stimuli in health⁵³ and disease.⁵⁴ Meanwhile, we should aim at providing patients with as clear an understanding of their disease as possible and using the drugs available with circumspection, remembering that treatment is likely to be lifelong. Decisions should be made with, rather than for, the patient, making it possible to share disappointment at failure and pleasure when treatment is effective.

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Care for the infirm elderly

A widening gap between the poor and the better off

The 1990s seem likely to be a worrying decade for the elderly in Britain—all of whom are uneasily aware that at some time they may need residential care. The publication of the white paper *Caring for People* on 14 November 1989¹ put an end to the speculation about whether and how the government would respond to the Griffiths report on community care.² It also completed another part of the jigsaw of radical reorganisation of health and social services provision that began with *Promoting Better Health*³ and *Working for Patients*.⁴ The latest white paper has provoked less controversy than its predecessors, but it falls short of the Griffiths report's recommendations, and it spells out new arrangements for financing and providing services for elderly people that require close analysis.

The white paper cites the 100-fold increase in public subsidy of residential and nursing home care over the past 10 years as evidence of the government's investment in community care. But it also acknowledges the criticism by the Audit Commission⁵ and Griffiths that existing social security policies have created "perverse incentives" towards institutional care. In the new proposals a unified budget covering the costs of "social care" will be introduced and managed by local authorities. It will be available for either domiciliary or residential care according to individual need. People in residential care will be entitled to claim income support or housing benefit on a means tested basis, as they would in their own homes, but they will be required to pay most of that income to the local authority that is funding their care. Social services departments will be given the responsibility for assessing the social care needs of dependent people and for planning and purchasing packages of care. They will be expected to collaborate closely with health and other agencies, to set up a system of quality control, and to reduce the part they play as direct providers. The government expects local authorities to make "maximum use" of independent sector

homes and will discourage (through financial penalties) the continued use of part III accommodation.

The creation of a climate for innovation and growth in domiciliary care will be welcomed, though it is disappointing that the community care budget will not be "ring fenced," as Griffiths recommended. Nor will the new provisions include the long stay hospital sector (even for the elderly)—which would have increased flexibility and helped to avoid the new gulf between hospital and social care which the simplistic distinction in the white paper may encourage.⁶ The greatest anxiety, however, must be over the level of funding—particularly in the transitional stage—which Griffiths argued so cogently would be the key to the success of the whole scheme.

Laing and Buisson have recently shown just how far costs in private residential and nursing home care have outstripped even the massive growth in public subsidy over the past few years. Two fifths of elderly residents finance their own care completely, but the remaining three fifths are funded by social security, health, or local authorities.⁷ Only 3% of private homes currently charge fees that are at or below the income support level; the average fees for shared (that is, the cheapest) rooms are £30-40 per week above this level. This financial gap bars entry to Department of Social Security clients unless their families can find the money to top up the payments. With these gaps increasing there will inevitably be underfunding as social security money is diverted to the community care budget. Savings from the purchase of (possibly) cheaper domiciliary care packages will be offset by the higher costs of placing people in residential or nursing home care.

The reality may well be that local authorities will have to choose between more care for fewer people or less care for more. Hence the effect of the white paper may be to widen the distinction between the poor and the better off in old age. The elderly poor, who make up half the population in residential care, will have little choice between different homes: they will have to go into those homes with which the local authority can afford contracts. Few will have the option of a single room. Those at the other end of the social scale will have much wider choice in both domiciliary and residential care. Owner occupiers with limited income whose "social care" will be means tested will have a reasonable choice within the residential sector once they have sold their homes, but they seem likely to have cash flow problems with expensive domiciliary packages. As Laing and Buisson comment, many elderly people may be "asset rich," but they are often "income poor."⁷

The crucial question for many elderly people is: What happens when the money runs out? *Caring for People* addresses this issue in part. Residents of residential and nursing homes who are already receiving income support will continue to do so when the new funding structure comes into existence on 1 April 1991. Other residents, who are currently

financing their own care but who eventually spend down their capital to income support limits will also be entitled to public support, though they may have to move to cheaper homes. New residents entering residential care after April 1991 should not, in principle, run out of money because local authorities will have accepted financial responsibility for them. Nevertheless, they may find that if they or their families cannot top up their social security entitlements they will be forced into the poorest and cheapest accommodation.

Radical changes in financing residential care are likely to have a major impact on the way the care is organised and marketed. Reduced public subsidies may see the closure of some homes, economies made in staffing costs and amenities, and the growing dominance of commercial providers (such as brewers, hotel chains, and the leisure industry), which benefit from economies of scale. Local authority provision is likely to decline, and the cottage industry of family run homes will give way to more profit orientated care supplied by major corporations. While the physical facilities in homes may improve as a result of these changes, there may be as little sympathy for the elderly person running out of resources as there is for the hotel guest who cannot pay the bill. The new provisions for inspecting and monitoring residential care will be vital in protecting the interests of vulnerable elderly people who buy, or have bought for them, a package of services in the market place.

Mr Clarke will enjoy a wider measure of professional support for this white paper than has been his experience at the Department of Health, though there will again be anxiety at the flaws and oversimplification inherent in the broad sweeps of his brush. He must be given credit for placing the central responsibility on social services departments, but they will be taking on a very tall order with little time to deliver. Successful implementation will require exceptional good will and detailed collaboration over workload and budgets locally. If this is to succeed adequate funding will be absolutely crucial, particularly in the period of transition.

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