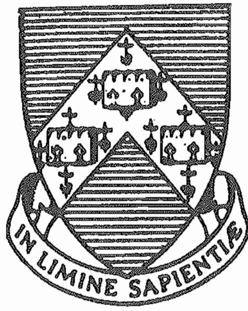

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Care in the Community: A Study of Services and Costs in Six Districts

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EXECUTIVE SUMMARY

Drawing on evidence collected from all providers of community care in 6 districts, this study finds:

1. Total Public expenditure on all services for community care client groups distributed across providers as follows.

DHAs	52%
Local Authorities	34%
DHSS Benefit payments	11%
Private/voluntary sector	3%

   The split varies widely between districts.

2. Per capita public spending on all community care client groups varies from £100 to over £170 in the districts studied.

3. 54% of all public expenditure on community care client groups goes on services to the elderly, about one fifth each to mental illness and mental handicap services, and less than 5% to services for the physically disabled.

4. The balance of care is still dominated by hospitals and other institutional facilities, which command 73% of all publically provided resources being directed towards the client groups. In the DHAs, 85% of all client group spending went into institutional provision. From all providers, the expenditure on community services for the

client groups is in the region of £22 per head of population.

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SECTION 1

TERMS OF REFERENCE

1. Following a report by the Audit Commision published at the end of 1986, the Government asked Sir Roy Griffiths, Vice Chairman of the NHS Management Board, to conduct a review of Community Care. This review is proceeding and will report early in 1988.

1.2 In order to place evidence before the Griffiths Review, the General Managers' Group of the 14 Regional Health Authorities commissioned the Health Economics Consortium at the University of York to undertake a study of the current level of costs and resources being committed to community care. The objective of the study was to give a broad picture of the volume, range cost and of services being provided, and to examine variations between different parts of the country.

1.3 The study was conducted on behalf of all Regional Health Authorities. All local government Chief Executives and Directors of Social Services, and all DHA District General Managers in the areas concerned, were informed of, and co-operated with the study. Each participating DHA appointed a liaison officer to the study.

1.4 The study selected six District Health Authorities that are representative of the diversity of district-based NHS provision. Within each district, the study

attempted to identify publicly funded community care services provided by the DHA, local government, other public sector agencies, and private and voluntary organisations. The client groups of interest were the elderly, the mentally ill, people with a mental handicap and othe younger physcially disabled.

1.5 The collection and compilation of the data was undertaken during three months beginning August 1987. The final report was presented to the Regional General Managers, Group at the beginning of November 1987.

1.6 This report presents the main findings of the study carried out by the Health Economics Consortium. Due to the confidential nature of some of the data provided by DHAs and D/SSs the participating districts and local authorities have not been identified by name. Also, some of the details of the services provided which were included in the original study have been omitted from this report.

SECTION 2

METHODOLOGY

2.1 DISTRICTS

The study aims to identify all services and related public expenditure on community care in a selection of Districts. The 6 Districts included in the study vary greatly in population, structure and size, geographical areas and pattern of services.

2.1.2 Some DHAs are coterminous with LAs, others have boundaries which cross several LAs. Some are in RAWP-gaining Regions, other in RAWP-losing Regions.

2.1.2 They include a seaside area with a large retirement population (District 1), a London Borough (District 2), a metropolitan district (District 3) a Home Countries District (District 4) a sparsely populated rural area (District 5) and a predominantly rural district with centres of mining and industry (District 6).

2.1.3 Although the 6 Districts are not a representative sample, they are typical in their diversity.

2.1.4 The sample is too small to draw detailed conclusions about the total provision of and expenditure on community care in England, but should do two things.

(i) Give a broad indication of the total level of provision.

(ii) Show a range of levels, styles and systems of provision and funding.

2.2 DEFINITION OF CARE IN THE COMMUNITY

2.2.1 For the purpose of this study, care in the community was defined as services for the four main client groups concerned, excluding acute care and residential accommodation without any staff support.

While realising the importance of Primary Care for Care in the Community policies, there was insufficient time within this study to examine this area in any depth. However, one Local Medical Committee provided anecdotal evidence which suggested that community care policies are having a significant, but unquantifiable impact on the role of General Practitioners. Table 1.4 shows that GP services are unevenly spread across our 6 Districts.

2.3 TYPE OF PROVISION

The services included in the study covered:

- hospital care (including day hospitals)
- institutional/residential care
- group homes
- unstaffed homes
- day care
- respite care
- community health services (including provision by health visitiors, district nurses, community psychiatric nurses, chiropodists, physiotherapists, dentists, psychiatrists and other medical staff).
- general community services (including home help/home care services, fieldwork services, luncheon clubs, laundry schemes, etc).
- housing and transport services
- employment and OT services

Hospital care and other forms of residential/institutional care are not normally considered to be part of care in the community. Information on them has been collected and presented in order to place the scale of provision of other services to the client groups in a broader perspective.

2.4 THE CLIENT GROUPS

2.4.1 The groups in receipt of care who have been considered are:

- people with a mental handicap
- the elderly
- those with a mental illness (including the elderly confused)
- younger physically handicapped people

2.4.2 Where possible services for Elderly Severely Mentally Ill (ESMI) have been included with services for the Mentally Ill rather than the Elderly. In practice some of the data subsume ESMI with elderly services.

2.4.3 Service for the Physically Handicapped include provision to the Younger Physically Handicapped client group: that is, the 16-65 age group. The main sources of provision for the under 16s are Education and Paediatric services, and the study attempted to include medical expenditure by exclude educational provision. The over 65 age group of physically disabled people, unless otherwise stated, are included under services for the Elderly.

2.4.4 Education services for the Mentally Handicapped have been excluded, but other DHA/LA services for under 16s are included. In the sections

covering services for the Mentally Ill we have excluded services relating to alcoholism and addiction.

2.5 THE PROVIDERS

2.5.1 Care in the Community is provided by District Health Authorities, social service department staff, other statutory agencies, voluntary organisations, commercial organisations and unpaid informal carers, including family, neighbours and friends. Finance for some of the care provided by commercial and voluntary organisations comes from social security and other government sources, and this has been included in the study. As the focus of the study was Public Expenditure on Community Care, no attempt was made to quantify the very large expenditure independantly raised by the private and voluntary sectors for example, though fund raising activities, bequests and charges.

For the purpose of this study the boundary of Community Care was defined as services which are paid for, or formally organised by a charity, religious of voluntary organisation, or by social services, but informal help by family or neighbours was excluded.

