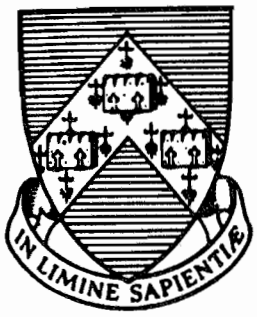

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An Analysis of Joint Finance in Seven non-London Health Authorities

by KAREN GERARD

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CONTENTS

ABSTRACT

Joint finance is a source of National Health Service money which has been targetted by the Department of Health and Social Security to be spent on community care. In particular it is to be used by agencies (statutory and non-statutory) in collaboration with the health service to facilitate the phasing out of long-stay hospital institutions by replacing these services with more appropriate facilities in the community.

Joint finance has come under much criticism over the role it plays in supporting community care initiatives. The critics argue that the transitional costs necessary to support two parallel services as the balance of care shifts, involves a scale of financial support greatly in excess of that which joint finance can provide. Although this is certainly true for major transfers of resources away from institutions, this is being particularly critical of the joint finance programme.

There have been limited successes obvious from this programme. Furthermore, given that the requirement of flexibility is necessary in meeting individual needs in the community, then joint finance, in relation to this range of needs has a definite supporting role. This role is, however, limited by the size and structure of the joint finance budget.

This paper analyses some data from joint finance programmes in seven non-London health authorities. By analysing these data in terms of the beneficiaries of the programmes, the agencies involved, the nature of community services provided and the financial arrangements used in funding projects, the relationship between joint finance and community care is examined more closely.

The results suggest that joint finance has been instrumental in pump-priming the development and improvement of day services, respite services and primary health services for elderly and mentally handicapped people. Furthermore, these service developments and improvements tend to predominate in areas of service provision for groups already living in the community requiring long-term care or for those considered at risk of future hospitalisation rather than for the direct transfer of people out of long-stay hospitals.

There is no reason to believe that this role will not or could not be extended in the future to provide care for other priority groups, particularly mentally ill and physically handicapped people, who have tended to be ignored in existing joint finance programmes.

1. INTRODUCTION

Joint finance programmes have been part of health authority budgets for over a decade. During this time the scale of the national programme has increased in real terms by a factor of three, but still the impact of this budget on community care tends to be viewed sceptically.

Joint finance and community care

Joint finance is just one of many financial instruments which is used to attain community care objectives. As a fund it is designed in such a way as to be accessible to those agencies which have common interests with health authorities in supporting community living for groups of people such as elderly, mentally handicapped, and mentally ill people.

The joint finance mechanism has two purposes. First as a direct source of bridging finance for community care schemes, and second to provide a financial incentive to reward provider agencies who collaborate together in planning and delivering services to priority client groups.

As a source of bridging funds, joint finance can be spent on schemes which transfer people and resources out of long-stay institutions and into the community. It can also be spent on the build-up of community resources aimed directly at preventing or forestalling the future hospital admission of those people in the community considered most at risk. In other words, joint finance can be used to reduce dependence on long-stay hospitals.

As a financial incentive to encourage effective joint planning and joint working, joint finance has a limited role. It is one of many other factors which influence the extent of practical collaboration between agencies. Booth (1981) for example, explains how political, organisational and wider financial factors largely affect collaborative efforts.

Community care is a way of both thinking about service developments and delivering services to priority client groups. The basis upon which community care is founded is to provide care within a person's own home. In its widest sense, community care is taken to mean all care outside of institutions. In practice the interpretation of this principle varies across the different client groups but broadly means to aim to ensure elderly people stay in their own homes for as long as possible and mentally ill and handicapped people can enjoy equal rights in their accommodation, the facilities available to them and the life they lead in comparison with the rest of the population.

In the recently published Audit Commission's report (Audit Commission, 1986) it was pointed out that the development of community care has to date been disappointingly slow. According to this report, community care has been impeded because of two fundamental problems: both a lack of adequate bridging finance and a diversity of responsibility and decision-making at local level.

This suggests that as one of the financial structures designed to enhance community care over the last decade (DHSS, 1983), joint finance may not have proved an effective mechanism. In which case it is important to understand its limitations more accurately and consider its role for the future.

