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Programme Budgeting Revisited :
Special Reference To People With Learning Disabilities

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Abstract

The recent reorganisation of community care removed many of the perverse incentives identified in the previous system. However, the organisation of care for many people is still divided across several agencies in the public and independent sectors. As purchasing and providing agencies in both the NHS and local authority personal social services attempt to co-ordinate policy objectives and the means to achieve them, the total resources available and their allocation across different care groups and amongst people in the same care groups form a consistent focus of attention. The principles and practice of programme budgeting provide important lessons for planning and monitoring expenditure. This paper rehearses such principles in the specialised area of policies for people with learning disabilities and draws on the experience of mapping expenditure on relevant services in a survey over ten local authorities in England.

Introduction

The difficulties of inter agency collaboration are ever present on the community care agenda. Although some of the perverse incentives were removed by the recent reforms, much of the organisational fragmentation and confusion described by the Audit Commission (1986) remains. Community care continues to be the responsibility of a number of agencies at local levels. There has been progress in some areas as authorities pursue jointness, through common statements of philosophy and policy, and through moves towards joint commissioning. However, there has been an absence of guidance on what budgetary arrangements are appropriate to accompany this process of integration.

This paper proposes that programme budgeting can provide a suitable framework which would also present an opportunity to link local programme budgets to the current national programme budget. The principles and practice of programme budgeting are illustrated with reference to services for people with learning disabilities.

A Brief History of Programme Budgeting

The concept of programme budgeting gained prominence in 1961 with its adoption by the US Department of Defense. Although its roots may be traced to earlier years (Novick, 1967), it was the apparent success of its limited application in the Department of Defense (Hirsch, 1966) which stimulated President Johnson's extension of this initiative to all the departments of the Federal government in 1965. Following the US central government experience, programme budgeting techniques were introduced widely elsewhere (Novick, 1973). In the

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UK, initiatives introduced covered both local authorities (IMTA, 1971), and central government, where the term "Output Budgeting" was preferred (DES, 1970).

In view of this progress, it is perhaps surprising that there developed no definitive description of what became variously known as Programme Budgeting (PB), Planning Programme Budgeting (PPB) or Planning Programming Budgeting Systems (PPBS). As early as 1965, Wildavsky noted that for Programme Budgeting there "was no standard definition" (Wildavsky, 1966). Later Dror (1969) concluded, "no single dimensional and single description can do adequate justice to the heterogeneous phenomena and ideas using that name".

Instead, attention focused upon identifying the main elements of the approach. Novick (1973) suggests that to carry out the major objectives of programme budgeting, three general areas of administrative and operational activities are involved. These are programme structure, programme analysis, and information and reporting. The development of a programme structure requires the identification and definition of an organisation's objectives, and the grouping of the organisation's activities into programmes that can be related to each objective. Programme analysis represents a decision making process where, "the resource and cost implications of program alternatives and their expected outputs or accomplishments may be estimated, examined, and compared". Information and Reporting refers to the importance of adopting ongoing accounting, statistical and reporting systems to meet programme budgeting requirements.

The approach was developed in response to the limitations of traditional budgeting (Jones and

Pendlebury, 1984; Henley, 1989). Traditional approaches were invariably annual, incremental, input orientated processes, intended as a control mechanism. Under such arrangements, there is not only a natural tendency to favour existing programmes, but the budgetary process becomes simply a mechanism for allocating or rationing particular inputs, with no explicit relationship developed between the inputs and the intended outputs or outcomes of a particular public service (Henley, 1989).

In contrast, programme budgeting is planning, rather than management or control orientated. Indeed, Henley et al (1989) suggests, "it would be more useful if it were retitled programme resource allocation planning to emphasise this is primarily a planning exercise". The real innovation which permits the shift in orientation is the programme structure. It is this defining of objectives, and classification of existing activities in terms of the extent to which they contribute to the stated objectives, which reveals the extent to which existing resource allocations are compatible with an organisation's planning priorities. The programme structure should cut across conventional lines of responsibility and departmental structures to draw together all the activities that are directed towards a particular objective (Jones and Pendlebury, 1984).

