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PUBLIC EXPENDITURE ON SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

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ABSTRACT

The allocation of resources to health and social care agencies for services for people with learning disabilities has long been a source of debate and disagreement, centring around the failure of the balance of financing to reflect the increasing consensus that the overwhelming need of people with learning disabilities is for social care, and concerns that the funds released from institutional closure programmes were failing to reach the community.

This paper presents the results of a two year project to explore these and related issues by developing national estimates of expenditure on services for people with learning disabilities through information gathered from a stratified sample of local authority areas. At local levels, information was requested from social services, health authorities, district housing authorities, and local education authorities. The information from health and social services authorities was extrapolated to national levels to allow comparison with the most recent national programme budget figures. The information from housing and education authorities was to inform debates over substitution, where health and social services substitute the activities of other local authority departments for their own.

The results confirm that at local levels the majority of expenditure remains under health auspices. The national estimates also represented a significant increase over the programme budget figures, though this was anticipated given the different service coverage. The paper concludes with a discussion of the implications of the results both for local agencies and central government.

INTRODUCTION

The allocation of resources to health and social care agencies for services for people with learning disabilities has long been a source of debate and disagreement, centring around the failure of the balance of financing to reflect the increasing consensus that the predominant needs of people with learning disabilities are for social care (NHSME, 1993). Central initiatives have attempted to promote the realignment of statutory responsibilities or introduce mechanisms to ensure the transfer of finance and responsibilities. Recently, the debate has also surrounded the total levels of expenditure available for this client group, amid fears that funds released from institutional closure programmes were failing to reach the community (Glover et al, 1993).

Reference to official statistics offers partial answers. Analysis of the most recent national programme budget information (Health Committee, 1993) reveals that most of the identified expenditure remains under health auspices. There also appears to be no decline in the total resources available.

The limitations of the national programme budget exercise should be recognised. The restricted agency coverage means that the programme budget is an increasingly unreliable indicator of total expenditure upon this client group, as the two statutory agencies seek to diversify their funding sources and deflect costs elsewhere. Even within the coverage of the two main agencies, there are omissions. For social services, there are no allowances for fieldwork or the input of management and support services. For health authorities, the increasingly important community health and paramedical services are not included, with the

exception of specialist nursing. As Jones and Prowle (1987) have pointed out, the result is "a broad apportionment of spending."

This paper presents the results of a two year study to explore these and related issues. Research in a stratified sample of ten local authority areas gathered information from social services, district health, district housing and local education authorities. This information was used for three purposes. The information from health and personal social services was extrapolated to national levels for comparison with recent programme budget figures. The information from housing and education authorities question whether health and social services substitute the activities of these agencies for their own, especially for the provision of residential and day services. It was further hoped that the methodology could be extended to other client groups and repeated in the future to monitor changes in expenditure over time.

The definition of learning disability adopted was service led i.e. people with learning disabilities are those in receipt of services for people with learning disabilities, therefore our focus was upon those services where the inputs into this client group would be discrete and identifiable. For social services, this excluded a range of services (home care, for example) which respond to the needs of small numbers of people with learning disabilities. For the health services, inputs provided by general practitioners and referrals to the acute sector were similarly omitted.

Following a description of the sampling process and the sample areas, the results from each of the agencies are considered in turn with a commentary. The national estimates for health and social services derived are then compared with the most recent programme budget figures.

The paper concludes with a summary of the main implications of this research for local agencies and for central government.

Composition and description of the sample

The selection of the local authorities was informed by a sampling frame based on the Craig classification (OPCS, 1985), which applied cluster analysis to data covering thirty five socio-economic variables derived from the 1981 Census returns. The results grouped local authorities into twenty eight clusters in six families.

This approach was not entirely suitable for our purposes since the classification for non metropolitan local authority areas was based upon district councils rather than county councils. The constituent districts of each county were considered with reference to their "family" and resident population, and where possible the county was allocated to an existing family. County councils were allocated to a single existing family where over fifty per cent of its resident population were identifiable with a single family. The remainder formed two distinct categories and these formed two additional families. The frame also included client group expenditure data derived from CIPFA Personal Social Services Statistics 1990/91 Actuals, (CIPFA, 1992).

