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Abstract

A lack of management theory which is relevant to human service agencies, combined with a failure to recognise the very large contribution which older people make to their own care makes it difficult to deliver supportive services. Self care by elders is divided, in this preliminary classification, into new strategies for everyday living, the reallocation of time and the avoidance of risk. Managers who understand that service users are co-producers of care and recognise the need to manage the users, as well as their own staff and relations with other agencies, are more likely to be able to deliver good services. However the management of co-production is at present only theorised for the private sector where ethical issues are less pressing and users are customers. In future a greater understanding of co-production and the development of theory and practice which will combine the management of co-production with the empowerment of users will be essential.

Introduction

Public sector human service agencies in Britain have traditionally operated within a bureaucratic model of organisation. Services were offered on a take it or leave it basis and rationing was usually achieved by a combination of waiting lists, poor quality and stigma (Griffiths 1988). The white paper Caring for People (Cm 849, 1989) and the subsequent NHS and Community Care Act 1990 were intended to introduce a new approach to public management (Pollitt, 1993) to social care agencies. Services were to be consumer oriented ('needs led provision') and management was to be more competitive and market oriented in style. Local authorities were to become service enablers while voluntary and private sector agencies (assumed to be customer oriented) were to take over large areas of service provision.

The changes leave managers of services for older people with conflicting priorities. On the one hand policy rhetoric urges them to increase choice and to empower users (a market oriented model of service provision). On the other hand, the reality of policy implementation when budgets are stationary and needs are rising demands strict rationing combined with fair distribution (a bureaucratic model). As Dopson and Stewart (1990) have pointed out, the Act did not resolve the fundamental conflict between consumer empowerment and service equity. Managers have been left with little relevant theory or practice to fall back on in this time of rapid organisational and ideological change. This paper, drawing on recent work with service managers and with older people in the community (2), presents a preliminary discussion of two related areas where further research is urgently needed. The first is the application and development of theories of co-production to the management of community care services.

The second is the particular relationship between co-production of care and self care by frail older people.

Co-production

In human service agencies co-production is a way of theorising the division of labour between patients and professionals or between formal and informal carers. In this paper the emphasis is on the division between professionals and frail elders who live in the community. One key characteristic of a service industry is that consumption involves a range of activities by the consumer, or user, as well as by the provider (Sasser, Olsen and Wyck, 1978; Normann, 1991). For example, in the case of university education the final output of an educational qualification cannot be achieved unless the user (in this case a student) undertakes a series of co-production activities ranging from private study, through attendance at lectures or practicals, to essay writing and examination performance. Similarly, care can only be delivered in the community if care recipients, and/or their informal carers are willing and able to undertake many care tasks themselves. The NHS and Community Care Act 1990 gave de facto recognition to one aspect of co-production by accepting that informal carers were major contributors to care and requiring local authorities to provide services which support them.

While co-production in terms of work to be performed has been recognised for some time, the implications for service managers have not been discussed. Stacey (1984) for example, discussed the division of health care labour between professionals and patients and unpaid workers, mainly women. She concluded that the patient should be seen as a health worker. The lack of a management approach is hardly surprising. Recent emphasis in public services management has been on importing theory from private sector manufacturing industry. The model of independent firm competing with others to deliver a unique and defined product is clearly unsatisfactory but the widget has taken a remarkable hold over management education. For example, recent health service guidelines on management competencies fail to make any mention of the management of interprofessional or interagency relationships (NHS Training Directorate, 1993). The model is one of the manager with a defined span of control operating within a single clearly bounded organisation. However recent work indicates that managers who have anything to do with community services (including hospital discharge) find themselves managing services which depend on the input of other professionals and other agencies (Dockrell and Wilson, forthcoming).

