The 'Quasi Market' in Social Care and its Responsive to Differentiated Need:
A Case Study of Service Provision for Older 'African-Caribbean' People in Two
London Authorities

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UMI Number: U213357

UMI

Dissertation Publishing

ProQuest

Acknowledgements

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Abstract

This study is an exploration of the extent to which the introduction of a 'quasi-market' within Personal Social Services in England had enabled them to respond more sensitively to the different needs of those they served compared to the previous model of large scale local authority provision. This issue was examined in depth by concentrating on the possibly, distinctive needs/preferences of older 'African-Caribbean' people, as an illustration of the opportunities and difficulties that this new style of 'public management' presented in two London Authorities.

To explore this question, three discrete, but connected methods of inquiry were pursued. The first focused on the implementation of the 'NHS and Community Care Act 1990', and more specifically the recommended introduction of a range of 'private' and 'not for profit' provider's under contract. The findings suggest this was only partially implemented. There were changes to the way in which services were purchased, and the way they were provided, but these changes did not constitute a genuine 'quasi-market'. The development of the purchasing function offered the potential for local authorities to respond to 'ethnic diversity', but this did not happen. Indeed an exploration of service developments suggested that the previous model was more responsive to the differentiated needs of older 'African-Caribbean' people than this new model.

The second dimension of this research explored the 'mixed economy' of care through a case study of 'meals' provision. The findings suggested a tendency to monopoly provision, with 'risk' and 'cost' operating as more significant factors than 'differentiated need' in shaping purchasing decisions.

The third part of this study explored whether there were distinctive service preferences expressed by older 'African-Caribbean' people for 'culturally specific' provision, and found that whilst there were some, there were also a range of preferences within that community.

<u>Chapter One: New directions in Social Policy – 'Markets in Welfare'</u>
<u>'Diversity', 'Choice' and the 'NHS and Community Care Act 1990'</u>

<u>Introduction</u>
Following the election of a Conservative government in 1979,

greater emphasis was placed on the 'free market' or 'quasi-market'

elements, as a more appropriate mechanism for solving a range of

problems, ranging from inner city regeneration to welfare provision.

The shift towards 'market-oriented' solutions and the 'new public

management' reflected an international trend in policy, but was

especially applied in Britain, Australia and New Zealand. (Barzelay,

M, 2001; Glennerster, H, Midgeley, J, 1991; Le Grand, J, 2002) This

new policy direction was accompanied by an increasing

acknowledgement of the need for greater diversity and choice in the

delivery of welfare services.

In April 1993, the Conservative government introduced the NHS and

Community Care Act 1990, which provided the basis for a major

reorganisation in both health and social care. One major focus of

this legislation was to bring about significant changes to the way in

which services were delivered to 'older' people. The 'new' policy

required a shift to a 'mixed economy of welfare and greater

involvement of users/consumers of welfare. This policy direction was

not restricted to Britain, but was a common theme of many policy

reviews carried out at that time in many OECD countries.

(Organisation for Economic Cooperation and Development, 1994)

The original motivation for this study was to explore how far the

introduction of a 'quasi-market' within the Personal Social Services in

England had enabled them to respond more sensitively to the

different needs of those they served compared to the previous

model of bureaucratically planned services. A conclusive answer to

such a question on a national scale was clearly beyond the scope of a Phd with the resources at my disposal. The issue was examined in depth by concentrating on the possibly distinctive 'needs/preferences' of older 'African-Caribbean' people, as an illustration of the opportunities and difficulties that this new style of public management presented, in two London local authorities.

In this chapter, we review the shift from the previous model of service delivery to the introduction of 'quasi-markets' and 'market type mechanisms' as a response to broader social and economic changes which restrict and shape social policy. We consider the decline and contestation of the 'Beveridgean welfare settlement', and the emergence of a new 'organisational framework/settlement' - of which the 'quasi-market' is one part. We review the literature on 'quasi-markets' in particular, focussing on the implementation of the 'quasi-market' in social care.

We begin by considering some theories that have helped to contextualise this new policy direction.

Post-Fordism', 'Globalisation', and Social Policy
There is now a growing body of literature, which suggests that fundamental changes taking place in the organisation of the economy and society, move us into another epoch, in terms of the possibilities for welfare provision. Initially, analysis emerged within a 'Post-Fordist' paradigm, but more recently, a growing body of analysis has emerged exploring the implications of 'globalisation' for social policy. The concept of 'Post-Fordism' was initially applied to understanding economic change, but was then applied changes taking place within welfare. According to (Carter, J, Rayner, M, 1996, p348):

> "Post Fordist ideas draw heavily on Shumpeterian long wave
> theory emphasising the shaping influence of particular

productive technologies on historical settlements. These settlements in turn become associated and defined by specific organisational patterns, labour processes and consumption patterns."

From this perspective it is the economic context more generally, and the production process more specifically which are crucial for making sense of welfare systems. This theory is developed by (Jessop, B, 1994) who distinguishes between a 'Fordist' and 'Post Fordist' mode of production and the implications of these two regimes both for the role of the state, and the organisation of welfare.

For Jessop the 'post War' 'Keynesian Welfare State' reflected a 'Fordist' mode of production. Under this 'mode of production', the labour process was characterised by full employment; mass production of consumer durables; mass consumption and operated mainly within a national economy. The state committed itself to providing a universal 'cradle to grave' welfare state for all of its citizens underpinned by full employment. This gave rise to a 'Welfare regime' characterised by 'universal' standardised services delivered through large bureaucratic organisations.

He argues that we are now moving towards a 'Post-Fordist' era, which is characterised by flexible production; flexible workers; social polarisation; flexible and differentiated consumption patterns operating in an increasingly international economy. He argues that a 'Post Fordist' state, is more likely to give rise to what he describes as a 'Shumpeterian Workfare' State characterised by work compulsion; welfare retrenchment; increasing use of the private sector and private provisioning/financing of welfare. He predicted a shift to greater flexibility for both clients and those working in welfare.

(Bagguley, P, 1994) suggests that rather than a neat transformation

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from one welfare system to another, it is more likely that various layers of different welfare innovations, expansions and contractions will be integrated into a new system. This is of relevance in that the implications of increasing polarisation suggests a shift away from universal provision to a far more residual role for state welfare with the expansion of private provision. On the other hand , the commitment to universalism, which is clearly associated with a 'Fordist' regime continue to remain strong themes within both Labour and Conservative parties fighting the 2001 election on a platform devoted to improving two key areas of universal public provision i.e. health and education. Therefore the process is a dynamic one.

Observations made within the 'Post Fordist' paradigm and their implications for social policy, have been mirrored in an emerging literature, addressing itself to the implications of 'globalisation' for Social Policy. Within this literature there are differing perspectives on what this means for 'welfare'. These views range from what (,Clarke, J, 2004, p72) refers to as 'Apocalyptic' predictions related to the terminal decline of welfare to less pessimistic predictions.

It is argued that in an increasingly 'globalised' economy, the power of a 'nation state' to determine welfare policy within their own 'nation state' boundaries, has decreased, whilst the power of 'trans-national corporations' has increased. Essentially, countries compete to attract 'trans-national corporations. Writers such as (Mishra, R, 1999) and (Deacon, B, 1997) suggest that 'nation states' have had their ability to determine welfare provision weakened, and we are likely to see a shift away from universal high quality welfare provision to a more residual model, with significant expansion of private provision. Similarly, (Townsend, P, 1993) identifies a trend

towards increased poverty and polarisation of incomes in many countries, particularly the UK, linked to the process of globalisation. However, (Deacon, B, 1997) has also speculated on the possibility of an emerging 'global social reformism' as a response to 'neo-liberal' policy failures of the 1980's and 1990's, suggesting there is not a straight forward trajectory on these issues.

Theories of the impact of both 'globalisation' and 'Post-Fordism' on welfare tend to accentuate the negative, moreover, they tend to be 'economically reductionist'. The implications of both are that welfare will generally deteriorate over time, with rights to welfare being significantly eroded over time. There is an 'inevitability logic' built in to this argument that has created a sense of pessimism, evident in interviews with many policy makers and 'front line' workers.

This pessimistic view of the impact of globalisation on welfare and living standards has been challenged by other writers, such as (Pierson, C, 2001) and (Esping Andersen, G, 1996) who argue that whilst we clearly do live in a world in which the relative power of the nation state has declined, and international capital has become more powerful, different nation states have responded to these changes in different ways. (Clarke, J, 2004, p75) uses the 'concept' 'national political institutional differentiation', as an alternative and more helpful way of exploring the impact of 'globalisation' on social policy, within specific 'nation' states. Moreover, he suggests that a 'neo-liberal' agenda is simply one way of responding to these challenges.

(Alcock, P, 2001) observes that the European Union is attempting to avoid downward pressures on welfare, by imposing EU wide rights and standards on workers within the European Union as a way of

avoiding 'social dumping'. Within Britain, the election of 'New Labour' has brought a slightly different policy orientation to the issues thrown up by 'globalisation', such as the introduction of a minimum wage and a range of poverty alleviation strategies.

(Johnson, N, 1999) is also critical of the overriding influence of 'globalisation' on welfare, and draws on the work of Hutton to argue that the balance of power between the nation state and the world market is very complex, with no other participants yielding the same power as the ' nation' state.(See, Hutton, W, 1997, p31). However, Johnson suggests there has been a shift away from welfare expansionism, as embodied in the Keynesian Welfare State. He argues that a new orthodoxy has emerged in terms of welfare spending and service delivery underpinned by the need for restraint rather than expansionism, and supported by a range of agencies from the European Union to the World Bank. He suggests that even those people who support 'welfare' would reject the further advancement of 'statism', and instead advocate a 'mixed economy' of care, which is on the ascendancy in many countries of varying political complexions, therefore Johnson reinforces the global nature of this trend to 'marketisation'. (Clarke, J, 2004, p27) argues that rather than predicting the 'end of welfare':

> "it is more accurate to talk of the 'persistence'; 'resilience' and 'survival' of welfare states, even in the face of intensifying pressures".

For Clarke, 'neo-liberalism' is simply one way of responding to globalisation, that has now become the dominant form of intervention, but is not the only possible model, reiterating similar concerns to Deacon cited above. Clearly there have been a number of changes in relation to the ways in which welfare is being delivered and the elaboration of 'market type' mechanisms and the expansion

of the 'mixed economy of care' is one dimension of these new changes. Therefore, rather than predicting the collapse of welfare systems, it is more helpful to consider ways in which welfare is being reformulated and reconstructed.

A New Welfare Settlement?

This project is an exploration of the impact of a particular policy change on service responsiveness, i.e. are quasi markets more able to respond to need than bureaucratically planned services? However, this raises the question as to what is the possibility for a return to bureaucratically planned services if the 'quasi-market' is tested and found not to be able to deliver services more able to respond to differentiated need. A range of theories have suggested that this mode of delivery was part of a different welfare settlement, in other words, it may not be possible to return to bureaucratically planned services, therefore this has implications for any conclusions and recommendations that we might draw.

(Hughes, G, 1998, p4) uses the concept 'welfare settlement' or 'settlements' to make sense of changes affecting welfare:

> "By settlement we do not want to imply that the frameworks
> through which state regulated welfare is delivered are fully
> fixed and agreed upon, rather a kind of framing consensus
> becomes established which sets the limits within which
> comprises over what and how, and by whom, and for whom,
> welfare services are delivered... In this sense then a settlement
> is a set of positions negotiated by the key or most powerful
> groups in society."

Hughes identifies four dimensions of the 'Beveridgean' settlement that have been 'unsettled' and 'reformulated' i.e. Economic; Political; Social and Organisational. We will briefly consider each dimension of the 'settlement'. Economic policy was underpinned by a

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commitment to 'Keynesianism' that would facilitate 'full employment' and finance 'welfare expansionism'. Politically, there was a cross party commitment to the 'Welfare State' and consensual policy making, -exemplified in 'corporatism'.

Socially, the settlement was based on a 'male/breadwinner' citizenship model. He would work and pay taxes and would be entitled to a range of benefits for himself and his family. Therefore eligibility was based on contributions paid through work, resulting in an 'inferior' or 'dependent' citizenship for some groups such as 'migrant' workers and 'women' who did not have full contributions records.

Organisationally, services were to be planned and delivered by the State both locally and nationally and underpinned by a 'bureau-professional' model that would deliver services determined by 'professionals', with users 'passively' receiving services in a 'deferential' way. Whilst, 'Migrant' labour was a crucial part of the organisational settlement, their needs were not anticipated in the design of services. Services were delivered in a 'mono-cultural' way based on the assumed needs of a 'White', 'male breadwinner' and his family.

There is some debate as to when the 'Beveridgean' settlement began to crumble and fracture, but clearly the settlements described above did begin to shatter towards the end of the 1970's. Explanations for this change are complex. Pressure for change emanated from both 'right' and 'left' of the political spectrum. The 'Keynesian Demand' model of economic management was challenged during the 1970's with the emergence of 'stagflation'. The publication of (Bacon, R, Eltis, W, 1976) seminal work in 1976

was popularized, arguing that the state was 'crowding out' the private sector, both through employing large numbers of the population in the so called 'unproductive', sector and secondly through the excessive growth of public expenditure. This critique of the implications of welfare for the economy, were mirrored on the left with Marxist writers such as (O Connor, J, 1973) suggesting that the Welfare State was designed to underpin 'capitalist accumulation', but was increasingly undermining 'capitalist accumulation'. The Labour Government abandoned 'keynesian' economic policy in 1976, and introduced 'monetarist' policies, as a condition of an IMF loan, However, 'monetarist' policy was favoured by the incoming 'Conservative' government.(Hill, M, 1993)

The 'political settlement' also began to fracture during the 1970's, not least with the 'winter of discontent'. However, the election of a Conservative government in 1979, marked both the end of a consensus on the 'welfare state', and cooperative policy making. (Lewis, G, 1998) The 'Social' settlement' also began to fracture. There had been a number of changes, that undermined the 'male breadwinner' model as a vehicle for responding to social need, such as an increase in divorce; lone parenthood; and female participation in the labour market. More generally, there had been a wide ranging critique of the limited model of 'citizenship' that underpinned the 'Beveridgean' settlement, with a range of groups, such as 'Black and Minority Ethnic' groups' 'Women'; 'Gays and Lesbians'; 'People with Disabilities' arguing for a more inclusive model, with implications for the organisation of welfare services.(Lewis, G, 1998) We return to this in Chapter Two.

Given that the 'organisational settlement' is central to this thesis, we will consider this dimension in more detail. We will begin by

considering the ideas of the 'new right' and the 'public choice' school as these ideas were significant in shaping this new 'organisational settlement.

The 'New Right' and Social Policy

The 'new right' is not a comprehensive set of ideas, but as (Gamble, A, 1986) notes in his essay 'The Political Economy of Freedom', a contradictory set of ideas emphasising simultaneously a 'strong state', and a 'free economy'. These contradictory perspectives reflect the two distinct strands of thought broadly associated with the 'new right', i.e. 'neo-liberalism' and 'neo-conservatism'. The former stressing freedom and the latter a more authoritarian perspective. Moreover within these different strands it is possible to identify a continuum of views. From the 1970's onwards the 'new right' began to become more influential, in social policy debates. Whereas in the 'post war' period, the state was seen as a solution to many problems, the 'new right', was increasingly identifying state intervention as a problem in itself. (Murray, C, 1984, Joseph, K,1976; Levitas, R, 1984).

Two thinkers who were influential in advocating and informing 'new right' ideas, were Frederick Von Hayek and Milton Friedmann.(Hayeck, F, A, 1944; 1976; Friedmann, M, Friedmann, R, 1980). Frederick Von Hayek's critique focused on the role of bureaucratic planning and the 'social democratic' project more generally. For Hayek the market system was a more preferable way of satisfying needs and wants, because it operated as a 'hidden hand' satisfying needs, without favouring one individual. According to Hayeck we are self interested and not motivated by collective concerns, and therefore, the social order needs to reflect this.

Milton Friedmann addressed himself specifically to the economy.

Milton Friedmann is credited with the resuscitation of monetarism as a more appropriate economic philosophy than Keynesianism, along-with a general critique of state intervention/regulation, whether it be in the form of taxation, provision of services or controls on rent. According to (Gamble, A, 1986, p39)

> "What Friedmann offers in his writings on political economy as distinct from his more technical contributions to economic analysis are common sense maxims for business people. Every area where government has responsibility for is shown to be inefficient and to have failed. The market solution is then unveiled....Much of the policy output of new right think tanks such as the Centre for Policy Studies is devoted to analysis of particular policy areas from this perspective."

It is possible to see a range of policies introduced in the first term of the conservative government, which clearly embraced these ideas, such as the privatization of industries; selling off of council houses; abolition of a minimum wage; reductions and alterations in benefit rights for the unemployed; tax cuts etc.(Pinch, S, 1997). However, the extent to which the state was ever rolled back is questionable. (Glennerster, H, Hills, J, 1998) demonstrated that 25 years after the election of a Conservative government, there was not a 'rolling back' of the welfare state, rather the welfare state continued to take the same share of national income in 1995-6 as it did 20 years before.

Analysts such as Milton Friedmann would have recommended extensive privatization/marketisation of welfare provision, and indeed organizations such as the Adam Smith Institute and the Institute of Economic Affairs embraced these ideas in a number of welfare proposals. However, it was the work of the 'public choice' school which was to be more influential on the redesign of public services.

<u>The 'Public Choice' school</u>
The 'public choice' school emanated from the United States, but had an impact on economic thought worldwide. (Niskansen, W, A, 1971, 1986) was an influential theorist associated with the 'public choice' school who argued that neither those working in the private sector, nor those working in the public sector have an inherent motivation to be efficient, but whether or not they were efficient was dependent on the constraints and incentives under which they operated. He argued that prior to reform, producer groups within welfare agencies established a monopoly over service provision; increased costs and operated inflexible working practices. Moreover there was a constant demand for more resources, not necessarily in relation to need but as a way of 'empire building' Therefore, for Niskansen there was a need to develop structures and incentives that maximized efficiency and responsiveness. (Cutler, T, Waine, B, 1997)

The conservative government developed a far reaching critique of public organisations, and in particular questioned their ability to deliver good quality services. The 'post war' organizational settlement began to be reshaped in a number of ways. Firstly, in the post war period, the local state had been a central player in service design and provision. From 1979 the relative power and autonomy of the 'local state' was undermined. Central government became increasingly specific about the role of local authorities, reducing their ability to raise revenue, determine the levels and nature of services in their own area, and to act as service providers Their role was increasingly defined as 'enablers', rather than 'providers'. (Wilding, P, 1992; Miller, C, 2004) Therefore a key dimension of the organizational settlement was undermined.

Secondly, there has been a shift away from the 'bureau-professional'

model to a 'new managerial' model, summed up by (Butcher, T, 1995, p6) as:

> "A new set of practices and values, based upon a new language of welfare delivery which emphasizes efficiency and value for money, competition and market's; consumerism and customer care"

..

(Clarke, J, Gewirtz, S, McLaughlin, E, 2000) argue that it would be wrong to assume that public administrations across the country have undergone a radical change in favour of a 'new managerial' regime, rather implementation and change has been uneven. However they argue that the concept of 'professionalism' as a rationale for service management has increasingly been replaced by the concept of 'managerialism' which takes as its reference point, managerial practices in private sector organizations. Moreover they argue that 'New Labour' has continued with this new approach suggesting a new consensus on the management of services.

(Lewis, G, 1998) suggests that what we are seeing is a contestation and an 'unsettling' of the Beveridgean organizational settlement, but not a complete transformation in ways of working. Therefore, some people will continue to work in ways associated with the old model of 'bureau- professionalism', but that what has changed is the dominant mode for thinking about how we should organize services.

(Du Gay, P, 1999) argues that a combination both of 'public choice theory, and 'new managerialism', facilitated a shift to 'Entrepreneurial governance'. This new policy direction is summed up by (Osborne, D, Gaebler, T, 1992, p15) as:

> "Today's environment demands institutions that are extremely flexible and adaptable. It demands institutions that deliver high quality goods and services, squeezing out ever more bang out of every buck. It demands institutions that are responsive to the needs of their customers, offering choices of non

standardized services, that lead by persuasion and incentives
rather than commands."

We can see then that the 'organisational settlement' was reshaped
and influenced by the 'new public management'. Services would be
increasingly organized and managed in ways similar to that in the
'private sector, with a declining role for the state as 'provider of
services, and an increased role for the consumer. The 'quasi-market'
was to be a central feature of this new 'organisational' settlement
and it is to this that we now turn.

The Emergence of the 'Quasi-Market'
Another dimension of change specifically related to this project is the
emergence and implementation of the 'quasi-market'. From a policy
perspective it is helpful to consider three stages in the
'marketisation' of welfare. The first stage, post 1979 marked a shift
informed by 'new right' thinking towards the increased use of the
private sector, for example, in areas such as hospital catering and
cleaning; the funding of 'Grant Assisted' places.(Pinch, S, 1997)

However, from 1988 onwards a range of reforms were introduced in
Health, Housing, Education and the Personal Social Services which
had in common the introduction of a 'quasi-market'. These reforms
synthesized the 'old left' ideology of universalism with 'new right'
thinking related to markets and competition. Each policy area had a
slightly different format, but what they had in common was the
introduction of market type mechanisms as a vehicle for raising
standards, improving efficiency and responding to the demands of
users/consumers of welfare.

The concept 'quasi-market' was coined by (Le Grand, J, 1991) who
argued that they were nearly, 'markets.   Traditional markets
respond to supply and demand, in theory there are a range of

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consumers and a range of alternative providers to choose from. The introduction of quasi-markets has introduced competition into the supply of services but the 'state' has continued to retain responsibility for funding services. It could be argued that this is a political compromise, embracing some elements of 'new right' thinking, in particular drawing on the work of the public choice' school, whilst at the same time confirming a commitment to publicly funded provision.

(Le Grand, 2001, p2) sums up the policy intention:

> "by relying less heavily on public spiritedness as a motivating factor, and by tailoring incentive structures more to individual or to institutional self interest, the providers of public services would become more efficient, more dynamic and above all, more responsive to the wants and needs of the user."

The introduction of the 'quasi-market' was accounted for by its critics, as part of a general assault on the 'welfare state', and part of a strategy of 'privatisation'.(Loney, M, 1986, Pinch, S, 1997). However, from the perspective of the 'new right' these reforms did not go far enough. Indeed they contained elements of 'old left' thinking (a commitment to universalism), 'new left' thinking (a commitment to empowerment and consumerism) and, 'new right thinking (a commitment to markets). The reforms whilst embracing the concept of an internal market fell far short of what the Institute of Economic Affairs would have preferred, to the extent that in 1990 they published a pamphlet in response to the reforms of the health service, 'The NHS reforms: whatever happened to Consumer choice' where (Green, D, 1987) argued that the reforms of the health service were based on a defence industry procurement model of competition, which is sharply distinguished from a consumer sovereignty model, such as voucher schemes or opting out as proposed in his pamphlet 'Everyone a Private Patient: An analysis of

the structural flaws in the NHS and how they could be remedied'. Similarly, (Marsland, D, 1996) criticized the 'NHS and community care act 1990', arguing that community care' should be developed as an alternative to state welfare, and should not simply be about de-institutionalisation, and the re-organisation of services in the community. For Marsland, 'community care' should be based on encouraging people within communities to provide care voluntarily for family members, neighbours and friends.

The reforms focussed almost exclusively on the supply side of welfare embracing many of the ideas around 'producer groups' which emerged from the 'public choice' school. (Glennerster, H, LeGrand, J, 1995) make a number of interesting observations in relation to the introduction of a 'quasi-market'. Firstly, they argue that there is nothing new about the 'quasi-markets, this model of indirect state provision, dominated policy until the advent of the 'Beveridgean' Welfare System. Secondly, the model adopted far from reducing state bureaucracy/power would increase the power of bureaucrats. Thirdly, they suggest that the most convincing explanation for the introduction of the 'quasi-market' has far less to do with neo-liberal ideology, or the 'rolling back of the state', but more to appease the rising expectations of consumers with regard to services without increasing the tax burden. The reforms and the possibility /rhetoric of choice give articulate 'middle-class' service users the ability to get much more from the system.(Glennerster, H, Le Grand, J, 1995) Indeed (Dowding, D, Dunleavy, P,1996) argue that service users now demand 'private sector' point of service standards in all their dealings with formal organizations, and therefore the 'quasi-market' with its focus on specificity and choice facilitates this.

Indeed the fourth dimension of change linked to the new

organizational settlement, was to reconfigure the user of services enabling a shift from passive client to active consumer. This shift was at the heart of the new model, enabling the consumer of public services to drive quality and standards of care.

The extent to which this model is the best way of facilitating user choice as a vehicle for raising standards is part of a wider debate. (Clarke, J, 1998) reiterates the perspective of (Hircschman, N, 1970) contrast of 'exist' and 'voice', the former relying on the option of exit as a mechanism for signaling consumer preferences, and the latter extending notions of voice and representation to relay needs and preferences to providers. This latter option as a more desirable development has been stressed by some commentators, on the left. (Croft, S, Beresford, P, 1990) for example, have argued that the model underpinning the 'quasi-market' reforms is based on a 'supermarket' style consumerism, and they suggest it would be more helpful to develop 'voice' type mechanisms, as part of an extension of welfare rights.

(Bartlett, W, Le Grand, J, 1993) set out a number of conditions that can be used to assess whether the 'quasi-market' is successful in achieving both greater efficiency and responsiveness and choice, in an equitable manner, and we will reflect on these in the concluding chapter. 'Market structure' is identified as a crucial factor in determining the success of the 'quasi-market'. They argue that on the 'supply' side there needs to be a number of providers, along-with the potential both for new providers to enter the market, and poor providers to face bankruptcy, and therefore exit the market. On the 'demand' side they argue that there is a need for 'multiple' purchasers, as 'monopoly' purchasers, may also create conditions that are less favourable for responding to user choice. For example, they may be relatively distant from users, and/or they may exploit

their purchasing power by placing harsh requirements on providers. Moreover, they argue that competition among purchasers is required for efficiency because it ensures that resources are drawn into their highest valued uses. They also warn of the problems of a shift to monopoly purchasing and providing, which may result in a small number of people involved, who may have worked together under the previous system. This they argue would make it difficult to construct or maintain the distance that a market or bargaining process requires. Linked to the issue of 'market structure', is 'market change'. After the initial round of contracting, they predict a possible collapse of competition, as those who are unsuccessful, disappear from the market, resulting in much less or no indeed no competition, therefore eroding any benefits of 'marketisation'.

Another set of issues raised by (Bartlett , W, Le Grand, J, 1993) relate to 'transaction costs' and 'uncertainty. They argue that transaction costs are initially high when entering into a 'quasi-market' situation. Each contract has to be mapped out and monitored, and this can be done in more or less detail, with different time implications. Secondly, there are the additional costs of contract preparation and monitoring, possibly involving the purchase of specific equipment. Indeed the reliance on specific equipment may again be prohibitive in relation to the development of a 'competitive' market. Linked to the issue of 'transaction costs' is 'uncertainty', which they suggest is more likely to arise in 'health' and 'social service' purchasing, than in 'education. 'Uncertainty' makes it difficult to know what is required, and this poses a problem both for 'purchasers' and 'providers'. They argue that if the 'quasi-market' is to be successful, any extra transaction costs must not be greater than any cost savings generated.

Another factor identified as crucial in determining the success of the 'quasi-market' is 'motivation'. They argued that if the 'quasi-market was to be successful in stimulating the development of 'user orientated' services, then, purchasing decisions must be motivated by 'user' welfare, rather than for example, efficiency savings. The provider, on the other hand, must be motivated by profit, and a balanced budget, rather than 'user welfare'. They argue that the closer purchasing decisions are to those that use the services the more likely they are to stimulate 'user orientated services.

A fourth factor raised by (Bartlett, W, Le Grand, J, 1993) relates to 'equity'. They argue that this is an important criterion on which to evaluate the success or otherwise of the 'quasi-market. They argue that in order for the 'quasi-market' to achieve 'equitable' purchasing decisions, 'purchasers' must not be able to choose who they are going to purchase services for, other wise they may find ways of avoiding purchasing care for 'more expensive' users, who may have 'differentiated' and more complex needs, similarly, providers must not be able to select the 'less expensive'/problematic service users. In other words, then purchasers need to be motivated to purchase care for all potential users. Therefore these are helpful criterion to reflect on in the findings of this study.

(Cutler, T, Waine, B, 1997) critique this approach arguing that it has led to a depoliticized social administration with an emphasis on technocratic investigation rather than critical policy analysis. They argue that policy analysis needs to move away from seeing the 'quasi-market' as a technique and instead understand it more as a distributional mechanism that operates in a political space. Indeed, the two approaches are both helpful to this study, as the former helps us to make sense of and evaluate how the 'quasi-market' as a

technique operates/operated, and the latter helps us to contextualize the implementation of the 'quasi-market' in its wider context. It is a synthesis of these two approaches that have underpinned this study, and we will return to these in the concluding chapter.

This research study was initiated with a Conservative government in power. However, with the election of 'New Labour' it is possible to identify a third phase in the 'marketisation' of welfare. Interestingly,'New Labour' has confirmed rather than changed the development of 'quasi-markets'. One of the central planks of government policy is to raise standards in public services and develop what it describes as 'citizen centred services'.   There has been a range of policy initiatives such as the White Paper 'Modernising Social Services'; the 'Best Value' regime, and 'Private Finance Initiatives' which all confirm the government's willingness to use the independent sector, to extend the notion of competition to all areas of service provision. One difference between the two parties' rests on provider preference. Whilst the Conservatives clearly favoured the private sector,'New Labour' argue that they have no provider preference.(Millburn, A, 1997)

According to the White paper:

> "Our third way for social care moves the focus away from who provides the care, and place's it firmly on the quality of services experienced by and outcomes achieved for individuals and their carers."(Department of Health, Modernising Social Services, 1998, p4)

Essentially the policy direction has been to further elaborate the 'new managerialism', through mechanisms to improve quality, such as the publication of performance indicators and league tables; surveying users of social services; increasing regulation and more generally developing a culture of good practice, through the sharing

of knowledge through organizations, such as the Social Care Institute of Excellence. Many of the mechanisms introduced emphasise a top down approach to policy implementation.

'Best Value' is an important dimension of 'New labour's approach to 'marketisation' and the 'mixed economy' more generally. The 'Best Value' regime was introduced under the 1999 Local Government Act. The Act builds on previous legislation related to Compulsory Competitive Tendering and extends this to all local government services. The 'Best Value' regime embraces the concept of competition to be used as a management tool to raise standards. 'Best Value' does not require local authorities to expose each area of service to competitive tendering, but rather to examine each area of service assessing the relative costs of in house and external provision. There are a number of differences between 'Best Value' and Compulsory Competitive Tendering(CCT). Under CCT, cost was the driving factor behind provider choice, by contrast 'Best Value' authorities are required to reduce costs and raise standards. The emphasis is also on developing and promoting partnerships, and particularly joint ventures between local authorities and the private sector, such as Private Finance initiatives. According to (Martin, S, 2000, p212):

> "Whereas CCT led to conflicts between many local authorities and private contractors, the best value framework is intended to create the conditions under which there is likely to be greater interest from the private and voluntary sectors in working with local government to deliver quality services at a competitive price."

Indeed (Evans, M, Cerny, P, 2003) argue that 'New Labour' has confirmed a shift in policy from a 'welfare state', to a 'competition' state. They suggest that whilst the post war Welfare State was aimed in part at mitigating the impact of the free market, the new

model more explicitly orientates itself to supporting the 'free market'. More recently, (Miller, C, 2004) has noted that there is little chance of a return to a near monopoly of state services and therefore, the 'mixed economy of care' is here to stay.

So far then we have established that there has been a reorientation/reorganisation of the 'Beveridgean' settlement away from bureaucratically planned services towards a more 'marketised' model of provision. As we have seen above towards the end of the 1980's, 'quasi-market' type mechanisms were introduced in Education, health, housing and social care. Each configuration was slightly different, and each area raised slightly different concerns about the negative outcomes of this policy re-orientation, however, they were all shaped by the 'new public management' agenda. Let us move on now to focus specifically on the implementation of the quasi-market in social care, following the introduction of the 'NHS and Community Care Act 1990'.

The 'Quasi-Market' in Social Care –The 'NHS and Community Care Act 1990'
In order to make sense of the specificities of the 'NHS and Community Care Act; it is helpful to review policy developments albeit briefly over the last century. Government policy has throughout this century supported the idea of maintaining people in their own homes, as opposed to long stay institutions. This idea became particularly influential during the 1960's following the publication of (Goffman, I, 1968) 'Asylums' and (Townsend, P, 1962) 'The Last Refuge'. However, in this period the preference for 'community care' related, not just to 'care' in people's own homes, but 'care' in community based facilities such as small care homes, as compared to large and remote hospitals. In 1981 a white paper 'growing older' was published and this paper was interpreted as a

major departure in government policy and part of the trend of 'rolling back the state':

> "As pubic expenditure constraints have, increasingly, prompted the promotion of community care as a policy goal, so the emphasis on measures to implement that policy have shifted from statutory to informal and voluntary provision."(Department of Health and Social Security, 1981,Para 1.1)

Ironically what followed was a shift away from statutory provision and the massive expansion of private residential care homes funded, in the main, by the State. This expansion was an unintended outcome of legislative changes that enabled people resident in a private residential or nursing home who found themselves in financial difficulties to have their care paid by the Department of Social Security. However, until 1980, this was a discretionary power, but after 1980 discretion was removed and older people (subject to a means test) had the right to residential care paid for by the DSS. Local authorities at this time were entering a period of financial restraint in the light of 'rate capping', and many took advantage of this policy, steering applicants towards private residential care, which would be paid for by the Department of Social Security. Private sector care expanded massively and the bill to pay for care increased from £10 million in 1979 to £500 million by the mid 1980's. (Lewis, J, Glennerster, H, 1996) The government had inadvertently created a 'voucher' scheme, which allowed people needing or choosing to move into residential care the option of finding a home of their choice within the price limits available.

In 1986 the Audit Commission published a report ' Making a Reality of Community Care' that outlined a number of obstacles impeding the development of community based care. In particular the report highlighted the perverse incentive towards residential care, which

had come about as a result of the de facto 'voucher' scheme. In essence, individuals found it easier to enter residential care (at a considerable cost) to the government than stay in the 'community' because of the lack of support facilities that existed there. There were no financial incentives in place at this time that would have encouraged the development of Community based services, via health or social service departments.

In 1987 Sir Roy Griffiths was appointed:

> "To review ways in which public funds are used to support community care policy and to advise on options which would improve the use of these funds"(Department of Health and Social Security, 1988, P3)

His report 'Community Care: An Agenda for Action' published in 1988; made a number of policy proposals. These included identifying a central role for local authority Social Service Departments in the development and implementation of 'community care' policy. As in other areas of policy this would be in as 'enabler', 'purchaser'/arranger of care, assessing need at a 'macro' and 'micro' level, and designing and stimulating care services. In relation to provision he recommended that; Social service Departments would have a crucial role in the design, stimulation and specification of services, but not necessarily as a provider of services and that the private and voluntary sector, in its broadest sense, i.e. including informal sources of care, would play a much greater role in provision. The report emphasized the need to ensure that a new pattern of service provision be developed, which was 'needs-led' rather than 'service led'. This report then mapped out the framework for the implementation of a 'quasi-market' in social care.

In relation to finance, the report recommended the closure of the Department of Social Security route into residential care, and the

transfer of those resources to local authority social service departments, to use as a purchasing budget for 'community care'. The report also recommended the appointment of a specific minister with responsibility for 'Community Care', and a specific budget earmarked for 'community care'.

In 1989 the government published the white paper, 'Caring for People' which provided the basis for subsequent legislation introduced under the 'NHS and Community Care Act 1990'. This paper embodied the main principles of the recommendations set out in the Griffiths report. However, the paper rejected a specific community care budget (except for a special transitional grant for a limited period) and a Community Care minister. The white paper 'Caring for People' set out a number of policy intentions. These included developing good assessment systems; promoting domiciliary, day and respite care to permit independent living at home and stimulating/developing the independent sector.

The agenda for social care was set. The intention was to develop a system of care and service provision which would be more able to respond flexibly and sensitively to the needs of users and carers, offering a range of care options that would enable people to remain in their own homes. The mechanism for achieving this was, as in other areas of welfare, the 'quasi-market'. In this instance it involved a reinvention of the role of social service departments - From bureaucratic planner and administrator to enabler/purchaser, stimulating and encouraging the 'mixed economy of care'. The process of identifying 'need' and developing 'needs led' services was central to the process. The development of good assessment systems was crucial to this, and this was implemented via the development of 'care management', and it is to this that we now

turn.

The Development of 'Care Management'

Care Management as an idea was imported from North America who had piloted different mechanisms for managing care. There are three ways in which care management can be implemented. The first is to give individuals money to manage their own care (brokerage); the second is to give front line staff/care managers purchasing power which enables them to draw on a range of sources to develop 'care packages'. The third splits the purchasing process from the assessment process, giving 'care managers' the responsibility for assessing need, and purchasers responsibility for purchasing services. In Britain today the application of care management tends towards model one for a limited number of clients, particularly the disabled 'non-elderly' and model three for older people.

'Care Management' – Model One

Model one was influenced by the development of brokerage schemes in North America, whereby users were given sums of money to purchase their own care. This model was introduced as a pilot scheme in Britain. In 1988 Britain established the Independent Living Fund whose aim was to enable severely disabled people who would otherwise have entered residential care to purchase there own care, which may involve employing personal assistants around the clock. The scheme was popular because it was viewed as empowering, as it enabled highly dependent people to take control of their own care, and become employers stipulating exactly what their care needs were, rather than being dependent on state services.(Ungerson, C, 1993; (Lewis, J, with Bernstock, P, Bovell, V, Wookey, 1996))

In 1993, at the moment of 'Community Care' implementation, this model, which was clearly consumer-led and empowering, was replaced by a less empowering model under the Independent Living Fund (1993). The new guidelines stipulated that users had to receive a proportion of their domiciliary services from the local authority, and would then be eligible for a cash limited top up, giving them some flexibility. The first initiative was an empowering initiative, which gave the user control over their care the second initiative was clearly a reversal of this trend.(Morris, J, 1993)

However, following pressure from Disability Organisations, the then Conservative government reintroduced the original scheme. In 2000 this scheme was extended to include all older people and in 2004 this scheme was modified to enable monies to be used to pay relatives for care. (Department of Health, 2000; Department of Health 2004). Moreover, the government's Green paper on adult social care proposes the introduction of Individual Budget Accounts for all older people to purchase their own care up to the value of £10,000 per year.(Department of Health, 2005)

It is argued that such legislation is empowering as it gives individuals the ability to employ their own personal assistants and choose to purchase the type of support they desire. However, a number of concerns have been raised. The first is that not all potential users would be in a position to manage their own care, or would desire this responsibility, therefore the extent to which this model can be replicated more widely to 'older people' is questionable.(Clarke, H, Spafford, J, 2001) Secondly it may give rise to a deregulated market of care workers, who work long hours with few employee benefits, such as training, which may militate against quality of care(Ungerson, C, 1997, Spandler, H, 2004). Moreover,

(Beresford, P, 2005) has suggested that in order for this model to work there would need to be an infrastructure of user based organizations to support users.

However, evidence to date suggests that take up has been low. In 2001 the Social Services Inspectorate inspection of 23 local authorities found only 188 older people receiving direct payments. Five of those 23 local authorities, contained 78% of all direct payments to older people, whilst seven councils made no direct payments to older People.(Social Services Inspectorate, 2001)

'Care Management' - Model Two
The Personal Social Services Research Unit at Kent University piloted the second care management model. It is this model, which was influential on government policy at the moment of 'Community Care' implementation. The Kent pilots involved identifying/targeting users on the verge of entering residential care. Case managers were given a budget for a client, which was equivalent to 2/3 of the cost of residential care, which they could spend in innovative ways. According to (Lewis, J, Glennerster, H, 1996) the success of the projects depended not just on topping up existing domiciliary care services, but radically rethinking the nature of provision. They had the power to commission services from the independent sector or the informal sector. Care managers were given budgets, which they could use creatively. In many instances budgets were used to pay volunteers a small sum of money for providing assistance with care, or care was purchased from an agency, which was able to respond more flexibly to client need. The findings from these small scale projects were that 'Care Management' was able to achieve benefits in terms of quality of care by allowing people to remain in their own homes at a lower cost, in other words the goal of community care was achieved at lower cost. The research also suggested that these

gains would only be achieved if 'care management' were applied to those on the brink of residential care and not for all users/clients. (Lewis, J, Bernstock, P, Bovell, V, 1995)

The results of the Kent pilots were appealing to the Conservative government as the findings suggested that it was possible to stimulate a 'mixed economy of care', facilitate 'community care', and save money. Government legislation and guidance related to 'Community Care implementation' gave the development of assessment and care management systems high priority, and suggested a number of different models. However, the intention was to reproduce the kind of results found in the Kent Pilots. (Lewis, J, Bernstock, P, Bovell, V, 1995) The 'care manager' was seen as the agent responsible for working with users and carers to identify need and design care plans to meet that need, these identified needs would then be met by drawing on the emerging 'mixed economy of care'.

Interestingly, some authorities such as the London Borough of Camden and the London Borough of Hammersmith and Fulham considered contracting out the assessment and care management process to specialized agencies, for some groups, such as 'Black and Minority Ethnic' communities. However, this model was not adopted.((Lewis, J, with Bernstock, P, Bovell, V, Wookey, F, 1996)

In reality there were a range of reasons why the Kent 'care management' pilots were not directly reproducible to a local authority setting. The Kent schemes were successful in part because care/case managers had small caseloads, as time of course is crucial in negotiating complex care packages -the caseloads were much higher when applied to a local authority setting. The Kent Pilots

were also based on employing informal carers such as neighbours and friends at a relatively low cost to facilitate 'care in the community'. Once again this was not acceptable within a local authority setting, as it raised issues of employee rights, and would have met with resistance from trade unions.(Lewis, J, Glennerster, H, 1996) Therefore, perhaps, it was never going to be possible to develop the small, specialized and successful 'care management' schemes to all clients on the verge of entry into residential care in this way.

However, the reality was that neither, Model one or Model two was implemented either in the first case study authorities, or in the second case study authorities. Local Authorities have tended to split the purchasing function between care managers/assessors, and macro purchasers. Therefore, neither the user of the service, nor the 'care manager' was involved in the immediate purchasing decisions/choices.

'Care Management' - Model Three
The development of 'care management' systems in local authorities following 'Community Care' implementation, tended to develop within a context of macro purchasing. A centralized commissioning type section was established to negotiate with residential care homes and private care agencies about terms and conditions. 'Care managers' would then select services from this menu developed from the centralized commissioning unit.(Lewis, J, Glennerster, H, 1996)

'Care Management' and User Choice
This then raises the question 'to what extent has there been a shift in responding to user choice' facilitated by the development of 'care management'. Research studies to date suggest that there has not

been a generalization of the good practice found in Kent. Both
(Lewis, J, with Bernstock, P, Bovell, V, Wookey, F, 1997) and
(Cheetham, J, 1993) suggest that care managers have had difficulty
in identifying need over resources and continued to be 'service-led'.
Moreover they both argue that there was little evidence of 'care
managers' being given any real purchasing power to make decisions,
or indeed a wide range of options to choose from on a block menu.
(Lewis, J, with Bernstock, P, Bovell, V, Wookey, F, 1996) This
finding was confirmed by (Forder, J, Knapp, M, A, Knapp, M, Hardy,
B, Kendall, J, Matosevic T, Ware, P, 2001) who found only very
limited devolution of budgets to care managers since community
care implementation, which they argue is a crucial part of facilitating
a more 'needs led' service.

The decision to locate decision making within centralized units, does
not in it-self mean that decision-making will be unresponsive to user
preferences. However, it is how purchasing decisions are informed,
and by whom, that is crucial in determining the extent to which user
led services emerge. In the study undertaken by (Lewis, J,
Glennerster, H, 1996) contrasting approaches were identified in two
authorities studied. In one authority the contracts unit appeared to
act independently of both other parts of the department, and any
user input mechanisms. In this authority the central contracts unit
renewed a meals on wheels contract, which was so unpopular with
users, that in many instances 'care managers' were allocating an
additional one-hour per day of personal care to enable them to
prepare a meal for the client. Whereas, another authority, ensured
that purchasing decisions within the centralized contracts unit,
responded to user based information as a basis for informing
purchasing decisions.

(Jones, C, 2001) carried out a qualitative study of social work following the election of 'new Labour' and suggested that the implementation of care management was deskilling social work. Workers had large caseloads and insufficient time to deal with them. This change was summed up by one 'care manager' in his study:

> "Being a 'care manager' is very different from being a social worker, as I had always thought of it. 'Care management' is all about budgets and paperwork and the financial implications for the authority, whereas social work is about people, that's the crucial difference."(Jones, C, 2001, p553)

Essentially then it is the 'gatekeeping' role that has been accentuated, with little time or money to develop anything but a very limited model of 'choice'. The influence of the 'public choice' school and the need for financial incentives is clearly built into the system. Amidst this rather depressing picture, there is evidence of some innovation, for example Portsmouth Social Services Department established a 'care management' pilot to look at new ways to increase older people's choice and control over schemes. This pilot was set up in 1999 and was popular with staff.

> "Some care managers were immediately enthusiastic about a scheme which would give older people more choice and control, and give them more time for developing imaginative solutions to meeting needs. However, care managers had to manage the scheme on top of their already heavy workloads."(Clark, H, Spafford, J, 2001, p3)

This illustrates well how issues of 'choice' and 'diversity' have been incorporated into the reforms, they have not been a central feature of implementation, rather they have been marginal. Therefore, measures to enhance user choice continue to be added on/taken off depending on local factors, or within an 'experimental' type approach as in Portsmouth. They are not an intrinsic part of policy implementation.

To date the development of 'care management' appears to be pushed between a radical model, which gives complete purchasing power to the user, and a more conservative model where care managers choose from a limited menu developed by a centralized commissioning unit that may or may not be informed by user preferences. It appears that following the implementation of the 'NHS and Community Care Act 1990' the model that was implemented was least likely to generate 'needs led' service provision, as it was neither the 'user' of services, nor the 'care manager' that determined purchasing decisions, but rather a 'third party' who may have relatively divorced from the assessment process. However, the current government is now proposing the introduction and generalizing of the more radical model of giving purchasing power to all users, and we return to this in the concluding chapter.

Whilst 'care management' was to encourage a shift from 'service' to 'needs led' assessments at a micro level, the 'Purchaser/Provider' split would facilitate this at a macro level. According to (Lewis, J, Glennerster, H, 1996) the first round of government guidance stressed the need to develop 'care management' systems. However, by 1991 the Department of Health had turned its attention to the purchasing function. The separation of purchasing and providing was promoted by the government within Social Services Departments as a vehicle for providing greater choice, and more generally to encourage a shift in the role of local authorities from 'provider' to 'enabler'.

The Introduction of a 'Purchaser/Provider' Split in Social Care
As we have already seen the introduction of a 'purchaser/provider'

split is based on the premise that bureaucracies are unable to deliver user led services, and instead deliver services that reflect what the provider wants/is willing to provide, this is explained in part because there is no competition and in part because providers are given budgets irrespective of performance. Therefore by separating the purchasing function from the providing function, the provider of services will be less able to determine the nature and quality of services available, and this should result in services, which more closely reflect the needs of users.

However, for the 'quasi-market'/'purchaser/provider' split to be a successful, 'purchasers' have to be able to alter the profile of services, and choose between different providers. Following implementation of the 'NHS and Community Care Act, Local Authority Social Service departments effectively had two 'community care' budgets. The first related to existing expenditure, tied up with domiciliary care, day care etc. The second related to a much smaller budget, the Standard Transitional Grant, allocated to authorities to meet their new obligations under the 'NHS and Community Care Act 1990'. The latter was not linked to existing service provision, and as (Lewis, J, with Bernstock, P, Bovell, V, Wookey, F, 1996) demonstrate was used in very different ways to existing monies. However, the budgets were only a very small part of a department's overall budget, and therefore to fully operationalise the 'quasi-market'/'purchaser/provider' split a total budget transfer would be necessary.

(Lewis, J, with Bernstock, P, Bovell, V, Wookey, F, 1997) identified a major problem confronting authorities in transferring budgets, and therefore making a reality of the 'purchaser'/'provider' split. Budgets were tied up with existing services, and therefore to change the

profile of services, would have its own costs, in terms of potential redundancy payments, that may outweigh any benefits of using the 'independent sector', therefore the status quo of in 'house service' provision remained, resulting in a very limited application of the 'quasi-market'.

The extent to which the 'purchaser/provider' split is embraced will also be shaped by local factors, such as, the political complexion of the local authority; attitudes to the 'quasi-market' within the local authority'; specific regulations, such as the 85% rule linked to the 'community care' transitional grant; the 'voluntary sector" 'campaigning type groups, and attitudes to the 'quasi-market' within local authorities.(Lewis, J, Glennerster, H, 1996)

The Personal Social Services Research Unit(PSSRU) have been researching the 'mixed economy of care' since the beginning of the 1990's. Between 1990 and 1992 they interviewed officers and 'elected members' in a number of local authorities and concluded that despite widespread support for a shift to 'needs-led' home based service provision. There was a widespread reluctance within local authorities (of all political complexions) to develop a market in social care. Reluctance was explained in part by a view that 'social care was different' and, therefore, should not be opened up to market forces in the same way as other areas of service provision. Strategies for stimulating the 'mixed economy' tended to favour 'voluntary sector'/'trust' type organizations. Nevertheless, despite this reticence, researchers observed the beginnings of a cultural change with a greater acceptance to work with the 'independent sector'.

In 1993 the researchers revisited their sample authorities and

identified a considerable shift in attitude towards the 'mixed
economy of care'. Authorities were far less likely to view social care
as different, and appeared to be coming to terms with markets.
They suggested that rather than the emergence of an enthusiasm
for markets, authorities had become 'market pragmatists'. Moreover
there was an increasing recognition of the possible
benefits/advantages of markets, such as; acting as a stimulus for
change; cost reductions; quality enhancement, and as a vehicle for
responding to diversity and choice.(Wistow, G, Knapp, M, Hardy, B,
Forder, J, Manning, R, Kendall, J, 1994)

(Lewis, J, with Bernstock, P, Bovell, V, Wookey, F, 1997) suggested
that prior to the introduction of the NHS and Community Care Act
1990 in April 1993 some authorities who were politically committed
to 'contracting out', moved quickly to introduce a purchaser/provider
split. They argue that where the split was introduced prior to 1993,
it was simply aimed at elaborating a privatized model of welfare
delivery, by replacing local authority provision with private provision.

However they suggest that after 1993 a more specific 'social care'
approach emerged towards 'purchaser/provider' splits, informed by a
philosophy of user preference and the potential benefits of using a
'mixed economy of care. As authorities began to make plans for
purchasing residential/nursing and spending their 'Standard
Transitional Grant', some authorities who had initially moved
towards implementation with reluctance, began to realise that the
shift towards 'enabling' may actually be compatible with a more
'user-led' approach.
One authority for example cited the previously unsuitable
placements they had uncovered where 'Asian' people were placed in
homes on the South Coast, completely isolated from other members

of their communities, and unable to converse with workers. Therefore the new system offered the potential to use the 'quasi-market' as a vehicle for raising standards of care.

Another crucial determinant of success, in relation to the implementation of a 'quasi-market'/'purchaser/provider' split in social care, is the extent and nature of the social care market. (Knapp, M, Hardy, P, Forder, J, 2001) reviewed the development of social care markets since the introduction of the 'community care' legislation, and found that there had been substantial development of the private domiciliary care market. For example, in 1992, the independent sector had provided just 2% of home care hours funded by local authorities, and by 1999 this had increased to 51%(most of which was in the private sector).

However, they argue that developments in other areas of service provision, such as day care have been much more limited. This is crucial as it indicates that what has emerged is a rather limited social care market, in the private sector, providing domiciliary care in ways that may enable people to have greater choice about care in their own home, and may indeed enable people to stay in their own homes, but in terms of adding to the quality of life of people who now remain in their own homes, with additional services, there has been limited development. This was a finding identified by (Lewis, J, with Bernstock, P, Bovell, V, Wookey, F J, 1997) where they found that the introduction of a purchaser/provider split had enabled Social service departments to purchase more flexible care for users, who were able to go to bed at a time of their choice rather than fitting in with a schedule of in house providers. (Spall, P, McDonald, C, Zetlin, D, 2005) reviewed 'quasi-market' implementation in Australia and concluded that there had been an insufficient focus on service

developments resulting in an inadequate supply of services resulting in a lack of choice for consumers.

Above we considered a range of criteria that might be applied to evaluating the success or otherwise of the 'quasi-market'. One of these referred to the implications of 'monopoly purchasing', which may lead to unfair conditions and expectations being placed on providers - Therefore distorting the market. (Knapp, M, A, Wistow, G, 1996) undertook some research on this topic and found that local authority purchasers had too much power over providers, resulting in unrealistic cost limits being set by local authority departments, that did not actually cover the actual cost of residential/nursing home care or domiciliary care, they also found that local authorities were operating in discriminatory ways towards private care providers. For example, some local authorities operated an 'In House' first policy, with the private sector used to fill in gaps, such as providing out of hours care with more dependent clients. Overall strategies were seen as unsupportive. Moreover, (Wistow, G, Knapp, M, R, A, Hardy, B, Forder, B, Kendall, J, Manning, R, 1996) raised concerns that such practices may lead to market failure.

We can conclude then that the 'purchaser/provider' split/'quasi-market' has been operationalised in a limited way. There has been a partial development of the 'purchasing' function within 'local authorities' and a limited development of the 'independent' sector. One of the clear policy intentions of the 'purchaser/provider' split/'quasi-market' was to enhance user choice and it is to this that we now turn.

The 'Purchaser/Provider' Split and User Choice
A range of studies have suggested that this was a neglected dimension of 'Community Care' implementation. (Knapp, M, R, A,

Wistow, G, 1996) pursued the issue of choice post 'implementation'. They observed that one of the central goals of the government was to promote 'choice and independence' which would be achieved in part by the development of a 'flourishing independent sector alongside good quality public services. They distinguished between choice at a macro level(market) and choice at a micro level(User). They found that few users were given any choice about services used or the timing, or organisation of the care services – with choice effectively limited to, refusing the service.

(Hardy, B, Forder, J, Kendall, J, Knapp, M, R, A, Wistow, G, 1999) suggest that choice had simultaneously increased and decreased following 'Community Care' implementation. Increased choice was identified in terms of a wider range of services being provided, such as out of hours care and in terms of the growing numbers of agencies providing care. However, choice had decreased for those who were categorized as having lower levels of need and were therefore excluded from services. Moreover, the increasing costs of home care for the highly dependent had resulted in some users entering residential care because of cost considerations.

(Perri, G, 2003) explored the extent to which choice had been enhanced following the introduction of 'quasi-market' reforms in a range of areas and suggested that there had been very few studies to explore this issue in relation to social care, but of those that had the implication was that choice had been enhanced in a limited way, for example he refers to the choice of residential care homes in major cities and seaside towns, though this choice existed prior to the reforms.

(Hardiker, P, Barker, M, 1999) observed implementation in one

county council and adopt a more positive view, arguing that many of the 'core' and 'near core' policy goals of community care have been implemented. Specifically they refer to the growing 'independent' sector and the establishment of new and empowering methods of assessment, which gave users greater control, and targeted services to those to the people that needed them most. However, it may be that what has developed is what Denise Platt, former director of the Association of Directors of Social Services, described as a 'Rolls Royce' service, for those very highly dependent, with the remainder excluded from services.(Platt, D, 1993). It is too this increased targeting of services, and the interpretation of 'needs led', provision that we now turn.

