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The potential impact of changes in public funding for residential and nursing-home care in the United Kingdom: the Residential Allowance

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ABSTRACT
The pursuit of independence and avoidance of unnecessary care-home admissions are key elements of British government policy for the care of older people. The present government's objective to maintain independence has been compromised by the 'Residential Allowance' which, as a component of social security payable to residents in independent-sector homes, could be seen as an incentive to place people in care-homes rather than seek care-at-home. In order to remove this incentive, the government proposed to abolish the allowance and instead transfer resources by a grant to local authorities. This was intended to promote independence by making available funds with which social services departments could support domiciliary care. This paper examines the potential impact of the proposal from the perspective of front line practitioners and managers. Calculations of the proposal's likely effects in five authorities were made from a simulation of their usual decision-making processes. The results, applied to the national picture, showed only a marginal effect of the change upon admissions to care homes. The potential effect of the change in diverting admissions from care homes was seen to be hampered by organisational influences which vary between authorities.

KEY WORDS – old age, public funding, care homes, balance of care.

Introduction

Several aims characterise current policies for the social care of older people in the United Kingdom. These include maintaining independence, enhancing home-based care and promoting greater consistency of care, both between geographical areas and across the public and private sectors (Cm 4169 1998; Cm 4104 1998; Cm 4818-I 2000). These objectives are largely shared among many developed countries (Kraan *et al.* 1991; Challis 1996). The public funding of residential and nursing-home care in England

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has provided one area in which to realise such policy objectives, as seen in both previous and current reforms (Cm 849 1989; Cm 4169 1998; Department of Health 1998). Evaluating the potential impact of such funding devices is crucial to assessing the likely outcomes of policy and the role played by these mechanisms in policy implementation (Sabatier 1985).

Before the implementation of the community-care reforms of April 1993, when the financing of older people in publicly-funded residential care became the responsibility of local authorities, the objective of supporting people at home was seriously compromised by the ready availability of social security funds for institutional care. This funding system was described as a 'perverse incentive' by the Audit Commission (1986), and removing it became one of the main drivers for change in the system of care, as recommended in the Griffiths report (Griffiths 1988). The subsequent White Paper, *Caring for People* (Cm 849 1989), pursued the objective of maintaining people at home by changing the funding arrangements for residential and nursing-home entry: funds were allocated to the local authority social services departments and they were made responsible for the assessment of need and care co-ordination. Similarly, the objective to maintain older people at home, voiced as part of the present government's wider reform programme (Cm 4169 1998), was compromised by the existence of the 'Residential Allowance' (RA). This was a component of the social security benefit, Income Support, that was payable by the Department of Social Security to residents placed in independent residential or nursing homes, and which was intended to assist with the accommodation costs of people in such facilities. Set at a weekly rate of £61.30 per person (in 2000, outside London), the RA contributed directly to the fees and was not paid to the resident. Local authorities were able to recoup this payment through the normal means-testing procedure and use it towards the payment for a place in an independent-sector home. The allowance was not, however, payable to residents of residential care homes directly provided by social services departments. Introduced by the then Conservative government, and attached to placements in independent sector homes, the allowance was intended to discourage local authorities from making placements in their own homes. After the community-care reforms, local authorities continued 'to meet the full cost of maintaining people in authorities' own homes, including the costs of accommodation and food' (Cm 849 1989: para 3.7.10). As a consequence, the RA provided a subsidy to the social services department in meeting the living costs of those entering independent-sector residential and nursing homes, and an incentive to provide for the care of older people in these settings.

This discrepancy in payment of the RA between independent and local authority-owned homes generated two perverse incentives, which the

current government proposed to address (Cm 4169 1998; Department of Health 2000*a*). The first is the incentive, already described, to place people in independent-sector rather than local authority provision. The current aim to promote equity in the provision of care between the local authority, voluntary and private sectors was therefore compromised by the RA payment. This aim is supported by the duty of 'Best Value' (Cm 4014 1998), which was designed to avoid care being provided preferentially in either the public or private sectors, or in favour of the lowest cost provider. This is a duty to seek the best possible services, taking equal account of price and quality, in whatever sector those services are available (Geddes and Martin 2000).

The second incentive is that the RA encouraged care-home placement as the preferred option when social services departments were considering the care options available for an older person. Whilst the RA contribution to the costs of independent residential and nursing-home care was in force, the net cost to social services departments of placements in such facilities could be less than that of equivalent domiciliary packages (Wistow 1995). This cost differential could act as an incentive for authorities to choose care-home placement in preference to home-based care, irrespective of the most appropriate care (Department of Health 1994). The current government's aim to promote the independence of older people (Cm 4169 1998) was therefore also compromised by the existence of the allowance, since its payment hampers the flexibility of social services departments in targeting resources towards appropriate domiciliary services.

The replacement of the Residential Allowance

Given these perverse incentives, the government proposed to abolish the RA and instead to transfer resources into a special grant to local authorities (Cm 4169 1998: paras 7.24 and 7.25). In support of the general aim of promoting equity between the local authority and independent sectors, this would equalise the treatment of older people admitted to care homes of either sector. The redistribution of funds would also promote the independence of older people by making revenue available which social services departments could use more flexibly to support domiciliary alternatives. This approach was endorsed by the *Royal Commission on Long Term Care* (Cm 4192-I 1999) and in the *National Health Service Plan* (Cm 4818-I 2000). The government later specified that the change applied to new admissions only and was to be implemented by local authorities for new cases from 1 April 2002 (Department of Health 2000*b*). Before this proposed change to the funding arrangements for care-home admissions, the government sought the views of local authority representatives on

the possible consequences of abolishing the RA (Department of Health 2000*a*).