Elders as Co-producers of care

Now that old age, defined as beginning at 60, embraces two generations a new dimension has to be taken into account in any discussions of informal caregiving. While it is often presumed that the young, defined as those under retirement age, look after the old, defined as those over retirement age, in fact the situation is very much more complex. The GHS survey in 1985 (Green, 1988) showed that the peak age for caregiving was 45 to 59 (21% of total caregivers). However the share

fell only to 17% of the total for the 60 to 75 age group. As the numbers of over 80s have increased since 1985 it seems highly likely that the GHS figures understate the amount of caring now being done by the young elderly, those aged 60 to 75. These are the younger generation of active elders but they are nevertheless classified as "old" by younger members of the population. In addition, since elderly spouses, the main elderly caregivers, often see themselves as simply fulfilling their marriage vows, rather than as caregivers, it is very likely that the GHS data underestimates the amount of care provided by elders.

According to an analysis of the General Household Survey for 1985 by Evandrou (1990), the age distribution of elder caregivers differed for men and women. 18% of female caregivers were aged 60-74 and only 6% were 75 or over. In contrast, 14% of male caregivers were aged 60-74 while 10% were over 74. This difference reflects the fact that most older male caregivers are husbands looking after an elderly wife, while women have a wider range of caregiving roles. A wife may for example be looking after an elderly disabled husband but equally she may be the main caregiver for a handicapped adult child or for a parent in her nineties. Women are also more likely to provide care outside the household to older or younger relatives and neighbours.

Apart from being heavily involved as informal carers, active older people are making a contribution to voluntary sector organisations (Smith, 1992). It is not at present clear how this input will develop in the new contract environment of community care. As voluntary sector agencies become services providers working to contract, they may either deliberately take on more trained staff, or they may find volunteers less willing to work in the new contract culture and be forced to substitute paid staff for volunteers. Certainly if voluntary agencies are to take over large areas of community care, as government policy suggests they should, there will need to be changes in the way volunteers are recruited and managed (Connelly, 1990; Billis and Harris, 1992). However these issues are not dealt with in this paper since the emphasis here is on self care rather than informal care.

The total current input to caregiving by older people has not been quantified but an understanding of its importance in terms of informal and voluntary sector activity is increasing. The total amount of care needed by frail elders is similarly unmeasured. The question of need is usually answered in terms of how many people receive care services, combined with some estimate of unmet need, also defined in service terms. Care needs not covered by state services (such as window cleaning or privately funded home cleaning) are usually omitted from any calculation of 'need' made for planning purposes. Self care, as defined below, continues to be entirely ignored. In future, as the numbers of potentially frail elders rises, there is little chance that services will keep pace. Co-production of care, both self-care and by informal carers, will have to increase (Hickey et al., 1986).

Self care

Self care has been characterised more in terms of health practices and self medication (De Friese et al., 1989) than as a contribution to community care. It has taken on a range of meanings in the medical and nursing literature. Illich (1975) saw self care as a way of combatting the power of the medical profession. A less empowering version of the term sees it as an exercise in partnership. In some chronic conditions which affect younger people, such as diabetes, patients have been increasingly accepted as partners in maintaining health. Alternatively self care is defined as treatment for a perceived symptom and refers simply to self medication with non-prescription drugs. In this case it may or may not be viewed as beneficial by health professionals (Haug et al., 1989). A more modern development which is diametrically opposed to Illich's original approach sees self care as a component of health promotion. On this model those whose self care is deficient may be blamed for their own health problems (Kickbush,1989). Self care by elders has been recognised within a medical framework (Dean, 1989; Haug et al, 1991; Penning and Chappell,1990). Dean (1989) linked self care to self help and addressed the need to improve the interface between self care and formal health services but still did not consider the management implications. In the UK, self care (defined as the ability to perform activities of daily living (ADL), has been recognised as a conceptual area by Booth et al. (1983) but in this case only for those living in institutions. Levels of self care in terms of a score for activities of daily living may be used to discriminate between those who should go into a residential home or a nursing home or who are ineligible for either. In such cases it is reasonable to see self care assessment as a deficit measure which determines dependency, rather than measuring a positive contribution to care.