<u>'Needs Led' or 'Risk Management'?</u>
The development of a 'needs' led' service was received positively by those working within social care. This was to be achieved through the development of good assessment systems and the stimulation of new services in the independent sector. Local Authorities were required to have assessment systems in place by April 1993. According to (Lewis, J, Glennerster, H, 1996) who reviewed the guidance to local authorities related to community care implementation argued that, there was a lack of clarity about what 'needs led' would actually mean, however:

> "What the manual was, however, very clear on was that assessment had to be developed as a separate function within each agency, free from the constraints to thinking that come from being associated with a service providing body".(Lewis, J, Glennerster, H, 1996, p14)

Section 47(1) of the Act NHS and Community Care Act had imposed a duty on authorities to assess any person who may be 'in need' of 'community care' and to decide on what services to provide. In December 1992 a circular CI 92 34 was sent to local authorities

stressing that authorities do not have a duty to assess on request, but only where they think that the person may be in need of services. More importantly they were advised when carrying out assessments of need, that this should be recorded separately from decisions about which services were to be provided.(Laming, H, 1992) The government was acknowledging that once a need had been identified with a service, the local authority may have a responsibility to meet that need. (Lewis, J, Glennerster, H, 1996) found that in the authorities that they were studying this caused a frenzy of action at the last minute and a redesign of assessment forms that separated assessments of need from any specific service recommendation.

The discussion of 'needs led' assessments very quickly entered a legalistic discourse about the implications of identifying needs that could not be met. Once individual need had been formally assessed the local authority would have had a statutory responsibility to meet that need, as was found in Gloucester-shire, where a local resident successfully appealed to the Appeal Court against a decision to withdraw a particular level of support because of lack of resources.[1]

Essentially local authorities were being advised to be cautious about what needs were being identified, on the basis that need had to be measured within the context of available resources. In 1993 The Audit Commission issued advice to local authorities stating that they need to develop eligibility criteria for services which would enable them to provide support to 'just enough people', in other words, drawing the criteria to ensure that not too many people were eligible for support, this led to a cautious approach to 'needs led' assessments.(Audit Commission, 1993) Therefore the development

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[1] It should be noted that this decision was later overturned by the House of Lords who ruled in 1995 that resource considerations could in fact be used to justify a withdrawal of services.

of the new system was taking place against a context in which 'needs led' was being implemented in a very contradictory way, as it was the level of resources that was to be more important in the determination of 'need', rather than 'need' itself.

(Mackintosh, M, 1997) explored the establishment of the quasi-market in two local authorities and found that an economic culture had developed whereby the economic thought world, which surrounded community care, was one based on cost consciousness and price based competition. In other words, workers/assessors were working within a 'mindset', which gave greater significance to resource constraint and the limitations that this placed on their work, as a rationale for not focusing on user empowerment/choice etc

> "These problems of imagination stem..not from a lack of imagination about what should or might be done, but more from the intense straitjacket on economic imagination and indeed economic confidence imposed by the funding structure for community care and by the dominant economic generalisations of the last 15 years...More responsive social care is going to require among other things...a more creative economic culture."(Mackintosh, M, 1997, p93)

(Blom, B, 2001) explored 'quasi-market' implementation and Sweden and concluded that intrinsic economic values had become primary in terms of implementation with low costs and profits coming before social work.

(Barnes, M, 1998) argues that by the mid 1990's resource constraints had come to dominate the policy agenda. For Barnes there were two legal test cases that were pivotal in determining the limited and cautious approach to 'needs led' assessments. The first was the Gloucestershire case(see above) described above and the

second as a subsequent case in Lancashire the court ruled that 'resource considerations were relevant' in determining the way a need could be met. In this instance a woman requiring 24 hour care wanted the care provided in her own home, the local authority wanted to place her in a nursing home. She goes on to argue that these test cases confirmed that in reality it was the 'assessment of risk' that underpinned the implementation of the legislation and not 'assessment of need.' She uses a statement from a report of the director of Social Services at (Staffordshire County Council, 1996) to illustrate this:

> "It is proposed that the general eligibility criteria for access to services should be that: 'The necessity for the provision of services must be evidenced by risk of significant harm if the service is not provided." (quoted on page 107 , Barnes, M, 1998)

(Rummery, K, Glendinning, C,1999, p341) argue that the only 'universal principle of need' being applied is one of financial probity. They argue that essentially 'community care' implementation has reduced citizenship rights in terms of accessing free nursing home care and has led to increased gate-keeping mechanisms. They carried out a study of assessment procedures in two local authorities, observing the processes determining access to an assessment, and the assessment itself. They identify gate-keeping at two levels. At the managerial level related to the framework and structures agreed by managers, and at a street level by receptionists and duty social workers. They argue that assessment is more about assessing people out of the system than in.:

> "The operationalisation of these new responsibilities allowed additional new managerial and procedural mechanisms to be introduced which further shape and circumscribe the social rights determining access to long term care services."(Rummery, K, Glendinning, C, 1999, p346)

(Spall, P, McDonald, C, Zetlin, D, 2005) conclude that in Australia

the implementation of the 'quasi-market' had resulted in cut backs in service, inadequate service supply and an increased focus on assessment procedures.

Therefore it is possible to observe a demise of 'social rights' or a remodeling of the 'social citizenship' model reflected in the 'Beveridgean' settlement towards a more limited 'social welfare' model reflecting a 'safety net' approach to meeting need.

Conclusion

This chapter has provided a context to this study. We observed that following the election of a Conservative government in 1979 the 'free market' or 'market type' mechanisms were promoted as a more appropriate mechanism for solving a range of problems. Moreover this shift towards the 'new public management' and 'market orientated' solutions was not restricted to Britain, but was part of an international trend. We considered that whilst this trend was clearly shaped by ideas emanating from the 'new right' and the 'public choice' school. The wider context was a 'reordered' world with 'globalisation', restricting, shaping and framing the type of policy solutions available to policy makers.

The concept 'settlement' was used to make sense of specific changes shaping the organisation of welfare services in Britain, with the 'quasi-market' a major organizing principle in this new settlement. We reviewed the rationale for the introduction of 'quasi-markets' and criteria that might be applied to measure its success and return to this in our conclusion.

We explored the rationale and implementation of a 'quasi-market' in social care, and reviewed existing knowledge in relation to the implementation of the 'NHS and Community Care Act 1990'

generally, and the 'quasi-market' more specifically. We began by exploring the implementation of 'care management'.

'Care management' was a crucial dimension of 'community care' implementation, as it was envisaged that 'care managers' would play a crucial role in the 'quasi-market' as 'micro-purchasers'. A range of models had been applied to 'care management' some more empowering than others. However, the model that was operationalised following 'implementation' was the least empowering, with 'care managers' divorced from 'purchasing decisions, whilst increasingly aware of financial restraint, therefore accentuating their role as 'gatekeeper'. However, we observed that the recent Green Paper had stressed the possibility of generalizing a direct payments type model to all older people and we return to this in the concluding chapter.

We reviewed the 'operationalisation' of the 'purchaser/provider' split'/'quasi-market' at a macro level, and concluded that there had only been a partial development of the 'purchaser/provider' split, and a limited development of the 'independent sector', therefore questioning the extent to which it is possible to talk about the introduction of a 'quasi-market' in social care. We also pursued the issue of 'choice' and again concluded that this was a relatively neglected dimension of 'implementation'.

In the final part of this chapter we reviewed the way in which the concept 'needs led' had been 'operationalised'. We concluded that the development of 'needs led' assessments had been shaped by 'resource constraints', with the level of resources being more significant in determining the assessment of 'need' than 'need' itself, and suggested that the model that had emerged was more

about managing 'risk, than assessing 'need'.

However, what has been relatively neglected within the study of 'Community Care' implementation and the introduction of a 'quasi-market' in social care' had been its impact on 'Black and Minority Ethnic' groups. Therefore, this study will attempt to fill this void, by focusing specifically on the experiences of older 'African-Caribbean' people and it is to this we now turn.

<u>Chapter Two</u>

<div align="center"><u>'Race', 'Racism' and 'Ethnic Diversity' in Britain</u></div>

In the last chapter we explored the emergence of a 'quasi-market' in
Social Care. This 'quasi-market' was aimed at developing an
organisational framework more able to respond to 'differentiated need'
(in its broadest sense). In this chapter, we will explore the
development of policy and service provision for 'Black and Minority
Ethnic' groups, focussing specifically on older 'African-Caribbean'
people.

If we consider again, the concept of an 'imagined' settlement', then
what becomes clear, is that the 'Beveridgean' Welfare Settlement' was
based on an imagined citizen who was 'White', 'Male', and in work,
and his family. Services were bureaucratically planned and delivered
based on this assumption. Therefore, a particular interpretation of
'univeralism' underpinned the 'organisational' settlement which was
'mono-cultural' in approach, equating 'sameness' with 'equality'. An
important feature of this organisational settlement was the pivotal role
of the state in developing services. The failure of both the 'local' and
'national' state was evidenced in a number of reports, and a significant
'Black and Minority Ethnic' voluntary sector emerged to fill in the
'gaps'. Therefore, the emergence of a new 'settlement' focussing
increasingly on 'need' and emphasising the further elaboration of a
'mixed economy of care' offered greater potential for responding to
differentiated 'needs'.

This chapter begins by exploring the pervasive and continuing nature
of discrimination and disadvantage experienced by 'Black and
Minority' Ethnic groups in general, and 'African-Caribbean' people in
particular. We then move on to consider the various policy responses
of both central and local government to issues of 'race', 'racism' and
'ethnic diversity' in the post war, and contemporary period, both,

generally, and more specifically within Social Service Departments. Finally, we review existing literature on the impact of 'community care' implementation and 'Black and Minority Ethnic' groups and demonstrate the need for a research project which explores whether the introduction of a 'quasi-market' in social care is more able to respond to 'differentiated' need than bureaucratically planned services.

Terminology
The very way in which 'race'/'racism' and 'ethnicity' is discussed is problematic, There is no commonly agreed formula for discussing such issues, and a range of labels are applied reflecting different perspectives. Let us briefly consider some of the issues that are raised when discussing issues of 'race', 'racism' and 'ethnic diversity'.

The use of the term 'race' in policy discussions is increasingly viewed problematically.
The notion that that it is possible to divide the human 'race' into distinct biological groupings, has it's roots in Europe's expansionist project of colonialism and imperialism dating back more than 400 years. A range of scientists from 1781 onwards began to develop 'racial' classifications for the population, ordered into a hierarchy, which justified imperialist domination of large parts of the world on the basis of the superiority of the 'Caucasian/European' race. Therefore, science legitimised racism. (Kurji, M, 2002)

From the second world war the scientific validation for the notion of discrete 'racial groupings' was increasingly challenged, from within the scientific community. For example UNESCO published a report in 1964, where it was argued that there were no pure 'races', - but simply a continuum of different gene pools. They also argued that there were as many differences within 'racial' groups, as there were between 'racial groups'.(Kurji, M, 2002)

Some scientists and Social scientists do continue to operationalise notions of 'race' linked to human attributes such as intelligence.(Herrstein, R, A, Murray, C, 1984), but within the disciplines of 'sociology' and 'social policy' the concept of 'race' as a meaningful category has generally been rejected. Writers such as (Fanon, F, 1967; Miles, R, 1993) have argued that it is more helpful to use the concept 'racialisation' which explores the way 'race' is constructed to define boundaries between people. 'Race' then from this perspective is a social construct, developed at a particular historical moment, not in some neutral way, but as a mechanism for justifying exploitation and differential treatment of particular groups.

The study of this differential treatment and outcomes arising from this process has given birth to an extensive 'race relations' industry. Though for Miles this continues to reinforce 'common sense' ideas that different 'races' exist and have a biological reality. The use of the concept 'race' has increasingly been problematised. However, (Law, I, 1996) suggests that from a policy perspective it is important to continue to explore 'racism' as an outcome of 'racialisation', therefore 'racism' is a more helpful concept than 'race'. Some textbooks continue to use the term 'race', whilst others have increasingly moved away from this term and favour the category 'ethnic', and this term is used in this study.(Parekh, B, 2000)

It is increasingly recognised that racism as a blanket term for exploring the complexity of discrimination in the 21st century is problematic. 'Black and Minority Ethnic' groups who came to Britain in the post war period, continue to experience particular kinds of 'racism', whilst new migrants to Britain will experience different forms of discrimination. Moreover, even within those groups who came to Britain at similar

times, and who may have lived here for two or three generations, there may be differences in the way in which 'racism' is experienced. For example, middle class 'Indian' children may perform well at school but still experience 'racist' bullying, whilst working class 'African Caribbean' Children, may be subject to negative stereotypes from teachers. 'Multi-racist' is a term used for thinking about 'racism' in this way.

During the 1960's, the term 'Black' was used in a political sense, to refer to those people and their descendants who came to Britain in the Post War period from the 'New Commonwealth and Pakistan'. The category 'Black' was used by different 'Black and 'Minority Ethnic' groups', to describe and respond to what was perceived as a common experience of 'racism'. The term 'Black' continues to be used in some social policy texts, which stress the commonality of 'racism'.[2]

However, it has been challenged for three reasons. First, 'post-modern' writings stressing the importance of heterogeneity and difference have impacted on this debate, challenging the notion of a homogenous 'Black' identity/experience. Secondly, government agencies have responded to cultural difference by funding schemes for different 'Black and Minority Ethnic' groups. Thirdly, it is problematic to talk about a 'Black' experience, as there is considerable diversity in the experience of 'Black and Minority Ethnic' groups, which needs to be reflected in academic research.(Blackstone, T, 1988, Parekh, B, 2000, Pilkington, A, 2003)

'There has been a recent shift to focus on 'ethnicity' and 'ethnic categories', rather than 'race' and 'racial' categories, as a way of measuring and discussing issues of difference and discrimination. However, this also raises a number of problems. 'Ethnicity' is often

used as synonymous with 'not White', and implies great difference between 'White' and 'Black and Minority Ethnic' groups, and limited diversity within groups. These categories tend to reflect some of those people who came to Britain in the post war period, but exclude groups such as the Irish who are collapsed under the 'catch-all' 'White' category, or the more recent 'White' migrants from Eastern European countries. Moreover, 'ethnicity' can reinforce the notion that, individuals can be systematically processed into separate and fixed 'Ethnic' groups, ignoring the increasing number of people who may identify with a range of different 'ethnicities', and ignoring the way in which 'ethnicity' is simply one identity of many, and possibly not the most significant one. According to (Mason, D, 1995) the strength of using 'ethnicity' over 'race', is that it avoids 'biological determinism', though clearly the possibility of 'ethnic determinism' remains.

The shift from 'race' to 'ethnicity' has given rise to plethora of studies, which explore differences in employment, educational achievement, housing position and in some instances 'ethnically essentialist' explanations are used to account for these differences, in other words, differences are explained in terms of cultural practices/attitudes of different groups rather than the practices of particular institutions.(Pilkington, A, 2003; Modood, T, 1998)

- Another major weakness of the use of the variable 'ethnicity' is that it is divorced from other dimensions of inequality such as 'class'. The term 'Ethnic Minority' has also been rejected, as it suggests a lesser importance (in relation to the 'White' majority), and may be misleading in terms of actual numbers i.e. not constituting a minority, and therefore, 'Black and Minority Ethnic' groups has

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[2] See for example, (Penketh, L, 2000)

increasingly become more acceptable. (Burman, E, Smailes, S, Chantler, K, 2004) have more recently used the term 'minoritisation', arguing that groups and communities do not occupy this label/position by virtue of an inherent property, but rather as an outcome of socio-historical processes. The terminology used in this study is 'Black and Minority Ethnic' groups.

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The terminology for describing people from the 'Caribbean' has also changed. The term 'West Indian' and 'Afro-Caribbean' have been rejected. 'West Indian' because it denotes an area identified as part of the colonial project, which has since been renamed. 'Afro-Caribbean' because 'Afro' has little meaning, and has been replaced with 'African-Caribbean' as it implies a positive statement about origin. 'Black-Caribbean' is a term also used to describe people and their descendants from this region. In this study the term 'African-Caribbean' is used to describe people from the 'Caribbean, except when quoting directly from studies which use an alternative 'descriptor'.

A Demographic profile

Let us move on now to explore some demographic data related to 'Black and Minority Ethnic' groups in Britain. Data from the 1991 census indicated that 'Black and Minority Ethnic' groups' accounted for 5.5% of the total population of Britain (around 3.015 million) and this rose to 8.2% in the 2001 census. (Office for National Statistics, 1996a; Lupton, R, Power, A, 2004) More-over, the 'Black and Minority Ethnic' population is growing at a faster rate than the 'White' population and this trend is likely to continue.(Browne, A, 2000, Lupton, R, Power, A, 2004)

Traditionally data on 'ethnicity' has been collected to explore the experiences of 'African-Caribbean' and 'Asian' groups living in Britain and the categories used have reflected this. In the 2001 census, categories were widened and a number of interesting findings emerged. For example, people who categorized themselves as 'White' other, comprised a substantial part of the population in some London boroughs, suggesting that a range of 'diverse ethnicities' may be overlooked in contemporary approaches to 'race equality/"ethnic diversity'.[3] Secondly, the ability to place people in distinct 'ethnic' categories may also become increasingly problematic, given that data from the 2001 census indicated that 15% of all 'Black and Minority Ethnic' groups and 1% of the total population of Britain were 'mixed race'. Indeed, this group was larger than the 'African-Caribbean' population (Lupton, R, Power, A, 2004).

Older 'Black and Minority Ethnic' Groups

Data from the 1991 census indicated that 3.22% of the 'Black and Minority Ethnic' population were over retirement age (1.10% of the

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[3] In Kensington and Chelsea, 25.6% of the population, were people who identified themselves in the 'White' other group.

total 65+ age group) compared to 16.80% of the total
population.(Office for National Statistics, 1996b)

The table below was drawn from the 1991 census and demonstrates
that whilst 'African-Caribbean's comprised a relatively small
proportion of the older population in 1991 they were likely to
increase substantially by 2001. Indeed, data from the 2001 census
confirmed that by 2001, ' Black Caribbeans' had the largest
proportion of people aged 65 and over(11%) of any 'Black and
Minority Ethnic' group reflecting their earlier migration to Britain,
followed by 'Indians'. However, whilst in 2001 other 'Black and
Minority Ethnic' groups' such as Pakistanis and Bangladeshis were
relatively younger, it was predicted that this too would change
overtime.(National Statistics, 2005a)

Table One:Age Distribution of 'African-Caribbean' Population aged 50+
for England

Age	Male	Female
50-59	37,145	35,061
60-69	23,242	17,768
70-79	5,947	5,003
80+	903	1,303

(Volume 2 of 2, Office for National Statistics, 1996b, p639)

Spatial Patterns of 'Black and Minority Ethnic' groups

One of the main issues in relation to 'ethnic diversity' and service
development is that 'Black and Minority Ethnic' groups are not spread
evenly throughout England, but are concentrated in particular areas.
This was identified in the 1991 census and confirmed again in the
2001 census(Owen, D, 1992, Lupton, R, Power, A, 2004). For
example, of those categorised as 'Black Caribbeans' in the 2001
census, 61% lived in London. (Lupton, R, Power, A, 2004, p6)
observe that:

"The effect of the concentration of minority groups in certain large urban areas means that in 2001 most local authority districts in Britain (332 or 81%) had ethnic minority populations at or below the national average. Only 37 districts (9%) had more than 15% of their population from ethnic minorities.

Indeed of those 37 districts with more than 15% of their populations from 'Black and Minority Ethnic' groups, 26 were London authorities. On the other hand, the number of 'Black and Minority Ethnic' groups grew in nearly every local authority in Britain.(Lupton, R, Power, A, 2004) It is clear then that the task of responding to 'ethnic diversity' is especially pertinent in some areas. However, that is not to say that areas with small numbers of 'Black and Minority Ethnic' groups can ignore this issue, as based on existing trends it is likely that all areas will become more 'ethnically diverse' over time. However, 'ethnic diversity' is of course nothing new. 'Irish', 'Jewish', 'African-Caribbean; 'African' and 'Asian' migrants have a long history in Britain. Moreover, 'ethnic diversity' was a central feature of the post war 'settlement' with Britain actively encouraging migration from the 'New Commonwealth' and 'Pakistan'. However, the documented experience of 'Black and Minority Ethnic' groups continues to be shaped by discrimination and disadvantage and the failure of government policy to tackle these issues and it is to this that we now turn.

<u>'Discrimination', 'Disadvantage' and 'Black and Minority Ethnic' groups</u>
There appears to be an ongoing correlation between disadvantage and 'ethnicity. (Owen, D, 1994) found that 'Black and Minority Ethnic' groups were more likely to live in areas of greater disadvantage than the 'White' population. This was confirmed in a report carried out by the (Social Exclusion Unit, 2000) where they observed that not only were they more likely to live in the most deprived local authorities in the country, but they were more likely to be over-represented amongst the 'disadvantaged' in that area. For

example, 'Black and Minority Ethnic' populations in greater London were 2.5 times more likely to be unemployed than 'Whites'.

Any discussion of work and Britain's 'Black and minority Ethnic' populations has to understand that the older generation, who are the subject of this study have had a distinctive work experience, characterised by overt racism. (Mason, D, 1995) makes three important observations. The first relates to patterns of settlement. New migrants were recruited to work in specific service sectors, such as 'Transport' and 'Health' services. Such employment was located in areas, which were later to experience urban decline. Secondly, migrants occupied the least desirable jobs, in the least desirable industries, with 'racial' divisions inserted into the labour market, for example, through the operation of different shifts. Thirdly, migrants were more likely to work in semi-skilled and unskilled occupations.

Research carried out by (Bhalla, A, Blakemore, K, 1981) which looked specifically at older 'Asian' and 'African-Caribbean' people in Birmingham, found that hardly any of their sample had worked in non manual jobs before retirement, or even clerical or 'lower middle class' jobs. At a moment of full employment, new migrants coming to Britain found themselves in the least desirable sectors of the labour market. However, research evidence confirms that 50 years on the experience of Britain's Black and Minority Ethnic' groups, continues to be characterised by discrimination and disadvantage.

Data from 2002/3 confirmed that 'Black and Minority Ethnic' groups currently have lower rates of employment and higher levels of unemployment. This varies for different 'Black and Minority Ethnic' Groups. Let us begin by considering data from the Labour Force

Survey 2004. This survey found that in 2002/3 Unemployment rates for people from non-White ethnic groups were generally higher than those from White ethnic groups. Men from Bangladeshi and Mixed ethnic backgrounds had the highest unemployment rates at 18 per cent and 17 per cent, followed by Black Africans(15%); Pakistanis(14%) and 'Black Caribbeans' (13%). These rates were around three times that for 'White British' men. Unemployment rates for Indians were (7%) and for Chinese men (6%). These rates were similar to those of 'White British' or 'White Irish' men (5 per cent for each group).

Women also had higher rates of unemployment. Pakistanis had the highest unemployment rates (17 per cent), followed by 'Black African'; 'Black Caribbean' and 'Mixed Ethnic' women (12%). These rates were similarly three times that rate for 'White' women (4 per cent).(National Statistics UK, 2005b)

Employment rates are also lower for different 'Black and Minority Ethnic' groups. 'White' groups of all ages experience higher levels of employment. For example in 2003, Employment rates for those defined as 'White' were 77%, compared to 69% for 'Indians'; 68% for 'Black Africans'; 62% for Black' or 'Black' British'; and 42% for 'Bangladeshis' (Office for National Statistics, 2004)

This weaker labour market position is likely to impact on older people in two ways. First the disadvantaged position in the labour market makes it difficult for younger people to support their parents. Secondly, the disadvantage they experienced themselves will have an impact on retirement incomes (see below).

The weaker labour market position is reflected in income position. Data has consistently confirmed lower levels of income for 'Black and Minority Ethnic' groups. Data compiled by the Family Resources Survey in 2000/2001 confirmed that the risk of falling into low income for working age adults was higher for 'Black and Minority Ethnic' groups. likely to be poor than the 'White' population. For example, 18% of 'Black Caribbean' households had incomes less than half the national average.(Berthoud, R, Modood, T, 1997, Department of Work and Pensions, 2002)

The housing situation/experience of 'Black and Minority Ethnic' groups generally, and 'African-Caribbean' groups in particular, is similarly characterised by disadvantage. The racism encountered by migrants who came to Britain in the 1950's and 1960's is well documented in a number of publications.(Smith, D, J, 1977; Giles, R, H, 1977; Smith, S, 1989). A recent report from the Social Exclusion Unit noted in relation to 'Black and Minority Ethnic' groups:

> "Whilst there has been some improvement since the early 1980's, they are still more likely to be less satisfied with their homes than 'White' people and to live in poorer quality and less popular types of accommodation, regardless of tenure."(Social Exclusion Unit, 2000, p16)

Ironically, whilst initially excluded from local authority housing, many have become increasingly dependent on social housing, at a time when owner occupation is increasingly the norm. People categorised as 'African-Caribbean' and 'Bangladeshi' are least likely to own their own homes and most likely to live in social housing.(Social Exclusion Unit, 2000)

It is clear so far then that the experience of 'Black and Minority Ethnic' groups continues to be characterised by discrimination and disadvantage. Let us now consider more specifically the concept of

disadvantage in relation to older people from 'Black and Minority Ethnic' groups, focussing on the particular experiences of older 'African-Caribbean' people.

'Disadvantage' and Older People from 'Black and Minority Ethnic' Groups

Older people from 'Black and Minority Ethnic' groups are more likely to experience disadvantage in their old age. Let us begin by considering the financial situation of older people from 'Black and Minority Ethnic' groups. (Evandrou, M, 2000) analysed the socio-economic status of different 'ethnic' groups. She found that 'African-Caribbean' people aged between 60 and 69, were least likely to have any formal qualifications of any 'ethnic' group, and were most likely to have worked in a semi-skilled or unskilled capacity of any 'ethnic' group based on their last occupation before retirement. In relation to income in old age, 'African-Caribbean' older people fared worst than the 'White' or 'Irish' population, with 34% in the bottom quintile of the income distribution. A relatively high proportion of older 'African-Caribbean' people (58%) were receiving income support compared to older 'White' people (33%). However, they were less likely to be in the lowest quintile group, than older 'Indian', 'Pakistani' and 'Bangladeshi' people.

Those categorized as African-Caribbean', were more likely than other 'Black and Minority Ethnic' groups, but less likely than the older 'White' population to receive an occupational pension. Evandrou accounts for the relatively high proportion of the 'African-Caribbean' population receiving an occupational pension as a result of employment patterns, with many working in large public sector industries such as the health service and London Transport. It is clear then that older 'African-Caribbean' people are more likely to face financial hardship in old age compared to their 'White counterparts,

but are slightly better off than other 'Black and Minority Ethnic 'groups.

There is now an emerging literature on 'health' and 'ethnicity'.
Analysis of the 1991 census found that 'African- Caribbean' people had
a slightly higher incidence of longstanding illness than 'White' groups.
(Owen, D, 1992) Similarly, the Department of Health's 1999 Health
Survey for England focussed on the health of 'Minority Ethnic' groups.
This was the first national study to explore 'ethnicity' and 'health'.
Interestingly, 'African- Caribbean' Men and Women aged 55 and over
were more likely to rate their own health as bad or very bad, more
likely to have a severe lack of social support; and more likely to suffer
from diabetes than the general population, and 'African-Caribbean'
men were more likely to visit their GP. (Department of Health, 1999)

According to (Fenton, S, 1987, p28):

> "It is likely that much ill health is related to working lives. Many
> respondents spoke about accidents at work and the effect on
> their health for many years of arduous employment including
> unhealthy foundry work, building work and amongst women
>   nursing and hospital domestic work."

One can conclude that a lifetime of disadvantage will have an impact
on health, which in turn may translate into higher needs for welfare
intervention. There is a huge body of evidence linking social class and
health outcomes.(see for example, Townsend, P, Whitehead, M,
Davidson, N, ed., 1992; Blane, D, Drever, F, 1998) and therefore,
one could predict a greater degree of poor health amongst Britain's
Black and Minority Ethnic' older communities'.

It is clear then that the material circumstances of older 'Black and
Minority Ethnic' people, and more specifically older 'African-Caribbean'
people, has a greater propensity to 'disadvantage' than the 'White'
population and that this 'disadvantage' has been both enduring, but

changing since those early migrants came to Britain. This then raises the question of how the 'British State' both 'national' and 'local' has responded to this?

'Race', 'Racism, 'Race Equality' – The Social Policy Response

At first glance, it would seem that issues of 'race', 'racism, and 'race equality' have been given prominence for some time, within social policy. This is both true and untrue. There is a parallel story to be told related to the Social Policy response to issues of 'race' and 'racism'. On the one hand there has been considerable discussion about issues of 'race' and 'racism'; policy statements identifying the need to respond to diversity, research studies documenting continuing disadvantage, legislation dating as far back as 1965 and updated most recently in the Race Relations Amendment Act 2000 aimed at tackling racism. Yet there is continuing evidence of discrimination and disadvantage within the field of social policy, and when individual areas of social policy are examined from a policy perspective, strategies related to 'race equality' are critiqued. Essentially, we have statements of intent in relation to 'race equality'/'ethnic diversity' that do not appear to have been accompanied by action. As we will see in the remaining part of this chapter, 'race equality' has remained a peripheral issue within social policy.

To make sense of government policy on issues of 'race' and 'ethnic diversity, a useful starting point is the immediate 'post war' period, as this marks the beginning of significant immigration into Britain, along-with the introduction of the 'Beveridgean' Welfare settlement, marking a new approach to 'social welfare'.

The severe labour shortage after the war led to a massive overseas recruitment campaign, initially in Ireland and Continental Europe and then increasingly in the New Commonwealth and Pakistan. The British

Nationality Act of 1948 gave citizenship rights to every colonial or ex colonial subject. The legacy of colonialism had underdeveloped and distorted the economies of these countries and this made migration attractive, and therefore Britain was able to take advantage of this huge supply of cheap labour. (Sivannandan, A, 1982)

(Sivannandan, A, 1982) argues that in the initial period, Britain adopted a 'laissez faire' approach to immigration. The 'free market' determined the numbers that came and the colonial legacy of 'racism' determined the nature of the work. 'Racism' was rife. Immigrants were overcharged for living in some of the worst housing in the country. By the 1950's the contradictions thrown up by the shortage of housing became apparent. 'Race' increasingly became the lens through which housing shortage was seen and understood rather than government inaction. In 1958 there were 'race' riots in Nottingham and Notting Hill. Two different explanations and policy responses were offered.

The first drew attention to the high incidence of racism, the failure of governments to anticipate problems and develop coherent social and economic policies to meet the social needs of immigrant labour. From this perspective the way forward was a programme of government action designed to tackle racism, racial discrimination and the social and economic disadvantages of the poor - both 'Black' and 'White'. The second explanation was very different, it argued that Britain was basically a tolerant society and had welcomed immigrants to this country. It was immigration itself that was the problem.(Pilkington, A, 2003)

'Limitation' and 'Integration'
What followed was a strategy of immigration policy presented as a vehicle for promoting harmony. (Pilkington, A, 2003)

According to Roy Hattersley, the then Home Secretary:

> "I believe that unrestricted immigration can only produce
> additional problems, additional suffering and additional hardship
> unless some kind of limitation is imposed and
> continued."(Quoted in Skellington, R, 1996, p69)

It is important to note that Britain until the late 1980's continued to be
a net exporter of people, in other words more people were leaving
Britain than coming to Britain. A series of immigration acts were
introduced from 1962 onwards initially aimed at immigration from the
New Commonwealth and Pakistan. Immigration from these regions fell
from 136,000 in 1961 to 22,800 by 1988. (Skellington, R, 1996) In
1985 the Commission for Racial Equality undertook a review of the
legislation and concluded that it was directed at reducing 'Black'
migration into Britain rather than immigration per se, and was
therefore 'racist'.(CRE, 1985) Similarly, in 1989 the Runnymede Trust
concluded that by focussing on controlling entry to the United
Kingdom as a strategy to promote so called 'race relations'. The British
state had sanctioned institutionalised 'racism':

> "'Black' people are a problem and unwelcome here. That is the
> message, which is restated and reaffirmed every time
> immigration policy is made more restrictive. It is a message not
> lost on 'our people in Britain - on the employers who can ask,
> with reason, why they should have them in their firm if the
> government does not want them in the country, on the tenants
> who don't want them in 'their' streets or housing estates, or the
> parents and pupils who do not want them in 'their
> schools."(Runnymede Trust, 1989, p5)

(Hall, S, 1978) suggests a 'historical amnesia' underpinned this
approach that forgot, the long history of relations between the 'British'
and the people of the 'Caribbean' and the 'Indian Sub continent',
assumed they had met for the first time in 'post war' 'Britain' and
'discovered' they could not mix.

Immigration from the 'New Commonwealth and Pakistan' has more or less halted, though recent labour shortages have meant that Britain once again needs to draw on overseas labour to meet labour shortages in the health and education service. Therefore the current approach is to operate a selective and very restrictive immigration policy.(Sivannandan, A, 2000)

As mentioned above a dual approach to the issue 'of 'race' and 'immigration' was adopted related to 'limitation' and 'integration'. Therefore, the state began to legislate against 'discrimination' as part of a strategy of 'integration'. The first piece of legislation was introduced in 1965 and outlawed direct discrimination in public places, this was revised in 1968 to include housing, employment, education and credit and insurance facilities. In 1976 the legislation was amended to include 'indirect discrimination'. Section 71 of this act imposed a duty on local authorities to promote equality of opportunity and good race relations and to ensure that employment and service delivery arrangements paid due regard to the need to eliminate unlawful discrimination.(Bagihole, B, 1997)

Implementation of Anti-discriminatory legislation was initially vested in the Race Relations Board, and then in 1976 the Commission for Racial Equality was established to oversee the implementation of the 1976 Race Relations Act. This legislation was seen as relatively ineffective, because there were neither sufficient resources, nor sufficient sanctions to make a substantial difference. This was in sharp contrast to the implementation of 'immigration' controls.(Bagihole, B, 1997) The Race Relations Amendment Act 2000 was introduced most recently, aimed at strengthening existing legislation. This legislation places specific requirements on authorities and public bodies to make clear their plans in relation to promoting racial equality and

good relations between 'ethnic' groups in the community. However, in reality it has been in the local arena that struggles related to 'race equality' have taken place.

From 'Central Government' to 'Local Politics'
(Saggar, S, 1993) argues that one of the defining features of the British state's response to issues of 'race' and 'racism' has been to shift policy from 'central' to local government'. First by agreeing to remove it from election campaigns and then:

> "..the issue was devolved to the local level, or rather more
> precisely, allowed to remain there and continue to racialise the
> world of urban politics." (Saggar, S, 1993, p44)

The reasons for this are complex. Two important policy initiatives were to be implemented by the 'local state'. Section Eleven of the 1966 Local Government Act allocated monies to local authorities with 'substantial numbers of people from the 'New Commonwealth and Pakistan' 'settled in their areas. Monies were used for employ specific workers with a specific brief to work with 'Black and Minority Ethnic' communities, and in some authorities these monies were used to further 'race equality' objectives, such as the development of 'culturally specific' services. Secondly, local authorities were given a clear role in promoting 'race equality' under the 1976 'Race Relations Act'.

However, as we shall see the extent to which these issues were either addressed or ignored was the outcome of local politics, as it has been in the local arena that struggles about 'racism' and 'race equality' have been played out. By the end of the 1970's and the beginning of the 1980's, Local Campaigns emerged raising questions about the 'mono-cultural' and 'racist nature of service provision, across a range of policy areas, ranging from housing to education. Moreover, the uneven distribution of 'Black and Minority Ethnic' groups meant that in some areas they comprised a significant part of the electorate

and by the early 1980's this began to affect local politics.

<u>The Rise and Fall of 'Municipal Anti-Racism'</u>

At the beginning of the 1980's a number of radical left wing administrations were elected to run local authorities across Britain, such as Manchester, Brent, Islington, Lambeth, and the then Greater London Council. What was distinct about this political era was that 'equal opportunities' and the concept of redress for 'disadvantaged/oppressed groups' came to occupy centre stage within these authorities. A range of groups were singled out within 'equal opportunity' policy documents, such as 'Black People', 'Women', 'Gays and Lesbians; and 'People with disabilities', this has been referred to as the era of 'municipal anti-racism', as whilst 'race' was not the only dimension of inequality addressed, it was a central part of this new policy agenda.(Ouseley, H, 1990)

New 'equality' type structures were put in place in some local authorities, with the aim of transforming the social policy response to these issues. These structures typically involved the establishment, of 'race equality' machinery, such as a senior 'Race Equality' Officer, located in the Chief Executive's office, supported by a 'Race Equality' unit. In some instances specific 'Race' officers were attached to each department. Within those authorities that did pursue 'municipal anti-racism', there was a review of employment practices, service provision and in some instances the extension of 'grant aid' to 'Black and Minority Ethnic' groups to develop 'culturally specific' provision. Some authorities made use of Section eleven monies available under the 1966 Local Government Act to further 'race equality' objectives.

(Ouseley, H, 1990) accounts for this shift towards more 'radical' policies as the result of pressure from outside of the local authority in the form of 'Black' community groups and from 'within' in the form of increasing numbers of local 'Black' politicians. Others such as

(Young, K, 1990) have emphasised the importance of urban unrest as a lever for change. In reality, the number of authorities which did adopt radical 'anti-racist' machinery was limited to a small number of high profile authorities, with the majority of authorities continuing to do very little about tackling racism. Moreover, even within these authorities where change did occur, there was not necessarily the shift in policy anticipated. Positive change then was limited to a handful of authorities, and even within those authorities change has been piecemeal and lacking as will become clear in this study.(Butt, J, 1994a, Law, I, 1996; Bagihole, B, 1997; Commission for Racial Equality, 1989)

The 1980's, then was an era in which issues of 'race equality' was put firmly on the policy agenda and the policy agenda was driven from below. Ironically, it was perhaps because the policy agenda was shifted from central government to the local arena, that for most people that radical moment had limited impact. On the other hand, it was precisely because policy had shifted from the central to the local arena, that a Conservative government presided over one of the most radical moments in policy implementation related to 'race equality'.

What was also significant was that the theoretical framework for thinking about issues of 'race' and 'race equality' increasingly became contested. In some radical local authorities, the 'assimilationist'/'cultural deficit' models were displaced by 'multi-cultural' and 'anti-racist' policies, with the latter accentuating the role of institutional racism in perpetuating disadvantage. Therefore, in these more radical authorities there was a transformation in the way in which 'race'/'racism' came to be understood.

However, by the early 1990's (the moment of community care implementation) there had been a general shift away from 'anti-racism', in those authorities that had introduced more radical 'race equality' programmes. Two competing strategies emerged that replaced the more radical models. In some authorities there was an abandonment of 'anti-racism' and its replacement with an 'anti-anti-racist' policy agenda, and in others a stated commitment to 'anti-racism' remained, but it was significantly diluted and incorporated as part of a new 'generic' approach to 'equality' which established one unit to address all the various dimensions of 'inequality'. According to (Lewis, G, 2000, p96):

> "Changes in the organisation of financial relations between central and local government, departmental restructuring, and an atmosphere in which equalities specialisms were seen as increasingly unrealistic, led to a blurring of conceptual distinction and complexity. The overall result was the conceptual simplification and policy marginalisation of the diverse and complex world of inequalities."

More-over she suggests that 'new managerialism' and the shift to 'marketisation' meant that the 'market' or 'quasi-market' mechanisms would be the new force for equality, as the 'market' and more specifically the effective management of that market would be the mechanism for achieving greater responsiveness to a highly differentiated 'customer' group. (Lewis, G, 2000)

Similarly (Law, I, 1997) identifies a shift away from 'anti-racism' by the early 1990's and its replacement with what he describes as 'ethnic managerialism'. He argues that the introduction of 'new managerialism' affected both the discourse and policy/practice related to 'racism'/'anti-racism' in social policy. In particular, the role of 'Black and Minority Ethnic' groups as advocates and innovators, were reorganized from 'participative' to a 'contractual' relationships.

In this new model he suggests 'race equality' was to be achieved through strategic management and target setting type interventions with 'race equality' subsumed as one part of a 'quality' agenda, and its implementation optional and linked to the 'goodwill' of the relevant manager.

In reality, 'ethnic managerialism' perhaps, suggests a more coherent approach to policy implementation than was the case, and perhaps better describes the more recent approach of 'New Labour' to 'race equality'/'ethnic diversity'.

We can conclude that at the moment of 'community care' implementation, there was a significant 'deprioritisation' and 'depoliticisation' of issues of 'race equality', and in some instances the adoption of an 'anti-anti-racist' stance. We also see that the shift to 'managerialism' and 'marketisation' began to provide the framework for responding to 'race equality' which itself was reinvented in this new 'depoliticised' climate to become 'ethnic diversity'. However, the extent to which either 'race equality' or 'ethnic diversity' was prioritized remained optional.

So far then we have reviewed the general policy framework for responding to issues of 'race', 'racism' and 'race equality' in Britain. Let us move on to focus specifically on the Personal Social Services and explore how they have responded to this issue. In this next section we consider how issues of 'race'. 'race equality' and 'ethnic diversity' have been incorporated into the work of 'Personal Social Service' departments.

'Race Equality'/'Ethnic Diversity' and the 'Personal Social Services'
One of the traditional critiques of 'mainstream' social policy has been its relative neglect of issues of 'race/ethnicity'. Interestingly, this neglect is then compounded in some of the Social Policy text-books,

which take 'race' or 'ethnicity' and Social policy as their starting point. Neither, (Mason, D, 1995 Race and Ethnicity in Modern Britain, 1995) or (Pilkington A, 2003, Race and Ethnic disadvantage in Britain)address specifically the 'Personal Social Services'. This neglect was reflected in the Parekh report (Parekh, B, 2000, The future of Multi-Ethnic Britain), which addressed issues of health and Social Services in one chapter, reducing the complexity of issues raised by the provision of Personal Social Services to a few pages. (Law, I, 1996, Racism, Ethnicity and Social Policy) provides the most extensive coverage. This poses a problem for policy makers working in this area, in that knowledge related to the Personal Social Services is somewhat undeveloped and dependent on a small number of research studies.

Implementing 'Race Equality' in Social Service Departments
Let us begin then by drawing on empirical research studies to understand how Social Service departments have responded to 'race equality'. In 1978 the Association of directors of Social Services and the Commission for Racial Equality published a report, 'Multi-Racial' Britain: The Social Services Response' reviewing how Social Service Departments were responding to the 1976 Race Relations Act.

This report identified a clear role for 'Social Service Departments' to mitigate the effects of discrimination experienced by 'Black and Minority Ethnic' groups in housing, employment and education. This early report identified a long- standing concern about the over-representation of 'Black' children in care, and the under-representation of 'Black and Minority Ethnic' communities as recipients of 'caring' services. Moreover the report argued that in areas where there were large numbers/or a predicted increase of 'Black and Minority Ethnic' elders', services should be tailored/developed to meet their needs. Support for the 'Black and Minority Ethnic' voluntary sector was seen

as a positive way forward in achieving this goal, along with a review of all existing services to ensure that 'race equality' issues were addressed in service delivery.(Association of Directors of Social Services/Commission for Racial Equality, 1978)

This report did place 'race equality' on the agenda of Social Service Departments and requested that all departments review their work in relation to the needs of 'Black and Minority Ethnic' groups. They were asked to examine the relevance of current priorities and practices; develop mechanisms for involving 'Black and Minority Ethnic' communities in services and planning, and to generally carry out an audit on the need of 'Black and Minority Ethnic' communities. Moreover in relation to assessment and service provision there was a recognition of the need to shift from a 'mono-cultural' to a 'multi-cultural' approach to assessment and service provision.

The Policy Studies Institute carried out research at three different points in the 1980's to review progress in implementing the recommendations of the report and 'race equality' more generally. The first study in 1981 found that progress on undertaking policy reviews had been slow, and where progress had been made it was in areas where 'Black' councillors had been active. One of the key points made in this review was that there was a massive under-representation of 'Black and Minority Ethnic' communities in the decision making progress, either as workers or councillors, which tended to give rise to a marginalization of 'race' issues. Moreover there was reluctance within many departments to accept that there was a 'race' issue to be discussed. According to Young and Connelly who undertook the review, the concept of treating everyone the same, as being the best vehicle for achieving equality was deep rooted within the psyche of those working within Social Service

departments.(Young, K, Connelly, N, 1981)

In 1985, (Connelly, N, 1985) revisited the issue and found
considerable progress had been made in many social service
departments, with 'race' issues gaining prominence. She identified an
increasing number of issues being considered. These included; 'racism'
amongst employees and users of social service departments; direct
and indirect discrimination in current policies and procedures; equal
opportunity in employment; positive action in relation to training and
opportunities for 'Black' staff; and methods for involving 'Black and
Minority Ethnic' communities. However, one major weakness identified
was that the organisational structures/mechanisms set up to address
'race equality' i.e. 'race units' and the appointment of specific workers
in each department with a responsibility for 'race equality' was
ineffective as such staff found themselves marginalized from
'mainstream' policy making and therefore, it was difficult to affect the
work of the department.

It was in 1989 at the height of 'municipal anti-racism' that (Connelly,
N, 1989) identified the most significant shift in policy:

> "To someone observing 'race issues' from the outside it certainly
> appears that something has changed over recent years. ...Yet
> this may hardly have gone beyond an acceptance that there are
> issues to be addressed and a willingness to discuss them. Any
> such change may be virtually invisible to concerned 'Black' and
> 'White' staff, and to those in local 'Black' communities hoping for
> a reduction of barriers and increased access to opportunities for
> themselves or others."(Connelly, N, 1989, p6)

Connelly suggests that one of the fundamental shifts had been the
recognition that a 'colour blind' approach to service delivery was not
'race' neutral'. She accounts for this change, as an outcome of the
'trans-racial' adoption and fostering' debate.(see below) However, she

also observed continued resistance to change from within departments. This resistance ranged from resentment to the emphasis placed on 'race' training' and a perceived 'overemphasis' on 'Black and Minority Ethnic' groups, over other disadvantaged groups such as 'Women', and more general concerns about 'reverse discrimination', therefore essentially Connelly documents the rise of 'Municipal Anti-racism' whilst identifying the beginnings of an 'anti-anti-racist' backlash, which was to become more significant from then on. However, where positive change had taken place, it was accounted for in terms of pressure from below, either from 'Black and Minority Ethnic' councillors, or from 'Black led' pressure/community groups, in other words, policy change could not be accounted for as a result of the voluntary-ism of existing employees, or social service departments. Similarly, (Butt, J, 1994) argues that where change has taken place it has simply been a reaction to pressure from below, and therefore policy developments tend to be ad-hoc.

The 1980's, then, were an era of both change and no change, There was a concerted struggle by 'Black and Minority Ethnic' communities to achieve equality of access to a range of welfare services and employment within those services. 'Race' had been given more prominence within the Personal Social Services, yet there was also resistance to change, with change limited to a small number of authorities. (Pearson, S, 1989) for example, analysed data from SSI visits at the height of 'municipal anti-racism' and concluded that most Social Service Departments they had visited had no policy for responding to the needs of a 'multi-cultural' population.

Moreover, there is little evidence that the application of 'New Managerialism' was any more effective in stimulating change. For example, in 1995 the Commission for Race Equality began to

promote 'REMQ' – 'Race Equality means Quality', a toolkit for integrating 'Race equality' into all dimensions of local authority work. (Speeden, S, Clark, J, 2000) analysed the implementation of the 'REMQ' and argued that many authorities did not demonstrate a commitment to 'race equality' and even those that did, lacked the organisational and managerial capacity to implement such strategies.

As we have already discussed above, by the late 1970's and early 1980's 'Black and Minority Ethnic' groups began to raise a number of concerns about the 'racist' and 'mono-cultural' nature of welfare services in Britain. A wide ranging critique of housing, health, education and the 'personal social services' emerged. Within each area of policy different concerns were raised, and we will now consider in more detail the particular issues raised in relation to 'Social Service Departments'.

It is possible to identify two important strands of thought that have been important in shaping a policy response to 'race and ethnicity' within the Personal Social Services, and influencing strategies pursued by those authorities who did pursue an agenda of 'municipal anti-racism'. The first relates to the 'trans-racial adoption' debate, and the second relates to the 'care/control' paradigm, Indeed both strands of thinking were evident in the first ADSS/CRE publication on the topic, discussed above.(ADSS/CRE, 1978)

The Emergence of 'Same Race'/'Culturally Specific' provision
The emergence of debates related to 'same race'/'culturally specific' services initially entered the policy agenda as a result of debates related to 'trans-racial' adoption and fostering. The 'trans-racial' adoption and fostering debate had its roots in the United States of America. In the early 1970's, the National Association of Black Social

workers in the U.S. and other organised pressure groups began to campaign against 'trans-racial' adoption and fostering placements. This debate then became influential in Britain. Organisations such as 'Black Kids in Care', formed in 1975 and the 'Association of Black Social Workers and Professionals'(ABSWAP) formed a little later began to campaign about the unsuitability of placing 'Black' children with 'White' adoptive and foster parents.

The campaigns focused on two things. The first, related to the importance for 'Black' children to grow up in 'Black' families. From this perspective it was only 'Black' families that could equip 'Black' or 'mixed race' children to cope with the 'racism' they would encounter in a 'racist' society. Therefore 'same race' placements would facilitate a positive self-esteem. Secondly, it was argued that there was a need to revisit adoption/fostering criteria, which favoured 'White' middle class adopters. Essentially, this was part of a wider political debate about racism and the need for redress:

> "Transracial placements as an aspect of current childcare policy is in essence a microcosm of the oppression of 'Black' people in Society. It is in essence a form of internal colonization..a new form of slave trade(although) this time only 'Black' children are used."(Association of Black Social Workers and Practitioners, 1983, p12)

The shift to 'same race' placements particularly in adoption and fostering was a policy minefield, challenged on a number of fronts. (Kirton, D, 1997) argues that it is now generally accepted that 'same race' adoption or placement is preferable, but it is the degree to which this policy is applied which is at issue. For some, it is preferable for 'Black' children to remain in care, for others this is 'anti-racism' at its worse and 'any home' is better than 'no home'.

A range of perspectives contributed to the debate related to 'same

race' adoption. For example, (Gilroy, P, 1993) questioned the 'essentialised' view of ethnicity embodied in the policy, arguing that 'racial' boundaries are not fixed but continually changing, and therefore, a position which views 'Black' identity in a static way is flawed. This perspective was reinforced by writers such as (Tizard, B, Phoenix, A, 1993) who explored the 'racial identities' of 'mixed race' children, questioning the extent to which such children characterise themselves as 'Black' and therefore, should be categorized as 'Black' by policy makers. Similarly an edited collection was complied arguing that whilst 'same race' adoption was preferable, if it is not available 'trans-racial' adoption should be considered.(Aldridge, G, ed, 1993) In reality the evidence is inconclusive on this matter, but what the debate exemplifies well, is that the shift to 'same Race' policies was 'politically driven', rather than empirically informed.(Thoburn, J, Norford, L, Rashid, S, P, 2000) Moreover, as in other areas of policy there has been a weakening of this policy. For example, The Children Act published in 1989 at the height of 'municipal anti--racism' confirmed the need to pay due regard to a children's, race, religion or culture in placement decisions. However, the more recent 'Adoption' legislation introduced by the government was criticized for its failure to acknowledge issues of 'ethnic' identity in placement decisions.(Community Care, 2000)

Nevertheless, the 'municipal anti-racism' agenda was shaped by the 'same race' adoption and fostering debate which was seen as crucial to the 'race equality' agenda. Moreover, this policy was reflected in other areas, so that it was assumed that if same race' placements were appropriate in 'adoption and fostering' they would also be preferable in other areas, such as 'home care' and 'social work'.

The shift to 'same race' service provision was more complex, than

simply expressing a preference for a 'same race' carer or social worker. It was based on the view that there are some needs that can only be met by people from the same 'race', this may be in relation to understanding 'racism'; 'hair care' or religious requirements in relation to bathing.(Atkin, K, 1993) The problem was that there was simply a shift in policy based on a 'culturally essentialist' approach, again with a limited amount of empirical data that could confirm or reject 'same race' provision as a preference.

(Owen, M, Farmer, E, 1996) carried out some interesting research related to the racial matching of social workers. Their research revealed the complexity of 'racial matching' social workers with clients in a social work setting. Whilst some respondents clearly felt this was important and helpful to the assessment process, others felt that it was inappropriate, and based on incorrect assumptions. Objections related to the assumed commonality of experience, based on 'ethnicity', which downplayed differences of either 'gender' or 'class', or to 'same race' policies generally.

They conclude that:

> "Our study suggests there is much value in 'experiential affinity' the link of shared experience between worker and client, which ensures the latter's experience of hardship or oppression will be adequately understood. Our results underlie the importance of racial or cultural matching, wherever possible in the allocation of workers, but they also emphasise the importance of other issues such as gender, and class, which must be seen and understood in the racial and cultural context."(Owen, M, Farmer, E, 1996, p310)

Moreover, they argue that 'a sensitive female social worker could succeed in supporting and empowering an 'Asian' mother, even if her 'racial' and 'cultural' background were different.

(Wilson, G, 2002) highlights the way in which a 'Black'/'White' binary

divide, emerged based on the assumption that there was a distinctive 'Black' culture, different from 'White' culture. Moreover, it was only members of the 'Black' community who could understand the 'Black' experience. Therefore, for Wilson, 'race' becomes 'culture' and the task became appropriate interpretation and understanding of different 'cultures', thus the onus for change remained with 'Black and Minority Ethnic' groups themselves.

Therefore, we see a shift to 'same race' provision, which whilst contested in the field of 'adoption and fostering' appeared to have much less debate in other areas of provision. However, the extent to which 'same race' service development was initiated in other areas of provision, was minimal. (Butt, J, 1994) We return to this issue in Chapter seven.

'Care' and 'Control'

The other strand of thinking which has had a huge impact on policy development relates to the notion of 'care' and 'control'. It was argued that the 'Personal Social Services', provides 'care', such as services to older people, day care, meals on wheels, and 'control', through its exercise of power to compulsorily institutionalize people or remove children from their families. It was argued that 'Black and Minority Ethnic' groups were more likely to experience the 'controlling dimension' of the Personal Social Services, and less likely to access 'care', such as 'day care', and 'meals on wheels' for 'older' people. (Dominelli, L, 1989; Ahmad, B, 1990)

(Law, I, 1996) whilst not wishing to deny the existence of racism, takes issue with the 'care/control' paradigm which he suggests is not borne out by evidence. First, not all 'Black and Minority Ethnic' groups were over-represented in care. More specifically it was children of 'African-Caribbean' origin who were over-represented, whilst children of 'Asian' origin were under-represented. Secondly, data used to

confirm over-representation was based on the numbers in the population generally, and not numbers in that specific age group.Thirdly, when looking at routes into care for different 'ethnic groups', he cites the work of (Barn, R, 1990) which found that 'White' children were more likely to enter care on a compulsory basis, whereas 'Black' children were more likely to enter care on a voluntary basis as a result of relationship breakdown/Socio-economic conditions. Barn therefore, refutes the 'care/control' paradigm. She did, however, acknowledge that racism did operate within the assessment process and policy response to 'Black and Minority Ethnic' families. (Barn, R, 1990)

Service Provision for Older People from 'Black and Minority Ethnic' groups

A plethora of studies began to explore take up of services amongst older people from 'Black and Minority Ethnic' groups. These studies did confirm an 'under-use' of services, and a number of explanations were offered to account for this. These included a lack of knowledge about services; stereotypes about 'Black and Minority Ethnic' groups looking after their own'; negative perceptions of using services; and the inappropriateness of mainstream provision for 'Black and Minority Ethnic' groups.