2.5.2 Data on the services identified in para. 2.3, were collected from the providers of care. (In the timescale involved it was not possible to collect information on the basis of individual

recipients of community care). The main sources of data were:

- District Health Authorities
- Social Services Departments
- Joint NHS/SSD planning and management groups including joint finance schemes
- Other government agencies (ie the Housing Corporation)
- Housing associations
- Voluntary bodies (eg. MIND, Mencap, Age Concern, etc).
- DHSS - Social Security
- Existing studies of Community Care
- Family Practitioner Committees

2.5.3 In addition to collecting data from sources identified above, a survey of a small number of private and voluntary homes in each of the six Districts was conducted. The aim of the survey was to try to esimate the type and level of financial support received by residents in private and voluntary nursing and residential homes. Although too small to draw definitive conclusions the survey served as a validation exercise which confirmed that the homes fitted in with other national evidence. Table 2.1 presents our estimates of this financial support.

2.5.4 Each participating District provided a liaison officer to arrange access within the DHA, with social services and to initiate contacts with other providers. The liaison officer was responsible for obtaining access to other departments and organising data collection within the DHA.

2.6 GENERAL ISSUES

2.6.1 Information Base

Our intention was to collect data for the most recent year available. Most sources provided data for actual expenditure/activity for 1985-6 However, where data have been provided for a year other than 1985-6 we have inflated or deflated accordingly so all data on the tables are at 1985-6 price level.

2.6.2 Where possible we have used gross cost in assessing expenditure. We are will aware that the net statutory costs to LA are well below this level in many areas of provision. However gross rather than net costs, are a more accurate measure of total inputs and provide a better interpretation of total resources going into services.

2.6.3 In reporting the costs of running particular services, Administration and Headquarters expenditure for both DHA and LA have not been taken into account of. We have assumed that they are spread across the client groups in line with the pattern of expenditure we are reporting.

2.6.4 In reporting costs of Private/Voluntary Sector activity we have included only grants from the

DHAs and LAs plus payments for DHAs and LAs for services provided. Expenditure raised from other sources such as fund raising and donations has not been included.

As noted in para 2.5.1. above, the main reason for excluding such expenditure is that the focus of the study was public expenditure on Community Care. There would be formidable problems on collecting information on private and voluntary expenditure met from non public sources, but it is to be hoped that future studies will try to tackle these problems.

SECTION 3

SUMMARY OF MAIN FUNDINGS

3.1 The main findings of this study are presented in Tables 3.1 to 3.12, and figures 1 to 5. They show the total, per capita, and percentage distribution of public expenditure on the client groups which are at the centre of care in the community policies. They also place community service in the context of existing institutional provision.

Who Provides?

3.2 Table 3.1 and Figure 1 show the distribution of expenditure on all client groups in each of the districts included in this study, arranged by provider. On average, district health authorities provide just over a half (51%) of all expenditure, and local authorities just over a third (34%). DHSS benefit payments to people in homes provided by the independent sector equalled 11% of all spending, and other public expenditure through the private and voluntary sector comprises 3% of the total.

3.3 There are very marked variations in the pattern of expenditure across the country. In District 4 and District 5, for example, over 70% of all expenditure comes form the DHA and less than a quarter from the local authority. The pattern is very different in

District 2 and District 3, where total expenditure by the local authorities surpasses that of the DHAs.

3.4 The relative role of the DHSS benefit payments also varies widely. In District 1 almost a third (31%) of all public expenditure on the community care client groups came from this source; in District 5 only 4%. Note also that in District 1 the total expenditure on DHSS Benefits to the client groups being studied is almost the same as total local authority expenditure on the same groups.

3.5 Private and voluntary sector expenditure includes only moneys from DHAs and LAs towards the provision of services, and does not include moneys raised from fundraising, donations etc. It is therefore consistently underestimated in all districts. Nevertheless, the role played by the private and voluntary sector also shows substantial variations: from 1% of total public expenditure in District 5 and District 6, to 7% in District 2.

3.6 Table 3.2 shows the same expenditure figures as Table 3.1, but standardised on a per capita basis. It can be seen, first, that total expenditure per capita varies widely aroung the average of £123 District 5 have over £160 per person and District 4 over £170 while District 3 has only £106 and District 1 precisely £100.

3.7 Table 3.2 also shows that per capita expenditure on the community care client groups is extremely uneven within each category of provider. District 5 DHA spends three times as much per person as District 1, and District 4 three times as much as District 3. Similarly, expenditure on DHSS Benefits varies by a factor of 4 or more.

Who Receives?

3.8 Table 3.3 and Figures 2 and 3 show total public expenditure by all providers on each of the four main client groups. On average, well over one half (54%) of all expenditure can be attributed to services for the elderly, around on fifth of the total to each of the mental illness and mental handicap client groups. Expenditure on all service for the physically disabled constitutes only 4% of the total.

3.9 Once again, wide variations exist across the country in the distribution of expenditure by client group. In District 1 and District 3 around 70% of all spending goes on service for the elderly, but in District 5 less than 40% and in District 4 less than 30%. Similar differences exist with respect to services for mentally handicapped and mentally ill. Provision for the physically handicapped is more uniform, nowhere exceeding a 6% share of total spending.

3.10 Examined on a per capita basis (Table 3.4 and Figure 4,) the study shows that on average the total expenditure from all sources on services for the physically disabled is not more than 5 per head of population.

3.11 Table 3.5 shows total expenditure on the elderly population per head 3 of population aged 65+. In Table 3.6 the total expenditure on services for the 65+ client group is divided by the 75+ population. As the greatest proportion of the expenditure on the elderly falls on the 75+ population, the data in Table 3.6 are probably a truer reflection of <u>per capita</u> expenditure levels. There are wide variations in the distribution of expenditure: in Districts 1 and 4 <u>per capita</u> expenditure (including DHA inpatient costs) is less than £700 for the, 75+ population while in District 6 it is over £1,700.

3.12 Table 3.7 shows per capita expenditure on mental illness client group with DHA inpatient costs included and excluded. This breakdown shows that the widest variations occur in expenditure on hospital services. In District 4 per capita expenditure on hospital services was £51.7 compared with £8.9 in District 1 and £4.2 in District 3. Similar variations occur in provision of inpatient services for mental handicap clients. Table 3.8 shows District 4 and 5 with a per capita expenditure on hospital services of £46.5 and

£54.6 respectively compared with £2.9 in District 2 and nil in District 1.

