

routine data against the better prognostic estimations and greater costs of disease specific physiological data.²⁷ Until more is known about costs, benefits, and valid methods it will be advisable to proceed with caution, building up information about prognostic groupings condition by condition and using empirical data from medical audit systems and outcomes research to validate them.

While this is taking place the conclusion reached in the United States, notwithstanding the sums already spent on outcomes research there, is that for the time being risk adjusted outcomes data are best used for quality management by hospitals themselves, flagging up areas for internal investigation. Publication of crude mortality figures inadequately adjusted for risk would be counter productive if it resulted here, as it did in the United States, in the most egregious rates being found at a hospice for terminally ill patients somewhere in the West.²⁸

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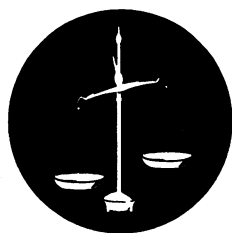
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Equity in the NHS

Equity in community care

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This is the fourth of a series of five articles

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The implementation of the NHS and Community Care Act 1990 made local authority social services departments responsible for the organisation and funding of support and care in the community. This development took effect at the same time as a blurring of the boundaries between health and social care. One consequence is that the relevance of equity (a guiding principle of the 1946 National Health Service Act, but relatively lacking from the 1948 National Assistance Act, the foundation of many social services) has come to be more keenly appreciated within personal social services. Equity questions arise in community care over the distribution of public resources between different client groups, income groups, generations, and localities. Moreover, no mechanisms exist to monitor the trends that emerge from different ways that people get access to care. Yet there is a risk that substantial divisive consequences may occur, particularly between generations.

The implementation of the 1990 National Health Service and Community Care Act on 1 April 1993 made local authority social services departments responsible for organising and funding support and care in the community to "enable people affected by ageing or disability to live as independently as possible."¹ Both

the concept of community care and responsibility for its organisation have been notoriously difficult to pin down. For example, a study by the Department of Health and Social Security in 1981 noted the conflicting interpretations of community care by health and social services authorities.² For the NHS, community care usually referred to care provided outside the health service, including local authority residential care. For social services departments it referred principally to non-residential care. The recognition in the 1990 legislation that in practice "people frequently need both social care and health care" is an important acknowledgment of the complexity of this policy area and of evolving distinctions between health and social care responsibilities.

The 1990 legislation was not concerned with the other major users of social services—namely, children and their families. These were the focus of the Children Act 1989, which set out the principles underpinning a new philosophy of partnership between parents and the statutory authorities in the care and protection of children. Unlike the Community Care Act, the Children Act did not, however, introduce a new system for assessment or for funding child care. None the less, local authority social services departments are currently implementing two major pieces of legislation focused on different client groups. Each may have substantial

resource and practice implications for the implementation of the other.

Philosophical framework of personal social services

In contrast to the central principles of equity and universalism embodied in the National Health Service Act 1946, the National Assistance Act 1948 created a selective framework for assistance, which was essentially targeted at specific categories of people for whom familial or private provision could not be made. Part III of the act gave local authorities the duty to provide care and attention for those people for whom such care was otherwise unavailable—that is, it provided the legislative base for the public provision of residential and domiciliary care. Part IV introduced the registration and inspection of private and voluntary homes for older people and people with disabilities.

Recently the boundary between health and social services has become blurred, particularly in the provision of residential and nursing care. With a reduction in the provision of (free) continuing care beds within the NHS, there has been increased reliance on means tested nursing care provided or purchased by local authority social services departments. An integral part of the community care reforms was the passing of financial responsibility for funding long term care to local authorities. This has had two major effects. Firstly, the NHS and the social security system have been replaced as the principal funders of residential and nursing home care. Secondly, because of the use of a means test, financial liability has been transferred from public authorities to individuals and their families.³ One consequence is that the importance of equity has come to be more keenly appreciated in personal social services. In particular, questions about equity have been identified in the distribution of public resources between different client groups, income groups, localities, and generations.

In this paper we explore two issues which have emerged from this process—namely, access to care and the funding of care, both public and private. In theory these are separate issues, but in practice they are inextricably linked. Moreover, the importance of both is apparent in the relations and transfers between generations, most obviously between users and carers. These are early days in the implementation of the community care reforms, and substantial diversification of the independent sector into domiciliary and day care services has not yet occurred. In consequence, this paper focuses largely on issues of access and funding for residential and nursing home care (table), but these issues are also relevant to domiciliary and day care services.