Let us begin with lack of knowledge. (Atkin, k, Rollings, J, 1993) undertook a literature review related to 'community care' in 'multi-racial' communities and suggested that that there was a lack of knowledge about social work services; OT Services; home Help services; Meals on wheels; Luncheon Clubs; Day care and Institutional and Family respite care. However, they suggest that the lack of knowledge about service provision was much more profound for the 'Asian' community, than those from the 'Caribbean'.

Nevertheless (Bhalla, A, Blakemore, K, 1981; Mc Calman, L, 1990)

found that whilst older people from the 'Caribbean' had a greater knowledge of service provision than older 'Asian' people, in both instances knowledge was lower than amongst older 'White' people. The lack of knowledge about service provision was accompanied by a lower use of services. (Atkins, k, Rollings, J, 1993) summarised the findings of a range of studies that have consistently shown a lower take up of 'meals on wheels'; day centres'; and luncheon clubs for both 'African-Caribbean' and 'Asian' communities. However, they also observe that studies have tended to neglect more qualitative aspects, such as the actual quality of service delivery. Both (Gunaratnam, Y,1993) and the (Department of Health/Social Services Inspectorate, 1997) suggest that 'common sense' assumptions about 'Black and Minority Ethnic' groups looking after their own, can lead to a failure to allocate services to 'Black and Minority Ethnic' groups.

(Boneham, M, A, Williams, K, E, Copeland, J, R, McKibbin, K, B, Wilson, K, Scott, A, Saunders, P, A, 1997) explored barriers to service use for older people from 'Black and Minority Ethnic' groups in Liverpool and drew on a framework utilised by a previous study carried out in the US, which explored low take up in terms of knowledge barriers, lack of access such as transport/affordability and lack of intent(acceptability barriers). Their study confirmed that there was a low take up of services and explained this in terms of lack of knowledge and lack of intent with a perception of unsuitability of existing services affecting decisions about whether to utilise a service. (Gunaratnam, Y, 1993) argues that take up of services may be affected by wider racist ideologies, which may make potential users uneasy at the risk of being labeled a 'welfare scrounger'.

'Triple Jeopardy'
Two concepts have played an important part in exploring the particular position/experience of older people from 'Black and Minority Ethnic'

groups. 'Double Jeopardy' is drawn from the US literature and highlights the problems associated both with old age and the cumulative effects of racism. According to Dowd and Bengston:

> "Like other older people in industrial societies, they experience the devaluation of old age found in most modern societies...Unlike other older people, however, the minority aged must bear the additional economic, social and psychological burden of living in a society in which racial equality remains a myth."(Dowd, J, J, Benston, V, L, 1978, p427)

(Norman, A, 1985) who has looked at issues facing older people in Britain suggested that the concept 'triple jeopardy' is helpful in understanding the experience of older people from 'Black and Minority Ethnic' groups. She argues that 'Black' older people suffer both the combined effects of racism and old age and the added disadvantage of unsuitable social/welfare services. (Forbat, L, 2004) has more recently used the term 'abuse' to refer to 'institutional abuse' or neglect related to the racism and discrimination in service provision faced by older people from 'Black and Minority Ethnic' groups.

(Atkin, K, 1998) suggests that it is interesting to explore ways in which racism is resisted, Older people are not simply victims, but develop coping strategies to challenge discrimination, and these coping strategies may generate new and more relevant policy interventions, and as we shall see in this study it is resistance to 'racism' that has been crucial in developing more relevant services for older people, particularly for older 'African-Caribbean' people.

Policy Responses to Under-Use of Services
For those authorities committed, or under pressure to change, strategies pursued were based on improving information and the palatability of services. Therefore the recommendations tended to focus on the need to ensure that all 'mainstream' services were accessible, and to support the development of 'culturally specific'

services by using 'grant aid' to stimulate the emerging 'Black and Minority Ethnic' voluntary sector.

(Blakemore, K, Boneham, M, 1994) identify a range of obstacles that made it difficult to change 'mainstream' provision. These include a reliance on one off commitments to fund specific initiatives; staff not trained/equipped for working with diversity and hostility to an agenda of 'culturally specific' as opposed to 'colour blind' services. (Tuvey, M, Bright, L, 1996) reviewed residential care for 'Black and Minority Ethnic' older people and identified both 'under use', and a failure on the part of homes to positively promote themselves as able to meet the needs of 'Black and Minority Ethnic' groups.

It was not only 'mainstream' statutory services, that were required to change, but also the 'mainstream' voluntary sector. Studies began to suggest that whilst there were some examples of good practice within mainstream' voluntary organizations, for the majority progress on these issues was slow.(Field, S, Jackson, H, 1989, Connelly, N, 1990) Moreover, (Williams, A, 1990) suggests that the existence of a 'Black' voluntary sector has enabled 'mainstream' agencies to absolve responsibility for these issues.

Essentially, then the failure of either the 'mainstream' statutory or voluntary sector to respond to these issues has led to a reliance on the development of a 'Black and Minority Ethnic' voluntary sector. (Atkin, K, Rollings, J, 1993) identify an increasing number of 'Black and Minority Ethnic' voluntary groups involved in the provision of day care. However, Bowling's description of the West Indian Parent's Association Day centre for the elderly raises issues about equity:

> "Four days a week in one cramped and dingy room of a church
> hall twenty two or Afro-Caribbean 60 - 81 year olds come to play
> dominoes or do Craftwork..despite the obvious needs of these
> elderly Afro-Caribbean people and the quality and low cost of the

service run there was still prevarication and doubt over continued funding."(Bowling, B, 1991, p649)

The reliance on the 'Black and Minority Ethnic' voluntary sector as a solution raises a number of problems. First then there are the problems of having to rely on grant aid, and the uncertainty this brings with it. Secondly there is the issue of equity, with services often provided in less than ideal conditions. Thirdly, the focus on developing 'culturally specific' provision has enabled the statutory sector to resist change. (Sashidarian, S, 2003) There are also two further related problems, first as (Field, S, Jackson, H, 1999) note it is simply not possible to reproduce a range of highly specialized services, for each 'ethnic' group, and linked to this, it is unlikely that all groups under-represented as 'users' of services will form organizations and apply for 'grant aid' funding.

Moreover, some writers have critiqued this strategy more generally, arguing that such a strategy focuses on 'culture', rather than 'racism' and the 'right to be different' rather than the right to be 'equal'. They have also emphasized the potentially divisive nature of this strategy with 'Black and Minority Ethnic' groups competing with each other for limited funding.(Malik, K, 1996, Penketh, L, 2000, Johnson, A, 2000)

Nevertheless, a framework for responding to 'race equality' in service provision had emerged. This framework had three main elements. This included 'racial matching' in service delivery and sometimes staffing; the funding of specific services; and a review of mainstream provision to ensure it was 'multi-cultural' in approach. In reality it was the first two dimensions that informed policy-making, and as should be clear by now, change was limited to a small number of authorities.

A 'Race Equality' Agenda for Social Work

In addition to changing social service provision, there was also concern about 'social work' practice. It was argued that social work practice was underpinned by 'racist' assumptions that permeated the assessment process and was responsible for the 'care'/'control' response to 'Black and Minority Ethnic' groups. The 'cultural deficit' model, which had explained the cause of many problems encountered by 'Black and Minority Ethnic' communities as a result of problems within the families or the communities themselves, and the 'Colour blind'/'assimilationist' model which chose to treat everybody the same irrespective of difference/racism, began to give way to two models, a 'multi-cultural' model and an 'anti-racist' model.(Ahmad, B, 1990, Dominelli, L, 1989; Ely, P, Denney, D, 1987)

Within policy analysis these models are often treated as if they are diametrically opposed. For example, (Lavallete, M, Pratt, A, 1997) argues that a 'multi-cultural' approach is based on the notion that ignorance is at the heart of 'discrimination' and therefore a strategy that educates and celebrates all 'cultures' will reduce 'discrimination'. There are a range of criticisms made of this model in particular it divorces 'culture' from its wider context – a racist society; it assumes 'racism' is an outcome of 'ignorance' It may also perpetuate negative stereotypes about different cultural groups. An 'anti-racist' approach on the other hand, focuses on structural deprivation and 'racism'; as the outcome of practices within institutions, and within society more generally and therefore implies the need to tackle 'racism'. However, clearly there would be a crossover between the two, when trying to operationalise 'race equality' in an area like social care.

At the end of the 1980's it was 'anti-racism' that began to permeate the framework for education and training in social work, culminating in Paper 30. In 1989, the Central Council for Education and Training in

Social Work made a clear commitment to developing an 'anti-racist' agenda for social work, through the publication of Paper 30. This laid out clear requirements in relation to social work trainees, programme providers and training agencies: Programme providers were to have:

> "Clear and explicit anti-discrimination and anti-racist policies, and explicit practices and procedures which provide evidence that these policies will be implemented and monitored in all aspects of the programme."(CCETSW, 1989a, p22

However, the implementation/translation of CCETSW's Paper 30 proved to be problematic. (Penketh, L, 2000) reviewed the implementation of CCETSW's Paper 30 and found that despite the good intentions underpinning the initiative, it was a top down initiative which was not implemented, largely because of institutional racism. She identified three institutional barriers, which were the lack of 'Black' staff; under-representation of 'Black' clients and ineffectiveness of anti-discriminatory policies.

According to (Penketh, L, 2000, p36) , referring specifically to 'practice teachers' who were an important dimension of change:

> "The majority of practice teachers, although not hostile to 'anti-racism', nevertheless felt defensive, insecure and anxious about discussing issues associated with 'race' or dealing with 'racism'. It would be wrong to conclude that these practice teachers were racist. Instead, they had been put in a position where they were expected to facilitate anti-racist learning experiences even though they lacked knowledge, awareness, education and training."

As in other areas of policy related to 'race' by the early 1990's, commitment to paper 30 was beginning to wane. Writers such as (Pinker, R, 1989) argued that the approach was dogmatic and suggested that it was not about rational argument but enforcing 'political correctness' in a way that effectively censored, rather than

encouraged dialogue. Tony Hall the then Director of CCETSW responded to such criticisms by making clear that it was not about political correctness but preparation for social work students to work in a multiracial/multicultural society. However, by 1993, a new Chair of CCETSW was appointed who reviewed Paper 30 and reduced its commitment to tackling racism.(Penketh, L, 2000) Therefore, again at the moment of 'Community Care' implementation there was a weakened commitment to issues of 'Race equality' within social work training.

Moreover, the 'new managerial' strategies also began to influence social work, resulting in a more 'depoliticized' social work profession. This is evident in what (Patel, V, 2003) describes as the new big idea in social care as 'cultural competence'. (O Hagan, N, 2001) who has published a recent text dedicated to 'cultural competence in the caring professions' arguing that 'anti-racist' policies, led to a downplaying of culture and difference in the operationalisation of policy, which needs to be given more prominence/significance in the assessment process. However, this raises two problems. In the first instance it raises the issue of how we respond to culture? Do we respond in a conservative and unchanging way operationalising a cultural' checklist, which locates people, their problems, and the solutions to their problems; within a 'cultural' framework?, and secondly, what emphasis is given to issues of 'institutional racism'?

So far then it is clear that there is a parallel story to tell of both considerable discussion on issues of 'race', 'race equality' and 'ethnic diversity', and at the same time limited action. It is also clear that where policies have been implemented they have to a large degree focused on the development of 'culturally specific' provision, either within or outside of mainstream provision. Therefore, the 'mono-

culturalism' of the Beveridgean welfare settlement remained more or less in tact, with changes taking place at the margins. The introduction of the 'NHS and Community Care Act' with its emphasis on 'needs led' services, 'choice' and a greater role for the 'independent sector' offered the potential to respond more effectively to 'ethnic diversity', and it is to this that we now turn.

'Race Equality/'Ethnic Diversity' and 'Community Care'
There is a dearth of literature on 'Black and Minority Ethnic' groups and 'community care'. The White Paper 'Caring For People' did acknowledge that people from 'Black and Minority Ethnic' groups have particular needs:

> "The government recognizes that people from different cultural backgrounds may have particular needs and problems. Minority communities may have different concepts of community care and it is important that serve providers are sensitive to their variations. Good community care will take account of the circumstances of Minority communities and will be planned in consultation with them.(Department of Health, 1989, para 2.9)

The Race Equality Unit at the National Institute for Social Work in their submission on the White Paper 'Caring for People, summed up the problem:

> "Black and Minority Ethnic communities are in urgent need of community care services. A serious imbalance exists at present – existing statutory services in large measure fail to take into account the needs of people in Black and Minority Ethnic Communities. ..Many community care needs of Black and Minority Ethnic people are met at present by voluntary and community organizations..such ..organisations are seriously under-resourced...The White paper on Community care in laying down a framework for the future, should make a point of ensuring that the needs of Black and Minority Ethnic' users, carers and communities are fully taken into account by those responsible for community care"(Ahmad, B, 1990, p95)

The nature of the reforms was such that the reforms did offer the

potential to better meet the needs of 'Black and Minority Ethnic' communities, with the explicit recognition of shifting to a 'needs led' service, However, there were no explicit incentives built into the legislation which would have pushed the authority in this direction. According to (Ahmad, W. I. U, Atkin, K, 1996, p5):

> "Policy remains underdeveloped, comprising little more than bland statements in support of racial equality, whilst the mechanisms that might achieve racial equality, and the principles that underlie them, remain unexplored."

As should be clear by now government policy has tended to be reactive, and in this instance complaints made about the relative neglect of 'race equality', led to the establishment of a London Wide group on 'Incorporating Race Equality principles into Community Care' organized by the London Region of the Social Services Inspectorate. This group produced a short document which was then referred to in circular(CI 92 35) 'Community Care and the needs of 'Black and Minority Ethnic' communities, as a helpful document in relation to 'policy implementation'.

There have been a small number of studies which have reviewed 'community care' implementation in relation to 'Black and Minority Ethnic' groups. The Northern health, Social Services and Social Security forum undertook a study in 1993, that found that most authorities did have an understanding of the demographic make up of their area in relation to 'Black and Minority Ethnic' groups and most had undertaken specific events in relation to consultation with 'Black and Minority Ethnic' communities. On the other hand, most authorities did not know what services they were providing for 'Black and Minority Ethnic' communities. 52% stated that they did not have a method for identifying shortfalls in provision, and only 16% had a strategy to ensure 'Black and Minority Ethnic' groups participated in the contracting process. (The Northern health, Social Services and

Social Security Forum, 1993)

(Begum, N, 1995) undertook a review of 'care management and assessment' in three local authorities. She found that greater attention was paid to the needs of older people from 'Black and Minority Ethnic' groups and mental health service users, but very little on other groups, such as those with physical disabilities or learning difficulties. She identified a lack of understanding about different 'religious'/'cultural' requirements in the assessment process, and demand for the introduction of checklists for different 'Black and Minority Ethnic' groups, though she suggested this may give rise to a static view of culture, which may simply reinforce stereotypes about different 'Black and Minority Ethnic' groups.

She did identify good practice, for some 'Black and Minority Ethnic' groups, but this was uneven, reflecting the numbers of that particular group in an area, and within an area. For example, if one particular 'ethnic' group was well represented in an authority they were more likely to have their needs met. However, even in an authority where such services were available, they may only be available in parts of the Authority where that group was well represented. She identified an ongoing tension between whether to provide 'mainstream' or 'culturally specific' services.

(Walker, R, Ahmad, W, 1994) undertook a study of 'care' providers' perspectives on 'community care' with specific reference to 'Black and Minority Ethnic' groups in Bradford. This study found a mixture of optimism and concern. For example, it was felt that the shift to 'needs led' provision and a greater focus on strategically planning services, could bring real improvements in care. On the other hand, it was argued that it was likely that 'Community Care'

implementation would be shaped by its policy context, which was the demise of 'collective' forms of welfare.

Specific concerns were raised about the lack of consultation with 'Black and Minority Ethnic' groups, both as providers and potential users of services and the viability of the 'Black and Minority Ethnic' sector in the 'contract culture. There was a perception that the 'contract culture' did offer the potential for more secure funding. However, it was also expressed that the 'Black and Minority Ethnic' voluntary sector would need to be strengthened to enable them to compete effectively in the emerging 'mixed economy of care'. This study, whilst generating some interesting findings told us little about actual implementation.

In 1996 a book entitled 'Race and Community Care' was published. This book provides a wealth of information on a number of community care related issues, and does highlight specific concerns and issues related to community care services, and 'Black and Minority Ethnic' groups in Britain, but does not help us to understand the impact of the 'NHS and Community Care Act 1990' on 'Black and Minority Ethnic' groups.

(Atkin, K, 1996) does, however, raise a number of questions in relation to the possible impact the shift to a 'mixed economy of care' may have on 'Black and Minority Ethnic groups'. He raises concerns about the increased role in service provision anticipated for mainstream' voluntary sector organizations, given their poor record on responding to 'ethnic diversity; and the difficulties 'Black and Minority Ethnic' voluntary sector providers might encounter in an increasingly professionalized 'contract culture. He questions whether purchasing decisions will be neutral or simply reflect political

preferences, and therefore reinforce the status quo of disadvantage for 'Black and Minority Ethnic' groups.

(Jeyasingham, M, 1992) also raises concern about the possible impact the 'contract' culture might have on the 'Black and Minority Ethnic' voluntary sector. She predicts that they may become dependent on 'mainstream' voluntary organizations to compete and in the process lose their autonomy. In 1997 the Commission for Racial Equality published a report 'Race, Culture and community Care: An agenda for Action' and concluded that:

> "Despite pockets of good practice, there is much evidence that many people from ethnic minority communities – especially those from 'African-Caribbean' and 'Asian' backgrounds – lack access to community care services, receive inappropriate assessments and are faced with services that do not adequately reflect their way of life and aspirations."(CRE, 1997, p5)

The CRE then went on to publish in conjunction with the NHS a toolkit encouraging local authorities to develop commissioning strategies that respond to 'ethnic diversity including commissioning 'culturally specific' services and funding 'Black and Minority Ethnic' providers.(CRE/NHS, 1997)

In 1998 the Department of Health/Social Services Inspectorate carried out an inspection of community care services for 'Black and Minority Ethnic' older people in eight authorities with large 'Black and Minority Ethnic' communities. They identified what they described as a:

> "a genuine attempt to ensure that the services to ethnic minority older people were relevant and accessible."(Department of Health/Social Services Inspectorate, 1998, p6)

Nevertheless despite some examples of good practice, they

identified an 'ethnocentric' approach to service provision, which resulted in limited choice for 'Black and Minority Ethnic older people, making it difficult for assessors to meet their needs. They concluded that services were undeveloped and sometimes inappropriate assumptions were made in relation to 'Black and Minority Ethnic' groups 'looking after their own'. One of the recommendations of this report was that there was a need to develop 'culturally specific' services, rather than being over concerned with criticisms related to 'special treatment'. The SSI/Audit Commission joint reviews of Social Services have also begun to uncover a catalogue of poor practice within Local Authorities in relation to 'community care' services for older 'Black and Minority Ethnic' groups.(Audit Commission/Social Service Inspectorate, 1997; Audit Commission/Social Service Inspectorate, 2001; Audit Commission, 2004)

Therefore when this study commenced in 1995, 'community care' implementation and 'ethnic diversity', was a relatively neglected dimension of research. Moreover, the small number of studies that have been published since indicate that the negative experience of social care experienced by 'Black and minority Ethnic' groups has continued with the introduction of the 'NHS and Community Care Act 1990'.

Conclusion

This chapter has provided a context for understanding why 'ethnic diversity' is an interesting exemplar through which to explore whether the introduction of a 'quasi-market' in social care is more able to respond to differentiated 'need' than bureaucratically planned services.

In this chapter it has become clear that 'Black and Minority Ethnic' groups, generally, and 'African-Caribbean' people in particular continue to experience 'discrimination' and 'disadvantage', as an enduring feature of life in Britain. However, the response of 'social service

departments' to this disadvantage has been to reinforce, rather than offset this disadvantage.

We have reviewed the response of the British government to issues of 'race' and 'racism'. The government has pursued a two pronged approach of 'limitation' supported by strong immigration controls, and 'integration' backed up by a much weaker programme of 'race relations' legislation. However, we have seen that the defining feature of its approach has been to push such issues into the local arena. Once in the local arena, issues of 'race' and 'ethnic diversity' have been either prioritised or ignored depending on the 'politics' of that local area.

We have explored debates related to 'race'/'race equality', and 'ethnic diversity', within the 'Personal Social Services', and a number of issues have emerged. In the first instance, it was clear that local authorities have been slow to address these issues and where they had been addressed it has been the result of pressure from 'Black and Minority Ethnic' groups themselves. It was clear the 'municipal anti-racism' was instrumental in ensuring that these issues were prioritised. The most significant debates to shape the policy response to issues of 'race', 'racism' and 'ethnic diversity' within social service departments related to the emergence of 'same race'/'culturally specific' provision in the light of the 'trans-racial/adoption and fostering' debate and the 'care/control' critique of 'social services provision', raising concerns about issues both of 'assessment' and 'service provision'.

During the 1980's a number of more radical policies were introduced, these policies were not empirically informed, but politically driven. Whilst the stated policy was to ensure all workers support 'race equality objectives' either as 'assessors' or 'providers'. The reality was

that the onus for change lay with 'Black and Minority Ethnic' groups themselves either as 'race equality' officers; 'social workers' or 'voluntary sector providers'. Moreover, change was limited. Therefore the 'mono-culturalism' of the 'Beveridgean' settlement remained more or less in tact.

However, by the early 1990's, when the 'NHS and Community Care Act 1990' was being introduced the emergence of 'anti-anti-racism' had become more significant than 'anti-racism'. Moreover, 'new. managerialism' began to permeate policy on 'race equality' leading to an increasingly 'diluted' and 'depoliticised' policy agenda.

We have considered specifically the position of older people from 'Black and Minority Ethnic' groups and concluded that these groups have been particularly disadvantaged in society generally, and poorly served by 'Social Service departments. Moreover, we have seen that demographic change is resulting in an increasingly older 'Black and Minority Ethnic' population, and, therefore, the need to address this issue has become urgent.

The introduction of the 'community care' legislation with its focus on the development of 'needs led' services offered the potential to remedy this. There have been a small number of studies undertaken that have explored policy change in some local authorities following the introduction of the 'NHS and Community Care Act 1990' in relation to issues of 'race equality'/'ethnic diversity. These studies have been general, covering a range of topics related to 'implementation, and have in the main focused on a range of client groups. This study will focus on one group older 'African-Caribbean' people as a vehicle for exploring more specifically whether the introduction of a 'quasi-market' in social care was more able to respond to 'differentiated need', than

bureaucratically planned services.

Chapter Three

The Research Methodology

The Research Question

In the previous two chapters, we have reviewed the context to this study. In this chapter the research methodology adopted to undertake this study and the methodological problems and issues that have arisen during the course of this study are reviewed. As noted in Chapter One, the original motivation for this study was to explore how far the introduction of a 'quasi market' into the provision of personal social services in England had indeed enabled them to respond more sensitively to the different needs of those they served compared to the past. A conclusive answer to such a question on a national scale was clearly beyond the scope of a PhD with the resources at my disposal. However, I hoped to throw light on this issue by examining in depth the way in which two London local authorities had responded, and to concentrate, in particular, on the possibly distinctive needs of older 'African-Caribbean' people. This would serve as an illustration of the opportunities and difficulties which this new style of public management presented.

To explore this question, three discrete, but connected methods of inquiry were pursued. The first focusing on the operationalisation of the 'quasi-market' in the two case study authorities; the second focusing specifically on the 'mixed economy' through a case study of meals provision; and the third exploring service preferences with a group of older 'African-Caribbean' people.

This study focuses on one particular ethnic' group, - older 'African-Caribbean' people, for the following reasons:-

1. The disadvantage and discrimination encountered by this group is

well documented, and, therefore, one would expect this group of older people to be particularly dependent on support from the 'Personal Social Services'.

2. Research evidence suggests that the concept of 'triple jeopardy' described as the 'Black and Minority Ethnic' experience of care reflects the experience of 'African-Caribbean' older people.

3. Data from the 1991 census, confirmed that African-Caribbean's, had the largest proportion of people in the 60-64 age group, followed by 'Indian's', reflecting the early post war migration of this group to Britain in the late 1940's and early 1950's, many of this group have now retired or are nearing retirement.(Office for National Statistics, 2000, p25)

4. The majority of people from the 'Caribbean' have English as their first language, therefore reducing possible language barriers when interviewing.

Choosing a Method – 'Administrative Anthropology'

The method adopted was shaped by the experience of working on a similar study, as a research officer, under the direction of Professor Howard Glennerster and Miss Sally Sainsbury. This study adopted both a 'Case Study' and 'administrative anthropological approach to monitor the implementation of the 'NHS and Community Care Act 1990' in four local authorities and a County Council.(Lewis, J, Glennerster, H, 1996)

According to (Cosley, D, Lury, D, 1987, p65):

> "The case study uses a mixture of methods: personal observation, which for some periods or events may develop into participation; the use of informants for current and historical data; straightforward interviewing; and the tracing and study of relevant documents and records from local and central government."

The methodology adopted utilized an 'Administrative Anthropological' approach. This involved searching through documents and relevant reports; carrying out semi-structured interviews with relevant individuals at different levels, both within the Local Authority and within relevant agencies; and attending key meetings as a 'non-participant' observer. This approach was used in a previous study. (Glennerster, H, 1983) The approach draws on informal as well as formal observations, such as conversations on the way to meetings. This data was used to make sense of not simply the 'outcome of implementation; but the 'process' of implementation. Both (Hyman, Mc, C, 1995; Lewis, D, 1999) argue that this approach enables us to go beyond the formally stated goals of officials in order to understand the way in which organized power is deployed within organizations.

The research undertaken by (Lewis, J, Glennerster, H, 1996) attempted to understand not only what decisions were made, but why they were made? What were the 'push' factors? How might we account for a particular policy response? Who were the 'key players' and how did this shape the outcome? Thus, a similar methodology was adopted to research this topic. In addition to this, interviews were undertaken with users and potential users of services. This was a gap in the original approach and reflects a different perspective on the way service organizations interact with those they are meant to serve.

According to (Yin, R, K, 1994) the case study is an appropriate method when the phenomenon under study is not readily distinguishable from its context. Indeed, it will become clear that it is the local context which is crucial for making sense of why 'Black and Minority Ethnic' groups may find that their needs are either

neglected or prioritized in service planning. The 'administrative anthropological' approach pays attention to process; to relationships between actors; to ways in which guidance and legislation are interpreted in the local context, which are all important for understanding why services for older 'African-Caribbean' people may or may not develop.

A 'Case Study' Approach

The decision to use a case study approach lends itself to criticisms of representativeness, according to (Stake, R, E, 1995, p4):

> "It may be useful to try to select cases which are typical or representative of other cases."

However, he goes on to argue:

> "Case study research is not sampling research. We do not study a case primarily to understand other cases." (Stake, R, E, 1995, p4):

This then raises the question of what is the value of a case study approach to understanding a research question. Stake suggests that whilst the 'case study' approach does raise the issue of 'generalisation', in the sense that one may simply be observing one or two cases, it's strength is 'particularisation', in other words getting to know a particular case in great detail, whch provides a uniqueness that by definition implies a knowledge of others. (Yin. R, K, 1994) on the other hand argues that case studies are generalisable to theoretical propositions, and not to populations.

It might be helpful at this time to consider what alternative research strategies might have been applied. There is a strong positivistic tradition within the Social Sciences that assumes that it is both possible and necessary to be as scientific in our study of human

behaviour, as natural scientists are assumed to be. According to (Walker, R, 1985), this assumption generates a concern to establish causal laws, which are based on empirically verifiable statements, which are drawn from quantifiable standardised data collection.

In this instance we could have explored the extent to which choice had been enhanced for older 'African-Caribbean' service users by developing a postal survey, which could have been distributed to all Social Service Departments in England. The responses then could have been analysed through a method of counting, for example how many authorities had developed such policies, on a number of areas. However, there were a number of anticipated problems with this approach. In the first instance, it was predicted that the response rate to a non official survey by a student would have been low. However, even if there had been adequate responses it was likely that such responses would reflect official positions, and not the actual practice being followed or give insight into how official guidance was being interpreted.

What was interesting in this study was that in both 'case study authorities they would appear to have relevant policies in place, therefore they could respond positively to such questions. However, as will be demonstrated in subsequent chapters, when one looks beneath the surface such policies are riddled with confusion; lack of consistency; lack of commitment, and a general lack of overall strategy on these issues, therefore if such policies existed they were incidental, yet could be cited to demonstrate action in a particular area. Therefore in this instance the 'case study' approach was a preferred method.

This problem was apparent in the study undertaken by (Lewis, J,

Glennerster, H, 1996). For example whilst working as a researcher on this project it was clear that whilst a local authority might be able to respond positively to particular questions related to the development of a 'mixed economy'. For example, an authority might be asked, Have you taken any steps to stimulate the mixed economy? They might answer 'yes', and perhaps even justify this statement by stating an activity undertaken. However, by being based in a particular authority over a two- year period, it became clear that there was a lack of strategic planning/direction related to stimulating the 'mixed economy of care', and therefore policies were ad hoc, and reactive. Therefore, to gain a clearer understanding of ways in which the 'mixed economy of care' was stimulated, more qualitative methods were needed, such as interviewing representatives from the 'mixed economy'; senior managers and front line staff.

This was evident in this project, for example, one of the authorities studied, appeared to have introduced a number of measures aimed at developing services specifically for Older 'African-Caribbean' people. For example, they had provided a specific meals service since 1990. However, it became apparent through the interview process that there was a lack of commitment to such provision. According to one senior manager, "actually the meals service had been a sham, there had been little commitment to developing appropriate provision", for example, a 'Caribbean' meat dish was served with boiled potatoes and carrots. This then translated into a low take up of service, which was then interpreted by policy makers as a lack of demand for such a service. These issues are important and may have been lost with the operationalisation of a different strategy.

Moreover, at the time of this research local authorities had a legal requirement not to discriminate against different 'Black and Minority Ethnic' groups, either directly or indirectly, under the Race Relations Act 1976. Guidance on 'community care' implementation also indicated the need to take into account the 'multi-racial' nature of the community, and this in itself may have affected the way in which an authority might respond to a self-completion questionnaire. Having decided then on an appropriate research methodology let us move on to consider other methodological considerations.

Researching 'Race Related' Topics

There are two sets of methodological considerations, which are relevant to this project:

1. Methodological/ethical issues arising from undertaking 'race' related research.
2. The possible impact of my own 'ethnicity' on the research findings.

In chapter two we have considered some of the issues that arise when undertaking a research project with a 'race' related dimension, in particular reviewing critically concepts, such as 'race' 'racism' and 'ethnicity'. In this study when such terms are used, inverted commas are used to indicate that these terms serve as 'concepts' for making sense of the 'racially stratified' society in which we live.

The language adopted for discussing issues of 'race' or 'ethnic' difference are constantly changing and have changed during the course of this study. In this study the term 'Black and Minority Ethnic' groups is used to describe 'Non-White' groups who may have a common experience of disadvantage. This of course is problematic, as it implies great difference between 'White' and 'Black

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and Minority Ethnic' groups, and limited diversity within groups. There is little doubt that this terminology will change, but was the preferred terminology used in the 'Journal of Ethnic and Racial Studies' in 1999. [4] Similarly, 'African-Caribbean' is now more commonly used to refer to those people and their descendants who came from the 'Caribbean', replacing 'Afro-Caribbean' and 'West Indian'. The term 'African-Caribbean' has been used in this study.

The research question could have been pursued by focusing on all 'Black and Minority Ethnic' groups, or using the concept 'Black' in political way to refer to all 'Black and Minority Ethnic' groups. However, the decision to focus on one group older 'African-Caribbean' people, is a further extension of the 'case study' approach. This approach enabled me to pursue policy developments and policy changes for this group in depth. Such an approach has not enabled me to draw conclusions on the impact of the 'community care' legislation on services for any other specific 'Black and Minority Ethnic' groups, such as 'Bangladeshis', but it has enabled me to understand how the 'case study' authorities responded to 'ethnic diversity'.

Implicit in an exploration of the extent to which the changed policy climate enabled social service departments to purchase services which were more responsive to 'ethnic diversity', is an imagined 'end' state of 'equality' in purchasing and provision. (Law, I, 1996) makes an interesting point here, where he argues that in social policy, the definition of 'race equality' tends to be based on a measure linked to the 'White' norm. So that for example, it implies that the desired state of affairs is one in which, what is available to the 'White' population should be available to all 'ethnic' groups.

For a detailed discussion of terminology see (Parekh, B, 2000)

Indeed if we consider 'social care' services for older people, it is partly because of the inappropriateness and inflexibility of services for 'White' older service users that we have this policy redirection, therefore, to aspire to the 'White' norm in itself may give rise to a relatively conservative set of services. This study does not, however take as its starting point the 'White' service user, rather it focuses on one ethnic' group exploring policy and service developments for this particular group.My decision to do this was based on untested assumptions about disadvantage in relation to service provision for this group. On reflection it would have been interesting to compare ways in which the experience of choice in service provision changed following 'Community Care' implementation, continuing to focus on the experience of older 'African-Caribbean' people, and including a 'White' group for comparison. In particular, there are two contradictory but 'common sense' assumptions about 'ethnicity' and service provision. One based on the assumption that older 'White' people have their needs met to a greater extent than those from 'Black and Minority Ethnic' groups and another suggesting that the needs of 'Black and Minority Ethnic' groups are prioritized over the needs of the 'White' population. This would have enabled a more fuller exploration of the interaction between 'ethnicity' and 'choice'.

'White' Researchers and 'Race Related' Research
In terms of researching 'race' related issues, there is a 'Black'/'anti-racist' informed literature, which raises methodological issues related to undertaking 'race' related research. Just as an anti-racist agenda emerged during the 1970' and early 1980's advocating 'same race' provision, then similar arguments began to emerge within the research community related to 'race' related research. Existing 'race related' research was criticised and in its place a 'Black' informed research was advocated. (Stanfield, J, H, Rutledge, D, M, 1993) argues that for decades, 'White' academics were viewed as holding

the authoritative view on 'racial' and 'ethnic' matters. Research studies either perpetuated the 'cultural deficit' model, which blamed many of the problems experienced by 'Black and Minority Ethnic' groups on themselves, or they have been excluded entirely from 'general' research studies.

Robert Moore when giving evidence to the Home Affairs committee's investigation on ethnic and racial questions in the census, argued that:

> "Statistics have seldom been used to the advantage of the 'Black' population, but have been the basis for abuse and for building a climate of opinion in which the numbers game proclaims that 'Blacks' are intrinsically a problem."(Minutes of evidence to Home Affairs Committee, 1989)

The solution for positive change lay in 'Black and Minority Ethnic' researchers undertaking research related studies and setting the research agenda on issues related to 'race' and 'ethnicity'. (Ohri, S, 1988) for example argued that there was a need to develop a specifically 'Black' perspective on the collection and use of 'race' statistics, particularly when thinking about how to challenge prevailing racist conceptions of the position of 'Black' people in contemporary Britain. This then raises the question of whether it is ethically appropriate for a 'White' researcher to undertake research with a race dimension.

According to (Butt, J, 1996, p11):

> "You do not have to be 'Black' to do research on 'Black' communities. However you must recognise that you do have a perspective and it is important for you to be clear from the start about this, and not to get lost in some pseudoscientific debate about empirical research being value free. It is important to 'Black' communities that you develop a perspective that is informed by the need to combat racism. It has to be committed research. It has to be research about helping 'Black' communities."

(Hammersley, M, 1995) in a discussion of research and 'anti-racism' highlights a number of problems with this strategy, which suggests that research is only valid when it is instrumental to the struggle against 'racism'. He suggests that while it is important that academic work should have desirable consequences, it is a very different issue to suggest that its instrumentalism is a test of its validity.

He describes a so called 'non-foundationalist'[5] model in operation, as an explanatory framework within 'anti-racism'. This is based on the idea that racism is institutionalised in British society, and that there are substantial inequalities in outcomes for members of 'Black and Minority Ethnic groups' in many areas of life. These inequalities derive from fundamental structures operating within society and in organizations, and are not the result of actions of individual members of the 'majority', or 'minority' community. He argues that:

> "Claims within a research community should be based on judgments about the plausibility and credibility of evidence. By plausibility here I mean consistency with existing knowledge, whose validity is taken to be beyond reasonable doubt. By credibility I mean the likelihood that the process which produced the claim is free of serious errors"(Hammersley, M, 1995, p75)

Hammersley, however, does accept that research is not simply about advancing knowledge but about changing society. He suggests that there are two ways in which research may serve practical purposes. The first is to provide information about a particular issue, which can provide the basis for review and possible change. The second is to serve a propaganda role, which simply legitimates action taken, or contributes to a critique of opponents. The model adopted for this project fits into the first model, in that it clearly starts from a

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[5] A Foundationalist model accepts the findings of each research study on the basis of actual evidence, a non foundationalist model involves an evaluation of how findings fit in with existing beliefs.

perspective that social service provision should respond to 'ethnic diversity'. This then bring us to the next question of what other methodological issue are raised for a 'White' researcher undertaking fieldwork on such issues.

Arguments that research should be undertaken from a 'Black' perspective emanate from both an ethical and methodological perspective.

According to (Blauner, R, Wellman, D, 1973, p329):

> "There are certain aspects of racial phenomena, however, that are particularly difficult, if not impossible, for a member of the oppressing group to grasp empirically and formulate conceptually."

Essentially this is an argument made from the perspective of 'standpoint' theory. Hammersley suggests that from this perspective, people's experience and knowledge is treated as valid or invalid, based on membership of a particular social group. Those with membership are assumed to have a superior knowledge compared to those who are not. This of course could be translated into many other areas of research, for example, should only 'working class' researchers be employed to study 'working class' educational achievement? Or should only 'women' be employed to study 'women's position in the labour market?

(Andersen, M, 1993) makes two helpful points here, in the first instance she argues that it is not that 'White' people should not be involved in carrying out 'race' related research but that their views should not be seen as the most authoritative, and secondly White' researchers need to critically evaluate the way that 'racism' and 'racist assumptions' may impinge on the formulation of the research question/process. A second methodological issue arising from 'White' researchers carrying out 'race related' research relates to reliability.

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(Rhodes, P, J, 1994, p548) sums up the problem as:

> "Racism is an inherent feature of British Society. Black People's
> mistrust of White people in general, will, therefore, be
> extended to the White researcher or interviewer, preventing
> access or, if access is obtained, distorting the quality of
> communication which ensues."

Much of this debate focuses on interviewing, and suggests that the
'ethnicity' of the researcher may distort the research findings,
implying that 'same race' interviewing might yield more reliable
results.   Much of the literature on this topic is drawn from the US
and suggests that one of the areas in which the 'race' of the
interviewer has an impact, is where the topic has an explicitly 'racial'
content. (Hyman, H, H, 1954)

(Barn, R, 1994) reflecting on his experiences of carrying out
research in a social service department, questions whether a 'Black'
researcher can gain an accurate picture of 'White' social worker
perceptions. He suggests that they may withhold their true
perceptions for fear of being 'politically incorrect'.
However, he suggests there is a danger of falling into a situation of
'ethnic credentialism', based on a relatively static view of culture,
whilst ignoring other issues that may affect the interview process,
such as class background of the interviewer/interviewee. According
to (Pilgrim, S, Fenton, S, Hughes, T, Hine, C, Tibbs, N, 1993, p84)
> "Some 'Caribbean' respondents said openly they only agreed to
> take part because the interviewer was 'Black'".

(Rhodes, P, J, 1994) suggests that whilst the 'race' of interviewer
may impact on the response it may not necessarily invalidate the
findings or have the effect one might assume. Rhodes a 'White'
researcher carried out research on fostering and adoption with
'Black' foster carers'. She undertook the fieldwork and employed

two 'Black' women to undertake some of the interviewing. She found that as a 'White' interviewer, she had a 'stranger' value which led the respondents to develop particular views in greater depth, and in relation to sensitive issues surrounding 'racism'. She observed that many people were prepared to talk openly and at length about their experiences and opinions, giving a greater degree of detail than that they would have given to another 'Black' person, where they would have assumed a greater degree of knowledge.

Rhodes found that two respondents who were opposed to a policy of 'same race' foster placements, did not want to express these views to a 'Black' researcher and refused to be interviewed by a 'Black' researcher. Rhodes does not dismiss the role of 'race' in the interview process, rather she suggests that 'race' was an interactive factor in each interview, and therefore needs to be considered in data analysis. Rhodes makes clear that she is not suggesting 'White' researchers are equally capable of carrying out research with 'Black and Minority Ethnic' groups, but that concerns about achieving 'truth'/'accuracy' would be better directed towards an analysis of the relationships of power within which they are produced. Furthermore she argues:

> "In conventional survey research, the interview questions, and language are determined by the researcher. Using qualitative, ethnographic techniques the content and language are more open to negotiation. A more interactive approach can give interviewees greater power in negotiation of the pace and content of the interview, to direct the flow of conversation, and to ask questions of themselves. Where interviews take place in respondents homes, familiar territory generates confidence, the interviewer is invited in as a 'guest' and the balance of power is more likely to tilt in the interviewee's favour."(Rhodes, P, J, 1994, p558)

This is helpful then in thinking about the impact of 'ethnicity' on the research process. (Andersen, M, 1993) similarly suggests that in

order for 'White' researchers to develop more inclusive and less partial and distorted accounts, it is necessary to operate a less formal process. She argues that using semi-structured interviews, gives respondents space to express their views, and interviewing in locations in which the interviewee feels comfortable in will also aid the reliability of the research process.

It is clear then that as a 'White' researcher, there are some additional methodological problems raised when choosing to undertake this particular piece of research. It is my intention that this project be relevant and potentially beneficial in practical terms and has consistently adopted a 'race aware' as opposed to 'colour blind' approach throughout this study. When interviewing older 'African-Caribbean' people, I was particularly aware of the possible impact of my 'ethnicity' on the reliability of the research. To mitigate this people were interviewed in their own homes, using a semi-structured interviewing format, with space for discussion. My own 'ethnicity' did impact on the project, but in a much more complex way, than simply leading to less reliability.

Selecting the 'Case Study' Areas – Generating a sample
There were two clear criteria guiding the selection of the 'case study' areas. The first was to focus on local authorities with relatively large numbers of people who were either 'African-Caribbean' or of 'African-Caribbean' descent, where one would have expected a policy response to these issues. The second was political control. Ideally it would have been preferable to contrast the approaches of different political administrations i.e. Conservative and Labour, who have in common a relatively large older 'African-Caribbean' population, but who may diverge on their commitment both to developing a 'mixed economy' and 'race- related' policies.

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This project commenced in 1996, a search was undertaken to identify the ten authorities with the highest concentration of 'African-Caribbean' people, eight were 'Labour'-controlled, one was 'Conservative'- controlled, and one was a 'hung' council.

Initially the one Conservative Controlled authority was contacted. The Conservative controlled authority stated that they were already participating in a number of 'community care' type studies, and were not able to participate in any further studies. The 'hung' council who had been 'Conservative controlled at the time of implementation was then contacted and they subsequently agreed to participate in the study.

There were many more Labour authorities to contact. Initially the 'Labour Controlled' Authority with the highest number of 'African-Caribbean' people was contacted. However, they were not willing to participate in the study. Then the Labour controlled authority with the second highest number of 'African-Caribbean' people was contacted and they agreed to participate in the study on the basis that a paper summarizing key findings would be presented on completion of the project.

Authorities were initially contacted by telephone and contact made with the principal research officers within the Social Service Departments. It was possible to ascertain at this point whether authorities were willing to participate. For the two authorities that did agree to participate I was requested to write a letter stating the remit of the project and the likely impact on their time.

Both authorities were assured that they would remain anonymous in any reports or publications published as a result of this study. The 'hung' council, which was under a Conservative administration at the

time of 'Community Care' implementation in 1992, will be known as Authority A and the consistently Labour controlled authority will be known as Authority B.

According to (Owen, D, 1994) of the twenty districts with the highest percentage of 'Black and Minority Ethnic' groups, 16 are in Greater London, with those defined as 'African- Caribbean' concentrated in Inner and South London, and Birmingham. Both authorities selected were in the London area. This was suitable from a methodological perspective given the concentration of African-Caribbean's in the London area and also facilitated greater accessibility given that I was also based in the London area.

Sample Characteristics - Authority A
At the time this research was undertaken, Authority A had a population of 243,000 and was defined as the second most culturally and racially diverse authority in Britain, with 'Black and Minority Ethnic' groups making up 44.8% of the total population(Owen, D, 1994). Moreover, data from the 2001 census identified this authority as one of only two authorities in the country, whereby 'Black and Minority Ethnic' groups comprised the majority of the population(Greater London Authority, 2003).

Authority A's 'Black and Minority Ethnic' population is drawn from a wide range of groups. However, in 2001, those categorized as 'Indian' and 'African-Caribbean' were the largest of any 'Black and Minority Ethnic' group(Office for National Statistics, 2001). In 1991 'African-Caribbeans' comprised 10.3% of the population and this had increased to 10.5 by 2001(Teague, A, 1993; Office for Population and Census Statistics, 2001). Moreover this authority had the third largest proportion of people who described themselves as 'African-Caribbean' of any authority in the country. (Greater London

Authority, 2003)

Data from the 2001 census indicated that 'Black and Minority Ethnic' populations in this authority were proportionately younger than the 'White' population. However, the 'African- Caribbean' and 'Indian' population was proportionately older than other 'Black and Minority Ethnic' groups reflecting their earlier migration to Britain (Office for National Statistics, 2001). In 1991 14.2% of the population was of retirement age, and this had declined to 13.7% by 2001.(Office for National Statistics, 2002) In 2001, 15.38% of the population was aged 60 or over, compared to 20.85% in England and Wales, therefore, this authority had a proportionately younger population.(Office for National Statistics, 2002)

Authority A is characterized by areas of extreme wealth and poverty. The north of the borough is relatively wealthy, whilst the south of the borough is relatively poor, and includes five of the ten most deprived areas in the country. Overall the authority has unemployment levels above both the average for London and nationally. Moreover, 'Black and Minority Ethnic' groups are over-represented amongst the unemployed in this authority. 'African-Caribbean' groups are more likely to live in the more deprived parts of this authority (Office for National Statistics, 2001).

This authority has been characterized by political instability. At the time when this research was undertaken, Authority A was a hung council. However, from the 1980's onwards, political control has switched backwards and forwards from Labour to Conservative, with the Liberal Democrats holding the balance of power. According to (Cross, M, Brah, H, Mc- Cleod, M, 1991), commenting on the 1980's. Political control rested either with a small number of Liberal

Democratic Councillors or the shifting loyalties of defecting Councillors.

This authority was one of the more radical authorities in relation to 'anti-racist' policies introducing a range of radical programmes during the 1980's. However, as will be illustrated in subsequent chapters, this commitment to radical policies came to a rapid halt in 1990, when the incoming Conservatives adopted an 'anti-anti-racist' position. In addition to this change of direction on issues of 'race' and 'racism'. The authority initiated a massive transformation programme, with the aim of becoming a Conservative 'flagship' borough supportive of 'marketisation', and 'Client/contractor splits'. (Authority A, 1996a) In May 1998 political control was returned to the Labour Group who committed themselves to abolishing the client/contractor split and increasing the share of in house 'home care' within the personal social services. Therefore this authority is subject to far reaching policy shifts, dependent on who is in control.

The political instability in this authority is a reflection of a 'social class' divide. The north of the borough is predominantly middle class with a dominance of Conservative councillors, The South of the borough is characterised by urban decline, high unemployment and poor housing with a dominance of Labour councillors.(Times Educational Supplement, 27.2.1987)

This then is an interesting 'case study' as it has a large 'African-Caribbean' population and has adopted a pro market stance. Therefore, whilst not being Conservative controlled at the time of this research, it was at the time of 'community care' implementation.

Sample Characteristics – Authority B
Data from the 1991 census indicated that Authority B had a

population of 231,000 and this had increased to 248,922 by 2001(Office for National Statistics 1996; 2001). In 1991 'African-Caribbeans' constituted 10.1% of the total population, and were the largest 'Black and Minority Ethnic' group and this had increased to 12.27% by 2001(Teague, A, 1993; Greater London Authority, 2003). Indeed in 1991 this Authority had the second largest 'African-Caribbean' population in Britain, and in 2001 they continued to have the second largest 'African-Caribbean' population of any authority in the country.(Greater London Authority, 2003)

Authority B was not as ethnically diverse as Authority A. The 'White' population continued to be the largest ethnic group in 2001, comprising 67% of the total population followed by 'African-Caribbeans' and then 'Africans'. Those who described themselves as 'Indian' and 'Vietnamese' comprised a much smaller proportion of the population(Public Health Team, 2004a). In 1991, 7% of those who described themselves as 'African-Caribbean' were of pensionable age, and this increased to just over 10% by 2001.(Office for National Statistics, 1996b; Public Health Team, 2004a) In this authority, 14.03% of the population was aged 60 or over, compared to 20.85% in England and Wales, therefore, this authority had a proportionately younger population(Office for National Statistics, 2002). Moreover, those of retirement age had declined from 16.85% in 1991 to 12.8% by 2001(Office for National Statistics, 2002).

Authority B is characterised by higher than average levels of deprivation, with 20 of the 26 wards being in the worst 10% nationally when using the housing index of Multiple Deprivation(Public Health Team, 2004b). The Authority also has above average levels of unemployment compared to the national

average and higher levels of poverty, with 27% of families with dependent children having no adult in employment. In 2001, 7.2% of the population was unemployed compared to 3.4% in England and Wales(Office for National Statistics, 2001).

This authority has been consistently Labour controlled, and like many other 'Labour' authorities demonstrated an initial reluctance to embrace the 'quasi-market' and the 'mixed economy'. However, the authority had then become a pragmatic convert to the possible benefits of the 'quasi-market' and the 'mixed economy of care'. As in Authority A, this authority had begun to develop 'anti-racist' policies in the 1980's but had weakened their commitment to these issues in the 1990's adopting a 'generic' approach to such issues.

Authority B, lent itself well to the criteria identified for the selection case study authorities, as they had relatively large numbers of people who were either 'African-Caribbean' or of 'African-Caribbean' descent, and the authority was 'Labour' controlled.

The Research Strategy
Having reviewed the chosen method and identified a range of methodological issues that confronted me in undertaking this particular project, Let us now move on to look in more detail at the strategy pursued to answer the research question. As we have already seen, the strategy adopted drew on the framework used in the initial study, the 'administrative anthropological' approach. In the initial study, two research officers spent two years monitoring 'community care' implementation in five local authorities. These research officers undertook a literature review linked to 'community care' implementation in those authorities; interviewed a range of people working in the agency at different levels, and undertook the role of 'non-participant' observer in a range of meetings linked to

implementation. Observations were also undertaken with front line social work staff on the duty desk. Therefore observations were undertaken at a number of levels and fed into further observation. Relationships were formed with managers, and sometimes information acquired outside of a meeting or interview, was used to get a good understanding at the nature of 'implementation' in that particular authority. Thus the 'administrative anthropological' approach used a number of methods of inquiry to make sense of the implementation process.

It was not possible to operationalise this methodology fully in this study. In the first instance the fieldwork was undertaken a number of years after implementation, and therefore it was not possible to observe meetings related to implementation. Secondly, the time-scale available for undertaking the fieldwork was much shorter, and therefore, the detailed focus adopted in the first study could not be reproduced in this study.

The research strategy evolved and was modified over time .For example, a detailed investigation of the market in food was later added, and this proved to be a more useful exemplar for exploring the 'mixed economy of care'.
There were many dimensions of the approach adopted in the first study that were reproduced in this study. A literature review was carried out, reviewing similar types of documents to the first study; semi-structured interviews were undertaken with managers at different levels of the hierarchy, in both Authority A and Authority B and relevant individuals in non-governmental agencies involved in developing or delivering social care services to 'Black and Minority Ethnic' older people, along-with meetings with front line staff on the duty desk in both authorities.

This study included two further dimensions that were not included in the first study. This study explored the changing nature of service provision, through a case study of 'meals' provision. This study also interviewed a sample of older 'African-Caribbean' people about issues of choice' and 'preference'. All three dimensions of this study are discussed in depth below.

The Research Question In More Detail
I wanted to examine the extent to which the introduction of a 'quasi-market' in social care was more able to respond to the particular needs of older 'African-Caribbean' people, than the previous model. I wanted to examine whether, or indeed what priority purchasers had given to either, purchasing or stimulating the development of services for this group, and more generally responding to diversity. I wanted to find out how the 'social care market' had responded to this group. Had the existence of a relatively large and growing group of African-Caribbean older people led to the development of new services in the 'independent' sector, targeted specifically at this group?

What had happened to the voluntary sector - both 'mainstream' and those providing specific services for the 'African-Caribbean' community? Were they playing an increasing role in service provision? Was the contracting process used to ensure greater specificity over meeting and responding to diverse needs? How was the concept of 'choice' being interpreted? Was it being linked to questions of 'ethnicity' and 'diversity' or were these issues being neglected? Did older 'African-Caribbean' people have a distinct set of preferences in relation to services? Do these preferences inform the policy process? More generally, how does, and how should social policy respond to ethnic diversity?

Literature Review – Phase One

Prior to undertaking the fieldwork an extensive literature review was undertaken of the following areas:

-The shift in policy from bureaucratically planned services to 'quasi-market's.

- A detailed exploration of the 'NHS and Community Care Act 1990' and its implementation.

- The response of the 'British' state, both 'centrally' and 'locally' to issues of 'race' and 'racism'.

- The response of 'Black and Minority Ethnic' groups to British social policy.

- An exploration of issues of 'race' and 'racism' within the Personal Social Services

- An exploration of issues of 'race' and 'racism' in 'Community Care' implementation.

Literature Review – Phase Two

The second phase of the literature review related to the two case study areas. This involved a search of local newspapers; relevant reports such as SSI Community Care Monitoring reports; Social Service Committee Papers; Community Care Plans and minutes of specific 'Community Care' implementation Groups (where appropriate). The themes pursued in this literature related to:

- The policy response to 'Community Care' and 'Community Care' implementation from the Local Authority; Social Services Department; Voluntary Sector and Community Groups/pressure groups including 'Black and Minority Ethnic' pressure groups' and private care providers for the period 1990 - January 1998.

-The policy response to issues of 'race', 'racism' and 'ethnic diversity' from the Local Authority; Social Services Department; Voluntary

Sector and Community Groups/pressure groups including 'Black and Minority Ethnic' pressure groups' for the period 1980 - January 1998.

As you will see two different timescales were selected. This was because local authority policy responses to issues of 'race' and 'racism' can be traced back to the beginning of the 1980's, whilst 'community care' legislation was 'implemented' almost one decade later.

From this review it was possible to:

-Identify policy responses to 'community care' implementation within the two case study authorities.

-Identify policy responses to 'race'/'racism'/'ethnic diversity' from the two case study authorities.

- Identify key 'players'/actors involved in policy making related to 'Community Care' implementation, and policy responses to 'ethnic diversity' generally, and older 'African-Caribbean' people in particular from the local authority; voluntary sector, and health authority, as a basis for identifying appropriate interviewees.