What is Provided

3.13 Table 3.9 shows the type of services being provided by the different providers involved. Overall (figure 5) it is evident that the balance of care still lies very heavily with institutional facilities which command almost three quarters (73%) of all resources being directed towards the client groups, compared with less than on fifth (18%) being spent on all community services.

3.14 The predominance of institutional care is especially noticeable in DHA provision. In the 6 districts studied, no less than 85% of all expenditure on the client groups went into institutional provision, and only 10% in community services. Actual expenditure sums make this balance (or imbalance) of care forcibly: £112 million on institutional care, £13 million on community services.

3.15 On average local authority provision is less focused on institutional care, and we estimate that over a third (34%) of all local authority expenditure on the client groups is going into community services. However, fieldwork services are not readily amenable to programme analysis of this type, and the estimation

methods used in this study may well have exaggerated the fieldwork input to the services for the four client groups.

3.16 Our findings suggest that expenditure through the DHSS SB Board and Lodging mechanism now accounts for 15% of all institutional spending on the four care in the community client groups, and reinforces the continuing bias towards institutions in the balance of care.

3.17 As Table 3.10 shows, the sums available per person for the provision of community services are small: £7 from DHAs, £15 from local authorities, and £1 from the independent sector.

The Balance of Provision

3.18 From Tables 3.11 and 3.12, it can be seen that each client group has a very different pattern of reliance on the main providers. The elderly obtain 36% of services (measured by expenditure) from DHAs and 45% from local authorities, while the mentally ill rely on DHAs for 90% of services.

3.19 The private/voluntary sector contributes no more than 3.4% to the package of care received by three of the four client groups. But the fourth, the physically disabled, relies on the private/voluntary sector for almost a fifth (18%) of the services provided for it.

SECTION 4

POLICY IMPLICATIONS OF FINDINGS

4.1 Balance of Care

The information collected in this study demonstrates that there are very large variations in all dimensions of care in the community: across client groups, between providers, across the country, and in type of provision. Some of these variations reflect local circumstances, but many reflect a lack of policy direction. In particular, while there is some evidence of an emerging balance of care for the elderly, the evidence on mental illness and mental handicap suggests a continuing imbalance towards hospital based provision. The evidence on services for the physically disabled suggests underfunding and lack of policy.

4.2 Joint Finance

Some information on joint finance programmes in the six districts is contained in Table 1.3. The total sums involved average no more than 3% of the identified total spending on the client groups by DHAs and LAs, and range as low as 1%. It is difficult to see how such small sums can significantly influence progress towards community care objectives.

4.3 RAWP

The growth of expenditure through the DHSS SB Board and Lodging mechanism has introduced a large and uneven

element to a resource distribution pattern that is already very uneven. In this study of six districts almost £30m annually has been identified from this source, with spending differences between districts of more than £10m. In comparison with such sums, sub-regional resource allocation through RAWP formulae are overshadowed.

4.4 Information

Standard systems of collecting information by all agencies involved in community care are inadequate to the tasks of monitoring or measuring progress, and will need to be altered very significantly if future policy making at district level is to be adequately informed.

A P P E N D I C E S

APPENDIX 1

DISTRICT 1

1. General

1.1 DEMOGRAPHY

The total resident population of District 1 Health Authority in 1985-6 was 440,000. The population has been growing at a relatively rapid rate and has an age structure skewed significantly towards the elderly: 22.7% are aged 65+ (15.3% average), 10.6% aged 75+ (6.7% average) and 2.2% 85+ (1.3% average). (Table 1.1).

1.2 COTERMINOSITY

District 1 Health Authority is coterminous with 5 District Councils. It contains 70% of the population of the County Council. Historically, the MI and MH residential facilities for District 1 have been located in an adjacent DHA, but this is now changing.

1.3 MANAGEMENT STRUCTURE

The client groups covered by this study are covered by two Units: a Community and Elderly Services Unit, and a Mental Illness/Mental Handicap Unit.

1.4 EXPENDITURE

Total revenue expenditure by the DHA in 1985-6 was £59.445m or £134 per resident.

Total gross local authority expenditure in 1985-6 was estimated at £20.207 million (per capita all County x District 1 population), equivalent to £45.62 per resident and well below average local authority expenditure per person in England and Wales of £64 (Table 1.2).

1.5 JOINT FINANCE

The total revenue and capital allocation to District 1's Joint Finance schemes in 1986-7 was £1,251,000 (40% capital, 60% revenue). Total spending was £1,045,000 or an underspend of £205,600. Total expenditure was split 37% health authority schemes, and 63% local authority schemes. 78% of total expenditure was attributable directly to the 4 client groups examined in this study. The split by client groups is shown in Table 1.3.

1.6 PRIMARY CARE

In 1987 there were 241 GPs based in the District 1 DHA area, up from 220 in 1986. The average number of residents per GP is 1,838 (Table 1.4).

APPENDIX 2

DISTRICT 2

1. GENERAL

1.1 DEMOGRAPHY

The total resident population of District 2 Health Authority in mid 1986 was 196,000. The population has experienced long-term decline. District 2's elderly population, 26,360 or 13.4% aged 65+, 12,050 or 6.1% aged 75+ is below the national average. (Table 1.1).

1.2 COTERMINOSITY

District 2 DHA has coterminous boundaries with those of a London Borough.

Catchment areas for mental handicap and community services correspond to the DHAs boundaries. For the elderly, District 2 services part of another DHA, and is in turn part served by an adjacent DHA. The cross-boundary catchment probably evens out. MI and ESMI services are similar to those for the elderly, but are shifting to a coterminous basis under Regional Strategic Guidelines.

1.3 MANAGEMENT STRUCTURE

There are three management units. The District Services Unit is responsible for services to

the client groups viewed by this study.

1.4 EXPENDITURE

Total revenue expenditure by the DHA in 1986-87 was £50,000 million, or £245 per resident. Total Gross Local Authority expenditure in 1985-86 was £26.320 million, equivalent to £149 per resident, and well above average local authority expenditure per person in England and Wales of £64. (Table 1.2).

1.5 JOINT FINANCE

District 2's Joint Finance programme in 1986-87 totalled £481,510, with Local Authority schemes accounting for 80% and Health Authority schemes 20% of the total. The distribution of joint finance expenditure by client group is shown in Table 1.3.

1.6 PRIMARY CARE

There were approximately 155 GPs in the District 2 DHA area in 1986, equivalent to one per 1,265 residents. (Table 1.4).

