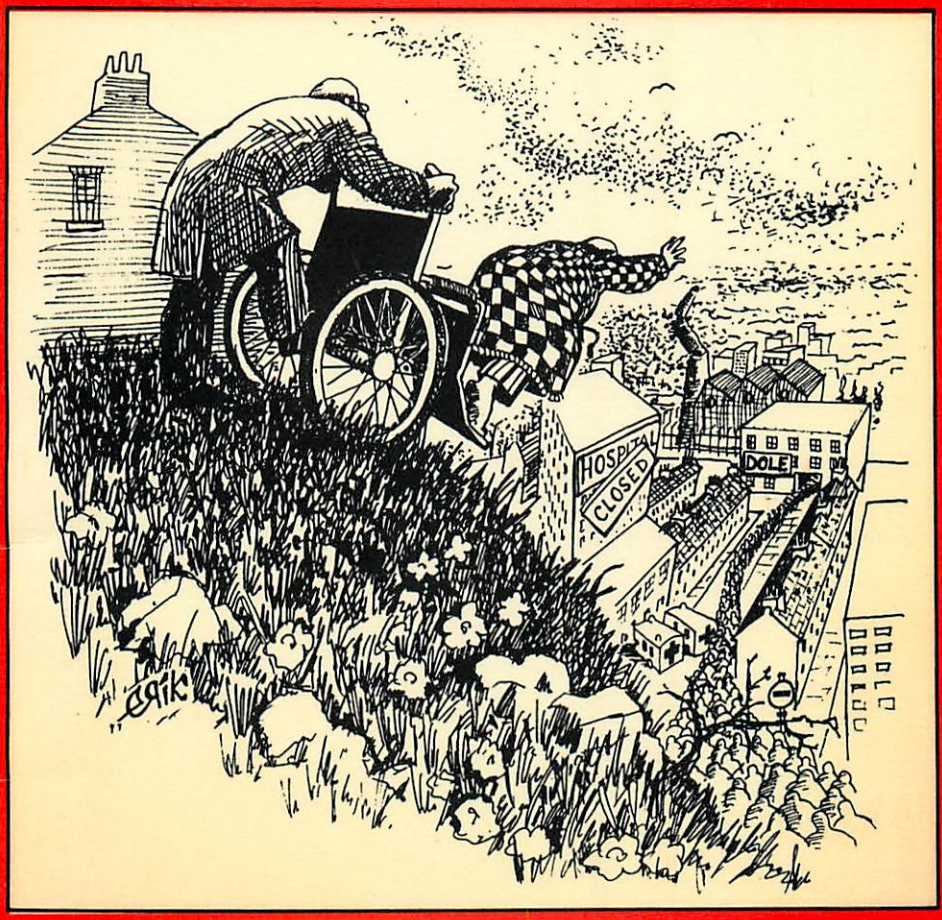
A reply to the Griffiths Report

Community Care: Agenda for Disaster



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Introduction

Since its publication in February 1988, Sir Roy Griffiths' report *Community Care: Agenda for Action* has received a surprisingly sympathetic response from opposition leaders, trade unions, health academics, local authorities and media commentators.

Some have seen the task as emphasising the "good" bits of the Report and urging their implementation – ignoring the fact that Sir Roy is emphatic in stating that the *whole* package of proposals must be taken together. Others, on apparently little detailed reading, have simply embraced the proposals en bloc and accepted the Report as a serious attempt to improve community care. Some have even read their own aspirations into the Report, despite the fact that Sir Roy begins and ends with very different views – such as the trade union press release which "generally welcomed" the report, praising what the author apparently believed were "proposals to move towards a needs-led service".

This reaction is astounding. The Griffiths Report certainly *does* contain what the Kings Fund Institute describes as 'the most far- reaching proposals on the subject for at least 20 years": but this is because it represents a blueprint for a fundamental attack on a major sector of the National Health Service, with huge and potentially disastrous implications for health workers and for the elderly patients who make by far the most use of community care services.

The Griffiths proposals can only be properly understood in the context of the consistent government policy since 1980 of reducing the share of

national wealth allocated to the NHS, and the secretive cabinet review which has been investigating new ways of containing or concealing the scale of the financial crisis now confronting the NHS, while maximising the role of the private sector.

Clearly any policy which would remove large numbers of costly patients from the free care they receive under the NHS, and oblige ever-increasing numbers of the elderly to pay for their own care from their own savings and resources will be seen as an attractive prospect by the government – particularly if it can be done in such a way as to land the blame for inadequate services onto local authorities.