- Develop a profile of service provision for older 'African-Caribbean' people.

The Fieldwork

Most of the fieldwork was carried out between January and July 1998, though a small number of interviews were carried out in October and November 1998.

Interviews – Key Personnel - Phase One

Between March and October 1998 semi-structured interviews were undertaken with; senior management; front line assessors/social work staff and key personnel from local voluntary and private organisations involved in providing services to older people in the

two case study authorities.

The format pursued in each case was of a focused interview. An interview guide was prepared prior to the interview, with a list of topics/questions for discussion. Each interview included different questions related to the specific role of the person being interviewed. The topics were all addressed but not necessarily in the order planned, probes were used to elicit more information on a particular topic. According to (Fielding, N, 1993, p139) the object of this approach is to:

> "Find out what kinds of things are happening, rather than to determine the frequency of predetermined kinds of things that the researcher already believes can happen."

The purpose of the research was explained to each informant at the beginning of the interview and confidentiality and anonymity was assured in relation to their responses. At the beginning of each interview, permission was requested to tape record each interview. It was explained to each interviewee that the purpose of tape recording each interview was to enable me to concentrate more on their responses without having too take lengthy notes. Permission was always granted to tape record the interview.

A Day on the Duty Desk

As part of the first 'implementation' study a day was spent with front line social work staff on the 'duty desk' within the respective authorities, this enabled access to the views of front line staff in an informal way. This method was reproduced in this study. As the timescale was shorter in this study, than in the first study, one half of a day was spent on a duty desk in each authority. Staff talked about the impact of 'community care' implementation on service provision generally, and more specifically on service provision and

assessment processes for older 'African-Caribbean' people. It was possible to explore issues of 'choice' and 'responsiveness' with staff involved in the assessment process. As in the first study it was interesting to pursue issues of 'implementation' with staff at different levels of the organisation. Observations were recorded in an informal way

This part of the study generated some interesting findings and it would have beneficial if more time had been available to pursue this dimension of the research. Frontline staff had a wealth of information and knowledge about how things operated in practice. The issue of 'ethnicity' featured prominently in this part of the study, with workers from 'African-Caribbean' backgrounds in both authorities more likely to express negative views on how the local authority was responding to the needs of older 'African-Caribbean' people, than 'White' workers. Moreover, 'White' workers were more likely to express hostile attitudes to 'culturally specific' provision, than 'African-Caribbean' workers. This highlighted the contested nature of such policies.

From these interviews and the time spent on the 'Duty Desk' it was possible to understand, how the 'case-study' authorities had responded to:

- the needs of older 'African-Caribbean' people, both now and over time and the main factors shaping this response.
- implementation of the 'NHS and Community Care Act 1990'.

This part of the research enabled me to gain a clearer understanding of what had been prioritized and what had been neglected in terms of 'community care 'implementation'. It was possible to identify

how issues of 'race', 'racism,' and 'ethnic diversity' had been
incorporated into policy making related to 'community care
implementation' and how and why the profile of services for older
'African-Caribbean' people had changed. It was possible to gain a
clearer understanding the impact the 'NHS and Community Care Act
1990' had made to services, compared with other policy initiatives
such as 'municipal anti-racism' and to gain an insight into the impact
the introduction of the legislation and the shift to
'purchasing/contracting' was having on 'African-Caribbean' voluntary
sector service providers.

'The Mixed Economy' – Mapping the Social Care Market for Older
'African-Caribbean' People
As discussed in chapter one, the rationale for the introduction of a
'quasi-market' is that it will be more responsive to 'user'
'needs'/'preferences'. It was therefore interesting to consider what
kind of services existed for older 'African-Caribbean' people, why
they had developed, and how they had changed over time. Did the
existence of purchasers, stimulate new services? How had the shift
to purchasing/contracting impacted on social care providers?
Initially, the study focused on 'Day care' and 'Residential Care', two
important dimensions of 'community care' policy. A mapping
exercise was undertaken which simply explored service provision
prior to, and then after the implementation of the 'community care'
legislation. This provided a basis for further exploration in the semi-
structured interviews described above. However, it became clear
that the 'meals service was a useful 'case study' to explore in more
detail.

Meals provision – A Case Study
As the research evolved it became clear that there had been a
neglect of 'ethnic diversity' in relation to community care planning.
However, one area that was particularly interesting to explore was

'meals provision, as part of a 'mixed economy of care'. This was interesting for a number of reasons.

1. If one takes the hypothesis that the 'quasi-market' will be more responsive to consumer demand' , it is based on the notion of an 'ideal' type 'market', which is assumed to be more responsive to consumer demand. Therefore, it was an interesting case to study as the market already plays a huge role in food provision, and therefore offered great potential in terms of the development of a 'mixed economy'

2. It also became clear whilst undertaking this research, that one of the early initiatives undertaken by local authorities in responding to 'ethnic diversity' was the development of 'culturally specific 'meals provision. Therefore it was interesting to understand how policy and practice had changed over-time, and what had been the impact of 'community care implementation' on this important dimension of policy.

3. The desire for 'culturally specific' food was clearly a very important area of service delivery, which had been cited in many of my interviews with older 'African-Caribbean' people.

4. The burgeoning number of 'Black and Minority Ethnic' restaurants, suggests great potential for the involvement of private providers in the development of meals provision.

Therefore for this part of the study, an additional literature review was undertaken specifically focusing on; the sociology/anthropology of eating and food; 'African-Caribbean' cuisine; the emerging market in 'ethnically diverse foods; policy developments within local authorities in relation to 'culturally specific' meals provision. In

addition to academic sources, 'African-Caribbean' cookbooks; specialist journals and newspapers, such as the Grocer, the Voice, Mintel and Social Services Committee papers provided valuable information, alongwith a specialist library at the London Food Commission. The London Food Commission had collated a specific file of information and newspaper cuttings on 'race equality' and meals provision. An additional source of information was a specific seminar run by a London borough who was attempting to involve independent 'African-Caribbean' meals providers in 'meals' provision.

Policy and policy change was explored in both case study authorities. Both case studies revealed interesting findings. In Authority A 'culturally specific' meals provision had emerged from the old model of 'bureaucratically planned services and continued to be provided 'in house'. This service was clearly popular with users, yet expensive. The major challenge facing Authority A, was that with the increased emphasis on efficiency and cost, they were under pressure to reduce costs, by abandoning what was clearly a 'needs led' service. Authority B on the other hand, had found it very difficult to develop a 'culturally specific; 'Caribbean' meals service, and moved from one unsatisfactory solution to another. Currently, they were purchasing provision from a large multinational provider but this was not popular with users. An exploration of policy in both these authorities, suggested that pressure was downwards in terms of quality, with a tendency to monopoly provision, clearly an interesting finding in relation to the question.

Generating an Additional Sample – Meals Provision
Given that the findings were interesting, it seemed appropriate to pursue this issue in other authorities, in order to identify any trends in this important dimension of the 'mixed economy of care'. The meals policy was reviewed in six additional authorities, all with

relatively large 'African-Caribbean' populations. The authorities chosen had relatively high proportions of the population, who described themselves as 'African-Caribbean' in the 1991 census.(OPCS, 1993) A relatively simple method was adopted. In each authority a senior manager with responsibility for the meals service was contacted and interviewed over the telephone. Each manager was asked the same questions – Do they have or have they ever had a specific 'African-Caribbean' meals service? When was the service set up? Why was it set up? Who provided 'African-Caribbean' 'meals' in the current period? Had it changed? If so, why had it changed? If it hadn't changed, was there pressure to change the service, or plans to change the service. How would they respond to a request for 'culturally specific' meals from a relatively small 'Minority Ethnic' group?

All authorities participated in the survey, and provided interesting information, in some instances sending additional information, such as committee reports. In most of these authorities, there had been relatively recent reports/discussions related to 'meals provision; as a result of 'Best value' type audits.

Therefore the methodology adopted was mainly quantitative in approach, providing a descriptive picture of change in each authority which facilitated the observation of any trends. Qualitative questions were also included to make sense of why these policy changes had been implemented.

In retrospect this was a much more interesting part of the study, than initially envisaged. It generated some interesting questions in relation to how authorities responded to 'ethnic diversity' more generally, and the huge potential to stimulate a plurality of

providers, as part of the development of a 'mixed economy of care' to meet 'culturally specific' needs. It is not possible to generalize from what is happening in these authorities, with trends across the country, but it does clearly give an indication of trends in London Authorities in relation to 'meals' provision.

Semi-Structured Interviews – Phase Two – Older 'African-Caribbean' people

One of the key questions of this study relates to the extent to which the introduction of the 'quasi-market' into the Personal Social Services would be better able to respond to the differentiated needs/preferences of consumers, encouraging a shift from 'service led' to 'needs led' provision, whereby monies would be separated from provision and used to purchase relevant service provision. This then raises the question of what purchasers would buy in this new 'social care market? It seems that in order to move to a model of service based on need/preference, purchasers need to ascertain what preferences consumers/service users may have. What factors are important to older 'African- Caribbean' people when using services? Is there a demand for differentiated services for people from different 'Black and Minority Ethnic' groups? Does this demand relate to all areas of service provision? If older 'African-Caribbean' people express service preferences irrespective of existing patterns of provision, what would they be?

Therefore, it was decided to pursue an additional dimension of research exploring service preferences with older 'African-Caribbean' people. Because of a mixture of limited time and resources, twenty four people were interviewed – twelve in each case study area. The interviews were not a 'needs audit' of Older 'African-Caribbean' people, and it is not possible to make any generalisations from these interviews about what service preferences 'African-Caribbean' older

people have, if indeed it is possible to talk about any group, and infer service preferences on the basis of membership of that group. However, in order to pursue the issue of choice and diversity in service provision, it is important to have some sense of whether there is a relationship between what kinds of support people would like and what types of services are actually available, or are thought desirable by policy makers, such as 'culturally specific' provision.

This part of the research posed two methodological challenges. The first related to identifying a sample, and the second relating to designing an appropriate research instrument.

Identifying/Generating a Sample of Older 'African-Caribbean' People

It was my intention to interview 12 older (60+) 'African- Caribbean' people in each authority. It was therefore, necessary to find some method for identifying a sample. One method I could have used, would have been to get a list of existing service users from either local authority, or specific providers, for example, through a Voluntary organisation for older 'African-Caribbean' people, though this may have created an in built bias for 'culturally specific' provision. Another option would have been to visit local shopping centres', and interview relevant individuals. The problem with this approach is that it may have yielded a sample of relatively fit people, who were not using services, and had possibly not contemplated using such services.

(Kalton, G, Anderson, D, W,1986) suggest that one possible way of identifying a sample is through a specific list, such as an electoral register, or GP's list, However, the electoral register did not give a breakdown of 'ethnicity' and therefore this was not a suitable method. One strategy adopted by a previous study seeking to interview older 'African-Caribbean' people, was through a local GP.

However, this was likely to involve some time in relation to negotiating access with a GP and as I had a short timescale in which to carry out the study (around three months) I rejected this method.(Richards, M, Brayne, C, Forde, C, Abas, M, Levy, R, 1996)

The strategy adopted was initially based on identifying parts of the Authority with relatively high proportions of people from the 'Caribbean'. Initially two streets were selected. A simple screening procedure was undertaken, when a person who did not appear to be of 'African-Caribbean' origin, answered, they were asked "Do you use Community Care Services?" And thanked them for their time. When the person opening the door may have come from the 'Caribbean' or be of 'African-Caribbean' descent they were asked if there was anyone living in the household from the Caribbean who was aged 60 or over. If someone was identified then they were asked if they would be willing to give up some time to be interviewed.

As (Kalton, G, Anderson, D, W, 1986) observe, one of the huge problems in undertaking research when looking for a 'special' population, is the huge cost of undertaking the screening process, where the population is difficult to identify. Four visits to the case study authorities were made. However, this only enabled access to two older 'African-Caribbean' people in each local authority who were willing to be interviewed in this way. One option would have been to adopt a snowball or chain referral sampling method.

According to (Biernacki, P, Waldorf, D,1981) such a process allows access to a sample by asking interviewees to provide information on others, who possess the characteristic that is of research interest. They suggest it is a method that is particularly suited to sensitive

issues such as those involved in deviant behaviour. However, according to (Welch, A, 1975) such an approach can lead to bias in terms of under-sampling isolated member of the community and over-sampling those with more extensive networks, who have wider circles of friends and greater participation in various organised groups.

Essentially at this point there was a change in approach. This change of approach was brought about not only as a result of the problems in finding the sample from a methodological point of view, but because of a 'perceived fear of danger'. When commencing this part of the study I was advised that it is now the policy of the London School of Economics for a woman not to knock randomly on people's houses, because of the degree of risk involved. Initially there appeared to be no alternative to such a strategy and therefore this part of the study was initiated in this way. However, I gradually became very apprehensive about my visits, and on one occasion when looking for a particular street I went into the local police station, where I was advised that the area was 'dangerous'.

During the half day spent on the duty desk, an alternative method was recommended. It was suggested that a good method for identifying older 'African-Caribbean' people would be by visiting sheltered housing schemes in the borough. Authority A did not have any 'race' specific sheltered housing, and Authority B only had one 'race specific' sheltered housing scheme that had opened in the previous year. It was decided to visit 'mainstream' sheltered housing schemes, in the same wards initially identified. This would avoid any potential bias in favour of culturally specific provision, as few would have been given such a choice. By returning again and again to the different schemes it was possible to interview twenty four people,

twelve in each authority.[6]

This revised methodology was not ideal, given that in one authority, there was a culturally specific sheltered housing scheme, and therefore those living in a 'mainstream' sheltered housing scheme, may be less likely to indicate a preference for 'culturally specific' provision. However, a review of the sample revealed that this was not the case, with residents in 'mainstream' provision, in this authority, just as likely to express a preference for 'culturally specific' provision. Moreover, respondents, who lived in 'Sheltered housing' did not appear to be any more likely to know about or receive services, than those initially interviewed.

Sample Characteristics – Older People
Twenty four people were interviewed, thirteen were male and eleven were female. Most of the respondents were in their seventies, with fifteen falling in this category; six were aged between 60 and 69 and three were over 80. At the time when these interviews were undertaken, the number of 'African-Caribbean' people over 80 was still relatively small.(Haskey, J, 1996) Nineteen of those interviewed suffered with health problems, and six of these suffered from diabetes, which is particularly common in 'African-Caribbean' communities. Health problems were prevalent in all age groups. This reflected the findings of other research studies.(Pilgrim, S, Fenton, S, Hughes, T, Hine, C, Tibbs, N, 1993; Department of Health, 1999) All respondents had come to Britain in the 1950's to work, and respondents had worked in a variety of occupations. Seven had worked in Transport including British rail and London Transport. Three had worked in health settings, including domiciliary care, nursing and a porter, the remainder had worked in a variety of jobs

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[6] Sheltered housing comprises individual housing units, with the added security of on an on site warden in case of emergencies.

ranging from machinist to engineer.

Interviewing Older People

Just as 'ethnicity' may have an impact on interviewing, there is also a body of literature which raises concerns about interviewing older people. It is important to acknowledge that there are specific issues that need to be acknowledged when interviewing 'older' people. Older people are particularly vulnerable in their own homes and could become anxious. An ID card was carried at all times and the telephone number of the course secretary, who could verify the project was bona-fide. (Richards, S, 1994) suggests that older people may be tired or feel too ill to participate, or may feel lonely and wish to talk. On some occasions interviewees did say they were about to have a sleep and asked me to return another day. Richards also raises the issue of possible sensory barriers to effective communication such as deafness, where communication is difficult it will be important to avoid an interviewer effect. According to (Hoinville, G, 1983, p15):

the conflict between the interviewer's role as an automaton who will not influence respondent's answers and her role in motivating, explaining, encouraging is particularly exaggerated among interviews with the elderly."

Designing an Interview Schedule

The aim of this part of the research was to ascertain what preferences older 'African-Caribbean' users and potential users of services had regarding support. Essentially if we are to shift towards a 'needs led' model of service provision we need to shift to a 'needs led' or 'preference based' methodology for framing research. However the 'service led' model continues to dominate research, and this essentially limits 'user based' research too ascertaining satisfaction with existing services.

<u>'Need' versus 'Preference'</u>

The shift to a 'needs' led service was widely welcomed within policy making circles. However, the concept of 'need' is itself problematic, as it can be interpreted in a broad way - generating wide ranging and expansive provision, or in a limited and restrictive way, with minimal provision.   In Chapter one it was clear that the concept of 'needs led' provision had to be contextualized against a background of 'welfare retrenchment' rather than 'welfare expansionism.

(Glennerster, H, 1983) notes that one important assumption underlying the development of the welfare state was that it was possible to identify 'need' in an objective way; allocate resources accordingly; and that there was a general consensus about what constituted 'need'. However, writers from the 'right' increasingly attacked the ability of 'bureaucrats to identify 'need', arguing that 'need' was subjective and separated from resource implications. Therefore a 'need' may be identified by the state, and supported by the public, because neither had to pay directly for that 'need' to be met. According to (Charles, S, Webb, A, 1986, p11):

> "Even to describe social need...We require some standards or criteria: needs do not just exist in the real world already labeled. To call a condition, such as poverty, a social need implies an idea of what is not or ought to be acceptable."

For them, this can only ever be subjective. (Doyal, L, Gough, I, 1991) on the other hand, challenge the notion that 'need' is subjective. They argue that it is indeed possible to identify universal, objective basic needs, which are not 'culturally specific' but relate to physical health and survival. Moreover, in addition to these basic needs, they identify a range of 'intermediate needs', which contribute to health and well-being, such as; appropriate health care; a non hazardous environment and physical security.

The Department of Health produced guidance on 'need'. According to this guidance 'need' is:

> "..a shorthand term for the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life, as defined by the particular care agency or authority - . Need is a dynamic concept, the definition of which will vary over time in accordance with changes in national legislation, changes in local policy, the availability of resources and the patterns of local demand.. Need is thus a relative concept to be defined at the local level."(Department of Health, 1991, p12)

Therefore 'need; was defined in a subjective and changing way. Responsibility for defining need was placed within the remit of local agencies and local assessors, within a framework set by local authority members. The definition of 'need' then was both shifting and subjective. Moreover, despite the focus on consumerism, 'need' was to continue to be defined in a 'top down' way by both resources and professionals.

It is perhaps, easier to make sense of what 'needs led' provision was to replace, which was 'service led' provision. Essentially, it was the separation of need from provision, achieved via the 'purchaser/provider' split, which would facilitate the purchase of services, related to a clients' need, with service provision responding to need, rather than users fitting in with existing services. Therefore if the policy intention is to elaborate a more consumer orientated model of provision, then we need to develop a research methodology which is capable of exploring issues of user choice/preference?

(Culyer, A, 1980) suggests that 'need' assessment implies a desired end state, and the assessment of various means to achieve this end state. Therefore it is the preference for how this 'end state' might be

achieved that we need to consider further.

<u>Developing a 'Preference' Based Methodology</u>
Issues of 'preference' and 'choice' are implicit in the new policy
direction. According to (Allen, S, Hogg, I, Peace, S, 1992) "there has
been little discussion of issues surrounding choice, as it applies to
consumers of care services as opposed to consumers of goods. They
pursued the issue of choice and participation in care decisions
through a large research study carried out during the late 1980's
and found that; few if any older people had any choice in terms of
what went into their package of care; about the time at which the
service was delivered; or the person that delivered it. The definition
of choice in this instance appeared to be based on choosing from
locally available services, rather than questioning the existing set of
services.

Post 'Community Care' implementation there have been some
potentially helpful books produced in relation to devising a
'preference based' methodology for this research project. However,
on consulting these texts they were still limited as a guide for
developing a 'preference' based methodology. (Wilson, G,1995)
produced an edited collection 'Community Care - asking the users?
And, (Percy Smith, J, 1996) similarly produced an edited collection
'Needs Assessments in Public Policy' both of which at first sight
appear to be helpful in thinking about what users or possibly
potential users actually want. However, according to Wilson:

> "The users referred to by most authors in the book are the
> people who used to be known as clients, patients or
> carers."(Wilson, G, 1995, p9)

Percy Smith's book on the one hand did recognize the need to shift
to a 'needs based approach:

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> "What is perhaps distinctive about community needs
> assessments is that they tend not to start with a particular set
> of services or a policy area, and then find out how many and
> what kind of people need those services. Rather in keeping
> with the move towards 'needs led' rather than 'producer led'
> services they begin with people. This is important since the
> 'service led' approach is inevitably conservative and will at best
> result in marginal improvements to existing services. It is
> unlikely to generate information needs for an entirely different
> range of services."(Percy Smith, J, 1996, p7)

However she sees only a limited role for the views of individuals:

> "Focusing on individuals and groups own perspectives of need
> might also be limited by lack of knowledge about the
> possibilities of having their needs met, narrow horizons,
> powerlessness or a resigned acceptance of a state of affairs
> they have simply learned to live with."(Percy Smith, J, 1996,
> p8)

Therefore her emphasis is based on reviewing the collective needs
of the community, through the enhancement of 'voice' type
mechanisms. Hence, neither takes us any closer to developing a
'preference based' methodology from an individual user perspective.
Similarly, Community Care Magazine produced a special edition of
'Research Matters' in 1998, entitled 'User Focused Research' again
the focus was on how to involve users in the research process and
user satisfaction with existing services.

If services are to be shaped by consumer preferences we need to
gauge not only what present users of services feel about services, as
their view on services will be shaped by their experience of services,
but to ask potential users of service or 'non-users' of service, what
their service preferences might be. Moreover, as we embrace a more
'consumeristic' model of social care, we need to transcend existing
models of service provision, and try to think imaginatively and in
new ways about meeting an identified need. For example, if an older

person is identified as needing social interaction, this 'need' could be met in a traditional day centre setting, or could be met in other ways agreed in consultation with the person using the service. The monies used to purchase the traditional day centre place could be used in alternative ways which are more preferable to the user. Therefore it was these possible preferences that were to be explored in the interviews.

The interview schedule included quantitative and qualitative questions. The interview schedule included three types of questions. The first provided descriptive data on age; health; length of time in Britain; type of work and place of origin'. The gender of the interviewee was also recorded. This provided an overview of the sample, locating the interviewees in their wider social context. The second set of questions related to family support, interests, friendships and family support. Interviewees were asked if they were receiving support from any other individuals or agencies? They were asked what sort of things they liked to do? They were asked whether they were restricted in what they liked to do? Whether they had any health problems, which limited what they were able to do? Interviewees were asked who they met with on a social basis? They were asked whether they also came from the 'Caribbean'? They were asked about services they were using, or had used, and their views on such services. Interviewees were asked about the food they ate. They were asked to describe the food they had eaten that day and the day before. Interviewees were asked what would be important to them if they were no longer able to prepare meals for themselves.

This set of questions provided an insight into preferences, based on existing arrangements, eating habits and social networks. An

additional question was initially included in this set of questions asking interviewees if they were given a sum of money to purchase services, what would they buy. Interviewees found this question particularly difficult and this question was removed from the interview schedule.

The third set of questions related to service provision and service usage. The issue of preference in relation to 'culturally specific' service provision was explored in this section. Interviewees were asked about preferences in relation to 'meals at home' 'day care' and 'residential care. Interviewees were least able to answer questions related to residential care, as the prospect of entering 'residential care' was clearly painful for many interviewees to contemplate. This section was interesting in relation to possible effects of the 'race 'of the 'interviewer' on the response. Four interviewees who initially said that they didn't care either way, later indicated that they would in fact prefer 'culturally specific' provision. It appeared that as time passed, interviewees felt more confident to express such preferences, without fear of offending me. An alternative way of exploring this difficult area, on reflection may have been through the use of photographic images, with the interviewee asked to select the setting most preferable.

The format pursued was semi-structured, each interview asked the same questions in the same sequence. The purpose of the interview was explained to each informant and confidentiality and anonymity was assured in relation to their responses. At the beginning of each interview, permission was requested to tape record each interview, permission was always granted. Tape recording each interview enabled me to concentrate more on each response and sometimes probes where used to elicit more information.

This part of the research did provide some insight into the kinds of things people choose to do when they are able to make such choices, and this is clearly helpful in thinking in alternative ways about meeting 'need'. However, it was less successful in engaging people to think in alternative ways about how needs might be met. As a pilot study it does demonstrate a potential area of study that could be developed, on a larger scale, perhaps again using visual images as a way of enabling people to imagine alternative arrangements for meeting need.

Analysing the Findings - Implementing 'Community Care' in the Two Case Study Authorities

As we can see from the methodology, a variety of data sources were collected for this study. In particular an extensive literature review was undertaken which enabled me to explore existing knowledge in relation to:

- 'Community Care implementation' in general.
- 'Ethnic Diversity'/'Race', and 'Social Service' provision more generally, and 'Ethnic Diversity'/'Race' and 'Community Care' more specifically.

This facilitated me with an overview and greater understanding of the topic and policy intentions. From this I was able to identify areas neglected in research and too clarify the research question. The next stage of data collection involved a review of literature in relation to the same two topics in the 'case study' authorities. From this it was possible to explore whether Authority A and B either confirmed or rejected the findings of other research projects and to identify further questions neglected in existing research that seemed relevant to the question and to focus specifically on the research question.

The analysis of the first part of the study which explored 'Community Care implementation' in general was an important reference point for analyzing the findings from the second part of the study. This particular approach was adopted as it was felt that this would have an important bearing on any conclusions that might be drawn in relation to the research question. For example, we may have found that 'differentiated need'/'preference'/'user choice' had been key themes in implementation, whilst 'ethnic diversity', as a dimension of 'differentiated need' had been neglected. This may have led us to draw conclusions about the extent of 'institutional racism' in community care planning. However, the findings suggested that issues of 'user/preference' and 'choice' had been neglected and therefore, it was this that provided a context for making sense of the neglect or partial inclusion of issues of 'ethnic diversity' in 'community care planning.

The findings then were analysed by exploring both 'implementation' in general and 'ethnic diversity' in particular, and as we have seen a variety of sources were used including semi-structured interviews and discussions on the duty desk, and an extensive literature search. From this data it was possible to generate a new set of findings and a final literature review was undertaken to explore ways in which these findings were reflected in existing literature, and differed or reflected the policy goals of the 'NHS and Community Care Act 1990'.

Analysing the findings – The 'Mixed Economy of Care'
The third stage of the project focused specifically on the 'mixed economy of care'. This part of the study initially explored three areas of service provision in the two 'case study authorities, and then developing a more detailed analysis of 'meals' provision. A mapping

exercise was undertaken of provision pre and post 'Community Care implementation'. Sources used to undertake this mapping exercise ranged from semi-structured interviews with purchasers and providers; Social Service Committee papers; and interviews with those either directly or indirectly involved with specific areas of service provision, along-with analysis of local papers and documents, such as committee reports and care plans.

In both authorities all those involved with providing 'culturally specific' day care for older 'African-Caribbean' people were interviewed, which in conjunction with committee papers and documents provided a detailed overview of service developments and service change. The research findings were analysed along-with the findings of existing studies on day care for 'Black and Minority Ethnic' groups. These studies also helped to provide prompts for relevant questions to pursue in interviews. From this data it was possible to discern trends in relation to service provision and explanations for these trends, which again could be related to the broad policy goals of the 'NHS and Community Care Act 1990'.

The review of meals provision was more extensive. Analysis was broken down into three parts. First a review of sociological/anthropological literature on eating preferences generally and the eating preferences of 'ethnic' groups was undertaken to draw conclusions in relation to this issue. Secondly, a review was undertaken of how the 'private sector' responded to diverse eating preferences. For this part of the study, a review of private sector trade journals, and Mintel were used to identify trends in practice.

Thirdly, analysis of trends in meals provision was undertaken initially

in the two 'case study' authorities, and then in six further authorities. Data was drawn from a wide range of sources including interviews with meals providers and relevant officers within local authority social service departments; articles in newspapers and trade journals; relevant reports and committee papers and discussions with meals providers in the independent sector, alongwith observation at a seminar on developing culturally specific meals for older 'African-Caribbean' people. This provided a detailed overview of trends in meals provision, both at this point in time and overtime and this was explored in relation to the broader policy goals of the 'NHS and Community Care Act 1990'. From this it was possible to draw conclusions on policy developments and change following the introduction of the legislation. However, it was clear from interviews that trends in meals provision were also shaped by other factors, such as legislation related to food safety and contracting, and therefore this was reflected in the overall findings.

Analysing the findings - Interviews with Older People
The final stage of this study involved interviewing older 'African-Caribbean' people about issues of choice and preference. Analysis began with a literature review that explored issues of choice and preference, both generally, and more specifically in relation to 'ethnicity'. From this it was possible to design a research instrument and identify relevant questions. The first part of the interviews explored issues of preference, identifying the kind of things respondents liked to do and what kind of 'care options' they might purchase if they had budgets as opposed to service provision. Respondents were unable to think about what they might purchase, but could clearly describe what they liked to do, and therefore, this limited analysis to what people preferred to do. The second set of questions explored issues of preference in relation to 'ethnicity', and here respondents were able to indicate preferences in a range of

ways. Findings were analysed in relation to these two issues and explored in relation to existing knowledge. A final literature review was undertaken to explore ways in which these findings were reflected in existing literature, and conclusions were drawn both in relation to the question, and the continued policy intention of generating more user responsive services.

Conclusion

In this chapter we have reviewed the methodology adopted to answer the research question. The project explores the research question through a 'case study' approach and pursues the question in three different ways. The first reviews the 'community care' implementation process in the two case study authorities, specifically exploring the introduction of a 'quasi-market' in social care and the way in which 'ethnic diversity' and more specifically the needs of older 'African-Caribbean people' were either included or excluded from this process. The second focuses on the changing nature of supply in relation to services generally, and meals provision more specifically, and the third explores service preferences with a group of Older 'African-Caribbean' people. The findings of each of these areas of study are discussed in subsequent chapters.

One interesting observation from the perspective of working as a researcher, was the contrasting experience I had on the first study compared to the second. The first study explored 'Community Care' implementation in a general way. Staff at all levels of the Social Service Departments involved in the first project, were co-operative and positive about the study. By contrast, I had a much more negative experience in the second study, which focused specifically on older 'African-Caribbean' people. This negativity was projected by a small number of staff in both authorities. Comments included, "Well the 'African-Caribbean's' get everything anyway", and "what

about 'White' people." Indeed this level of hostility reveals the difficulties organizations may have in generating positive change in this area. As a lone researcher it was an isolating experience.

In the next chapter we review the implementation of the "NHS and Community Care Act 1990' in the two case study authorities.

<u>Chapter Four</u>
<u>Implementing the Legislation</u>
In chapter one, we reviewed the policy context related to the

implementation of the 'NHS and Community Care Act 1990' and the

introduction of a 'quasi-market' in social care. In this chapter we will

consider the specific responsibilities/policy direction arising from this

legislation and review how the two case study authorities responded

to this. We will explore what kind of policy goals were prioritized,

and what were neglected. We will begin by considering some

theoretical perspectives on 'policy implementation'

<u>Implementing 'Policy' – Some Theoretical Perspectives</u>
Before moving on to look specifically at how our two case study

authorities responded to these new tasks, it is helpful to visit some

of the theoretical debates surrounding 'policy implementation'.

(Minogue, M, 1993) argues that analysis of 'policy implementation'

tends to be shaped by two competing and irreconcilable traditions,

'managerialism' and 'political science'. He argues from a managerial

perspective:

> "Management science ...is distinguished principally by the claim
> to offer a superior application of rationality both in making
> decisions(policy) and in implementing decisions
> (administration); it would also lay claim to more rigorous
> methods of investigation, and more effective means of
> operation. In short, management science holds us to the
> promise of better policies which are better
> administered."(Minogue, M, 1993, p13)

This is the dominant model which, guides practice in government

policy-making. From this perspective the state develops a 'policy'

specified in a legal document such as the 'NHS and Community Care

Act 1990', local authorities are then given guidance on specific

aspects of implementation, backed up by a series of circulars laying

out in a more detailed sense what is expected of them. Directives

move from central to local government who are given the task of implementation, the outcome – successful implementation. However, from this perspective successful implementation is dependent on the design of the 'implementation' instruments, which must be logical and systematic to achieve the 'end' goal. Therefore, the failure to implement policy is accounted for in terms of poor management systems, guidance etc, with the solution resting in improved managerial tools.

It is of course necessary to distinguish between 'policy implementation' and 'policy outcomes'. According to (Loasby, B, 1976, p18):

> "It is dangerous to assume either that what has been decided will be achieved, or what happens is what was intended."

However, the crucial point is how we make sense of the failure to achieve a particular outcome. From a 'managerial' perspective it may be explained in terms of faulty tools, whilst from a 'political science' perspective a greater emphasis will be placed on interested groups and the general context in which policy implementation is taking place. According to (Minogue, M, 1993, p10):

> "The policy analyst who seeks to provide description of and prescription for specific decisions on particular policies, cannot ignore the overall policy process which is created by the interaction of decisions, policy networks, organizations , actors and events."

For Minogue, politics needs to be interpreted in its broadest sense, to include relations between groups and individuals competing to control and influence resources, policies and practices.

(Lukes, S,1993) explores the concept of power, and suggests that it is necessary to explore power three dimensionally. Firstly, he argues that early 'pluralist' analysis explored power as a one way process, in

which interested groups and individuals lobbied around particular issues. This approach was criticized widely, partly, because of its view of the state as a neutral institution, and partly because it ignored ways in which a 'pluralist' system may favour or be biased against certain groups.

A two dimensional analysis to power emerged which began to consider the operation of 'pluralism' within a structurally unequal society.   A well known study undertaken by (Bachrach, P, Baratz, M, 1970) explored 'poverty', 'race', and 'politics' in Baltimore and demonstrated ways in which demands were deflected, by a range of strategies to defuse the issue, such as making certain appointments, introducing welfare measures etc. However, (Lukes, S, 1993) finds their analysis unsatisfactory as it focuses on individual decisions/strategies that defuse the situation, but does not explain how the issue of 'race' was kept off of the policy agenda by both the inactivity of politicians and institutions for so long.

Lukes suggests we need to explore the exercise of power, as not simply the result of action, but also the result of non-action, and the way in which this non-action, may lead others to non-action. Therefore, 'silence' on a particular issue, has to be interpreted as an action rather than a non-action, and is an 'exercise of power'. He argues that:

> "In this way local political institutions and political leaders may exercise considerable control over what people choose to care about and how forcefully they articulate their cares', restrictions on the scope of decision-making may 'stunt' the political consciousness of the local public by confining 'minority' opinions to 'minorities'."(Lukes, S, 1993, p51)

(Pawson, R, Tilley, N, 1997) argue that in order to evaluate policy outcomes, one has to explore the complex relationship between

both the context and the mechanisms for implementation. There is some attempt then to merge the 'political' framework with the 'managerial' framework for making sense of policy implementation. This study has adopted an approach that has located policy change in its wider political context, which should be apparent in previous chapters. Another literature that is helpful in considering 'policy implementation' is that related to 'decision making'.

According to (Smith, G, May, D, 1980, p163):

> "The notion of decision making is indisputably central to studying the process through which policies are both designed and effected."

They argue that two models of decision-making have dominated this, particular, debate. The 'rational' and 'incremental' model. According to (Etzioni, A, 1967, p879):

> "Rationalistic models are widely held conceptions about how decisions are made and ought to be made. An actor becomes aware of a problem, posits a goal, carefully weighs alternative means, and chooses among them according to his estimate of their respective merit, with reference to the state of affairs, he prefers."

There has been a range of criticisms made of this particular model. Some of which mirror those made of the 'managerial' model. In particular, this model is criticised for ignoring 'politics' and the ways in which different constraints such as knowledge and resources impact on the type of options available. Moreover there is a perceived clarity about intended outcomes that may in reality be ambiguous.

(Lindblom, C, E, 1977) directs criticism at the assumption that ends and means; values and decisions; facts and values are all separated. He argues that essentially means and ends are often chosen

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simultaneously and this is apparent when studying several stages of the policy implementation process. He argues that what exists is a 'disjointed incrementalism' or 'muddling through' model, which is based on the idea that only a restricted number of policy alternatives are reviewed, and a limited number of consequences envisaged. Policies are essentially modified and adjusted at the margins of the existing framework.

Essentially the model is criticised for being narrow and limited in approach, but is perhaps helpful as a descriptive account of how policy is implemented, which we will return to when considering the Case Study Authorities. Indeed (Smith, G, May, D, 1990) argue that essentially the debate is a false one, as the models are both explanatory and normative - They are expected to serve two functions. i.e. how decisions are made, and how decisions should be made. They argue that the 'rational' model and the 'incremental' model are about two different things. The 'rational' model lays out how things should be, and the 'incremental' model focuses on how things are.

The 'rational' versus 'incrementalist' debate relates to the process of decision-making. However, there is a third perspective, which is of relevance for this particular study and this relates to the process of 'implementation' or 'implementation theory'. According to (Hill, M, 1997) this debate has been preoccupied by whether the implementation of policy can best be understood by adopting a 'top down' or 'bottom up' model for analysis.

'Top Down' Implementation Perspectives
(Sabatier, P, A, 1993) argues that there has been considerable research, which has sought to explain variation in implementation success, across policy areas from a 'top down' perspective. They

start with a mandate and follow the extent to which its objectives were achieved. Variations of this approach have shaped a range of policy studies. Essentially it has some similarities with the 'managerial' school of thought as it assumes that if a list of instructions, are clearly set out, then successful implementation should follow. The mechanisms viewed necessary for successful implementation will vary between policy contexts, but might include clear objectives, perhaps set out in a legal mandate. A theoretical framework which allows the intentions of the policy to be understood by implementing officials; the need to maintain political support throughout the implementation process; the need to develop mechanisms which constrain the behaviour of those implementing policy, such as in the case of 'street level bureaucrats' (see below) through the use of sanctions and incentives and the importance of hierarchical integration of implementing agencies.

According to (Hill, M, 1997), (Marsh, D, Rhodes, R, A, W, 1992) adopt a 'top down' approach in an analysis of 'Thatcherism' and policy change. They trace how far policy intentions have become policy realities. Where policies have not been implemented, it is explained in terms of 'unintended consequences'; 'inappropriate tools'; 'wrong models' and conclude that the 'Thatcherite' revolution was more one of rhetoric than policy impact. (Hill, M, 1997) is critical of this approach. He argues that the impact of 'Thatcherism' on policy has been far more than simply rhetoric in terms of transforming central -local relations; management and control of education etc:

> "These changes are a product of interaction between top-down inputs and reactions from below, as Marsh and Rhodes show, but it is not helpful to suggest through the use of concepts like 'implementation gap',.that what has happened should be seen as either a consequence of unanticipated reactions or incomplete policy analysis..determined ideologies have driven

us into uncharted territory. Once in that territory they have naturally improvised and compromised."(Hill, M, 1997, p377 – 378)

In other words, the problems did not lie in the mechanisms of implementation but in the dynamic relationship between policy and implementation – the relationship between the 'bottom' and the 'top'.

'Bottom Up' Approaches to Implementation

One of the most notable advocates of this particular approach was (Lipsky, M, 1993), in his seminal work on 'street level bureaucracy': According to (Lipsky, M, 1993, p389):

> "I argue that the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out.. I argue that public policy is not best understood as made in legislatures or top floor suites of high ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street level workers."

Lipsky cites the case of Social workers employed and with an aspiration to give an individual service; carry out assessments of individual needs; assist and support clients. However, the reality of life as a social worker is that it is characterised by large caseloads; inadequate resources, and despite being trained to respond to individual needs, they have to develop strategies which enable them to process their caseload on masse, developing a conveyor belt type approach. According to Lipsky some 'street level bureaucrats' will drop out or burn out relatively early in their careers. Those who stay on, often grow in the jobs adjusting their work habits and attitudes to reflect lower expectations for themselves; their clients; and the potential of public policy.

(Lipsky, M, 1993) identifies three types of response; 'modification of client demand'. This is achieved through the power relationships that exist. Clients are assessed in the individual workers setting; information is withheld; clients are isolated from one another. 'Modification of Job conception' -Workers themselves modify their own job conception which enables them to match better their ability to perform. Strategies might include psychological withdrawal, resulting in a workforce unconcerned that there is a gap between what they are supposed to do and what they actually do. Mediocrity is encouraged and innovation discouraged.

'Modification of client conception' - In a context of limited resources 'Street level bureaucrats' devise rationing mechanisms to cope with demand. Conceptual frameworks are developed to rationalise differential treatment on the basis of 'deserving'/'undeserving' or 'cream skimming' those clients who are perceived as most able to benefit from resources and such strategies may reinforce and reflect 'class' and 'ethnic' divisions.

According to (Hudson, B, 1993, p394):

> "The essence of Lipsky's case is that street level bureaucrats
> have enormous power which is scarcely acknowledged in the
> literature on public administration; that this power extends not
> only to control over service consumers but also to a
> considerable autonomy from their employing agency...the
> crucial source of power is discretion..Unlike lower level workers
> in most organisations, street level bureaucrats have a
> considerable amount of discretion in determining the nature,
> amount and quality of benefits and sanctions provided by their
> agencies."

The employment of 'street level bureaucrats' is necessary in a situation where demand for resources far exceeds supply. Therefore in recognizing the need for 'street level bureaucrats' to ration such

resources, one also has to assume a degree of power/discretion to such workers. On the one hand they are powerful 'policy implementers', and on the other hand then they are shaped/limited by the very structure in which they operate.

(Hudson, B, 1993) suggests that one way too override the power of the 'street level bureaucrats' and give accountability to the client/consumer, would be through the use of voucher schemes; advocacy; self advocacy; and democratic forms of participation. Like Lipsky, Hudson argues that one must not simply draw the conclusion that 'street level bureaucrats' are cunning and malicious but that they are constrained by the nature of their work. Lipsky's findings are of course directly relevant to 'front line' staff/assessors in this study. However, more generally it raises the crucial question of discretion, which, can operate in a range of contexts, and shape what is prioritised and what is not prioritised.

(Sabatier, P, A, 1993, p275) acknowledge Lipsky's findings but:

> "did not accept the pessimistic conclusions concerning the inevitability of 'adaptive' implementation in which policy makers are forced largely to acquiesce to the preferences of street level bureaucrats and target groups. Instead, they sought to identify a number of legal and political mechanisms for affecting the preferences and/or constraining the behaviour of street level bureaucrats and target groups, both in the initial policy decision and then subsequently over time."

(Hjern, B, Hull, C, 1982) developed a research methodology for 'implementation studies' reinforcing a 'bottom up' approach. They operationalised this method by talking to people on the front line about their goals, strategies, activities and contacts. They then used these contacts as a vehicle for developing a network technique that identified local, regional and national actors involved in policy implementation. They argued that programme/policy success was

more dependent on the skills of specific individuals involved in implementation, at a local level, than the efforts of central government officials. Their framework does not limit itself to one specific policy initiative, but explores the interaction between different policies and policy agendas.

(Hill, M, 1997) suggests that actually different policy contexts will have an impact on how policy is implemented with implications for analysis. He cites the implementation of the poll tax as a clear policy failure, despite very clear enforcement strategies. By contrast, he cites the work of (Glennerster, H, Matsaganis, M, Owens, P, 1994) who studied the implementation of GP fundholding and suggested that there was a far more complex and dynamic relationship which evolved through interaction/collaboration between the fundholders, the department of Health, and the health authorities themselves, with far less prescription. They describe this as:

> "Lewis and Clark Planning ...The American explorers, Lewis and Clark were merely told to find a route to the Pacific. They did so by finding the watershed, following the rivers to the sea using their wits as they went..in this instance there was telephonic contact between the field explorers and the equivalent of Washington and regular flights back to discuss progress with other explorers."(Glennerster, H, Matsaganis, M, Owens, P, 1994, p30)

(Bowe,R, Ball, S, J, Gold, A, 1992) carried out a research study on the implementation of Educational reform where they conclude that policy is not simply received and implemented, rather it is subject to interpretation and then modification. (Hennessey, P, 1996) suggests that the British system of policy implementation is characterised by a 'peculiar mix of extreme centralisation and remarkable ambiguity about the hidden wiring.'(cited in Hill, M, 1997, p147)

It is clear then that there is not one set of ideas that can be drawn

on when studying the policy implementation process, but a range of competing theoretical frameworks that can be used to make sense of how a particular piece of legislation is implemented, why some aspects of the legislation are prioritised over others, and why some pieces of policy are more 'successfully' implemented than others. In this study we will adopt a framework for understanding 'policy implementation' which is neither 'top down', or 'bottom up', but instead explores the dynamic interaction between two and locate our understanding of 'policy implementation' within its wider political context. This context is not simply about 'left' or 'right' preferences, but about 'unwritten rules' which shape/affect policy implementation. It is about networks, groups or key players who may push a particular agenda or issue, or may seek to ensure that a particular issue does not get onto the agenda. Having reviewed some theoretical perspectives that may be helpful in exploring 'policy implementation', let us now review the mechanisms and guidance that were established to shape 'community care implementation'.

Implementing the 'NHS and Community Care Act 1990' – Legislation and Policy Guidance

Let us consider the objectives set out in the 1989 White paper 'Caring for People' and the subsequent 'NHS and Community Care Act 1990'. The six primary objectives were:

- To promote the development of domiciliary, day and respite care to enable people to live in their own homes.
- To make proper assessment of need and good case management, the cornerstone of high quality care.
- To promote a flourishing independent sector.
- To secure better value for taxpayers money.
- To clarify the responsibilities of different agencies i.e. National Health Service and Local Authorities.
- To provide support for carers'.

The strategy pursued by the government to ensure that local authorities responded to their new responsibilities, was by issuing policy guidance, and circulars, setting out timescales for which specific tasks related to implementation needed to be in place. Circular EL 92(13) 1992 for example was a joint circular from Andrew Foster and Herbert Laming, setting out key tasks that had to be in place by April 1993, in order for local authorities to receive transferred monies from social security(Foster, A, Laming, H, 1992). Therefore financial penalties were used to ensure compliance.

Guidance on 'community care implementation' began to filter through from 1990 onwards. However, implementation of the Act was subject to considerable delays. For example one of the central mechanisms for enabling local authorities to carry out their responsibilities was to be through the transfer of a special Transitional Grant, which was initially to have been transferred in April 1991, and was then rescheduled for April 1993.(Lewis, J, Glennerster, H, 1996)

The government clearly put considerable resources into the development of 'community care' guidance, According to (Lewis, J, Glennerster, H, 1996, p10)

> "There was more guidance given to local authorities in interpreting the purposes of this legislation than for any other recent statute. It took the form not just of departmental circulars but glossy manuals written by management consultants and guidance for practitioners written by the Social Work Inspectorate."

A community Care support Force was established comprising a range of interested parties. The Social Services Inspectorate was given a central role in monitoring and advising local authority Social Service

Departments. There was a mixture of general guidance to aid 'implementation' and some circulars which provided less choice in terms of interpretation. For example, Circular LASSL (92)12 related to the Standard Transitional Grant(monies transferred from the DSS) and made clear that Social Service Departments had to spend 85% of this money in the 'independent' sector(LASSL(92) 12, 1992). This strategy had a dual purpose. On the one hand it ensured that all local authorities however, ambivalent to purchasing services in the 'independent' sector would have to do so. On the other, the government was under pressure from Private residential and Nursing homes to ensure that the transfer of monies, would not result in the collapse of this sector. Therefore one could argue that given the undeveloped nature of the 'independent' domiciliary sector at this time, such a strategy might result in an emphasis on using residential care, as opposed to home based services to meet the 85% target, which was clearly at odds with the new policy direction.(Lewis, J, Glennerster, H, 1996)

The 'choice' directive was also significant in shaping the arrangements made for the purchase of 'residential care'. This directive made clear that residents must be given 'choice' within financial limits about the residential care home in which they were placed. Essentially, this policy simply reinforced consistency with the previous system of care funded through the DSS budget. However, it had an impact on 'implementation', as it resulted in the development of 'spot' rather than 'block' contracting for residential care, which was more in line with a 'consumer' oriented model.(Department of Health, 1992)

Therefore Social Service Departments were effectively being bombarded with guidance on the development of new systems for

assessment - at a micro level (care management) and at a macro level (commissioning/purchaser provider splits, production of community care plans) all of which were essentially encouraging shifts in policy and practice towards a more 'consumer led' system. However, in reality much of this guidance was vague, and non-specific. The guidance was, however, more specific on the need to ensure that the level of resources was to be more important in the determination of 'need', than 'need' itself. (Lewis, J, Glennerster, H, 1996) remind us that the explicit context to this new policy direction was to halt the burgeoning social care budget, and if possible reduce it, and therefore this focus on resources is in reality unsurprising.

'Community Care' Implementation in the Two 'Case Study' Authorities

Let us move on then to consider specifically 'community care implementation' in the two case study authorities. We will begin by reviewing the political context in the two case study authorities.

Authority A - Implementing the 'Community Care' Legislation

At the time of writing up this research, Authority A was a Labour controlled Authority. However, as an authority it has swung from 'right' to 'left' and back again on a regular basis during the 1980's and 1990's. From the 1980's onwards, political control has switched backwards and forwards from Labour to Conservative with the Liberal Democrats holding the balance of power. According to(Cross, M, Brah, H, Mcleod, M, 1991) political control rested either with a small number of Liberal Democratic Councillors, or the shifting loyalties of defecting councilors, during the 1980's.

When commencing the fieldwork, the Authority had 28 labour councillors, 33 Conservative councillors and 5 Liberal Democratic Councillors. The council was ruled by a Liberal/Labour pact with

Labour having the Mayor's casting vote, therefore the situation was volatile and subject to change. The political divide in the borough was not a reflection of a battle over ideas with the electorate choosing between these two parties, but a 'social class' divide. As stated in Chapter three the north of the borough is predominantly middle class with a dominance of Conservative councilors. The South of the borough is characterised by urban decline, high rates of unemployment and poor housing with a dominance of Labour councillors. (Times Educational Supplement, 1987)

Before moving on to focus specifically on the 1990's and the moment of 'community care implementation', it is helpful to gain some understanding of the way in which the Social Services Department had been run in the 1980's. The Social Services Department appeared to be pervaded with a sense of crisis, throughout the 1980's and 1990's, and was the subject of negative media coverage throughout the 1980's, related both to its stance on 'race equality' and its management of child protection issues. One particular child care inquiry resulted in lots of adverse publicity, and the then Social Services director was sacked by the Labour group, rather than the council, indicating the extent of member involvement in the running of the council. According to an article in Social Work Today:

> "The Social Services Committee wanted her to deliver reports
> in their own image..if if the report did not go the way they
> wanted they saw it as political naiveity..For instance she was
> asked to produce a report in three months showing that the
> large number of 'Black' children in care was due to the attitude
> of 'White' social work staff. She refused to do this in the way
> the members wanted"(Social Work Today, 1988, p7)

A high profile director was appointed as her replacement who had no management experience, but had previously worked as a social worker. He also raised a number of concerns about the management

of the department and commissioned a report that recommended the introduction of a revised organizational structure underpinned by a stronger management system. (Cross, M, Brah, H, Mcleod, M, 1991) By the end of the 1980's a further crisis was to affect the department when it emerged they had a £1 million overspend. The Director and members disagreed over the best way forward, and the director was sacked, apparently learning of his dismissal from a national newspaper.((Social Work Today, 1988, p7)

Essentially then there was a clear lack of stability in the Social Services Department, which seemed to be on the verge of crisis during the 1980's. Moreover there was a high turnover of senior management and a highly interventionist political group who did not foster good worker/politician relationships. By 1990 and at a time when planning for 'community care implementation' was getting underway, the Authority had a new director; a poor media image (with a perceived overemphasis on 'race'); a budgetary crisis and a new political group taking control with a clear view of what needed to be changed.

Analysis of central government policy tends to take 1979 as a point in which there was a substantial reorientation of policy. A similar analogy can be drawn with authority A and the shift in control of the authority to the Conservatives in 1990. The authority underwent a massive transformation programme with the intention of becoming a Conservative flagship Authority. Client/contractor splits were introduced throughout the authority reflecting the support for 'quasi-market' type mechanisms and the authority adopted a vociferously 'anti-anti-racist' stance, which we will explore in more detail in chapter five.

The Local Authority established a substantial reorganisation programme, which resulted in massive job losses/relocations throughout the authority. The Social Services Department was also subject to a major overhaul:

> "In 1986 the Council had no system of accountability, no structure of financial control. No systematic review or forward planning, they were a poor monopoly provider."(Authority A,1996a, p1)

In 1990 the Authority began a process of introducing 'client/contractor' splits throughout the authority, and decentralising budgets with cash limits in place. Commissioning Teams were established across the authority in housing, libraries, environmental health, as well as within the Social Services Department. Within the Social Services Department they adopted a client group commissioning model. The Authority developed a mission statement:

> "Quite simply the best local authority in the country. A local Authority in which the community we represent and serve and the staff we employ have pride."(Authority A, 1994c, p1)

However, despite this upbeat statement, further on in this report, it became clear that many of the staff were very unhappy with this new programme of change. Staff morale was low - partly as a result of the extent of redundancies, and partly because 'equal opportunities' now had a relatively low priority within the authority. Despite the emphasis on decentralised management structures, change was being centrally driven and there was a need for greater ownership of change by staff. (Authority A, 1994c)

The impetus for the introduction of the client/contractor split within the Social Services department, was pushed by other parts of the local authority, responding to more general concerns about controlling resources and developing an internal market, and less

influenced by the requirements of the 'NHS and Community Care Act' policy agenda. The department had moved from a 'generic' to a 'specialist' model of service provision in the 1980's and this was embodied in the client/contractor split. Specialist Commissioning Units were established within Children and Families; Adults; and Elders, along with specialist provider/contractor units. The Commissioning Units were encouraged to make use of the private sector, though this focus on the private sector appears to have been restricted to the use of residential care homes and domiciliary care.

Despite a sense then that this department moved early on to implement a purchaser/provider split, (in name) the development of a commissioning function proved problematic with internal purchaser/provider relations appearing to be particularly fraught. For example, in 1995 Auditors were called in to investigate an overspend in the elders Commissioning Unit:

> "The commissioning unit was trying to ask its business units to pay back approximately £200,000 from the amounts paid to them in 1995/6, so that the commissioning unit overspending could be reduced, and shifted over to the business units...the commissioning unit has entered into schemes with private sector agencies to provide services which has meant that the resources in the internal units have been made idle at a continuing cost to the council, while services such as home care were transferred to outside agencies."(Authority A, 1996c, p81)

This statement indicates the politically driven nature of commissioning, which had negative consequences on in-house provision, and appeared to be driven by an agenda intent on undermining 'in house' provision, and developing private sector provision, without any wider policy intentions. Moreover, despite the shift to devolve budgets to the elders Commissioning Unit. There is little evidence that this purchasing power led to the development of a more innovative profile of services. For example when the Head of

Elders commissioning was asked to comment on whether the new system had created a more 'needs led' approach, he commented:

"That's fine if you have the resources, we were in a situation of year on year cuts."

Therefore the task of commissioning was interpreted in a narrow way and rationalised in terms of limited resources. The 'contracts' unit functioned in an 'administrative' rather than 'strategic' way, organizing contracts for residential care, domiciliary care, etc and from 1993 was also responsible for administering grants. In 1993 they began a process of rationalization, where voluntary organisations had to demonstrate their relevance to social services, and some were moved from 'grant aid' funding to 'service level' agreements.(Authority A, 1993b) Moreover, decisions related to the purchase of services, appears to have been part of a political game of football. For example, when the Conservatives were in control of the council they told officers to use more private domiciliary care, and when they were under Labour control, they were told to move back to using 'in house' services.