The aim of this paper therefore is to investigate the future scope of joint finance as a source of bridging finance by examining the current practice of joint finance in this role. This is done by considering the achievements of joint finance programmes in seven non-London district health authorities in terms of who benefits from the programme, which agencies are involved in the provision of projects, what type of services

are provided and the financial arrangements used in funding projects.

In conclusion, it is suggested that, given that the requirement of flexibility is necessary in meeting individual needs in the community, then joint finance has a definite role, albeit limited by the size and structure of its' budget, in relation to the range of needs which can be potentially met by community care.

2. BACKGROUND

Many concerns expressed about the achievements of joint finance programmes have been reported in the literature (Booth, 1981; Wistow, 1983; Wistow and Fuller, 1986; Green, 1986 and HMSO, 1985). These concerns have centred around the general themes of financial and non-financial issues.

Financial issues

The financial issues include the size of the joint finance fund, the current financial climate of local governments and the particular financial arrangements incorporated into the joint finance mechanism.

The programme nationally does not constitute a large share of resources, three percent of the total personal social services expenditure or less than one percent of National Health Service spending (HMSO, 1985; CIPFA, 1986; HMSO, 1987). Therefore it does not and cannot expect to achieve any major permanent transfer of resources from the health sector to local authorities, but may make some transfer. Green (1986), for example, is concerned that joint finance lacks any significant contribution to the transfer of resources. Particularly, the transitional costs necessary for supporting two parallel services as the balance of care shifts involves a scale of financial support greatly in excess of the support available from

joint finance monies (Hudson, 1987).

The present rules which govern the spending of joint finance are likely to act as a disincentive to local authorities wishing to embark upon new schemes because stringent financial control over local government expenditure programmes penalises increases in their budgets. Joint finance operates on a tapering basis, this means that for negotiated time periods (usually 3 years or less) joint finance can fund, fully, a scheme. Thereafter, and again for a negotiated period and rate of taper, the full revenue support from joint finance is gradually transferred across to the receiving agencies. Therefore, any new joint finance schemes which taper onto local government budgets run the risk of overloading targets set for these local government budgets. Instead, there is an incentive for local authorities to increase spending on resubmitting existing joint finance projects or even not to spend all their allocation of new joint finance monies.

The effect these tapering patterns have on receiving agencies' management of joint finance can be to shift the focus of joint finance projects away from long-term expenditure on staff and towards either capital projects with no revenue consequences or short-term revenue projects.

The time profile of the programme may also be problematic, particularly for local authorities. The programme is rolled forward annually, readjusted according to agreed tapering commitments. The problem for local authorities as partners in the programme, is that their own base budgets, set within a political arena and on an annual budget-setting cycle, incorporate much uncertainty about the future availability of

resources. Subsequently, local authorities are cautious about taking on joint finance projects with future revenue consequences.

Non-financial issues

The non-financial concerns over the joint finance programme broadly centre around issues over common priorities and policies, organisational structures of agencies and the time costs involved in planning and operationalising joint finance projects.

Agreed priorities and policies are an essential prerequisite to collaboration. It is not unreasonable to think that where agencies have common priorities there may be different views about both the nature of the problem and its' solution. This problem is likely to increase as the number of professions involved in the joint decision-making process increases. Equally, there may be differences in the priorities attached by agencies to different groups. This is likely to vary between localities according to local resource supplies, population needs, pressure groups, local politics, and other factors. Where there are divergences in either priorities and/or policies, the scope for joint planning and joint financing becomes more difficult (Nocon, 1987).

The organisational structure and administration of a geographic area can vary considerably. In those areas where there are particularly complicated boundary relationships between agencies there may be unclear lines of demarcation for jointly planning services. These situations can require relatively large investments in time of both professions and organisations in order to produce effective planning and working arrangements of joint finance projects.

Thus, the relative time invested in joint finance can be substantive. The balance between the joint planning effort of a joint finance scheme may be unfavourably disproportionate to the contribution the scheme makes to a community care programme. Consequently this may deter some professions and agencies from using this particular approach preferring instead to seek alternative approaches.

In view of these concerns a small sample analysis of joint finance data demonstrates the operationalisation of joint finance programmes.