Central to the Griffiths proposals, therefore are:

- Removing tens, later hundreds, of thousands of elderly patients and chronic sick from the NHS (thus effectively reducing much of the NHS to an acute service only);
- Placing them under means-tested services provided by local authorities under tight government scrutiny;
- Forcing local authorities to put every aspect of these services out for private tender to maximise the involvement of profit- making firms;
- Seeking new ways of tapping the life-savings and property assets of individual elderly patients to help underwrite the costs of their own care;
- Forcing local authorities – with restricted resources at their disposal – to carry the can for the consequences of central government policy;
- Bundling tens of thousands of health workers from one employer to another with scant regard to the implications for them or their patients and no serious discussion on adequate training;
- Establishing a new low-paid skivvying post of "community carer", possibly involving unemployed youth conscripted through the YTS scheme (and now adult unemployed drafted in under the controversial new ET scheme) on the threat of losing their benefit if they refuse;
- Longer-term plans to force today's working-age population to pay additional insurance premiums or make other provision to finance their own care when they become elderly;
- Continuing to lumber over 1.25 million mainly women "informal carers" with the primary responsibility of looking after sick adult relatives in the home.

This pamphlet is the first serious critique of these, the core proposals of the Griffiths Report, and the first firm argument that it should be rejected in its entirety as a major threat to health services, patients, relatives and health workers alike.

Included in these pages are a , detailed analysis of the proposals and

the problems they raise in each case for * Patients and relatives; * Local authorities; * Health workers and the unemployed; and the implications of privatisation in this sensitive field of health care. These are followed by a "readers' guide", a summary and commentary on the main controversial points of the Griffiths Report.

Some have speculated that the low-key launch of the Report and the subsequent lack of general publicity may indicate that the recommendations will either be dumped or placed on the back burner. We see this as an extremely dangerous assumption which totally ignores the substantial authority which Sir Roy commands in and around Downing Street.

Our message to health and local government unions, the wider trade union movement, councillors and MPs is that it is still not too late to fight the Griffiths proposals: but there is no time to be lost if the ground already surrendered is to be recaptured and the dangers spelled out to the wider public.

The pamphlet should also be seen as a contribution to the debate which should be taking place in the labour movement, but which appears to have sunk without trace – on what kind of community care service we would like to see, who should run it, and how it would be funded.

JRL and GCM
September 1, 1988.

Patients and relatives

The elderly are the largest single user-group of hospital services, occupying over half of all hospital beds and accounting in 1985 for 45% of all non-maternity NHS expenditure. Most NHS patients classified as "psychiatric" (40% of all occupied NHS beds) are also elderly. Griffiths himself points out the extent to which the actual numbers of elderly are continuing to rise:

"Between 1986 and 1996 the number of people aged over 85, who are most dependent on support from others, will grow by nearly 50 per cent. Thus the number of people of this age has risen from 459,000 in 1976 to 603,000 in 1986 and will rise to 894,000 by the year 1996." (p10)

Official projections point to a population including 4 million people aged over 75 by 1991. There is clearly a major financial incentive for ministers to find ways to exclude many of these elderly patients from NHS

care. On average the NHS spends *three times* as much on each person in the 65-75 age group (£420 per head) compared to those of school or working age, and over seven times as much (almost £1,000 per head) on each person over 75.

Yet the NHS even now cares for only a small proportion of the chronic sick. An estimated 1.25 million mainly women carers are responsible for supporting adult dependents in the home – and the burden is increasing as NHS and local government services are cut back. Over 25,000 hospital beds for the elderly and mentally ill have closed since 1976 – but only 9,000 day care places have been established in their stead, despite a steady increase in numbers of elderly people.

Numbers in homes for the elderly outside the NHS have almost doubled from 130,000 in 1974 to 250,000 today, with the largest increase being in the private sector. At least 50% and possibly as many as 65% of the patients in private homes are paying their own fees from their life savings or the sale of their own homes. In local authority homes for the elderly 36% of the costs are "clawed back" from residents through means-testing, forcing elderly people or their relatives to pay for services. The sums of money involved are already huge – around £1 billion a year – eight times the annual revenue from prescription charges, and massively outstripping the comparatively small amounts raised by "income generation" and other schemes floated by health authorities.

The new Griffiths proposals would boost this involuntary contribution still further. By denying the long-stay elderly the possibility of free NHS care, and placing them automatically in the means-tested social services sector, three birds can be killed with one stone:

■ NHS spending can be substantially reduced by unloading vast numbers of patients, but without the high-profile publicity attached to cuts in the acute sector;

■ The patients switched to social service care will be subjected to means-testing, which can open up their savings accounts and property assets to the grasping hands of the government. The aim of minimising government spending in this field can only be achieved by *maximising* the financial liabilities imposed on each individual.

■ Those patients or relatives who seek to avoid this trap can only do so by seeking or providing more unpaid care "at home" – at no cost to the Exchequer. Already one recent survey has shown that 83% of carers receive no support whatever from the state: this is one area where even larger financial savings – at the expense of domestic misery for thousands of women carers – can be hoped for under Sir Roy's proposals.

In exchange for the new charges to which they will be subjected, elder-

ly patients will receive not a service geared to need, but one still confined by overall cash limits: Sir Roy is determined that services must be "tailored to available resources". His suggestion for "vouchers or credits for particular levels of community care, allowing individuals to spend them on particular forms of community care and to choose between particular suppliers if they wish," clearly suggests a pricing mechanism designed to extract additional cash and put the whole service on a commercial footing.

