THE SCOTTISH DIFFERENCE:

POLICY AND PRACTICE IN COMMUNITY CARE

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Introduction

The development of community care has been an objective for health and social work services in Scotland for more than a quarter of a century as, indeed, has been the case in England and Wales. In a recent study, we have shown that the Scottish commitment to community care has been more muted than elsewhere in Britain.[1] Nonetheless, it has been official policy since the Mental Health (Scotland) Act of 1960, if no earlier, to develop an extended range of services 'in the community' which would operate alongside a proportionately reduced level of hospital facilities. This approach has been reflected in Scottish Office planning for the priority groups of elderly, mentally ill, mentally handicapped and physically handicapped people.

A central policy goal for the priority care groups has been to develop a more flexible spectrum of care as a replacement for services historically focussed on long stay hospitals. Underpinning this approach has been the belief that it would enable the variety of individual needs to be met by a variety of responses. This and a number of the other essential elements of community care have been well expressed by the DHSS in England in the following terms: 'community care is a matter of marshalling resources, sharing responsibilities and combining skills to achieve good quality modern services to meet the actual needs of real people in ways those people find acceptable and in places which encourage rather than prevent normal living'[2] The range of resources to be combined is indeed extensive. Government functions with a potential role in the provision of community care include health, social work, social security, housing, education, transport, employment and physical planning. Voluntary organisations, the private sector and the informal caring networks of family and neighbourhood have increasingly been seen also to have important contributions to make.

It follows from these considerations that a number of conditions must be fulfilled if community care is to be implemented effectively. First, it depends upon the achievement of high levels of inter-service and inter-sector co-ordination in the delivery of care and, thus, in planning the

availability of appropriate service mixes. Moreover, such inter-servi planning is necessary at the level of both Scottish Office departments a local field agencies. Second, it requires community services to accept larg – and hospitals smaller – roles in the total pattern of care than h historically been the case. Third, it implies that this new balance of agen responsibilities must be adequately funded: the flow of resources in community services (and specially social work departments) needs to commensurate with their planned increase in responsibilities.

Given the breadth of its functions, the Scottish Office would appe well placed corporately to initiate and carry through a coherent programn of community care. Yet, in practice, the instruments necessary f implementing a community care strategy have been developed more slow in Scotland than in England, or in Wales. This situation, in turn, reflects relatively weak commitment to community care objectives in Scotla compared with elsewhere. In what follows, therefore, we critically asse the nature of Scottish community care policies and attempt to explain w Scotland has been relatively strongly wedded to hospital (and oth institutional) options for the care of priority client groups.

Administrative Responsibilities for Community Care

The Scottish Office comprises five departments, three of which sha an involvement in community care – the Scottish Home and Heal Department (SHHD), the Scottish Education Department (SED) whi has the Social Work Services Group (SWSG) attached, and the Scotti Development Department (SDD) which is, *inter alia*, responsible f housing.[3]

While appearances may suggest that by bringing together a range functions under a single Minister, the Scottish Office is able to take a mo corporate view of policy and administration and to achieve a greater degr of coordination than is possible in England, the Scottish Office is far fro monolithic in its operation. Functions are divided between its department often in a curious way. This is no more evident than in community ca where health and social work services are split between SHHD and SE respectively. Such divisions are especially apparent in a context where, Gibson puts it, 'the old intense departmental loyalties have not yet bee fully replaced by a strong Scottish Office loyalty'.[4]

Since 1979 there has been a Minister for Health and Social Wo embracing the functions of the SHHD and the SWSG.[5] Generally th move is seen as beneficial although integration has been slow. A number examples are cited as evidence of a closer working relationship, includi the 1985 circular on community care, joint planning and support finance and the interdepartmental working group which revised health priorit (see below).[7] Not surprisingly, in view of their differing traditions an

distinct organisational separation a lot of which is in contrast to practice elsewhere in Britain, there is not complete harmonisation between the SHHD and the SWSG. Indeed, a Rayner scrutiny suggested that the possibility of locating the SWSG within the SHHD should be studied with a view to eliminating overlap in the work of the two departments.[9] There exists no obvious reason, other than trying to achieve a balance in the size of departments, why the SWSG is located within the SED. Working across the administrative boundaries separating the SHHD and the SWSG has proved difficult as Wiseman found in a study of collaboration within the Scottish Office.[9]