3. METHODOLOGY

Examples of joint finance programme are based on seven non-London district health authority localities in England. The criteria administered to select these seven localities initially included the coverage of a range of regional health authorities, combinations of regional and district RAWP gaining and losing positions and coverage of different boundary relationships with respective local authorities. This selection procedure gave rise to a wide representation of local circumstances. The seven examples selected demonstrate the extent of coverage of client user groups and service providers involved, the range of services provided and the nature of the financial arrangements used in local joint finance programmes.

The information relates to a review of each locality's 1985/86 joint finance programme. This review was achieved through a combined process of open-ended interviews with relevant personnel and reviews of local documents relating to issues of joint finance. This static approach has been necessarily for two reasons. Firstly, not all authorities were able to supply information on earlier programmes in comparable detail, eliminating the feasibility of time series analysis. Secondly, changes

taking place over time relate largely to local circumstances and cannot therefore be generalised - particularly because each authority is endowed with different amounts and types of resources.

Client user groups

For an analysis of client users the classification system used considered schemes which could be directly attributable to one main client user. If this was not possible (either because a scheme related to more than one client user or was non-client specific) then it was entered under a miscellaneous category.

Provider agencies

For an analysis of service providers a straightforward process of identifying each agency responsible for taking up the financial and recurrent consequences of each project after the termination of joint finance support was used to attribute projects to agencies.

Service provision

In order to analyse the type of service provided by joint finance two classification systems were devised. The first one related to the specific nature of each project in terms of whether the project was part of a support system for day services, residential services, respite services, domiciliary services or primary health services. The second method acknowledged whether the scheme contributed to a service development, an extension or improvement to existing services, a staff training/re-training programme for community based issues or a research initiated project.

Financial arrangements

The final method of joint finance analysis breaks down programmes into capital-based and revenue-based projects. Since there are a variety of short-term and longer-term commitments arising from joint finance arrangements , it seemed appropriate to highlight these. The exact nature of this analysis is discussed later.

4. ANALYSIS OF JOINT FINANCE PROGRAMMES 1985/86

Client user groups

TABLE 1

Client Users of Joint Finance (Number of Projects)

Health Authority	Mentally ill people	Mentally handicapped people	Elderly people	Elderly mentally ill people	Physically handicapped people	Miscellaneous	TOTAL
A	3	8	7	-	2	3	23(8%)
B	6	4	10	-	2	3	25(8%)
C	7	11	12	1	-	21	52(17%)
D	3	23	8	2	1	19	56(18%)
E	2	8	6	1	1	9	27(9%)
F	6	18	19	2	3	22	70(23%)
G	11	15	3	1	2	20	52(17%)
TOTAL NO OF PROJECTS (%)	38(12%)	87(29%)	65(21%)	7(2%)	11(4%)	97(32%)	305(100%)

Table 1 indicates the range of client groups benefiting from individual schemes across each health authority's joint finance programme over a fixed period. Both collectively and individually, a large number of schemes have been devoted to services for people with mental handicap (87 (29%)) and for elderly people (65 (21%)). This is not surprising since, in both cases progress in the development of community care has been more prolific than for groups such as mentally ill people, elderly mentally ill people and physically handicapped people. Wright (1987) reports on this stark imbalance as he reviews the literature on cost-effective community care for elderly, mentally handicapped and mentally ill people.

For most mentally handicapped people it is now widely accepted that an 'enabling' approach to the provision of their personal and social needs is more appropriate than a traditional model of care based on nursing and medical models (MENCAP, 1986). The growth (and future growth over the next decade) in the elderly population has also focussed attention on the need to build up comprehensive and integrated residential, day and domiciliary services for those who may benefit more appropriately from community-based services than outdated and expensive hospital-based care.

A limited number of schemes in this analysis do however show a response to the special needs of elderly mentally ill, mentally ill and physically handicapped people, despite the slow progress nationally. These policies are still relatively new and therefore the role of joint finance more limited, but they can expect to develop and offer wider scope for joint finance in much the same way that mental handicap and elderly policies have developed.

Thirty-two percent of schemes did not fall into the five main priority groups identified. This miscellaneous category includes schemes aimed at other priority groups (eg alcoholics, under fives), schemes which either cannot be attributed to any one group or may serve a particular mix of clients and schemes involved with administratively-related problems. The presence of this miscellaneous group of schemes reflect the diversities inherent in the concept of community care, may of which remain to be evaluated in terms of cost and outcome.