How many elderly people want such a service? It will come as a shock to many that the great dream of a "property-owning democracy" should be so rudely interrupted with plans for a system of care in old age which would oblige vast numbers of people to plunder their own savings and sell their own homes to pay newly-imposed charges.

There must be no mistake: the whole plan involves forcing more people to pay. A whole chunk of Griffiths' proposals centre on ensuring that "those able to pay the full economic cost of community care should be expected to do so," (6.33) explicitly referring to use of the means-test (6.39) and charges to the individual for residential care (6.43).

Sir Roy also follows the path controversially opened up by Health Minister Edwina Currie, who suggested not only that people forego foreign holidays to finance private health care but that elderly patients might take loans or mortgages for private treatment using their houses as security. We can hear the till bells ringing and the knife sharpening as Griffiths suggests:

"Many of the elderly have higher incomes and levels of savings than in the past .... This growth of individually held resources could provide a contribution to meeting community care needs...." (6.61)

However the Report is not just a threat to today's elderly: it also looks at much wider-reaching ideas for extracting payment from today's workforce to finance their own care in old age, through various "initiatives" which heavily overlap the more extreme suggestions of the right wing Think Tanks, especially the proposal for:

"social/health maintenance organisations, insurance/tax incentives, not simply for the individual but for the individual in a family context."

Entirely missing from the Report is any concept of seeking the views of patients – present or future. Yet the annual report of the Association of Community Health Councils of England and Wales points out that community services and community care already generate more complaints to CHCs than the hospital sector, and that complaints are increasing as budgets are cut.

Sir Roy shows no consideration for how elderly and disabled people

may feel about their domiciliary services being provided by potentially disgruntled unemployed youth and adults unwillingly drafted in as low-paid "community carers" under threat of the loss of their benefits: it may be cheap, but is this really the kind of service Sir Roy would like to receive in *his* home in his old age? Why should he feel that less wealthy people should be forced to put up with a cheap and nasty service while the wealthy, given "choice" always choose to spend more on their personal comfort?

Equally controversial is the question of private firms carrying out domiciliary services: in view of the difficulties experienced even by top managers in major hospitals in trying to enforce contractual standards on incompetent private cleaning and other companies, what chance would individual elderly patients have of pursuing complaints and ensuring they receive the service to which they were entitled? Sir Roy's proposals make no provision for inspecting the standards of such work, and make no reference to the miserable experiences of privatisation in our hospitals.

Implications for health workers

One of the major implications of the Griffiths Report which the pundits seem to have avoided like the plague is the impact that the proposals would have on the front-line workers expected to deliver Sir Roy's twisted version of community care.

Nobody, except perhaps a supermarket entrepreneur, would expect to be able simply to switch a large number of workers from one type of care and authority to another without examining the implications in any detail. Griffiths skips over htis in a few brief sentences – as if it were as easy as switching staff from canned goods to the biscuit counter in Sainsbury's. His discussion of the problems raised in the transfer of staff is restricted to throwaway lines such as:

"It is inexcusable for general progress to be halted because of this issue." (7.13)

This approach seems almost deliberately designed to antagonise the staff affected rather than convince them that they have a future after a Griffiths-style reorganisation.

The Report does refer to some possible transfer options, including secondment, transfers without redundancy but with retention of NHS superannuation scheme membership, and finally redundancy followed by engagement by the local authority.

It is of course quite possible that such a transfer of staff could pave the way for discrimination or victimisation against individual employees. Sir Roy is either blissfully unaware of this or completely uninterested, since he fails to outline any safeguards to prevent it happening or reassure staff.

The lack of any identifiable parallel between local authority and health authority grades and pay scales would enable local management to dabble in a bit of penny-pinching downgrading. Experience to date of the new nurse re-grading exercise has added weight to the fear that cash-conscious managers will use any excuse to claw back a few quid.

There has been some scepticism as to whether the Government would wish to implement Sir Roy's suggestions, since they appear to bolster the role of local government: however from the present government's point of view it would be a very shrewd move to transfer responsibility for community care to local authorities without adequate funding.

The rigid cash limits and brutal "market forces" under which local authorities would have to operate after the transfer of responsibility would be a cast-iron guarantee of conflict with the workforce, though central government would be able to wash its hands of the problems.

It is no accident that Sir Roy stresses repeatedly that care policy, and therefore employment policy, must be tailored to fit the resources made available by central government. Local government would be left to take the stick for the chaos which would result from the funding gap.

Griffiths does claim that he recognises the importance of retaining the skills of former NHS employees:

"It is important that the skills of staff formerly employed in long-stay hospitals are not lost as patients are discharged and responsibility for their care passes to another authority." (7.13)

That sounds a fine commitment on paper: but the problem is that the flaws in Sir Roy's version of community care would serve to accelerate rather than reverse the departure of experienced staff. The current situation in long-stay hospitals has had a bad enough effect on staff morale; but by creating a new barrage of uncertainties to surround those trying to provide community care in a low-paid, under-funded service, and by stressing the need for increased reliance on the private and voluntary sectors, Griffiths could have the dubious distinction of making this bad situation even worse.