Of course, the issue of interdepartmental working is much more than a structural matter. Individuals, their personalities and operating styles, are of crucial importance in any intervention. Departmental tradition and culture can also either aid or impede interpersonal contact and contribute to frontier problems. Wiseman's point about an absence of direct political input at the formative stages of policy development while not peculiar to the Scottish Office is particularly acute there. The centre of the political stage is in Westminster and not in Edinburgh. Such factors are not unimportant in the evolution of community care policy and provision in Scotland.

Resource Profile

The level of spending on the health service in Scotland is strikingly high compared with England and Wales. In 1985, as table 1 indicates, per capita expenditure was 28 and 19 per cent greater than that in England and Wales, respectively. These additional resources enable services to be made available which are considerably more extensive than their English and Welsh counterparts. For example, in 1985 the number of available beds in all specialities was 59 per cent higher than that in England and 39 per cent above the Welsh figure (table 2). In the same year, the number of medical and dental staff in hospital and community health services (and overwhelmingly in the former) was 44 and 39 per cent greater than the equivalent figures for England and Wales, respectively (table 2). These data indicate that Scotland's additional resources are disproportionately allocated to hospital services. In addition, an earlier study has shown that in 1980 there were 43 per cent more hospital nurses and hospital medical staff per 100,000 population in Scotland than in England.[10]

Personal social services expenditure is also greater in Scotland than south of the border: 20 and 37 per cent above that in England and Wales, respectively (table 1). Moreover, just as a higher proportion of health spending goes into the hospital service, so a higher proportion of personal social services spending was allocated to residential care in Scotland than in England and Wales: 21.9 per cent compared with 17.4 and 15.8 per cent respectively.[11] Part of the differential in overall spending levels is

accounted for by the inclusion of the probation service within the Scottish personal social services whereas it remains a separate service in England and Wales. Nonetheless, Scotland remains the best resourced part of Britain for both health and personal social services functions with a bias towards institutional (hospital and residential) rather than community (ie domiciliary) care.

Developing Community Care Policies

The lead in the development of community care policies has come nationally and, in the main, from the Scottish Health Service Planning Council (SHSPC) which advises the Secretary of State on health policy. The Council's relationship with the SHHD has been an uneasy one as its first Secretary has documented.[12] Four reports produced by the Council's multidisciplinary programme planning groups between 1979 and 1985 dealt specifically with the care of the priority groups and with community care issues.[13] [14] [15] [16] The SHSPC reports did not represent firm government statements in the manner of White Papers, each report being obliged to carry a disclaimer to this effect, although many of their main recommendations subsequently found their way into the national priorities document, *Scottish Health Authorities Priorities for the Eighties (SHAPE)*, published in 1980.

SHAPE represented the first serious attempt in Scotland to determine future priorities for health care. Unlike the programme planning group reports, upon which much of the priorities document was based, *SHAPE* was a solo SHHD production rather than, as might have been expected, a joint report with the SWSG. Criticism of this exclusion appears to have been a factor in the decision to establish an *interdepartmental* working group in 1985 to review *SHAPE*. Its Report, *Scottish Health Authorities Review of Priorities for the Eighties and Nineties* (*SHARPEN*), is presently being considered by the Planning Council. No decision has yet been taken on when the final report will be published. In its current form, *SHARPEN* does not represent government policy and it is likely that the final approved version will be substantially different. All subsequent references to *SHARPEN* are to the consultative version.