This paper reports a contribution to that process, a study of the potential impact of the funding change on admissions to care homes as perceived by the field staff and managers of local authority social services departments. It was commissioned by the Department of Health as an element of the implementation of the *Modernising Social Services* programme (Cm 4169 1998; Department of Health 1999). The study uses case summaries, characteristic of national admissions to care-homes, to examine the decision-making in a group of social services authorities, both before and after the RA change. In this way, the envisaged potential impact of the redistribution is determined and then applied to the national picture. The potential impact of the redistribution in diverting older people from care-home admission is estimated by examining the factors which may mediate the change and by calculating its potential effect across various case types. The results were intended to inform the policy before implementation rather than retrospectively (as has usually been the case).

Estimating the potential effects of the change on diversion from care homes is difficult. The change may be viewed as a relative price effect, whereby the RA redistribution closes the price differential between independent and local authority care. This will, in effect, raise the price or unit cost to authorities of independent residential and nursing-home care, while the funds made available by the transfer are also intended to promote domiciliary alternatives. There are, however, several influences on care-home admission other than price, which may counter the effects of the change. These include the *needs* or *demands* of users (their dependency-related characteristics and functional status), the influence of *carers* and *professionals* (who may exert pressure on the decision-making process), and the role of *system variables* (bed supply and the availability of domiciliary resources), and of local *policy factors* (eligibility criteria, purchasing arrangements and local interpretations of need) (Power 1989; Green and Ondrich 1990; Warburton 1994; McAuley and Travis 1997). There is therefore likely to be significant inter-authority variation in the scale of the impact on admissions.

There is also the question of which group of older people will be most affected. In April 2000, around 170,000 older people in Great Britain, at various levels of dependency, were receiving the allowance (Department of Health 2000*a*). The abolition of the allowance and its redistribution to local authorities was likely to have the greatest effect on marginal entrants to care homes, namely older people for whom domiciliary alternatives might be most appropriate but who had been placed in care homes as a consequence of, for example, poor assessment procedures, the high cost of

domiciliary care packages, and problems of hospital discharge. This group is likely to be less frail than the majority of older people who are funded by social services departments to enter care homes. By concentrating on this group, the capacity is created to shift the 'balance of care' from residential to home-based care at reasonable cost (Challis and Hughes 2002; Mooney 1978).

Method

The study comprised a two-stage evaluation of the impact of the policy before its implementation. The first stage adopted a senior management perspective and the second a front-line perspective. It was thought that because the first-stage estimates of the policy's likely impact were made by older people's social services managers, they might reflect local policy rather than local practice and thereby fail to capture the full range of likely responses (Clarkson *et al.* 2003). The second-stage study therefore estimated the potential effects of the funding change on new admissions to residential and nursing-home care from the perspective of front-line staff and their managers.[1] It had four elements:

- The production of 20 case typologies representative of national admissions to residential and nursing homes in England, to identify which groups were likely to be affected by the RA redistribution.
- A simulation exercise with care managers in five local authorities that created care plans for each of the case types and subsequently costed each plan and validated them for feasibility in each authority.
- An extrapolation of the simulation findings to the national level through a sensitivity analysis of the policy's potential effects on the different case types.
- Ascertainment of key decision makers' views in five authorities about the mediating effects that may have compromised the ability of the funding change to influence care-home admissions.

It was believed important that each type of authority was represented in the study. Seven social service authorities were approached, but two declined to participate (partly because of the imminent reorganisation of older people's services). Information was collected from August to December 2000 from two metropolitan boroughs, a London borough, a shire county and a new unitary authority.[2]

The first element, the case vignettes, represented 20 types of cases of older people at risk of admission to homes. The selection used the following dimensions: sex (male or female); referral source (community or

hospital); cognitive impairment (alert or confused); physical dependency (low/moderate/high); and the presence or absence of a carer. The data were drawn from two sources. The first was a national survey of 2,544 residential and nursing-home admissions of people aged 65 or more years in 18 English local authorities (Bebbington *et al.* 1996). For each case, data were available on sex, referral source, cognitive impairment as measured by the 'Minimum Data Set Cognitive Performance Scale' (Morris *et al.* 1994, MDS CPS), and physical dependency as measured by the 'Barthel Index of Activities of Daily Living' (Collin *et al.* 1988).[3] These dimensions produced 24 possible case categories. The second source was a study by Challis *et al.* (2000) of 233 admissions to care-homes over nine months in one social services authority. This study contained data on carer availability alongside the dimensions listed above. For each of the 24 categories, the proportions with carers available were applied to the national data to estimate the prevalence (per 1000 admissions) of each of the 48 case types.[4] From these, 20 case types that represented 80 per cent of all national cases were selected.[5] Individual real cases were then randomly selected within each of the 20 types and the case vignettes produced using data from case files (Challis *et al.* 2000). The vignettes comprised the older person's living situation; their location prior to admission; current physical and mental health status; activities of daily living; attitudes to future care; use of formal and informal support; other specific needs; the personnel involved in the assessment process; risk factors; and specific requirements.

The second element was a simulation exercise conducted with care managers in each of the five authorities. The aim was to recreate the decision-making procedures in these authorities, thus maintaining 'ecological validity' (Banister *et al.* 1994). Five panels (one from each authority), each comprising eight local authority fieldwork staff, were asked to create hypothetical care packages based on the information in the 20 vignettes. They were directed to prepare the care packages in a manner that would enable the individuals described in the vignettes to remain safely in the community, given the agencies and services available in their areas. Each care package was then costed using the authority's costing structure.[6] The plans were subsequently assessed by the local authority representative normally responsible for sanctioning spending in each authority (usually a senior social services manager). From this, decisions about each case were made as to whether admission to a care home would normally be approved or whether the proposed community-care package was acceptable. In addition, whether the funds made available by the RA transfer would alter the authority's decision on home admission was recorded. Every attempt was made to reproduce the usual pattern of decision-making on the approval of care packages.

The third element was a sensitivity analysis of the estimated effects on admissions to care homes of the RA change using the findings of the simulation exercise. For each case type, frequency counts were made of the number of authorities that responded by three envisaged outcomes:

- *The potential diversion rate* – those in which a community-based package of services could be provided with the additional funds for users who would otherwise be admitted to care homes;
- *The community placement rate* – those in which care-at-home for users was feasible, who could still be provided with such care with the additional RA funds;
- *The met residential need rate* – those in which care-home placement for users remained appropriate despite the additional funds available from the RA transfer.