It is common sense that any large-scale shift towards community care and any major change in working practices affecting so many staff would have to be backed up by a detailed staff training programme. Griffiths skips swiftly over this issue.

There are no detailed recommendations on how training and skills needs would be met, or where the funding for such a programme would come from. With Sir Roy's version of community care being entirely cash-limited, staff training does not just take a back seat – it is stuffed into the boot along with the other excess baggage!

The Report does make some brief references to increased "managerial skills" for professional social services staff. There is nothing wrong with that, of course: but it is implied that these staff would be office-based, while the bulk of the front- line care would be provided by so-called "community carers".

This new grade of workers was first advocated by the Audit Commission, but Sir Roy's interpretation of who they should be and what they should do is alarming to say the least:

"... a new multi-purpose auxiliary force to be given limited training and to give help of a practical nature in the field of community care." (Introduction, para 35)

Griffiths pulls no punches on the "community carer" issue. It's clear that in his view the provision of community care would hinge on an army of low-paid, under-trained, under-valued workers doing the dirty, manual jobs at the sharp end of the service.

Community carers would be seen as a simple extension of NHS domestics and local authority home helps. Both of these are seen almost exclusively as women's jobs, and community carers would follow the set pattern of undervaluing women's work, with all the built-in discrimination and exploitation that goes with it.

Just for good measure, Sir Roy also recommends that in his version of community care, YTS-style MSC schemes should play a significant part in dragooning in sufficient cheap labour:

"Major experiments should be initiated and should involve not only mature adults, but particularly school-leavers, YTS etc." (Introduction, para 35)

The low pay, lack of training and temporary nature of YTS schemes is no solution to the staffing needs of a genuine community care service; the proposals to use such measures exposes Griffiths' lack of real concern for community carers – or their clients. Elderly, disabled and otherwise vulnerable people in need of assistance could well under these proposals find themselves confronted in their own homes with "community care" provided by unwilling and disgruntled unemployed, drafted into the job on pain of loss of benefit: scarcely the kind of supportive and trusting relationship that a serious community care service would seek to ensure.

The obvious grounds for concern created by Sir Roy's Report last February are amplified further by the government's refusal to guarantee that the new "ET" employment training scheme will not be made compulsory for the long-term unemployed. The application of a ruthless "workfare" policy would pose a further threat to standards of community care.

Once again the greatest pressure to undertake such work in community care would fall upon women among the unemployed. Is this the way to staff a caring service?

The threat of privatisation

Of course on the horizon throughout this process will be the constant threat of privatisation.

Griffiths makes it clear that in his view every aspect of community care should be subject to "competitive tenders or other means of testing the market." (Introduction para 24)

In fact the "competition" would not be equal, because the bias throughout the Report is towards the private sector, placing the onus on local government to prove that they had done sufficient to encourage private sector involvement.

The vultures of the private sector, whose abysmal track record in the NHS would have had them thrown out long ago from any self- respecting commercial concern, will be rubbing their claws in anticipation of picking up new lucrative contracts for community care.

Firms which have found the going tougher than they expected in hospitals, where staff complaints and NHS management monitoring have often forced them to make penalty payments or even terminate failed contracts, would relish the idea of contracts for domiciliary care in which they would be subject to virtually no monitoring or quality control.

We can safely predict that if such services are privatised, the catalogue of contractors' failures already experienced in the NHS and the rapid decline in cleaning standards and patient care that followed privatisation would swiftly be overtaken by countless thousands of smaller-scale, unpublicised disasters brought about by cheap-skate private contractors in the homes of elderly and diasabled patients.

The two main NHS domestic contractors, Mediclean and Exclusive, both part of major multinational corporations, would relish the chance

of moving in on Griffiths' version of community care. With the low pay and poor employment conditions of privatised services running alongside the threat of "workfare" conscription in the public sector, the outlook for workers as well as patients would be bleak indeed.

However it is not just the community carer grades which the private sector would seek to pick off. Griffiths is advocating that the *whole* community care operation be put up for grabs from top to bottom.

Homes, day centres, and the rest of the nuts and bolts of care would face the threat of a takeover by private firms. For the workers involved it would mean a loss of job security, lower wages, loss of pension and other employment conditions, and exposure to the dubious employment practices of the private sector.

A policy that threatens the existing workforce, and could result in a continual rapid turnover of low-paid staff in what should be a caring service, is a policy that also threatens the well-being and security of existing and future patients. Sir Roy has plainly not considered their views worth asking: still less has he attempted to imagine himself in the place of an elderly or disabled person dependent upon the services which he seems so keen to carve up.

Implications for local government

Those local authorities which have in any way welcomed the Griffiths Report could well soon find themselves repenting their enthusiasm. Some rested their case for more or less critical support to the Report on the apparent conflict between the role given to local government under the proposals and the Thatcher government's track record of restricting the powers and functions of local government.