Before considering the particular and continuing relevance of these approaches, it is illuminating to follow the US experiences of implementation to their conclusion. As Novick (1973) reported, only two years after its introduction as, "a potentially significant innovation in government", the application of programme budgeting across Federal government was suspended in 1972. Some of the reasons for this dramatic rise and fall were anticipated during the implementation phase (Wildavsky, 1966, 1969), and more recently, clarification

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has been forthcoming from a number of case studies of the time (Dennison, 1979; Bevan, 1983; Robinson, 1992).

There are two particular lessons we can learn from the US experiences. The first is that it is important to be realistic about what programme budgeting can be expected to achieve. In its original conception, it was assumed that "it was possible in each budget process to review critically all expenditure, and all alternative expenditure options, so as to determine an "optimal" allocation of resources between competing ends". Such an approach ignores the political and organisational realities of large organisations. Future use of programme budgeting techniques must, "dispense with the comprehensive, rationalist, centralist intellectual baggage of programme budgeting and address the issue in the real world context of incrementalist, interactive budgeting processes" (Robinson, 1992).

The second insight concerns the importance to be attached to programme structure, described by Wildavsky (1969) as "the most pernicious aspect of PPBS". There are often huge difficulties encountered in defining objectives and grouping activities with objectives, as Wildavsky (1969) exposes:

"A mere recitation of some programme categories from the Department of Agriculture - Communities of Tomorrow, Science in the Service of Man, Expanding Dimensions for Living - makes the point better than any comment".

It is these very substantial costs of obtaining reliable information on actual expenditure in terms of output categories which leads Robinson (1992) to conclude that the output

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classification is inferior to the organisational, functional classification from a cost benefit perspective. The preferred programme structure should therefore be simple, capable of expressing clearly the contribution of activities towards broad objectives, and yet should not impose substantial costs upon an organisation.

Although the US experiences cast doubt on the effectiveness of programme budgeting techniques, the subsequent case studies reveal it was the manner of implementation which were responsible for the ultimate failure of the Federal Government's wider approaches. Programme Budgeting techniques continue to be applied in the US Department of Defense (Jones, 1991), as well as in varying forms in Canada (Sutherland, 1990) and Australia (Pugh, 1984).

Programme Budgeting in health and social care

There are examples of the use of programme budgeting approaches in health care in the UK, both at central government and at local levels. In central government, as early as 1971, the Department of Health and Social Security recognised the inability of their systems to reconcile policy advice for the priority groups with the resources allocated through the Public Expenditure Survey (Banks, 1979). The result was a departmental reorganisation the following year. Client group divisions were created, and a national programme budget was established, designed to allow the expression of future expenditure plans in client group terms. This national programme budget formed the basis of the consultative document, Priorities for Health and Personal Social Services in England (Department of Health and Social Security, 1976).

This document represented "the first attempt to establish a single, coherent set of priorities across both sets of services and to express them in terms of quantified targets to be achieved within specified timescales" (Wistow and Henwood, 1990). Followed by the establishment of planning systems for health and local authorities (DHSS, 1976; DHSS, 1977), and of joint planning mechanisms (DHSS, 1977), a system was developed whereby, "local plans could, in principle, both be influenced by detailed national guidelines and monitored in the extent to which they corresponded with such norms and priorities" (Wistow and Henwood, 1990). These developments were shortlived. In a revised priorities document in 1977, "firm targets" become "hopeful aspirations" (Brown, 1977). By 1981, planning guidance had abandoned all targets (DHSS, 1981). There was no longer any mechanism for measuring local progress towards national policies and priorities.

The national programme budget has been retained, and an update of programme budget material is provided for the Health Committee of the House of Commons (1993). This does not represent an application of programme budgeting but is merely, "a broad apportionment of spending". (Jones and Prowle, 1987). The current classifications do not move beyond inpatients, outpatients, community nursing, residential care, day care. The deficiencies of this particular approach are also outlined by Jones and Prowle, who emphasise that it is important to distinguish between "the provision of data in a programme budgeting format with the operation of a system of programme budgeting".

Although there is a considerable amount of literature on the relevance and the application of Programme Budgeting ideas to British local government (Stewart, 1969; Hambleton, 1978; Bourn, 1979), less exists on the application of these techniques to health and social services.