APPENDIX 3

DISTRICT 3

1. GENERAL

1.1 DEMOGRAPHY

The total population of District 3 Health Authority in mid-1986 was £480,000. The population structure is similar to England as a whole, with 16.1% of residents aged 65+ (15.3% average) and 6.9% of residents aged 75+ (6.7% average). (Table 1.1).

1.2 COTERMINOSITY

District 3 DHA has coterminous boundaries with those of the Local Authority.

1.3 EXPENDITURE

Total revenue expenditure by DHA in 1986-7 was £142 million or £294 per resident. No information was available on District 3's total gross local authority expenditure in 1985-6. Using an average expenditure per person of £65 (as in a neighbouring District) gives a total expenditure estimate for District 3 of £31,395 million (Table 1.2).

1.4 JOINT FINANCE

The cumulative revenue and capital expenditure on District 3's DHA and LA Joint Finance schemes was £4.463 million by 1986-87. By

applicant the total was split as follows: 36% District 3 Health Authority; 63.1% District 3 Metropolitan District. The split by client group is shown in Table 1.3.

1.5 PRIMARY CARE

There are 270 General Practitioners in District 3 DHA. 1,789 population per General Practitioner (Table 1.4).

APPENDIX 4

DISTRICT 4

1. GENERAL

1.1 DEMOGRAPHY

The total resident population of District 4 Health Authority in 1985-6 was 166,700. As Table 1.1 shows, the population structure differs significantly from that of England as a whole, with 17.8% of residents aged 65+ (15.3% average) and 7.8% of residents aged 75+ (6.7% average).

1.2 COTERMINOSITY

District 4 Health Authority covers part of four District Councils and three Social Service areas. It contains 16.5% of the population of the County Council, which in turn covers 11 District Councils and 7 District Health Authorities in liaison, planning and provision of services. The difficulties of District 4 Health Authority are compounded by the existence within its boundaries of a scheme, 5 hospitals in one area run by 4 districts in two regions and containing patients from a widespread area.

1.3 MANAGEMENT STRUCTURE

There are 3 Units in the District 4 Management structure; a Mental Handicap Unit, a Mental Illness Unit, and a General Unit. There is thus no separate community unit, each Management Unit instead encompassing its own community services.

1.4 EXPENDITURE

Total Revenue Expenditure by the DHA is 1985-6 was £39.5 million (forecast 1986-7 £41.5 million), or £237 per resident (£248 per resident forecast 1986-7). Total Gross Local Authority expenditure in 1985-6 was estimated at £6.57 million (ie, 16.5% of the County Council expenditure), equivalent to £39 per resident, and substantially less than the average local authority expenditure in England and Wales of £64 per capita (Table 1.2).

1.5 JOINT FINANCE

The cumulative revenue and capital expenditure on District 4's Joint Finance schemes was £3,982,652 over the period 1976 to 1986. By applicant the total was split as follows: 33% District 4 Health Authority; 38% the County Council; 22% District and Borough Councils; and 7% other. The split by client group is shown in Table 1.4

1.6 PRIMARY CARE

There are 81 GPs based in the District 4 DHA area, and the total number of patients registered with them - 179,207 - is slightly higher than the DHA resident population. The average list size, at 2,219, is above the County average of 2,000, (Table 1.4). the FPC is second only to Lancashire in the number of authorities it has to deal with, and thus it too experiences difficulties in liaison.

APPENDIX 5

DISTRICT 5

1. GENERAL

The total residential population of District 5 Health Authority in 1986 was 301,000. The population structure is similar to England as a whole, with 15.7% of residents aged 65+ (15.3% average) and 6.5% of residents aged 75+ (6.7% average). (Table 1.1)

1.2 COTERMINOSITY

District 5 DHA has coterminous boundaries with those of the Local Authority.

1.3 MANAGEMENT STRUCTURE

For the purpose of day to day administration of services, District 5 is subdivided into six units, each with its local management structure. Three are defined geographically, the other three cover specialist services.

1.4 EXPENDITURE

Total revenue of expenditure by DHA in1986-87 was £64 million or £173 per resident. (Table 1.2).

Total gross local authority expenditure in 1985-86 was estimated at £16.561 million equivalent to £55 per resident and below the average local authority expenditure per person in England and Wales of £64.

1.5 JOINT FINANCE

The cumulative revenue and capital revenue by both DHA and LA on District 5's Joint Finance schemes in 1985-6 (based on data for 1986-7 deflated by 4%) was £633,800. There is no split by applicant. The split by client group is shown in Table 1.3.

1.6 PRIMARY CARE

District 5 DHA has 53 General Practices with a total of 168 General Practitioners or 1789 residents per General Practitioner. (Table 1.4)

APPENDIX 6

DISTRICT 6

1. GENERAL

1.1 DEMOGRAPHY

District 6 Health Authority, provides services for a population of approximately 520,000. Approximately 9% of the total resident population are aged 65+ and approximately 3.5 percent of the total are 75+. The OPCS projections for the population growth in 1994 show an increase in total resident population to 536,000, with a 7.7 percent increase in the 75+ age group. (Table 1.1)

1.2 COTERMINOSITY

District 6 Health Authority is coterminous with five local District Councils.

The Health Authority contains approximately 60% of the population of the County. Where Local Authority services cannot be identified for the five Districts coterminous with District 6 Health Authority a per capita estimate has been used - 0.6 times all-county data.

1.3 MANAGERMENT STRUCTURE

The health services in District 6 are divided into six management units:

Unit 1 - Acute services

Unit 2 - Acute services

Unit 3 - Mental Handicap Services

Unit 4 - Mental Illness Services

Unit 5 - Based on Local Hositals

Unit 6 - Community Services

1.4 EXPENDITURE

Total revenue expenditure by DHA in 1986-87 was £94 million or £180 per resident. Total gross local authority expenditure in 1986-7 was £30.420 million, slightly below average local authority expenditure per person in England and Wales (Table 1.2).

1.5 JOINT FINANCE

No information available on Joint Finance Programme. (Table 1.3)

1.6 PRIMARY CARE

District 6 has 94 General Practices within the DHA; 27 of which operate as single handed practices. There are a total of 279 General Practitioners giving each Doctor an average of 1864 patients. (Table 1.4).