However, Sir Roy is one of the closest advisors of the Thatcher cabinet: to imagine that he would formulate a report allocating increased responsibilities to local government if this really conflicted with government strategy is naive in the extreme. Why shouldn't the present government welcome a policy which enables them to make major cuts in NHS spending and leave a large gap in social service provision, while forcing local authorities to carry the can for all the deficiencies?

The Griffiths proposals are not really in contradiction to the battery of local government legislation imposed by the current government. Only the GLC and metropolitan councils have actually been abolished – while the remainder of the legislation has concentrated on restricting the powers (Local Government Acts) and revenue (ratecapping, the Poll

Tax) of local councils and obliging them to attack their workforce by putting services out to tender, while leaving them nominal responsibility for a wide range of under-funded services. Griffiths follows the same logic, proposing new laws to impose obligations on councils for which insufficient funds will be available – enabling the government to make major reductions in spending while local councils take the blame.

Even the "empire building" argument – that the Griffiths proposals give more scope for enlarging local government departments – falls a bit flat when Griffiths spells out the ways in which the sums of money that would be provided from central government would be rigorously monitored, "ring-fenced" and paid only after all relevant plans have been rubber-stamped by Whitehall. All the strings would be in the hands of central government, headed up by the new "Community Care" minister: the extended role for local government is as puppets, convenient to take the blame when things go publicly and embarrassingly wrong.

Labour-controlled authorities in particular are not likely to relish the obligation placed on them by Griffiths to maximise the privatisation of services, with the "onus in all cases ... on the social service authorities to show that the private sector is being fully stimulated and encouraged..."

Already the Association of Metropolitan Authorities has complained that registration of private residential homes costs them over £1,000 a time, yet they are allowed to charge a registration fee of only £570. The AMA also point out that social security money paid out for private residential care has rocketed by 40% to £700m a year in the past 18 months, creating a profitable boom for the private sector while the public sector languishes under ratecapping and cash limits.

To make matters worse, the same authorities could find themselves taking the stick for confrontations with health and local government unions over the ill-thought out transfer of NHS staff to radically different scales pay and working conditions, as well as the whole vexed issue of training, so nimbly side-stepped by Griffiths.

In addition, few with any recent experience of the way in which recent on local government Acts have taken shape would be anything but suspicious that the new legislation proposed by Griffiths could contain all kinds of further restrictions on councils and further intervention by central government.

The alternative approach

To oppose the Griffiths approach does not imply by any means a rejection of community care: it means a rejection of the "cash- limit" method of deciding health policies, and instead looking to measure the actual levels of need for community services and then provide adequate resources to meet that need.

Demand for community care is not by any definition of the word "infinite": it is required by a relatively small, if growing, section of society – the frail elderly, disabled, and chronic sick for whom hospitalisation is not required or counter- productive. These numbers can be measured – either by modern "sampling" or by old-fashioned head-count methods; and it is quite possible then to draw up plans for the various types of care and support that are necessary to enable these people to preserve the maximum independence consistent with their well- being and security.

Griffiths makes clear his contempt for actual figures and the detailed information needed for such a planning exercise: but if the services are not planned to meet the *whole* demand, and individuals are therefore to be faced with arbitrary exclusion and anomalies due to inadequate resources, what value is there in planning at all?

We must also reject the notion that all those over retirement age should be subjected to means-testing, with a large proportion forced to pay from their hard-earned savings for their own community care. Whether the service be run by the NHS or by local government it should follow the NHS principle of "free for all at time of use, funded through general taxation" (not by Poll Tax or charges). Those (like Sir Roy Griffiths) wealthy enough to be able to afford private care will no doubt still choose to do so: but there is no evidence that most elderly people, if they were really given a choice of adequate state provision, would choose to spend large sums of their own money on the uncertain advantages of a private residential home. The Griffiths proposals, far from creating "choice", actually *deprive* them of the choice of public sector care, serving only to frog-march more and more of the elderly into the private sector with or without their willing consent.

The sole merit of the Griffiths proposals is the suggestion that the resulting service should be run by a locally-elected and therefore democratically accountable body. However this in our view is an argument for elected local health authorities to replace the present quangos rather than for removing long-term care of the chronic sick from the NHS to local government.

The proper planning and development of community care services to provide long-overdue relief to 1.25 million "informal carers", and long-term care for hundreds of thousands more, also requires a commitment from central government to fund a proper professional rate of pay, and adequate training not only for the high-flying white-collar and management figures but also for the community carers themselves who must deliver the actual help to patients and clients on the front line of the service. Only this way can a loyal and experienced workforce be retained, and the correct relationship be established between carers and their elderly and disabled clients.

All notion of using conscripted labour from "training schemes" and dole queues should be immediately discarded, and attention focussed instead on proper conditions of work, staffing levels and NHS/social service training packages designed to attract a team of dedicated health workers to a vital job.