To reflect inter authority client group specific expenditure patterns, the sample consisted of five non metropolitan county councils, three metropolitan districts, one inner London borough and one outer London borough. The particular authorities were selected for a number of reasons. Each of the main "families" was be represented, and an even geographical

distribution was pursued. The presence of large long stay facilities, and the existence of first wave trusts, were other determining factors. Finally, importance was attached to the need to avoid areas which were already collaborating with research initiatives.

The ten social services authorities selected were coterminous with ten local education authorities, and thirty nine district housing authorities. At the time of selection, the ten social services authorities contained twenty two district health authorities. The population of the areas ranged from 152,000 to 1,035,000, with an average across the areas of 467,820 (OPCS, 1993). The total population of the sample areas represented 9.73% of the national population.

Results from Social Services Authorities

This section describes the results from the ten social services departments in the sample, with expenditure categorised either as relating to residential care, day care, fieldwork, or management and support services. Gross expenditure per capita of the general population in each of the sample areas is shown in Table 1. The category analyses include the results from only eight sample areas, since in the remaining two areas, the expenditure information received was not classified by type of care.

The residential care figures include all directly provided residential and respite services, as well as services purchased from private and voluntary bodies and other local authorities. The higher levels of expenditure are associated with those authorities involved in large resettlement schemes. Income in the eight authorities covered 31% of gross expenditure, dominated by income from health authorities (15%), and from residents (13%). There was an increasing

move towards group home schemes which were frequently self financing as residents received both income support and housing benefit.

Day care expenditure relates to the purchase or provision of places in adult training centres, resources centres (including community, social and leisure centres), and employment services. Gross expenditure on day care was dominated by adult training centres which accounted for 82% of total expenditure. Income from all sources covered 13% of total gross expenditure. The figures describing gross expenditure per capita on fieldwork and management and support services are only indicative, owing to the different methodologies used in compiling the estimates.

Review of the total expenditure figures across the social services authorities reveals a range from £9.83 to £24.84 with an average across the ten authorities of £16.40. In general, gross expenditure was highest in the London boroughs and lowest in the shire counties. The largest element of gross expenditure in most of the authorities was day care. The Audit Commission suggested that spending by social services departments on services for people with learning disabilities varies by a factor of up to six to one (Audit Commission, 1986). Although not borne out by the total expenditure figures, when gross expenditure on individual categories of care are considered similar trends do emerge. Gross expenditure per capita on residential care, for example, varies by almost six to one.

Table 1 **Gross expenditure on services for people with learning disabilities per capita of the general population in the ten social services authorities. 1992/3 prices**

	Residential Care £	Day Care £	Fieldwork £	Management £	Totals £
Non Metropolitan Counties (1)	2.18	5.00	1.48	1.83	10.49
(2)	5.06	6.32	0.61	2.10	14.10
(3)	-	-	-	-	24.84
(4)	-	-	-	-	10.07
(5)	4.58	4.64	0.53	2.02	11.78
Metropolitan Districts (6)	7.12	6.00	1.34	2.85	17.31
(7)	12.30	6.39	0.61	2.92	22.21
(8)	2.06	5.20	0.76	1.82	9.83
Outer London Borough (9)	6.34	11.04	1.91	4.41	23.69
Inner London Borough (10)	11.58	4.43	0.71	2.95	19.67

Discussion

There were large variations in the ability of the financial systems in the sample areas to identify expenditure relevant to the provision of services for people with learning disabilities. Residential care expenditure was identifiable, allocated to specific units or budgets, although the attribution of income was more difficult where income from health authorities or residents was held in a central budget. The identification of the main elements of day care expenditure was also accomplished without difficulty. Complications arose only where new service developments (social and leisure centres, employment services) served a range of client groups. In such instances, local activity information was used where available for the purposes of apportionment.