A closer examination of the lives of elderly people (2) indicates that there is a wide range of activities which constitutes self care in advanced old age. Most activities of daily living are taken for granted by young able-bodied people. In later life, after an accident, or through ill health, or simply because strength declines, activities of daily living can become problematic. Many people find that they can only continue living without assistance if they make major changes in the way they perform a range of basic functions. The situations that call these changes into play may come about suddenly or imperceptibly. They may also be general, as in the case of declining mobility, or much more specific like loss of eyesight. As the disability lobby has so strongly pointed out (see for example Morris, 1991; 1993), many people are not disabled by their own condition but by the society in which they live. For example, older people who cannot manage the step on a bus would have a great deal more freedom to move about and to do their own shopping if all buses had steps that could be lowered to ground level, as they do in some regions of Sweden (N Desai, personal communication). The approach of adapting mainstream services for use by a wider range of people has added advantages of community integration and normalisation. Some elders prefer them to individualised methods such as cheap taxi fares.

Self care needs will therefore vary according to the physical and mental state of the older people concerned but also according to the

environment - physical and social - in which they live. This complex relationship varies between individuals and over time for the same individual. The variation may go some way to explaining why studies of the delivery of services to elderly people frequently find that large numbers who might be said to be in need are not receiving a service while others who are receiving a service could manage without it (Goldberg and Connelly, 1982; Booth, 1983).

While much greater recognition is now being given to elders as informal carers and as volunteers, their contribution to co-production in terms of self care is still unrecognised. There are therefore no statistics. Their input is, however, almost certainly larger in terms of hours spent or money saved, than input by informal carers. The 1980 GHS (Evandrou, 1988) showed less than a third of all elderly people had received any form of state provided care in the previous year. The proportion receiving some caring services rose to 56% among those over 80. This sounds impressive but in fact it amounted to relatively little assistance with daily living. For most older people such services average much less than half an hour as week. E.g the chiropody service, used by 13% of all people over 65 in 1980, usually amounts to less than 30 minutes every three months.

The services that consume large amounts of resources were even more thinly distributed. Only 9% of men and women over 65 received home help in 1980. Five percent were visited by a district nurse in the year before the survey. The same proportion went to day centres for older people and only 2% received any meals on wheels. When it is realised that in large parts of the country meals on wheels was not a 5 or 7 day service but was typically confined to two or three days a week, it can be seen that the great majority of elders with care needs were looking after themselves or relying on their relatives and friends. There is no reason to believe that this distribution changed greatly between 1980 and 1990. Since then a number of Social Service Departments, for example Greenwich, Kent and Birmingham, have considered transferring the home help service to the private sector, cutting the hours or restricting the service to users who need personal care. It is unclear whether the proportion of frail elders receiving care has fallen or whether the amount of care received is now spread more thinly, or both.

The numbers of frail older people has increased since 1980 and is projected to go on increasing. It is argued here that self care includes all those activities which allow older people with care needs to continue living in the community without recourse to formal or informal health and social care. The state, in particular, provides assistance with a very narrow range of life activities. The help which is provided may do very little to ensure good quality of life, though it may stave off entry into an institution. In future the steps which older people themselves take to substitute for formal and informal care should be added to any consideration of caregiving in later life.

Such self care can be divided into three major categories: new strategies which allow activities of daily living to continue even though the method is different; major changes in the use of time; and

the avoidance of risk. These categories are not exhaustive and they may often overlap. For example the avoidance of risk associated with going to the shops may entail giving up shopping and accepting an offer of help, or ceasing to cross a major road and so limiting the shops used, or simply moving much more slowly.

New strategies

In advanced old age most people experience some limitation in their activities even if they are only slowed down rather than actually prevented by ill health or disability from doing things they formerly did (Day, 1985; 1991). Chronological age cannot predict how much time self care will take in later life but among those over 75 the majority are likely to find that some attention to strategies in terms of activities of daily living is essential if they are to continue living without assistance. An example is going up and down stairs in a sitting position rather than standing up. Such an activity cannot, due to social constraints, be undertaken outside the home, but it will enable a person with severe knee problems to go on functioning in a house with stairs, even though they can no longer negotiate steps in a conventional manner. Taking a bath by standing in a washing up bowl falls into the same category. It is not a normal way of washing in modern Britain but it may be the only way for elders who cannot get in or out of a bath unaided and who have no shower. The choice is between a deterioration in personal hygiene which could lead to skin problems or a new strategy. Most elders are unlikely to see a fortnightly visit from a bath nurse or other paid caregiver as a solution but may accept it as part of an inevitable deterioration in the quality of life. Other strategies may be specific to a particular environment. For example there may be ways of getting to and from shops that do not involve raised curbs on the pavements, or special routines that allow cooking to be done with the minimum of effort.

