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ABSTRACT

An analysis of the response of British health, social care, and housing agencies to the needs of the elderly was conducted. The purpose of the study was to determine how the British are improving their services to meet the needs of the rapidly increasing population of the elderly in an era of slow growth of public spending. The analysis showed the presence of some types of innovation particularly suited to improve efficiency: (1) more intensive inputs of home care delivered at more appropriate times; (2) plans organized by social service departments using social workers to undertake some of the core tasks of case management and organize more intensive care, targeted at those at high risk of admission to institutions for long-term care; (3) neighborhood-based care plans intended to increase the degree of horizontal target efficiency of the care system and reach some types of clients with severe needs; and (4) plans involving the collaboration of housing with social care agencies to combine shelter with support. Most such efforts, however, are local in scope and fragmentary in effect, not parts of a clearly articulated plan. What is now needed is greater clarity in the analysis of the main sources of inefficiency and models that relate service policy and arrangements directly to these sources of inefficiency. One such model, the "community care approach," developed at the Personal Social Services Research Unit in collaboration with various British agencies, creates incentives to clients, caregivers, and workers who manage the allocation of services to improve efficiency. Early evaluation of applications of this model shows a halving of the possibility of entering long-term care homes and improvement in recipients' quality of life. (KC)

IMPROVING EFFICIENCY IN THE DELIVERY OF SERVICES TO THE AGED IN GREAT BRITAIN

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THE ORGANIZATION AND ITS MISSION

The International Exchange Center on Gerontology is an organization of centers and programs for gerontological research and teaching in both public and private universities throughout Florida. The University of South Florida is the headquarters or "host institution" for the IECG. The Center is new, having received its permanent funding in 1982, and operates under a Director and an Advisory Board of representatives from the participating universities.

The purpose of the IECG is to make available to policymakers in the State the best information that can be secured on policies, programs, and services for the elderly. This means collecting and analyzing experiences in such areas as transportation, health care, income security, housing, social services, nutrition, and other subjects that have a significant meaning in the daily lives of our elderly citizens. To carry out this mission, the IECG must communicate with political leaders, program administrators, academic institutions, and with experts in gerontology throughout the United States and the world.

Special attention will be given to program innovations, and to experiences that reveal both strengths and weaknesses in various approaches that have been tried in addressing the aspirations and needs of the elderly. Careful and frank exchange of information, and thorough analysis of policies and programs by policymakers and specialists in higher education offer an opportunity for examination from both theoretical and practical perspectives.

Florida has a unique opportunity for leadership in this field through the Center. Its concentration of elderly persons, and innovative programs like community care for the elderly, demonstrate the possibilities for both give-and-take of experiences. With assured continuing support, a small but highly qualified staff and faculty available in higher education throughout Florida, the IECG can develop a program that will greatly benefit all states. The pressures on state leadership to come up with wise decisions in human services is especially intense under the changing federal emphasis. The initiative is shifting more and more to the states, as federal funding is reduced. Useful information exhange will help state leadership to make increasingly difficult choices among competing priorities for limited funds.

Against the backdrop of a future which will feature exponential economic growth in the State, the influx of growing numbers of persons of working age, and the continuing increase in the number of persons over 60, Florida's policymakers need the best intellectual resources and insights that can be tapped. As a center for collecting, analyzing, and disseminating information of this quality and depth, the higher education community can be of inestimable service to the political and administrative leadership of Florida. The IECG can serve as a vital link between the universities and colleges, and state and local governments.

Foreword

The conjuncture of population aging and fiscal austerity in developed countries over the past decade or more has stimulated a systematic approach to seeking the best, most effective and efficient ways of providing services for the elderly. Eminent among the social policy analysts who are developing and applying this perspective is Dr. Bleddyn Davies, Professor of Social Policy, and Director of the Personal Social Services Research Unit, at the University of Kent. That organization was explicitly created to ascertain which forms of social service provision are models of improvements in efficiency.