Conclusion

It has been suggested by some that critical support for the Griffiths recommendations from the workforce or from local government could be necessary to pave the way for later amendment of the nasty bits. Others, such as the academics of the Kings Fund Institute, have argued that the real danger is that Sir Roy's "radical" proposals could simply fall by the wayside because of "excessive paranoia about local government and a preoccupation with the NHS".

Few of these voices of "critical support" have objected in any detail or seriousness to the grave dangers embodied in the Griffiths proposals, spelled out in this pamphlet, which in our view massively outweigh Sir Roy's few tokenistic phrases which pretend a concern for community care.

Griffiths himself is adamant that his proposals come as a complete package. The idea that bits and pieces can be selected from the package, and the rest negotiated away flies in the face of every experience of the ways of the current government.

At London Health Emergency, with our base of support amongst health service trade union branches, we take the view that the Griffiths Report must be seen as a whole – and opposed as a whole. It certainly shouldn't be seen as a "pick and mix" stall where the worst bits can be ignored and only the positive bits selected.

Our opposition goes hand in hand with the view that in place of this

kind of business management-style approach, it is high time health and social services workers put forward *their* vision for care in the community, based on their own experience, and not shackled by the straitjacket of cash limits or market forces.

It's not too late to fight back: but time is running out!

The Griffiths Report on Community Care

A summary of the key points, with commentary.

Introductory summary

1. Griffiths insists (iii, 7) that he will not deal with levels of funding for community care services. Certainly the Report mentions no figures at all. However the presumption is that strict cash limits will continue to dictate the extent of services irrespective of levels of need. This is underlined by the fact that he also insists that services must be tailored to available resources (iv, 9). Later Griffiths goes on to argue that "What cannot be acceptable is to allow ambitious policies to be embarked on without the appropriate funds." (ix, 38) In other words, if the funds are not available, the plans must be scrapped.

2. Sir Roy tells us he is not recommending any reduction in spending (iv, 8); but his proposals do set out to maximise the proportion of services provided through means-tested local government and private sectors, while minimising the scope of NHS services, which are provided without charge. Likewise, in examining the relationship between local authorities, health authorities and social security, Sir Roy contrasts the "open- ended financial commitment" of social security with the "budgeted" provision of local government social services (v, 15).

3. The constant presumption is of restrictive government-imposed cash limits, waring that "if overall resources are limited, residential accomodation may take an undue proportion of available money... " (v. 16)

4. The Report ignores the extent to which cash requirements and

means-testing are already a major factor in forcing tens of thousands of elderly people into means-tested residential accomodation. Instead he asserts that "it is a matter of chance" whether a person needing long stay care "finds himself [sic] in a geriatric ward, or in a nursing home or a residential home." (v, 17).

5. Griffiths' most positive statement of the rights of the patient to a clear package of care and a named care worker responsible for them simply echoes the previous pronouncements of the Audit Commission and the Commons Select Committee. However he also again repeats that such plans must be tailored to cash limits – i.e. "plans which are *above all* realistic in the light of the particular community and of the staffing and facilities likely to be available." (v, 18).

6. The Griffiths proposal for an extension of central government control over local social service provision would operate through the allocation of a new central government grant covering not more than 50% of the costs of the plans adopted. This money would be separately and tightly monitored, "ring-fenced" (vi, 23) and only paid out at all subject to prior government approval of the social services programme. (vi, 22; viii, 31) This is not so much expanding local authority control as interfering with it at reduced price.

7. Central to the whole package of proposals is an extension of the private sector into this potentially profitable sector of care provision. Again the involvement of central government is largely to twist the arms of local government into increased privatisation: "The onus in all cases should be on the social service authorities to show that the private sector is being fully stimulated and encouraged, and that competitive tenders or other means of testing the market, are being taken." (vii, 24).

8. By "substantially" reducing the social security contribution towards payment for residential care and leaving it up to social services to fill the gap, Griffiths proposes to increase the involvement of cash-limited (rate-capped) local government, insisting that "As part of the decision-making process the social services authority should take account of the total resources available for the provision of care." (vii, 26)

9. In looking at staffing, Griffiths' preoccupation is to reduce levels of skills (and therefore wage levels), proposing "a new multi-purpose auxiliary force to be given limited training," ... and suggesting "major

experiments" involving "mature adults, but particularly school leavers, YTS, etc." There is no discusson on the prospects of salary or promotion for such de-skilled "community carers". His attitude to community care staff and training is dealt with at more length elsewhere in this pamphlet.

10. Local authorities have reason to feel they are being "set up" to take the rap for long-term underfunding of the service, since Griffiths lays stress on the notion that responsibility for care would be "clearly within the local community, which can best determine where money should be spent." However they will not be free agents in deciding *how much* money should be spent, since they are restricted by rate-capping and soon by the Poll Tax provisions. In any case some authorities will be much more willing than others to hold back spending on community care, no doubt keen to "bolster experiment and innovation at local level" (vii, 27) by providing rock-bottom services.