All the authorities had some specialist fieldwork services, however in only four areas did a separate budget exist for fieldwork services for people with learning disabilities. In the remaining authorities, existing establishments were examined where possible to identify relevant managers and practitioners, the salary details for the individuals collected from personnel systems, and on costs and non pay expenditure apportioned pro rata. Failing this, total fieldwork expenditures were apportioned pro rata to that percentage of total client group specific expenditure incurred in the provision of services for people with learning disabilities.

Identifying management and support services was also difficult, particularly in isolating a consistent core of services for classification purposes. The core functions identified characteristically included a range of social services based functions (management, training, research and development, etc) and any recharges from other local authority departments

(central establishment charges). In only five authorities did local methodologies exist for recharging management and support services across client groups, most developed only recently in response to,"Accounting for Social Services" (CIPFA, 1993). In the remainder, the general approach used for fieldwork services was applied in a similar manner to management and support services.

Results from District Health Authorities

At the time of selection, the ten local authorities contained twenty two district health authorities. During the data collection stage, mergers to form larger purchasing consortia reduced the number to nineteen. Information was forthcoming from fourteen of these, at least partially covering nine sample areas.

The project began during the first year of the purchaser provider separation in health care. In the first purchasing authorities approached, information related to the first year of the new arrangements, and under the existing system of block contracts, only contract totals were available. In later years, as contracting and information systems developed, further detail became available. In view of the differences in form and detail, the information could not be displayed in a common form. The information described in Table 2 represents the most detailed return from any authority.

The largest contract in all but one authority was between the purchaser and the local community provider unit. Contracts with providers outside of the host districts accounted for almost a third of total purchaser expenditure across the thirteen authorities (the information

from the pilot area being excluded as it predates the purchaser provider separation). Each purchasing authority had contracts with between one and nine out of district providers, producing an average of seven out of district contracts.

There was an increasing tendency for purchasers to contract directly with non health care providers (although many of the contracts with non health care providers remain managed by health care providers, and the expenditure accounted for within health provider contract totals). In one authority, 34% of total purchasing expenditure was transferred to social services. In another, 36% of expenditure was contracted to a housing consortium, established for the purpose of providing housing and care for people with learning disabilities, through a partnership between health and social services, housing associations, and the voluntary sector. In a third, 22% of expenditure was accounted for by a single contract with a local provider of community care group homes.

Table 2 **Summary of contract information available in one sample area towards the end of the project. 1992/3 prices**

Summary of contract with local provider unit (£,000).

Service Description	Contract Total
Long Stay	701
Community Residential	1415
Day Services	0
Respite Services	446
Community Services:	
Specialist Nursing	119
Psychology	48
Occupational Therapy	50
Physiotherapy	17
Speech Therapy	19
Contract total	2815

Summary of out of district contracts (£,000).

Provider Number	1	2	3	4	5	6	7	8	9
Long Stay	786	793	287	110	82	59	32	31	31
Residential, Day and Respite Services	217	202	0	0	0	0	0	0	0
Mental Illness Service	139	26	0	0	0	0	0	0	0
Contract Totals	1142	1021	287	110	82	59	32	31	31

Discussion

The extent to which health purchasers were able to identify expenditure on services for people with learning disabilities was more varied than for social services. Although explained in part by the very recent introduction of the purchaser provider separation in health care, the quality of the information base in some authorities was still surprisingly poor. By the end of the study, some authorities remained unable to disaggregate their community contracts into the constituent elements of community, mental health, and learning disability services.

However, in the later authorities contacted, there were signs of significant progress, although the dangers of different approaches being developed in different localities, both in terms of definitions and methodology, were also evident. Recent guidance from the centre (NHSME, 1993) should ease these dangers.

Results from the sample areas

The results from combining the health and social services estimates in each of the sample areas are shown in Table 3. The district health authority figures for each of the sample areas were derived by aggregating the results from the constituent authorities. The figures in brackets highlight those areas where the information available from health authorities covered only a part of the particular local authority's resident population. In the first, the information received from health purchasers encompassed 63% of the local authority's population (four out of five purchasing authorities), whilst in the second the figure was 39% (one out of three purchasing authorities). Expenditure remains highest in the London boroughs, whilst the gap

between non metropolitan counties and metropolitan districts has narrowed, since the lower expenditure on social services in non metropolitan counties is compensated for by higher health authority expenditures.