TABLE 2

Joint Finance Expenditure on Mental Handicap Services and Elderly Services

Health Authority	(1) Expenditure on mental handicap services	(2) Expenditure on elderly services	(3) = (1) + (2) Combined expenditure
	(%)	(%)	(%)
A	80.0	16.2	96.2
B	00.0	47.6	47.6
C	27.8	30.7	58.5
D	26.8	23.5	50.3
E	21.8	36.6	58.4
F	23.0	33.6	56.6
G	27.4	12.2	39.6
AVERAGE	29.5	28.6	58.1

Expenditure analysis outlined in Table 2 further indicates that mentally handicapped people and elderly people in this sample tend to be major beneficiaries of joint finance programmes. The average expenditure on mental handicap services was nineteen per cent of total expenditure and similarly twenty-eight per cent for elderly services. The variation between districts however was large, especially for mental handicap services.

Provider agencies

The 1983 and 1984 DHSS circulars (DHSS, 1983; DHSS, 1984a) changed some of the arrangements for joint finance. For instance, the range of providers now eligible to apply for joint-finance funds was extended to voluntary agencies, local authority education departments, housing departments and housing associations. Furthermore, health authorities themselves were now eligible users of joint finance.

TABLE 3

Service Providers using Joint Finance: Number of Projects and Percentage of Joint Finance Expenditure

Health Authority	Health Authority (HA)		Local authority social services (LASS)		Joint HA and LASS		Voluntary agencies		Local authority Housing Department		Local authority Education Department		TOTAL	
	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp
A	3	(8.6)	19	(86.3)	1	(5.1)	-		-		-		23	(100.0)
B	7	(13.7)	17	(84.2)	-		1	(2.1)	-		-		25	(100.0)
C	18	(22.6)	33	(75.2)	-		-		1	(2.3)	-		52	(100.0)
D	12	(14.6)	40	(12.0)	-		-		4	(13.4)	-		56	(100.0)
E	7	(16.0)	19	(76.0)	-		-		1	(8.0)	-		27	(100.0)
F	10	(11.2)	57	(79.3)	-		1	(0.7)	1	(4.3)	1	(4.5)	70	(100.0)
G	21	(35.7)	20	(34.4)	11	(29.9)	-		-		-		52	(100.0)
TOTAL NO. OF PROJECTS (%)	78	(26%)	205	(67%)	12	(4%)	2	(-)	7	(3%)	1	(-)	305	(100%)
AVERAGE TOTAL % EXPENDITURE		(17.5)		(72.5)		(5.0)		(0.4)		(4.0)		(0.6)		

This extension of participants sought to recognise the need for a more collaborative effort in the community care programme and to enhance the transfer of resources across administrative boundaries. There was particularly strong feeling that the mechanism was not used by the housing departments and associations, who contribute in their own right to the development of community living, nor the education services, who also provide part of the comprehensive community service for people with a mental handicap.

Although the data in Table 3 reports on programmes two years after the introduction of these new arrangements, collaboration remains dominated by local authority social services and health authorities. It would appear that progress towards more comprehensive collaboration in these seven study localities had been slow. Only seven local authority housing schemes, two voluntary schemes and one local authority education department scheme had been successful participants, and furthermore representing small proportions of the joint-finance budgets locally. Health authorities themselves had secured seventy-eight schemes (an average of 17% of total expenditure) and a further twelve held jointly with social services. This

relative health sector dominance, particularly in relation to other non-LASS agency participants, may reflect some of the local authorities' concerns about using joint finance.

An apparent lack of progress in extending the range of agency participants should be expected. The rolling nature of the joint finance revenue programme (excluding one-off payments or time-limited arrangements) makes for the slow introduction of new agencies. Any local system currently heavily committed to funding existing revenue schemes has relatively less of an annual joint finance allocation available for supporting new schemes. If, however, a local system is not heavily committed in this way then explanations as to why the uptake by new participants is slow may not be quite so simple or obvious. At the same time it should be recognised that social services alone are a large element in any community programme and so it is likely they will remain the largest single participating agent.

Service provision

If community care is to succeed there are important elements which need to be addressed. To acquire the flexibility and diversity necessary to meet the individual needs of people, a range of community-based services are required. Essentially these fall into five categories; residential services, domiciliary services, day care services, respite services and primary health services. By selecting different combinations of particular services within each broad category, packages of individual care can be provided.