The major thrust of *SHAPE* and *SHARPEN* is away from the acute hospital services and towards increased provision for community care and long-term services for elderly people and people with mental disorders. As a general and overriding concern in respect of its priorities across all the care groups, *SHAPE* made it quite clear that:

> ...collaboration in planning and in the sharing of resources between health boards and local authority services is crucial to the success or failure of attempts to achieve the proposed objectives. Failing close collaboration *at every level*, results will continue to fall short of what

is attainable...[17]

SHARPEN's four priorities – services for old people with dementia; care in the community with particular reference to elderly, mentally handicapped and mentally ill people; prevention and health promotion; services for the younger physically disabled – involve services and client groups all of which fall within the category A priority of *SHAPE*. Where *SHARPEN* departs from *SHAPE* is in recommending that the priority for service development for older people, and for people with a mental handicap or a mental illness, lies in care in the community and not in institutional provision. Considerable emphasis is placed on the need for joint approaches by health boards and local authorities, and within the Scottish Office.

We review below the extent to which collaboration at local level has been developed since *SHAPE*. First, however, we comment on the policies specifically developed for each of the three main priority groups – elderly people (including those who are mentally infirm), mentally ill people and mentally handicapped people – in order to demonstrate the distinctive nature of community care policy and thinking in Scotland.

Elderly People

Historically, as we have noted, Scotland has enjoyed a high level of NHS beds. For example, the level of geriatric bed provision in Scotland in 1980 approached twice the level in England and Wales (13.3 per 1,000 population aged 65 and over as against 7.8). Hospital beds therefore dominate the service system. According to *SHAPE*, the overall objective of policy was 'to prevent inappropriate admissions to long-stay hospital accommodation by means of increased emphasis on care and support of the elderly in the community'.[18] *SHAPE* endorsed the recommendation of the programme planning group on services for elderly people that the target level for provision of geriatric beds should be related to the 75 and over age group, and that the proposed basic minimum ratio should be 40 beds per 1,000 population aged 75 and over.[19]

It was pointed out that geriatric hospital provision could not be considered in isolation from community provision. On the basis of the latest figures then available (1976), residential places in local authorities and voluntary homes were being provided at the rate of 19.9 places per 1,000 persons over 65 compared with the target of 25 places. The provision of sheltered housing and amenity housing places fell well short of the programme planning group's targets of 50 places and 100 places respectively per 1,000 persons over 65.

In terms of day hospital places, again *SHAPE* accepted the programme planning group's target of two geriatric day hospital places per

1,000 population aged 65 and over.

SHAPE emphasised the importance of health boards and local authorities cooperating closely in drawing up plans for residential provision for elderly people which would achieve a balance between hospital and community care. *SHARPEN* centres on the need for community care on the grounds that the targets for hospital provision have largely been met.

In regard to elderly people with mental disorders, *SHAPE*, again drawing on the relevant programme planning group report, recommended hospital provision for old people with dementia of 10 beds per 1,000 population aged 65 and over, half of which would be in units called continuing care units which would vary in size from 40 to 60 beds at one extreme to 20 beds at the other.[20] The authors of *SHAPE* thought it would be some time before the target would be attained and suggested that the best hope for progress at reasonable cost lay in adapting existing units. The target may be contrasted with that in England of three beds per 1,000 over 65 although it is expected in England that the majority of elderly people with mental disorder who require inpatient care are likely to be dealt with in general psychiatric beds where the guideline is 0.3 to 0.5 per 1,000 total population.

In regard to psychogeriatric day hospital places, *SHAPE* recommended a target ratio of 2.5 places per 1,000 population over age 65. It noted that very few health boards provided special day facilities for elderly people with mental disorders.

SHARPEN, broadly endorsing *SHAPE*, recommends an increase in the number of hospital beds – the current rate of 6 beds per 1,000 population aged 65 and over falls far short of the *SHAPE* target of 10 beds – and support services.

Mentally Ill People

SHAPE appeared before the completion of the programme planning group's report on mental health services for adults in Scotland.[21] The report recommended a far greater emphasis on community care and adopted the DHSS's guideline in England for day places.