Another characteristic of this department related to the extent of change. The department has undergone a number of reorganizations, often on an annual basis, driven by the need to make financial savings. This has created a lack of dynamism in this authority. It has meant that people with relevant skills have not necessarily been placed in key purchaser/provider posts. For example, when the Commissioning function was developed, an existing person was redeployed to this post. He had worked in the department for several years, and had worn a number of different 'hats', including Head of the Disability Unit in the 1980's. Despite being in the authority for a number of years, he appeared to have

little knowledge of the thinking around either 'community care' implementation; contemporary debates about services for older people, or ways in which the concept of 'choice' might be operationalised in purchasing decisions. When he was asked about the rationale for the introduction of a purchaser/provider split , He commented:

> "I am just trying to think back now, because we tend to reorganise every year, virtually, its a bit blurred, At one point, there was a commissioning Unit, there was assessment and care management."

This appears to be an authority that has consistently restructured to address particular problems, shifting employees from one position to another, who do not get the chance to get to grips with their new tasks/briefs. This particular problem manifested itself in a number of interviews, in relation to continual change, combined with the loss of posts, revealing low morale amongst those staff remaining. Given the amount of change required to make a reality of the purchaser/provider split the appointment of new personnel to occupy relevant posts might have made a significant difference. The approach adopted in this authority simply seemed to reshuffle positions to meet the requirements of the new system. This resulted in the creation of a job title linked to the revised system, with little evidence of more fundamental change. The concept of 'muddling through' was a helpful interpretation of 'policy implementation' in this authority.

There was no sense within this authority, that the 'community care' legislation had generated a new discourse or reality about creating user-orientated services, there does not appear to have been much emphasis given to freeing up monies to change the profile of services. According to the Head of the Elders Commissioning Unit:

"I dont think it has been a priority in terms of the commissioning staff, because most of our STG money was used in the private/voluntary sector, most of our time was applied to ensure contract maintenance, rather than additional stimulation of market, However, the dynamic culture of this borough(I dont mean 'ethnic' culture) is such that the authority is bombarded with plenty of requests for diversification of service provision without us going out to stimulate it, even if we had resources to stimulate it."

Indeed as we will see in the next chapter, this authority paid more attention to issues of 'race equality'/'ethnic diversity' in the 1980's. During this period, 'equality' based strategies generated a buoyant voluntary sector responding to diverse needs. However, following tation of the 'community care' legislation, there appears to have been little if any priority given to diversity and choice in the development of 'care' services. Moreover, the authority did not developed a system of monitoring unmet need from individual assessments which would be crucial in identifying gaps, and still relies on feedback from 'joint planning' type user groups to identify 'unmet need'.

In the study of community care implementation undertaken by (Lewis, J, Glennerster, H, 1996) it appeared that in many instances there was a difference in the perception of what front line staff and senior management felt about community care implementation. Senior managers were often far more positive about the benefits and possibilities of 'implementation', whilst front line staff appeared far more pessimistic feeling constrained by resources, and a sense of declining service for users. Within Authority A, there was low morale and a sense that things were getting worse, at all levels within this Authority.

The concept of greater choice and diversity was not on the agenda.

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The Manager of the Elders Care Coordination Unit,(responsible for care management) was able to talk positively about the choices available when selecting residential care, which interestingly was the only area related to choice, legislated by Central Government(see above). On the other hand, she was more pessimistic about the policy changes, again highlighting the issue of lack of resources and the tightening of eligibility criteria. In this authority, caution about the need to control budgets, had meant that 'care managers', were not financially empowered to purchase more relevant services, and again the role of 'care management' appeared to be more about renaming 'social workers' than facilitating a more 'user orientated' approach.

There were a number of themes that appeared to run through 'community care implementation' in this authority, in the first instance there was a strong discourse about limited resources being a huge obstacle in terms of bringing about change, and the problems of operating in a context of continuous cuts. There was a sense in which things were only 'getting worse' and certainly 'not better'. The lack of resources manifested itself at every level so that there was a lack of personnel working in strategy/personnel to think through changes, According to a senior manager:

> "We are now down to twenty people at the core(including admin) managing a £66 million budget covering everything the government is throwing at us at the moment, budget containment; joint planning with health; and monitoring the key contracts externally, without a separate contracts unit, I think if you compare us with any other authority in London its is probably around 30% smaller."

Therefore, it appeared that 'community care' had been implemented, and they had now moved on to other areas of policy. According to this manager, the major changes to have arisen as a result of the implementation of the purchaser/provider split relate to:

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> "Historically going back to the late 1980's it was basically all in house services, what has happened since then is that in house services have been deleted, the budget hasn't been transferred it has been cut, and the budget from the central government is used as fluid purchasing budgets without being fixed in any specific service context."

There was no sense however, that these fluid purchasing budgets had been used to purchase services that responded more effectively to 'need'. The development and tightening of eligibility criteria has been a central preoccupation within this authority following implementation. According to one senior manager, eligibility criteria for residential care, has been tightened to such a degree that in the future they predicted only purchasing nursing home care.

It is helpful at this point to reflect on what we can say about how this authority responded to 'community care' implementation. They appear to have responded to 'implementation' in a mechanistic way, producing 'community care plans' as they were instructed to do; implementing the 'choice' directive as they were instructed to; spending the transitional grant in the 'independent' sector and making greater use of the independent sector, as they were instructed to do. On the other hand, the 'quasi-market' has been implemented in a very limited way and this minimized its potential benefits. The overriding feature of implementation in this authority related to a sense of crisis.

Authority B – Implementing the 'Community Care' Legislation
Authority B is an authority that has been consistently Labour controlled, with a large majority. For example, in September 1996, Labour had 64 seats, the Liberal Democrats had two seats, and the Conservatives had one seat. This authority has been described as a flagship 'Labour' authority. The Authority whilst committed to 'in-house' provision has introduced a purchaser/provider split in its

Social Services Department and was keen to work in partnerships with the private sector. For example, when the fieldwork for this project was being undertaken, the department was planning to purchase significant proportions of home care from the private sector, and was developing a Private Finance Initiative to provide 'meals'. In general this is an authority that has embraced the 'mixed economy' slowly and is not opposed to greater involvement of both the private and voluntary sector in service provision.

Despite the authority being described as a 'flagship Labour' authority, as in Authority A, there appear to have been lots of organisational/management weaknesses within this authority, particularly at the 'moment' of implementation. The managerial problems have not manifested themselves as in Authority A with huge amounts of publicity, rather there appears to have been a huge weakness in terms of strategic capacity/thinking within this authority, which was a vital missing link at the time of 'implementation'.

From a research perspective, it was difficult to trace thinking on the development of either assessment/care management or purchasing/commissioning as there was a minimal number of people working in strategic planning roles, and there had been a high turnover of staff within the senior management team, since the initial moment of 'community care' implementation. Therefore, an understanding of 'implementation' was shaped to a lesser extent by interviews, and to a greater extent by literature such as Community Care Plans; Social Service committee reports; and research reports commissioned by the department.

In the study of 'community care implementation' undertaken by

(Lewis, J, Glennerster, H, 1996) it was clear that as 'community care implementation' got under way the 'community care plan' became a vital source of information for understanding the thinking of different departments in relation to 'community care'. A review of early community care plans gave little insight into the thinking of this department, in relation to 'community care' implementation, indeed this was the case in both Authority A and Authority B. The 'Community Care Plan 1992/3', directly preceding implementation in Authority B did provide a minimal amount of detail in relation to 'community care implementation'. For example, a minor reference was made to the development of 'case management', stating that the borough was currently making arrangements for 'case management'. (Authority B, 1992, p8) It could be argued that the department simply responded to the requirement to produce a 'community care' plan, by producing a range of 'community care' related information, which was more like a directory to services than a statement of purchasing intent or strategic direction.

The department did introduce a nominal 'purchaser/provider' split following implementation, but there was little evidence that this was operationalised beyond the structure diagrams. A number of those interviewed suggested that the early approach to implementation represented a dominance of 'old Labour', which slowly gave way to a more pragmatic 'new Labour' approach.

In 1994 a new director was appointed within the Social Services Department, and in August 1995, the department appointed consultants to review the future strategy of the department; its organisational structure; and the balance of service provision. Increasing financial pressures were an underlying rationale for this study.

The appointment of external consultants was an indication that there was not the strategic capacity within this department to address these issues. Indeed the consultants identified weaknesses within the department, at a strategic and organisational level, and in relation to service delivery. Essentially it was argued that at a strategic level there was a lack of direction in terms of the development of the commissioning/ purchasing function. They argued that the Purchaser/provider split was defined, but not reflected in working arrangements, resulting in a situation where providers continued to drive service delivery. There was a lack of senior management who were thinly spread across the department. Therefore, again it appeared that the department responded to the requirement to develop a split, in a nominal way, meeting the criteria, by developing something called a 'purchaser/provider' split, without achieving any more meaningful change (KPMG, 1995)/

A number of criticisms were made of service provision. It was argued that service provision was spread thinly and not concentrated on the most dependent clients and 'in house' residential care services were not cost effective. They also recommended an overhaul of domiciliary and day care provision, with greater use of the 'independent sector'. The consultants identified a range of positive features at the level of service delivery related to innovation; well trained staff; service knowledge and expertise and quality accreditation in a number of service areas.

Indeed 'post implementation' one of the areas the department did prioritise early on, was the development of 'quality standards' as a way of improving services. Interestingly this was a strategy pursued by another Labour controlled authority in the study undertaken by

(Lewis, J, Glennerster, H, 1996) as a mechanism for raising quality as an alternative to the 'quasi-market'. Essentially then the authority was quite successful in the previous model of service delivery with evidence of good quality and innovative services. However, they had not satisfactorily shifted to the 'new' model. This strategy then directed by external consultants would facilitate this shift. Indeed the appointment of consultants was significant, in that it symbolised the lack of strategic capacity within the department, and also meant that the future direction of the department would be determined by external consultants(KPMG) who were supportive of the then government's policy.

The final report from the consultants argued that the authority should become a strategic provider of services, retaining enough direct service provision to be able to influence the local market and to protect against any danger of monopoly provision. They identified a key role in terms of developing/stimulating local markets, which would then promote quality and value for money. The consultants argued that different strategies would be needed to meet the needs of different client groups.(KPMG, 1995)

In relation to service provision for older people, they argued for increased use of the 'independent sector'; 'increased targeting' of provision and increased flexibility. They argued that 'day care' was "inflexible" and not focused on the most dependent or orientated towards rehabilitation, implying that there was a need to shift away from a 'universal' preventive model of 'day care' to a more 'targeted' 'risk' led model. The consultants argued that the introduction of a purchaser/provider split had simply reinforced the status quo through the use of block contracts with 'in-house' provision. It was recommended that the department:

"Rationalise level of internal provision; make greater use of the independent sector of residential and home care; review day care provision; concentrate home care provision on personal care and externalise or market test non-core activities such as cleaning and shopping Services."(KPMG, 1995, p59)

The report referred specifically to the concept of 'need'. However, 'need' was interpreted, not in the sense of achieving a more 'user-orientated' service, but from a 'limited resources' perspective. It was asserted that given the huge financial constraints on the department, and the need to undertake statutory responsibilities arising from the NHS and Community Care Act 1990, the department had to ensure it was in a position to meet the complex needs of those assessed financially and physically through the availability of complex care services. From a policy perspective this meant the introduction of eligibility criteria, and greater use of the independent sector, facilitated by the introduction of purchaser/provider splits. Despite the department's stated concern with 'Black and Minority Ethnic' groups, the report made no specific recommendations on this issue, which was clearly not part of the brief.

The department responded positively to the report implementing a number of key recommendations, in particular the department strengthened its strategic capacity and attempted to make a reality of the purchaser/provider split. The department begun to use the market as a mechanism for bringing about change within the Department's own services, and to shift the balance of service provision with increasing use of the independent sector. The issue of targeting was addressed by the introduction of tighter eligibility criteria.

Following on from this report, the department undertook a review of review of services for older people, in conjunction with the Service

Planning Group for older People (a group functioning as part of the joint planning machinery) in 1996. This was to be a strategic planning document for the period 1996- 2001. The recommendations of this group reflected some of the KPMG recommendations, for example, they supported the greater use of the independent sector (including the voluntary sector), as a vehicle for enhancing service standards through the use of accreditation and approved lists. This report did address the issue of 'race equality', arguing that mainstream services should offer high quality services to all 'Black and Minority Ethnic' groups, along-with the development of specialist provision, and that purchasing and contracting mechanisms should be used to ensure good quality care for all. They also identified a role for the purchasing arm of the social services department to stimulate independent sector provision for those no longer eligible for social services, the document identified a crucial role for the 'voluntary' and 'private sector' of filling in these gaps.(Centre for Policy on Ageing, 1996)

At the time of undertaking this research (January - June 1998) plans for change were slowly trickling onto the policy agenda, but not without resistance. For example, plans to close one in-house home which needed considerable expenditure was met with lots of local opposition. The closure was deemed to be a cut in the existing level of service rather than a way of freeing up finance to make service improvements elsewhere.

The department had adopted a new structure (to better facilitate the 'purchaser/provider' split), and plans were underway to increase the private share of the market in Home Care. In 1997, 79% of home care was purchased in house, with a further 19% from the Private Sector and 3% from the Voluntary Sector. The department intended

to shift this profile by the year 2000 to 66% in house; 23% private and 10% Voluntary Sector.(Authority B, 1997d) This profile would mean that the authority was in line with national trends (see below).

The consultants also stressed the need to develop eligibility criteria. The department did introduce increasingly restrictive 'eligibility criteria. In 1996 the department agreed to prioritise support to those with 'medium' to 'high' levels of need, with support for those with low levels of need, given only where it could be shown that without such support they would deteriorate. In November 1996 members agreed to tighten eligibility criteria further, limiting the maximum cost of a care package for someone in medium need to 45% of the net cost to the department of residential care.(Authority B, 1996a; 1996b) Essentially as in the case of Authority A, once eligibility criteria were introduced within a context of limited resources, it opened up a space for an increasingly stringent definition of 'need'.

Another area of policy change triggered by the implementation of the NHS and Community Care Act 1990 in this authority related to consultation, and the review of the joint planning machinery. Consultation related to the 'community care' plan was given prominence, and a review of the joint planning machinery took place, the joint planning groups were renamed to reflect the shift to commissioning, and a new layer of 'user' based groups were established to input their views into the planning process. However, these groups were incidental, and were not where policy decisions were made. We return to this in the following chapter.

Authority B then was slow to change, but was gradually moving in a new direction which involved strengthening its capacity, innovating and developing a 'quasi-market' in social care. The sense of doom

pervading in Authority A at all levels could not be found here, but was apparent amongst front line workers, who clearly felt they were given an impossible task, perceiving 'community care' to be synonymous with cuts and reductions in service. As in Authority A there was a strong discourse about 'cuts'.

It is, perhaps, a mixture of a lack of commitment within this authority to vigorously embrace the 'quasi-market', and the lack of strategic capacity that helps us to understand the direction of implementation early on in this authority. This was then followed by a subsequent realisation that the 'quasi market 'offered the potential for savings at a time when the government's allocation to this authority was declining (see below), combined with the appointment of a new Director and Head of Commissioning more open to the possibilities of the 'quasi-market'. It does appear then that at the time that this project was being undertaken, the 'quasi-market' was being operationalised in a more strategic way than in Authority A, though the scope of the 'quasi-market' was as in Authority A, relatively limited and applied almost exclusively to the purchase of residential and domiciliary care.

The employment of particular consultants who were likely to frame their recommendations within the general framework of central government policy was also significant. Some argue that the early approach to implementation in Authority B represented a dominance of 'old labour', which slowly gave way to a more pragmatic 'new labour' approach. However, it does suggest a degree of 'convergence' on policy implementation, and the declining significance of local government in determining policy.

Finance and Expenditure Trends in the Personal Social Services

Given that there was a strong discourse in operation in both Authority A and Authority B related to limited resources, and indeed evidence suggests that this is a discourse that operates at a 'national' level, it is worth reviewing national and local trends in expenditure.

(Evandrou, M, Falkingham, J, 1998) reviewed expenditure trends within the Personal Social Services over time. They began their analysis by reviewing real government expenditure on personal Social services across the period 1973/4 to 1995/6. They make a number of interesting observations. In the first instance they argue that real government expenditure on Personal Social Services increased across this period, at an annual growth rate of 4.2%. However, this growth has not been consistent but has varied, and has actually fallen in two years. However, they observe that between 1987/2 to 1992/3 expenditure increased at an average growth rate of 5.1% per annum. Moreover this trend has continued since 1993/4 following the introduction of 'community care'. However, as they observe this tells us little about how this relates to costs, in terms of wages and prices, which constitute a large part of 'Personal Social Services' expenditure. Taking volume costs into consideration, rates of growth have been slightly lower for the period 1985 onwards.

They break down elements of government expenditure, to trace trends in different sources of funding over time. Local Authorities currently receive a Revenue Support Grant, based on a Standard Spending Assessment(SSA) from central government, and this is combined with monies allocated by the local authority to pay for 'Personal Social Services'. From 1973/4 onwards there has been a continued divergence between central government and local

government funding. Central government funding has remained
more or less stagnant, whilst local authority funding has continued
to increase. Evandrou and Falkingham account for this increase in
local authority finance, partly in terms of joint finance i.e. input from
health for specific projects. Income is also raised from the use of
fees and charges, which have actively been encouraged by central
government. [7]

Given this project has a focus on 'older' people it is interesting to
review expenditure trends for this particular client group. (Evandrou,
M, Falkingham, J, 1998) observe that expenditure for 'older' people
grew at a rate of 6.8% during the financial period 1974/5 - 1978/9;
2.2% during the period 1978/9 to 1984/5; and 6.4% during the
period 1986/7 to 1994/5. They argue that the decline in
expenditure between 1978/9 is explained by the opening up of the
Department of Social Security route into residential care, and
observe that by 1994/5, older people had regained their dominance
in overall expenditure.

They observe that the DHSS estimated that in order to be able to
cope with increased need, expenditure would need to increase at a
rate of 2%, which they later revised downwards to 1%. However,
real growth has averaged 4.2% per year. This raises the question of
where the climate of 'limited/insufficient resources/cutbacks' come
from?

The number of older people has risen dramatically, for example the
number of people aged over 75 in the UK increased from 3.7 million
in 1986 to 4.2 million in 1996(an increase of 7.4%). When one looks
at specific areas of service provision such as meals provision, it is

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[7] For example the Audit Commission (1996) Balancing the Care Equation: Progress with Community Care
London, Audit Commission make clear that charges should be introduced where a client can afford to pay them.

clear that there has been a decline in levels of service. In 1974/5 local Authorities provided 15,500 meals per 1,000 and this figure fell to 12,200 per 1,000 in 1994.(Evandrou, M, Falkingham, J, 1998) Explanations given for this decline include increased targeting and greater use of luncheon clubs. However, they cite data from the General Household Survey which found that there was a decline in the number of people with mobility problems who required meals at home who were in receipt of them. In other words less people, who might normally receive meals at home, were receiving meals at home.(General Household Survey, 1995)

Since 1992 there has been an increased trend towards private provision of meals with local authority provision declining. In 1992 Local Authorities provided 60.3% of meals; the voluntary sector provided 34.8% of meals and the private sector provided 4.3% of the meals. By 1995 Local Authorities provided 55.1% of meals; the voluntary sector provided 33.4% of meals and the Private Sector provided 9.4% of meals.(Evandrou, M, Falkingham, J, 1998)

There was a sharp increase in home help hours after 1992/3 purchased by local authorities in England. Home Help and Home Care hours increased by 41% between 1992 and 1995. Again, there was a substantial increase in the proportion of home care purchased from the Independent Sector under Contract. In 1992 the Private Sector provided 1.9% of all home help and home care hours and this increased to 25.9% in 1995. Similarly, the voluntary sector share increased from .4% to 3.2%, while the local Authority share of provision declined from 97.6% to 70.8%.((Evandrou, M, Falkingham, J, 1998)

There has been a sharp growth in numbers of day care places for

older people, rising by 69% between 1973/4 and 1992, compared to a population growth of 40%. Between 1993 and 1995 the number of places at Day centres in England increased by 14.6%. The voluntary Sector increased its share of provision from 10.9% in 1993 to 16.6% in 1995; Private Sector provision increased from .3% in 1993 to 1.3% in 1995; and the local authority share of provision declined from 88.7% in 1993 to 82.3% in 1995. (Evandrou, M, Falkingham, J, 1998)

Expenditure on residential care declined quite sharply from 1988 onwards, explained in part by the increase in DSS placements, where local authorities could take advantage of placing people in residential care at no cost to themselves. The decline in the number of local authority residential care homes has continued to decline. However with the introduction of the 'community care' legislation, this trend has reversed and since 1992 local authority expenditure on residential care has continued to grow. However, According to (Evandrou, M, Falkingham, J, 1998, p221):

> "Even by 1995/6 the number of total local authority sponsored residential care places for the elderly remained lower in absolute terms than in 1973/4 despite the fact that the population aged 75 and over increased by nearly 50% across the period."

They go on to acknowledge that this is a partial picture and as discussed earlier despite the policy shift towards community care, there has been a huge growth in residential and nursing home care within the private and voluntary sectors paid for from central government funding.

(Evandrou, M, Falkingham, J, 1998, p221) conclude that:

> "Growth on expenditure on PSS has been maintained despite Conservatives planned local authority expenditure cuts, and greater constraints through cash limits and rate capping during

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the late 1980's... growth in expenditure on the PSS appears to have not only kept pace with changes in need but to have exceeded it....Domiciliary and other support services have increased, but not at a sufficient rate to keep pace with a growing elderly population... Unit costs have risen across the PSS. these changes can only be partly accounted for by the general rise in input prices and changes in the circumstances of clients, with greater levels of dependency. In the absence of solid evidence pointing to a rise in quality, there appears to be a prima facie case that efficiency within the PSS declined during the 1980's."

Expenditure Trends in the Two 'Case Study Authorities

Let us now turn to our two case study authorities and review expenditure trends here.

Table Two: Total Personal Services Gross Expenditure: Authority A

Financial Year	Authority A	Authority A(real expenditure at 2002 prices)	GDP Deflator
1992-3	50097	38953	77.8
1993-4	54430	43475	79.9
1994-5	57828	46871	81.1
1995-6	58802	49049	83.4
1996-7	60761	52432	86.3
1997-8	67745	59941	88.5
1998-9	73285	66712	91.0

Source: (Department of Health, R03 returns, 1992, 1993, 1994,1995, 1996, 1997, 1998, (deflator: www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_anne x.cfm)

Table Three: Total Personal Services Gross Expenditure: Authority B

Financial Year	Authority B	Authority B(real expenditure at 2002 prices)	GDP Deflator
1992-3	52749	41016	77.8
1993-4	56081	44794	79.9
1994-5	62703	50823	81.1
1995-6	68400	57055	83.4
1996-7	76410	65936	86.3
1997-8	83267	73675	88.5
1998-9	91051	82885	91.0

Source: (Department of Health, R03 returns, 1992, 1993, 1994,1995, 1996, 1997, 1998, (deflator: www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_annex.cfm)

It is clear from an examination of the tables two and three that
Personal Social Services gross expenditure continued to increase
quite rapidly in the years following implementation. In column four
of tables two and three we have applied a deflator to explore the
impact of inflation on these figures, and using this deflator we can
see that expenditure continued to grow but not as much in cash
terms.

Table Four: Personal Social Services Percentage Share of Total
Expenditure in each Local Authority

	1992-3	1993-4	1994-5
Authority A	14%	17%	17%
Authority B	18%	19%	20%

(Chartered Institute of Public Finance Accounting, 1993,1995)

The table above shows that the Personal Social Services took an
increasing share of local authority expenditure following, 'Community
Care' implementation. This growth would be accounted for in part by
the STG monies given to local authorities to carry out their
community care responsibilities.

Indeed a committee paper confirmed that the Social Services budget
in Authority A had grown at twice the rate of inflation. Authority A
has increased the proportion of resources allocated to the personal
Social Services by 3% between 1992/3 and 1994/5. The
SSA(Standard Spending Assessment) allocated to this authority for
the Personal Social Services, was slightly higher than that allocated
to the Personal Social Services(PSS) over this period, but by 1995-6
the PSS received a lower SSA allocation (-4.1%) than that allocated
to the Authority to cover the cost of the PSS. Authority B increased
the percentage share of total expenditure allocated to the PSS by
1% per annum across this period, despite a declining SSA. In 1995/6
there was a -6.9% difference between the total SSA covering PSS

Services and the PSS budget, and this difference increased to -
10.1% in 1997/8(Authority A, 1994a; Authority A; 1998c ;Authority
B, 1997a; 1997b).

<u>Table Five: Gross Expenditure Rates on Services to the Elderly in
Authority A</u>

Financial Year	Authority A	Authority A(real expenditure at 2002 prices)	GDP Deflator
1992-3	10893	8470	77.8
1993-4	12587	10054	79.9
1994-5	18293	14827	81.1
1995-6	21009	17524	83.4
1996-7	22117	19085	86.3
1997-8	24296	21497	88.5
1998-9	23373	21277	91.0

Source: (Department of Health, R03 returns, 1992, 1993, 1994,1995, 1996, 1997, 1998,
(deflator: www.hm-
treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_annex.cfm)*Up to 1993/4
figures refers to expenditure per capita 65 and over. Data Collection changed in 1995/6 to expenditure per capita
75 and over

<u>Table Six: Gross Expenditure Rates on Services to the Elderly in
Authority B</u>

Financial Year	Authority B	Authority B(real expenditure at 2002 prices)	GDP Deflator
1992-3	15684	12195	77.8
1993-4	16200	12940	79.9
1994-5	25954	21036	81.1
1995-6	28222	23541	83.4
1996-7	29943	25838	86.3
1997-8	30742	27201	88.5
1998-9	32078	29201	91.0

Source: (Department of Health, R03 returns, 1992, 1993, 1994,1995, 1996, 1997, 1998,
(deflator: www.hm-
treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_annex.cfm)*Up to 1993/4
figures refers to expenditure per capita 65 and over. Data Collection changed in 1995/6 to expenditure per capita
75 and over

In terms of expenditure on older People we can see that this has
continued to increase quite rapidly in Authority A and B. However,
when we use a deflator we see that in Authority A in the financial
year 1998-9 there was an actual cut in expenditure, though for all

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other years expenditure continued to increase.

Table Seven: % Breakdown of Expenditure by Service Type in Each
Authority

Auth. A	Res. Care	Day Care	Home Help	Meals	Other
1991/2	32%	11%	37%	10%	10%
1993/4	27%	17%	32%	12%	12%
Auth.B					
1991/2	41%	12%	29%	10%	7%
1993/4	42%	13%	27%	7%	11%

(Chartered Institute of Public Finance Accounting, 1993,1995)

The table below explores service change both before and
immediately after 'Community Care implementation'. It can be seen
from the above that within Authority A there has been a decreasing
proportion of resources allocated to both residential care and home
care, and an increasing proportion of resources allocated to meals
and day care suggesting a shift away from residential care in line
with the overall policy intentions of 'community care', but not a
comprehensive redirection of resources towards 'community care'
services. One would have expected the percentage of resources
allocated to home care to increase over this period. Authority B, on
the other hand, has actually increased the amount of resources
allocated to residential care (by 1%) and Day Care by (1%), whilst
there has been a small decrease in the proportion of resources
allocated to both meals and home care, two essential planks of
community care. Though, overall it appears that spending patterns
changed very little across this period.

Essentially then for the first few years of implementation the notion
of cuts is not borne out by the data, and suggests that there was
the potential to think imaginatively about 'community care'
implementation. The Standard Transitional Grant provided an
opportunity to use monies in different ways. However, neither
authority took advantage of this and simply absorbed these monies

into existing budgets. Neither used these monies to stimulate more 'needs led' provision. However, by 1995/6 the economic situation does appear to have worsened for both authorities, however, the PSS budget does appear to have been protected in Authority B.

Nevertheless the discourse that operated in Authority A and B at every level within the hierarchy was based on the notion that it was impossible to talk about choice when the local authority was faced with such huge expenditure cuts. For example according to the Head of Elders Commissioning in Authority A:

> "It is all very well talking about identifying unmet need, but if you ask a social worker they will tell you they are dealing with year on year cuts to baseline budgets."

As we have already seen the climate/context of implementation in local authority departments has been pervaded by notions of 'cut back' in terms of both resources and eligibility, this was reflected in both Authority A and Authority B. This has crowded out a more innovative approach, with 'need' interpreted, according to one social worker as: "Just as much as you need."

Conclusion
In this chapter we have reviewed the 'policy implementation' literature and the guidance/legislation shaping and directing 'community care' implementation. We have reviewed 'community care 'implementation in the two 'case study' authorities. What is clear is that the 'quasi-market' was only partially implemented in the 'case study' authorities. There were changes to the way in which services were purchased, and changes to the way they were provided, but these changes did not constitute a genuine 'quasi-market, and therefore, the anticipated benefits could not follow. The policy goal of achieving greater choice was not a central concern of either authority. Both authorities implemented the legislation with a

pre-occupation with finance. Both developed 'gate-keeping' mechanisms which reduced entitlement to service. Moreover the implementation of choice was translated in policy terms into more domiciliary care provided by Independent Sector care agencies, or the implementation of the 'choice' directive which gave prospective residents a choice about which home they entered. Moreover, even choice about whether to live in your own home or enter residential care was increasingly driven by finance.

This emphasis on resources and the narrow definition of choice embraced by these authorities reflect the findings of studies discussed in chapter one. Essentially then, 'choice' has been a neglected dimension of 'community care' implementation. This theme will be developed more fully in the next chapter.

How do we explain this narrow focus? It would be helpful at this point to return to the 'policy implementation' literature and ask why did the policy goal of 'securing better value for taxpayers money' become an over-riding policy objective, and why was 'choice' defined within such narrow parameters?

At first sight it appears that a 'top down' analysis of policy implementation would provide an adequate explanation. The then government sent a set of circulars through to the authorities, the Authorities themselves were suffering from information and policy change overload and it appears that in both these authorities, they had cut resources in the area that would be most significant in achieving a more 'needs led' and imaginative approach to 'policy implementation. If Authorities are to become 'enablers' they must have sufficient people in post that can facilitate this 'enabling' and in both these authorities, there was a deficit in these areas.

Therefore, the small number of 'enablers' or 'strategic planners in post, had to focus on the more directive central government guidance. Moreover, the guidance on 'needs led' assessments was important in creating a climate of caution about 'needs assessment' very early on.

Interestingly as noted in Chapter one the underlying rationale for the introduction of this legislation was to reverse the perverse incentive towards residential care and cap the fast growing social security budget, which was funding this expansion. In this sense they were successful. Moreover the growth of independent sector provision was also a clear policy intention achieved by the stipulation of the 85% rule in relation to spending the STG budget. Choice, then, was synonymous with both more, and more flexible domiciliary care, and greater involvement of the 'independent sector'. It was perhaps never about providing meals that reflected user preference, or about creating leisure/social opportunities which reflected more of what a user would like to do.

The then government did however, push towards the introduction of purchaser/provider splits and the Audit Commission made clear that it was important to use the STG monies in flexible ways as this money was not tied to existing service provision. However, there were no penalties, for not stimulating a diverse range of service alternatives, or rewards for identifying need in imaginative ways.

This appears to be reinforcing a top down managerial/rational perspective, i.e. in order to achieve a policy goal it needs to be accompanied by a detailed set of instructions/regulations. However, in an authority with few staff working in a capacity to think through

change, only a limited number of requirements can be followed through, as it is likely that 'implementers' will develop a system of rationing, to identify which guidance has the most punitive sanctions for 'non-implementation'. Also we have seen that even where guidance is followed, such as the introduction of the purchaser/provider' split, or the production of the 'community care' plan, it may simply be meeting the requirements of the act in a mechanistic way, without reflecting the broader policy intentions, therefore policy makers, simply 'muddle through' in a way similar to that depicted of the front line workers in Lipsky's study, modifying their expectations of what is expected. Therefore, it appears that an analysis which explores the interaction between the 'bottom' and 'top' is a more helpful way to make sense of 'implementation'.

In the next chapter we will consider the extent to which responsiveness to 'differentiated need' was prioritized in 'community care' implementation, by focusing on 'community care implementation, and service provision and service change for older 'African-Caribbean' people in the two case study authorities.

<u>Chapter Five</u>

<u>'Race', 'Ethnic Diversity' and 'Community Care' Implementation</u>
In this chapter we will consider how the two 'case study' authorities
responded to the task of implementation, with specific reference to
issues of 'race', 'race equality' and 'ethnic diversity'. We will begin by
mapping out the response of the two 'case study' authorities to
issues of 'race'; 'racism' and 'race equality' during the 1980's and at
the time of 'community care implementation'. We will then move on
to look specifically at the way in which these issues were
incorporated into the 'community care implementation' process. We
will explore the changing nature of service provision for older
'African-Caribbean' people, and account for changes/developments
in service provision. Finally, we will consider more generally the
extent to which the 'community care' legislation has generated a
system more able to respond to differentiated need.

<u>Promoting 'Race Equality' – The Response of the Two 'Case Study'</u>
<u>Authorities</u>
It is helpful to trace our review of how the two 'case study'
authorities responded to issues of 'race'; 'racism' and 'race equality'
back to the 1980's. In Chapter two, we reviewed the 'rise' and 'fall'
of 'municipal anti-racism'. More specifically we observed that the
1980's marked a massive transformation in the way that some 'local
authorities' responded to issues of 'race'/'racism'. This was
characterised by:
1. The establishment of 'race relations' machinery (at a senior level)
within local authorities to address 'racism' within local government.
2. Strategies to change the profile of staff within the local authority
to reflect the 'ethnic' make up of the population
3. The introduction of a range of service delivery initiatives aimed at
better responding to the needs of 'Black and Minority Ethnic' groups.
4. Increased funding to 'Black and Minority Ethnic' groups to develop

services.

5. The increasing significance of 'institutional racism' as a theoretical framework for understanding 'racial disadvantage'.

However, by the early 1990's (the moment of 'community care' implementation) the high profile commitment to tackling racism within many local authorities began to fade. There were three significant trends.

1. A de-prioritisation of 'anti-racism' within policy agendas.

2. The re-organisation of structures put in place to tackle 'race equality'.

3. The introduction of 'new managerial' type strategies to promote 'race equality'

Let us now consider how the two 'case study' authorities respond to issues of 'race'/'racism' and 'race equality' in the 1980's? How this changed in the 1990's? and, how this impacted on 'community care implementation'.

Authority A -Implementing 'Race Equality' in the 1980's

Authority A adopted one of the most high profile 'race equality' strategies in Britain during the 1980's establishing a radical 'anti-racist' strategy. Both Conservative and Labour administrations were committed to this strategy during the 1980's. The strategy was initiated in 1982, when the authority appointed a Principal 'Race Relations' Advisor (PRA). The Advisor was located in the Chief Executive's office, emphasizing its high priority. Once in post, the Principal Race Relations Advisor drew up a strategy for achieving 'race equality'. As part of this strategy, a Race Relations sub-committee was set up which reported to the Policy and Resources Committee. This was considered important in terms of influencing policy and accessing resources to facilitate policy implementation. The intention was to ensure that 'race equality' was built into all

areas of work including service planning, delivery, and recruitment. A central 'race relations' unit was established employing 'race' advisors, some of whom were attached to specific departments.

The high priority given to 'race' within this authority was not a result of change within the authority, as such, but the local context. The authority had a large 'Black and Minority Ethnic' population, and at the beginning of the 1980's a significant number of 'Black and Minority Ethnic' Councillors were elected for the first time. These councilors forced 'race equality' onto the agenda.

However, the implementation of 'race' equality strategies, were to prove difficult to implement in this authority. (Cross, M, Brah, H, McCleod, M,1991) argue that one of the tensions arose from the 'race equality' implementation machinery'. For example, it was unclear whether departmental advisors were accountable to the 'race unit', or the Department in which they were located. This led to widespread criticisms that those 'race equality' officers attached to specific departments found it difficult to affect change within the department. This was a finding identified by (Connelly, N, 1989) in her research on implementing 'race equality' in local authority social service departments.

On the other hand, in recognition that there may be resistance to organizational change, 'race' advisers were given enhanced powers. For example the departmental directors had to consult the 'race' advisor about any paper taken to the committee. The 'race' advisor, on the other hand, was able to take a paper to a committee, without consulting the director of that department. (Cross, M, Brah, H, McCleod, M,1991) suggest that this created in built tension and may have instilled a reluctance to change. They observe a rather limited

attempt by the Social Services department to achieve race equality, and quote a newly appointed director of Social Services who commented in 1989:

> "I was quite surprised at what I considered to be a very poorly developed race policy. It is difficult to find anything other than generalised statements. (Cross, M, Brah, H, McCleod, M,1991, p126)

Therefore again indicating that even in an authority perceived to be at the forefront of 'radical' policy in this area, change was limited. The departmental 'race' advisor observed a significant shift in the ethnic composition of the staff, both in 'mainstream' and 'race' specific jobs. However, this did not result in achieving an integrated approach to the issue of 'race/ethnicity'. According to the initial Principal Race Adviser:

> "We saw many changes in education, not as many in social services, if any change happened in social services it would be more through grass roots moves from below." (quoted in Cross, M, Brah, H, McCleod, M,1991, p126)

By the end of the 1980's the high profile given to 'race equality' both in Authority A and in other authorities began to wane. In Authority A the continual bombardment of the media against the so called 'loony left' led to increasing caution by members. According to (Solomos, J, 1993) by the late 1980's many previously radical local authorities began to adopt a lower profile on issues concerned with 'race equality' following the negative attention given to such policies. He observed that the Labour party itself increasingly sought to distance itself from being directly associated with the actions of the 'urban left' and 'minority' issues. He goes on to argue that the press was successful in reinforcing an, 'anti-anti-racist' position with 'anti-racism' seen as a bigger threat than 'racism'. More generally, there was a specific shift within this authority to adopting an 'anti-anti-

racist' position.

(Cross, M, Brah, H, McCleod, M,1991) identified a range of
problems in terms of policy implementation. For example, race
equality strategies had been more successful in achieving and
focusing on equality in the workplace. However, this had been at the
expense of service delivery, and its integration into strategic
planning mechanisms. They also observed a general lack of support
for 'race equality' measures from senior managers.

Authority A's, 'Black and Minority Ethnic' population came from a
range of different 'Black and Minority Ethnic Groups'. These groups
had different priorities in relation to policies aimed at tackling 'race
equality'. This created conflict between different groups:

> "It should come as no surprise that if one set of priorities is
> stressed in local authority policy, then this is likely to find more
> approval in one 'ethnic' group than another." (Cross, M, Brah,
> H, McCleod, M,1991, p140)

This was to manifest itself in 1988. A group of 'Asian' Councillors
wrote to all Councillors and officials within the authority, implying
that the 'race equality' strategies of the department did not work in
the interests of the whole community, and instead favoured 'African-
Caribbean' communities'. Interestingly, this perceived favouring of
one 'Minority Ethnic' group was not borne out by research evaluating
the 'race equality' strategy in this borough. However, it was
sufficient to lose support from 'Asian' councillors.

According to (Cross, M, Brah, H, McCleod, M,1991) this
misconception had arisen because the 'African-Caribbean'
community were more likely to suffer from high levels of
unemployment, and live in more 'deprived' parts of the borough.

Applications for schemes to tackle this deprivation were more likely to be supported through the central government funded Urban Programme. On the other hand, members of the Asian community wanted to develop 'community centres' which were less likely to be supported as a priority by central government funding policy. This was then interpreted as a perceived favouring of one 'Minority Ethnic' group over another.

Authority A - The shift to 'Anti-Anti Racism'

This led to intense debate over 'race' policy within this Authority, a split of the initial players who had placed it on the agenda and the adoption of an 'anti-anti-racist' stance. In 1990 the Conservative group took control of the council with support from the Liberal Democrats. The Social Services Committee in June 1990 voted to delete any reference to 'race' or 'racial equality' from the department's action plan. This included abandoning plans to develop operational services for 'African-Caribbean' and 'Asian' elders, and an ethnic monitoring system. In 1991 the Council passed a motion to disband the 'race' unit and establish an Equal opportunities unit, which would employ one 'Asian', one 'African' and two 'European' advisors, in other words the unit would directly discriminate against 'African-Caribbean's' by excluding them from the unit. Two 'African' councillors from the labour group voted with this motion, which was passed. The Chief Executive referred them to the CRE. The proposed unit was never established. (Cross, M, Brah, H, McCleod, M,1991)

The low commitment to issues of 'ethnic diversity' was apparent in many interviews, where a range of staff commented on their apprehension about raising such issues. Essentially there was a self censorship amongst staff about issues of 'ethnic diversity'.
"We tended not to put forward proposals on such issues, because we knew members did not want them."

This is a good example of the way in which 'silence' became an 'action' rather than a 'non-action'. As we have seen above, the authority was relatively successful in achieving a more 'ethnically' representative workforce. However, the incoming group sacked a number of 'Black and Minority Ethnic' workers and in 1995 there were 49 cases of alleged racial discrimination pending against this Authority.(Kolawale, H, 1995) Moreover, much of this change in the workforce was accounted for by the use of 'Section eleven' monies. This authority had relied heavily on the use of 'Section Eleven' monies to finance 'Black and Minority Ethnic' workers.(Authority A, 1992a)

In 1996, the Labour group regained control of the party with support from the Liberal Democrats. They resurrected a much more watered down and 'generic' approach to 'equality' issues. They established a relatively low profile, 'Excellence and Equality' sub- committee. Each department was requested to produce an Equality Action Plan. A review of the minutes for this committee reveals a lack of consensus related to the goals of this committee. More specifically it raised questions about the commitment to 'equality' issues from the Social Services Department, who had failed to produce their 'Equality Action' Plan. According to the committee:

> "We are concerned that the social services committee should not consider it a priority to support the monitoring and review of the plans."(Authority A, 1998d. p2)

By 1996, then equality issues were beginning to return to the policy agenda, but the policy did not appear to have widespread support across the authority, and many managers appeared unaware of the existence of this new committee.

Authority A, then is an interesting authority in relation to 'race equality'. During the 1980's 'race equality' was rarely off of the agenda. However, the extent to which this translated into policy outcomes is questionable. Nevertheless at the moment of 'community care' implementation they had begun to adopt an 'anti-anti-racist' stance with a particular animosity to the 'African-Caribbean' community. Below we will consider how this impacted on the implementation of the 'community care' legislation and the priority given to issues of 'race equality' and 'ethnic diversity' generally, and older 'African-Caribbean' people in particular.

Authority B – Implementing 'Race Equality' in the 1980's

Authority B adopted a similar strategy to Authority A. However, they received much less media attention. Whilst Authority A, was rarely out of the spotlight of media attention, Authority B was rarely under the spotlight. In the early 1980's the department set up identical 'race equality' structures to Authority A, again giving considerable power to the principal 'race' advisor. The department employed its own 'race equality' officer. The authority made little use of 'section eleven' monies arguing that such an approach marginalized 'race' issues. Towards the end of the 1980's, the department reviewed its strategy. According to one senior manager:

> "Workers within the 'race' Unit were publicly criticizing the work of senior manager's within this authority. This became an embarrassment to the local authority."

He suggested that the work of the 'race' unit created a dilemma from a policy perspective. The 'race unit's role was to monitor the work of the authority, but they were employed by the authority. Workers were effectively pursuing a 'pressure group' approach to policy, highlighting the shortcomings/'racism' of the local authority, whilst at the same time being employed by the local authority.

Moreover the effectiveness of the approach was questioned. As in Authority A, the departmental 'race advisers', had remained peripheral to the work of the department, and had found it difficult to initiate change.

Authority B – A 'Generic' Approach to 'Equality' Issues
Unlike Authority A, this authority remained committed to 'race equality' (at least in theory) and therefore reorganized its strategy to embrace a 'generic' approach to 'equality'. The rationale for this reorganization was based on the impossibility of separating problems of disadvantage into discrete units, as there were issues for example, that affected 'Black' women, or 'Black' disabled women. Moreover each unit was costly, as each unit had a head and a separate committee to report too.

The brief of the new unit was extended embracing a wide definition of disadvantage, which included 'older' people and 'gays and lesbians'. Each department was to employ a specific 'equalities' officer, though at the time of this research, this post remained an unfilled vacancy in the Social Services Department, indicating possibly the low priority given to such issues. The response of the social services department was to give one policy officer, key responsibility for 'equality' issues.

In chapter two we considered some of the weaknesses in implementing 'race equality' in the 1980's. In particular, one key criticism was its ineffectiveness in penetrating the work of local authorities. Therefore, for those authorities that did retain a commitment to 'race equality' and 'equality' type issues more generally, a strategy emerged which was based on giving every worker a responsibility for addressing 'equality' issues by incorporating it into all job descriptions. The new structure then was

driven by the supposed ineffectiveness and unpopularity of the previous structure, and in a context of cost savings, the new structure was much cheaper and therefore popular with management. Authority B, adopted this model.

Essentially, then there were two policy changes identified in responding to 'race equality by the early 1990's, the first reflected the implementation of an 'anti-anti' racist position, which was the stance of Authority A. The second was a 'dilution' of 'anti-racist' machinery, and its replacement with a 'generic' approach to 'equality' issues, which was the stance of Authority B.

Within both authorities then the radicalism of the 1980's had waned by the time 'community care implementation' was on the policy agenda. Authority A moved from a high profile anti-racist campaign, to adopting (on a local level) a high profile 'anti-anti' racist profile. Authority B shifted towards an 'equalities' agenda, which was a strategy replicated in many local authorities, suggesting a more diluted commitment to 'race equality'. Interestingly, both provide an account of policy change linked to problems of implementation, though it is unlikely that the new strategies would be more successful in dealing with 'race equality'. This policy re-orientation was replicated in other local authorities, suggesting the abandonment of radical 'race equality' policies and their replacement with a much more diluted approach to problems of 'race equality'. However, as we shall see, despite a sense in which these former strategies had been perceived as ineffective in bringing about policy change, they were in reality a crucial mechanism in bringing about a policy shift, that created a climate more responsive to at least, 'some' differentiated 'needs'.

'Community Care Implementation' and 'Race Equality'

In chapter two we reviewed 'community care implementation' in relation to 'race', 'race equality' and 'ethnic diversity'. It was clear that whilst the White Paper 'Caring for People' (1989) did include one paragraph related to the need to reflect 'ethnic diversity' in 'community care' implementation, there were no clear incentives or sanctions for failing to do this. Guidance was initially limited to one circular referring to a publication of the 'London group on Race Aspects of Community Care', and this itself was prompted by criticisms from 'Black and Minority Ethnic' groups(Laming, H, 1992).

As we made clear in chapter two, the nature of the reforms was such that the reforms did offer the potential to better meet the needs of 'Black and Minority Ethnic' communities, however, the reality appears to have been that the extent to which 'community care implementation' has responded to issues of 'race equality' has been a result of 'local conditions'. For example, in one London borough, local 'Black and Minority Ethnic' communities formed a 'Black and Ethnic Minorities' Community Care Forum which then made a successful bid for monies under the 'Caring For People At home initiative'[8] to develop services in the independent sector for 'Black and Minority Ethnic' Communities.(Institute of Race Relations, 1993) Similarly, it was apparent in the study undertaken by (Lewis, J, Glennerster, H, 1996) that it was simply the presence of a 'Black' assistant director, that led the authority to place more emphasis on issues of 'race equality' in 'community care' planning and implementation. When this director was present at meetings, she placed such issues on the agenda, when she was absent, these issues were missing from the discussion.

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[8] The Caring For People At home Initiative was funded by the Department of Health and Social Security to stimulate 'independent sector' provision as part of the 'community care' implementation. Local authorities were invited to compete for funds in innovative ways which would stimulate independent sector care to support people living at home. Monies were allocated on the strength of bid, rather than 'need' in that area.

Clearly given the extent of documented disadvantage in relation to service provision for 'Black and Minority Ethnic' groups, greater emphasis should have been placed on this issue by central government. However, this neglect was challenged by 'Black and Minority Ethnic' groups and a specific working group was established by the London region of the Social Services Inspectorate to address these issues.

London Group on 'Race' Aspects of 'Community Care'
Both Authority A and Authority B sent representatives to this group. Initially the Director of Social Services from Authority A attended the meeting, implying a strong commitment to 'race equality'. However, the establishment of this group coincided with Authority A, 'deprioritising' 'race equality' and thereafter a range of less senior officers attended these meetings and there is no sense in which ideas and issues emanating from this forum were fed into the work of the department. (Minutes of the London Group on 'Race' aspects of Community Care, 1991/1992)

Authority B sent a fourth tier officer to this forum who was responsible for coordinating the community care plan and was the officer in the department with the 'equalities' brief. The 'London group' had a range of sub groups related to different issues, and this officer participated in a sub-group, which focused on consultation. Interestingly, this Authority, did prioritise the need to consult with 'Black and Minority Ethnic' Communities about community care (see below). However, there was no sense in which the wider messages of the group on purchasing and assessment were fed back into the work of the Department.

Community Care Plans
One of the starting points in relation to implementation of the 'community care' legislation related to the production of a Community Care Plan. Both Authority A and B did acknowledge the needs of 'Black and Minority Ethnic' communities in community care plans and strategies for older people. According to Authority A:

> "Two key trends are the growing number of over 85's and the increasing number of people from Ethnic minorities...Whilst the proportion of 'Black and Ethnic Minority' elderly as a total proportion of the total elderly population is much lower, because of the younger age profile of the 'Black and Ethnic minority' population, this is likely to change. Any review of Services must therefore include an assessment of the differing needs of the various communities, including religious and cultural needs."(Authority A, 1996f, p8)

According to the Community Care Plan 1996/99 for Authority A:

> "There has been considerable debate between the Health Authority, the council, and the voluntary sector, concerning possible responses to these issues. This has involved discussion as to whether there should be services specifically designed and provided for people from 'Black and Ethnic Minorities, or whether existing services should be adapted to ensure they are accessible and offering appropriate responses to the needs of all ethnic groups."(Authority A, 1996i, p5)

Authority B identified similar trends in relation to the increasing number of 'Black and Minority Ethnic' older people and included a specific section in its Community Care Plan for 1992/3:

> "Services have significantly failed to meet the needs of 'Black' elders in the community. Specific Attention is needed to redress this. Services for 'Black and Ethnic Minority' elders should be part of mainstream services, not separate from them, within this it may be necessary to provide different services for different needs."(Authority B, 1992, p.5)

What is interesting specifically in relation to both Authority A and B is that nearly twenty years after the implementation of the Race

Relations Act 1976, and the publication of the ADDS/SSI report on 'Social Services in a Multi cultural society' and more than a decade after the implementation of a radical set of 'race equality' strategies within both Authority A and Authority B, little progress appears to have been made on such issues, along-with the continued recycling of the debate about 'mainstream' versus 'specialist' provision.

The poor response to the needs of older people from 'Black and Minority Ethnic' groups is acknowledged but little progress in relation to policy implementation. Moreover neither, Authority A or B, identified the strengths of existing services, therefore, it would appear that both authorities provided a 'mono-cultural' set of services. It was as if the authors of the plan had no knowledge of existing services, and essentially reiterated the concerns of the earlier 'care'/'control' paradigm, that services had failed to meet the needs of older 'Black and Minority Ethnic' groups. However, similar statements were included in subsequent plans, suggesting that in this case, not silence, but a continued acknowledgement of the problem, without a specific plan of action would legitimate a strategy of non-action on the issue. Indeed one would assume that in order to plan and develop a 'mixed economy of care' one of the first tasks would be to produce a mapping exercise of what exists, in order to ascertain what does not exist, but this was not the approach adopted in either authority. This failure to undertake any kind of mapping exercise, or adopt a more strategic direction on issues of 'race equality' was identified in a study undertaken by the (Northern Health, Social Services and Social Security Forum, 1993).

<u>From 'Joint Planning' to 'Joint Commissioning' – a 'Race Equality'</u>
<u>Perspective?</u>

One of the common reorganizations, identified in our earlier study

related to an overhaul of the planning machinery, with a revamped

structure named 'joint commissioning'. According to (Lewis, J,

Glennerster, H, 1996, p168):

> "Authorities have devoted a lot of time to developing new joint
> commissioning structures, yet there has been no agreed
> definition of joint commissioning. Many of the research
> authorities began with the idea that they would eventually
> either make purchasing decisions in conjunction with health
> authorities or actually engage in joint purchasing. It is not
> evident that joint commissioning in this sense is in sight."

In their study, two of the 'case study' authorities paid significant

attention to 'race equality' when reviewing the 'joint commissioning'

structures. These authorities changed the membership of groups to

ensure that 'Black and Minority Ethnic' representatives were included

on all planning groups, and established specific forums focusing

specifically on the 'community care' needs of 'Black and Minority

Ethnic' groups. Both Authority A and Authority B reviewed their 'joint

planning' machinery. This then raises the question of how 'race

equality' was incorporated into these reviews.

Authority A moved early on to replace it 'joint planning' groups with

'joint commissioning' groups. However, 'race equality' was absent

from the review of 'joint commissioning' in this authority and

appeared to be neglected within documents emanating from this

structure. For example, despite the 'community care plan 1996 –

1999' stating that there was a need to develop services for 'Black

and Minority Ethnic' older people. The section on services for older

people, written by the Joint commissioning Team for the elderly and

included in the same plan, made only one specific reference to 'race

equality'/'ethnic diversity' related to the need to take into account

the needs of 'Black and Minority Ethnic' communities when purchasing 'respite care'. In this authority, it appeared that the radical moment of 'anti-racism' had not permeated the 'joint planning structure' and was certainly absent in the move from 'joint planning' to 'joint commissioning'.

Authority B on the other hand undertook a substantial overhaul of its 'Joint Planning' process as part of its 'community care' implementation to respond more effectively to the views of 'Black and Minority Ethnic' groups. In an early 'community care' plan consultation event, concern was raised about the lack of consultation with 'Black and Minority Ethnic' groups. In response to this, the authority organised two half-day consultative meetings specifically for 'Black and Minority Ethnic' groups. One of the outcomes of this was that it was agreed to reform 'planning' mechanisms to include the views of 'Black and Minority Ethnic' groups.

The 'joint planning' teams were renamed 'service planning groups' and the membership of each group was revised to include two representatives from 'Black and Minority Ethnic' groups. In addition to this a specific 'Black and Minority Ethnic' Community care forum was established to feed into the community care plan and monitor the equalities dimensions of other service planning groups. Whilst the revised structure may have been responding to complaints about consultation, it was also shaped by developments taking place in other authorities. The officer from the Social Service Department with responsibility for 'joint planning' was the same officer, who had represented this authority in the 'London Group on Race aspects of Community Care' and participated in the group on 'consultation' and therefore it is likely that ideas from this group shaped the nature of

the review in this authority.

However, whilst the reorganization clearly suggested a commitment to 'race equality' the changes appeared to be ineffective. For example the 'Black and Minority Ethnic' community care forum was set up in 1992 with the intention of meeting every two months. The minutes demonstrate some tension as to the role of the group and in 1994 terms of reference were agreed which included:

-   Reviewing the community care planning structure with particular reference to, and participation of and consultation with 'Black and Ethnic Minority' Groups.
-   Provide a forum for liaison including reps of 'Black and Ethnic Minority' groups.
-   To monitor progress on community care action plans in relation to developments for 'Black and Ethnic Minority' service users and carers and to advise and support the Service Planning Groups.
-   To support and advise groups on joint planning applications.(Authority B, 1992-1994, March 1994)

The group then played a 'monitoring'/'consultation' role, rather than a more strategic/purchasing role. There was a perception that the group was ineffective and in 1996 the group was renamed the Service Planning group for 'Black and Ethnic Minorities', to give it parity with other 'joint planning' mechanisms. Whilst this group does appear to symbolize a positive step in responding to 'race equality' the group was perceived as ineffective: According to the senior manager with the responsibility for coordinating the group:

> "The group doesn't meet very often and as far as I can
> understand there is a difficulty. It is meant to put reps from
> 'Minority Ethnic' communities onto the other service planning
> groups, but it has trouble finding sufficient people to do that
> ...but our aim is to have a user or carer and someone from the

'Ethnic Minority' community on all the SPG's."