TABLE 4

Distribution of Joint Finance Support for Component Parts of Community Care:

Number of Projects and Percentage of Joint Finance Expenditure

Health Authority	Day Services		Shortstay/ Respite Services		Residential Homes		Hostels		Group Homes		Semi and independent living units		Domiciliary Services		Primary Health Services		Miscellaneous		TOTAL	
	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp
A	5	(45.9)	1	(3.2)	1	(12.8)	6	(17.9)	-		-		-		4	(12.0)	68	(8.2)	23	(100.0)
B	5	(14.3)	-		2	(27.7)	6	(40.3)	-		-		-		5	(10.6)	7	(7.1)	25	(100.0)
C	10	(17.4)	2	(7.4)	3	(6.4)	1	(4.6)	3	(6.8)	1	(8.9)	3	(16.8)	13	(19.0)	16	(12.3)	52	(100.0)
D	6	(16.4)	5	(6.7)	3	(8.0)	2	(4.0)	6	(3.0)	1	(7.4)	5	(13.6)	12	(21.6)	16	(18.0)	56	(100.0)
E	2	(27.1)	5	(14.5)	-		-		1	(2.4)	-		3	(25.0)	5	(21.7)	11	(9.3)	27	(100.0)
F	20	(15.0)	3	(7.9)	4	(7.9)	-		6	(7.5)	5	(7.6)	3	(11.3)	10	(35.9)	19	(14.8)	70	(100.0)
G	4	(5.2)	5	(18.9)	-		-		-		2	(4.8)	4	(7.2)	14	(45.3)	23	(18.6)	52	(100.0)
TOTN. NO. OF PROJECTS (%)	52 (17%)		21 (7%)		13 (4%)		15 (5%)		15 (5%)		9 (3%)		16 (5%)		63(21%)		100 (35%)		305	
AVERAGE TOTAL % EXPENDITURE	(20.1%)		(8.4%)		(8.9%)		(9.5%)		(2.8%)		(4.1%)		(10.5%)		(23.7%)		(12.6%)			

Table 4 shows that joint finance has contributed to the enhancement of all five aspects of community living. In particular the areas of day care, domiciliary care and primary health services appear to have important places in the programme.

Prominent areas of day service in these localities have tended to be in new developments for mentally handicapped adults, particularly Special Care Units. These developments conform with government guidance (DHSS, 1984b). Other day care initiatives focus on the expansion of services for elderly and elderly mentally infirm people. Particularly important is the role residential homes have had in providing a basis for day services.

Domiciliary care has been increasingly recognised as an important area of community care for joint finance support (Audit Commission, 1985) Crossroads schemes (voluntary services) for example, are widely supported from joint finance programmes (Gerard and Wright, 1987). Other domiciliary care includes the extension to existing home help services and meal and laundry schemes for elderly people, again, important elements in helping people to live in their own homes.

Primary health services projects include schemes which aim to assess, direct and monitor appropriate resource packages to individual needs. The most obvious candidate for joint finance being the establishment of community mental health teams. Such teams involve the appointment of various component specialist staff. This initiative is expanding rather belatedly in response to DHSS guidance (DHSS, 1971) with the help of joint finance.

The impact that joint finance has on providing alternative community-based residential services suggests that all categories of alternatives

have, at least, been considered by the collective programme. However a flexible approach from individual authorities is inevitable due to their different priorities for service developments and timetables for running down existing long-stay hospitals.

A second consideration of service provision considers the distribution of joint finance between extensions and improvements of existing services, new developments, staff training programmes in aspects of community care and research projects designed to enhance the level of knowledge on local population needs (especially the community needs of people moving out of hospital).

TABLE 5

Distribution of Joint Finance Support for Service Types
(Number of Projects)

Health Authority	Extensions/ improvements of existing services	Service developments	Staff training programmes	Research projects	Unclassified	TOTAL
A	8	7	-	1	7	23
B	10	8	-	-	7	24
C	30	13	1	3	5	52
D	42	12	-	2	-	56
E	14	7	-	1	5	27
F	35	25	1	2	7	70
G	14	10	14	1	13	52
TOTAL NO. OF PROJECTS (%)	153 (50%)	82 (27%)	16 (5%)	10 (3%)	44 (14%)	305

Table 5 shows the distribution for all schemes which can be specifically allocated to one of these areas. These data clearly indicate that service improvements and developments are the key areas on which joint finance has focussed, although one authority did spend joint finance on staff training schemes. A paucity of research schemes suggests a lack of evaluation of innovative ideas despite their being tested out in a pilot situation. This is perhaps disappointing as it was a specifically highlighted area in the DHSS guidance.