These data were aggregated and applied to the national distribution of case types after establishing, through comparison with national figures (Department of Health 2001), that the study authorities were representative of their authority type in terms of the numbers of new permanent placements to care homes. An overall diversion effect of the RA transfer was then calculated for England and expressed as the number of admissions per 1000 older people. The fourth element was a survey of the opinions of senior managers and front-line practitioners in the study authorities about impediments to care-home diversions. Views on these factors were used to support conclusions concerning the estimated diversion consequent on the policy change.

Results

Representative case typologies

Table 1 outlines the 20 case typologies estimated from the data on national admissions to residential and nursing-home care. These case types represent 80 per cent of admissions to care homes in England. The national prevalence of admissions represented by these typologies shows that 37 per cent of this group of admissions were from hospital (47% of admissions overall), and that 49 per cent of the individuals were cognitively impaired and 35 per cent had high dependency. These figures are not dissimilar to those from a national study (Netten *et al.* 2001). The combination of characteristics reflected in these typologies, being indicative of those older people admitted to care homes nationally, was used to estimate the potential effect of the transferred RA funds in at-risk cases from care homes.

TABLE 1. *Description of case types representing national admissions to care homes*

Case type	Cognitive impairment	Referral source	Sex	Dependency[1]	Carer	Prevalence[2]
1	Confused	Hospital	F	H	Yes	72.1
2	Confused	Hospital	F	H	No	36.0
3	Confused	Hospital	F	M	No	27.6
4	Confused	Hospital	F	L	Yes	43.2
5	Confused	Hospital	M	H	Yes	31.9
6	Confused	Hospital	M	H	No	21.2
7	Confused	Hospital	M	M	Yes	22.5
8	Confused	Community	F	H	Yes	66.9
9	Confused	Community	F	M	Yes	52.1
10	Confused	Community	F	L	Yes	66.5
11	Confused	Community	M	H	Yes	24.0
12	Confused	Community	M	L	Yes	27.6
13	Alert	Hospital	F	H	Yes	37.6
14	Alert	Hospital	F	M	Yes	23.9
15	Alert	Hospital	F	L	Yes	36.8
16	Alert	Hospital	M	H	Yes	22.0
17	Alert	Community	F	H	Yes	42.9
18	Alert	Community	F	M	Yes	50.5
19	Alert	Community	F	L	Yes	69.6
20	Alert	Community	M	L	Yes	26.2

Source: From national survey data (Bebbington *et al.* 1996; Challis *et al.* 2000).
Notes: 1. Dependency level: H High, M Moderate, L Low. 2. Rate per 1000 admissions. Sex: F Female, M Male.

Simulation exercise in five local authorities

The simulation exercise was conducted in a manner that reflected the actual decision-making processes in each authority. Care-managers were asked to devise community-based care packages for the 20 case types that were chosen as nationally representative of care-home admissions in England. The nature and cost of these care packages were then presented to a senior manager responsible for approval of community-based care or for sanctioning spending on supported admissions to care homes. Table 2 shows the results of the simulation exercise for these 20 case types across the five authorities. The care managers in all five authorities were able to devise hypothetical community-based care packages in at least 80 per cent of the cases. Many of the differences in the average costs per week of the care packages for the 20 case types arose from variations in the authorities' costing procedures. There was also between-authority variation in whether the various care-package types would be approved and in whether the approval changed with a transfer of funds given the abolition of the RA. In two authorities (A and B), no change was envisaged in the patterns of approval arising from funding changes, but in authorities C and D, the

TABLE 2. *Results of simulation exercise in five local authorities across 20 case types*

Study authority	Cases for which community care packages could be prepared Number (%)	Average cost (range) of community care package[1] £	Community care packages approved	
			Under existing circumstances Number (%)	With transfer of RA funds Number (%)
A Shire county	16 (80)	169.34 (25.8–438.5)	15 (75)	15 (75)
B Metropolitan district[2]	17 (85)		12 (60)	12 (60)
C Metropolitan district	17 (85)	129.81 (35.8–188.5)	9 (45)	16 (80)
D Unitary authority	20 (100)	241.21 (69.6–537.6)	11 (55)	17 (85)
E London borough	18 (90)	196.79 (67.8–465.8)	17 (85)	18 (90)

Notes: 1. Standardised across authorities as costs per week, averaged over number of case types for which care-packages were constructed. 2. This authority did not ordinarily cost care-plans at the time of the study.

assessors believed that as many as 30 per cent of the care packages would be newly approved as a result of the changed financial arrangements.

Sensitivity analysis of the likely impacts

Table 3 shows the adjudged outcomes of the RA transfer across the five authorities and 20 case types (N = 100). It shows the numbers of authorities that reported (a) possible diversions from placements in care homes, (b) cases of home-care under usual arrangements, and (c) appropriate care-home admissions. The anticipated diversion effect of the policy was small, for it was reported in only 14 responses (14%). In all but four responses, the diversion was of cases that would normally have been considered for a residential care home not a nursing-home. The largest potential effect, reported in 64 per cent of the responses, was judged to be 'community placement', *i.e.* cases for which care-at-home would ordinarily be possible and who would still be cared for at home with the addition of the RA funds. These figures represent, in a standard fashion across all five authorities and bearing in mind current decision-making parameters, the overall impact of different assumptions regarding case types and the potential effects of the RA transfer.