The role of the group seemed marginal to the work of the department and was more about information sharing than decision-making. This approach raises a number of issues linked to questions of democratization/social inclusion/participation in service planning. Interestingly, despite the strategy of common ownership of 'race equality' vis a vis the incorporation of such goals into all job descriptions, it was left to 'Black and Minority Ethnic forums', and 'Black and Minority Ethnic' representatives on Service Planning groups to highlight these issues. Yet, this was the model that had been dismantled within this local authority because of its ineffectiveness within local authorities. Secondly, it assumes that a member of any 'Black and Minority Ethnic' group, can and will represent the complex interests of all 'Black and Minority Ethnic' groups. This is an attempt to democratize decision making but is highly flawed as a strategy for enhancing 'race equality' or developing 'user' based services.

One of the central roles of the Service Planning groups in this authority was to input into the Community Care Plan. Each service planning group, was responsible for producing a section related to the needs of their respective client groups, these sections were essentially statements of intent with regard to service development. From these documents it would appear that it was here that decisions were made with regard to service developments for the different client groups. However, despite the dominance of these strategies in the 'community Care' plan, according to those involved with these fora, they were little more than talking shops, and the only monies they had a direct input over was 'Joint finance' monies. According to one representative from the 'Black and Minority Ethnic' voluntary sector:

"I have become very skeptical about joint planning...We used to send voluntary sector reps to those groups and now its petering out we cant get people interested in attending those groups, and my view is that...they were incidental. They weren't where the decision making process was, the decisions were happening on a day to day basis and the decisions were happening within Social Services...we would find out about them because they would be reported back, they never originated from the SPG's."

From the outset, both Authority A and B did acknowledge the need to plan for the increasing number of 'Black and Minority Ethnic' older people. Both Authorities held specific community care plan consultation meetings, and Authority B took this a step further by overhauling its joint planning framework to better incorporate the needs and views of 'Black and Minority Ethnic' communities. Both authorities attended the 'London Group on Race Aspects of Community Care' and interestingly the officer who attended these meetings for Authority B attended a specific sub group, which focused on consultation, which appears to have been given considerable importance in terms of community care planning.

There are other initiatives that can also be traced to 'community care implementation', which were essentially one off, unfocussed attempts to embrace 'race equality' to some extent.   Prior to the change of administration in 1990, Authority A, prepared a section eleven funding bid to establish an 'elders case management' project for 'Asian' and 'African Caribbean' older people. This bid was not approved and the scheme did not go ahead. It is likely that if the previous administration had continued to determine policy in this Authority, there may have been more strategies aimed at promoting to 'race equality' linked to 'community care' implementation(Authority A, 1992a). This Authority also commissioned a research study that explored the 'sheltered

accommodation needs' of older 'Black and Minority Ethnic' groups, which we will return to in Chapter Seven(Sills, A, Sawhney, S, 1996).

The focus on consultation in Authority B appears to have been the major way in which 'ethnic diversity' has been embraced in 'community care' implementation. However, this consultation has been incidental to the decision making process related to the development of the 'quasi-market' in social care. Consultation has led to a number of one off reactive initiatives. For example in 1990, Authority B commissioned a study, in response to a 'community care consultation' event that reviewed 'The needs of Elderly Black People'; Carers'; and Black People with disabilities'. This report identified a lack of commitment to delivering equitable services to 'Black and Minority Ethnic' elders, and a lack of understanding about why specific services should be developed.

The report made a number of recommendations including employing a 'Caribbean' cook to supply 'Caribbean' meals; staff training on race equality issues within home care; and a specific worker to develop and improve care services.(Cole, J, 1990) A member of staff was seconded to follow up some of the recommendations. Her view was that change was too slow, and it placed her in a difficult position as a 'Black' worker, having to consistently raise issues related to the lack of diversity in service provision, which were not owned by the whole department.

Interestingly the senior officer with responsibility for 'equalities' and 'consultation' within the social services department was not aware of the existence of this report. The report appeared to have little impact on the operation of the department and a second 'community care' report, was commissioned by the 'Black and Ethnic Minorities

Community Care Project' which was never completed.

Despite Authority B clearly taking some steps to address issues of 'race equality' the perceptions of some staff were that there was a lack of commitment to these issues and it was reliant on the goodwill of different officers: According to one voluntary sector rep:

"It relies on the goodwill of people in particular positions, once they leave it goes back to where it was before they ever came."

According to one 'Black' member of staff:

"I feel as if I have to keep going on about these issues, otherwise they get ignored and I get the feeling that some people think, I am just moaning about these issues all the time."

On the other hand according to one 'White' member of staff:

"The African-Caribbeans' get everything anyway."

Interestingly in both Authority A and B, the perception of the relative significance given to 'race equality' and the need to give this issue significance, appeared to be shaped by 'ethnicity' with 'Black and Minority Ethnic' workers more likely to perceive the issue of 'race equality' as neglected, compared to 'White' workers who were more likely to suggest that this issue was over-emphasised.

The Changing Profile of Service Provision – Towards More 'User Focused' Services?
One of the intentions of the 'community care' legislation was to encourage a shift from 'service led' to 'needs led' provision. This raises the question of how far the profile of services/choices for older 'African-Caribbean' people changed following the implementation of the 'community care' legislation. It also allows us to consider whether the previous model of service provision was as ineffective in responding to 'diverse' need as assumed.

<u>Day Care</u>
In chapter two we observed that the (ADSS/CRE report, 1978)
recommended that local authorities reviewed 'day care' for older
people with a view to ensuring that mainstream provision was
accessible, in addition to funding 'culturally specific' provision.
During the 1980's, many 'Black and Minority Ethnic' run voluntary
organizations were established. Funding for these organizations,
came from Local Authorities, and the Greater London Council(GLC).
According to (Ouseley, H, 1990) one of the central achievements of
the GLC in terms of addressing the issue of 'race equality' was in
relation to supporting the development of a 'Black and Minority
Ethnic' voluntary sector. Indeed research undertaken by the Social
Services Inspectorate in eight local authorities, found that 'day care'
was one of the few areas in which all authorities had developed at
least some 'culturally specific' provision.(SSI, 1998)

<u>Authority A – Day Care</u>
 Many groups within Authority A received support from the GLC and
the local authority. Five organisations were established within the
voluntary sector, responding to the recreational/social needs of older
'African-Caribbean' older people. One organisation provided a
luncheon club/Day Centre for older 'African-Caribbean' people, and
an advice service for other organizations, operated as a a catalyst
for developing new services to respond to 'unmet' need within the
'African-Caribbean' community.

During the 1980's, two Church based organizations, also began
developing 'day care' services for the 'African-Caribbean' community.
Initially they developed educational services for younger people,
because of concerns related to 'underachievement' within the
education system, but according to the coordinator of one of the
schemes:

> "We also realised that another vulnerable section within the 'Black' community, was the 'Black' elderly. Around 1984 local authorities, didnt have the data in terms of the numbers of 'Black' elderly, and then there was the view that people all fly to the Caribbean when they retire. We approached the local authority. The view was that there were no 'Black' elderly, and where they were, they were expected to dovetail to existing facilities. We made the case that there were very specific cultural and recreational differences, so they said, well if you find them we will fund you...we quickly realised there was a great demand and grew from two days a week to providing four days a week day care...there was a great need and very distinct cultural, dietary and recreational differences, and if you are looking at this generation, you are dealing with a generation that has grown up apart."

The climate, which operated during this period was favourable in terms of developing provision to respond to 'unmet need'. However, as we have already discussed, by 1990, there was a backlash against 'anti-racism', with a particular antipathy to the 'African-Caribbean' community, and facilities diminished after this period. The two other facilities continued to be funded until 1996/97, when they lost funding for their services, following substantial cuts to the budget for voluntary organizations.(Balchandani, R, 1997, Authority A, 1996d)

Of the remaining two organizations, one was church based and the other organisation was located in a building which had been abandoned by one of the organizations that had lost their funding. According to the coordinator of one of the schemes:

> "We are fortunate, in that we used to be based in a small building, but a 'Black' groups was here, they were not given adequate support to succeed, and they made a mess of things."

The remaining two organizations were still operating, but with standstill budgets. According to the Co-ordinator of one of the schemes:

"The budget is standstill and you have to keep going, you struggle, the money is limited we havent had a payrise for three to four years..we manage to do a lot of things through the help of our volunteers.".

The strength of the remaining two organizations, was clear in terms of their commitment to providing a relevant service. For example, in response to the increasing numbers of older 'African-Caribbean' people suffering from Alzheimer's disease, one of the schemes had developed a reminiscence project specifically aimed at their experience in Britain. This involved constructing a typical lounge characteristic of a 1950's 'African Caribbean' household living in Britain, with the aim of stimulating memory, they were also reviewing the possibility of developing a residential care facility:

"We have the passion and we also want to get the best for our people, we obviously put ourselves out in order to deliver the services with minimal input from social services. Without us I dread to think what would happen to our elderly."(Coordinator of Day centre)

This is a good example of the benefits of 'culturally specific' services and was reflected in a study by (Harris, M, Halfpenny, P, Rochester, C, 2003) that reviewed the strengths of 'faith based organisation's as providers of services. Moreover, these organizations were innovative in identifying unmet need and advocating for older 'African-Caribbean' people.

However, they were finding it difficult to continue to operate in an independent way. Both organizations developed in a whollistic way, providing services for all sections of the community. However, funding for the range of services they offered diminished, with the emergence of contracting, funders wanted to be specific about the type of service they were funding/purchasing, and were less willing to fund a whollistic service meeting a range of 'community needs'.

This was a finding reflected in another study reviewing implementation.(Social Services Inspectorate, 1998) According to the coordinator of one scheme:

> "We have been affiliated to youth and community, but for years now we haven't been able to get a paid worker, they fund us for the senior club, for a paid worker and running costs."

Moreover their autonomy in delivering services for older 'African-Caribbean' people was also being challenged. Despite working within standstill budgets, the groups have had to expand to cope with increasing demand, given the demographic trends of an increasingly older 'African-Caribbean' population and the closure of other facilities. Moreover post 'community care' the local authority wanted to be increasingly specific about who they were purchasing care for, by specifying in the contract that the organisation provide care for a certain number of social service referrals. At the time of this research this was being resisted by the two organizations, who wanted to operate an 'open access' policy. Similarly a contracts manager commented that:

> "Saying they provide solely to 'African-Caribbean's is not correct. They will open their doors to members of the community, providing they meet the criteria to attend that centre...We do not purchase services from an organisation which focuses on one particular client group..if someone, Indian or White UK needs to go to X they would not turn them away."

This is a good indication of the way in which the 'contract culture' may reorganise the role of 'voluntary' sector provision, from one which 'compliments' statutory provision, to one that simply replaces 'statutory' provision and increasingly reflects the policy goals of the local authority. This finding has been reflected in other studies.(Lewis, J, Glennerster, H, 1996;Weeks, J, Aggleton, P, 1996)

The local authority clearly recognized the strengths of the remaining providers, and wanted to work with them as they were viewed as offering 'value for money'. A review of day care stated:

> "The evidence shows that these clubs are providing more than just the luncheon facility. They provide personal care services to very dependent elderly at the same level as the day centres. Their unit cost is much lower, based only on the grant contribution from Authority A."(Balchandani, R, 1997, p11)

However, there was a lack of strategic direction in relation to funding 'culturally specific' day care. For example, in 1997 the Department undertook a formal review of day care for older people. Despite an acknowledgement of the increasing numbers of older people from 'Black and Minority Ethnic' communities in this authority, this was ignored in this review. Essentially the review was a mapping exercise, of local authority and voluntary provided day care undertaken in a 'colour blind' way. The review made no specific observations about existing patterns of service and their ability to respond to the demographic profile of those living in the authority. As in most policy documents issues of 'race equality'/'ethnic diversity' were limited to one paragraph which proposed that there was a need to develop more 'culturally specific' day care, though this was rather a vague and predictable recommendation, which failed to acknowledge either the disappearance or existence of 'culturally specific' services.

There are a number of things that can be concluded about day care provision for older 'African-Caribbean' people in this Authority. First there was a lack of strategy in relation to providing day care, and what exists in terms of day care is a result of historical accident and expenditure constraint. Secondly, the era of 'bureaucratic' planning had facilitated the development of provision responding to

'differentiated need', though this was based on those 'differentiated' groups lobbying local government for change, and was therefore reactive rather than pro-active. Moreover, a climate of 'municipal anti-racism' was clearly significant in facilitating a positive climate in which to respond to such issues. The implementation of the 'community care' legislation had not generated more 'culturally sensitive' or 'needs led' day care – but was increasingly formalizing and reducing the autonomy of existing 'voluntary providers' who clearly provide a vital and efficient 'social service'.

Interestingly, the existence of 'culturally specific' day care provision for older 'African-Caribbean' people has its roots in the strategy of 'race equality' pursued during the 1980's, and not 'community care implementation'. However, whilst the needs of older 'African-Caribbean' people are met to some extent in Authority, A, the same could not be said of other less organized 'Black and Minority Ethnic' groups.

Authority B – Day Care
At the time this research was being undertaken, Authority B had three day care venues catering specifically for the needs of older 'African-Caribbean' people. The development of these services was not part of a comprehensive day care strategy, but rather, arose incidentally following pressure from 'below'. We will refer to these facilities, as Centre one, Centre two and Centre three. At the time of this research two of the three centres, were run by the local authority. Within this Authority there was never a particularly buoyant voluntary sector, and there was resistance to providing services for older 'African-Caribbean' people in the voluntary sector, as it was felt this would make them marginal. Elected members pursued a strategy of ensuring that the needs of older 'African-Caribbean' people were part of a mainstream strategy of 'day care'

provision, rather than being dependent on 'grant aid' funding in the voluntary sector:

"Many of our 'Black' members on the council have been very supportive of all three centres, seeing them as an Authority responsibility."

It was perceived that this would provide more financial security. According to the head of one Centre:

"The funding is more stable than if we were out in the voluntary sector."

As in Authority A the 1980's was a period of radicalism. A Community Development team was established in the 1980's to identify and respond to unmet need. A specific worker was appointed to support the development of 'culturally specific' services for 'African-Caribbean' communities.

Authority B - Centre One

The first Centre opened in 1985. This was one of the first 'culturally specific' day centres' for older 'African-Caribbean' people in the country. It was the outcome of a local campaign. A community group set itself up on a voluntary basis, the group met in the houses of different members. They campaigned for a centre to meet the specific needs of older 'African-Caribbean' people and were supported by the Local Race Equality Council. The Centre was designed for the 'active elderly' and did not take into account the increasing frailness of the community, in either the design or staffing of the centre. The centre had loose admission criteria, attempting to operate an open door policy based on a waiting list rather than eligibility criteria.

The centre was developed by the Social Services Department, and at the time of this research was managed by the Social Services Department. However, the nature of this centre and its client group

fit a different pattern of service provision, from the post 'community care implementation' climate of eligibility criteria and targeted resources. The Social Services Department was considering transferring responsibility for the centre to the leisure department within the local authority. According to the head of the centre:

> "Given the nature of the people using the service, being low to medium care needs, I wouldnt be surprised if they weren't looking for it to go out to tender, in the private or voluntary sector...I think social services would really like it to be managed by someone else, but at the same time they see the points they score, which are favourable points to the wider community and nationally."

This is interesting then, a centre developed in the 1980's in response to a general climate of 'service development' and 'race equality', no longer fits in with the post 'community care' climate. On the other hand, the centre is held up as a good example of 'ethnically sensitive' provision, and therefore to close the centre would be politically problematic.

Authority B - Centre Two

The second centre opened on the opposite side of the borough during 1996 and was also the result of a local campaign. Three different voluntary organizations had been meeting in church halls in the north of the borough, where they provided luncheon clubs. The three groups formed an alliance to campaign for a day centre in the north of the borough (the first centre was in the south of the borough). The group was supported by the local authority and was successful in accessing a large grant from City Challenge and monies from the Local Authority Social Services Department, to develop a centre. (Authority B, 1995)The centre opened in 1996, following several years of campaigning. The intention was that this organisation be managed in the voluntary sector, however, following a number of disagreements within the Management Committee, the

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project was initially being managed (until December 1998) by the Social Services Department.

Those individuals initially involved in campaigning for the centre were not satisfied with the outcome. They wanted a 'drop in' type resource, which, would be accessible to all. The Social Services Department in line with its overall policy of targeting limited resources and prioritizing via eligibility criteria, stressed a need to make the centre accessible only to those falling in the 'medium' and 'high priority' categories. This is interesting as despite the policy intention that the centre be located in the 'independent' sector, it was clearly not to be run in an 'independent' way, rather it was the 'monopoly purchaser' that would determine how the organisation, operated rather than those involved in developing the centre. (Weeks, J, Aggleton, P, 1996, p114) identify a similar conflict in their study:

> "Founders and early volunteers often find themselves
> marginalized..as their ambitions for the organisation may differ
> significantly from those who now manage the agency."

This then is an interesting case, like Centre one, it was the result of 'grassroots' campaigning, but the nature and likely management of the centre in the future, was shaped by the policy agenda of the 1990's, which was about targeting resources, eligibility criteria, and a 'sub-contractual' role for the voluntary sector.

Authority B - Centre Three
The third source of day care provision specifically for older 'African-Caribbean' people was opened in 1995, within a new sheltered housing scheme. At the time of this research the scheme was managed by a Management Committee, and a local Housing Association. Once again it was not the result of strategic planning but reactive. A local group, meeting at the first day care centre in

the mid to late 1980's, identified a need for a sheltered housing scheme for older 'African-Caribbean' people and started a campaign that gained support from local 'African-Caribbean' councilors.

When the scheme was completed, it was apparent that there was room within the scheme to provide day care for medium to highly dependent older people. The management of the centre met with the local authority about the possibility of providing day care. The local authority subsequently invited organizations to tender to provide day care to highly dependent people, and the Centre applied.(Authority B, 1995) However, according to the coordinator, the tendering process was a formality, it had already been agreed beforehand that they would provide day care. The local authority then purchased 50 places from the centre. This is the only service provider that has such an agreement. According to the head of Community Development:

> "It has been provider driven with member support, some of
> that has been because of the absence of a commissioning
> strategy in terms of where we are going with things, in a sense
> we are having to actually backtrack, and think in terms of what
> we know about need."

This Authority was funding three different day care centres, at the time of this research. Each had developed as a response to 'unmet need' identified by the 'African-Caribbean' community. They were all reactive, rather than part of any overall strategic plan to respond to 'ethnic diversity' in day care provision. Whilst all three schemes evolved from 'race equality' initiatives, the 'community care' agenda was influential in terms of increasingly determining both the nature of the service and the service user, again with a reduced autonomy for service providers.

There were three factors that were crucial in the development of this

provision. In the first instance, there was an organized 'African-Caribbean' community, ready to make demands on the local authority; Councillors of 'African-Caribbean' origin, sympathetic to 'culturally sensitive' provision; and a Community Development Worker who had been employed as part of the Community Development Work prioritized in the 1980's by this authority, and for whom developing community provision for older 'African-Caribbean' people had been part of their brief. This worker left his position at the beginning of this research and his post remained unfilled as part of a programme of budgetary cuts/savings.

Interestingly then in contrast to Authority A, Authority B had an expansion of day care for 'African-Caribbean' older people in the 1990's. However, as should be clear this was reactive rather than proactive, and grew out of campaigns for 'race equality' that emerged in the 1980's. However, this reactive approach to policy making came at a price for the local authority. Two officers felt that this had created an 'oversupply of provision' for older 'African Caribbean' People, both in relative terms based on their numbers in the population, and given the closure of other facilities, and the implementation of tighter eligibility criteria, that had affected service provision generally. Moreover, as the department did begin to operationalise the 'purchaser/provider' split and think more strategically about this issue, it created a policy dilemma, the Local authority had a diverse population comprising many different 'Black and Minority Ethnic' groups. Were they going to replicate this pattern of service delivery for all 'Black and Minority Ethnic' groups? According to one senior manager:

> "We realise there is some hugely sensitive stuff there, as
> 'White' officers we are very aware of that.. er.. in the best
> possible worlds we would want to make sure there was plenty
> of provision available, but there are some potentially difficult
> choices."

Indeed, the lack of strategy, and the reactive nature of policy developments was generating some unpalatable contradictions. According to one Officer:

> "Ideally, the Turkish would like their own centre, but we are not in a position to fund that. We have identified space in one our day centres and we are going to use it for older 'Asian' older people two days a week, and older 'Turkish' people three days week."

Therefore the provision of three 'day care' centres catering specifically for older 'African-Caribbean' people is not an indication of an authority that is responding to 'ethnic diversity' but rather an authority that responds to the demands of well organized groups, and in the process generates a hugely unequal pattern of service provision.

One could argue then that the existence of culturally specific provision in Authority A and Authority B, was reactive. Indeed this was a finding of (Butt, J, 1994) in an analysis of the implementation of 'equal opportunity' policies, in three local authorities. He argues that:

> "The majority of the reasons for funding 'Black' community groups was more pragmatic and reactive rather than representing a planned pro-active stance..without pressure from these groups they would not have developed. They respond to the most organized groups." (Butt, J, 1994, p42)

Residential care
In Chapter one, we saw that with the introduction of 'community care', local authorities were allocated a standard Transitional Grant (STG monies) to purchase appropriate care. These monies were not attached to existing provision, and therefore, the authorities could use this money in creative ways to purchase relevant care, including

residential care. The initial focus within commissioning/contracts units was on developing arrangements for the purchase of residential and nursing home care(Lewis, J, Glennerster, H, 1996)

There was some evidence that existing placements for older people from 'Black and Minority Ethnic' groups had been inappropriate. For example, some people had been placed in homes on the 'South' coast - socially isolated from other 'Black and Minority Ethnic' groups'; food was inappropriate; and sometimes service users were unable to communicate with staff because of language barriers. (Lewis, J, Glennerster, H, 1996, Audit Commission/Social Services Inspectorate, 1997)

With the advent of 'municipal anti-racism', some authorities had developed 'culturally specific' provision within their own 'residential care' establishments. This involved the allocation of two or three beds as part of a unit. However, the extent to which a three bedded unit, could be construed as an adequate response to 'cultural difference' is questionable, as the experience of living in such a unit, may be one of 'cultural marginalisation'.

How then did our two 'case study' authorities embrace 'ethnic diversity' when developing their arrangements for the purchase of residential and nursing home care?

<u>Authority A – Residential Care</u>
This authority did not give any priority to 'ethnic diversity' when developing arrangements for purchasing/commissioning residential care. For example, the Head of Commissioning was asked what priority had been given to 'ethnic diversity' when developing commissioning arrangements for the purchase of residential and nursing home care:

> "I think it was high in terms of providing meals at lunchtime...it didnt equate in the same way in residential care.. if you went through the committee reports for that period you would see that 'race' specific services would not have been actively encouraged."

Therefore the 'non-action' on this issue was a result of a perception that a strategy that responded to 'ethnic diversity' would not have been acceptable to 'members'. The commissioning unit produced a guide to aid 'care managers' when selecting a 'residential' care home. However, this provided very superficial information such as a list of care homes, and contact names and addresses. There was no information on how the specific needs of different individuals might be better met in one residential care home, compared to another. Choice, then was presented in an undifferentiated 'mono-cultural' way. This failure to purchase care in a way that acknowledged the 'ethnically diverse' community, was interesting given statements about the need to consider this in 'community care' planning documents.

The manager of the Elders Assessment Unit expressed the view that the new legislation and the choice directive had facilitated greater choice. However, choice was presented in a 'mono-cultural' and undifferentiated way. From her perspective, there was not a demand for 'culturally specific' residential care. According to this senior manager:

> "African Caribbean' older people, want integrated care, they want to eat what we want to eat, we want to eat what they eat, 'Asian' older people want specific services because of language barriers."

The introduction of 'race equality' policies in the 1980's had led this authority to develop 'culturally specific' provision for older 'African-Caribbean' people within one of their own residential care homes. A three bedded unit was established specifically for older 'African-

Caribbean' people. It was the low take up of this unit that led this manager to conclude that there was not a demand for such a service.

However, this was contested by two assessors who worked in the Elders Assessment Unit, and were of 'African-Caribbean' origin:

> "People who say this, dont understand the experience of older people, they work on that assumption by looking at the younger generation you cant make the same assumptions about the older generation."

They accounted for the low take up of this unit, in terms of it's limited size and a lack of commitment to the service. They had been disappointed at the neglect of issues of 'ethnic diversity' when commissioning residential care:

> "They dont ask providers what they do to cater for 'African Caribbean' and 'Asian' elders."

However, some staff had developed informal strategies to ensure that 'culturally specific' needs to be met. For example, when placing an older 'African-Caribbean' person in residential care, some assessors were arranging 'culturally specific' day care, as part of the package. There was also an informal knowledge network, whereby some homes were identified by care managers as more able to meet the needs of older 'African-Caribbean' people than others. These responses were limited it seems to some 'Black and Minority Ethnic' groups, and were not applied in a general way when undertaking assessments.

Whilst the fieldwork for this project was being undertaken, this Authority had transferred management of its 'in-house' residential care homes to a Housing Association and then contracted with them to provide residential care. The Authority stipulated in the contract that they should provide a specific unit for older 'African-Caribbean'

people, therefore maintaining the existing level of provision, without including any more comprehensive 'race equality' goals. According to one Care Manager, the unit had neglected the needs of older 'African-Caribbean' people:

> "I have visited clients there, and there was no attention given to cultural needs, food was not catered for, appropriate skin care was not given."

Another ''voluntary sector' provider of 'culturally specific' day care was pursuing the possibility of developing a specific residential care home for older 'African-Caribbean' people.

In this Authority then arrangements for purchasing residential care had been implemented in a 'colour blind' way. This has to be understood against a background of hostility to 'culturally specific' provision, both from councilors and officers. However, despite this, strategies had evolved to meet at least some 'culturally specific' needs through an 'informal knowledge' network and the purchase of appropriate day care, essentially compensating for the lack of appropriate residential care. However, the extent to which this would be applied equally to all individuals passing through the assessment process was questionable.

What was clear throughout this research, and illustrated again in the purchase/commissioning of residential care was that the lack of a coherent strategy to meet diverse needs, had led to the development of ad hoc initiatives aimed at filling these gaps, however, these initiatives would have been unevenly applied, related to the perspective of the assessor.

Authority B - Residential Care
This Authority operated a similar policy to Authority B, in the purchase/commissioning of residential care post 'community care'

implementation. A 'colour blind' approach was adopted in negotiations with homes and the construction of a list of providers. Therefore, at the time of this research the authority was unable to provide a list of providers who could meet the needs of different 'Black and Minority Ethnic' groups'. This again was at odds with statements related to the need to incorporate the needs of 'Black and Minority Ethnic' groups in 'community care' planning. According to the manager with responsibility for 'equalities' issues, in response to this failure to reflect 'ethnic diversity' in purchasing decisions:

"A lot of these homes are run by 'African-Caribbeans, anyway'."
As in the case of Authority A, a small unit (two bedded unit) had been established within their own provision for older 'African Caribbean' people in the 1980's, again in response to an agenda of 'race equality'. There had been a low take up of this unit, which as in the case of Authority A was interpreted as a lack of demand for such a facility. However, this policy was clearly at odds with the authorities provision of day care and sheltered housing for which there had been a high take up. Moreover, one has to question again, whether a two bedded unit really constitutes 'culturally specific' provision? Therefore low take up may simply indicate caution about the possible isolation associated with residing in such a small unit.

As in Authority A, there was a general sense of disagreement about whether older 'African-Caribbean' people wanted separate or integrated service provision. Similarly, workers from 'Black and Minority Ethnic' communities were more likely to reinforce this need for 'specific' provision compared to 'White' workers who suggested there was a preference amongst older 'African-Caribbean' people for integrated provision. Three 'African-Caribbean' social workers in this authority, indicated that there was a huge problem in relation to

providing appropriate residential care, which translated into older 'African- Caribbean' people being placed in homes where there cultural needs were not being met, with staff unable/willing to comb their hair, apply appropriate skin care etc. According to the manager seconded to implement the recommendations of the report undertaken by (Cole, J, 1990):

> "In residential care, when a "Black" worker is on duty looking after a 'Black' client certain personal care needs will be addressed, For example, their hair will be combed, their scalp oiled, but if they are not around their hair doesn't get combed until the 'Black' worker is back on duty,...so that part of their personal care needs get missed out.".

There were clear parallels in both Authority A and B, in relation to the failure to address 'ethnicity/diversity' in the purchase of residential care. This did not fit in with other dimensions of care provision. Moreover, user feedback in this Authority had raised the need for 'culturally specific' residential care services early on in 'community care' consultation meetings. According to the manager with the specific equalities brief:

> "We did look at developing our own provision, I am not sure what came of that, two thirds of the homes are in the independent sector anyway and a lot of them are run by minority ethnic staff and owners."

A perceived lack of demand was flagged up in this Authority. According to the Commissioning manager:

> "The problem has been the numbers coming in, we surveyed nursing homes and there were ten people in 'non white' categories in nursing homes."

The perspective from senior Management in the Authority was that the commissioning of residential care and 'ethnic diversity' was not on the policy agenda, at the time of implementation, but there was increasing awareness in relation to this issue. This Authority was

belatedly moving towards developing strategies to meet diverse needs. According to the Head of Commissioning:

> "I think where an older person goes into a nursing home, where they are the only 'Black' person, that they should have access to full proper cultural support, we want to make sure there is proper support...In terms of residential care contracts where it is clear that people's cultural needs should be met... We have agreed we will pay extra to have their needs met, its fairly modest £20, a week...but it means if their first language is Turkish or they have religious needs they can be met."

However, it may be that such a limited sum, will lead to a very limited recognition of 'cultural needs', embracing what could be described as a 'minimalist'/'tokenistic' approach to 'ethnic diversity' in the commissioning process, with sums of money insufficient to purchase services to meet 'cultural needs'.

Both Authority A and B then neglected to consider 'ethnic diversity' when purchasing residential and nursing home placements. Unlike Authority A, the hostility to 'culturally specific' provision at a senior management level was not apparent in Authority B, however, Authority B, simply reacted in an ad hoc way to pressure from 'below'. Given that there was no pressure on this issue, this became a neglected issue in relation to 'community care implementation'. The strategy of a sum of money to meet 'cultural needs' could be interpreted as either an indication of a more strategic and equitable approach to this issue or the further marginalization of these issues.

Identifying New/'Unmet Need'

One of the crucial ways in which patterns of service provision would change following 'community care implementation' was through the development of improved systems to identify new and unmet 'need'. Guidance on 'community care implementation' was clear that 'needs assessments' needed to be carried out at both a 'macro' and 'micro' level, implicit in this task was a role for identifying 'unmet need'.

Moreover, the development of systems, which were better able to identify unmet need would be an important tool in responding to 'diversity'. How then did these two authorities, respond to the task of identifying new and changing needs?

Authority A - Identifying New/Unmet Need'
This Authority did not prioritise the issue of identifying new needs. According to the Head of Commissioning:

> "We have got SID, but it struggles to sustain a comprehensive client index, it has not been used for unmet need analysis at all, and unmet need, is usually only identified through the strategy groups, through the user input on it..There is no systematic process at all for identifying unmet need, it is done on a representative basis by organisations."

The rationale for the failure to identify unmet need related to the limited capacity they had to respond to unmet need:

> "If you ask a front line manager, since I think 1994 we were making budget reductions every year, so in terms of the organization, identifying unmet need on an individual basis to develop services which arent resourced, what we have been doing is cutting base services year in/year out. If you have say one day centre for people with disabilities, the variation on in house provision is limited."

It was clear in this authority that 'needs led' services were not perceived as a possible benefit of implementation. There was no sense in this authority that the 'community care' legislation might provide the opportunity to develop more user orientated services even with the limited resources at their disposal. The focus was on responding in a minimalist way to statutory guidelines and responsibilities. Therefore, this crucial part of implementation was ignored in Authority A.

Authority B - Identifying New/Unmet Need'
Authority B also neglected the issue of identifying unmet need. According to one manager in relation to the development of a

system for identifying unmet need:

> "I dont think there is one, it was one of the big issues early on about how you classify unmet need and I think we were one of the councils which were criticised for not aggregating that data in any systematic way, I guess if there is a system at all it would be through individual service units."

As should have become quite clear by this point, this Authority has been reactive in responding to need rather than pro-active, 'need' would essentially continue to be identified through the re-vamped joint planning machinery, but the vital information from individual assessments would not be recorded and therefore this vital resource would be lost. However, with plans to more fully develop the purchaser/provider split, this vital part of 'community care implementation' may be developed.

Conclusion

In this chapter, we have reviewed ways in which the two "case study" authorities responded to issues of 'race', 'race equality' and 'ethnic diversity', both in the 1980's and then prior to 'community care' implementation. We have also considered ways in which 'ethnic diversity' was either included or excluded from different dimensions of the 'community care' planning process.

Authority A was an interesting 'case study'. This Authority adopted a radical stance on 'race equality' in the 1980's and strongly embraced 'municipal anti-racism'. The election of a significant number of 'Black and Minority Ethnic' councilors was significant in this policy redirection. Despite a perception that the previous model of service delivery was ineffective in responding to 'differentiated need', the policy climate of the 1980's appeared to be favourable in relation to responding to at least some 'differentiated need'.

However, prior to the introduction of the 'community care' legislation, the authority had adopted an 'anti-anti-racist' position and issues of 'race', 'race equality/'ethnic diversity' were a neglected dimension of 'community care implementation'. Each dimension of 'community care' planning reflected a failure to acknowledge 'ethnic diversity', this was evident in the review of joint planning; the review of day care; and the purchase of 'residential and nursing home' care, it was only the 'community care' plan itself that made reference to this issue.

Despite this neglect, some workers committed to responding to 'differentiated need', found ways to ensure that 'cultural needs' were acknowledged and met, and voluntary organizations were continuing to develop and deliver 'culturally sensitive' services to older 'African-Caribbean' people, therefore essentially it was the energy of individuals in voluntary organizations and working within the local authority that services continued to be 'culturally sensitive', in spite of, rather than because of the policy climate. Moreover, there was an actual reduction in the level of day care provision for older 'African-Caribbean' people.

However, as we saw in Chapter four this was a strategically weak authority with limited capacity to think innovatively about 'community care' implementation, and this also helps us to understand why this issue, was neglected. However, had the previous administration continued to manage this authority, it is likely that 'ethnic diversity' would have had been given greater priority in 'community care implementation', though it is also likely that this response would have been limited to certain more organized and well represented groups.

One outcome of 'community care implementation' in this authority has been the impact of the introduction of a 'contracts culture' on voluntary organizations, providing services to older 'African-Caribbean' people. Whilst some organizations have closed, those that remain find that they are losing their autonomy, and are increasingly replacing rather than complimenting local authority provision. Moreover the whollistic nature of provision delivered by 'African-Caribbean' organizations is clearly at risk in this policy context.

Authority B is also an interesting authority. This authority also embraced 'municipal anti-racism' in the 1980's, following the election of a number of 'Black and Minority Ethnic' councilors who placed these issues on the agenda. However, change appeared to be slower in relation to the development of 'culturally specific' services for older 'African-Caribbean' people. Unlike Authority A, the voluntary sector was never stimulated as a mechanism for developing 'culturally specific' services, nor the use of section eleven monies, as both were seen as a way of marginalizing 'race' issues. A 'Community Development' team was established to respond to 'unmet need', with one worker responsible for working with 'African-Caribbean' communities. This worker worked with local campaigning groups to develop 'culturally specific' provision within the local authority.

At the moment of 'Community Care' implementation, this authority had also revised its 'race equality' strategy, adopting a 'generic' approach to 'equality' issues. It could be argued that 'ethnic diversity' was both incorporated and ignored in 'community care' implementation. 'Ethnic diversity'/'race equality' was incorporated in an ad hoc way. For example a specific consultation meeting was

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held in relation to the 'community care' plan, and the 'joint planning' machinery was overhauled to reflect more closely the policy intention of 'race equality'. On the other hand, these structures appeared to be incidental to the process of implementation, and therefore one of the key dimensions of 'community care' implementation, the purchase of residential care homes, completely ignored 'ethnic diversity'.

'The development of 'culturally specific' day care provision for older 'African-Caribbean' people in this authority was the outcome of campaigns for 'race equality' and 'community development' in the 1980's, and not the 'community care' agenda of the 1990's. However, the 'community care' agenda was shaping how these organizations operated in the 1990's and this was particularly apparent in the funding, organisation and clientele of Centre's Two and Three. However, it was the 'providers' rather than the 'purchasers' that had shaped provision in this area. The failure of this authority to respond strategically had created problems, and there were clearly attempts to respond in a more strategic way.

Both Authority A and Authority B then were able to provide some culturally specific services, but neither had strategically incorporated 'ethnic diversity' into the 'community care' planning process, interestingly despite operating in very different political contexts, from the perspective of the older 'African-Caribbean' service user, the portfolio of services on offer in both authorities was very similar.

We can conclude then that whilst the implementation of a 'quasi-market' did offer the potential to respond more effectively to 'ethnic diversity', this did not happen. Indeed an exploration of service developments suggested that the previous model was more

responsive to the differentiated needs of older 'African-Caribbean' people than this new model. Following the introduction of the 'NHS and Community Care Act 1990' services were purchased for an undifferentiated service user. Therefore, we can predict that this new framework would have been indifferent to the needs of 'Black and Minority Ethnic' groups and would have treated 'White' Service users as a homogeneous mass. We return to this in the concluding chapter. In the next chapter we review developments in the 'mixed economy of care' through a 'case study' of meals provision.

The 'Mixed Economy of Care' – A Case Study of Meals Provision

This chapter is a case study of 'meals on wheels'. It explores the impact of the 'NHS and community Care Act 1990' on this important dimension of 'community care' provision, and the contribution that this legislation has made towards generating user orientated responses. 'Meals' provision is an interesting area to pursue because it lends itself well to the possibilities of responding to diverse needs through the use of the 'mixed economy of care'. However, this case study demonstrates some of the problems, which are generated by a shift to market based solutions as a strategy for responding to diverse needs.

The development of culturally specific 'meals on wheels' provision was identified as a policy objective in 1978.(ADSS/CRE, 1978) During the 1980's some local authorities began the process of developing specific meals provision. By the 1990's the provision of more culturally responsive 'meals on wheels' provision had come to be seen as 'good practice'. Both Authority A and Authority B provided a specific meals service for older 'African-Caribbean' people. Authority B has had considerable problems in developing 'culturally specific' meals provision, and this is a problem reflected in many local authorities.

We begin this chapter by reviewing 'African-Caribbean' food and exploring whether assumptions made by policy makers about a specific 'African-Caribbean' diet and the eating preferences of those who either come from the or are of 'African-Caribbean' origin are appropriate, and more generally consider the social/cultural significance of food and the relationship between 'eating patterns" and 'ethnicity'. We review the literature on 'ageing and eating' as a significant dimension of 'meals' provision. We then consider how the

two case study authorities and an additional six local authorities
have responded to this issue in order to identify policy trends. We
conclude by reviewing problems and possible strategies in
responding to differentiated need in 'meals provision'.

What is 'African-Caribbean' Food?

One of the things that have become clear, since commencing this
part of the project is that there is clearly, a style of cooking and a
mix of ingredients which could be described as 'Caribbean'. There is
it would seem a growing interest in 'Caribbean' food, with the
publication of 'African- Caribbean' cookbooks in 1999 and 2000
aimed at those who had perhaps sampled food whilst on holiday.

According to (Mackley, L, 2000, p8):

> "The cuisine of the 200 islands of the 'Caribbean' is a mixture
> of so many styles that it is almost impossible to define...Certain
> basic styles bring together both the diverse ingredients and the
> cooking methods from Europe, Asia and Africa, but each
> national group of islands has its own characteristics and
> individual flavours."

Aziz similarly acknowledges that there is both similarity and diversity
in 'African Caribbean' food:

> "In this book of 'Caribbean' cookery, I have attempted to give a
> general impression of the kinds of food prepared and eaten in
> the hundreds of islands that stretch out in a gentle curve from
> the tip of Florida to the North-East of Venezuela in South
> America. It is an almost impossible task when you think of all
> the different countries that have laid claim to various islands
> over the centuries."(Aziz, K, 1982, p3)

What currently constitutes 'African –Caribbean' Food is drawn from a
complex history of forced migration from Africa to the Caribbean;
interaction with the Carib and 'Arawak' Indians; and colonisation by
various European countries, such as Spain, France, Holland and

Britain.

The original inhabitants of the Caribbean were the 'Carib' Indians who remain in very small numbers (it is estimated that around 3,500 live on the Island of Dominica) and the 'Arawak' Indians who have been wiped out.(Ekwin, K, I, R, 1988) In 1492 much of the Caribbean was occupied by Spain, and at different periods, different Caribbean Islands were dominated by the French, Spanish, English, and in some instances, Dutch colonizers.

The main crops grown in the Caribbean prior to initial occupation by the Spanish; included sweet potatoes; cassava; corn; yams; beans; peppers; pumpkins and tannias. According to (Elwin, K, I, R, 1998) there was little wildlife on the islands, and therefore the bulk of the diet was made up of fish, root crops and maize. She argues that the first inhabitants of the island, the Arawak Indians who originated from South America, had as their principle diet; corn; sweet potatoes; yampie; beans; callaloo; hot peppers, pimento; fish; iguanas crabs; guavas; pineapples; prickly pear and paw-paw. Cocoa was a popular drink at the time.

Spain colonised Jamaica in 1492 and settled on the island in the early 16th century. They imported pigs, cattle, goats and horses. The island became an important supplier of smoked and salted meat to Spanish ships. According to (Benghiat, P, 1984) The Arawak Indians in Jamaica spit roasted fish and meat, including jerk pork, which continues to be a popular way of cooking in the 'Caribbean'.

The 'colonizing' powers tended to use vast areas of land for cash crops such as sugar cane, cocoa and coffee. These crops were produced under a system of forced/slave labour. Initially, drawing

on the labour of native Indians, and then following near extinction, the importation of slaves from Africa(Taylor, D, 1967). The plantation owners had substantial control over the diet of slaves. They provided the slaves with most of their foods, which comprised salted and pickled meats or fish; and flour imported from Europe. Africans were initially not allowed their traditional foods. They were prohibited from rearing livestock and were prevented from eating fresh fish of fresh meat, and so came to depend on salted fish, which continues to be a popular dish.

"For most slaves their diet was bland and monotonous and it was they who made the most of the Island's pungent spices and seasonings to flavour their broths and stews."(Grant, R, 1999, p11)

Africans maintained some of their traditional cooking methods. For example they continued to use an earthenware pot for slow cooking (referred to by some as 'one pot' cooking) and smoking meat over a kitchen fire. Indeed the earthenware cooking pot continues to be a popular cooking method associated with preparing and cooking 'Caribbean' food (Grant, R, 1999).

Slaves were allotted small garden plots where they could grow crops to supplement their diet, such as yams, tannias, dasheen, and coconut, some of which were grown on the island prior to colonization, and some of which the Africans introduced. Colonisers brought their own additions, such as bananas, breadfruit, coffee, cocoa, dasheen, mangoes and plantain (Grant, R, 1999). According to (Elwin, K, I, R, 1998) The use of wheatflour, white potatoes, meat(beef, mutton), Rice, salt-fish(cod), pickled meat and milk are examples of early European introductions into the Dominican diet. The impact of the French on the Dominican diet is obvious when reviewing Elwin's cookery book. Many recipes have French sounding

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names such as Cod au Boillon; Fricasse mountain chicken; Ton Pitche; Crapaud(frogs legs soup) demonstrating the impact of the French on eating habits.

Other islands had slightly different influences. Jamaica, for example, remained under British rule for 300 years, and this has impacted to some extent on the Jamaican diet with the continued use of corned beef, buns and tarts today. However, the Jamaican Cuisine has been affected by many influences. For example, when Slavery was abolished in 1830, many of the former slaves refused to work on the Plantations, and workers were brought in from India, Ireland, Germany and Syria. One of the most popular 'Caribbean' dishes today is 'Curry Goat' which was a dish invented by Indians who settled in Jamaica (Mackley, L, 2000).

It is clear that there is something, which could be described as 'African-Caribbean' cuisine. This cuisine relies to some extent on a common stock of ingredients, prepared in slightly different ways and shaped by diverse histories of colonization. What is also clear is that what has shaped the 'African-Caribbean' diet is a history of forced movement, racism, colonization, as well as resistance to this domination. We have established then that there is indeed a specific 'African-Caribbean' diet. This brings us to our next question, which is, what is the cultural significance of food? In other words, why do we eat what we eat, and why does it matter?

The Cultural Significance of Food
There is a relatively small literature on the relationship between food and eating habits, particularly in relation to ethnicity. (Mennell, S, Murcott, A, Van Oterloo, A, H, 1992) identify a 'sociology of culinary culture', which explores why different 'social/cultural' groups, and particularly different nation states or societies came to develop

different tastes and attitudes over time. However this literature tends to focus more on the supply of food, rather than taste/preference.

(Simmel, G, 1910, p245) argues that 'primitive' peoples did not have meal times, but that the construction of meal times is the first indication that what we eat has broken with a 'naturalness' of eating.' (Brillat Savarin, A, 1825,) in a seminal text 'La Physiologie de Gout'('The Physiology of Taste') Suggests that to make sense of people 'sociologically', we need to study what they eat. (Douglas, M, 1972) argues that food is not simply about nutritional requirements but that the deciphering of a meal reveals issues of hierarchy, inclusion, exclusion, boundaries, and transactions in relation to what is shared. Similarly, For (Levi Strauss, C, 1966) the cuisine of a society is a language into which that society unconsciously translates its structure, and from which its hidden contradictions can be uncovered, which is clearly relevant in relation to the 'African-Caribbean' diet.

It is clear then that what we eat is more than simply about meeting nutritional/biological requirements. Whilst there is a relatively large literature on the 'sociology of food', there is a relative dearth of literature on the impact of 'ethnicity' on food choice in Britain. Much of the literature that does exist emanates from the US. (Goode, J, Theophano, J, Curtis, K, 1984) studied the eating habits of 'Italian Americans' and found that meal cycles reflect both change and continuity, with 'American' food being incorporated over time. (Theodoratus, R, J, 1977) identified similar findings for Greek immigrants in the US. (Freedman, M, R, Grivetti, L, E, 1984) identify a 'generational' impact in relation to eating habits, with third generation 'Greek American' women abandoning traditional dietary

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practices.

(Freedman, M, R, Grivetti, L, E, 1984) suggest that food contributes to creating ethnic unity in culturally isolated population groups, to the extent that common 'ethnic' food practices can still be seen after a century of geographic and cultural removal from the homeland. Moreover they use the concept 'bi-palatism' to refer to a situation where migrant foods eat local foods in public, whilst retaining their own cuisine at home.

However, any exploration of eating habits needs to consider broader global processes taking place in relation to food consumption. (Goody, J, 1982) refers to the development of 'world cuisine', which he traces back to colonialism. He argues that food increasingly moved in a two-way flow around the world and in a 'post- colonial' world:

> "New waves of immigrants constantly came back to the 'mother countries' bringing their cuisines with them. Migrant workers from Mediterranean and North African countries moved into Northern Europe and established their own cuisines. The melting pot of races, cultures and flavours which has been furthered by mass tourism is increasingly reflected in the eating habits of peoples from all over the world."(Goody, J, 1982, quoted in Mennell, S, Murcott, A, Van Oterloo, A, H, 1992, p75)

For Goody then eating habits have become less framed by 'nationality' and increasingly reflect a global exchange of eating habits and preferences. This raises an important point of caution in any discussion, which talks about the 'British' diet or the 'African-Caribbean' diet. (Keane, A, Willets, A, 1995) found that most of their London informants thought that there was no longer any such thing as 'British' Food, with the 'British' now showing a preference for curry over roast beef or fish and chips. Indeed the growth of a whole range of 'Minority Ethnic' foods in supermarkets, is not only a

response to the presence of 'Black and Minority Ethnic' groups within Britain, but to the changing eating habits of the 'British' population generally.

We have identified then that there is evidence that migrants both retain and modify their eating habits, we have also seen that it has become increasingly problematic to talk of 'nation' state cuisines given the increasingly 'globalised' world in which we live, this brings us to the question of preference in relation to older 'African-Caribbean' people. In Chapter two we suggested that we need to be cautious about reproducing notions of 'ethnicity' that define people in cultural terms, independent of other factors, such as age, class, gender and sexuality. (Brah, A, 1992, p129) describes this as 'ethnicism', which she argues:

> "Defines the experiences of racialised groups primarily in 'culturalist' terms: Cultural needs are defined largely as independent of other social experiences, centred around class, gender, racism or sexuality."

(Hall, S, 1992, p258) suggests that to usefully draw on the concept of 'ethnicity':

> "What is involved is the splitting of the notion of ethnicity, between on the one hand the dominant notion which connects it to nation and 'race', and on the other a recognition that we all speak from a particular place, out of a particular history, out of a particular experience. We are all, in that sense ethnically located, and our ethnic identities are crucial to our subjective sense of who we are."

In this sense, then 'ethnicity' defines where we come from? This project is concerned with those people who came from the Caribbean to Britain in the post war period. The notion of a common 'African-Caribbean' diet, emerging from a shared 'ethnicity' was an

important and recurring finding in this research: Below are some responses in relation to questions related to eating habits:

> "I eat 'West Indian' food, yam, banana, rice and peas, I don't like English food and Im very fussy who cooks my food."

> "I only eat 'Caribbean' food, rice and peas, pumpkin, sweet potato."

In some instances, living in Britain was also impacting on and modifying eating patterns:

> "I eat 'Caribbean' Food most days, some times I make chips and mashed potato for my grand-daughter."

> "I eat a mixture of West Indian and English, I like rice and peas."

> "I eat a mixture of food, half and half."

Moreover if one visits an area with a large 'African-Caribbean' population, such as Brixton in South London or Dalston in East London, there is clear evidence of the huge demand for ingredients necessary to produce 'African-Caribbean' food. (Round, J, 1980, p46) writing in the Independent in 1980 wrote a special feature on Brixton market, where he observed:

> "The vegetable stalls are piled high with a dozen varieties of Brown yam, One stall has a hand written list, yellow yam, white yam, Barbados yam, One of the largest stalls, 'Back home foods', has okra, sweet potatoes, limes..."

We can conclude then that there does appear to be continuity and commitment to 'African-Caribbean' food for first generation migrants. However, drawing on evidence from other migrant populations it is clear that this is likely to change over time. Moreover there are more fundamental shifts in eating habits linked

to a process of both tourism and population movement which challenge the very notion of 'nation-state' cuisines. It is also clear that there is diversity within what we might describe as 'African-Caribbean' food, reflecting each island's history and cultural traditions. Therefore the task of responding to 'culturally specific' meals provision for older 'African-Caribbean' people is complex and a dynamic response to this issue is needed.

<u>Ageing and Eating</u>
There is a relative dearth of literature on 'ageing' and food consumption in the UK. However, there is a substantial US literature, that raises some interesting issues. One theme running through the literature relates to the importance of access to nutritionally balanced meals.

According to (Choi, N, G, 1998, p397):

> "Nutritionally balanced meals are essential for elders to maintain good health and to mitigate health problems... Older people are more likely to be at nutritional risk than younger people because of elders impaired digestion, absorption or utilisation of nutrients due to chronic disease or drug nutrient interactions...Age related changes in gastrointestinal organs . can affect food intake and interfere with digestion and absorption of nutrients."

A second issue clearly linked to 'ageing and eating' relates to the social dimension of eating and food neglect. (Quandt, S, A, Mc Donald, J, Arcury, T, A, Bell, R, A, Vitolins, M, Z, 2000) argue that the social processes associated with growing older such as becoming widowed; having reduced income, lack of transportation; lack of social interaction and depression can all lead to dietary neglect. Moreover they cite a range of studies carried out in the US, which make a link between older people living alone, and dietary neglect. (Lankshear,G, Giarchi, G, Debenham, G , 1994) argue that risk factors for malnutrition include being frail; housebound; living alone, not having regularly cooked meals, being on income support,

being of social class 4 or 5 and having depression. (Balmer, R, 2001) argues that malnutrition is common amongst older people with a prevalence of between 10 - 40%.

'Meals on wheels' then is a policy response in part to possible nutritional neglect, deficiencies/malnutrition with old age acting as a potential 'risk' factor. However, the palatability of the food on offer is likely to be important to users that may have reduced appetite for a range of reasons. Indeed (Choi, N, G, 1998) investigating 'determinants of frail elders stay on meals on wheels' in New York, US found that a much higher proportion (28.2%) of 'Black' service users , compared to (12.6%) of 'White' service users stopped receiving meals, and were more likely to cite food/food preferences as the reason. Therefore the provision of palatable 'meals on wheels' to a user who may have a poor appetite needs to be an important dimension of policy making. Failure to do this may have severe implications for the users or potential users of the service who may become malnourished.

So far then, we have considered ways in which 'race'/'ethnicity' and 'age' may impact on food preferences/consumption. We will now consider how the market has responded to 'cultural diversity'.

The Market and 'Minority Ethnic' food
Many of the large superstores now produce what they describe as 'ethnic'[9] food. The production of 'ethnic' food is partly a response to different 'Black and Minority Ethnic' communities, but it is essentially a response to increasingly diverse eating habits of the British population. According to Sharwoods an estimated 500,000 people eat Curry every day, with 'Indian' food now more popular than Fish and Chips.(Licensee, 1999)

According to (Mintel Marketing Intelligence, 1999, p5):

> "Emerging restaurant styles are the most buoyant sub-sectors in the ethnic restaurant market. Expenditure in ethnic restaurants, such as Thai, Other South East Asian, Japanese, Middle Eastern and Caribbean increased by 38% between 1993 and 1997...Long haul travel is on the rise...21% of holidaymakers say they try to cook recipes they have tasted on their return."

They go on to describe food, as part of an 'emerging style of eating' drawn on food from the Americas, and argue that:

> "At present, consumers do not have enough information to competently distinguish between 'Cajun' and 'Caribbean' flavours."(Marketing Mintel Intelligence, 1999, p5)

This is a good illustration of the way in which the 'discourse' about the increasing consumption of 'ethnic foods' is framed i.e. not from the perspective of the presence of 'Black and Minority Ethnic' groups in Britain, but from the 'British' population who have developed a taste for diverse foods.(Mintel Marketing Intelligence, 1999) identify a 22% increase in retail sales of 'Cajun'/'Caribbean' foods. This is accounted for by the development of frozen ready-made 'Cajun' food, and sauces for 'Caribbean' food.

Mintel suggest that major growth has been in the area of Cajun Food, with more limited development of 'Caribbean' food.

> "Few manufacturers have produced 'Caribbean' ready meals, although in late 1998 Asda introduced a range including Lamb Stew, Jerk Chicken and Rice and Black Eyed Beans." (Marketing Mintel Intelligence, 1999, p19)

They go on to assert that

> "'Caribbean' food is generally low value and associated with barbecue cooking. It is often cooked fresh, and as a result there is little opportunity for ready meals." (Marketing Mintel

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The notion of 'ethnic' food is problematic as it equates 'ethnic' with non-British or English.