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However, the approaches were used in the area of social services (Hambleton, 1978), while the relevance of such approaches were considered by others for the Health Service as a whole (Pole, 1974) and in the context of an area health board (Mooney, 1977). More pertinent to this paper is the work of Glennerster (1983) who considered that local planning requires the development of care or client group budgets at local levels. His model entailed the creation of joint committees who would assume responsibility for particular client groups within defined geographical areas. It would be their responsibility to manage a client group budget, incorporating all relevant local and health authority expenditure on the client group in the area, and any out of borough expenditures. These budgets would reveal the current balance of care, identify the consequences of proposed changes in the balance of care, and form the basis for inter service bargaining, monitoring and review.

More recently, there has been a resurgence of interest in programme budgeting ideas, usually in association with marginal analysis, as a result of the health service reforms. As purchasers now have the capacity to alter their purchasing strategies so programme budgets can usefully reveal existing priorities and identify areas where expansion or contraction might be appropriate (Mooney et al, 1992; Robinson, 1993).

However, programme budgeting has yet to be adopted widely. The revival in interest has concentrated mainly on applications within the acute sector. Even greater benefits can be realised through the application of these techniques to the provision of community care services.

The client group focus

The choice of client group is important. The learning disability population is (or should be) almost entirely known to local authorities, is largely static, and individuals tend to receive services on an ongoing basis, often for life (Wertheimer and Gregg, 1993). As a result they form "a discrete group for planning purposes" (Glennerster, 1983). Although there may be difficulties in classifying people who have in addition major mental health and physical health problems.

This client group had consistently been at the forefront of new developments both at central and local levels. At central government level, the 1971 White Paper "Better Services for the Mentally Handicapped," (DHSS, 1971) represented, "the first comprehensive priority client group strategy evolved by the Department." (Glennerster, 1983). This precedent was followed by the Jay Report on mental handicap nursing and care (1979), and through the establishment of the National Development Team. Much of the debate over the future organisation of care in the 1980's focused upon people with learning disabilities.

At local levels, the learning disability client group have frequently formed the initial focus for inter agency collaboration at an organisational level, through hospital closure programmes, and at professional levels, illustrated by the early and continuing development of Community Learning Disability Teams (formerly Community Mental Handicap Teams) (Brown and Wistow, 1992). These initiatives are unsurprising when it is considered that much of the health services provided for people with learning disabilities is in fact "social care" (Wertheimer and Gregg, 1993). Recent joint commissioning initiatives have also largely

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concentrated on this client group (Wertheimer and Gregg, 1993; Kings Fund, 1993).

Concerns remain over progress towards resettlement. Whilst,"the broad picture is of increased expenditure on personal social services and community health services and lower expenditure on hospital services", (Health Committee of the House of Commons, 1993), reference to the most recent programme budget material confirms the rate of progress is very slow. Furthermore, beneath these aggregates, as the Audit Commission noted in 1986, as some authorities are known to have made considerable progress, in others the rate of change must be very slow indeed.

The recent reforms cannot be relied upon to relieve these difficulties. Although the new arrangements were intended to, "clarify the responsibility of agencies and so make it easier to hold these to account for their performance", (DOH, 1989), much of the fragmentation and confusion described by the Audit Commission in 1986 remains. The boundary between health and social care is still "not so much an objective reality as a focus for negotiation and competition". (Hudson, 1992). The increasing numbers of NHS Trusts and GP Fundholders are altering the parameters of collaboration and adding to the agenda. These developments have a particular significance for hospital closure programmes since individual providers must now negotiate with multiple purchasers. A recent study for the Department of Health across a sample of thirteen purchasing authorities revealed that each health purchasing authority contracted for services for people with learning disabilities with between one and nine distant providers, with an average across the sample of seven distant contracts (Jones and Wright, 1995).

Reasons for the reemergence of programme budgeting

There has been convergence between the philosophies of care adopted for this client group by the two main statutory agencies. Central government has recognised in recent guidance that people with learning disabilities are "predominantly in need of social care", (NHSME, 1992) and so have local authorities. Also as Wertheimer and Gregg (1993) observe, "it is rare to find people working in the field of community services for people with learning disabilities who feel that attempts to identify the boundaries between health and social care are productive."

The importance of coterminosity is being recognised, as health purchasing authorities merge to become purchasing consortia, in part seeking a less fragmented relationship with Social Services. It may take time before the benefits are realised. Recent research has indicated that where the merger involves a number of health purchasing authorities, there may be delays in integrating the different information systems.