T A B L E S

TABLE 1.1 : DHA Population and Demographic Structure (1986 or nearest date)

	1 Total Resident Population ('000)	2 % of Population aged 65+ (England = 15.3)	3 % of Population aged 75+ (England = 6.5)
District 1	443.0	22.7	10.6
District 2	196.1	13.4	6.1
District 3	483.0	16.1	6.9
District 4	166.7	17.8	7.8
District 5	300.6	15.7	6.5
District 6	520.0	9.0	3.5

Source: DHAs, OPCS

TABLE 1.2: Total DHA and LA Expenditure (1985-86)

	1 DHA total Revenue Expenditure (£'000s)	2 DHA expend. per capita (£s)	3 LA Total Gross Expenditure (£'000s)	4 LA expendture per capita (£'000s)
District 1	59,445.3	134	20,207	46
District 2	49,964.4	245	29,320	149
District 3	136,281.6	282	31,395	65
District 4	39,470.0	248	6,571	39
District 5	60,990.3	203	16,561	55
District 6	89,848.3	173	29,203	56

Source: (1) & (2) DHAs

(3) & (4) CIPFA Personal Social Services Statistics

Notes:

1. District 1 : DHA Hospital and Community Services only
2. District 2 : DHA = 1986-7 figures deflated by 4% to 1985-6 basis
3. District 3 : 1986-7 DHA expenditure for 1986-7 deflated 4% to 1985 -6 basis.
4. District 4 : LA total expenditure calculated on a per capita basis as 16.5% of total expenditure of the County Council.
5. District 5 : DHA expenditure for 1986-7 deflated by 4% to 1985- 6 basis.
6. District 6 : DHA and LA expenditure for 1986-7 deflated by 4% to 1985-6 basis.

TABLE 1.3: Joint Finance by DHA and Client Group (1985-6)

	(1) Elderly	(2)	(3) Mentally Ill	(4)	(5) Mentally Handicapped	(6)	(7) Physically Disabled	(8)	(9) Others Unattributable	(10)	(11) All	(12)
	£'000s	%	£'000s	%	£'000s	%	£'000s	%	£'000s	%	£'000s	%
District 1	181.5	18	62.0	6	373.1	37	169.7	17	214.8	22	1001.1	100
District 2	115.5	25	119.9	26	130.7	28	96.2	21	0.0	0	462.3	100
District 3	2,723.0	64	303.4	7	852.4	20	88.3	2	316.8	7	4,284.8	100
District 4	136.1	34	21.8	5	217.2	55	19.5	5	3.7	1	398.3	100
District 5	140.2	22	203.5	31	232.3	36	27.8	5	30.0	6	633.8	100
District 6	N/A		N/A		N/A		N/A		N/A			
ALL DISTRICTS	3,296.3	49	710.6	10	1,805	27	401.5	6	565.3	8	6,779.4	100

Source: DHAs

Notes:

1) District 1 = 1986/7 figures deflated by 4% to 1985-6 basis
2) District 2 = 1986-7 figures deflated by 4% to 1985-6 basis
3) District 3 = 1986-7 figures deflated by 4% to 1985-6 basis
4) District 4 = 10 year cumulative revenue and capital expenditure ÷ 10

TABLE 1.4: General Practitioner Services (1987)

	1 Number of GPs	2 Population per GP
District 1	241	1838
District 2	155	1265
District 3	270	1789
District 4	81	2219
District 5	168	1789
District 6	279	1864

Source: FPCs

Table 2.1: Estimates of Total DHSS Benefits Payments to Residents of Independent Residential Care and Nursing Homes (1986)

	(1) Elderly	(2)	(3) Mentally Ill	(4)	(5) Mentally Handicapped	(6)	(7) Physically Disabled	(8)	(9)
	Total Resid.	Total Payments (£'000s)	Total Resid.	Total Payments (£'000s)	Total Resid.	Total payments (£'000s)	Total Resid.	Total Payments (£'000s)	Total Payments (£'000s)
District 1	5033	12,837.2	94	392.8	110	482.6	81	285.1	13,997.7
District 2	599	1,527.8	66	276.1	6	26.3	0	0.0	1,830.2
District 3	719	1,833.9	48	200.8	124	543.9	268	943.3	3,521.9
District 4	592	1,509.9	162	677.6	6	26.3	104	366.1	2,579.9
District 5	453	1,155.4	77	322.1	98	429.9	65	228.8	2,136.2
District 6	1811	4,619.1	0	0.0	55	241.3	107	376.6	5,237.0
6 DISTRICTS		23,483.3		1,869.4		1,750.3		2,199.9	29,302.9

Notes: 1) Average payment in £ per week was taken as £98.10 (February 1986 prices)

Source: Public Support for Residential Care, DHSS, 1987 p90 Table 3.

2) The percentage of total residents financially supported by Supplementary Benefit Board and Lodging (SB B & L), and by SB B & L topped up, was calculated from the findings of a survey of 854 establishments in 17 local authority areas conducted in Autumn 1986 and Spring 1987. This survey was commissioned by the DHSS and conducted by the Centre for Health Economics University of York, and the Personal Social Services Research Unit at the University of Kent. The percentage supported by SB B & L were as follows: Elderly 50%; Mentally Handicapped 86%; Mentally Ill 82%; Physically Disabled 69%.

Table 3.1 Total Expenditure on all Client Groups and all Types of Provision, by DHA and Provider (1985-6)

	1 DHA £'000s	2 % ROW	3 LA £'000s	4 % ROW	5 Private/ Voluntary £'000s	6 % ROW	7 DHSS Benefits £'000s	8 % ROW	9 All £'000s	10 % ROW
District 1	15555.4	35	14002.2	32	964.0	2	13997.7	31	44519.3	100
District 2	10990.9	40	12657.9	46	1966.0	7	1830.2	7	27445.0	100
District 3	21686.3	42	23378.7	46	2626.0	5	3521.9	7	51212.9	100
District 4	20411.4	71	5159.6	18	549.9	2	2579.9	9	28700.8	100
District 5	34711.3	71	11542.3	24	366.0	1	2136.2	4	48755.8	100
District 6	29849.7	51	22456.3	39	764.6	1	5237.0	9	58307.6	100
District Total	133205.0	51	89197.0	34	7236.5	3	29302.9	11	258941.4	100

TABLE 3.2: Per Capita Expenditure on all Client Groups and all Types of Provision, by DHA and Provider (1985-6)

	DHA £s	LA £s	PRIVATE/ VOLUNTARY £s	DHSS BENEFITS £s	ALL £s
District 1	35	31	2	32	100
District 2	56	64	10	9	140
District 3	44	48	5	7	106
District 4	122	30	3	15	172
District 5	115	38	1	7	162
District 6	57	43	1	10	112
6 District Average	63	42	3	14	123