The extent to which the sample authorities were representative of England was also investigated, to assess the appropriateness of inferences about the national effects of the new funding system. Table 4 shows the number of new permanent placements to residential care of each study authority in relation to the average for all similar authorities in England in 1995/96 (shire counties, metropolitan districts, London boroughs or unitary authorities) (Department of Health 2001). These data confirm that

TABLE 3. *Envisaged potential outcomes of RA transfer across five local authorities (frequencies)*

	Case type description[1]				Envisaged outcomes		
Case type	Cognitive impairment[4]	Referral source[5]	Dependency[6]	Carer[7]	Potential diversion rate	Community placement rate	Met residential need
1	C	H	H	C	1[3]	2	2
2	C	H	H	N	1[3]	1	3
3	C	H	M	N	2[3]	3	0
4	C	H	L	C	0	4	1
5	C	H	H	C	1	3	1
6	C	H	H	N	0	2	3
7	C	H	M	C	1	3	1
8	C	C	H	C	1	3	1
9	C	C	M	C	0	5	0
10	C	C	L	C	2	3	0
11[2]	C	C	H	C	1[3]	2	1
12	C	C	L	C	1	3	1
13	A	H	H	C	0	4	1
14	A	H	M	C	1	3	1
15	A	H	L	C	0	5	0
16	A	H	H	C	0	3	2
17	A	C	H	C	1	2	2
18	A	C	M	C	0	5	0
19	A	C	L	C	0	4	1
20	A	C	L	C	1	4	0
Total envisaged effect (percentages)					14	64	21

Notes: 1. From national data sources (Bebbington *et al.* 1996; Challis *et al.* 2000). 2. One missing response for this case due to care plan being judged inadequate for a decision to be made in one authority. 3. All envisaged potential diversion effects are from residential care apart from these cases where one authority in each case envisaged diversion from nursing home care. 4. C = confused; A = alert. 5. H = hospital; C = community. 6. H = high dependency; M = medium dependency; L = low dependency. 7. C = carer; N = no carer.

the admission rate to residential care in each of the study authorities was broadly representative (within a five per cent margin of error) of the national picture.

Table 5 applies the results of the sensitivity analysis to the national distribution of case types for England. These data summarise the contribution of each case type to the national admission rate, for both residential and nursing homes, expressed as numbers per 1000 admissions. The sensitivity of the RA transfer in promoting diversion is also expressed for each case type by multiplying the frequency of the potential diversion effect by the national admission rate for each case. These figures therefore express the potential national diversion effect of the funding change for each case type. The estimated total national effect is a diversion of just over 112 per 1000 care-home admissions in one year. As the collected case types

TABLE 4. *Variation between study authorities and national clusters of each type on numbers of new permanent placements to residential care*

Study authority (type)	Study authority	National figures (per 1000 population aged 75+ years) Average for authority type	Range (SD)	95% c.i.
A Shire county	21	22	12–33 (4.5)	14 to 31
B Metropolitan district	23	22	10–34 (5.3)	11 to 32
C Metropolitan district	18	22	10–34 (5.3)	11 to 32
D Unitary authority	–[1]	22	10–34 (5.3)	11 to 32
E London borough	18	14	6–22 (3.9)	7 to 22
All authorities	–	19	6–36 (6.1)	8 to 31

Source: Data from Department of Health (2001).
Notes: 1. National data unavailable. Study authority judged against figures for metropolitan districts. Figures for residential care from indicator OA25 – numbers of new permanent placements per 1000 population aged 75 or more years.

represent 80 per cent of care-home admissions nationally, this figure should be treated as a minimum estimate of the funding change. Assuming that these remaining admissions can be treated similarly, the maximum potential diversion effect was calculated by increasing the estimate by 20 per cent, to give a range of the potential national diversion from 112 to 140 per 1000 admissions.

For simplicity, a summary indicator that more directly compares the estimated diversion across the authorities was calculated. Table 6 presents a standard figure for the number of new admissions *per 1000 older people* that can potentially be diverted from care homes in one year. The age-group threshold (over 75 years) is that most likely to be at the margin of admissions to care homes (Bebbington and Davies 1980). The weighted average effect, of between two to three admissions per 1000 older people, was therefore judged to be very marginal indeed. The estimated national diversion effect, of between just under 8,000 to just over 10,000 older people from admission to care homes in one year, was applied to local social services authorities in England to exemplify the contrasting outcomes for authorities with different at-risk older populations (Table 7).

Survey of key decision makers

The survey of decision makers in the five authorities that was conducted during the simulation exercise provided contextual information about the factors that mediated the effect of the RA redistribution on diversion from care homes. It was carried out in two stages: first, following the simulation,

TABLE 5. *The potential diversion effect of RA transfer across five authorities and its application to the national distribution of case types*

Case type	Case type description[1]				Numbers per 1000 admissions nationally[1]	Potential diversion effect[2]	Potential national diversion effect[8]
	Cognitive impairment[3]	Referral source[4]	Dependency[5]	Carer availability[6]			
1	C	H	H	C	72.9	0.2	14.4
2	C	H	H	N	36.0	0.2	7.2
3	C	H	M	N	27.6	0.4	11.0
4	C	H	L	C	43.2	0.0	0.0
5	C	H	H	C	31.9	0.2	6.4
6	C	H	H	N	21.2	0.0	0.0
7	C	H	M	C	22.5	0.2	4.5
8	C	C	H	C	66.9	0.2	13.4
9	C	C	M	C	52.1	0.0	0.0
10	C	C	L	C	66.5	0.4	26.6
11	C	C	H	C	24.0	0.2	4.8
12	C	C	L	C	27.6	0.2	5.5
13	A	H	H	C	37.6	0.0	0.0
14	A	H	M	C	23.9	0.2	4.8
15	A	H	L	C	36.8	0.0	0.0
16	A	H	H	C	22.0	0.0	0.0
17	A	C	H	C	42.9	0.2	8.6
18	A	C	M	C	50.5	0.0	0.0
19	A	C	L	C	69.6	0.0	0.0
20	A	C	L	C	26.2	0.2	5.3
Total envisaged effect (per 1000 admissions)[7]							112.4

Notes: 1. From national data sources (Bebbington *et al.* 1996; Challis *et al.* 2000). 2. Frequency of each response type in the sampled authorities as a proportion of overall effect from authorities expressed as a proportion of unity. 3. C = confused; A = alert. 4. H = hospital; C = community. 5. H = high dependency; M = medium dependency; L = low dependency. 6. C = carer; N = no carer. 7. Due to missing response in one authority, the total envisaged effect represents 99 per cent of possible responses. 8. Per 1000 admissions.