In regard to the provision of inpatient care, *SHAPE* reported that an increased demand for hospital psychiatric services was likely to be offset by a higher turnover rate and a decrease in the number of occupied beds. *SHAPE* endorsed the programme planning group's main objective which was to work towards a community based service for mental illness. However, the group's report was not unequivocal on this point. It stated: 'despite the shift of emphasis towards community care, the psychiatric hospital will continue to play a major role, albeit a changing one, in the

future'.[22] Each year some 25,000 people are admitted to Scottish psychiatric hospitals of whom two thirds have already been inpatients on or more occasions.[23] Although the number of beds in psychiatric hospitals fell from 20,200 in 1965 to 16,900 in 1980, Scotland still had in that year almost twice as many people in psychiatric hospitals for the size of population as England.[24] *SHARPEN*, following *SHAPE*, emphasises the need for an expansion in community-based services and for a reduction in the levels of institutionalised care.

A policy of maintaining a long stay institutional sector has been defended on the grounds that it is better that individuals be looked after in hospital than be neglected altogether, particularly when there will always be a need for some hospital beds. While there is some force in this argument, inherent contradictions in policy abound but are not conceded. For example, a decision by Grampian Health Board with Treasury and SHHD approval to spend £16 million on the major redevelopment of a 700 bed psychiatric hospital (the Royal Cornhill) has caused many to ask what has happened to community care and joint planning. In endorsing the decision the Health Minister at the time (John MacKay) denied that it would have an adverse effect on community care. But the revenue implications of running a new hospital *and* starting up new community care developments will be major and are likely to defeat the Minister's optimism, especially when the twin aims of policy prove to be incompatible. As a psychiatrist put it, 'if you build you will fill'.

Mentally Handicapped People

Plans to shift the balance of care for mentally handicapped people were drawn up by the Scottish Office in 1972[25] and were further developed in the 'Peters Report' of 1979.[26] The latter document formed the basis for the *SHAPE* report's mental handicap planning targets. Hospital services continue to be the dominant form of provision and all the more so compared with the remainder of Britain. The number of residents aged 16 and over in mental handicap hospitals at the end of 1984 was some 42 and 62 per cent greater than the equivalent figures for England and Wales, respectively. Also, local authorities provided proportionately fewer residential places but more day care than in England or Wales.

In general terms, the relatively higher rate of hospitalization is consistent with official policy goals. The Peters Report set planning targets of 1.2 per 1,000 population for hospital places but only 0.6 per 1,000 for residential places in the community. (By contrast the English and Welsh target for hospital places was only 0.65 per 1,000, including 0.10 for day patients.[27]) The report did suggest that the balance between hospital and community places might subsequently be adjusted in favour of the latter but emphasized that 'many mentally handicapped people may be more lonely and more restricted in an uncaring community than in an arguably

artificial but at least richer social life enjoyed in hospital'.[28] However, a recent balance of care study conducted by the Scottish Health Service's Information Services Division contains indications that, in certain respects, the quality of life for hospital residents was significantly lower than that for residents of other staffed accommodation.[29]

The same study also throws into question how far hospital provision is necessary for so large a proportion of the client group as Scottish Office policy has historically assumed. Indeed, it suggested that 'perhaps 90 per cent or more of those resident at the time of the study in mental handicap hospitals or hospital units would be capable of living outside hospital in the kind of facilities which already existed somewhere in Scotland'.[30]

Over the past year there have been some indications of a shift in thinking taking place within the Scottish Office. A recent official statement has made it clear that 'the Government accept that more mentally handicapped persons than previously envisaged could live in the community, subject to the provision of facilities and services for them, and that the time has come to move beyond the Peters targets'.[31] The Secretary to the Scottish Health Service Planning Council has been more specific, suggesting that it may be time to reverse the ratio of places set out in the Peters Report and provide 1.2 places per 1,000 in the community and 0.6 places per 1,000 in hospital.[32] *SHARPEN* backs this approach and envisages that long-stay accommodation should be provided by both the health service and social work departments in small-scale units in the community. A growing role for district council housing provision and housing association schemes is also advocated.