TABLE 3.3: Total Expenditure from all Sources on all Types of Provision, by DHA and Client Group (1985-6)

	1 Elderly £'000s	2 % ROW	3 Mentally Ill £'000s	4 % ROW	5 Mentally Hand/cppd £'000s	6 % ROW	7 Physically Disabled £'000s	8 % ROW	9 All £'000s	10 % ROW
District 1	31784.3	71	6232.2	14	4411.1	10	2091.7	5	44519.3	100
District 2	13891.5	51	8138.5	30	4093.8	15	1321.2	5	27445.0	100
District 3	34849.9	68	5075.6	10	8172.2	16	3115.2	6	51212.9	100
District 4	8203.6	29	10168.8	35	9053.3	32	1275.0	4	28700.8	100
District 5	19063.4	39	9152.5	19	19375.7	40	1164.2	2	48755.8	100
District 6	31242.0	54	12746.4	24	11925.4	20	2393.7	4	58307.6	100
; District Total	139034.7	54	51514.0	20	57031.5	22	11361.0	4	258941.4	100

TABLE 3.4: Per capita Expenditure from all Sources on all Types of provision, by DHA and Client Group (1985-6)

	Elderly £s	Mentally Ill £s	Mentally Hand/cppd £s	Physically Disabled £s	All £s
District 1	72	14	10	5	100
District 2	71	41	21	7	140
District 3	72	10	17	6	106
District 4	49	61	54	8	172
District 5	63	30	64	4	162
District 6	60	25	23	5	112
6 District Average	66	24	27	5	123

Table 3.5 : Expenditure on Elderly Client Groups per head of Population 65+, (1985-6)

	1 Including DHA Inpatient Care £s	2 Excluding DHA Inpatient Care £s
District 1	316	266
District 2	529	456
District 3	448	291
District 4	276	193
District 5	404	262
District 6	668	464

Table 3.6 : Expenditure on Elderly Client Groups (65+) Divided by the 75+ Population (1985-6)

	1 Including DHA Inpatient Costs £s	2 Excluding DHA Inpatient Costs £s
District 1	676	570
District 2	1161	1002
District 3	1046	670
District 4	631	439
District 5	980	635
District 6	1717	1194

Table 3.7 Per Capita Expenditure for Mental Illness Client Groups - Including and Excluding DHA Inpatient Costs (1985-6)

	Including DHA Inpatient Costs	Excluding DHA Inpatient Costs
	£s	£s
District 1	14	5-1
District 2	41	6-4
District 3	10	5-8
District 4	61	9-3
District 5	30	4-0
District 6	25	2-9

Table 3.8 Per Capital Expenditure for Mental Handicap Clients including and excluding DHA Inpatient Costs (1985-6)

	Including DHA Inpatient Costs	Excluding DHA Inpatient Costs
	£s	£s
District 1	10	10
District 2	21	17-1
District 3	17	10-2
District 4	54	7-5
District 5	64	9-4
District 6	23	13-9

TABLE 3.9: Total Expenditure Across all 6 Districts on all Client Groups, by Type of Provision and Provider (1985-6)

	1 District Health Authorities £'000s	2 % ROW	3 Local Authorities £'000s	4 % ROW	5 Private/ Voluntary Sector £'000s	6 % ROW	7 DHSS Benefits £'000s	8 % ROW	9 All £'000s	10 % ROW
RESIDENTIAL/ HOSPITAL CARE	112321.3	59	42769.6	23	4740.7	3	29302.9	15	189134.5	100
(% of column)	(85)		(47)		(65)		(100)			
GROUP HOMES	2293.0	99	17.2	1	-	0	-	0	2310.2	100
(% of column)	(0)		(2.4)							
DAY CARE	4447.1	23	14716.7	77	-	0	-	0	19163.8	100
(% of column)	(3.3)		(16.0)							
RESPITE CARE	397.9	40	600.0	60	-	0	-	0	997.9	100
(% of column)	(0.3)		(0.6)							
COMMUNITY SERVICES	13745.7	29	31093.5	66	2495.8	5	-	0	47335.0	100
(% of column)	(10.0)		(34.0)		(34)					
ALL TYPES OF PROVISION	133205.0	51	89197.0	34	7236.5	3	29302.9	11	258941.4	100
(% of column)	(100)		(100)		(100)		(100)			

TABLE 3.10: Per capita Expenditure across all 6 Districts on all client groups, by Type of Provision and Provider (1985-6)

	District Health Authorities £s	Local Authorities £s	Private/ Voluntary Sector £s	DHSS Benefits £s	All £s
RESIDENTIAL/ HOSPITAL CARE	53	20	2	14	90
GROUP HOMES	0	0	0	0	0
DAY CARE	2	7	0	0	9
RESPITE CARE	0	0	0	0	0
COMMUNITY SERVICES	7	15	1	0	22
ALL TYPES OF PROVISION	62	42	3	14	121

TABLE 3.11 : Total Expenditure Across All 6 Districts on all Types of Provision by Provider and Client Group (1985-6)

	1 Elderly	2	3 Mentally Ill	4	5 Mentally Hand/cppd	6	7 Physically Disabled	8	9 All	10
	£'000s	% ROW	£'000s	% ROW	£'000s	% ROW	£'000s	% ROW	£'000s	% ROW
)ISTRICT IEALTH ιUTHORITIES	50174.6	35	45730.4	36	36265.2	26	1034.7	1	133204.9	100
(% of column)	(36)		(90)		(63)		(9.1)		(51.4)	
ιOCAL † ιUTHORITIES	63103.0	71	3001.8	3	17039.8	19	6052.4	7	89197.0	100
% of column)	(45)		(4.9)		(29)		(53)		(34.4)	
'RIVATE/ 'OLUNTARY ;ECTOR	2273.8	31	912.5	30	1976.2	27	2074.0	29	7236.5	100
% of column)	(1.6)		(1.5)		(3.4)		(18)		(2.8)	
'HSS BENEFITS	23483.3	80	1869.4	6	1750.3	6	2199.9	8	29302.9	100
% of column)	(16)		(3.0)		(3.0)		(19)		(11.4)	
LL PROVIDERS	139034.7	54	51514.0	20	57031.0	22	11361.0	4	258941.4	100
% of column)	(100)		(100)		(100)		(100)		(100)	