11. Sir Roy's emphasis on collecting better information is focussed once again not on matching services to need but on cash questions – "the cost-effective use of resources." (vii, 28)

12. The pretence that the proposals would actually produce a nation-wide, integrated policy for community care is exposed by Sir Roy's own insistence that "the control [by central government] is intended to be a minimum consistent with there being any national policy in this area." (vii, 29, 30, 31). It will be in short a figleaf to hide central government's real responsibility for the lack of adequate services in each locality.

13. Griffiths consciously "side-steps" any real restructuring of community care as had been suggested in the extensive and well- researched Audit Commission report (vii, 32, 33). The Commission had proposed a "lead authority" should be designated as responsible for care of the mentally ill, the elderly, and the mentally and physically handicapped. However, despite Griffiths' references to "cost-effectiveness" and other pet phrases of business management, it is clear that his whole Report revels in the ambiguity of a service for which no one authority is accountable, and central government policies can be imposed behind the scenes.

16) The significance of the term "experiment" as a euphemism for increased *privatisation* of key services is underlined in Sir Roy's summary of the "whole variety of initiatives" he has in mind:

"social/health maintenance organisations, insurance/tax incentives, not simply for the individual but for the individual in a family context. ... More immediately there is no reason why, on a controlled basis, social services authorities should not experiment with vouchers or credits for particular levels of community care allowing individuals to spend the on particular forms of domiciliary care and to choose between particular suppliers if they wish." (x, 39)

Chapter 3: "Community Care"

Sir Roy emphasises that at present "families, friends, neighbours and other local people provide the majority of care." These are also the cheapest option for the state, since many do so with no help whatsoever and at considerable cost to themselves (through loss of wages, etc). It is no surprise that the Report should insist that:

"The proposals take as their starting point that this is as it should be..." (3.2).

Griffiths also makes a major theme of the Report the truism that "The resources available for public services will always be finite." However it would be more honest to admit that the limits up to now have been fixed not by outside factors but as a result of political decisions taken by the government of the day in prioritising the allocation of national wealth.

Sir Roy might also have admitted that the *demand* for public services – and in particular the demand for community care services, which are used by only a measurable and relatively small percentage of the population – is also finite. Were he carrying out a similar exercise for Sainsburys, Sir Roy would seek to match the measurable "market" – the level of demand – with sufficient supply of "goods" – community care services – not artificially restrict resources in such a way as to leave hundreds of thousands without support.

However the Griffiths approach is clearly that resources will *never* match demand for community care, and therefore some must be left out, through the application of what he politely terms "priorities" (3.5, and 3.8(iv))

Chapter 4

While the prevailing drift of Sir Roy's approach is to minimise and cash-limit the state involvement in community care at each level, the

second strand is to maximise the involvement of the private sector. This is seen in a totally one-sided way, with no examination whatever of the likely problems of privatised health care: referring to private sheltered housing and domiciliary care services, for example, Griffiths writes: "The best examples show how services can respond very flexibly ..." (4.5). What of the *worst* examples? What of the *average* examples?

In similar fashion, Griffiths attacks the "potential monopoly power of the public sector", without looking at the economic and planning advantages of an integrated, publicly-run system. He goes out of his way to attack the "dangers" in the present system of regulation and inspection of residential and nursing homes, which he asserts "can result in higher standards of provision being required from private (and voluntary) homes than similar homes in the public sector often provide." (4.6)

Yet his conclusion is not that standards should be *raised* in the public sector, but that the already scandalously inadequate regulation and inspection procedures should be further relaxed, allowing even more rip-off landlords and "homes" to fleece their victims and local authorities unhindered.

Sir Roy's guiding light is summed up in his call to "encourage a proportionate increase in private and voluntary services, as distinct from directly provided public services." (4.6)

Griffiths also admits that a very large percentage of those requiring community care are elderly, and draws attention to the expected near-doubling of numbers of the most dependent over-85 age group in the 20 years 1976-1996. This needs to be remembered in the light of subsequent proposals for a big extension of means-tested services.

Chapter 5

Sir Roy tells us that "elected local authorities are best placed, in my judgement, to assess local needs, set local priorities, and monitor local performance." (5.2) This might seem to be an argument for elected local health authorities, but in fact Griffiths is proposing local government become "accountable" for policies determined and policed by central government.

Amid much talk of "incentives" towards efficient management, Griffiths also points out that even after local councils have agreed a set of planning objectives with central government, there may not be the cash available to attain them: but as ever the budget (cash limit) must come first:

"So, for example, if resources are not great enough to meet agreed

objectives, a budgetary system will provide a firm information base from which to make decisions about either reducing the scale of set objectives or identifying the precise resources needed to discharge them." (5.6)

One crumb of comfort which local authorities may grasp at in this generally bleak scenario is that Griffiths does at least suggest they be given some advance figures and security of funding to provide community care services. However the other side of this is tough central control over the money allocated:

"Equally central government needs clear mechanisms to hold local authorities to account for centrally provided resources devoted to community care." (5.10)

Chapter 6

Social services authorities encouraged by Sir Roy's proposal that they – rather than social security offices – should take control of administering the "community care element of the Social Fund" (6.8) may well be less than enthusiastic about their new obligation under the same proposals to "maximise choice and competition by encouraging the further development of private services." (6.9)

The role of health authorities is restricted under Griffiths' proposals to provision of medical care:

"investigation, diagnosis, treatment and rehabilitation undertaken by a doctor or other professional staff... health promotion and the prevention of ill health. *Health authorities should not provide services which fall outside this definition."* **(6.12)**

This narrow definition seems designed to exclude much long- term care from the NHS, and thus push many elderly patients from free NHS care into the means-tested social services sector.