TABLE 6. *Calculation of a nationally comparable figure of potential diversion consequent on the RA transfer for England*

Quantity	Estimate
Range of potential diversion (per 1000 admissions)	112 to 140
Expressed as percentage of national admissions over one year	11 to 14
Average number of new admissions (per 1000 population aged 75+ years)[1]	19.36
Potential national diversion effect (per 1000 population aged 75+ years)	2.13 to 2.71

Note: 1. For England, from Department of Health (2001), indicator OA25.

care managers gave their views as to the key factors that affected their decisions when devising the care plans; second, senior managers gave their views about the spending constraints on care packages as opposed to care-home placements.

TABLE 7. *The scale of potential annual diversion for selected authorities and for England as a whole*

Authority name	Population of older people[1]	Rate of admissions[2]	Potential diversion effect[3]	Number of diverted admissions[4]
Shire Counties				
Cheshire	51.2	18	1.98 to 2.52	101 to 129
Cumbria	41.3	32	3.52 to 4.48	145 to 185
Derbyshire	57.1	21	2.31 to 2.94	132 to 168
Gloucestershire	47.3	12	1.32 to 1.68	63 to 80
Oxfordshire	41.1	16	1.76 to 2.24	72 to 92
Metropolitan Districts				
Birmingham	68.3	17	1.87 to 2.38	128 to 163
Bolton	18.7	23	2.53 to 3.22	47 to 60
Kirklees	27.5	22	2.42 to 3.08	67 to 85
Manchester	26.4	19	2.09 to 2.66	55 to 70
Rochdale	13.2	21	2.31 to 2.94	31 to 39
Sefton	25.8	23	2.53 to 3.22	65 to 83
Wirral	27.3	18	1.98 to 2.52	54 to 69
London Boroughs				
Brent	11.5	11	1.21 to 1.54	14 to 18
Bromley	24.3	18	1.98 to 2.52	48 to 61
Camden	11.6	14	1.54 to 1.96	18 to 23
Havering	18.1	18	1.98 to 2.52	36 to 46
Islington	9.1	19	2.09 to 2.66	19 to 24
Westminster	13.1	6	0.66 to 0.84	9 to 11
All England average	3712.2	19	2.13 to 2.71	7,907 to 10,060

Notes: 1. Thousands aged 75 or more years. 2. Per 1000 aged 75 or more years; from Department of Health (2001). 3. Envisaged effect in the range of 11 to 14 per cent of admissions expressed per 1000 population aged 75 or more years. 4. Potential numbers of older people (aged 75+ years) diverted from care homes over one year. Data on unitary authorities were unavailable in national data (Department of Health 2001).

The care managers' interpretations of need were often based on presumptions as to the burden that carers could cope with. Therefore, additional funds would be more influential in the cases involving an informal carer, since they could be supported by the purchase of additional day or domiciliary care. Where good relationships with carers existed, supporting very vulnerable older people at home was made more possible with the funds released by the RA transfer. The analysis of sub-groups confirms this perception, for the cases with a carer accounted for 84 per cent of the total diversion effect across the 20 case types (Table 5). Certain types of case did however present difficulties, including those of older people with cognitive impairment and mental-health problems, for these led care managers to consider carefully the availability of specialist services and the risks of home support. If specialist services were unavailable, the ability to offer alternatives to care-home admission was constrained. In fact, more generally, the influence of 'local service system' attributes was

a prime constraint. Night-sitting, meals at weekends and specialist day-care services for those with dementia were unavailable in some authorities, while in others access to residential care had been limited through closures.

Care managers were also affected by an authority's purchasing arrangements. A change from 'block' to 'spot' contracts (Le Grand 1992) had made it less likely that providers would invest in long-term innovations as they had become vulnerable to fluctuations in purchasing practice (Wistow and Hardy 1999). This made it difficult for care managers to make even small adjustments to care packages without prior agreement. This lack of flexibility was a constraint on innovative practice, and reduced the diversion opportunities. A related factor was the constrained financial environment in which care managers had to work. Even when a care package was seen as the most appropriate way of meeting an older person's needs, many were not sanctioned by senior managers because of resource constraints. The funds released by the RA transfer were often insufficient to change this scenario. In one authority, for example, the transfer was equivalent to only five or six hours of home care per week, which would have made a difference in only a few cases. Overall, the decision-making process of front-line assessors was largely resource-led rather than needs-led.

Second, for senior managers, local policy factors and restrictions on the supply of relevant services compromised the ability of the funding change to enable diversions. The limited extent to which services were costed, and the manner in which this was done, also reduced the potential for change. The costs of care packages varied among the authorities. Since the RA transfer presumes a relative price effect upon care-home admissions, it was hypothesised that the degree to which care packages were price sensitive would affect the ability to divert cases from residential care. This hypothesis was confirmed in the discussions with senior managers, *e.g.* in authority B, care packages were not costed at the time of the research, and the simulation found no opportunities for diversion: the same number of care packages were approved both before and after the transfer of funds (Table 2). Although care packages were costed in the other participating authorities, there was considerable variation in the components that were subject to costing. Whilst all of the remaining four authorities attributed costs to domiciliary care, only one authority (E) extended this to all other service components. Authority C was the most price sensitive, for it envisaged a 35 per cent increase in the number of care packages supported by the additional RA funds (Table 2). Interestingly, this authority's care-package indicative costs were calculated in terms of the equivalent domiciliary-care hours applied to each component of the care plan.