There is evidence of new collaborative arrangements. Although authorities are required to collaborate over hospital discharge procedures and in the preparation of Community Care plans (DOH, 1989), developments extend far beyond these limits. Health purchasing authorities are increasingly ringfencing the resources available for the learning disability care group, and working with social services towards the introduction of innovative joint purchasing and commissioning arrangements (Wertheimer and Gregg, 1993; Kings Fund, 1993).

More important, from the perspective of developing programme budgets, are the fundamental changes to health and social services financial information systems. Until recently, the development of comprehensive client group specific budgets would have been fraught with difficulties. In social services, difficulties would arise in isolating fieldwork expenditures, and quantifying the input of management and support services. In district health authorities, the involvement of the community health services for example would have been difficult to identify.

For social services, the impact of the recommendations contained in, "Accounting for Social Services" (CIPFA, 1993), will be to make client group differentiation significantly easier. The continuing trend towards distinguishing between purchasers and providers means it is untenable for authorities to continue to regard fieldwork as a separate division of service. The recommendations also require that all costs defined as Social Services Management and Support Services should be fully allocated to other divisions of service.

For health purchasing authorities, following the achievement of "steady state" in the early years, increasing attention is being focused upon the contracting process. Purchasers are requiring more information from providers, and developing healthcare purchasing systems capable of assimilating and analysing all contract information. Most authorities would now be able to produce a "resource inventory" for the learning disability care group. Provider cost and activity information can be viewed with increasing confidence, and recent initiatives such as the National Steering Group on Costing (NHSME, 1993) should continue these improvements.

The extension of the GP Fundholding scheme from 1 April 1993 to include health services for people with learning disabilities will complicate this process, though its impact so far has been limited. GP's in general have not taken advantage of the opportunity to change existing referral and purchasing patterns.

Any moves to introduce programme budgeting should involve more than just the two main statutory agencies. Representatives from local housing and education authorities should be included as a minimum, though recent initiatives in these areas have not always facilitated this. The potential for the involvement of district housing authorities is greater than ever before. Under the NHS and Community Care Act, social services are required to consult local housing authorities in preparing their community care plans. In parallel, district housing authorities are expected to develop housing strategies for community care in association with social services and other housing providers (DoE, 1992). The availability of resources from the Housing Corporation should also be considered at every stage. The involvement of local education authorities in any collaborative machinery has been reduced by the transfer of the responsibility for funding further education to the Further Education Funding Council. The strategic overview in this area formerly provided by local education authorities is no longer available, and any discussions over the adequacy and appropriateness of further education provision may have to take place with individual colleges.

The information now exists to form local programme budgets for services for people with a learning disability. It remains to outline exactly how such a system might be implemented. For the purposes of exposition, the general approach outlined by Novick (1973) and described earlier will be revised. This specified three general areas of administrative and operational

activities; programme structure, programme analysis and information and reporting.

Programme Budgeting in Practice

1)   Programme Structure

It is the programme structure which is the "revolutionary aspect" of the system (Novick, 1967). It presents resources according to the programme to which they apply, it draws together inputs from different organisations, and concentrates attention on competition for resources between programmes, and on the effectiveness of resource use within programmes. A simple programme budget structure for services for people with learning disabilities is revealed in Figure 1. Unlike traditional programme budgeting approaches, the figure does not draw together all the inputs related to a single objective. The provision of residential care, for example, retains the distinction between health and local authority provision. The issue should not simply be what should be provided, but also who should be the most appropriate provider.

This document presents a strategic overview, by outlining major programmes, with the balance of care illuminated with expenditure and activity information. Individual authorities could assume responsibility for developing their own subprogrammes. Social Services might assess the balance of their residential care provision between hostels and ordinary group homes. Health purchasing authorities might examine their expenditure on community nursing and therapy services, and ensure that their purchasing strategies complement those of GP Fundholders.

