poor Law, with a Poor Law residue in our current policies which are focussed on determining who is not entitled to assistance (what was called under the Poor Law 'less eligibility'), with a continuing dependence on segregation in institutions (care homes), and with the 'parish rate' still alive and well through the council tax and territorial differences between local authorities in access to and standards of service and with disabled and older people having to be re-assessed when they cross local authority (the new 'parish') boundaries.

An alternative would be, firstly, to move to a rights-based rather than discretion-based system of social care entitlement, maybe with disabled and older people receiving funding direct from national social security disability and income support benefits. This would, at a sweep, do away with the need for 'direct payments' and 'individual budgets', but would still require a framework of care arrangers, brokers or, as they were called in the Adult Social Care Green Paper (Department of Health, 2005a), 'care navigators' who would assist the disabled or older person to access and arrange the assistance they might need and want.

A second alternative would be to move towards enhancing the whole-life experience of disabled and older people, with universal services provided by all the sectors, including for example retail, transport and recreation, being more geared to the needs of disabled and older people (as is already happening to some extent with home-shopping services), and with more opportunities for disabled and older people to continue as active contributing and participating citizens. This would be a move away from a focus on services to a focus on experience, which is how strategic planners and commissioners ought to re-frame their attention.

References

ADSS (1994) *Towards Community Care: ADSS Review of the First Year*. London: Association of Directors of Social Services.

Audit Commission (1986) *Making A Reality of Community Care*. London: London: Audit Commission.

Audit Commission (1992) *Community Care: Managing the Cascade of Change*. London: Audit Commission.

Audit Commission (1996) *Balancing the Care Equation: Progress with Community Care*. Community Care Bulletin No. 3, March 1996.

Avebury Report (1984) *Home Life: A Code of Practice for Residential Care*. London: Centre for Policy on Ageing.

Baldock, J. (1994) The Personal Social Services: The Politics of Care. In: George, V. and Miller, M. (eds.) *Social Policy Towards 2000: Squaring the Welfare Circle*. London: Routledge.

Barnes, C. and Mercer, G. (2004) *Implementing the Social Model of Disability: Theory and Research*. Leeds: The Disability Press.

Brown, L., Tucker, C. and Domokos, T. (2002) *The Impact of Integrated Health and Social Care Teams for Older People Living in the Community*. University of Bath.

Burgner, T. (1996) *The Regulation and Inspection of Social Services*. Department of Health and the Welsh Office.

Campbell, J. and Oliver, M. (1996) *Disability Politics*. London: Routledge.

Caring for People: Community Care in the Next Decade and Beyond (1989) *Cmnd 849*. London: HMSO.

Caring for People: Community Care in the Next decade and Beyond: Policy Guidance (1990). London: HMSO.

Challis, D. and Davies, B. (1986) *Case Management in Community Care: An Evaluated Experiment in the Home Care of the Elderly*. Aldershot: Gower.

Commission for Social Care Inspection (2004) *Direct Payments: What are the Barriers?* London: CSCI.

Commission for Social Care Inspection (2006) *The State of Social Care in England 2005-06*. London: CSCI.

Community Care (Direct Payments) Act (1996) London: HMSO.

Department of Health (1990) *National Health Service and Community Care Act 1990: A Brief Guide*. London: Department of Health.

Department of Health (2000) *Care Homes for Older People: National Minimum Standards: Care Home Regulations*. London: The Stationary Office.

Department of Health (2001) *National Service Framework for Older People*. London: The Stationary Office.

Department of Health (2005a) *Independence, Well-being and Choice*. London: The Stationary Office.

Department of Health (2005b) *Guidance on the Role of the Director of Adult Social Services*. London: The Stationary Office.

Department of Transport, Local Government and the Regions (2001) *Strong Local Leadership-Quality Public Services*. London: DTLR.

Department of Work and Pensions (2005) *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century*. London: The Stationary Office.

Edwards, P. and Kenny, D. (1997) *Community Care Trends 1997: The Impact of Funding on Local Authorities*. Local Government Management Board.

Evandrou, M., Falkingham, J., and Glennester, H. (1991) The Personal Social Services: Everyone's Poor Relation but Nobody's Baby. In: Hills, J. (ed.) *The State of Welfare*. Oxford: Clarendon Press.

Griffiths Report (1988) *Community Care: Agenda for Action*. London: HMSO.

Harding, T. (1992) *Great Expectations...and Spending on Social Services*. National Institute for Social Work.

Help the Aged (2004) *Older People: Our Neglected Assets*. Help the Aged.

Help the Aged (2006) *Necessities of Life: Older People's Experiences of Poverty*. Help the Aged.
Jones, K. (1994) *The Making of Social Policy in Britain 1830-1990*. London: The Athlone Press.
Jones, R. (2004) The Tables Turned: Taking the Pulse of Social Care Inspection. *ADSS Inform*, October 2004, p.21.
LGA (2004) *Our Future in Our Hands: Putting People at the Centre of Social Care*. Local Government Association/ Association of Directors of Social Services/ NHS Confederation.
Morris, J. (1993) *Independent Lives: Community Care and Disabled People*. Basingstoke: Macmillan.
National Centre for Social Research (2000) *The Health of Older People*. Department of Health.
National Health Service and Community Care Act (1990) London: HMSO.
O'Neill, O. (2002) *A Question of Trust*. Cambridge: Cambridge University Press.
Office of the Deputy Prime Minister (2006) *A Sure Start to Later Life: Ending Inequalities for Older People*. London: The Stationary Office.
Oliver, M. and Barnes, C. (1998) *Disabled People and Social Policy*. London: Longman.
Royal Commission on Long Term Care for the Elderly (1999) *With respect to old age: long term care – rights and responsibilities*. London: The Stationary Office.
Sampson, A. (2004) *Who Runs This Place? The New Anatomy of Britain in the 21st Century*. London: John Murray.
Seebohm Report (1968) *Report of the Committee on Local Authority and Allied Personal Social Services*. Cmnd 3703. London: HMSO
Seldon, A. (2005) *Blair*. London: Free Press.
Wanless, D. *et al*. (2006) *Securing Good Care for Older People: Taking a Long Term View*. London: King's Fund.

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