Table 3 **Aggregate results from nine sample areas. 1992/3 prices**

	Gross Expenditure Per Capita (£)			
	Social Services	Health Authorities	Totals	Group Average
Non Metropolitan Counties	10.49	17.51	28	
	14.10	13.73	27.83	
	24.84	21.09	45.93	32.51
	10.07	(25.54)	35.61	
	11.78	(13.41)	25.19	
Metropolitan Districts	17.31	16.16	33.47	
	9.83	13.91	23.74	28.60
Outer London Borough	23.69	30.76	54.45	54.45
Inner London Borough	19.67	21.50	41.17	41.17
Agency averages	15.75	19.29	35.04	

Results from District Housing Authorities

The social services departments in the sample were coterminous with thirty nine district housing authorities, with responses received from sixteen authorities. The housing element can be considered as two discrete elements; the role of district housing authorities and inputs from the Housing Corporation.

The transfer or leasing of local authority housing to health or social services to provide accommodation for people with learning disabilities was the most common arrangement. Apart from the minor expenses such as legal costs, there were no financial implications for district housing authorities as the amount of rent recovered from health or social services was the same as would otherwise have been forthcoming from a normal tenant. There are significant gains for health and social services. The properties are let at a council house rental value, which is significantly less than the figure payable for similar accommodation on the open market. The statutory agency is also able to recoup housing costs from residents who are eligible for housing benefit.

In developing their "enabling" role, district housing authorities were also becoming increasingly involved in partnerships with statutory agencies, housing associations and voluntary bodies. The primary input of the housing department in one area was to contribute to the work of a housing consortium for people with learning disabilities, with the aim of meeting the perceived accommodation needs of the large number of people with learning disabilities either requiring resettlement in the community from hospital, or living with elderly carers. The core membership was the social services and housing departments, the health authority and two housing associations.

Other schemes were encountered where the land was sold by the housing department to a housing association at a discounted value, with capital funding for construction forthcoming from the Housing Corporation. In other instances, the role of the housing department was simply to act as an adviser and facilitator. Examples include schemes where the health authority provided the capital funding for projects, with the construction and eventual management being the responsibilities of a housing association and others where a voluntary agency approached a housing association, who sought funding from the Housing Corporation and assumed responsibility for construction, before handing over management responsibilities to the voluntary body upon completion.

Housing departments were also becoming involved in the community care planning process, a development which has its basis in legislation. In developing their community care plans, Section 46 of the NHS and Community Care Act requires social services authorities to consult local housing authorities in so far as the plans are affected by the availability of housing in their area. Section 47 requires social services authorities to notify the local housing authority if there appears to be a housing need, and to invite them to assist in the assessment. Local housing authorities for their part are expected to develop housing strategies for community care in conjunction with social services departments and other housing providers (Department of the Environment, 1992). In most authorities who responded, housing officials were present on a range of groups, involved in assessing needs and developing collaborative strategies.

The Housing Corporation provides funding for housing associations for schemes which have the "primary purpose" of providing housing. It offers capital finance, in the form of Housing Association Grant (HAG), and revenue funding for special needs schemes termed Special Needs Management Allowance (SNMA). Other publications have speculated upon the future

for "special needs" housing, given the changing role of housing associations (Watson and Cooper, 1992). This section examines how far Housing Corporation allocations currently finance schemes for people with learning disabilities.

The distribution of the Corporation's capital funding in 1992/3 is analysed in Table 4 by client needs group, compiled through an analysis of investment codes, compulsory on all scheme applications, which identify the particular client needs groups at which a scheme is aimed. The table distinguishes between "general" needs groups, and "special" needs groups. "General" needs groups include the homeless and first time buyers while "special" needs groups are defined as requiring "housing which caters for tenants with a need for a more supportive and intensive style of housing management than is found in "ordinary" housing". Schemes for people with learning disabilities account for 1.23% of total expenditure, with the total expenditure on schemes for people with learning disabilities amounting to £20.3 million.