In 1998 Enco[10] produced a range of marinades, under the Dunns
River brand in response to huge demand at the BBC Good Food
Show. Despite the existence of these products, Mintel suggest that
the distribution of such products is limited to independent
supermarkets, which limits access to what they describe as the
'average' consumer. In general there is less optimism from
marketing agencies such as Mintel about the growth of food
production in this area, either through the production of ready meals
or the development of the Restaurant sector.

> "'Caribbean' restaurants on the whole, are fundamentally
> neighbourhood kitchens providing affordable food for the local
> community, and nationally are few in number." Marketing
> Mintel Intelligence, 1999, p19)

They contrast this with Cajun food, which is available in what they
describe as 'non- ethnic' restaurants. Interestingly they suggest that
the older generation, are less likely to be tempted by 'ethnic' food.
This reinforces the 'generational' differences in eating habits, with
older generations, perhaps, more committed to 'nation' state
cuisines and reinforces the view that older people from 'Black and
Minority Ethnic' groups are invisible in terms of marketing strategies.

The market then is beginning to accommodate diverse eating
preferences. However, as Adam Smith made clear it was not the
benevolence of the butcher, which made him sell meat, but his self-
interest (Smith, A, 1776). (Paulson-Box, E, Williamson, P, 1990)
argue that the growth of 'ethnic foods' is related to the growth of
tourism; the development of a range of cookery programmes and

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[10] Enco is a food brokerage company which produces a range of caribbean foods which are sourced and packed
in the Caribbean or are sent in bulk from the Caribbean to the UK and re-packaged. They have lines titled Dunn's
river which produces marinades, seasoning, and salt cod, and an Encona range which produces Cajun and
Caribbean sauces.

books which promote diverse cooking and eating; increased disposable income; and increasing numbers of people eating out of the home in restaurants and buying foods in 'take-aways'. This policy shift then is not in response to the growing numbers of 'Black and Minority Ethnic' groups living in Britain.

However, large supermarkets such as Sainsburys, Asda and Tesco do respond to 'ethnic diversity'. A walk round most supermarkets located in areas with 'ethnically diverse' populations' will reveal specific sections for different 'ethnic' groups, such as 'Kosher' 'Halal', . An article in the magazine 'Super-marketing' pursued this issue some time ago, when they focused on the opening of a new Tesco at Brent Park. According to the manager of the store, they saw the huge sales potential from the area's 'Indian' and 'Chinese' population and decided to start catering on a much larger scale than ever before for the needs of these customers. According to a senior Stock controller:

> 'We certainly seem to have pulled in many customers who had previously shopped at local independent ethnic stores'.
> (Supermarketing, 1985, p16)

Moreover, they suggest that such items have been purchased by what they described as 'non-target' groups. However, this supermarket was not as responsive to all 'ethnic' groups and according to the Senior Stock Controller:

> "One market that Tesco would not be delving into for the meantime would be Japanese products..To stock an ethnic range and to sell it as one, you've got to have the community and we haven't." (Supermarketing, 1985, p16)

The market then is responding to diverse eating preferences in two ways. In the first instance they are reflecting trends in eating

preferences amongst the 'general' population. Secondly they are responding to the eating preferences of 'Black and Minority Ethnic' groups in areas where they comprise a relatively significant proportion of the population. This may be part of a direct marketing/sales strategy or in response to customer requests.(Supermarketing, 1985) The market then is responding to diversity, but this is punctuated by the presence of sufficient numbers to make it profitable. They are less likely to cater for a small number of 'African-Caribbean' families living in a rural area. This then brings us on to the question, how have local authorities responded to 'ethnically diverse' eating preferences?

Local Authorities, 'Meals Provision' and 'Ethnic Diversity'

During the 1980's many local authorities and statutory agencies more generally began to consider the diverse eating preferences of their local populations. This policy response has to be understood partly in response to the 1976 Race Relations Act which placed a statutory duty on local authorities to promote equality of opportunity and good race relations, and to ensure that their employment and service delivery arrangements paid due regard to the need to eliminate unlawful discrimination. Moreover as illustrated in previous chapters the political climate was changing in some local authorities, with the advent of 'municipal anti-racism'.

The London Food Commission has compiled newspaper cuttings/magazine articles related to 'ethnic diversity' and food consumption since 1980. A review of these cuttings suggests there was more concern about this issue during the 1980's, than during the 1990's. In 1986 the trade journal 'Caterer and Hotelkeeper' set out an array of strategies being pursued in many local authorities with large 'Black and Minority Ethnic' populations. Similarly, the London Food commission organized a specific conference on

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'Minority Ethnic' communities and Food in 1986, where
representatives from many London Boroughs set out their strategies
for responding to 'ethnic diversity'. In the main these strategies
involved developing specialist kitchens within their own 'in-house'
provision to cater mainly for 'African-Caribbean' and 'Asian'
communities. The development of diverse meals provision was not
limited to meals on wheels, but covered a range of social and
institutional settings such as day centres and luncheon clubs. Some
authorities already had relatively long standing contractual
arrangements with independent 'Kosher' meals providers' for 'Jewish'
service users. (Caterer and Hotelkeeper,1986)

However, The Local Government Act 1988 was to have a significant
affect on the provision of meals on wheels. This Act reinforced the
view that the introduction of competition in local government
services would reduce cost and increase efficiency. The Act required
Local Authorities to submit many of its services to a process of
Competitive Compulsory Tendering. Contracts were to be given to
the provider who could meet the specification at the lowest cost.
Part II of this Act was restrictive in relation to factors that could be
taken into account when awarding contracts, such as quality, equity
or workforce matters. For example, the Act stated that local
suppliers, or particular ethnic enterprises could not be treated more
favourably. Whilst, social care services were not subject to this
regime, many local authorities did use a process of competitive
compulsory tendering for their meals service. At a time when local
authorities were increasingly looking for financial savings, many local
authorities moved away from 'in-house' provision, and began block
purchasing from large suppliers of frozen meals, as a way of
reducing costs, and subsequently in response to increasing food
regulation, as a means of ensuring 'food safety'. (See below)

By the 1990's then when the 'NHS and Community Care Act' was introduced the context for policy making had been set:

1. There was a sense of financial crisis and the need for savings.
2. Local Authorities had developed, or were in the process of developing more 'culturally responsive' food policies, as part of a 'race equality' agenda.
3. The introduction of the 1988 Local Government Act had led to the tendering out of 'meals' provision, based on the provider who could meet the specification at the 'lowest' cost.

This brings us to the next question. To what extent did the 'NHS and Community Care Act 1990' encourage the development of more consumer responsive meals service?

The 'NHS and Community Care Act' and Meals Provision

There was evidence from the study undertaken by (Lewis, J, Glennerster, H, 1996) that the introduction of the 'NHS and Community Care Act 1990' had led to more creative and imaginative thinking in relation to food preference. For example an Assistant Director for Commissioning, in one Authority, had continually cited the possibility of giving budgets to individual care managers to enable them to make individual arrangements with local food providers, such as the local pub. This scenario was presented to the Social Services Inspectorate in a monitoring meeting as an area of innovation being pursued by the Authority in relation to 'needs led' purchasing. However, within a few months the idea was abandoned. Such a scenario presented the local authority with two main problems 'risk' and 'cost'.

How would an authority ensure health and safety regulations were

followed? What would happen if a user contracted food poisoning? And of course, 'cost' – How much time would be involved with each care manager negotiating the individual food preferences of each service user? How much would each individual transaction cost? How would this compare to the block purchase of food?

There has been increasing concern throughout the 1990's about food safety. The Food Safety Act 1990 gave local authorities the responsibility of enforcement. This was followed by the Food Safety (General Food Hygiene) Regulations 1995 and the Food Safety (Temperature Control) Regulations 1995. These pieces of legislation led to increased caution within local authorities, about encouraging more complex and less controlled environments for food production.

This then brings us to the question, What impact did the introduction of the 'NHS and Community Care Act 1990' and the subsequent introduction of a 'quasi-market' in social care have on the way in which meals provision responded, specifically to the needs of older people from 'Caribbean' and 'ethnic diversity' more generally?

Authority A – Meals Provision
This department began to respond to 'ethnic diversity' in its provision of 'meals' from the mid 1980's. As we have seen in previous chapters, the authority had adopted a relatively radical stance on 'race equality' and this translated into a range of policies. According to the then head of the meals service:

> "We started with a request for a housebound man who was a strict vegetarian Asian and couldn't eat our existing vegetarian food, we realized there must be others like him. So we talked to groups and found there was a real demand across the borough. The council equipped a small kitchen in a former residential home and took on an Asian cook to provide 12

meals a day."(Caterer and Hotelkeeper, 1986, p66)

By 1986 the Authority had a 'Kosher' Kitchen; a 'Halal' Kitchen; and an 'African-Caribbean' kitchen. These kitchens supplied food for luncheon clubs, day centres, and the 'meals on wheels' service. The meals were cooked by 'African Caribbean' and 'Asian' chefs, and According to the head of the meals service:

> "They rarely had professional training and are found through
> the grapevine."

The 'meals service' in this Authority appointed two members of staff to work in a developmental role - one attached to the 'Asian' kitchen and the other attached to the 'African-Caribbean' kitchen. According to the worker with responsible for developing the 'African-Caribbean' meals service:

> "At that time we had a young 'Caribbean' service, providing
> about forty meals a day, my main role was to look at unmet
> need.. it basically involved knocking on doors introducing
> myself and telling people we were there to help.....I did a lot of
> work with voluntary organizations helping them to set up
> luncheon clubs. There was a strong commitment to promote
> 'ethnic' services. The post was funded by Section eleven
> monies."

As we saw in chapter two, under Section 11 of the local government Act 1966, additional financial resources were available to local authorities, which had 'substantial' numbers of people originating from the 'New Commonwealth and Pakistan'. Some local authorities took advantage of this money when developing their 'race equality' agendas.

In this instance then the monies were used to fund specific workers in a service development role. The authority was responding to diverse needs through the introduction of a more radical 'race

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equality' agenda and a climate in which innovation was actively encouraged. The provision of 'culturally specific' meals (for some groups) was an outcome of this process. The meals service through the use of specific outreach type workers was able to stimulate demand. Moreover, there was recognition early on that there was a need to recognize 'diversity' in eating patterns from across the 'Caribbean' in the development of a specific 'African-Caribbean' meals service:

> "One of the selling points, why I got the job, was because I reflected the fact that there were various tastes, and various ways of cooking different 'Caribbean' dishes, that may be specific to a small island. Even though you use the same ingredients they might be cooked in a different way, or called something else, so the dinners had to reflect that."

We saw in Chapter four that by 1988 this authority was experiencing a financial crisis. In 1988 the Social Services Catering function of the department was exposed to 'competitive tendering'. However, the 'in house' meals service won the contract and all subsequent contracts. According to a Contracts operation manager:

> "I think we maintained the in house service due to the high quality; high customer satisfaction; and the diversity of food we were offering...other external contractors couldn't provide a meals service."

Similarly, the manager initially responsible for developing the service stated:

> "We are a lot more expensive, but 50% of our users come from 'Black and Minority Ethnic' groups and that itself has a cost implication...."

The first time the meals service was put out to tender, the specification was designed to attract an alternative block provider who could meet the complete specification of meals provision provided by the 'in-house' service. There was no one provider who

tendered to do this. However, over time and following considering financial pressure to find additional savings, much of the meals provision has now been contracted out. Initially, the In-house meals service began purchasing frozen 'English meals' and then more recently frozen 'Kosher' meals. Both policy decisions were driven by cost savings, but acceptable to users.

At the end of November 2000, the local authority was continuing to provide meals in house. The meals service provided 800 'African-Caribbean' meals a day.(Authority, A, 2000) The meals continued to be freshly prepared and delivered to people in their homes, and in luncheon clubs. The provision of meals to luncheon clubs as part of this arrangement reduced the overall cost of this service, with savings linked to economies of scale. Customers have to select the 'African-Caribbean' menu, and if a service user wants to select an item from an alternative menu, such as 'English' meals, they have to transfer to that service for at least one week. According to one manager:

> "If one week a customer wanted an 'Afro-Caribbean' meal and the following week an 'English' meal we could accommodate that, but we couldn't swap from day to day, if they want to swap I would want to know the reason why."

Essentially, then there is a response to diversity, but this response in itself is limited and may not reflect preferred eating habits. Moreover, there was some disagreement as to how responsive they were to delivering a service that reflected the diversity of 'African-Caribbean' cuisine. Whilst the worker initially involved with developing the scheme felt that this was an important part of the service. The manager running the service suggested that this was not the case.

> "We have a look at the menus and select generic items that cut across the range of 'Caribbean' islands, generally I think it is

accepted..we have regular feedback with users to get to know their likes and dislikes."

This authority then has developed a meals service, which responds to the needs of older 'African-Caribbean' people, and continues to provide this from within 'in-house' provision. However, there is increasing pressure to move away from this model. In May 2000 the meals service was part of a 'Best Value' review. 'Best Value' is the current driving force for service improvements within local authorities introduced by the Labour government.

Best Value replaced CCT, which was driven by cost, and uses a wider range of measures, (only one of which is cost) to judge the most appropriate method of service delivery. This approach moves between a traditional 'left' perspective, which favours the public sector, and a 'right-wing' perspective, which favours the market, to a 'third way' position, of whichever works best (Davis, H, Walker, B, 1988).

Authority A undertook a 'best value' review of their meals provision in 2000.

> "The aim of the best value comparison is to review the community meals service currently provided by Elders Care for the London Borough of X, through contact with other London borough's of similar size to see how they work and examine any areas of the service which could become more efficient by adopting practices used by similar providers." (Authority A, 2000, p2)

The department compared itself with five other London Boroughs. The Review drew on a range of indicators to evaluate the service ranging from unit cost per meal to customer satisfaction. The review identified both strengths and weaknesses related to the existing service. The strengths of the service were identified as the

popularity of the service, reflected in positive user feedback and a low number of customer complaints; level of customer choice; large portions and intensive use of fresh produce. The weaknesses identified by this evaluation related to the higher operating costs, linked to the employment of a relatively large number of staff working in the kitchen and two personnel working on each delivery van. Morover it was suggested that the complexity of providing 'culturally specific' meals had its own additional costs: They concluded:

> "Particularly high scores were recorded in the area of quality..it is the willingness and readiness of the service to ensure that high quality meals are produced and adapted to meet service users needs that leads to this result and in turn to a higher average production cost when compared to most other authorities...without significantly reducing the quality of the services, it is not possible to further reduce costs by any great amount"(Authority A, 2000, p9).

Nevertheless at the time of this research, the Authority was beginning to consider ways in which the unit costs might be reduced further, such as using one member of staff on each vehicle instead of two; developing partnership strategies with the voluntary/community sector; shifting to a 14 day delivery of frozen meals, with home helps heating them up. Moreover they stated that:

> "The current methods of producing 'ethnic meals' are reviewed and the scope to improve economies of scale and out-source individual elements of production are investigated." (Authority A, 2000, p12)

According to one Manager:

> "The emphasis is on us to change and one of the things that came out of the best value review was that the 'Asian' service makes authentic Chapatis, we have 2.5 Gujerati cooks using traditional methods to cook chapattis between 7 and 10 in the morning, it is very labour intensive and attracts a high cost, you weigh that against buying frozen Chapatis, that is an

option members would like to see, because it is a cheaper
option, and we are still providing the service, but it is not
acceptable to the community, because it is alien, they are not
used to having a frozen regenerated product they don't know
where it is coming from, and where it is coming from is an
important point in terms of acceptability.. That is the sort of
role I have, to make sure that the service users are satisfied
but that it is affordable to members."

The provision of 'culturally specific' meals in this authority has been
identified as an area where cost savings can be made, and the
providers will be confronted with the dilemma of balancing issues of
quality with cost. The 'African-Caribbean' service currently achieves
economies of scale because it services luncheon clubs. However
according to one manager working in the meals service:

"One of the questions posed to me from a senior finance
manager was that people attending luncheon clubs don't meet
our eligibility criteria for meals on wheels, but then the purpose
of the luncheon club is not the same as meals on wheels, it is
meant to be preventative. If you close down luncheon clubs
they are going to end up on our meals on wheels
database..lots of the people who attend luncheon clubs are
very frail and rely on other members to help them."

Interestingly, the service delivery model in A, is essentially a 'Fordist'
production model. Initially producing a standardized menu, and then
in response to the emphasis on 'race equality' in the 1980's, adding
the eating preferences of the three larger 'Black and Minority Ethnic'
groups to the menu, each having a specific in house kitchen to meet
their needs. Gradually, over time, this has been reorganized, but in
the case of 'African-Caribbean' meals provision, there remains a
commitment to providing a high quality freshly cooked 'meals on
wheels' service, though the tension between user preference and
resources is clear:

"I presented my best value review and basically the chief
executive was saying, that yes this is a very high quality

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service but at what cost. Can we still provide a services that meets need for not so much cost and maybe one day they will decide it is too expensive, or to go down the frozen road."

Authority A then does appear to have been responsive to the 'differentiated need' of some relatively large 'Black and Minority Ethnic' groups and did appear to demonstrate a commitment to being responsive. For example, the manager of the meals service was asked how he would meet the needs of an older Vietnamese person referred to their service:

"I would have to research the needs, it wouldn't be cost effective to start cooking a specific meal, I would have to find out more about the cuisine, possibly contact specialist suppliers."

At the time of this research, Authority A was operating a popular high quality 'meals service' for older 'African-Caribbean' people, which had survived many years of cost saving initiatives; a hostile environment to 'race equality' initiatives; the implementation of a 'purchaser/provider' split and a policy goal aimed at stimulating the private sector. Ironically, this was at a time when many Authorities were abandoning the in-house production of meals and using frozen meals' contractors. The service was managed by workers who were clearly committed to providing such a service, some of whom had been involved from its inception, and this was clearly a factor in making sense of why this service has survived.

We can conclude that in Authority A, the development of 'culturally specific' meals provision responsive to differentiated need, had its roots in 'race equality' initiatives implemented in the 1980's and not the 'community care' agenda of the 1990's, moreover this suggests that the previous model of bureaucratically planned services was more responsive to user need than anticipated.

<u>Authority B – Meals Provision</u>

Despite Authority B embracing 'municipal anti-racism' in the 1980's, the issue of 'culturally specific' meals provision did not become a policy issue until 1990. As we have discussed in the previous chapter, in the light of 'community care' implementation and a stated concern with 'race equality' issues, this authority appointed a consultant to review 'The needs of Elderly Black People, Carers and Black people with disabilities'(Cole, J, 1990) The brief of this study was rather broad and the researcher was appointed on a six month contract. According to the researcher:

> "The short life of the project has prevented more thorough groundwork and networking within the 'Black' communities."(Cole, J, 1990, p3)

A discussion of 'ethnically' sensitive 'meals' provision was limited to just over half a page of this 35-page report.   At this time there appeared to be just 13 'Black' users of the 'meals on wheels' service (1.2%). These users were given a questionnaire about meals, and according to (Cole, J, 1990) the response rate was low. Nevertheless, on the basis of these responses she concluded that:

> "What is clear is that, 'Black' clients are only using the meals service where there is no alternative and 'Meals on Wheels' are inappropriate to 'Black' people." (Cole, J, 1990, p27)

Moreover, she adds:

> "An important point to note is many clients stated that ethnically sensitive meals would be acceptable providing: The chefs were 'Black'; That the meals were presented in an appetizing way; and that the contents of meals were relevant to their dietary needs. The prospect of a 'White' person who has been taught how to cook particular group dishes was even less convincing or in many cases was rejected as downright offensive." (Cole, J, 1990, p27)

In response to this report, the 'in-house' meals service employed a cook to provide meals for older 'African –Caribbean' people.

Therefore in both authorities we see that bureaucratically planned services were able to embrace 'differentiated need' to some extent. However, policy implementation was more fraught in Authority B. Moreover, the response to differentiated need was limited to one 'Black and Minority Ethnic' group, 'African-Caribbean's, whilst the eating preferences/requirements of other 'ethnic' groups continued to be ignored.

Unlike Authority A, there was not a developmental strategy linked to this service, and take up was low. By 1993 managers from the meals service began to argue that it was not cost effective to employ a cook specifically for this group. This low take up is interesting, given that the Authority A and Authority B had a similar number of 'African-Caribbean' people in their areas.

As we saw in Chapter four, this authority introduced a nominal purchaser/provider split in the Social Services department in 1993. In relation to the purchase of meals this simply meant formalizing existing arrangements into a contract between in house purchasers and providers. However, the providers of this service decided to sub-contract responsibility for the 'African-Caribbean' meals service. Local restaurants were asked to provide a main course, with the in house provider adding vegetables. Subsequently, a 'Caribbean' restaurant was awarded a contract to provide a certain number of 'main' meals. Therefore the local authority did make use of the 'mixed economy of care' to respond to 'ethnic diversity'.

However, this revised approach demonstrated a weaker commitment to the provision of 'ethnically sensitive' food. It was not a complete meal that was provided by the restaurant but simply a main course such as Curried Goat. Accompaniments such as vegetables and

potatoes were to be provided 'in house'. This meant that Curried Goat, which would have traditionally been served with 'Rice and Peas', was instead served with boiled potatoes and carrots.

We saw in Chapter five that there was often a divergence in relation to perceptions of the demand for 'culturally specific' provision from 'White' and 'Black and Minority Ethnic' staff, this was evident within the management of the 'meals service' in this Authority. From the perspective of one 'White' manager, it was clearly an un-necessary policy development:

"Don't they all go home anyway."

On the other hand her colleague who was herself from a 'Black and Minority Ethnic' group suggested that the low take up of the service should not be interpreted as a lack of demand, but as a lack of commitment to the service evident in a strategy that served 'curried goat' with 'boiled potatoes and carrots'. There was clearly a tension in this authority in accounting for the low take up meals, with some officers, citing lack of demand, whilst others emphasized the poor quality of the service. Again 'Black and Minority Ethnic' staff at all levels, were more likely to identify a need for such provision whilst 'White' workers were more likely to question whether older 'African Caribbean' people wanted 'culturally specific' meals.

Moreover it illustrated well the benefits of more qualitative approach to research, as whilst this authority could clearly state that they, provided a 'culturally specific' service, qualitative interviews provided a deeper understanding of the nature of service, and problems with the service.

There was both a lack of satisfaction and lack of knowledge about

'African-'Caribbean' meals in this authority:

> "My daughter phoned up for these meals on wheels and they
> come, I decide it is not to my liking so I give it up and don't
> bother with it, they sent frozen meals you cook it yourself, my
> daughter fix me up Sunday dinner..to be honest my daughter
> make sure I get 'Caribbean' food."

> "I see an old 'Black' Lady and an Old 'Black' man, getting meals
> on wheels, they throw the food away, I never see them bring
> West Indian Food to any of these people."

> "I would like 'African-Caribbean' meals, but I don't want to be
> any trouble."

This raises wider questions linked to the accuracy of assessments in identifying demand for 'culturally specific' meals.

The Meals Service was reorganized again in 1999. A major meals provider entered into a contract with Authority B, as part of a Private Finance Initiative. This company invested significant monies in modernising the 'meals on wheels' service, with the authority stating that they now had:

> "The country's largest fleet of meals on wheels
> chefmobils..with specially customized on-board ovens and
> refrigeration units. The ovens ensure that meals are kept
> piping hot for every customer whether they are first or last on
> the round."(Authority B, 2000 para 3.2)

In many ways Authority B serves as a useful illustration of the organization of a 'meals on wheels' service in the 21st century. Having moved from providing an 'in house' service, to using a small restaurant in the 'mixed economy of care', they have now entered into a contract with a large contractor, who provides meals for several local authorities across Britain. They have shifted responsibility for responding to 'ethnic diversity' to the contractor. The following is a quotation taken from that specification:

"The specification requires the contractor to make meals available which are acceptable to people from various ethnic and cultural backgrounds."(Authority B, 2000, Para 8.2)

This suggests a limited commitment to equality and diversity, which is illustrated by the use of language such as 'acceptable'. It meets the local authorities statutory requirement to respond to promote 'race equality' retains a commitment to culturally specific provision but does this in a minimal way. Moreover, the responsibility shifts. It is now the contractor who has the responsibility for responding to diversity. In this instance the contractor has terminated the contract with the local restaurant, and has contracted with an 'emerging provider' of what is described as authentic 'African Caribbean' food, Indeed this provider now provides 450 frozen meals daily to this contractor, which are distributed in a range of local authorities across the country.

Interestingly, many people interviewed about 'African-Caribbean' meals emphasized problems in shifting from a 'freshly cooked' to a 'frozen' 'African-Caribbean' meals service, because of the unsuitability of freezing such food and the unpalatability of such food when reheated. This problem continued to be stressed in Authority A. Nevertheless, Authority B, and as we will see many other authorities, are purchasing frozen meals as a way of meeting the needs of 'African-Caribbean' Service users.

The decision to adopt a strategy of block purchasing from one 'multi-national' meals provider was driven by both 'risk' and 'cost'. According to one officer involved in development this arrangement:

"There is so much health and safety legislation, because of all that has happened with food, it is a sue, sue, sue culture...providers have to know where all the ingredients come from, it has to be approved providers...they cant even go and buy eggs from up the road, because if there is a problem we

have to be able to trace it. The contractor did initially consider working with a local community centre, but it was too risky, in terms of being able to monitor health and safety"

The management of 'risk' then has been an important driving force behind the policy direction in this authority, moreover entering into this arrangement facilitated the modernization of the service, which would have been financially prohibitive for the local authority. The question is does it matter? If meals improve and users receive good quality food then is the source of provision irrelevant. This question cannot be answered by the research and is clearly a project in itself.

There are safety checks built into the contracting process, such as user feedback but an officer with responsibility for this task, was skeptical about this process, suggesting that users were sometimes anxious to express critical views about service provision. However, they had received negative feedback about the unpalatability of the frozen 'African-Caribbean' meals but, according to one officer, this was not enough to review the policy at this time.

Authority B, had essentially modified their menu, to cater for older 'African-'Caribbean' people, therefore extending the 'mono-cultural' meals service. The development of this service was in response to a small study undertaken in response to 'community care implementation', which attempted to address the issue of 'race equality'. However, the development of this service appeared reluctant, with little commitment to engage more fully with issues of 'differentiated' need in relation to 'meals provision.

Given that 'food' is a significant policy area in which 'ethnic diversity' is likely to shape eating preferences, and given that this area of specialist provision has been evident for some time in local

authorities, we will review trends in meals provision for older
'African-Caribbean' people in six additional London authorities, all
with relatively large 'African-Caribbean' populations. Data from the
1991 census was used to identify the local authorities and the
methodology for this part of the research is described in Chapter
three.

Authority C – Meals Provision

Authority C is a Conservative authority noted for its commitment to
the 'market'. According to the 1991 census 6.1% of the population
described themselves as 'Black-Caribbean' and the authority had the
9th largest 'African-Caribbean' population of any authority in the
country, by 2001 the 'African-Caribbean' population was still the
largest 'Black and Minority Ethnic Group but had declined to 4.85%
and had the ninth largest population.(Teague, A, 1993, Greater
London Authority, 2005) This authority did not develop 'culturally
specific' meals provision in the 1980's for any group, but with the
advent of the purchaser/provider split and the development of
contracting, this authority has pursued a similar strategy to Authority
B. They have a 'meals' contract with the same 'multi-national'
provider as Authority B. In that contract they specify that the
contractor must provide 'culturally specific' meals. The main
contractor, then sub-contracts with the same specialist 'African
Caribbean' frozen meals provider, used by Authority B. They
currently provide 15 meals a day for older 'African-Caribbean'
people: According to a manager working in the meals service:

> "We have very few 'African-Caribbean' users going onto the
> service. Families look after their own, more than in the 'White'
> community."

This then reinforces the view that there was very limited demand for
such provision, partly, because 'they look after their own'. The view
that they 'look after their own' or 'they all go home anyway' appears

to legitimate 'non-action' on these issues amongst those skeptical about the need for 'culturally sensitive' provision.

Authority D – Meals Provision

Authority D had the largest 'African Caribbean' population of any local authority in 1991, with 12.6% of the population describing themselves as 'Black Caribbean' decreasing to 12.1% in 2001, this Authority continued to have the largest 'African-Caribbean' population in the country, closely followed by Authority B. (Teague, A, 1993, Greater London Authority, 2005). As in Authority A an 'African-Caribbean' meals was added to their 'in house' provision in the 1980's, as part of its programme of 'municipal anti-racism'. As in Authority A, they appeared to have managers within the meals service committed to this provision, and as in Authority A, the service achieved economies of scale by providing meals to luncheon clubs and Day centres. In 1996 the authority reorganized its meals provision as part of Private Finance Initiative, similar to that implemented in Authority B. Most meals are now frozen and provided by a private company. However, it was decided that 'African- Caribbean' meals should continue to be freshly cooked on site on a daily basis given the unsuitability of freezing such meals. They had been offered samples of frozen food which they concluded were unacceptable in terms of quality.

Whilst this research was being undertaken the meals service was undergoing a 'best value' review. According to one manager, who was clearly committed to retaining 'in house' freshly cooked provision, she was apprehensive about the future of the service, given that it was more expensive than frozen meals and they were under pressure to make cost savings. What was distinct about Authority A and this Authority was that they had developed 'in-house' specialist provision early on. Managers in both authorities

appeared committed to such provision, and they achieved economies of scale by providing meals to a wider clientele than simply 'meals on wheels'.

Authority E - Meals Provision
According to the 1991 census, Authority E, had the seventh largest 'Black Caribbean' population, with those describing themselves as 'Black-Caribbean' comprising 7.2% of the population, increasing slightly to 7.3% by 2001, and had the eighth largest population describing themselves as 'Black Caribbean'.(Teague, A, 1993, Greater London Authority, 2005) Authority E is an interesting authority as it does demonstrate evidence of the kind of innovation in service provision that was predicted with the introduction of the 'NHS and Community Care Act 1990'. Prior to the introduction of the Act, an alliance of 'Black and Minority Ethnic' groups was formed to ensure that issues of 'ethnic diversity' were incorporated in 'community care' planning. These groups formed an alliance and established a specific 'Black and Minority Ethnic Community Care Forum'.(Institute of Race Relations, 1993)

This Authority attracted funding from the Department of Health, as part of a 'Caring for People at home' initiative aimed at developing independent sector 'community based' provision. One of the policy areas, prioritized for use of these monies was the stimulation of 'independent sector' meals provision for 'Black and Minority Ethnic' groups. It was anticipated that this would be achieved by tapping into the wide range of 'ethnically diverse' restaurants in the borough. Therefore, this strategy would stimulate economic development and the 'mixed economy' simultaneously. This authority had not developed 'culturally specific' meals provision prior to this.

However, they encountered a major problem in implementing this

strategy. The 1988 Local Government Act stipulated that they were unable to demonstrate a preference for a local provider, and therefore such a strategy would be illegal. A second strategy was put in place. This strategy was part of a SRB (single Regeneration Bid). A provider development project was established and located within the Social Services Department with the intention of stimulating a 'mixed economy' of care.(Sheperd, J, 1999) As part of this scheme, a 'meals in the home' brokerage scheme was set up whose aim was to extend service provision to a wider range of 'Black Minority Ethnic' communities by involving small 'Minority Ethnic' providers in the contracting process. The Authority developed a contractual arrangement with a 'multi-national' meals provider, and part of that arrangement involved working with small 'Black and Minority Ethnic' Providers to provide 'meals' in the home.

In order for the 'multi-national' contractor to develop links with small providers, a seminar was organised. Several Small 'Minority Ethnic' providers and potential providers expressed an interest in working with the 'large contractor' at an initial seminar, but the large provider, contracted with just one Small 'Minority Ethnic' provider, to provide freshly cooked hot vegetarian Asian food. The reluctance to work with a range of small providers was itself the outcome of 'risk' as the contractor was concerned that many potential providers did not have the capacity to ensure that health and safety legislation/regulations were adhered too. The 'multi-national' contractor developed an arrangement with a frozen supplier of 'African-Caribbean' meals. Therefore the policy goal of responding to 'ethnic diversity' was achieved in a very limited way.(Sheperd, J, 1999)

However, a subsequent 'joint review' of Social Service provision in

this authority, revealed considerable dissatisfaction with the 'frozen' 'African-Caribbean' meals service. This review identified a lack of specialist provision, and a need for a freshly cooked 'African Caribbean' meals service.(Audit Commission/Social Services Inspectorate, 2001)The authority then investigated this and in conjunction with their provider development Unit held a second seminar providing the opportunity for potential providers of 'African Caribbean' food to meet with the 'multi-national' contractor .

As an observer of that seminar it was clear that whilst the 'multi-national' provider was willing to work with 'small' providers, they were concerned about 'risk' in relation to 'health and safety'. For example, in an opening speech a senior manager representing the company commented:

> "Would you be able to tell me where all your produce came
> from, would you be able to use specific kinds of refrigeration
> equipment, ovens etc?."

It was clear that there were a range of potential providers keen to develop working relationships with the contractor, though for many they simply did not have the 'capital' to invest in appropriate machinery etc, for what might be a very small contract. What was also clear was that the 'partnership' between the contractor and the sub-contractor was likely to be unequal.

As a result of this seminar the 'multi-national' provider did enter into a contract with a local restaurant to provide freshly cooked 'African-Caribbean' meals. However, a senior manager from the local authority identified some problems with this arrangement. In particular the low demand for the service, that threatened the viability of such an arrangement. It was predicted that there needed to be a take up of 40 meals a day, to make this service viable.

However, actual take up had been much lower, at around 15 meals per day. According to one policy officer involved in developing the scheme:

> "It is a problem, people cant opt in and out of the service, as we are trying to ensure that there is sufficient take up to make the service viable. The restaurant has to employ a lunch time cook, who has to work Saturday and Sunday."

Therefore once again, reflecting the limitations in responding to 'diverse' eating preferences, once a user indicates a preference for 'African-Caribbean' meals they will have to have it every day, even if this may not reflect their eating habits. Moreover, whilst there was a commitment to responding to the needs of older 'African-Caribbean' people, this did not translate into responding to the diverse needs of all 'Black and Minority Ethnic Groups'. For example, I asked whether a similar strategy would be pursued for older 'Italian' people:

> "No I don't think we would be able to develop a specific service, there would have to be a certain level of demand."

There was ambivalence towards this policy within this authority. One officer responsible for developing the service suggested it was divisive and may create tensions with other groups. She implied that the 'meals service' was generally unsatisfactory for all service users and this policy was essentially providing 'special treatment' for older 'African-Caribbean' people:

> "No one really likes frozen food, it meets a dietary/nutritional need but it is not particularly appetizing...Some east enders' might like jellied eels, are we going to meet their needs?"

This then is a crucial issue, there is nothing divisive in itself about responding to 'ethnic diversity', but if this authority chooses to respond only to the preferences of the more 'organised' groups, then

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this itself is divisive. There is clearly a need for a policy/strategy on food quality/choice, which reflects diverse eating preferences in its broadest sense, and not simply those groups who are relatively well organized?

This authority then is interesting, as it initially demonstrated a commitment to using the 'mixed economy' as a way of meeting 'diverse' needs. This strategy however was abandoned, and a 'multi-national' contractor was appointed to develop 'partnership' arrangements with small providers. However, this itself was fraught with difficulties, as the 'multi-national' contractor wanted to minimize 'risk and therefore only one 'small' provider was considered viable enough to work with. Initially an arrangement was put in place for a frozen food supplier to provide 'African-Caribbean' meals but feedback given at a 'joint review' led to a review of this policy and the establishment of a freshly cooked 'African-Caribbean' meals service, provided by a small 'African-Caribbean' restaurant.

This authority highlights some of the problems involved with developing a 'mixed economy of care' and also raises questions about the power relationships that may emerge between 'sub contractor' and 'contractor'.

Authority F – Meals Provision

According to data from the 1991 census, Authority F had the second largest 'Black Caribbean' population, comprising 11.2% of the total population, and this figure had declined to 10.29% by 2001. However, by 2001 this Authority had the fifth largest population of people who described themselves as 'Black Caribbean' (Teague, A, 1993, Greater London Authority, 2005) Authority F, extended its 'in-house' meals service by establishing a specific 'African-Caribbean' kitchen in the 1980's, as part of its programme of 'municipal anti-

racism'. Education and Social Services had a joint meals service at this time and achieved economies of scale in this way. There did not appear to be the commitment to this service that was evident in some authorities, with a perception that there was a lack of demand. According to one manager:

"They still look after their own, maybe they don't know about the service, lots of them attend luncheon clubs."

The meals service has been reorganized recently and as in some of the other authorities, this authority has entered into a contract with a large 'multi-national' provider to provide meals. Again the need to provide 'ethnically diverse' meals provision was incorporated into the contract. The contractor sub contracts with a small specialist 'African-Caribbean' provider to provide 'frozen' meals.

At the time of this research the 'contractor' currently purchased 30 – 40 meals a day from the specialist provider, which was perceived by one manager in the meals service as a low demand. However, there did appear to be a willingness to respond to diversity, more generally. For example, this authority has worked with local restaurants to meet the needs of older 'Turkish' elders. Moreover in response to a question related to their ability to meet the dietary preferences of an older 'Italian' person, the meals manager, stated that:

"We would have to find a way of providing this."

On the other hand, the strategy of responding to 'cultural diversity' was based on a 'culturally essentialist' model. For example, in response to a query about whether 'White' service users would be able to express a preference for 'African-Caribbean' meals, she commented: 'no, it would all be too much." In this authority

'African-Caribbean' service users could opt in or out of the specific meals service on a four weekly basis.

<u>Authority G – Meals Provision</u>
According to the 1991 census, Authority G had the 8th largest 'Black Caribbean' population, comprising 6.1% of the total population. By 2001 this had increased to 8.2% and the Authority had the seventh largest 'African-Caribbean' population.(Teague, A, 1993, Greater London Authority, 2005) Authority G developed a 'culturally specific' meals service for older 'African-Caribbean' people in the 1980's as part of the agenda of 'municipal anti-racism'. There was a separate 'in-house' 'African-Caribbean' kitchen that freshly cooked meals. These meals were delivered to a luncheon club, frozen and then reheated and delivered as 'meals on wheels'. This Authority provides 'Asian', 'Kosher' and 'African-Caribbean' meals and has in the past provided meals for 'Turkish' elders, through a contract with another local authority.

In January 2000 this authority published a 'best value' review which led to the re-organisation of the meals service. The authority now purchases a mixture of frozen meals for clients to reheat, and frozen reheated meals delivered hot to the client, which are reheated in a central kitchen. The Authority purchases the meals from a 'multi-national' provider and as is the practice in some of the other authorities, sub contracts with a specialist provider of 'African-Caribbean' frozen meals. The decision to close their 'in-house' provision was in response to concerns about 'choice' and 'temperature'. According to a policy officer, involved in the new arrangement:

"It was felt the new arrangement would facilitate greater choice than was possible under the previous arrangement, and ensure meals were hot on arrival. It wasn't financially driven.

However, the decision to change the 'African-Caribbean' meals service was based on a cost saving, as it would not have been cost effective to continue to provide this one area of service provision."

The shift to frozen 'African-Caribbean' meals was not popular and one of the Authority's 'African-Caribbean' luncheon clubs had made an alternative arrangement, with a local centre to provide 'freshly cooked' meals. This Authority did consider a similar model to Authority E of stimulating local providers, but were concerned that no single provider could cope with the scale of service required.

Therefore this authority is also interesting. The previous model of bureaucratically planned services did appear to respond to 'ethnic diversity'. The 'new' model appears to be rationalized by enhancing 'choice' in a general way for an imagined 'British' service user, whilst, ignoring the possibility that this strategy may be detrimental to those expressing a preference for 'African-Caribbean' meals. Moreover, a single provider model was favoured, over a model based on stimulating a plurality of providers, and this decision had been based on the potential health and safety 'risks' of pursuing such a strategy.

Authority H – Meals Provision

According to the 1991 census, Authority H had the 6th largest 'Black-Caribbean' population comprising 9.3% of the total population. By 2001 this had increased to 9.5% and the Authority had the sixth largest population of people who described themselves as 'Black Caribbean'(Teague, A, 1993, Greater London Authority, 2005). This authority had a large multi-ethnic population, and was one of those authorities associated with radical 'race equality' strategies in the 1980's. Their pattern of service delivery is different from the other authorities. They have a limited 'diversity' strategy, providing

'culturally specific' meals for relatively well organized and represented groups. According to a senior manager, the 'culturally specific' meals services had developed in response to pressure from these 'communities'.

This authority provides a culturally specific' meals service for 'Asian'; 'African-Caribbean' and 'Cypriot' Older people.   The 'African-Caribbean' service started in the year 1982/3. The 'voluntary sector' was funded to provide 'meals'. Each of the three main 'Black and Minority Ethnic' groups receive funding. The 'African-Caribbean' centre provides meals for a luncheon club, and the 'meals on wheels' service, therefore, achieving 'economies of scale'. The authority funds a vehicle attached to each centre, enabling them to deliver the 'meals' to people's homes.

This authority adopted a 'culturally essentialist' policy, so that an 'African-Caribbean' service user would automatically be given an 'African-Caribbean' meal, with no discretion to opt in or out of the service. Moreover, the approach to 'diversity' was limited. According to one senior manager, expansion of 'culturally specific' meals to other groups was unlikely:

   "We couldn't cope with delivering services to smaller groups".

This authority then did respond to some 'differentiated need' and again this strategy had its roots in race equality initiatives of the 1980's and not 'community care implementation'.

Conclusion
In this chapter we have observed that there is an 'African-Caribbean' cuisine, though this varies slightly from island to island. We have also noted that 'culturally specific' food provision is important for many older 'African-Caribbean' people. However, it is also clear, that not all older 'African-Caribbean' people would indicate this

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preference and even if they did, may not choose to eat such food every day. We have also seen that eating preferences are shaped by 'generation' as well as 'ethnicity' and therefore demands for 'culturally specific' provision may change over time. This indicates the need for greater flexibility more generally in planning meals provision. We have noted that 'malnutrition' is a problem amongst older people generally, and that the need for appetizing and palatable meals is important.

We also considered how the market more generally has responded to an increased demand for 'ethnically diverse' food. We identified two strategies, the first in response to the changing eating habits of the 'British' population, and the second, in response to the emerging market, of 'Black and Minority Ethnic' consumers. However, this second strategy was punctuated by sufficient numbers of a particular group being present in a particular area, to make such a strategy viable.

It is also clear that despite a discourse of 'care' and 'control', the previous model of service provision was responsive to the differentiated eating preferences of older African-Caribbean' people. This strategy often evolved as part of a general strategy of 'municipal anti-racism' and was often in response to pressure from different 'Black and Minority Ethnic' groups. Indeed at the time of this research all authorities were able to provide 'culturally specific' meals provision for older 'African-Caribbean' people. However, as is the case with the private market, there was little evidence of responsive to differentiated need in general, but simply to larger and more organised 'Black and Minority Ethnic' groups.

The emergence of the 'quasi-market' clearly offered the potential for

responding to 'differentiated food preferences' more effectively. There was an already established supply of restaurants that could have played a role in provision. The two authorities that did embrace this strategy either abandoned the idea very quickly or modified it substantially. The two authorities that continued to provide their own 'in house' 'African-Caribbean' meals service, as part of a commitment to offering a good quality service, were under pressure to find cheaper alternatives, and therefore these services appeared to remain, despite, rather than because of the policy climate. It appears that the pattern of service delivery that is emerging is one of 'monopoly' provision, with a small number of 'multi-national' providers dominating 'meals' provision. For those authorities that developed their 'African-Caribbean' meals provision following the introduction of the 'NHS and Community Care Act 1990', the requirement to provide 'ethnically diverse' provision, appears to have been embraced in a minimalist way, by simply stating it in their contracts with large 'multi-national' providers.

The shift to 'monopoly' provision is less related to the 'NHS and Community Care Act 1990', but more an outcome of increasingly stringent health and safety legislation, that has highlighted the possibility of 'risk'. Therefore, in order for authorities to minimize risk, they need to opt for the safest (most risk free) option, and clearly a large 'multinational' provider is a lower risk, than a range of small providers. This highlights the significance of exploring the complexity of legislation that may affect policy implementation, as opposed to simply exploring one piece of legislation and linking all subsequent actions to that particular piece of legislation.

Moreover the cost of developing a large number of contracts was also prohibitive. (Abbott, B, Blackburn, R, A, Curran, J, 1996)

explored the role small businesses played following the introduction of Competitive Compulsory Tendering(CCT). They concluded that CCT had not created a wide range of opportunities for small businesses, as the cost of working with small businesses (in terms of increased negotiations) was viewed as prohibitive by local authorities. Interestingly they identified a trend for large contractors to sub-contract aspects of their work to smaller businesses, similar to that identified in this study.

Overall, it appears that the 'quasi-market' has not been any more successful in responding to differentiated need than the previous model of bureaucratically planned services. In general local authorities continue to respond to 'ethnic diversity' by purchasing 'culturally specific' services for those more organized 'Black and Minority Ethnic' groups. In relation to the development of a 'mixed economy of care' we see that despite the existence of a range of already established potential providers, i.e. small local restaurants, the tendency is to monopoly supply, with large 'multi-national' contractors dominating provision, with 'risk' and 'cost' acting as crucial determinants in this regard.

Chapter Seven

The Service Preferences of Older 'African-Caribbean' people

One of the key questions of this study is the extent to which the introduction of a 'quasi-market' in 'social care' would be better able to respond to the differentiated needs/preferences of consumers. However, in order to do this, it is important to gain some understanding of what preferences users have. In this chapter we assess the findings of twenty four interviews that were undertaken with older 'African-Caribbean' people in the two case study authorities. Whilst it is not possible to make any generalisations from these interviews about the services preferences of older 'African-Caribbean' people, (as indeed, it would seem problematic to draw any conclusions about service preferences on the basis of membership of a particular group). it is important to pursue whether there is a relationship between what kinds of support people would like, and what types of services are actually available or thought desirable by policy makers, such as 'culturally specific' provision.

We begin by reviewing the policy context that has shaped service developments for older 'African-Caribbean' people, and in particular the development of 'culturally specific' provision, we then review the emerging literature on service preferences amongst people from 'Black and Minority Ethnic' groups, more generally, and more recent developments in social policy related to 'community cohesion' and the implications that this may have on 'culturally specific' provision. We then move on to explore the findings of the interviews undertaken as part of this study.

'Culturally Specific' Provision – The Policy Context

In Chapter two, we considered how social policy has responded to

issues of 'race', 'race' equality', racism' and ethnic diversity'. A number of themes emerged:

1. A range of reports from 1978 onwards advocated a review of 'mainstream' service provision to reflect an increasingly 'multi-cultural' society, and the funding of a 'Black and Minority Ethnic' voluntary sector.

2. The emergence of 'culturally specific' or 'same race' services was shaped in part by debates related to 'adoption' and 'fostering'. This tended to generate 'culturally essentialist strategies' that reinforced a 'binary' divide between 'Black' and 'White' people and implied that 'Black' workers should be employed to work with 'Black' people, as 'social workers'; 'home helps'; service providers, as it was they who could understand the particular problems encountered by 'Black' people. Whilst this approach was intended to promote 'race equality' in reality it marginalised issues of 'race equality' and placed responsibility for tackling 'racism' on workers from 'Black and Minority Ethnic' groups.

3. The 'care'/'control' critique of Personal Social Service provision in relation to 'Black and Minority Ethnic' groups, was also significant as it was demonstrated that older people from 'Black and Minority Groups' were under-represented as users of 'caring' services provided by social service departments. In response to this policy recommendations stressed the need to ensure all services were accessible, along-with the development of 'culturally specific' services, though in reality, where change did take place, it was through the development of 'culturally specific' services, with 'mainstream' services continuing to neglect this issue.

4. However, it should be clear by now that it was neither the 'local' or

'national' state that initiated the development of 'culturally specific' services, it was 'Black and Minority Ethnic' groups themselves who responding to gaps in provision and advocated for the development of specific services, quite often provided with considerable 'voluntary input' and therefore at a lower cost to the state. Services then were provider driven, rather than a reflection of strategic planning objectives.

In Chapter Two it was clear that there was a lack of empirical evidence that either supported or rejected a policy reliant on the development of 'culturally specific' services, for older people from 'Black and Minority Ethnic' groups. The shift to 'same race' or 'culturally specific' service provision was essentially politically driven by 'Black and Minority Ethnic' groups themselves, who were challenging the 'mono-cultural' nature of service delivery underpinning the 'Beveridgean' organisational settlement, in an attempt to access a more equitable 'social citizenship'.

However, it was also clear in Chapter two that a range of studies did confirm a lower take up of services by older people from 'Black and Minority Ethnic' groups and identified a number of problems. These included a lack of knowledge about services; stereotypes about 'Black and Minority Ethnic' groups 'looking after their own' - leading to a failure to develop or provide services; negative perceptions/experiences of using 'mainstream' provision, related both to the 'racism' of other service users, and the isolation of possibly being the only user from a 'Black and Minority Ethnic' group, through to the 'mono-cultural' and therefore, inappropriate nature of service provision. Therefore, 'culturally specific' services appeared a logical response to these issues. However, there were also positive arguments in favour of this model of service provision:

"If you are looking at this generation, they are a generation
that has grown up apart, so their socialisation patterns are
different. An older 'African-Caribbean' man will be more
interested in playing dominoes, whereas an older 'White' man
might be more interested in playing darts. For the next
generation it will be a different ball game"(Coordinator, African
Caribbean Day Centre – Authority B)

"Black elders experiences of day centres, lunch and social clubs
were usually more positive than about any other service
provided. The service tended to be specific to their needs with
staff and other attendees from the same culture or religion."
(Department of Health/Social Services Inspectorate, 1998, p39)

Therefore the development of 'culturally specific' services was seen
as a desirable policy intervention. However, there was an ongoing
tension related to confirming a policy direction in favour of either
'mainstream'/'integrated' provision, or 'culturally specific' provision.
This tension was identified by (Begum, N, 1995) who found that
authorities were unclear about whether to provide 'mainstream' or
'culturally specific' services(Begum, N, 1995), and illustrated in a
study undertaken by (Fenton, S, 1987) for the Commission for Racial
Equality:

"In practice a good solution to, say, providing residential
accommodation for the minority elderly is neither 'carrying on
just as before' (ignorant of the needs of new groups of elderly)
nor is it 'separatism'. It can be simply well thought out
provision catering for some new needs (e.g. different diets)
and plenty of old ones – for companionship, privacy and a
degree of familiarity and stability." ((Fenton, S, 1987, p4)

'New Labour' and 'Culturally Specific' Provision
With the election of 'New Labour' in 1997, there has been an
increasing emphasis on equality type issues and the introduction of a
range of top down managerial tools to achieve these objectives.
'Equality' has been added to the three 'e' agenda of 'efficiency',
'economy' and 'effectiveness' on which to assess local authority
performance.(Audit Commission, 2002) A range of documents and

policy directives stress earlier policy objectives related to 'mainstreaming 'race equality', and in the light of the development of the purchaser/provider' split purchasing/commissioning relevant provision. Reports have continued to stress the need to develop complimentary culturally specific services by funding 'Black and Minority Ethnic' providers', and not being over concerned that this may lead to criticisms of special treatment (Commission for Racial Equality, 1997; Department of Health/Social Services Inspectorate, 1998; Department of Health, 2002).

One report on social housing specifically suggests the possibility of developing cross authority arrangements to commission specialist services to meet the needs of numerically small 'Black and Minority Ethnic' communities. (Department of the Environment, Transport and the Regions, 2001)

Having reviewed the policy context related to 'culturally specific' provision, let us now review the emerging literature on preference.

Preferences for 'Culturally Specific' Provision – A Review of the Literature

Since undertaking the research for this project a growing (albeit) small number of studies have begun to focus more specifically on the service preferences of ' Black and Minority Ethnic' groups, particularly in relation to the issue of 'mainstream'/'integrated' versus 'culturally specific' provision. One clear finding to emerge from these studies is that there is diversity of views on this issue.

For example, (Tuvey, M, Bright, L, 1996) explored the desire for 'culturally specific' residential care and (Sills, A, Sawhney, S, 1996) explored the desire for 'culturally specific' sheltered accommodation amongst older people from 'Black and Minority Ethnic' groups and both concluded that there was a stronger view for separate provision from

'Asian' potential service users, as opposed to 'African-Caribbean' service users, However, they argued that it was not possible to identify a clear consensus either way, but a variety of views.

(Raynes, N, Temple, B, Glenister, C, Coulthard, L, 2001) on the other hand, reviewed issues related to 'quality' as defined by 'users' and 'potential users' and found that older people from 'Black and Minority Ethnic' groups defined the provision of 'culturally specific' provision as an indicator of 'quality' service provision, though they did not differentiate between 'Black and Minority Ethnic' groups.

The 'Race Equality Unit' at the 'National Institute for Social Work' recently undertook a study with older people from 'Black and Minority Ethnic' groups. They identified three interesting findings. The first related to a perception that this issue had been over-researched without any significant change; the second again reinforced the finding of other studies, that there was a diversity of views on the issue of whether there was a preference for 'culturally specific' or 'mainstream' services, and the third reflected an increasing concern that assumptions about 'culturally specific' provision enabled 'mainstream' services to continue to ignore the needs of 'Black and Minority Ethnic' groups:

> "Some had lost faith in mainstream services and wanted services from and by their own community voluntary groups...Others felt that funding community voluntary organisations let the mainstream services off the hook."(Race Equality Unit, 2004, p3)

This point has also been made by (Sashidarian, S, 2003) in relation to the provision of 'mental health' services for 'Black and Minority Ethnic groups, who has also critiqued the over reliance on the development of 'culturally specific' services, which has led to a neglect of these issues by 'mainstream' providers.

(Jones, A, 1994) undertook a study that reviewed the needs of older 'Black and Minority Ethnic' people in relation to sheltered housing. This study identified a divergence in views in relation to 'culturally specific' provision, with 'Black' 'provider' organisations more likely to express a need for specialist provision, as compared with older 'African-Caribbean' people themselves, many of whom, it was argued, favoured 'integrated' schemes, therefore, from these findings it would appear that a 'culturally specific' strategy was 'provider' led.

There does appear to be a generational issue related to the issue of 'culturally specific' versus 'mainstream' provision. (Becher, H, Hussain, F, 2003) explored issues of service preference among 'South Asian Hindus' and 'Muslims' in Britain in relation to family support, and suggested that it was the 'mono-cultural' approach of mainstream services that needed to be challenged, rather than the development of 'culturally specific' services:

> "Families from 'Minority Ethnic' communities do not necessarily want separate services. They would be happy with mainstream provision if their needs were being met and if they didn't feel they were being patronised."(Becher, H, Husain, F, 2003, p2)

Similarly, (Vernon, A, 2002) reviewed service preferences with 'Asian' disabled people and identified dissatisfaction with existing services. Whilst some users and potential users of services, expressed a preference for 'culturally specific' services, such as 'Asian' social workers, home helps etc., others stated that they wanted services that respected' ethnic' diversity, but not necessarily delivered in separate ways. (Flynn, R, 2002) explored 'low take up; and access to 'short breaks for 'Black' disabled children and their parents. His study identified a preference for using services that had an 'ethnically diverse' workforce.