Access and funding

One of the principal objectives set out in the white paper *Caring for People* which preceded the 1990 act was to “encourage the targeting of home based services on those people whose need for them is greatest.”⁴ To this end care management was seen as the “cornerstone” of the organisation of the new system. Fundamental to care management was the development of, on the one

Social security route into residential care

Possible benefits for a single person aged < 65 (Updated from Wistow and Henwood⁵)

	£ Per week
Income support	45.70
Higher pension premium	24.70
Residential care allowance	48.00
Attendance allowance (higher rate)	45.70
Severe disability premium	34.30
<hr/>	
Total weekly benefit	198.40

hand, eligibility criteria which describe the social care needs which people must have in order to qualify and, on the other, of financial criteria by which to assess individuals' ability to pay some or all of the costs of care. Prospective service users now have two sets of hurdles to overcome. A person can no longer exercise his or her wish to enter residential or nursing home care on the basis of a means test alone; need must also be established. It might be argued, therefore, that people under the new system are relatively disadvantaged compared with those who entered care under the previous system. Moreover, while the assessment of the ability to pay was intended to be independent of the assessment of need, in practice the two seem to have become conflated.

In the new world of community care five groups of service users are distinguishable. First are “the relatively poor,” who are subject to a care test and a means test in order to receive public financial support to pay for their care; second are “the relatively affluent,” who can afford to pay for themselves at the level of publicly provided care—that is, about £200 per week; third are “the affluent,” people who can afford care at a significantly higher level than public care; fourth are people who have preserved rights to public support (although this may be less than the fees charged)—that is, people who entered care and were receiving income support on 31 March 1993 or who were paying for themselves at that date but their savings have subsequently fallen below £8000; and fifth are the people who are not subject to a care and means test administered by the social services department but who can accumulate enough public benefits to be able to pay for care at the lower end of the market—the “social security route” to paying for care (box).

The community care reforms reflect the government's preoccupation with the distribution of public sector resources in the widest sense. Thus, they were intended to “secure better value for taxpayers' money.”⁴ However, they were not concerned with establishing a care test for the relatively affluent. Such people have always been, and remain, outside the needs led assessment process. Insofar as the position of the relatively affluent has remained unchanged and the position of the relatively poor has worsened inequity has increased.

Nevertheless, there are grounds for challenging the assumption that the position of the relatively affluent will remain untouched by the community care reforms. Although people may initially be able to pay for their care, some will exhaust their funds, either because they stay longer than expected or because charges rise more steeply than expected. This phenomenon, known as “spend down,” will mean that the once relatively affluent who entered care after 1 April 1993 will need to be assessed by the social services department before they can receive public money to pay for their care.

Furthermore, as the largest purchaser of care

Residential care and nursing home places in England at 31 March 1981, 1986, and 1991

	1981	1986	1991	Change 1981-91
Residential care homes:	191 100	244 200	289 900	98 900
Local authority	114 900	115 600	97 900	-17 000
Voluntary	36 900	36 000	36 700	-200
Private	39 300	92 600	155 300	116 000
Nursing homes	18 200*	41 600	109 000	90 800

*1982. Adapted from third report of House of Commons Health Committee, 1993.

services, the local authority social services department will play an important part in shaping the market. There are early indications that some independent providers of care services wish to have substantial contractual relations with social services departments to secure stability of income in an uncertain market. The use of block contracts may reduce substantially the availability of residential places to self funding individuals. Moreover, such customers may also find themselves subject to an assessment process which mirrors that of the local authority, or they may be referred for assessment to the local authority. The extent to which the local authority will be able to influence the market varies greatly depending on local conditions of supply and demand and the ideological stance adopted towards the independent sector. In consequence, the use of needs assessment, or re-direction of potential self funding customers, is also likely to vary from place to place, raising important questions of territorial justice.