In the case of revenue funding, client needs group differentiation is possible by a process similar to investment code analysis. The amounts of Special Needs Management Allowance allocated to schemes for people with learning disabilities totalled £2.111 million in the financial years 1991/2 and 1992/93.

Table 4 **Distribution of Housing Association Grant. Financial year: 1992/3**

		Expenditure £,000	Expenditure as a percentage of total %	Expenditure as a percentage of special needs sub total %
"Special" Needs Groups	People with alcohol related problems	3087	0.19	1.86
	People with drug related problems	853	0.05	0.52
	Frail elderly	24307	1.47	14.68
	People with mental health problems	27926	1.68	16.86
	People with learning difficulties	**20389**	**1.23**	**12.31**
	Ex offenders	4732	0.29	2.86
	People with physical disabilities	30523	1.84	18.43
	Refugees	11012	0.66	6.65
	Vulnerable mothers and babies	12740	0.77	7.69
	Womens Aid projects	3716	0.22	2.24
	People with HIV/AIDS	7582	0.46	4.58
	Young people at risk	18721	1.13	11.31
"Special" Needs Sub Total		165588	10.00	100.00
"General" Needs Sub Total		1492396	90.00	
TOTALS		1657984	100.00	

Discussion

It is difficult to conclude from the information available whether health and social services are increasingly substituting the funding of other agencies for their own in discharging their housing responsibilities. The role of housing authorities in the sample areas was limited, rarely moving far beyond participation in community care planning mechanisms. As housing officers repeatedly pointed out, the housing needs of people with learning disabilities must compete with other groups (such as families) to whose needs they have a statutory obligation to respond.

It is too early to evaluate whether social services departments are consciously targeting sheltered housing for dependent clients. At this early stage, housing officers were concerned about the possibility of inappropriate referrals, and particular instances were cited to support this. It has been reported that many directors of social services "clearly see sheltered housing as a viable option to residential care for vulnerable and dependent people". (Johnson, 1993). The present statutory framework would permit this development and both local authority housing stock and Housing Corporation funds could be targeted for this purpose. Although the Housing Corporation will not provide funding for schemes which they see as the responsibility of other agencies (for example hospital resettlement schemes) this is a grey area and funding may be available from this source for individuals who have not come into contact with the two statutory agencies.

Results from local education authorities

The institutions involved in providing further education opportunities were primarily colleges of further education and colleges of arts and technology, providing discrete courses for students with mild or moderate and severe learning disabilities. There was increased importance attached to students with mild and moderate learning disabilities infilling onto mainstream courses.

It was not possible to develop expenditure estimates due to the inability of existing recording systems to accurately identify students with learning disabilities and their course participation, and also the inability of the financial systems to allow the costing of individual courses or course components.

The inability of individual colleges to identify students with learning disabilities has its source in legislation. The 1981 Education Act abolished the existing specific categories of handicap (such as mental handicap) in favour of an emphasis upon special educational needs. The definition of special educational need includes adults with learning disabilities, and also those with physical or sensory impairments, and emotional or behavioural difficulties. Although it was common for authorities to record the numbers of number of students with special needs on discrete courses, it was not possible within this group to isolate students with learning disabilities, or to identify students with learning disabilities on mainstream programmes.

The process was further complicated by the provisions of the Further and Higher Education Act 1992. This legislation established from 1 April 1993 a new Further Education Funding

Council which adopted a number of the statutory duties formerly held by LEAs. Some five hundred colleges of further education and sixth form colleges were transferred away from LEA control, and incorporated as independent institutions, funded through the Council (Department of Education, 1993).

The new arrangements uphold the requirement for the authorities to provide for, and have regard to, the needs of students with learning disabilities. The FEFC must ensure "adequate" provision of those courses covered under schedule 2 of the Further and Higher Education Act, which includes courses teaching basic skills, independent living and communication skills to students with learning disabilities. LEAs remain under a duty to secure further education for people with learning disabilities where the FEFC has no obligation, as in the case of non-certificated leisure classes.