The design of the programme structure is important, since it inevitably incorporates the values of the participants. Different structures could be designed to emphasise different issues. The structure in Figure 1 is designed to emphasise three particular areas of interest. Firstly, what balance of services should be provided in this authority? The services are therefore set out across the now familiar spectrum of care, with any remaining inpatient care deliberately isolated, distinct from provision for people with challenging behaviours. Secondly, who is the most appropriate provider of this preferred balance of services? Figure 1 indicates where there is a duplication of activities across the two main statutory agencies, and raises the issue of appropriateness. Thirdly, the structure considers the inputs of other agencies. Although the expenditure and activity information may not be so readily available, the involvement of these agencies is important. As a result of both changing philosophies of care and of resource constraints, there is increasing evidence of substitution, with both health and social services calling upon district housing authorities and housing associations to assist in meeting housing needs, and using further education opportunities as an alternative to their own day facilities.

As has traditionally been the case with programme budgeting approaches, many authorities will say "we do this already". In so far as expenditure and activity are analysed within agencies by client group, and in some instances intensive inter agency collaboration occurs over hospital closures, this is true. However such instances are rarely systematic, and do not form an integral part of the formal joint planning mechanisms. Similarly, rarely is attention paid to all relevant activities, or to all the resources allocated to the care of this client group.

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Figure 1

Programme Budget Structure for Services for People with Learning Disabilities

	1	2		3			
HEALTH PURCHASED SERVICES							
A District Health Authority	Inpatient Care	Residential Services - people with challenging behaviours	Community Health Services	Residential Care	Respite Care	Day Care	Domiciliary Care
B GP Fundholder			Community Health Services				
LOCAL AUTHORITY PURCHASED SERVICES **C** Social Services		Fieldwork		Residential Care	Respite Care	Day Care	Domiciliary Care
OTHER PUBLIC RESOURCES **D** District Housing Authorities, Housing Corporation, Local Education Authorities, Further Education Funding Council							
NON PUBLIC RESOURCES **E** Voluntary Care, Informal Care, Family Care							

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Revival of interest in programme budgeting may well be related to the relationship between the adeas behind programme structures and the development of joint commissioning, needs assessment and community care plans in the reorganised systems of health and community care. Care management arrangements and the operation of the purchaser/provider split also fit well with the programme budgeting methodology. Many of the goals taken from a recent survey of joint commissioning (Department of Health, 1993) including: mission statements, needs assessment, service specifications, outcome measurement, and monitoring procedures closely match those of programme budgeting as set out in the first part of this paper. The development of programme structures highlights this commonality.

Probably the most important feature of the programme structure is the way in which a total resource inventory is compiled for a major objective such as the care of people wtih learning disabilities. In effect, the structure is designed to clarify all the activities, objectives, and expenditures which contribute to each programme or sub programme irrespective of organisational or agency boundaries. Where needs assessment exercises have progressed so far as specifying objectives of policies to enhance social or health gain, a considerable proportion of the programme structure has already emerged. For example, the Welsh Health Planning Forum (Welsh Office, 1992) identified a whole set of key objectives concerning:

- the prevention of learning disabilities
- exploiting opportunities for health gain for people suffering conditions which relate to learning disabilities
- the enhancement of social support to people with learning disabilities and their carers

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Since these major objectives were supported by key sub-programmes and activites or services which would provide the means to the ends, a large part of a clearly articulated programme structure had emerged. The main missing component was the expenditure data, which would have given a picture not only of total spend in the main programme but also its distribution across the different sub-objectives or programmes and the contributions of the different agencies towards it.

This mappping of resources to needs provides valuable information for the purchasers of health and social care at the macro level because it enables them to test whether the expenditure pattern reflects their priorities within the programme and to examine the effect of switching resources from one sub-programme to another. The exercise becomes especially useful where outcome data enable purchasers to examine the costs and effectiveness of resource switches, where benefits lost from reduction in one sub-programme can be compared with benefit gains in sub-programmes where resources are increased.

The programme budgeting approach is also useful to "micro-level" purchasing where care managers are attempting to develop packages of care which meet individual needs as efficiently as possible. Since care management requires the devolution of budgeting or purchasing power to the care manager level, a programme budget indicates the total resources available for develution as well as those needed for residential, recreational, employment, and domiciliary care components of care packages.

The loss of enthusiasm for programme budgeting in the mid to late 1970's was possibly attributable principally to its demands for information on the costs and outcomes of

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programmes. On the financial side there were problems of developing dual sets of accounts which met the need for stewardship and probity and for strategic planning. On the outcomes side there were (and still are) the problem of developing valid and reliable measures which can be used both in programme analysis and in monitoring the effeciency and effectiveness of service delivery. Although progress is still to be made with outcome measurement, there are several measures available (Raynes et al, 1990) for some programmes as well as measures used in routine service delivery based on individual programme planning which could provide useful information sources for programme structure and analysis. On the financial side, developments in information technology are likely to ameliorate the difficulties that were faced by different forms of budget presentation.