Even if such a policy shift were adopted, it would still leave Scotland some distance from what has become official policy in Wales and what is rapidly becoming conventional wisdom in parts of England, namely, that all mentally handicapped people, irrespective of their degree of handicap, should have access to accommodation in ordinary housing with support services appropriate to their needs.

Implementing Community Care: Joint Planning and Support Finance

The Scottish Office has developed two mechanisms for promoting inter-agency cooperation: joint liaison committees (JLCs) and support finance. Significantly, each of them was not only introduced somewhat later than their English and Welsh equivalents but they also operate on a more discretionary basis than elsewhere in Britain.

Joint Planning

Joint liaison committees were introduced following the recommendations of the Mitchell Committee of 1977. Their prescribed role

was to 'establish the principles of cooperation' and to 'advise on the planning and operation of services of common concern'.[33] They were to consist of members and senior officers, meeting preferably not less than three times a year but without executive powers as 'this would amount to an unacceptable erosion of responsibility' from their constituent authorities.[34] The recommendation was adopted on an experimental basis in a circular published in 1980 and a review was promised in the light of experience.[35] Thus joint liaison committees were not established until four years after their English and Welsh counterparts and without the latter's statutory basis, though health boards and local authorities were placed under a general statutory obligation to cooperate with each other in the 1972 National Health Service (Scotland) Act.

The promised review of experience was completed five years later when new guidance replaced the original circular.[36] The new circular reflected the widely held view that collaboration, in general, and the joint liaison committees, in particular, had 'not been uniformly successful'.[37] This should be interpreted as civil service understatement for very low levels of activity indeed in some localities. A survey of the arrangements for collaboration in Scotland found that joint liaison commitees met, on average, 2.4 times during 1984 and in some health board areas such meetings represented the full extent of inter-authority contacts. Only six health boards reported the existence of senior officer support groups to the joint liaison committees and only seven joint planning subgroups were reported for the whole of Scotland.[38] By contrast, a similar survey in England found that, while joint consultative committees met no more frequently than in Scotland, their support machinery was much more substantially developed: all but one locality had a senior officer support group and the average number of joint planning subgroups was almost three per locality.[39] Against this background, the 1985 circular reaffirmed the importance of effective inter-authority cooperation and asked authorities to prepare, through their joint liaison committees, joint ten year plans for the provision of services to the main priority client groups. The first round of plans were to be drawn up by the end of March 1986 and kept under continuing review thereafter.

However, the circular explicitly eschewed enforcing this timetable by insisting on the submission of plans to the Scottish Office: 'they need not be formally submitted to the Secretary of State, and will not require his approval, although it would be helpful if copies were sent to him'.[40] Perhaps not surprisingly in these circumstances, only three joint plans (from Orkney, Shetland and Lothian) reached the Scottish Office by the March deadline. Though further health boards subsequently submitted plans, by no means all have yet done so.

The delay in submitting such plans suggests that local joint planning arrangements remain under-developed. Ample evidence exists to support

this conclusion. Information collected by Scottish Action on Dementia, for example, points clearly in that direction[41] as do survey data showing that the April 1985 circular made little impact in some areas and none at all in others.[42] Official sources have drawn similar conclusions. Thus, the Secretary to the Scottish Health Service Planning Council has publicly stated that 'we have not developed community care, we have not developed joint planning with local authority and voluntary bodies and as a result we have not made adequate provision for the care of the (priority groups)'.[43]

The failure of the joint liaison committee to provide an effective focus for joint planning has led to pressure for joint planning to be placed on the same statutory basis in Scotland as in England and Wales. Primarily originating from external lobbies (such as the Care in the Community Scottish Working Group, an alliance of 22 voluntary groups), this pressure resulted in the insertion of a clause to the 1986 National Health Service (Amendment) Act which provides the Scottish Secretary with reserve powers to establish the joint planning machinery on a statutory basis if the present voluntary arrangements fail. It remains unclear in what circumstances the Secretary of State would deem it necessary to trigger the operation of his reserve powers. Although in January 1987 Lord Glenarthur, the former Health Minister, told an Edinburgh conference on joint planning that a circular was being drafted on the new reserve powers, nothing had appeared by the summer of 1987. Such a lack of urgency on the Scottish Office's part is, as we have indicated, consistent with its approach to joint planning since the early seventies.