(Cusack, P, 2001) highlights the complexity of 'culture'/'ethnic diversity' in service provision in a survey of home care providers in Moss Side. This survey identified low take up of an Asian 'home carers' scheme amongst 'Indian' and 'Pakistani' potential users, because the 'Muslim' and 'Hindu' workers trained to provide personal care, were categorised as 'low caste' and therefore unacceptable. However, this raises an interesting question, related to 'user preference' and equality more generally. The rationale for developing 'culturally specific' services is based on a policy intention of promoting equitable access to services, and more generally social justice, therefore, should policy makers respond to user preferences that reinforce hierarchy and inequality?

We can conclude then that there is a complex relationship between 'ethnicity' and 'service preference' suggesting, both the desire for 'culturally specific' provision, and the need to 'mainstream' 'race equality' into all service provision. Moreover, it appears that there is a stronger preference for 'culturally specific' provision amongst older people from 'Black and Minority Ethnic' groups with younger groups expressing a preference for services and a workforce that reflect the 'multi-cultural' world in which they are based.(Becher, H, Husain, F, 2003) conclude that we need to develop an approach which is 'culturally sensitive' rather than 'culturally specific'.

What is also clear is that debates about 'race', 'racism' 'diversity' and service provision continue to be shaped by an exploration of two main groups who came to Britain in the post war period - Those from formerly colonised parts of 'Asia' and those from the 'Caribbean'. The framework for discussing issues of 'race', 'race equality', 'racism' and 'ethnic diversity' has focussed almost exclusively on these groups. This was a point noted in a recent

government study, which asserted that:

> "Some Ethnic Minority populations may be more 'visible' than
> others: this may be reflected in local authority policy and
> Service management and delivery. This visibility is unrelated to
> 'skin colour'." (Morgan, S, 2003, p63)

Indeed the studies we have reviewed in relation to 'preference' have
themselves focussed on these groups. However, if we are to
respond to the concept of 'differentiated need' in a meaningful way,
then difference itself needs to be reconceptualised and reformulated
in a way that is more inclusive. Indeed there is a new direction in
policy that is likely to impact on this issue and it is to this that we
now turn.

From 'Multi-Culturalism' to 'Community Cohesion'

The riots in northern cities in 2001 led to the publication of the
'Cantle' Report, which implied that 'multi-culturalism', with its
emphasis on 'cultural difference', had contributed to the creation of
cultural barriers between groups and segregation. This report
suggested the need for a common vision, a sense of belonging, and
strong and positive relationships between people from different
backgrounds as a key to achieving a 'cohesive' community. Local
government was given an explicit role in promoting community
cohesion, and a 'community cohesion' unit has since been
established by the government (Home Office, 2002). Interestingly
this report suggested that there was a need to rethink ways in which
policy makers responded to 'ethnicity' by developing a more inclusive
approach to the definition of 'ethnicity' that included 'White' groups
and 'asylum seekers'.

Whilst there are many criticisms that could be made of this report,
the key issue is its relevance to the debate about 'culturally specific'
versus 'mainstream' provision, as it clearly implies that 'culturally

specific' provision, may be divisive, and stresses the need to 'mainstream equality and anticipates that 'assimilationist' type policies might be more conducive to promoting a 'cohesive' community that respects 'ethnic diversity', than the previous approach. More recently Trevor Phillips, the Director of the Commission for Racial Equality has contributed to this debate, again implicitly critiquing 'multi-culturalism'(Phillips, T, 2004). (Lewis, G, 2003, p90) sums up the problem for policy makers:

> "At the beginning of the 21st century, British social policy is charged with the task of devising an ensemble of strategies, entitlement criteria, and organisational forms..which have the capacity to foster social solidarity and inclusion whilst recognising difference and multiplicity."

So far then we have reviewed the policy context that has shaped service developments for older 'African-Caribbean' people, and in particular, culturally specific' provision, we have reviewed the emerging literature on service preferences amongst people from 'Black and Minority Ethnic' groups, more generally and have considered the impact of more recent development in social policy such as 'community cohesion'. Let us now turn to review the findings of the interviews undertaken with older 'African-Caribbean' people

<u>Service Preferences and Older 'African-Caribbean' People in the Two</u>
<u>'Case Study' Authorities</u>
In the next part of this chapter we explore 'service preferences' with a

sample of twenty four older 'African-Caribbean' people in the two case

study authorities. The research methodology for this part of the

study is reviewed in Chapter Three. The aim of this part of the study

was to ascertain what preferences older 'African-Caribbean' users

and potential users of services had regarding support.

Interviews were semi-structured. Respondents were asked about

their age; health; length of time in Britain; type of work they did;

Which 'Caribbean' island they had come from; existing support (if

any) from family, neighbours, statutory/voluntary agencies. They

were asked about their life and interests - What sort of things they

liked to do? What sort of food they liked to eat? Whether they were

restricted in what they liked to do? Whether they had any health

problems? Respondents were asked who they met with socially

(were they from the 'Caribbean'?) Respondents were asked about

knowledge of local services for older people. Had they used local

services? What were there views on these services?   What factors

might affect their take up of services? Respondents were asked

whether they would prefer to use facilities and services designed

specifically for older 'African-Caribbean' people. Respondents were

asked if they had plans to return to the 'Caribbean'.

The same format was followed in each interview. One of the

questions that was initially included to encourage respondents to

think imaginatively about preferences, in a way that did not relate to

existing services, was to ask what kind of services they would buy, if

they were given money to purchase their own services/support?

Respondents had difficulty answering this question and it was

subsequently removed it from the schedule. The problem with

engaging users and potential users with thinking about services in different ways was identified in another study undertaken by (Turner, M, 2002).

Another methodological issue that emerged with older people, who were not currently in receipt of service, was the painful thought of requiring service provision. For many this was associated with increasing frailty and a lack of independence and therefore accessing service provision was perceived as a last resort, and this made it difficult to consider, for example, the issue of preference in relation to 'residential care'.

The themes and responses to the questions appeared to cut across the two authorities, and therefore responses are summarised in relation to the question and not the case study authority, except where directly relevant. Of those interviewed, thirteen were male and eleven were female. Most of the respondents were in their seventies, with fifteen falling in this category; six were aged between 60 and 69 and three were over 80. At the time when these interviews were undertaken, the number of 'African-Caribbean' people over 80 was still relatively small.(Haskey, J, 1996) Nineteen of those interviewed suffered with health problems, and six of these suffered from diabetes, which is particularly common in 'African-Caribbean' communities. Health problems were prevalent in all age groups. This reflected the findings of other research studies.(Pilgrim, S, Fenton, S, Hughes, T, Hine, C, Tibbs, N, 1993; Department of Health, 1999)

The majority of those interviewed in Authority A came from Jamaica, whereas in Authority B, respondents came from a range of 'Caribbean' islands. All respondents both male and female had

worked in manual jobs. These jobs ranged from London Underground; British Rail; the NHS and factory/machinist work. Three of the sample had taken early retirement due to health problems.

How Respondents Spent Their Time

In order to develop service options and support interventions that correlate more closely with need, it is important to develop an understanding of how people prefer to spend their time. Therefore, respondents were asked how they spent their time. Of the more healthy respondents, female respondents were more likely to mention shopping as a way of spending their time. Whereas more healthy men described a wider range of leisure activities ranging from watching cricket; working as a volunteer; going for a walk, or taking a bus ride:

"I go to a local cricket match, I am a follower of cricket. I do crosswords puzzles. I don't go to clubs I don't know where they are."

"I do voluntary work. Any teenager under 17 who is arrested they contact me and I go to the police station, I visit lonely old people it means more to me than money. There are two types of people I want to be involved with, people of my age group and young people. I would like to get them out of the way of life they are in."

"I go out and walk around the park, I always make friends, my friends are from all different nationalities."

"I just walk about. Sometimes I go to visit a friend. I was there playing dominoes yesterday evening until late."

"I have my free bus pass, I take a bus to Hyde Park Corner and have a look around..I go to the pub where my people is, they own it, they are 'Black'."

"I am a jehovahs witness. I go out knocking on doors."

The church played an important part in the life of many respondents, with some attending 'Caribbean'/'Black' churches.

"I go to church, church sisters come from Finsbury Park to get me. People from all over attend the church..."

"I cant walk Im dependent on transport. I have a pastor and a church sister comes to visit me."

"I go to church. All nationalities go there it is very nice socially"

"I am the carer for my husband I take my husband for a walk in the corridor. When he goes to a centre, I sometimes go to a 'Caribbean' luncheon club. My church visits me to give me support. They bring me a 'Caribbean' meal."

"I go to a Baptist church" (mainly people from the 'Caribbean' attend this church)

There was a perception that clubs and services were a place of last resort for those more 'disabled' older people.

"If I had a stick and difficulty I would find these places."

"I have heard about day centres but whilst I am able to, I do my own thing and have a walk I would rather do that."

"I went to a 'Caribbean' day centre, but there were too many rules, I don't go there anymore, I do my own thing, walk around, see people I know, play music."

Two of the twenty four respondents were using centres:

"I visit St Mauritius Day centre, they do crocheting, make table cloths and things like that. People say hello, there are a lot of Jamaicans they are all friendly to me."

"I go to a centre twice a week. They do a quiz, the centre is

mixed. I used to go to WISE(a 'Caribbean' Centre) but I didn't like dealing with 'Dial a ride' and I had no other way of getting there. I prefer that no one interferes with me and I don't interfere with them."

The sense of isolation apparent in the above quote was evident amongst those more frail respondents:

"I know about clubs but if I want to go there I would have to ask someone to take me. It would be a lot of inconvenience. The activities I might like, you would need to be able to see to read and write."(Respondent who had lost her sight)

"I feel sick and tired most of the time. I go out shopping, I don't go to clubs, I don't want to socialise."

"I don't go out, especially since I use a zimmerframe, I fell over once. One good friend from another island used to visit me, He died a couple of months back. I used to go out, but now I'm just waiting to die."

There are some interesting conclusions that we can draw about how people spent their time. Firstly, more healthy/mobile respondents spent their time undertaking activities such as; taking a bus ride; visiting a pub, shopping, and going to church, and therefore a system of social support that is based on user preference might facilitate these leisure options as part of a day care strategy. Secondly, attending more organised day care facilities was associated with a decline in health and a lack of choice about what to do, therefore, it was perceived as a last resort. Moreover, the preference of those who had experienced a significant decline in health, and who therefore, may be eligible for day care expressed a preference for staying in their own homes.

This is a small scale study, and therefore it is difficult to draw any firm conclusions from the findings, However, the findings do suggest that if we are to develop user based preferences then there is a

need to review what the policy intentions of day care are, and consider what alternative strategies might be put in place to achieve these goals.

Friendship/Support networks
Implicit in the development of 'culturally specific' provision is the idea that people from 'Black and Minority Ethnic' groups have a preference for spending time with people of the same 'ethnic' group. Therefore another theme pursued in this part of the study, was an exploration of 'friendship networks' and 'social support'. Did respondents choose to spend time with people from the same 'ethnic' group? Was social support mainly provided by groups or individuals from the same 'ethnic' group?

What was clear from an analysis of the findings was that many respondents expressed their desire to both mix and get along-with people from all 'ethnic' groups. Female respondents were slightly more likely to emphasise this than 'male' respondents.

"I get on with friendly people, no matter who the people are"

"I love and appreciate everyone in the world because God loves us all, the man over the road is 'Irish' sometimes I make him a cup of tea, Christmas time, I get my fruit cake I give some of them upstairs."

"I have a mixture of friends, some are from the 'Caribbean', some are 'Irish', I used to work with them..."
(female respondents)

"I visit my friend, she is a 'White' lady"

At the same time, some respondents did indicate that their friends were from the same 'ethnic' group.

"My Friends come and cook 'Caribbean' food for me."

"I visit my friends in Edmonton, they come from the same place as me."

"I go to the pub, where there is my people."

A small number of respondents stated that they didn't have friends:

"I haven't got a lot of friends, because they give you a headache."

"I haven't got friends, they are not a nice thing."

"I like to be on my own."

Whilst most of the respondents stated they had health problems, the majority were not receiving any help/support. Three were receiving support from 'Black' churches and two respondents stated that they received help from their family.

Food Preferences

In Chapter six we explored the significance of 'food' and identified a preference/desire for 'culturally specific' meals amongst older 'African-Caribbean' people. Respondents were asked to indicate what kind of food they ate that day and the day before:

"I eat rice and peas, 'Caribbean' food, I cook my own food, if I cant do it and no one can help me, I would get 'Caribbean' food. I don't understand any other kind of food."

"I eat mainly 'Caribbean' food, mixed with 'English'. Yesterday I ate rice, plantain, Salt-fish, dumpling and cabbage. If I needed help I would have my contacts bring me "Caribbean' food'. I was brought up on 'Caribbean' food, I would have a 'Chinese' or 'Indian' meal sometimes.

"I eat mainly 'Caribbean' food, though I eat chicken and Chips, and other take away food."

"I can eat 'English' dish if you want.. I would prefer 'West Indies' dish, that's what Im used too."

"I love 'West Indian' pepper pot soup, we put grains in it and things like that I love that."

"I eat a mixture of food, 'Caribbean' and 'English', half and half..If I got meals on wheels I would want it to be 'Caribbean'.

"If I went into a home it would be important that they provide 'Caribbean' food. I like spicy food, I've been eating 'Caribbean' food for so many years, I have a taste for that kind of food."

However, a small number of respondents stated that they did not eat 'Caribbean' food, citing cost, special dietary requirements or simply preference.

"Since I've become a diabetic, I can't eat foods like yam and green banana, I don't miss it, it doesn't taste any different to any other food."

"I eat anything, 'Caribbean' food can be very expensive, I eat whatever is available."

"I used to eat 'Caribbean', but I'm a diabetic so I can't eat it, I wouldn't opt for it."

"I never ate a 'West Indian' diet."

What was also interesting was that the satisfaction with meals in Authority A was reflected in a higher take up of meals amongst this sample, with four respondents receiving 'meals' provision. However, in Authority B, the unpalatable nature of the meals provision, had led to alternative arrangements:

"I had 'meals on wheels', it wasn't 'Caribbean' I decided it wasn't to my liking, so now my daughter brings 'Caribbean' food in.(Authority B)

"My family bring in 'Caribbean' food every day for me. I wouldn't want to have meals on wheels."(Authority B)

"The church brings us in a 'Caribbean' lunch."(Authority B)

"I don't like them they make me choke."(Woman who stopped receiving meals on wheels' – Authority B)

We can conclude then that the provision of 'African-Caribbean' food was important to many respondents. Most respondents did eat an 'African-Caribbean' diet, but this was not exclusively the case. What was also interesting was that the 'church' was filling in gaps in 'meals provision' in Authority B, with low take up interpreted as a lack of demand, rather than the nature of 'meals' provision itself.

Domiciliary Care

Respondents were asked about their preference for 'domiciliary care'. Before moving on to look at the findings it is helpful to consider issues related to the development of 'culturally specific' domiciliary care, as a context for these findings, as these issues have not been addressed in this study. During the 1980's some authorities began to develop 'culturally specific' domiciliary care provision, as part of a programme of 'municipal anti-racism'. The strategy emerged in part because of the low take up of services by older people from 'Black and Minority Ethnic' groups. The employment of 'culturally specific' carers was viewed in some authorities as a way of making 'care' acceptable for those with specific religious/cultural requirements who might otherwise be excluded from the service, or simply by focussing on the failure of 'mainstream' domiciliary carers to respond to 'differentiated' need: According to one senior Manager in Authority B:

> "The problem is that many domiciliary care providers might not provide appropriate hair and skin care for people from the 'Caribbean', so that there hair may not be combed, and t heir skin may not be creamed."

Essentially, then it was argued that carers from the same 'cultural background' would understand the skin and hair care needs of this group, though, such a strategy again places the emphasis for achieving equitable and appropriate services on 'Black and Minority Ethnic' groups themselves. Neither of the two 'case study' authorities operated such a scheme. However, research undertaken by (Cole, J,

1990) uncovered a covert 'racial matching' strategy in Authority B, with 'stickers' attached to the files of 'White' service users who did not want a 'Black' carer.

However, those respondents interviewed in this study appeared indifferent to this issue:

> "The most important thing would be what they did and not whether they came from the 'Caribbean'."

> "I don't think it would bother me who came in to give me domestic care."

The provision of 'domiciliary care' raises specific issues in relation to meeting diverse cultural needs, and for some 'cultures', these needs would have to be taken into account when providing 'domiciliary care'. In retrospect it would have been more interesting to pursue how important it would be for potential users of services to have these 'culturally specific' needs met, as a separate question distinct from the issue of preference for a 'culturally specific' carer.

Day Care
Respondents were asked about their preferences for 'day care' in relation to 'culturally specific' or 'integrated' provision. Most did express a preference for 'culturally specific' provision, and men were more likely than women to express this preference:

> "I would prefer to be with other people from Jamaica as you have so much in common, you can talk about mangoes" (male respondent)

> "If I used a 'Caribbean' centre, I would meet people I know."(female respondent)

> "I am colour blind but I suppose I would prefer to go with people from the 'Caribbean' for the simple reason that the games they play, I understand it dominoes, I understand it better."(male respondent)

> "I would rather be in an environment with other 'Black' people.

Some of the people here they are prejudiced, they don't say anything but they are."(male respondent)

"I would prefer a 'Caribbean' club, I would see people I know, my friends would come there" (female respondent)

One female respondent stated that whilst she would prefer a mixed facility, her husband (who was currently attending a mixed centre for people with dementia) would have preferred 'culturally specific' provision:

"My husband mainly mixed with 'Black' people. In a 'Caribbean' centre he would have the opportunity of meeting up with people from the same district."

However, some respondents expressed the irrelevance of 'ethnicity' in relation to service provision:"I don't care what 'race', I like to be with friendly people no matter who the people are."(Female respondent)

"I would prefer a facility to be mixed with not one particular ethnic group, though I would like access to 'Caribbean' food"

"I would be attracted to the centre for the kind of activities they do, baking, cooking sewing, I would prefer a mixed centre. I would prefer mixed facilities generally."

We can conclude then that here was clearly a demand for 'culturally specific' day care. However, a small group did express a preference for 'integrated' provision, suggesting that attention needs to be given to the development of 'integrated' provision that is responsive to 'ethnic diversity'.

Residential Care

Respondents were asked about their preferences for 'residential care' in relation to 'culturally specific' or 'integrated' provision. In general the responses were very similar to those made in relation to 'day-care' with most expressing a preference for 'culturally specific' provision. However, there was sometimes a reluctance to express a

desire for 'culturally specific' provision, as it was perceived as asking for special treatment:

> "There should be more provisions made not only for people from the 'Caribbean' but for everyone who has worked in this country, who has paid their taxes and who needs help. I am not one of these people who are prepared to say that 'Caribbean' people should have an advantage, but some people might prefer to be in a home which provides certain food, certain activities..I would prefer it."

> "I wouldn't specify a 'Caribbean' home, but I wouldn't reject it either, you understand. If they haven't got a 'Caribbean' home I would settle for whatever."

> "Yes, because I am a Carribean'."

As discussed above, the idea of entering residential care was painful and sometimes associated with life in England:

> "In the West Indies, we don't put people in a home, my mother lived until 105, and her neighbours looked after. I worked in a home, I know what it's like, I would rather go home than go into a home, but if I was to go in a home, I would like to be with other people from the Caribbean."

> A small number of respondents expressed a preference for 'integrated provision'.

> "Going into a home like that, you like to see someone you can talk to, whether they are West Indian, English or American."

> "I like everything mixed."

This lack of agreement over the demand for 'culturally specific' care was clearly played out, throughout this research project, and as I have described in the previous chapter, 'African-Caribbean' workers were much more likely to indicate that this was a preference compared to 'White' workers. What was clear from these interviews was that for many people 'culturally specific' day care, meals services and residential care were important.

Returning home?

One of the assumptions that is sometimes made in relation to older people from the 'African-Caribbean' is that as they grow old, they return home to the 'Caribbean'.(Blakemore, K, 1999; Golbourne, H, 1999;) There is a danger that these assumptions might lead to a failure to consider more fully the needs of older 'African-Caribbean' people. Therefore, respondents were asked whether they had plans to return to the 'Caribbean'.

Interestingly of the twenty four respondents interviewed, only one was likely to return to the 'Caribbean'. Some respondents had initially planned to return to the 'Caribbean' but had to reconsider their plans due to poor health, others felt this was their home, and others were restricted from returning home due to inadequate resources.

> "I did have plans to go home but I am now stuck with an eye problem my friends and doctors advised me not to go."

> "I did want to go back but I just come from the hospital, I just wanted to go back , but what they are telling me is I have to get the warfarin right."

> "We originally planned to return, but then my husband developed dementia."

> I want to go home, but Im so tired."

Others felt that Britain was their home:

> "No this is home I have been here for thirty years."

> "I have no plans to go home, if all my friends are in England I would have to make different friends."

> "My mother is dead, I have a sister and grandchildren here."

> "I have no plans to go home, my family are in the US".

For others, a desire to return to the 'Caribbean' was restricted by

income:

> "I cant afford to go home."

> "I would go home if I had the money, the last time I was there was in 1977"

We can conclude then that whilst there may be a desire amongst many older 'African-Caribbean' people to return home, the reality was that they were likely to remain in Britain. Assumptions then made by policy makers about older 'African-Caribbean' people returning home were not reflected in the findings of this small research study.

<u>Conclusion</u>

In this chapter then we have reviewed the policy context that has shaped service developments for older 'African-Caribbean' people, and in particular, the development of culturally specific' provision, we have reviewed the emerging literature on service preferences amongst people from 'Black and Minority Ethnic' groups, more generally and have considered the impact of more recent development in social policy such as 'community cohesion'.

The 'preference' based studies discussed above suggest that there is a stronger preference for 'culturally specific' provision amongst older people from 'Black and Minority Ethnic' groups, compared with younger groups who express a preference for 'cultural pluralism' in service delivery. However, not all younger people want 'integrated provision', and not all older groups wanted 'culturally specific' provision. On the other hand, more recent debates about 'community cohesion' and 'multiculturalism implicitly question the implications of using 'ethnicity' as an organising principle for welfare provision. However, such issues are beyond the scope of this study.

There were a number of interesting findings to emerge from these interviews. There was clearly a strong preference for 'culturally specific' provision for this group, particularly in relation to 'meals' provision'; day care'; and 'residential care'. However, there appeared to be little enthusiasm for such a policy in relation to 'domiciliary care'. Reasons given for preferring 'culturally specific' provision, were less about the potential 'racism' and 'isolation', that may occur in using 'integrated services' but more in relation to a 'common/shared' experience that might be found in such provision. This conflicted with earlier studies discussed above, and the views expressed by 'some 'White' officers in the two 'Case Study' Authorities. On the other hand, some respondents did not favour 'culturally specific' provision, and therefore a policy that relies solely on 'Black and Minority Ethnic' provision, would not reflect the preferences of all 'service users'. These interviews focused on people from older 'African-Caribbean' people who had both a common language and in many cases a common religion with many 'White' groups, and this finding is .

Another finding that emerged related to the desirability of 'day care' more generally. For those older people who were relatively independent, 'day care' was seen as a last resort, whereas for those who may be eligible for 'day care' the preference appeared to be to remain in their own homes. Therefore, a purchaser driven system that embraces 'user preference' may move away from existing models of 'day care' to purchase more innovative support that more closely reflects user preference.

Overall then we can conclude that older 'African-Caribbean' people in this study did express a preference for 'culturally specific' services, and, therefore a purchasing strategy which embraces preference is likely to support the development of 'culturally specific' provision.

Chapter Eight

Conclusion

We begin this concluding chapter, by restating the research question. We then move on to consider the main themes, issues and findings that have emerged drawing more general conclusions about policy contexts that may facilitate the development of 'preference' based services.

The Research Question

In this study we have investigated the extent to which the introduction of a 'quasi-market' within Personal Social Services in England had enabled them to respond more sensitively to the different needs of those they served compared to the previous model. This issue was examined in depth by concentrating on the possibly, distinctive needs/preferences of older 'African-Caribbean' people, as an illustration of the opportunities and difficulties, that this new style of 'public management' presented in two London Authorities.

The decision to focus on one 'ethnic' group, older 'African-Caribbean' people was an extension of the 'Case Study' approach. This enabled me to pursue policy development and policy changes for this group in depth. This approach has not enabled me to draw conclusions on the impact of the 'community care' legislation, on services for any other specific 'Black and Minority Ethnic' groups, but has facilitated a greater understanding how the two 'case study' authorities responded to 'ethnic diversity'.

One of the central questions of this study was the extent to which the

introduction of a 'quasi-market' in 'social care' would be better able to respond to the differentiated needs/preferences of consumers. Therefore, it is helpful to begin by considering whether we were able to identify a distinctive set of needs/preferences for this group.

A Distinctive Set of Service Preferences

The findings of this study suggest that this group did have a distinct set of preferences in relation to service provision. There was clearly a strong preference for 'culturally specific' provision, particularly in relation to meals provision; day care; and residential care. However, this was not apparent in relation to 'domiciliary care'. Reasons given for preferring 'culturally specific' provision, were less about the potential 'racism' and 'isolation', that may occur in using 'integrated services' but more in relation to a 'common/shared' experience that might be found in such provision.

However, it was also clear that some respondents did not favour 'culturally specific' provision, and therefore a policy that relies solely on the development of 'culturally specific' services would not reflect the preferences of all 'service users'. Moreover, previous studies had identified a concern that such an approach may enable so called 'mainstream' provision to continue to ignore these issues.

However, whilst people did indicate a preference for 'culturally specific' facilities there was a negative perception in general of services such as 'day-care'. For those older people who were relatively independent, day care was seen as a last resort, whereas for those who may be eligible for day care, the preference appeared to be to remain in their own homes. Therefore, a purchaser driven system that embraces 'user preference' may explore alternative ways of meeting the policy intentions of 'day care'. However, given the large attendance of older 'African-Caribbean' people at day centres in both Authority A and B, it

may be inappropriate to abandon such provision, but simply to facilitate more imaginative responses.

Having established then that there was a distinct set of preferences amongst older 'African-Caribbean' people, this brings us to the next question, was the 'quasi-market' more effective in responding to these needs?

Mechanistic Implementation

As we have already seen the policy intention of the 'quasi-market' was, in part, to facilitate a system more able to respond to 'differentiated need'. This was to be achieved through the development of improved needs assessment, at both a 'macro' and 'micro' level that would inform purchasing decisions alongwith the stimulation of the 'mixed economy of care'. A review of existing knowledge had suggested that there had only been a partial development of the 'purchasing' function and a limited development of 'independent' sector provision.

The findings of this study confirm that 'community care implementation' was implemented in a mechanistic way, embracing the detail rather than the spirit of the legislation. Both 'case study' authorities appeared to undertake the relevant tasks linked to implementation, such as; the establishment of a 'purchaser/provider' split; the introduction of 'care management'; and the production of Community Care plans. However, these tasks were approached in a mechanistic way.

The production of the 'community care' plans is a good example of this. Both authorities produced plans and therefore met the legal requirements of central government for them to do this. However, these plans did not embrace the intentions of a Community Care

plan, which were to develop a strategic approach to planning and therefore enable effective purchasing strategies based on the identification of need at a 'macro' and 'micro' level.

Partial Development of the 'Purchasing' Function

Similarly, if we consider changes made to the way in which services were purchased. In the first instance, neither Authority A nor Authority B, developed the micro-purchasing function, but instead developed a model which located purchasing in a separate contracts unit. These units simply organized contracts and developing purchasing arrangements for a very limited range of services in an administrative and ad hoc way divorced from either 'micro' or 'macro' needs analysis.

For example, one of the key responsibilities of the contracts units in both authorities was the purchasing of residential and nursing home care which was a new responsibility following 'Community Care' implementation, However, contracts were arranged which appeared to take little account of needs or preferences. Both units produced a list of care homes. However these lists did not provide any information on ways in which specific needs might be met in one home compared to another. Despite statements in the respective community care plans of the need to plan care services to meet the needs of the increasing older 'Black and Minority Ethnic' populations this was completely ignored when purchasing residential and nursing home care.

Similarly, Authority A, began purchasing domiciliary care from the 'private sector' but again this was not driven by any wider strategic policy objectives, but simply a desire by members to make greater use of the 'independent sector', which in itself led to financial problems. We can conclude that neither 'purchasers' in Authority A

nor Authority B appeared to be driven by user preference and this was a crucial factor for success identified by (Bartlett, W, Le-Grand, J, 1993).

As was clear in Chapter One the 'quasi market' was to operate slightly differently in each area of welfare, and in the case of the Personal Social Services, the implementation of the 'quasi-market' was implicit, rather than explicit. The introduction of the 'purchaser/provider' split was not mandatory in the same way as it was in health and education.(Knapp, M, Wistow, G, Forder, J, Hardy, B, 1994) This partial application of the 'quasi-market' did enable local authorities to engage less enthusiastically with the 'quasi-market' and does account in part for its limited application.

Purchasing Arrangements – 'Ethnic Diversity' – A Neglected Dimension

The development of the purchasing function clearly offered the potential to respond more effectively to 'differentiated need', and lever more desirable outcomes for 'Black and Minority Ethnic' groups. . However, 'purchasers', in Authority A and B appeared indifferent to 'ethnic diversity' and this was reflected in purchasing arrangements.

However, it was at the level of 'care management' or 'micro purchasing' that this issue was addressed, albeit partially. In both authorities informal systems had developed, whereby some 'care managers' who were sympathetic to these issues, identified specific care homes more able to meet the needs of particular groups, and included 'culturally specific' day care as part of a package of care. In Authority A, this was an informal system based on the 'goodwill' of 'care managers and in Authority B this had been formalized into a minimal cash sum added to 'care packages'.

It was clear in both authorities that those involved with assessment, held conflicting views on responding to 'ethnic diversity' and 'cultural difference'. This was reflected in discussions with staff, with 'White' staff more likely to reject the notion that older 'African Caribbean' people may have a preference for 'culturally specific' services, compared to staff from 'Black and Minority Ethnic' groups. Therefore, this is likely to translate into assessment decisions, particularly where arrangements are ad hoc. Indeed given the central role of 'care managers' in assessment decisions this is an area that requires further investigation.

The 'Purchaser/Provider' Split as a Rationing Mechanism

The role of purchaser or more specifically the development of the purchasing function has led to an increased specificity over what is purchased, and how this fits in with the goals and responsibilities of the authority. This increasing specificity has to be understood against a background in which authorities were being encouraged to elaborate 'gate-keeping' mechanisms which would ensure that 'needs' were assessed and contained within a context of limited resources. Therefore, it was the level of resources that was more important in determining 'need', rather than 'need' itself, and it was the 'gatekeeping'/'risk management' role that was accentuated over issues of user preference.

Therefore, whilst the previous model of provision, may have funded an array of services with generalised goals, the revised approach has become much more specific about how funding a service relates to their legal responsibilities/policy intentions. Moreover, the sense of financial crisis pervading both Authority A and Authority B, appeared to legitimate such an approach. (Knapp, M, Wistow, G, Forder, J, Hardy, B, 1994) identified a number of benefits that might arise

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from introducing a 'purchaser/provider' split, including needs analysis; specification of desired outcomes; accurate identification of the cost of decisions in ensuring a match between needs and resources and it does appear that it is the latter function that has dominated implementation. Moreover, (Le Grand, J, 2002) suggests that the overriding change following the introduction of 'quasi-markets has been an increased focus on what they are purchasing in relation to their goals and legal responsibilities.

It appears then that the policy goal of 'securing better value for money' became an over-riding policy objective, and it is this that dominated 'implementation' over other goals such as 'user choice'. The then government did however, push towards the introduction of 'Purchaser/Provider' splits and the Audit Commission made clear that it was important to use the Standard Transitional Grant monies in flexible ways, as this money was not tied to existing service provision. However, there were no penalties for not stimulating a diverse range of service alternatives, or rewards for identifying need in imaginative ways.

Too Few 'Implementers'
There were a lack of people working in strategic roles, that could have facilitated the 'quasi-market'. Both authorities were suffering from information and policy change overload and it appears that in both these authorities, they had cut resources in the area that would be most significant in achieving a more 'needs led' and imaginative approach to 'policy implementation. In both authorities it appeared that policy makers were simply 'muddling through' in a way similar to that depicted of the front line workers in Lipsky's study, modifying their expectations of what was expected. Therefore, the focus was on meeting the requirements that had the most punitive sanctions for non-implementation, and in this case the emphasis was on

balancing 'need' with resources.

Incorporating 'Race Equality' in 'Community Care' – More Positive Statements

In this study we considered in some detail ways in which 'race equality'/'ethnic diversity' was incorporated into the 'community care implementation' process. We have also identified elsewhere in this study, a tendency to respond to 'race equality' by making positive statements of intent on this issue that are not followed through into action.

As we have seen Authority A and B, were operating in different policy contexts in relation to this issue. Authority A had adopted an 'anti-anti-racist' position on policy at the moment of implementation, whilst Authority B retained its commitment to such issues. However, both authorities made positive statements about responding to the increasingly older 'Black and Minority Ethnic' populations in 'Community Care' plans.

Nevertheless despite these positive statements, Authority A, neglected this issue in each dimension of 'community care' planning. This was evident in the review of joint planning; the review of day care; and the purchase of 'residential and nursing home' care, it was only the 'community care' plan itself that made reference to this issue.

Authority B as we have seen remained 'committed' to these issues (at least on paper) and in this authority, the approach was more ad hoc. Consultation was one area that did receive attention. However, the arenas in which 'Black and Minority Ethnic' groups were included, were incidental to 'Community Care' planning and therefore, the purchase of domiciliary and residential care was

undertaken in a 'colour blind' way.

However, what was interesting was that despite the different policy
contexts of the two authorities, and the failure to acknowledge
'ethnic diversity' in purchasing arrangements. From the perspective
of the older 'African-Caribbean' person they were able to opt for
'culturally specific' day care and 'meals in the home' in both
authorities.

The Previous Model Was More Responsive to 'Differentiated Need'
An exploration of service provision suggested that despite a
perception that the previous model was unresponsive to
'differentiated need' a range of 'culturally specific' services had
developed, either in this period or immediately following this, and
that these services were an outcome of a policy agenda focusing on
'race equality'. In Authority A, these services were developed
through the use of 'Section Eleven' monies that facilitated the
employment of specific staff, and the use of 'grant aid' too stimulate
the development of a range of 'voluntary sector' providers, along-
with the development of 'culturally specific' meals provision. In
Authority B, 'culturally specific' services were initially generated in
the statutory sector. In both authorities specific workers were
employed in developmental roles to facilitate take up of existing
services and the development of new services.

The previous model then was more responsive to 'differentiated
need', partly because the policy climate of 'municipal anti-racism'
created a more sympathetic environment in which to make claims,
about 'race equality', and partly because the policy climate was more
favourable to the stimulation and development of new services to
meet 'unmet need', and therefore, a plurality of providers emerged.
In order for the 'quasi-market' to operate effectively there needs to

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be a focus both on purchasing and providing. However both the development of the purchasing task and the management/stimulation of the 'mixed economy' were neglected.

<u>Responding to 'Ethnic Diversity' – A 'Provider' Driven Model</u>
What was apparent in both authorities was a lack of commitment to these issues, resulted in an ad hoc array of initiatives, in response to different pressures and ambiguity about how to respond to these issues. Therefore, the model was provider driven both prior to and following the introduction of 'Community Care'.

What has become clear throughout this study, is that both the previous model of service delivery and the 'quasi-market' has been reactive, initially developing services and later purchasing services for more organized 'Black and Minority Ethnic' groups. (Bartlett, W, Le Grand, J, 1993) argue that an important criterion on which to evaluate the success or otherwise of the 'quasi-market is 'equity'. They argue that in order for the 'quasi-market' to achieve 'equitable' purchasing decisions, 'purchasers' must not be able to choose who they are going to purchase services for, other wise they may find ways of avoiding purchasing care for 'more expensive' users, who may have 'differentiated' and more complex needs.

This case study has illustrated quite clearly that 'purchasers' have not responded to 'differentiated need' in an equitable manner, but have simply responded to some 'differentiated need'. Moreover this inequitable approach would have been as much a feature of the previous model as this new model. However, as we have already seen, the purchasing function has developed in a way that focuses more clearly on how what is purchased fits with policy objectives/legislation and this may potentially lead to a more comprehensive debate on this issue, and indeed there was evidence

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that this was beginning to take place in Authority B.

Moreover, what is clear from this study is the significance of local politics in shaping 'quasi-market' outcomes, reinforcing the perspective of (Cutler, T, Waine, B, 1997) who argue that policy analysis needs to move away from seeing the 'quasi-market' as a technique and instead understand it more as a distributional mechanism that operates in a political space.

A More Prescriptive Approach for Service Providers

We have already seen that the development of the purchasing function had led to an increased specificity over what was purchased, and how this fitted with the goals and responsibilities of the organization. This was beginning to impact on those who were providing services for older 'African-Caribbean' people. Both Authority A and B had an active 'African-Caribbean' community who had campaigned and been involved in the development of services, often at considerable cost in terms of time and effort to themselves.

The shift to a contract culture had led to an increasingly prescriptive and formalistic approach to such organizations, which in turn reduced the autonomy of providers, as in both Authority A and B such organizations were dependent on 'monopoly purchasers', which as (Bartlett, W, Le Grand, J, 1993) warn may not deliver the best outcomes, as 'purchasers' yield considerable power in this instance, particularly where there are more than one provider as was the case in both Authority A and B. It also raises more general questions about the unanticipated consequences of the 'contract culture' which may erode values such as 'voluntaryism' and in the process result in much more expensive provision.

The 'Mixed Economy of Care' - Meals Provision - Responding to Diversity?

The emergence of the 'quasi-market' clearly offered the potential for responding to 'differentiated food preferences' more effectively, given that there was already an established supply of restaurants that could have played a role in provision, along-with clear indications of a preference for 'culturally specific' provision. Therefore, meals provision served as an interesting case study to explore the 'mixed economy of care', highlighting both the potential and the problems in stimulating a plurality of providers.

We considered how the market more generally had responded to an increased demand for 'ethnically diverse' food and concluded that the market had developed what was described as 'ethnic' food mainly in response to the changing eating habits of the 'British' population, but also in response to the emerging market of 'Black and Minority Ethnic' consumers. However, it was clear that where the market had responded to 'ethnic diversity', it was punctuated by the presence of a sufficient number of people from a particular 'ethnic' group to make such a strategy viable. This was significant as it means that if we expect the market to play a larger role in service provision, it is likely that this too will be dependent on a critical mass of service users.

Again, an exploration of 'meals provision' indicated that the previous model of service provision was responsive to at least some 'differentiated need'. During the 1980's many local authorities began to respond to the differentiated need of some more organized 'Black and Minority Ethnic' groups - generally the strategy was based on expanding 'in-house' provision to cater for 'newly identified' needs. Whilst this research was being undertaken, both case study authorities and the six additional authorities studied were

all able to provide 'culturally specific' meals provision for older 'African-Caribbean' people.

From 'Maximalist' to 'Minimalist' Approaches to 'Race Equality' in Meals Provision

It was possible to identify three discrete strategies in operation in relation to 'meals' provision. These will be described as Maximalist Strategy One; Maximalist Strategy Two and Minimalist Strategy Three.

Maximalist Strategy One

Maximalist Strategy One was dominant in some of those local authorities, who had developed 'culturally specific' provision in the 1980's. These authorities were continuing to provide freshly cooked meals provision, prepared in specialist 'in-house' kitchens, based on a rationale that 'African-Caribbean' food was only palatable when freshly cooked, and that there was a cost implication when responding to 'ethnic diversity'.

A characteristic of those authorities who had retained their 'in-house' kitchens was the presence of 'African-Caribbean' managers who had been involved in the service from inception, and were strongly committed to ensuring that meals were of a high standard. Such provision tended to achieve economies of scale by providing meals for luncheon clubs as well as meals in the home. However, this strategy was increasingly being perceived as too expensive, given the potential savings that could be achieved by sub-contracting with external providers. Therefore, the perception of staff working in these authorities was that the system was unlikely to survive, an increasingly 'cost conscious' culture.

Maximalist Strategy Two

A second strategy was discernible in two authorities and applied in

one. Indeed this strategy was based on making use of the 'mixed economy of care' and illustrates both the potential of the 'quasi-market' alongwith some of the problems in involving a plurality of providers in service provision.

It was anticipated that the introduction of the 'Purchaser/Provider' split would facilitate increased possibilities for preference based welfare. One of the authorities studied in the first implementation study (Lewis, J, Glennerster, H, 1996) explored the possibility of using 'pubs' and local restaurants to provide meals in the home. However, they encountered considerable problems in implementing this strategy. Partly because of the potential 'risk', how would they ensure health and safety regulations were followed? What if a user was to contract food poisoning? Secondly, how would such a system be resourced in terms of time? As such a model would require more time in terms of arranging and monitoring individualized arrangements.

In this study, one authority pursued the possibility of developing 'block' contracts with local restaurants as a way of responding to the eating preferences of a range of 'ethnic' groups. However, it emerged that such a model would conflict with regulations set out in the 1988 Local Government Act in relation to competition and a second strategy was pursued. This strategy was based on contracting with a 'multi-national' provider for meals provision, and requesting that the provider develop sub-contractual relationships with local 'Minority Ethnic' restaurants. However, there were two issues that emerged.

The first was 'risk' in relation to the health and safety factors raised above. This affected the willingness of the 'multi-national'

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contractor, to develop sub-contractual arrangements with local restaurants and resulted in relationships being established with just two providers. The second was cost, both to the potential providers who would have to purchase specific equipment, food etc and in terms of increased transaction costs, as each arrangement was costly to organize. Therefore the issue of transaction costs and risks identified by (Bartlett, W, Le Grand, J, 1993) was a factor suggesting that whilst this model was more 'user orientated' the costs of organizing and managing the model might be greater than the benefits. Moreover, such a strategy was only pursued in one authority.

Minimalist Strategy One

A third strategy appeared to be increasingly dominant in meals provision. This strategy was discernible in some local authorities who had closed their in house kitchens and contracted with large 'multi-national' providers, and in one authority who had developed 'culturally specific' meals provision for 'African-Caribbean' service users following the introduction of the 'NHS and Community Care Act 1990'.

In these authorities they had entered into contractual arrangements with a large 'multinational' provider and stipulated the need for the provider to ensure that meals provision was responsive to 'ethnic diversity'. As part of this arrangement the large provider had 'sub-contracted' with an emerging provider of 'African-Caribbean' frozen meals, as a way of delivering more cost effective services. Indeed this strategy was prevalent in some of those authorities more skeptical about the demand for 'culturally specific' provision. The rationale for such as a strategy was legitimated as a way of both minimizing risk and reducing cost, and ignored the 'quality' issues raised about the unsuitability of freezing 'African-Caribbean' meals.

This approach generates a number of concerns. Firstly, it passes responsibility for responding to 'ethnic diversity' to the contractor. Secondly, it suggests a low commitment to 'quality'. Thirdly, we have already seen that policy on 'race equality' has tended to be based on positive statements which are not followed through into action. Therefore, such an approach may simply legitimate further non-action on this issue.

A Tendency to Monopoly Provision

Overall then the dominant model appears to be one of 'monopoly' provision. However, this is less related to the 'NHS and Community Care Act 1990', but more an outcome of increasingly stringent health and safety legislation, that has highlighted the possibility of 'risk'. Therefore, in order for authorities to minimize 'risk', they need to opt for the safest (most 'risk free') option, and clearly a large 'multinational' provider is a lower risk, than a range of small providers. This highlights the significance of exploring the complexity of legislation that may affect policy implementation, as opposed to simply exploring one piece of legislation and linking all subsequent actions to that particular piece of legislation.

Moreover the cost of developing a large number of contracts was also prohibitive. (Abbott, B, Blackburn, R, A, Curran, J, 1996) explored the role small businesses played following the introduction of Competitive Compulsory Tendering (CCT). They concluded that CCT had not created a wide range of opportunities for small businesses, as the cost of working with small businesses (in terms of increased negotiations) was viewed as prohibitive by local authorities. Interestingly they identified a trend for large contractors to sub-contract aspects of their work to smaller businesses, similar to that identified in this study.

Overall, it appears that the 'quasi-market' has not been any more successful in responding to differentiated need than the previous model of bureaucratically planned services. In general local authorities continue to respond to 'ethnic diversity' by purchasing 'culturally specific' meals for those more organized 'Black and Minority Ethnic' groups. In relation to the development of a 'mixed economy of care' we see that despite the existence of a range of already established potential providers, i.e. small local restaurants, the tendency is to monopoly supply, with large 'multi-national' contractors dominating provision, with 'risk' and 'cost' acting as crucial determinants in this regard.

To return then to the original question 'Was the 'quasi-market' more responsive to differentiated need' than the previous model? It clearly was not. However, this was less to do with the 'quasi-market', than the way in which the 'quasi-market' in social care was implemented. As an abstract model the 'quasi-market' with its focus on the identification of 'micro' and 'macro' need, and the development of a 'mixed economy of care' clearly offered the potential to respond to 'differentiated need'. However, this did not happen.

(Phillips, C, 2005) has recently argued that the 'quasi-market' in areas such as health and education may have impacted negatively on 'Black and Minority Ethnic' groups, However, I would suggest that there is nothing inherent about this model that should impact any more negatively on 'Black and Minority Ethnic' groups than the previous model. It is the context in which the 'quasi-market' operates which is crucial. (Le Grand, J, 2003) has recently argued that the 'quasi-market' is the 'least worst' model. However, this study has identified some important strengths of the previous model in responding to difference.

Moreover, it is likely that the development of the purchasing function is likely to lead to increased scrutiny about each purchasing decision which may simply mean less care for all of us.

The implications of these findings for those from other 'Black and Minority Ethnic' Groups

Whilst this study focused on the experience of older 'African-Caribbean' people, its findings suggest that it is possible to generalise that 'ethnic diversity' was a neglected dimension in relation to 'community care' implementation, and where it has been addressed it is the result of the actions of particular officers, or groups advocating on behalf of a particular group.

The decision to focus on one 'ethnic' group has meant that we cannot draw any conclusions about service developments and service change for other 'ethnic' groups, including older 'White' people following 'Community Care Implementation'. Clearly, it would be interesting to explore in much more detail the impact of the shift to monopoly provided frozen meals in relation to the preferences of all service users, or trends and preferences for in day care provision. Nevertheless the findings do provide a useful insight into the terrain of service development and service change following 'Community Care implementation'.

The implications of these Findings for all Older Service Users

This study took 'ethnicity' as its focus. However, its findings confirm the findings of a range of other studies that suggest that user choice/preference in general was a neglected dimension of 'Community Care implementation' for all service users. My decision to focus on 'older' people was a reflection that the initial focus of 'Community Care' implementation was on 'older' people, though it would have been interesting to contrast this issue with different client groups, such as those with mental health problems, to explore

whether the neglect of user choice/preference was simply a reflection of the continuing neglect of services for older people.

Towards a 'Preference' Based Model of Care

What lessons then can we learn about how we might develop a 'preference' based model of care. One of the major problems in relation to the application of the 'quasi-market' was the mechanistic and partial approach to 'implementation'. Authorities focused on the detail rather than the principles, and one solution to this may be to encourage 'implementer's to start with policy goals, rather than methods. Moreover, it is clearly crucial to ensure that there are sufficiently skilled staff in post to implement and think imaginatively about policy.

Secondly we have seen that 'ethnic diversity' was in general a neglected dimension of policy. As we saw in the 1980's, structures and policies were put in place to facilitate 'race equality' objectives. Generally, these strategies were based on 'Black and Minority Ethnic' groups directing change, either as workers, or service providers. This model was dismantled, partly rationalized by its ineffectiveness. During the 1990's it appeared that it was still left to 'Black and Minority Ethnic' groups to raise this issue, but this was in a de facto, rather than planned way. Similarly, the only authority that did attempt to embrace the 'mixed economy of care' was an authority (Authority E) in which 'Black and Minority Ethnic' groups formed an alliance to lobby the local authority on these issues. Clearly in order to develop a 'preference based' model of care, stronger direction from central and local government is needed with a commitment from all those involved in delivering care. The Race Relations Amendment Act 2000 may go some way to addressing this. However, there appeared to be near contempt to this issue from some workers, and it is important therefore, that this is addressed,

in both a 'bottom up' and 'top down' way.

The current government in its recent Green Paper (2005) on Adult social care has stressed the possibility of distributing cash to all service users to purchase their own care. This clearly creates opportunities in terms of facilitating a model of care that more closely reflects preference. However, we saw that those older people interviewed in this study found it difficult to think in terms of spending 'cash' rather than 'care'. Moreover, we have also seen that meeting the needs of 'Black and Minority Ethnic' groups may have cost implications that would need to be included in any sum of money allocated.

However, in order to facilitate a system of care that responds to preference more attention is needed to consider how to stimulate the 'mixed economy of care' and more effectively manage the market. One of the possibilities that was created with the development of the 'purchaser/provider' split was of providers selling services to more than one authority. For example, a day care centre could be developed to cater for a relatively small 'ethnic' group, serving more than one authority. Similarly, Authority A's high quality provision could be marketed to more than one authority, possibly achieving greater economies of scale. There was no evidence that the 'quasi-market' generated these kind of interventions, but clearly such developments would be helpful and could happen.

Moreover, given the extent of 'ethnic diversity' in London, there is scope for the development of a London wide body, or specific regional bodies, such as London East, that might stimulate and support the development of new provision, both in the private and voluntary sector, across local authority boundaries. The voluntary

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sector had clearly made a huge contribution to the development of services for older 'African-Caribbean' people and it is therefore important to find ways in which such organizations continue to thrive and develop. A London Wide body could develop to undertake micro and macro needs assessment, stimulate new provision and act as brokers of care as part of a framework of support for direct payments. This model would be a step forward in developing a more preference based model of care.

The increasing 'commodification' of care reinforced by a 'direct payments' approach may lead to increased fragmentation of provision and create additional problems for service providers in terms of increased transaction costs and uncertainty. Therefore, a brokerage type model may be more successful in developing new services and organising individualized packages of care. Moreover, to overcome the problem of responding to more organized groups, a fund could be developed that allocates resources for the development of services for all 'ethnic' groups, proportional to their numbers in the population.

Towards a 'Racially' Inclusive Model of Policy Making and Provision
We have seen in this study that several years of 'race equality' strategies have not been successful in developing a cultural shift in policy making and provision related to 'race equality'. This issue remains a marginalized issue, addressed in an ad hoc way. The 'Race Relations Amendment Act 2000 places distinct responsibilities on local authorities with regard to these issues, that clearly at a policy level will force local authorities into action. Already there is evidence from studies of education that change continues to be slow (HEFCE, 2004; Gillborn, D, 2005).

Within the delivery of social services there are three distinct issues.

1. Failure at a policy level to prioritise 'ethnic diversity'.
2. Hostility to 'Culturally Specific' Provision, from some 'White' staff.
3. Failure to adequately consider what 'race equality' means in relation to the development of services.

Let us consider each in turn:

<u>The Failure at a Policy Level to Prioritise 'Ethnic Diversity'</u>
We have seen in this study that there has been a failure a policy level to prioritise 'ethnic diversity'. The appointment of 'Black and Minority Ethnic' workers at a senior management level is clearly an important mechanism for taking forward change on this issue. However, we have seen that 'race equality' strategies have been over reliant on 'Black and Minority Ethnic' staff and therefore it is important that whilst recognizing the importance of placing 'Black and Minority Ethnic' groups in senior positions, as a way of achieving change, more fundamental change has to be achieved that involves all staff.

There is scope for the application of both 'top down' and 'bottom up' managerial initiatives. At a 'top down' level, each policy needs to be audited to assess 'equality' implications; 'equality' opportunities' and 'equality' strategies. The audit of 'equality' implications would identify specific issues that are raised by the new policy. The audit of 'equality' opportunities would identify opportunities for improving services to better achieve 'race equality' objectives as a result of the policy directive. Thirdly, an 'equality' strategy would need to be devised to ensure change, and this would need to be monitored. Had such a process been in operation at the time of 'community care implementation' then it is likely that the findings of this study would have been different.

What was clear from this study was that a strategy of 'municipal

anti-racism' was effective in achieving change, and therefore, the appointment of specific workers to monitor and develop expertise would be a desirable rather than negative development.

Hostility to 'Culturally Specific' Provision, from some Staff.
What has become clear in this study is that there is hostility to this issue in both local authorities, particularly from 'White' staff that 'race equality' is a problem, and, therefore, it is too grassroots or 'bottom up' strategies that I now turn.

Failure to Adequately Consider what 'Race Equality' Means in Relation to the Development of Services
In order to develop strategies that will be implemented there needs to be more attention placed on winning staff of all 'ethnic' groups over to the benefits of change. This study has demonstrated that not only has 'ethnic diversity' been neglected, but 'diversity' more generally has been neglected. In other words, there has been a failure to develop preference based services that respect difference in all its forms and commission services appropriately. Indeed it is this failure to recognize difference that results in a situation where 'difference' is only recognized in some places, i.e. where specific groups draw our attention too it who may lobby on behalf of a specific group.

Therefore, more grassroots/'bottom up' discussions need to take place about what 'difference' means and what it means for service developments. Currently, policy only recognizes the differences of some 'ethnic' groups but a more inclusive definition would have benefits for everyone, as this would facilitate an approach that is more inclusive. However, it is not only that 'ethnic diversity' needs to be expanded in terms of its definition, but that 'diversity' needs to move beyond a simple focus on 'ethnic diversity' to develop a wider definition of 'diversity' which does not negate the significance of

'ethnic diversity'. (Phillips, T, 2004) has argued that the process of implementing 'race equality' strategies should act as a driver for improving services for everyone.

We also need to revisit debates and traditional assumptions about 'ethnic diversity'. First of all we need to balance the tension between respecting difference, and operating in an 'ethnically essentialist' way which reduces people to their 'ethnicity'. Membership of a particular 'ethnic' group does not automatically determine service preferences, but it may and this needs to be acknowledged, Moreover, this is a dynamic rather than static process.

We also need to move beyond the traditional 'White' 'good service'/'Black' 'bad service' dichotomy. A recent study by (Barn, R, 2005) challenged traditional views on the experiences of care leavers, where she found that 'White' care leavers were more disadvantaged than those from 'Black and Minority Ethnic' groups. Indeed we have seen in this study, that being a member of an older person from a 'Black and Minority Ethnic' group may actually have benefits, in relation to the level of community support available.

Overall then an effective strategy for change needs to address this issue in both a 'top down' and 'bottom up' way and has to focus on achieving change at all levels.

Methodological Reflections
Whilst undertaking the research it has become clear that more qualitative methods are essential when exploring issues of 'race equality, as this enables us to move beyond formal positions of to gain a clearer perception of what is actually happening.

I have become increasingly critical of the framework through which

issues of 'race' and 'ethnic diversity' more generally are explored. This study was an exploration of the extent to which the 'quasi-market' was more able to respond to differentiated need than the previous model, and used older 'African-Caribbean' people as a 'case study' to test this. However, what was clear was that despite services being relatively responsive to the needs of this group, they were not responsive to 'ethnic diversity' more generally.

The framework for considering 'ethnic diversity' has been shaped by the struggle of those people who came from the New Commonwealth and Pakistan in the post war period. These groups contested the limited model of 'social citizenship' bestowed upon them by the British state. Social policy responded to these concerns by developing a policy and research agenda that measured the experiences of these groups and their descendants. Social Policy needs to move away from this model to develop a more inclusive model of 'ethnic diversity' which may in turn generate a debate about whether 'culturally specific' provision is either a desirable or practical solution in an increasingly diverse society

There have been no studies to date that have considered how the implementation of direct payments might impact on 'Black and Minority' groups, and this could be a possible direction for future research.

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