The Chief Executive of the FEFC outlined at an early stage that it was "publicly committed to providing continuity of provision for students with learning difficulties and disabilities who are attending relevant courses" (Hewitson-Ratcliffe, 1992). To inform its allocation of resources for 1993/4, a comprehensive survey of colleges on behalf of the FEFC revealed there are currently around 100,000 students with learning difficulties and disabilities (sic) in further education colleges in England, with a further 1700 students placed in independent institutions.

Discussion

Although the poor data again prevents an assessment of whether health and social services authorities are substituting further education classes for their own day services, no such concerns were expressed. The main concerns of the education officers who responded were related to impact of the recent legislation upon the quantity and quality of further education provided for all special needs groups, including people with learning disabilities.

There were concerns that LEAs might be disadvantaged in the calculations for the initial transfer of funds to the FEFC, which were particularly serious given that LEAs have retained the statutory obligation to secure the provision of particular courses. Moreover, those colleges redesignated as further education corporations are now responsible for their own internal management, and their funding is a matter for determination between individual colleges and the FEFC, and LEAs are no longer able to provide any strategic or financial overview of provision in their area. Social services will in the future have to liaise directly with individual colleges, and as a result, the presence of LEA officials on the joint planning machinery was in doubt.

National estimates and comparison with programme budget figures

Our results are compared with the equivalent national programme budget figures in Table 5 (Health Committee, 1993). For each agency, two alternative methodologies for extrapolation are described. For social services, the age specific population base extrapolates the information in proportion to the percentage of the total national population under the age of sixty five resident in the authorities in the sampling frame (OPCS, 1993). To develop an activity related base, gross expenditure on residential care and adult training centres were isolated. These two elements, accounting for over two thirds of total social services gross expenditure in the sample areas were extrapolated separately with reference to Department of Health Local Authority Statistics (Department of Health, 1992a: Department of Health, 1992b).

The extrapolation of health information to national levels was complicated by the different methods of financing services for people with learning disabilities. In addition to districts allocating funds from their weighted capitation allocations, funds were also available from some regional health authorities who top-sliced district allocations in order to compensate those districts with more institutional providers than average and therefore more of those clients defined as "old long stay".

A three stage process was devised. The first stage involved grossing individual district expenditures, financed from weighted capitation allocations, to regional levels using age specific population information. Any regional expenditures could then be added to produce comprehensive regional totals. These regional totals were then extrapolated to national levels

using both population and activity information. In the absence of any purchaser based activity information, numbers of finished consultant episodes were used as the basis for extrapolation (Department of Health, 1993).

For social services, the figures produced by this research are, on average, over 52% higher than the programme budget figures. The difference can be partly explained by differences in coverage i.e. the programme budget excludes fieldwork and management and support services expenditures, though the individual Residential Care and Day Care ATC estimates produced using our activity base also represent increases on the programme budget figures despite similar coverage.

Comparison of expenditure on particular service areas was not possible for health authorities. Consistent service differentiation was not possible for the sample area information, while the programme budget differentiates only between Learning Disability Inpatients, Learning Disability Outpatients, and Community Mental Handicap. The two estimates derived from our research for the health service also represent increases over the programme budget figures. The age specific population base produced an increase of 28.47% while the use of the two alternate bases (age specific and activity) produced an increase of 3.27%.

Table 6 **Gross national expenditure on health and personal social services. 1992/3 Prices. Comparison of research estimates with national programme budget figures**

Personal Social Services

Research figures using		National Programme Budget figures
a) Age specific base	b) Activity base	
	Residential Care £308.832m	Residential Care £229.700m
	Day Care ATC £246.019m	Day Care ATC £240.800m
Total £703.927m	Total £729.395m	Total £470.500m

District Health Authorities

Research figures using		National Programme Budget figures
a) Age specific base	b) Age specific and activity bases	
Total £1100.661m	Total £884.751	Total £856.740m

Implications for local agencies

There are difficulties in identifying the resources currently available for services for people with learning disabilities in a particular locality. Success in this may determine the pace of progress towards joint commissioning. Recent developments offer the prospect of progress.