This particular paper, which formed the basis of Dr. Davies' presentations at the University of South Florida in February, 1985, deals with a community care approach as a possible way of increasing efficiency in services to the aged. The reader must examine the content and specifics of this approach as described by Dr. Davies, but suffice it to say that among the remarkable results of its implementation in the British communities studied is the reduction by one-half of the odds for admission to long-term care institutions. The methodology employed by Dr. Davies and his colleagues also sheds important information on the costs for the most dependent, compared to those for the least dependent, of persons in residential care. Another salient result was the reduction of stress and strain on family caregivers, a serious obstacle to non-institutionalization.

The International Exchange Center on Gerontology intends to continue its relationship with Dr. Davies and the Personal Social Services Research Unit, and to develop exchanges involving practitioners as well as researchers, in the efforts of the Center to gather and disseminate ideas, methods, and

practices designed to improve our own delivery of services to a variety of elderly in Florida and elsewhere. This brief paper should stimulate a keen interest in making those exchanges a reality.

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Director

Improving Efficiency in the Delivery of Services to the Aged in Great Britain

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The challenge of the 1980s and beyond is to procure effective service for priority needs in an era of slow growth in public spending. The gap between resources and needs must be at any rate partially filled by improving efficiency in the use of resources.

The response of British health, social care and housing agencies has recently been analysed. The evidence consisted of structured descriptions by all major social and housing agencies and some types of health agency. They described what they conceived to be their principal innovations aimed to improve the efficiency and effectiveness of their interventions for the frail elderly living in private households at risk of admission to institutions for long-term care (Ferlie, 1983; Ferlie, Challis and Davies, 1984a; Ferlie, Challis, and Davies, 1984b). The analysis showed the presence of some types of innovation of particular significance for efficiency improvement.

- Schemes, some with personal care as well as the more domestic care which consumes all but a trivial proportion of the domiciliary social care provision in the UK, and with more intensive inputs of home care delivered at more appropriate times. Authorities are therefore attempting to correct a source of inefficiency in the mix of tasks undertaken; a feature criticised elsewhere (Davies, 1980; Challis and Davies, 1985, chapter 2).

- Schemes organised by social services department using social workers to undertake some of the core tasks of case management and organise more intensive care, often including personal care. They are targeted at those at high risk of admission to institutions for long-term care. The model emphasises care management more than enhanced service provisions. There are also schemes run by health agencies. The range of case management tasks undertaken is variable and their specification is usually vague, reflecting the absence of hard analysis of and prerequisites for their effective performance in British policy argument.

- Neighbourhood-based care schemes intended to increase the degree of horizontal target efficiency of the care system; partly reflecting attempts to provide for groups neglected in a system which provides too narrow a range of service packages, and which therefore, fails to attract some types of client of severe need.

- Schemes involving the collaboration of housing with social care agencies to combining shelter with support. The tunnel vision of the separate providers of housing and social care and the resulting distortions in the major investments in human and physical capital during the decade of major growth ending with the oil crisis have been important leitmotifs of policy discussion for a quarter of a century (Davies, 1968; Minns, 1972; Plank, 1978).

These types are clearly visible. However, it would be wrong to infer that innovations of any of them are the rule rather than the exception. Indeed, the number of schemes with more elaborate case management might be less than twenty and all are highly localised (Ferlie, Challis, and Davies, 1984). Their geographical coverage is narrow. In few areas are schemes perceived as a step on a

long planned march to a new and better system, most innovations being instigated near the field level, disjointedly incremental not elements in a synoptic plan, and found in different areas. Few have been monitored to establish whether they have achieved intended effects. Many from an earlier cohort were soon corrupted by the pressures of their environment and the special characteristics of others were abandoned as soon as they lost their protected innovative status (Davies and Ferlie, 1982). No doubt that will be the case for the more recent cohort of innovations also. However, a comparison of cohorts separated by three years does suggest a rapid acceleration in efficiency-improving innovation during the early 1980s (Ferlie, 1980 and Ferlie, 1983).