TABLE 6

Distribution of Service Improvements and Developments Across Client User Groups
(Number of Projects)

	(A) Service Improvements			(B) Service Developments		
Health Authority	Community-based Clients	Patient transfers	Missing observations	Community-based Clients	Patient transfers	Missing observations
A	7	2		7	1	
B	5	-		3	-	
C	19	1		8	4	
D	26	-		7	1	
E	6	-		8	-	
F	16	3		19	1	
G	9	2		6	4	
TOTAL NO. OF PROJECTS (%)	88 (56%)	8 (5%)	65 (42%)	58 (70%)	11 (13%)	13 (16%)

Further analysis of schemes supporting improvements and developments to service models, as shown in Table 6, highlights joint finance as supporting populations already in the community. In light of the earlier discussion and the criticism levelled at the joint finance programme, this is not surprising. The resource consequences of running down large institutions in parallel with the building of new community-based services, in most instances,exceed the capabilities of joint finance, more so as regional health authorities formulate their own funding arrangements for this purpose. Joint finance in reality is focusing on reducing demand from the community on long-stay hospital care.

Financial arrangements

An analysis of the financial arrangements used in joint finance is important from a funding point of view, because, joint finance was first envisaged to provide an appropriate balance between capital and revenue in order to contribute to both the transfer of resources to the community and a build-up of resources in the community. In particular, the programme was expected to consist of approximately two-thirds of capital projects and

one-third revenue (HMSO, 1983). With increasing financial stringency imposed upon local government budgets, many have found it difficult to support the revenue consequences of capital projects and so the composition of the joint finance programme is different from initial expectations.

TABLE 7

Financial Arrangements of Joint Finance
(Number of Projects) (% Total Expenditure)

Health Authority	Capital projects with no revenue consequences		Capital projects with associated rev. consequences		Rev. projects of limited duration		Rev. projects with 7 year taper		Rev projects with 13 years support		TOTAL
	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No	%Exp	No
A	-		12	(53.2)	5	(5.1)	5	(40.1)	1	(1.6)	23
B	-		5	(16.4)	6	(19.0)	13	(62.5)	1	(2.1)	25
C	4	(11.4)	1	(4.2)	34	(27.9)	13	(56.9)	-		52
D	12	(15.8)	2	(12.2)	38	(30.7)	3	(39.3)	1	(2.3)	56
E	2	(8.0)	-		19	(47.1)	6	(44.9)	-		27
F	3	(17.2)	8	(26.8)	41	(35.0)	18	(21.0)	-		70
G	3	(13.2)	8	(17.7)	17	(29.4)	24	(39.7)	-		52
TOTAL NO. OF PROJECTS (%)	24 (8)		36 (12)		160 (52)		82 (27)		3 (-)		305 (100)
AVERAGE TOTAL % EXPENDITURE	9.3%		18.6%		27.7%		43.5%		0.8%		

Table 7 shows that there are five main divisions to be made on the basis of future revenue commitment. The first group consists of capital projects with no revenue consequences. The second group include capital projects with associated revenue consequences - these may include revenue consequences of limited duration or indeed requiring a total commitment after the completion of the tapering process. The third group are revenue projects of limited duration lasting less than the standard seven year period. The fourth group consists of revenue projects with seven year pick-up periods, ie during the course of the seven years the health authority contribution is phased out whilst the sponsoring agency's contribution is increased until the latter becomes fully financially

responsible. The new arrangements in the 1983 circular allowed the introduction of extended periods of time up to a maximum of thirteen years in which sponsoring agencies could respond to the financial consequences of joint finance. This then constitutes a fifth and final category.

The interesting feature of Table 7 for the seven health authority localities concerned is the disproportionately high number of projects funded on limited duration revenue arrangements. This would seem to suggest that the initial expectation that joint finance could act as a pump-priming fund to stimulate, in a limited way, the transfer and build-up of resources is not always realistic in the current financial climate.