For social services, difficulties were encountered in isolating the input of fieldwork and management and support services. However, implementation of the recent reforms requires that authorities undertake a radical revision of their financial information systems (CIPFA,1992), the impact of which will be to make client group differentiation easier. The trend towards distinguishing between purchasers and providers makes it increasingly untenable to regard fieldwork as a separate division of service. Similarly, the recommendations require that all costs defined as Social Services Management and Support Services should be fully apportioned to other divisions of service, either by means of an apportionment or a charge.

Information available from district health authorities will improve as they revise their contracting arrangements, moving away from block contracts towards more sophisticated contract forms. Purchasers are also reclaiming responsibilities for resettlement programmes which until recently had been subcontracted to provider units. Purchasers may for the first time have sufficient understanding of their current investment to evaluate the current balance of services and determine future priorities. Provider information will become more reliable, with present initiatives to prescribe minimum costing standards and to define common "currencies" for use in the contracting process assisting this process (NHSME, 1993), though this detail may not be shared with purchasers if perceived as market sensitive.

There was also increasing evidence of effective partnerships. Although stimulated by the need to collaborate over hospital discharge arrangements and in the preparation of community care plans, many strong local partnerships were already in existence, often based on the acceptance by health authorities that the overwhelming needs of people with learning disabilities were for social care. Joint statements of philosophy and policy were common, followed in a few authorities by initiatives to introduce joint purchasing or commissioning, to be driven by the establishment of a ring fenced budget through contributions from the two agencies. Similar progress is reported in other more detailed research (Kings Fund, 1993; Wertheimer and Gregg, 1993).

Implications for central government

This exercise has revealed little about the national programme budgeting exercise that was not already well documented. Pole (1974) offered a lucid account of its strengths and weaknesses only shortly after its development. More recently, Bosanquet (1986) has commented on the poor coverage of informal care or care in unstaffed schemes, and suggested that the programme budget could be adapted to provide much more information on need and dependency.

Our proposals are much less ambitious, and concern the relevance of the existing classifications. The division between Residential Care and Day Care ATC for social services and Learning Disability Inpatients, Learning Disability Outpatients, and Community Mental Handicap (sic) for health authorities are now failing to answer the most important policy questions. For social services, more appropriate distinctions might be between residential and

domiciliary care. There is also a need to extend the coverage to include services such as fieldwork. For health authorities, as the inpatient population continues to decline, this focus could be replaced by the monitoring of levels of service available in the community.

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). A revised programme budget would allow central government to monitor the impact of policies and practice guidance upon authorities, and assess progress towards implementation.

Conclusions

The development of national expenditure estimates with reference to local information sources will always be heavily dependent upon local information systems. This research found information systems in a stage of transition. Estimates were derived for health and social services authorities, though not without difficulties. For social services, a range of methodologies were necessary to apportion fieldwork and management and support services expenditures across client groups. For health authorities, the existing health care purchasing information systems rarely offered much detail. Recent developments promise that a similar exercise in the future could be completed with greater ease and accuracy. Further difficulties were encountered with district housing and local education authorities. Unlike health and social services, these agencies were not able to routinely produce financial information by client group.

Review of the information collected reveals that most expenditure remains under health authority auspices, with purchasing plans dominated by inpatient or residential services, and almost a third of all health expenditures in the sample areas flowing to provider units outside the host district. Social services expenditures were dominated by residential and day care, with day care expenditures in turn dominated by adult training centres. Although little information was available in relation to the other agencies, the anecdotal evidence suggested that their inputs are so far relatively small.

The research process highlighted some of the difficulties in extrapolating local information to national levels, caused by the different methods of funding health services for people with learning disabilities, and by the absence of any purchaser-based activity information. Provider based activity information was therefore used to extrapolate purchaser based expenditures to national levels.

The research has implications for local agencies and central government. Local agencies should continue to develop their information systems so that accurate and detailed information on current resource use can be introduced to collaborative arrangements. For central government, revisions to the existing national programme budget may be timely.

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