So there are clear signs that British agencies are increasingly focusing on the enhancement of efficiency and effectiveness rather than the mere lineal extension and proliferation of services. What we now need is greater clarity in the analysis of the main sources of inefficiency and models which relate service policy and arrangements directly to these sources of inefficiency. In the remainder of this paper, I shall describe the nature and results of one such model directed at the care of those in need of long-term care; what we call the "community care approach" developed at the Personal Social Services Research Unit (PSSRU) in collaboration with various British agencies.

The community care approach to enhancing efficiency is based on two arguments: (1) most social (and health) care resources are consumed by a minority of recipients, so a better use of resources in their support can have the biggest impact on overall efficiency; and (2) both patterns of utilisation and pressures to supply the resources are determined by the behaviour of carers, recipients and workers at the field level. The approach creates incentives to clients, carers and the workers who manage the allocation of services to progressively

improve efficiency and engineer the environment in which the behaviour occurs so as to help the incentives to work well. The approach is the most basic among several compatible modules being developed at the PSSRU for the main type of British social care agency, the social services department. They are consciously designed to allow the agency to achieve welfare goals with greater efficiency. The approach was first developed for and with the social services department of Kent County Council. It was first applied to the care of elderly persons living at home but at high risk of admission to a hospital or home for long-term care. The first experiment entered the field in 1977. Its success caused Kent to decide to apply the community care approach throughout the county. The first experiment has been fully evaluated by the authors. Two more implementations in Kent, an implementation in North Wales, and one in Gateshead are also being evaluated. The evaluation has been completed only for the first experiment.

Axioms about the Circumstances of Long-Term Care Groups

The long-term care groups have several characteristics in common:

(1) They are individually expensive consumers of a high proportion of social care expenditures. Between them, the groups consume perhaps three-fifths of social services department resources. Many are residents of homes. However, the groups include those at high risk of admission to care in residential homes, hostels, hospitals, or foster homes. Once resident in homes, they receive expensive resources from the health and social services; but often they do not receive vast resources before that. So, for instance, the PSSRU recently calculated that persons at high risk of admission to residential or hospital care living in their own homes each receive resources costing the social services department less than 14 percent of their costs to the department once resident

in homes. Between them, they receive about 2 percent of the social services department budget, whereas elderly people living in residential care receive one quarter. So a successful investment of resources which made their entry unnecessary without reducing their welfare could have large economic effects.

(2) Members of each group differ greatly in their needs; and so in the tasks whose performance would make most difference to them and the times at which the tasks would be performed to the best effect. We can illustrate from the elderly group. There is variety in the times of the day or night at which help would make most difference, in the care tasks required, in the minimal frequency with which tasks are most effectively performed, and the predictability of the most effective times for undertaking them. Variation exists in the duration of each episode of caring; the degree to which the recipient has unmet needs for relationships and the extent to which these unmet needs affect their morale; and their desire to function independently. Individual personality and behaviour traits of the elderly affect the ease with which they may be helped, the gratification of those who undertake the helping tasks, and the type of helper who can contribute most to them. There is also variation in the amount, complexity, nature, reliability, and potential of the family and other informal carers to provide care; the degree and nature of the strain they face; and the presence of ambivalences, misunderstanding and exploitation of carers and recipients. There is also variation in the degree to which members of the group themselves are able to find the required help from services and elsewhere, or whether they require extensive continuing and expert help to accomplish this.

(3) The combination services and other imputs which would meet their needs well without indefinite admission to residential care, are not easy to assemble, maintain and adjust to changing circumstances. The expansion in the number to

services, their level of provision, and the effectiveness of each in producing beneficial outcomes, have not been matched by progress in coordinating their provision for individual recipients. By 1963, Richard Titmuss had come to fear that with the growth and diversification of the previous decade, "everybody's business would become nobody's business", and that none of the service personnel would be able to match resources to needs with the flexibility required by the diversity of the needs. The problem existed for services provided by the same agency as well as those provided by different organisations. It is easy to be wise after t.e event.