2)   Programme Analysis

As has already been outlined the political and organisational realities within large organisational prohibit the use of the highly analytical approaches usually associated with programme budgeting. Instead, decisions are made through "pluralistic bargaining between different lobbies, modified by shifting political judgements, made in the light of changing pressures" (Klein, 1993).

Programme analysis should involve two parallel processes. The first, at a strategic level, should identify long term planning priorities. Such decisions would include hospital closures, and any arrangements involving major transfers of responsibilities, and require senior management involvement. The second, occurring at lower levels of the organisation, involves marginal analysis. This involves "evaluating marginal activities and shifting resources from

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those of low marginal benefit to those of high marginal benefit". (Mooney et al, 1992). These exercises, carried out at operational levels, would focus upon areas of concern, in the awareness that changes can be made and benefits accrued in the relatively short term.

It remains to identify how both of these decision making processes should be informed. Following the lead of Cochrane (1991) and Robinson (1993), several sources of information must be accessed: top down priorities, bottom up consultation, professional opinion, and research based evidence. This process is illustrated with reference to people with learning disabilities in Figure 2.
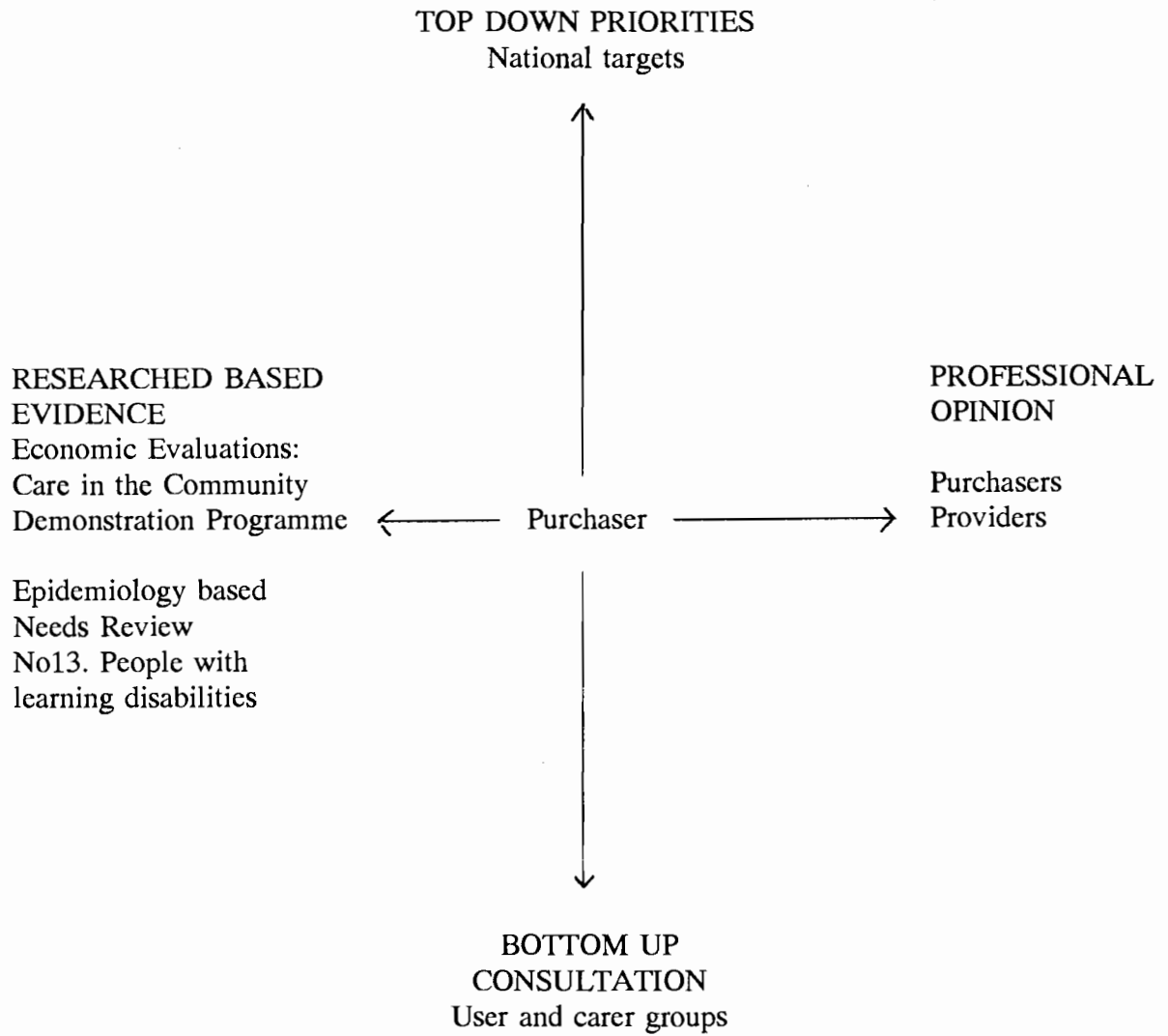
3)   Information and Reporting