Support Finance

Alongside the recommendation in 1980 that joint liaison committees be established, the Scottish Office also introduced support finance as a financial incentive to greater health board and local authority collaboration.[44] Just as the joint liaison committees were six years behind their English and Welsh counterparts, so the support finance initiative was launched four years after the equivalent joint finance arrangements in England and Wales.[45] In essence, support finance was a mechanism under which limited health service finance could be made available to support elements of the cost of statutory and voluntary organisation projects sponsored by social work departments and of benefit to the NHS. More specifically, under the terms of the 1980 circular, funds were top-sliced from the NHS Vote and retained by SHHD as an earmarked central fund for which health boards were invited to bid. Generally, the programme provided no more than 60% of the capital and/or revenue costs of particular projects. The local authority had to meet the balance which, in the case of revenue projects, increased to the full long-term cost as the support finance contribution tapered out, normally over a period of five years.

The amounts available under the programme, although lower than

under the English joint finance scheme, increased from £1m in 1980/81 to £4.6m in 1984/85 with take up of funds growing from 40 to 90 per cent over the same period. However, take up was geographically uneven as the two largest local authorities (Strathclyde, from the outset, and Lothian, subsequently) refused to participate in the scheme on the grounds that the scheme effectively pre-empted growth and distorted local government priorities in future years. This essentially political stance worked to the advantage of some of the smaller authorities, notably Highland, who were able to obtain larger sums than would have been the case had the funds been allocated to all health boards on a population related basis, as in England. Indeed, in contrast to the SHHD's preference for a 'hands off' relationship with health authorities, the centralised bidding process meant that there was far tighter central control over the management and distribution of support finance than existed in England where the allocation of resources to particular projects was determined by individual health authorities.

Within the Scottish Office concern grew that the central bidding system was becoming administratively burdensome as the programme expanded. In additionm local authority and voluntary organisations were critical of the lower level of support finance in Scotland compared with England. Such considerations influenced a review of support finance which resulted in a number of amendments to the original arrangements. Thus some concessions were made in the terms of support finance grants: the English arrangements of seven year revenue support including three at 100 per cent were followed and housing and education projects were brought within the scheme, in line with the position in England and Wales. Health boards were also empowered (as their counterparts in England and Wales had been in 1983[46][47]) to make lump sum or continuing payments to help meet the cost of moving patients into more appropriate forms of community care. Responsibility for the day-to-day administration of the programme was also completely devolved to health boards from 1985/86. The centrally reserved fund was discontinued and in its place each board was given a non-mandatory indication of the sum it was expected to devote to support finance projects from within its normal revenue allocation. This indicative allocation is based on population size, weighted to account for those in long-term care. Unlike the position in England, boards are free to exceed this indicative allocation or to direct it to NHS spending.

The indicative allocation system raises doubts about how far the sums nationally allocated to support finance will actually be used to support local authority and voluntary organisation projects. Evidence is only just beginning to emerge and a final judgment would be premature. Nonetheless, Scottish Office data show that only £3.2m of the £6.1m indicative allocation for 1985/86 was set aside for projects.[48] Other sources suggest that only 40 per cent of the Greater Glasgow Health Board's indicative allocation of £1.8m was made available to Strathclyde Regional

Council and only 18 per cent actually spent on projects.[49]

While the 1985 changes failed to satisfy fully bodies outside the health service, the new system also created anxieties for health boards. In particular, those boards which did well out of the previous bidding system feared receiving smaller amounts in their indicative totals. There is also concern that, by spreading the resources more thinly, the new arrangements will constrain the type and scale of development for which support finance can be made available. More fundamentally, however, support finance needs to be seen for what it is: a pump priming mechanism too limited in scale to support anything but a marginal shift in the balance of health and local authority responsibilities. More widespread progress depends upon increased mainstream resources for social work departments. However, local authority interests continue to argue that current funding levels are inadequate for this purpose.[50]