However, what Richard Titmuss had identified as a crucial problem with characteristic perspicacity was not addressed by the Seebohm Committee and others with the rigorous organisational analysis it required. So authorities, with countless other things on their minds, were left without a clear public discussion of how to tackle it. In most departments, there remains no field person with the unambiguous responsibility to match resources to needs with sufficient time to mobilise, support and, in some cases, create resources for setting up and maintaining arrangements in complex situations. Nor do field persons operate within an organisational structure which gives them sufficient authority, information and incentive to do so in ways which will progressively improve cost-effectiveness. They lack information about the cost implications or their decisions for other than their own time, and are often organised so they do not see the long-run consequences of actions taken during their short-term involvement, or indeed the immediate impact of what they do on the personnel of other agencies or family carers.

This excessive focus on developing individual services to the neglect of their field coordination reduces the efficiency and effectiveness of the whole system.

Efficiency and effectiveness depend on services being provided to all those and only to those for whom they are a component of the most efficient and effective set of support arrangements. Efficiency and effectiveness depend on mixing services and other inputs in the way which gets the best outcomes for the cost, and on aiming at a mix of outcomes which most matter for recipients and their family carers. We distinguish five aspects of efficiency in our analyses at the PSSRU. Of these, no less than four are directly and greatly influenced by success in performing the tasks implicit in this vague phrase "field coordination"; what, we call "case management" in our comparison of our community care projects with other British practice and the American experiments for improving field I have studied. Because organisation at the field level has not been designed to achieve the performance of the core tasks of case management with the greatest effectiveness, we can hope to design better arrangements for doing so, and thereby have a substantial eeffect on the ability of services to maintain people in their own homes.

(4) Members, senior and middle managers do not have the information to formulate, implement and monitor policy on some key issues in the support of members of long-term groups: for instance, the precise circumstances of users; what resources they consume and with what effects for them and their families. Therefore the whole structure of accountability is weak in important ways. There are not the precise checks by a separate section of the agency or by outsiders on conformity to stand procedures set out in manuals which I have observed in some American agencies; though since conventional practice norms and the formal policies and procedures have not been evaluated by the only criteria which really count -- the progressive improvement in the efficiency with which outcomes for users and carers are achieved -- the absence of these checks may not in all circumstances by an unmitigated loss. What formal devices

for securing accountability exist tend to press towards conformity to procedures and allocative norms. Used clumsily, they can depress the morale of workers, who are ofte. ·ble to do a better job by not fo'lowing policies and procedures to the letter.

However, checking the conformity to policies and procedures can never be sufficient to secure the progressive improvement in the attainment of outcomes because ic leaves uncontrolled to many of the most vital influences on the quality of the service. I have studied with interest the way fellow professionals are used to assess the quality of service in America, and (as will become clear later in this paper) we have drawn on this experience in developing community care. However, a balanced approach to accountability requires that, as far as possible, people should be accountable for the ultimate outcomes of their work. I believe it is becoming quite inexpensive already for there to be some information about outcomes for all levels of aggregation within departments; and that it is technically and economically feasible to have detailed and statistically reliable information about the circumstances of recipients and the outcomes of support for members of the long-term care groups available for teams as background for periodic reviews.

The greater the pressure to justify costs greater than the average, the more important it is to be able to demonstrate the additional benefits achieved from the higher spending, and also to show how much more appropriate is the pattern of resources use than its perhaps more typical alternatives. The work of the Audit Commission will hopefully set in motion a process which, in the long run, will greatly increase the efficiency and effectiveness of service provision. However, a major obstacle to it doing so is that author-

ities will not be able to produce the evidence needed to show that high and unusual patterns of spending on innovative strategies are as efficient as their alternatives.