The local policy concerning the price of residential and nursing-home care was also an important factor in the managers' evaluation of the opportunities for funding home-based care as an alternative to care-home admission. This was because some local authorities used the local price of independent residential and nursing-home care as a guide to the maximum cost of the care packages that would be approved. As noted, many factors, including local negotiations and demand and supply, influence the price of residential and nursing-home care (Wistow *et al.* 1996). For independent sector residential care, the negotiated price reported by the authorities ranged from £223 to £266 per week, and that for nursing-home care from £314 to £392 per week. Two of the authorities used the local price of residential and nursing-home care as a guide to the maximum cost of care packages that would be routinely approved. In authority A, care-home placements were made within a price range (£266 to £329 per week for residential care) rather than at a fixed price, and its simulation exercise revealed no evidence of diversion as a result of the RA redistribution (Table 2). It is interesting to note that the price range for residential care placements used in this authority was similar to the level of the RA. This pricing structure may have muted the potential for diversion consequent on the availability of additional funding for domiciliary care in contrast to a fixed price, which appears more sensitive to the proposed RA change.

The managers had serious concerns about the inelastic supply of domiciliary care. Confirming the projections made soon after the community-care reforms (Laing and Buisson 1996), it was found in both the local authority and independent sectors that a tight labour market led to difficulties in recruiting and retaining care staff, and that this made expansion of the service difficult. The capacity for service substitution was also a significant issue. In some areas, both social services department and NHS Trust services were available to the care packages. The simulated care plans revealed considerable variation in the mix of these services both between and within authorities: an important consideration given that NHS care is free of charge (and not a cost to the social services department). As an example, the use of day care was most salient because 70 per cent of the care plans constructed from the case vignettes included this provision: the overall number of days allocated was 47. The proposed provision was weighted towards NHS as compared to local authority day care in a ratio of 2:1. Of the 12 case types cited in Table 3 as showing a potential for diversion, six had day care in the care packages. Care plans in three of the participating authorities (A, D and E) included NHS day-hospital attendance which, because it did not incur costs to the social services department, offered scope

for diversion by making available additional funds for domiciliary alternatives.

The influence of other supply factors, notably of suitable accommodation, was also identified by the managers as a significant mediator of the potential effects of the RA transfer. The availability of suitable accommodation in the community is a prerequisite for the effective development of community care (Challis *et al.* 1995; Arblaster *et al.* 1996; Means and Smith 1996; Means *et al.* 1997). Managers recognised that some older people were admitted to long-term care partly because their homes were unsuitable or unsafe. For this group of older people, the additional funds made possible by the RA transfer would have little effect unless suitable alternative accommodation was found and the person wished to move to a new home. For this group, a move to residential care is often their preferred option and so they would be unlikely to be affected by additional domiciliary care.

Another and perhaps more significant factor was the extent to which housing adapted to the requirements of frail older people was available in the community. Such specialist housing has generally been developed through an agreed strategy between local authority social services and housing departments. In one of the study authorities, a scheme had allocated a specific number of home-care assistant hours to a sheltered-housing scheme on the basis of the assessed needs of its residents. The warden of the scheme, in conjunction with the home-care assistants, decided how best to allocate the hours. This allowed the latter to respond quickly to the changing needs of the users without consulting either a care manager or home-care manager (in a way exemplified in recent government guidance) (Means *et al.* 1997). In such circumstances, it is reasonable to assume that the availability of increased home-care hours made possible by additional funds would have an effect.

Discussion

Changes in public funding represent an important mechanism for managing the mixed economy of long-term care provision for older people. The use of such mechanisms to achieve policy aims is now attracting attention in several countries (Duckett *et al.* 1995; Joel and Dufour-Kippelen 2002; Ikegami *et al.* 2003). Faced with the growing demands of an ageing population, there is increasing pressure on public funds to provide appropriate responses to various needs. This is an international problem and, depending on the particular model adopted for managing this demand, corrections to the long-term care system through such

changes are necessary to ensure that any funding anomalies are removed and appropriate incentives are offered.

Estimating the possible impact of such changes in order to inform policy making is, however, exceedingly difficult. This study has estimated the potential effects of a funding transfer in England by examining its likely impact upon the placement decisions made by local authority social services departments. Several factors were thought to influence this decision-making, including the views of older people and their carers and other service professionals. Whilst, as far as possible, such factors were included in the case vignettes, the approach cannot fully replicate the influence of other stakeholders, *e.g.* older people's and carers' choices and involvement in the assessment process could only be indirectly taken into account as deviations from the average (Department of Health/Social Services Inspectorate 1991). Although it might be argued that this neglects the participation of users and carers, the evaluation fulfilled the intention of providing useful aggregate information to government about the envisaged effects of the change upon the way decisions concerning care provision are made. The intention was to capture the average impact of negotiations with users and carers with different forms of need, rather than to judge the policy's impact on individual service users. Thus, it can be considered a credible approach, which closely matched assumptions about how such a funding change might impact upon the independence of older people. In this sense, the evaluation can be considered valid (House 1980).

The information from the study was used to inform a later stage of the implementation process and to identify those likely to be affected by the policy. The study was also able to raise issues about its impact on different policy areas. It was thus a means of informing various groups within government and was but one contribution to a complex decision-making process. In this sense, the study contributed to a general evaluative process in government, which aimed to identify a policy's possible impact against tangible outcomes (Henkel 1991).

Inevitably, this relatively small study has made several assumptions. First, the simulation assumed that the transfer of funds would be distributed to older people's services provided or purchased by the social services authority. This was a reasonable assumption, given that the government confirmed that the funds were to be transferred to the 'Promoting Independence' grant to the authorities (Department of Health 2000*b*). Second, it was assumed that local authorities would not use the funds to maintain the supply of residential care; in other words, that they would respond to price signals and promote domiciliary initiatives. Third, the calculations assumed continuity in decision-making on the part of the authorities before

and after the transfer. Fourth, the calculated effects were those *envisaged* by local decision-makers.