The lack of response to the new extended financial arrangements, again, is partly due to the nature of the rolling programme. It is also due partly to the implications such an arrangement has on the remainder of the fixed joint finance programme. A commitment by a health authority to fund fully the revenue consequences of a project over thirteen years can impede the rate of new projects in forthcoming years.

5. DISCUSSION AND CONCLUSION

Although it is not possible to generalise from this analysis, it can be said that inspite of the concerns that joint finance programmes lack the means and focus to provide an adequate and appropriate bridging fund, they can nevertheless make important but limited contributions to the community care of particular client groups. Two policy concerns can therefore be dispelled, to some degree, from the evidence presented here.

First consider the role of joint finance as a bridging fund to develop community care. Although the joint finance programme has a small budget,

amounting to approximately £500,000 per health authority per annum, there are important parts of the community care programme which requires sums of capital and revenue affordable from this programme and which, at the same time, constitute a transfer of resources from health authorities to local authorities. The most readily citable example would be the response to government guidance to the special day care needs of people with severe and multiple handicaps. The joint finance programme has played an important role in pump-priming the development of Special Care units for the advantage of both people transferred from long-stay hospital into the community and people in the community requiring appropriate day-time support to maintain them in their community situation.

The second policy concern, the difficulty of appropriately focusing joint finance into areas of common concern, also seems unfounded. There would appear to be common policies and practices which are appropriate for using the joint finance mechanism. Examples in this analysis include service developments and improvements for people with mental handicap and elderly people. This is inspite of organisational or financial barriers, described by Booth (1981), which tend to impede collaboration. As the results of the learning process in these fields disseminate more widely, so service models for mentally ill, elderly mentally ill and physically handicapped people provide a focus for identifying elements in community care programmes most suitable for the joint financing approach. In particular, the consideration of joint finance to support the areas of day care, respite care and primary health care.

One tentative conclusion from this analysis is that the importance of short-term projects which have limited revenue cost consequences, are now a significant focus of joint finance projects, despite the original intentions of the scheme. There remain, nevertheless, both a large group

of revenue projects which use a seven year tapering pattern and a prominent group of capital-based projects which incur associated revenue consequences. This suggests that a balance between capital and revenue schemes and long and short-term financial arrangements are maintained within the prevailing financial climate, and in doing so allow some redress of the balance of care between health and local authorities.

What is not clear from the analysis is the implication of the large number of health authority projects supported with joint finance funds. Is this an effect of local authority unwillingness to participate in the programme or have health authorities carved their own independent niche in the joint finance programme?

Given the complex relationship between joint finance, the constituent supporting agencies and the varied external factors which directly or indirectly influence the programme, this limited analysis has served to highlight the nature of the difficult but important task of unravelling the relationships involved in managing joint finance and community care programmes.

In summary, the results of the small survey show joint finance has been instrumental in pump-priming the development and improvement of day services, respite services and primary health services for elderly people and mentally handicapped people. Furthermore, these service developments and improvements tend to predominate in areas of service provision for groups already living in the community requiring long-term care or for those considered at risk of future hospitalisation. Joint finance does not play a significant role in the direct transfers of people and resources out of long-stay hospitals. There is no reason to believe that the role for

joint finance described above will not or could not be extended in the future into similar areas for mentally ill and physically handicapped people.

On a more sobering note, joint finance has not been used in a particularly innovative manner, instead schemes tend to follow government guidelines on new developments or improve services in line with existing (and usually unevaluated) practice. There appears to be little entrepreneurship and over dependency on central direction.

There is a problem of financial stringency constraining collaborating agencies in seeking to improve the total care delivered to their clients. This should not be underestimated and the evidence revealed by practice in these seven localities suggests this has curtailed the role of joint finance.

One of the conclusions reached by the Audit Commission (1986) was the sheer inadequacy of funds available to bridge the transition phase of community care for people living in institutions. Revenue expenditure on joint finance and 'dowries' amounted to about £100 million a year out of a total NHS expenditure on services for these clients of some £3 billion a year. It seems pertinent, in the view of expenditure analysis for this small sample of health districts, that the scale of the joint finance programme could readily be increased to bridge this gap.

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