(5) Social care accounts for the largest inputs of real resources to members of the groups. Even when the central coordinating role is performed by other agencies, social care is over time the major consumer of resources. Indeed, the biggest input is from relatives. The implications are that

(a) the effectiveness of services for members of the long-term groups is more the responsibility of the social services department than of other agencies; and,

(b) since most of the care is basic, there is a wide range of resources which could undertake it without great training, so that the number of alternative sources for inputs could often be great.

So much for the argument about the importance of the long-term care groups and the degree to which the social care system now is adapted to achieving their efficient support. I shall now outline the design features of the community care approach and their rationale.

Features of the Community Care Approach

Each feature of the design was intended to contribute to the enhancement of efficiency. Among the features, four were the most essential.

(1) Authoritative and responsible long-term case management. Responsibility for effectively performing (or in some cases, ensuring the performance of)

the core tasks of case management was to be focused on the community care worker. They were to have case loads like those of staff working with vulnerable children. They had lower than typical case loads so as to enable them to make careful assessments, to work on the preservation, strengthening and indeed creation of inputs from family and others, and to match care plans more precisely to the circumstances of individuals. The workers were to be responsible for finding cases; screening out cases which did not meet the targeting criteria; assessing the precise circumstances of the person requesting specialist assistance as necessary; negotiating with informal carers and others to produce a care plan; arranging service; monitoring the quality of service and the success of the plan; and then amending it as necessary.

(a) This permits work to establish among those referring cases, an understanding of the circumstances in which users would most benefit from the approach and to spend time actively encouraging referrals.

(b) This allows an escape from the pressure which helps to cause cases to be assessed merely on their eligibility for one of a few packages of services of similar quantities and mix, rather than for the nature of their circumstances.

(c) This also permits an opportunity to negotiate with users and carers and to build around their inputs without imposing unfair or intolerable burdens, and to be resourceful in tapping or creating resources from outside the agency.

The workers maintain a continuity of responsibility for their cases. The

range and difficulty of these tasks is formidable. Therefore it was the intention to appoint trained social workers of considerable experience to the team. However, at least one authority has recruited more widely.

(2) Areas coterminous with those of other key agencies. It was intended to create a network based on exchange relationships with others, particularly district nurses and consultant geriatricians, and so to foster more effective cooperation. The command over a budget allowed the community care workers to participate more effectively in planning with other services, for instance in coping with the discharge of hospital patients.

(3) Targeting at high priority cases. The approach was aimed at those at high risk of needing long-term care in hospitals or homes in the near future; in practice, those with a probability of fifty percent or more of being sufficiently needy to enter residential or hospital care within one year.

(4) Budgets and costs information. Workers were provided with a list of the costs per unit of services provided by the department. The costs of social services department services that workers prescribed and any other expenditure they made on services from other organisations, firms or persons were to be charged against the budget. Workers were to have great discretion in using the budget. Field practices and procedures were to be adapted to enable the workers to act flexibly and resourcefully, the procedural changes being negotiated with the central controlling departments of the authority. No more than two-thirds of the cost of a place in residential care was to be spent on any one person without a review by the line manager, so creating an additional safeguard against the escalation of costs. This budget limit can be varied in the light of experience to reflect the relative priorities

attached by the authority to expanding the number of users managed by the community care teams and improving users' quality of life and care.

It was envisaged that the budget would be used to buy a wide range of inputs from many sources. This proved to be the case. How the money was spent reflected opportunities presented by the areas served by the teams.

The most important resource developed by deploying the budget proved to be helpers directly recruited by the community care workers. Some were paid expenses only. Most were paid more. The helpers were matched to users by a wide variety of criteria. Many developed relationships with clients which came to be seen by users as almost familial. The care they give seems to have many of the beneficial characteristics of informal care. The use of helpers providing almost informal care, has become a common feature of all community case projects. It is a development of great policy interest.