More generally, in England it appears that the obstacles to the development of domiciliary alternatives to care-home admission are unlikely to change in the short to medium term. The 'inelasticity' in the supply of home care needs to be confronted before any additional funding incentives can have the desired effect. Current evidence suggests that this will prove difficult. It is, for example, likely that the registration and training requirements introduced by the *Care Standards Act 2000* (Department of Health 2000*c*) will place additional pressures on domiciliary care providers. However, two other factors may have a more immediate impact. First, the variable extent to which health and social care agencies complement and substitute for one another – as in the contrasts for home care, day care and home nursing – will affect the degree to which 'transfer funds' have a large or small effect upon alternatives to care-home admission. Secondly, the availability of carers and levels of dependency significantly influenced the interpretations of need. Our findings suggest that the policy was likely to have the most effect on those with relatively low dependency for whom residential care is most appropriate. This group arguably offers more opportunities for diversion given the continued reduction in independent care-home capacity (Netten *et al.* 2002). Similarly, the impact of the transfer was perceived as potentially higher in households with a carer. This was because for older people who lived alone, the transfer was likely to support only a marginal increase in the care already provided by the social services department. The degree to which price was used in the decision-making of social services authorities was, however, important in mediating the effects of the change. Where a fixed price for care-home admission operated, there appeared to be greater sensitivity to additional funding incentives for domiciliary care. Overall though, the incentive offered by the redistribution had little impact in reducing care-home admissions and appeared to be swamped by long-term factors.

The potential impact of the transfer on promoting consistency and equitability between the local authority and independent sectors is more difficult to estimate. Because it is a universal instrument that provides additional funds across local authorities, the transfer may perversely magnify existing inequalities. It is likely to have a selective impact and to depend on the particular organisational arrangements in each authority. The funding incentive is only one tool for promoting such long-term goals, however, and its effects may be obscured by other major current policy initiatives. Further work on the effect of the transfer once the policy has taken effect should take account of these exogenous factors.

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NOTES

1 In a context in which a number of older people fund their own long-term care, residential and nursing-home placements are sometimes funded through social security benefits and contributions from relatives rather than local authority support. Typically this occurs in the period immediately after admission to long-term care for older people who are owner occupiers. In these circumstances, residents would have direct access to social security funding in the form of the Attendance Allowance, which would not be the case were they to be funded through the social services department. This is known as the 'Boyd loophole' (Goring 1999). In the present study, this group of older people have been omitted.

2 Local government in England outside London has been two-tier, with counties taking certain functions (normally including social services), and boroughs (or similar) other functions. Increasingly, this pattern is being replaced by a system of unitary authorities that are responsible for the entire range of local government functions.

3 To create the dimensions, scores on the Barthel Index were grouped into three categories: 0–8 'high dependency', 9–11 'moderate dependency' and 13–20 'low dependency'. Scores on the MDS CPS were dichotomised into: 0–2 'alert' and 3–6 'confused'.

4 This was done by applying the percentage proportions of each of the 24 categories who were in regular contact with a carer in the Challis *et al.* (2000) data to the same 24 categories in the national data (Bebbington *et al.* 1996). The proportions dichotomised into those with/without a carer were applied to the national data to produce 48 possible case types.

5 The sample of case types was selected from those with a prevalence of at least 20 per 1000 admissions to residential or nursing-home care in the national data (Bebbington *et al.* 1996). This produced 20 case types representing 80 per cent of cases admitted to homes on a national basis.

6 Costing structures differed among authorities. One authority used annual costings applied to domiciliary services whilst two others used weekly costs; another costed their services according to a notional unit cost of home care applied to all components of the care plan; whilst in one authority care plans were not costed. To compare authorities, unit cost information, however derived, was combined with service use in the care plan to determine the costs of each care package following a well-developed costing methodology (Allen and Beecham 1993).

References

Allen, C. and Beecham, J. 1993. Costing services: ideals and reality. In Netten, A. and Beecham, J. (eds), *Costing Community Care: Theory and Practice*. Ashgate, Aldershot, Hampshire, 25–42.

Arblaster, L., Conway, J., Foreman, A. and Hawtin, M. 1996. *Asking the Impossible? A Study of Inter-agency Working to Address the Housing, Health and Social Care Needs of People in General Needs Housing*. Joseph Rowntree Foundation, York.

Audit Commission 1986. *Making a Reality of Community Care*. Her Majesty's Stationery Office, London.

Banister, P., Burman, E., Parker, I., Taylor, M. and Tindall, C. 1994. *Qualitative Methods in Psychology: A Research Guide*. Open University Press, Buckingham.

Bebbington, A. C. and Davies, B. P. 1980. Territorial need indicators: a new approach. Part II. *Journal of Social Policy*, **9**, 433–62.

Bebbington, A., Brown, P., Darton, R. and Netten, A. 1996. *Survey of Admissions to Residential Care: The Lifetime Risk of Entering Residential or Nursing Home Care for Elderly People*. Discussion Paper 1230/2, Personal Social Services Research Unit, University of Kent, Canterbury, Kent.

Challis, D. 1996. Community care. In Ebrahim, S. and Kalache, A. (eds), *Epidemiology in Old Age*. BMJ Publications, London, 126–35.

Challis, D., Darton, R., Johnson, L., Stone, M. and Traske, K. 1995. *Care Management and Health Care of Older People*. Ashgate, Aldershot, Hampshire.

Challis, D., McNiven, F., Hughes, J., Darton, R. and Stewart, K. 2000. *Estimating the Balance of Care*. Discussion Paper M021/1677, Personal Social Services Research Unit, University of Manchester, Manchester.

Challis, D. and Hughes, J. 2002. Frail old people at the margins of care: some recent research findings. *British Journal of Psychiatry*, **180**, 126–30.

Clarkson, P., Hughes, J. and Challis, D. 2003. Public funding for residential and nursing home care: projection of the potential impact of proposals to change the residential allowance in services for older people. *International Journal of Geriatric Psychiatry*, **18**, 211–6.

Cm 849 1989. *Caring for People: Community Care in the Next Decade and Beyond*. Her Majesty's Stationery Office, London.