So far we have considered those individuals who have enough personal funds to afford average residential or nursing home fees. But some people can buy care at prices significantly above the rates current in the public sector and a group of providers is willing to meet this demand. Even these groups are unlikely to remain untouched by the community care reforms. Indeed, the changes provide perverse incentives for some providers to bypass the new system completely by inflating their charges to a level which puts them beyond the reach of care managers. The effect of such a polarisation of the market may well create an expensive and less regulated sector within the care industry.

Resource allocation

We have argued that questions of access and funding are inextricably linked, but a more detailed consideration of public funding raises a number of specific issues. We shall deal with two in particular.

Firstly, the distribution formula for the special transitional grant to local authorities was intended to be "transparent, adequate and fair." The grant is the finance transferred by central government to local authorities to fund people who need care. Before April 1993 part of this money was included in the social security budget allocation (see article by Judge and Mays in this series⁶). In constructing a formula for allocating the special transitional grant the government was faced with the problem of having insufficient data on where residents had lived before entering care. In consequence the formula is partly based on the distribution of residential and nursing home places and partly on standard spending assessments for personal social services for each local authority. This approach was described by the House of Commons health committee as "a compromise," and it has had the effect of reinforcing current patterns of provision. Since there are considerable differences in the level of residential and nursing home provision across Britain, with an overconcentration along the south coast and in other retirement areas, the formula reinforces territorial inequities as the price for preventing "unnecessary turbulence" among independent sector providers.³

Furthermore, the health committee received evidence that, in the short term at least, the formula is unlikely to promote community alternatives to residential care. For example, the Audit Commission confirmed that health authorities might be unwilling to see people placed in the community because of the extra demands this might place on the community nursing service. The requirement that 85% of the funds transferred from the Department of Social Security should be

spent in the independent sector has raised fears that this will serve to strengthen residential and nursing home care, the largest part of current independent provision, rather than promote the development of community based alternatives. This introduces a further dimension to the equity debate—namely, that the choices which the legislation was intended to promote will vary from place to place. Some people will be able to construct care packages from a full range of home based and residential based services, but others will have a much more limited menu to choose from. As the health committee concluded, the requirement to spend 85% of the transferred funds on independent sector provision may "impede some local authorities from implementing good local care plans."⁷ There will, in short, be inequity in the amount of choice available to people who need care.

SOCIAL SECURITY ROUTE TO RESIDENTIAL CARE

Secondly, inequity arises in the continued existence of a route into residential and nursing home care funded by social security payments. It has recently emerged that it remains possible for some individuals to accumulate enough weekly benefits to bypass a local authority assessment and to buy care at the lower end of the market (box).⁵ This raises important questions both about the failure of the legislation to meet fully its objectives and about the relative equity between different categories of residents in independent residential and nursing homes.

INHERITANCE AND INEQUITY BETWEEN GENERATIONS

The community care reforms have emphasised the importance of carers (mainly other family members). But not all people needing care have families, and even some of those who do will not have carers. Current policy does not directly address this basic difference in people's family circumstances. The white paper which preceded the community care reforms observed that "the government recognises that demographic trends will have implications for the future availability of carers." However, it failed to explore what these implications might be; indeed, the reforms continue to place the family at the centre of the care network. The implicit assumption that there will continue to be a supply of carers is open to challenge, not just because of social and demographic factors, but also because of the dysfunctional and contradictory consequences of the policy itself. The community care legislation may well influence the willingness and capacity of people to assume the role of carer. More specifically, the reforms change the incentive structure of people to care, seen most clearly in the issue of inheritance.

The much feared burden from the "rising tide" of old age⁷ has to a significant extent been stemmed by individuals realising their capital assets—usually a house—to pay for care in old age, and this is likely to become increasingly widespread.⁸ The costs of caring have been well documented, as have the motivations for caring,⁹ and it would be naïve to assume that the removal of the prospect of inheritance will have no effect on future generations' willingness to bear the expense and take on the responsibility of caring for dependent relatives. Having to sell a house to pay for care in old age might also be seen as contradicting the government's own aspiration that widespread owner occupation would prepare the way for "wealth cascading through the generations." Some of those individuals who might have expected to benefit from inheriting from elderly relatives will not do so, and the basis of solidarity between generations may be undermined.

Furthermore, those approaching old age may be more cautious about subsidising younger generations, given the uncertainty of paying for their own care in

later years. The widespread desire among older people to avoid being a burden on younger relatives may be satisfied only by reducing or withdrawing inter-generational financial transfers.