Speaking to the Social Services Conference at the end of September, the Secretary of State quoted the results of an academic review of research on informal care: " 'informal care seems to be an innate characteristic that can be stimulated and developed given the appropriate form of initiative and management' by support from organised services.... even in declining inner-city areas there was 'an innate ability to provide mutual support'." Community care projects are running successfully in a wide range of areas, including deprived inner-city neighbourhoods, and it is clear that they successfully mobilise the community's potential for informal support and allow informal supporters to perform some of the most important and difficult tasks in social care for those otherwise without it. These relationships depend on careful matching, introduction, and support. Therefore, the

success of their deployment as much reflected the style and intensity of the case management provided by the community care workers as the discretion conferred by holding a budget.

However, the budget was a catalyst which also encouraged other innovations. One example is the development of "mini day care" arrangements for four or five clients in the home of one of the helpers. This proved successful and inexpensive in providing social and rehabilitative care for persons who would have benefited less from traditional day care. The budget also financed the short stay of clients in helpers' homes after discharge from hospital. It was used to establish a luncheon club for residents of a sheltered housing unit. In innumerable other ways, it was used to fill gaps in service provision or to provide services which the agency and others could not undertake or undertake with comparable costs and benefits. Community care encourages its case managers to be as entrepreneurial in their response to area circumstances as to variations in user circumstances within areas, and the way teams used the budget clearly reflected differences between areas in opportunities and constraints; for example, forging strong patterns of cooperation with responsive geriatricians and other health personnel, contracting the recruitment of helpers to a lively voluntary organisation, and adjusting the mix of paid and volunteer helpers to the circumstances of local populations.

(5) Policies, records and accountability. Workers were to be provided with a framework of objectives and policies: for instance, the exhortation that clients and informal carers should be involved in the negotiation of the care plan. The new style of work based on intensive case management and command over the budget made necessary new procedures. A manual of policies and

procedures was produced for workers and others.

Important among the procedures were those creating an information system. This provides data for both workers and management. Routine analyses of the data base include description of client circumstances at assessment, objectives and resources committed by the care plan. Regular and event-triggered reviews of the care plan are used tc describe key performance and control issues for each worker team and are: notably targeting, unit costs of clients in similar circumstances, and case loads. The results have been regularly discussed in authority-wide meetings of all the workers and their managers. This has helped to generate a more collegiate, peer-orientated sytle in the development of policy and the planning of resources, and partially replaced control by close supervision and the regulation and scrutiny of means by the review of performance in achieving the ultimate goals of providing good and efficient service to recipients, and conformity to a few key policies of direct importance to priorities and efficiency.

Accountability requires a balance between the auditing of structural factors (like organisation and procedures or levels of resources), processes (like the adherence to norms of good practice) and outcomes. Most authorities focus on the first and in some cases are beginning to tackle the second. It was intended that the community care approach should embody review by peers, other community care workers. The aims were to ensure basic standards of practice and performance, achieve an acceptable degree of consistency between teams, disseminate good practice, and help to maintain the integrity of the information system and to identify and articulate issues of general policy concern. Peer review has been the most difficult of the ideas in the

approach to implement. It is still far short of the detailed review of the performance of teams, even what the Americans call "paper' reviews, far less detailed reviews which include "hands-on" assessment with home visits in the assessment of practice for samples of cases. It is important that any attempts to develop peer review should be made at a speed and in a way which maintains the commitment and goodwill of all staff.

The community care projects have done as much to lay the foundations for auditing outcomes as process. Although the information system in itself only measures outcomes crudely, it collects the initial circumstances of users in some detail. The authorities and workers have had no difficulty in accepting our research evaluation and this research has collected the most elaborate information about outcomes for users and carers of any we know about. The research tools we have developed could be used for periodic audits of outcomes. Other work in the unit is developing such tools for other long-term care groups.