An Assessment

Throughout *SHAPE*, and the programme planning group reports on which it is largely based, there is a commitment to the retention of a role for hospitals, to the development of community care alternatives, and to interagency collaboration. Crucially, and in striking contrast to policy in England, the commitment to community care is not to be at the expense of hospital development. Preventing inappropriate admission to, rather than encouraging discharge from, hospital is the thrust of national policy in regard to the three key priority groups we have considered. Such a policy stance involves at best a juggling act between maintaining the hospital sector for existing patients while at the same time developing community provision in order to avoid admission to hospital. At worst, the existing hospital services continue to absorb the bulk of available resources for development at the expense of the necessary expansion in community services. While *SHARPEN* moves further away from a commitment to hospital based provision it remains to be seen what impact this shift will have on policy at national and local levels.

To date, there is virtually no evidence of health boards shifting substantial resources into community services regardless of the care group involved.[51] On the contrary, and as we noted earlier, in regard to mental health services for example, some boards are intent upon investing in new or improved hospital facilities on the grounds that many of their buildings are unsuitable for psychiatric care. Ministerial statements in recent years have revealed a continuing commitment to a mix of hospital and community provision. But whereas hospital services already exist and in some cases are ripe for upgrading or replacement with numerous staff groups advancing the cause, the development of community care services is uneven, faltering and lacking in direction either nationally or locally. In June 1986, addressing the centenary conference of the Psychiatric Nursing

Association Scotland, former Health Minister, John MacKay, reaffirmed the Scottish Office's commitment to such a policy. He attached great importance to the replacement of old hospital buildings with new or upgraded facilities. This had to be done in tandem with building up community care services. 'I'm not one of those people who thinks it's an either or, I think it has to be both'.

SHARPEN apparently contains a softening of this approach in favour of a less ambiguous commitment to community services but it is unclear how far it will be carried through. Past history suggests that a degree of scepticism is in order. As a former Chief Medical Officer at the SHHD, Sir John Brotherston, has commented recently, 'it has proved easier to state objectives than to achieve them'.[52] Sir John argued that while limited progress had been made in building up geriatric services, little had been achieved in the way of improved services for people with mental disorders. In virtually no sector, however, had the build up of community care services in conjunction with local authorities and voluntary bodies been a top priority despite *SHAPE* and the monitoring of its implementation which appears to have had no impact on events. *SHARPEN* confirms these findings following an analysis of returns made by health boards.

Sir John believes that resource constraints, a 'vigorous defence mounted on behalf of the prestigious acute hospital service', and determined and well organised public opposition to hospital closures have in combination been responsible for the inertia afflicting comunity care policies. He predicts gloomily that:

> unless more funds are made available to the Health Boards or the public come to accept that resources should be transferred from acute hospital services to finance the expansion of community and long-stay services, it seems clear that progress towards the goals set by *Priorities for the Eighties* will continue to be unacceptably slow.[53]

If resource constraints offer a partial explanation for the state of affairs Sir John and others have catalogued, we do not believe them to be wholly responsible. After all, as we pointed out earlier, Scotland already enjoys the highest level of *per capita* funding in Britain. In theory, therefore, it ought to be easier and less painless to engineer the desired shift in service mix. Paradoxically, the healthier resource position may have blunted the desire to secure a shift from hospital based to community based care given the other obstacles to change. In our view, however, there are more fundamental and deep-seated problems and obstacles which account for why community care policies in Scotland remain substantially different from their counterparts elsewhere in Britain.

In Scotland the notion of community care does not sit easily alongside

the traditional concepts of care which largely determine health policy and which are widely held by sections of the medical profession and other professions. At all levels, political, administrative and professional, a more hospital-oriented perspective has been the dominant influence and there has been no sustained attempt to challenge it. In part this may be because the relatively high numbers of beds and other health resources has minimised cost-push and demand-pull pressures for the development of alternatives to hospital provision, especially for elderly people. Yet the continued reliance on relatively large-scale hospital provision for mental illness and mental handicap suggests the influence of additional factors located in the wider professional and social culture.