The seemingly radical proposal of establishing a new Minister of State responsible for community care appears to run counter to other Griffiths proposals that minimise the actual responsibility and role of central government. In fact the role of the Minister would be confined to policing cash limits and making general policy pronouncements:

"The Minister should promulgate a definition of community care values and objectives ... [and] would be responsible for ensuring that national policy objectives were consistent with the resources available to public authorities charged with meeting them and for monitoring progress towards their achievement." (6.20, 6.21)

Griffiths proposes that the central government funding should not exceed 50% of the cost of providing community care services (6.23), but generously concedes that "social services authorities would have discretion to "top up" from their other sources of funds" (6.25) (though these would be further restricted under the Poll Tax).

In looking at measurement of need for community care services, the Report again returns to the means-test criterion:

"The dependency indicators should reflect people's need for *publicly financed* [original emphasis] care and support; in more wealthy areas more people will be able to buy from both the private sector and social services authorities." (6.29(i))

In case anyone is under any misapprehension, and somehow missed the proposal that many more elderly people should have to pay for their own care, Griffiths says it again:

"It seems right that those able to pay the full economic cost of community care services should be expected to do so." (6.33)

Then he says it again – in the context of residential care:

"Public finance should only be provided following separate assessments of the financial means of the applicant (using a means test consistent with that for income support) and of the need for care." (6.39)

Much of the improved system of "assessment" of people for community care proposed by Griffiths is clearly designed to prevent some from receiving support:

"When the financial assessment showed that there was no entitlement to the income related residential allowance, the information collected should enable the social services authority to decide how much of the total cost of the residential care should be charged to the individual." (6.43)

Privatisation

Griffiths is quite specific in *opposing* "a general expansion of local authority run homes". He makes no bones about the fact that in his view:

"The objective should be to encourage further development of the private and voluntary sectors." (6.49)

Local authorities, he insists, should:

"look rigorously at the comparative costs of domiciliary services, where they may be judged sufficient and seek out the most efficient services there too, whether from the private, voluntary or statutory sec-

tors." (6.50)

Suggestions for registration and inspection of residential and domiciliary services are watered down by the proposal from Griffiths that the inspection system of local social services should itself then be monitored centrally – a procedure which in the case of NHS ancillary services has made it extremely difficult for dissatisfied health authorties to get rid of inadequate private contractors. We should remember Griffiths' concern that the private sector might be subjected to harsher scrutiny than public sector services when he recommends that:

"it should be a responsibility of central government to monitor the proper application by social services authorities of standards of registration and inspection..." (6.58)

Charges for care

The main body of people most affected by the Griffiths proposals are the elderly, most of whom have paid taxes and national insurance throughout their working lives as well as putting aside savings and often buying their own homes to prepare for their old age. Sir Roy now begins to cast avaricious eyes towards these savings and property, and floats wider ideas of compelling future generations of elderly to pay their own way:

"In looking at future options for the funding of community care, planning needs to take account of the possibilities of individuals beginning to plan to meet their own care needs at an earlier stage in life. Recent changes in pension legislation have increased the opportunities available to employees to take more personal responsibility for planning their pension provision [in other words, reduced the government's commitment to care for workers in retirement! – Ed]. Moves to make provision for anticipated community care needs is a logical extension of such an approach." (6.60)

Griffiths does not elaborate on how workers of middle age are to anticipate the extent to which they may be incapacitated after retirement, or how popular it might be to suggest they each put substantial extra cash into insurance schemes. However he does look towards extracting more from savings and property already owned by today's elderly:

"Many of the elderly have higher incomes and levels of savings than in the past.... This growth in individually held resources could provide a contribution to meeting community care needs.... There are already a number of interesting schemes for encouraging owner occupiers to

use their equity to provide income which can be used to pay for services in retirement and I believe that similar innovative schemes should be encouraged." (6.61)

Chapter 7

This works back through many of the points from the angle of how they could be implemented, recognising that new legislation would be needed to transfer many of the responsibilities to local authorities, while at the same time "enabling" them to "finance the provision of services by the private and voluntary sectors as well as directly providing services." (7.3)

Griffiths makes a ritual nod in the direction of existing NHS staff in long-stay hospitals, arguing that it is important that their skills are not lost (7.13): however much of the emphasis in earlier chapters has been on the increased role of much lower-paid "community carers".

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