RESULTS

Several of the implementations are being fully evaluated, clients in an experimental group being compared with persons from a comparison group receiving standard provision and matched by a wide range of relevant criteria. The evaluation takes into account a wide range of non-financial benefits and costs to various parties. Examples of the former are recipients' ratings of various aspects of their lives, and aspects of the strain imposed on family carers. Both resource costs and cash disbursements are described in some detail. However, only one of the set of field experiments has been fully evaluated so far. The main features are:

(1) A halving of the probability of entering institutions for long-term care during the first year, and a lower probability of being admitted at all points in time over the subsequent three years. Of course, community care clients admitted indefinitely to hospitals or homes were more deteriorated. The research done at the Unit and elsewhere during the last few years suggests that the most dependent fifth of persons in residential care cost at least 20 percent more than the least dependent. So community care affects the tasks facing other services and their needs for resources.

(2) On average, an improvement in recipients' statements about a dozen or so aspects of the quality of their lives and in the quality of care, as rated by a social work assessor using a score of criteria, during the first year.

(3) A reduction in the sense of strain on informal (usually family) carers as indicated by their self-rated perception of the consequences of care for areas of their life.

(4) A halving of the probability of death over the first year. This effect was not anticipated. However, it is routinely hypothesised in the American experiments which are the nearest in the international literature to the community care projects. Why it occurred seems clear from the evidence we have about policy and practice and how this had an impact on clients of different characteristics. In particular, it was associated with the reduction in the probability of admission to institutions. It remains to be seen whether it will be a regular and enduring benefit of the community care approach.

(5) Reduction in cost over the first year to the social services department without an increase in costs to the NHS. This was in spite of the increased

length of survival. However, community care increased the costs due to admissions to day beds and acute beds for short stays as much as it reduced the costs due to admission to long-stay beds. So social care replaced long-term hospital care for some of the very dependent.

(6) Unchanged social opportunity costs over the first year if account is taken of differences in average survival.

(7) The community care approach was markedly more cost-effective for some groups.

● One such group was persons who were extremely dependent, suffering both physical and mental frailty and receiving considerable informal support. Our statistical modelling suggested that just to maintain their quality of life and morale as we measured them cost the social services department £1,140 in 1976 prices, using the standard provision received by the control group. However, the cost advantage in using community care was even greater when the quality of life of users was improved. It cost only £363 using community care. To achieve a 30 percent increase in the score on our indicator of morale and a 60 percent increase on our measure of quality of care cost £2,617 using standard services but only £1,202 using community care. So, using community care, these great improvements were achieved at much the same cost to the social services department as just maintaining the quality of care using standard provision.

● A second group was the relatively isolated elderly with only a moderate degree of dependency and suffering from a minor psychiatric disorder. Again, the cost advantage of community care is greater the higher is the level of improvement in users' quality of care.

(8) Community care found itself attracting some types of cases to whose needs the social services department had been unable to respond as effectively in the past: groups like the severely mentally impaired and those with minor psychiatric disorders.

(9) Service staff have seen the benefits of community care, and have increasingly supported it. Community care clearly improved the morale of community care workers themselves. After early fears about its effects on their own services, almost all other senior staff came not just to accept but to support it. This is what should be expected. Sensitively introduced and well run, community care helps everyone to do their jobs better.

CONCLUSIONS

American case management for the elderly is highly variable. Some demonstration projects have clearly improved the efficiency of care. Hopefully, some of the most important features of the best projects will survive their demonstration status to provide models for widespread emulation. The PSSRU community care approach has clear similarities with some of the American projects, particularly those where: (1) case managers have small caseloads and the entire range of the tasks of case management are performed by the same person or team; (2) case managers work closely with informal carers, clients and others combining counselling and other case work activities with brokerage; (3) services are carefully targeted at those at high risk of admission to institutions for long-term care; and, (4) devices like budget caps are applied to spending on a wide range of services. The PSSRU community

care approach clearly has lessons to learn from these American projects. The results of the first experiment suggest that its arrangements and style of case management might also be of interest in the development of American ideas.

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