The community care reforms should not be seen in isolation from social and health policies in other areas. For example, current developments in social policy (such as the Child Support Agency) are placing an increased emphasis on the rights and responsibilities of individuals in the context of a rising divorce rate and family reformation. For some individuals the impact of such policies is likely to combine with the effects of reduced intergenerational transfers of wealth from old to young and indeed with increased financial liability for older dependent relatives. Quantification of this is impossible at this stage, but policy development must take account of these wider issues if the family is to remain a principal focus for social policy intervention. In summary, in the short term we run the risk, by default, of introducing inequities between generations in terms of their likelihood of acquiring capital assets and in the longer term of compounding disadvantage within and between generations.

Need for monitoring

Given the high stakes it is important to monitor the impact of the community care reforms. Present arrangements for monitoring have not advanced much beyond documenting the progress made in implement-

ing the key policy tasks, although bodies such as the select committee on health have given some useful pointers about how the distributional impact of community care funding can also be charted. However, the monitoring of these wider inequities between and within generations—which are potentially much more fundamental—is so far conspicuous by its absence. In particular, the documentation of individual and organisational responses to perceived inequities between individuals, between different localities, and between generations is not part of the current policy evaluation agenda. This omission exposes us to the risk of substantial unintended, and possibly deeply divisive, consequences.

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Statistics Notes

Regression towards the mean

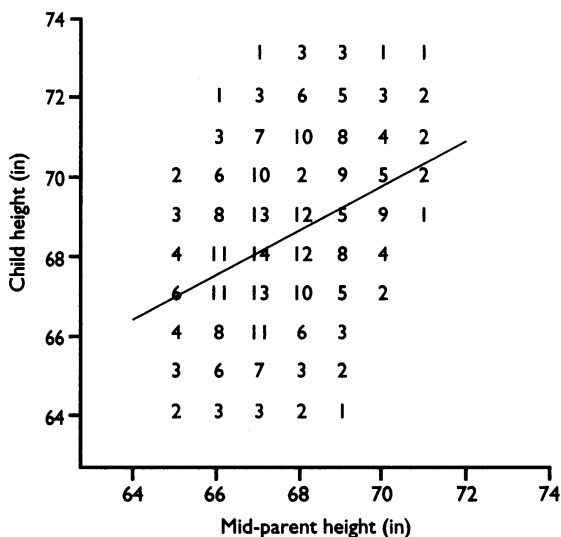
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This is the second in a series of occasional notes on medical statistics.

The statistical term "regression," from a Latin root meaning "going back," was first used by Francis Galton in his paper "Regression towards Mediocrity in Hereditary Stature."¹ Galton related the heights of children to the average height of their parents, which he called the mid-parent height (figure). Children and parents had the same mean height of 68.2 inches. The ranges differed, however, because the mid-parent height was an average of two observations and thus had its range reduced. Now, consider those parents with a mid-height between 70 and 71 inches. The mean height of their children was 69.5 inches, which was closer to the mean height of all children than the mean height of their parents was to the mean height of all parents. Galton called this phenomenon "regression towards mediocrity"; we now call it "regression towards the mean." The same thing happens if we start with the children. For the children with height between 70 and 71 inches, the mean height of their parents was 69.0 inches. This is a statistical, not a genetic phenomenon.

If we take each group of mid-parents by height and calculate the mean height of their children, these means will lie close to a straight line. This line came to be called the regression line, and hence the process of fitting such lines became known as "regression."

In mathematical terms, if variables X and Y have standard deviations s_X and s_Y , and correlation r , the slope of the familiar least squares regression line can be written rs_Y/s_X . Thus a change of one standard deviation in X is associated with a change of r standard deviations in Y . Unless X and Y are exactly linearly related, so that all the points lie along a straight line, r is less



Galton's original data showing the relation between the heights of children and their parents, with regression line¹

than 1. For a given value of X the predicted value of Y is always fewer standard deviations from its mean than is X from its mean. Regression towards the mean occurs unless $r=1$, perfect correlation, so it always occurs in practice. We give some examples in a subsequent note.

1 Galton F. Regression towards mediocrity in hereditary stature. *Journal of the Anthropological Institute* 1886;15:246-63.

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