TABLE 3.12: Per capita Expenditure across all 6 Districts on all types of Provision by Provider and Client Group (1985-6)

	Elderly £s	Mentally Ill £s	Mentally Hand/cppd £s	Physically Disabled £s	All £s
DISTRICT HEALTH AUTHORITIES	24	26	17	<1	67
LOCAL AUTHORITIES	30	1	8	3	42
PRIVATE/ VOLUNTARY SECTOR	1	<1	1	1	3
DHSS BENEFITS	11	1	1	1	14
ALL PROVIDERS	66	29	27	5	127

Figure 1: Total Expenditure on all Community Care Client Groups (%)

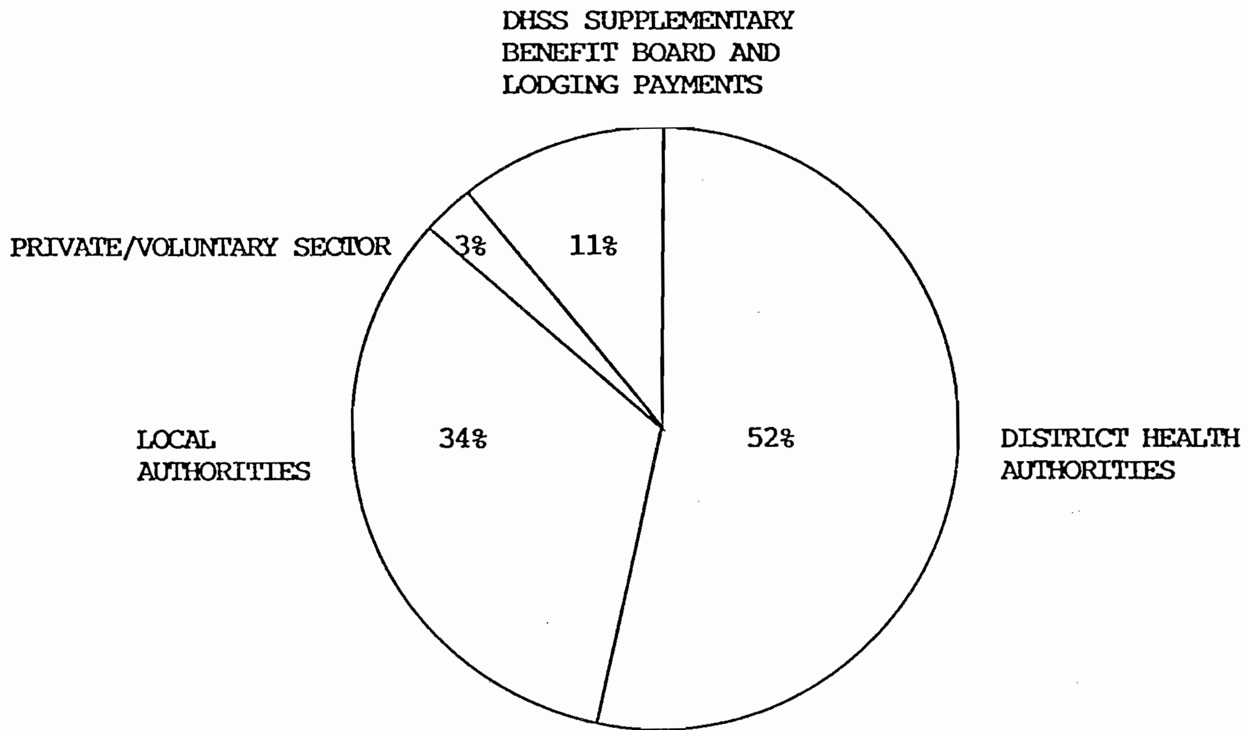

Figure 2: Total Expenditure from all sources on all types of Provision, by DHA and Client Group

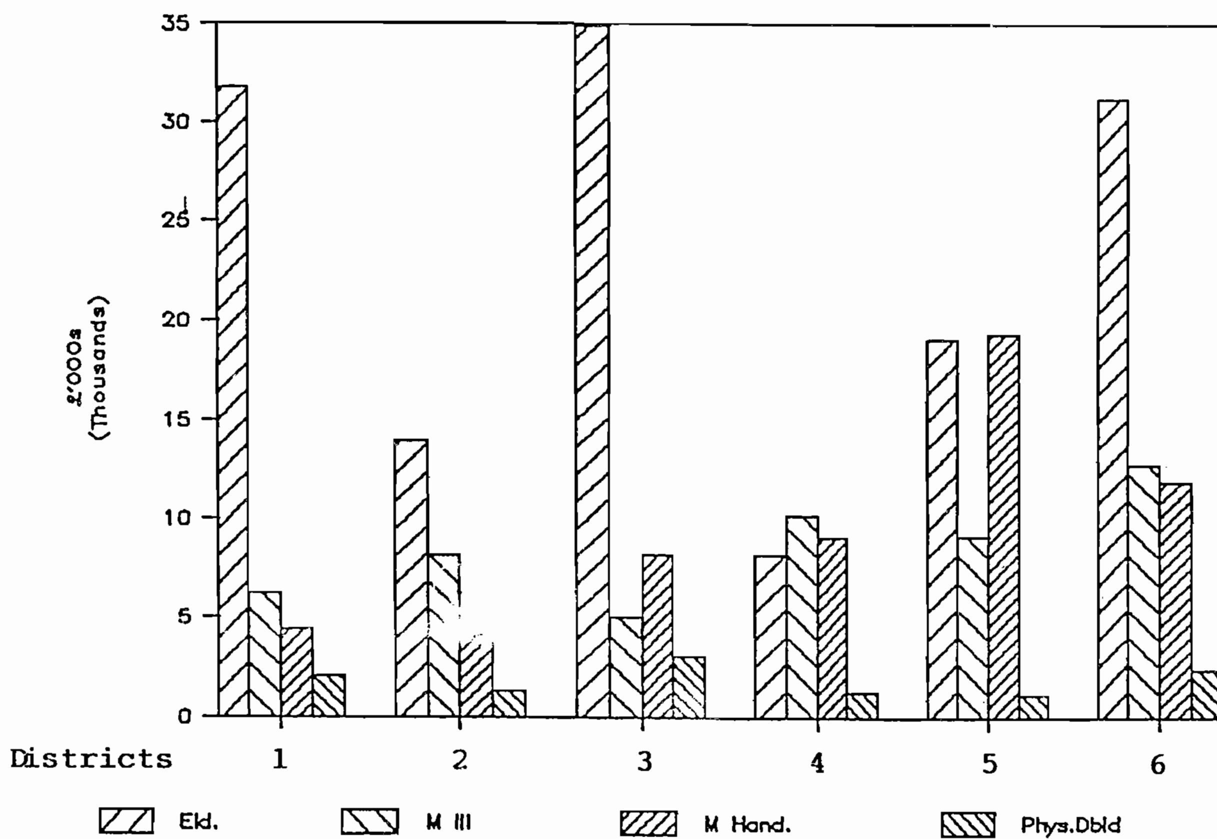

Figure 3: Total Expenditure on the 4 Main Community Care Client Groups (%)