Novick (1973) emphasised the importance of adapting the ongoing accounting and statistical systems in order to meet programme budgeting requirements, and provide continuing information (monthly or quarterly) on the use of resources and progress within programmes. Although perhaps optimistic at that time, subsequent improvements in financial information systems mean such report writing facilities should be available. In social services, for example, the larger financial coding structures allow the inclusion of separate client group and service identifiers. Current developments, as social services introduce new or adapt existing systems to respond to recent changes and health purchasers introduce new systems to manage the commissioning process offer an opportunity for authorities to ensure that detailed client group differentiation is a necessary specification. Continuous reporting would form the basis for regular monitoring and review.

Figure 2   **Informing the decision making process**

TOP DOWN PRIORITIES
National targets

RESEARCHED BASED
EVIDENCE
Economic Evaluations:
Care in the Community
Demonstration Programme   ←———— Purchaser ————→ Providers

PROFESSIONAL
OPINION

Purchasers
Providers

Epidemiology based
Needs Review
No13. People with
learning disabilities

BOTTOM UP
CONSULTATION
User and carer groups

An Integrated and Rational Planning Structure

This paper has outlined how programme budgets might develop at local levels. There is also opportunity to revive the relationship with central government. It is over fifteen years since the last efforts "to shape the development of health and personal social services within a single comprehensive framework of detailed national guidelines" (Wistow and Henwood, 1990).

Groves (1990) has asserted that "the biggest scandal of community care is that it has not been monitored adequately". Although Hudson (1992) suggests there is little enthusiasm for the revival of a national planning system the characteristics of the recent reforms, with the increasing plurality of purchasers and providers, suggest such a development might be wise. To reestablish the links may require prescription from central government. A revision of the existing statutory returns, through consultation with authorities, would bring two major benefits. Firstly, central government would be able to monitor the impact of policies and practice guidance upon individual authorities, and assess progress towards implementation. Secondly, the requirement for detailed information, perhaps in an integrated form, would induce authorities to collaborate and to generate the detail they need for effective local planning. Any revised return could specifically be designed for completion by health and social services together, as part of joint planning mechanisms. The detail required need not be exhaustive, but more should be requested than is available from the current broad categories.

Such an approach could be piloted with services for people with learning disabilities. The unified return would identify clearly what was the current balance of care, and to what extent

there has been a transfer of responsibilities, placing this client group at the forefront for any new developments. There continues to be no shortage of radical proposals for the reshaping of health and social care. It has been proposed that local authorities should combine responsibilities for health and social care, rendering district health authorities and family health services authorities redundant (Institute for Public Policy Research, 1991). Even more radical, a recent document proposes a single authority to purchase healthcare, housing, education, and social services (University of Manchester, 1992). Such approaches would bring huge advantages if introduced for services for people with learning disabilities.

Conclusion

There is a need for new approaches to the provision of services for people with learning disabilities. Single agency management as advocated by the Audit Commission (1986) has failed to find favour and inter agency collaboration is always difficult. The geographical, organisational and cultural differences have become part of health and social care folklore. However, as shown by the early results of the monitoring of the community care changes and the development of joint commissioning (Department of Health, 1993), there now exists the will and the capacity to effect change more than ever before and programme budgeting could provide a powerful tool in assisting this process.

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