Cm 4014 1998. *Modern Local Government in Touch with the People*. Stationery Office, London.

Cm 4169 1998. *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards*. Stationery Office, London.

Cm 4192-I 1999. *With Respect to Old Age: Long Term Care – Rights and Responsibilities*. Report by the Royal Commission on Long Term Care (Chairman: Professor Sir Stewart Sutherland). Stationery Office, London.

Cm 4818-I 2000. *The NHS Plan. A Plan for Investment. A Plan for Reform*. Stationery Office, London.

Collin, C., Wade, D. T., Davies, S. and Horne, V. 1988. The Barthel ADL Index: a reliability study. *International Disability Studies*, **10**, 61–3.

Department of Health/Social Services Inspectorate 1991. *Care Management and Assessment: Practitioners' Guide*. Department of Health, London.

Department of Health 1994. *Putting People First, Third Annual Report of the Chief Inspector Social Services Inspectorate 1993/94*. Department of Health, London.

Department of Health 1998. *Modernising Health and Social Services: National Priorities 1999/00–2001/02*. Department of Health, London.

Department of Health 1999. *Modernising Social Services Implementation Diary*. Local Authority Social Services Letter (LASSL) (99) 9, Department of Health, London.

Department of Health 2000*a*. *Preserved Rights Income Support/Residential Allowance*. Consultation Paper, Department of Health, London.

Department of Health 2000*b*. *Personal Social Services Funding: 2001–02*. LASSL (2000) 13. Department of Health, London.

Department of Health 2000*c*. *Care Standards Act*. Department of Health, London.

Department of Health 2001. *Key Indicators Graphical System 2001*. Department of Health, London.

Duckett, S., Cray, L. and Howe, A. 1995. Designing a funding system for rehabilitation services. Part 2: policy objectives and options for achieving efficiency and quality of care. *Australian Health Review*, **18**, 62–77.
Geddes, M. and Martin, S. 2000. The policy and politics of Best Value: currents, cross-currents and undercurrents in the new regime. *Policy and Politics*, **28**, 379–95.
Goring, D. 1999. *Residential Allowance and Diversion Rates*. Letter 8 January, Annex A, Department of Health, London.
Greene, V. L. and Ondrich, J. I. 1990. Risk factors for nursing home admissions and exits: a discrete-time hazard function approach. *Journal of Gerontology, Social Sciences*, **45**, S250–8.
Griffiths, R. 1988. *Community Care: Agenda for Action*. Report to the Secretary of State for Social Services, Her Majesty's Stationery Office, London.
Henkel, M. 1991. The new 'evaluative state'. *Public Administration*, **69**, 121–36.
House, E. R. 1980. *Evaluating with Validity*. Sage, London.
Ikegami, N., Yamauchi, K. and Yamada, Y. 2003. The long term care insurance law in Japan: impact on institutional care facilities. *International Journal of Geriatric Psychiatry*, **18**, 217–21.
Joel, M. E. and Dufour-Kippelen, S. 2002. Financing systems of care for older persons in Europe. *Aging Clinical and Experimental Research*, **14**, 293–9.
Kraan, R. J., Baldock, J., Davies, B., Evers, A., Johansson, L, Knapen, M., Thorslund, M. and Tunissen, C. 1991. *Care of the Elderly: Significant Innovations in Three European Countries*. Campus/Westview, Boulder, Colorado.
Laing and Buisson 1996. *Care of Elderly People: Market Survey 1996*. Laing and Buisson, London.
Le Grand, J. 1992. *Paying for or Providing Welfare*. School for Advanced Urban Studies, University of Bristol, Bristol, Avon.
McAuley, W. J. and Travis, S. S. 1997. Positions of influence in the nursing home admission decision. *Research on Aging*, **19**, 26–45.
Means, R. and Smith, R. 1996. *Community Care, Housing and Homelessness*. School for Policy Studies, University of Bristol, Bristol, Avon.
Means, R., Brenton, M. and Harrison, L. 1997. *Making Partnerships Work in Community Care: A Guide for Practitioners in Housing, Health and Social Services*. Policy, Bristol, Avon.
Mooney, G. H. 1978. Planning for balance of care of the elderly. *Scottish Journal of Political Economy*, **25**, 149–64.
Morris, J. N., Fries, B. E., Mehr, D. R., Hawes, C., Phillips, C., Mor, V. and Lipsitz, L. A. 1994. MDS cognitive performance scale. *Journal of Gerontology: Medical Sciences*, **49**, M174–82.
Netten, A., Darton, R., Bebbington, A. and Brown, P. 2001. Residential or nursing home care? The appropriateness of placement decisions. *Ageing & Society*, **21**, 3–24.
Netten, A., Darton, R. and Williams, J. 2002. *The Rate, Causes and Consequences of Home Closures*. Discussion Paper 1741/2, Personal Social Services Research Unit, University of Kent, Canterbury, Kent.
Power, W. E. 1989. Residential care for elderly people: characteristics of patients admitted to residential and nursing home care from hospital. *British Journal of Social Work*, **19**, 39–51.
Sabatier, P. A. 1985. What can we learn from implementation research? In Kaufmann, F. X., Majone, G. and Ostrom, V. (eds), *Guidance, Control and Evaluation in the Public Sector*. Aldine de Gruyter, Berlin, 313–25.
Warburton, R. W. 1994. *Implementing Caring for People. Home and Away: A Review of Recent Research Evidence to Explain Why Some Elderly People Enter Residential Care Homes Whilst Others Stay at Home*. Department of Health, London.
Wistow, G. 1995. Aspirations and realities: community care at the crossroads. *Health and Social Care in the Community*, **3**, 227–40.

Wistow, G., Knapp, M., Hardy, B., Forder, J., Kendall, J. and Manning, R. 1996. *Social Care Markets: Progress and Prospects*. Open University Press, Buckingham.
Wistow, G. and Hardy, B. 1999. The development of domiciliary care: mission accomplished? *Policy and Politics*, **27**, 173–86.

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