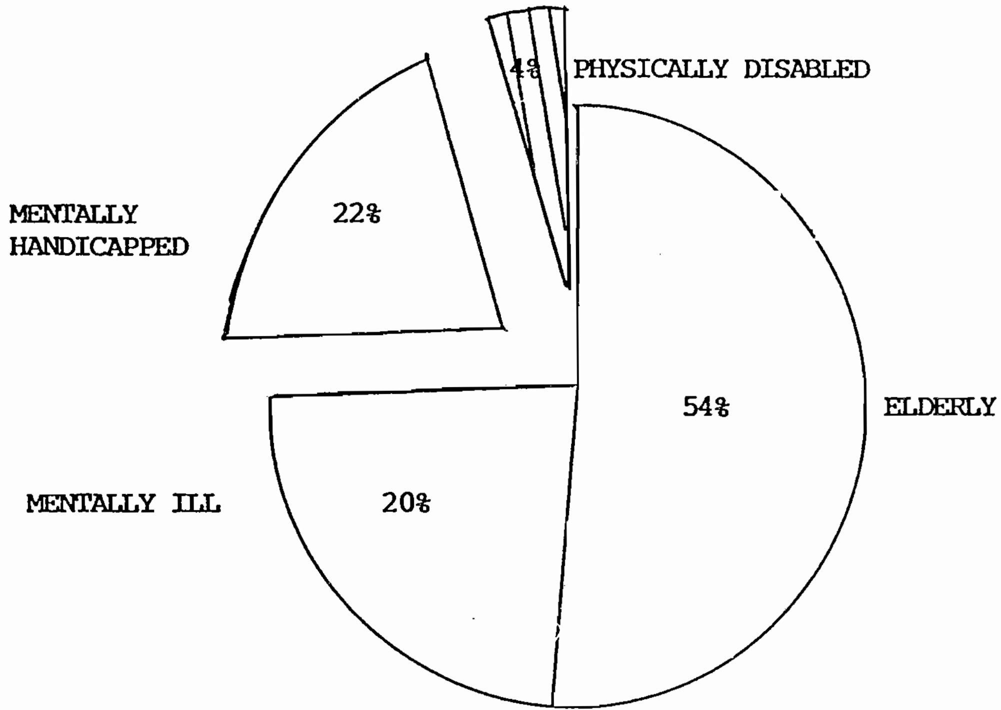

Figure 4: Per Capita Expenditure from all sources on all types of Provision, by DHA and Client Group

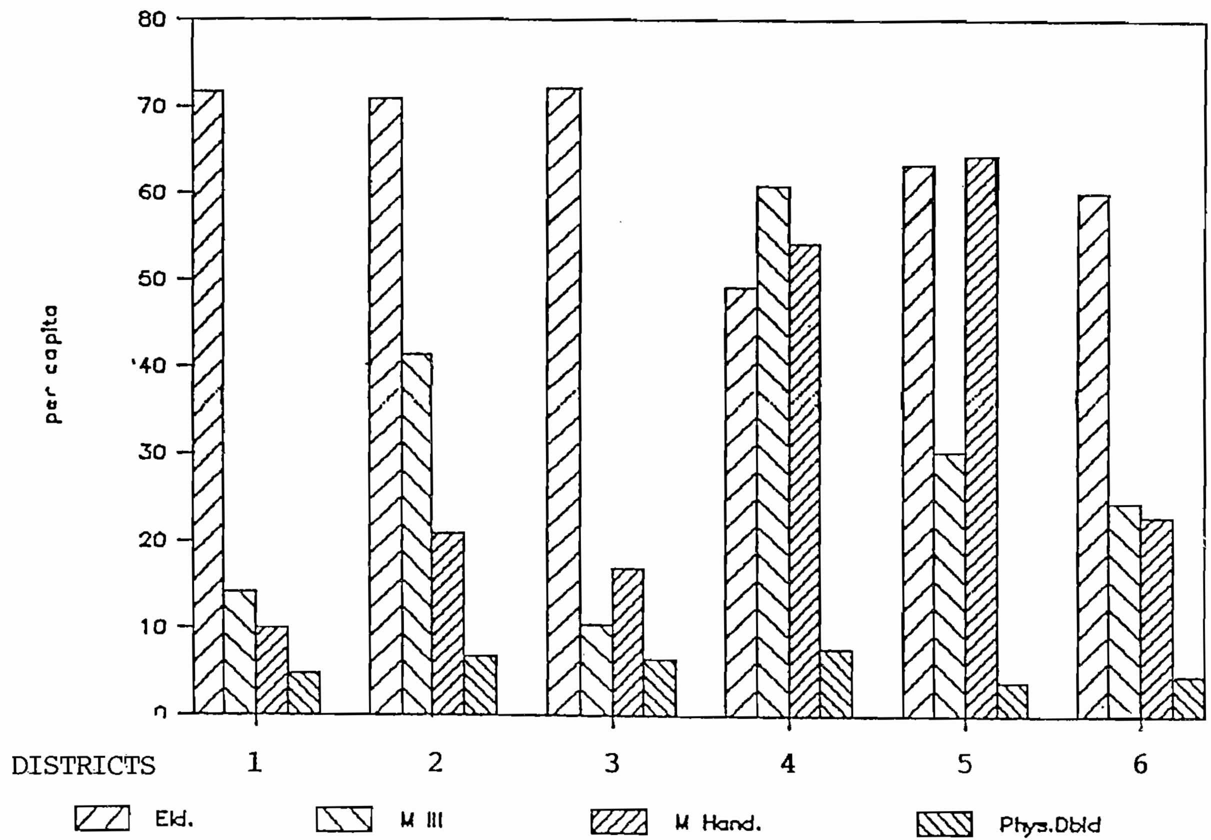

Figure 5: Expenditure from all sources on all Community Care Client Groups, by Type of Service