There has always been great caution in Scotland among doctors about letting go of beds and embracing community alternatives. This reflects a traditionally stronger emphasis on institutional, if not custodial, forms of provision: institutions for mentaly handicapped people and other groups all house more inmates than their English counterparts. Martin points out that the 'heavy dependence on hospital care went hand-in-hand with a low level of activity in the local health and welfare services'.[54] One could be cynical and argue that the maintenance of long-stay beds has made it easy for local authority social work departments to fail to acknowledge any responsibilities on their part, a luxury denied England and Wales where the pressure to close hospital beds and whole hospitals has been greater. Such an imbalance has probably also made it harder to make the shift towards community care *within* the NHS.

To some extent the Scottish Office may be criticised for failing to give a lead and develop stronger policy instruments. At the same time, its inclination to decentralise responsibility for implementation to field authorities can be criticised as either self defeating or, in an age of sustained resource scarcity, politically convenient. Nonetheless, it remains the case that pressure from the field to extend community care has been relatively weak and to that extent the centre might have little to gain by stepping too far ahead of opinion at local level. However, even a minimalist administration could require plans to be submitted and monitor their implementation. At the same time, it is becoming clear that joint planning requires more than a minimal financial underpinning. In England and Wales the case for more substantial funding of the shift to community care over and above the joint finance programme is being accepted through increased growth for social services departments in the former and the All Wales Strategy in the latter. In a context where the allocation of even the indicative support finance allocation to community care is now in question, it is evident that the financial no less than the planning mechanisms for achieving this goal continue to be poorly developed.

In the light of the Audit Commission's trenchant critique of community care policies in England and Wales [55] and the government's

response which was to invite its health adviser, Sir Roy Griffiths by the end of 1987 to complete a wide-ranging review of community care policies, [56] it is conceivable that Scotland will not for much longer escape the need for change. Pressure for it is steadily mounting.

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4. J S Gibson, *The Thistle and the Crown: a History of the Scottish Office*, HMSO, Edinburgh, 1985, p.181.

5. Between 1985 and 1986 home affairs was included in the ministerial brief; following the September 1986 ministerial reshuffle, the Highlands and Islands and tourism were substituted; following the general election in June 1987 the brief changed again with education replacing the Highlands and Islands and tourism.

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Table 1: Expenditure on Health and Personal Social Services Great Britain 1985

	Spending on Health Services		Proportion allocated to*			Spending on Personal Social Services	
	Total	Per Capita	Hospital Services	Community Health Services	Family Practitioner Services	Total	Per Capita
	(£000)	(£)	%	%	%	(£000)	(£)
England	12,986.5	275	54.0	6.0	21.4	2,353.1	50
Wales	838.8	298	53.4	6.1	22.1	123.1	44
Scotland	1,812.4	353	57.9	5.6	17.6	306.1	60

* Central administration, other services and capital expenditure percentages of total have been omitted.

Sources:

1) NHS data: Central Statistical Office, 'Regional Trends 22', 1987, HMSO.

2) PSS data: 'Personal Social Services Actuals 1984/5', CIPFA 1986 (for England and Wales); 'Rating Review: Actual Income and Expenditure 1984/5,Service Volume', CIPFA Scottish Branch, 1986 (for Scotland).

Table 2: NHS Staffing and Bed Levels Great Britain 1985

	Available Beds*	Occupied Beds*	Medical and Dental Staff**	Nursing and Midwifery Staff**	General Practitioners**
England	6.9	5.6	82.4	835.7	54.8
Wales	7.9	6.2	85.4	938.9	53.3
Scotland	11.0	9.0	118.8	1,207.0	68.1

* Per 1,000 population
** Per 100,000 population

Source: Central Statistical Office, 'Regional Trends 22', HMSO, 1987.