Planning is often essential. There is a range of things that frail elders can do if all goes according to plan. They may not however be able to cope with unforeseen interference. Long distance visits or holidays may frequently have to be given up for this reason. In one case an 82 year old woman explained that she had given up going to her niece in Birmingham because on the last visit her train had been one and a half hours late and she had only been able to get home because a young neighbour, now moved away, had waited for her and 'fetched her home'. Many others had given up rail travel on Sundays because of the delays. Another problem was that even carefully laid plans can involve long waits or difficult conditions. As another very frail 85 year old woman said:

'Every year I went (to visit friends in Switzerland) and there were always days when I was in a panic, when I thought I can't do this, I mustn't do this any more, next year I won't... Sometimes I think I have to become a bit more sensible and face it, that I can't do it any more. Last year I had to change from the railway to the airport in Switzerland, in Basle. It was terribly hot and I had to stand at the bus stop by the railway station going out to the airport and I still remember, it was terrible. When the

weather is cooler you don't feel it. I don't know whether I will go or not. It would probably be sensible not.

The reallocation of time

Second, some or all activities of daily living may become extremely time consuming (Sinclair et al., 1988: 53). When it takes two hours to dress in the morning, dressing can no longer be considered a 'normal' activity. It has become an activity that needs assistance to be completed in the normal time. With care, patience and planning it can still be undertaken by a motivated individual but without that care, assistance would be needed. Luckily most aspects of normal life are amenable to being performed very slowly. Cooking, cleaning and gardening are the most obvious.

Time saving equipment can help. As with other forms of disability, the saving of time becomes a saving of energy. Elders who can afford a microwave or who have relatives who give them one, are free of many of the problems of cooking. If they like, and can afford, ready made freeze chill meals there is little they have to do. Oven chips have also taken much of the drudgery out of cooking for many men and women. Cleaning has proved less amenable to technological advance. If relatives, home help or a private service are not available or not liked, cleaning can be dealt with by doing less of it more slowly. One 94 year old explained that her day was composed of housework in the morning, rest in the afternoon, preparation of an evening meal and then a visit to either of two friends in the same street. She lacked the energy to garden and found that these very basic activities took up all her time.

Avoidance of risk

Risk avoidance is often assumed to be a major prerogative of social service professionals - an area where professional judgement is called for (Brearley, 1982). Risk is often given as a reason for putting in paid help, but most risk avoidance is performed by elders themselves. Activities are voluntarily limited or given up completely. This approach to self care can easily be taken for granted. In Cumming and Henry's (1961) theory of ageing, withdrawal from social and other activities is elevated into a functionally rewarding approach to ageing. There is no doubt that society does willingly allow older people to give up many normal activities and to limit their lifestyles in important ways. Transport is perhaps the most obvious example. The risks involved in attempts to move around outside the home may increase, either permanently or temporarily in advanced old age. Strategies which reduce the risks associated with shopping or attending outside functions such as meetings or places of entertainment can be classified as self care. Unfortunately the commonest strategy is voluntary withdrawal. For example an 81 year old widow who had problems with balance said:

'Well I think I could get on a bus, but I would never dare to try to get off public transport without pitching forward, so it's taxis, lifts or rides.

The same may be true of window cleaning and other heavy cleaning or gardening. If relatives will not fill the gap there may be no alternative but to give up or to continue until an accident makes it clear that such an activity is too dangerous.

Recognising and operationalising co-production

The recognition of the full range of co-production activities as an essential consideration in the management of community care services has implications for purchasers and providers. In the first place it is hard to combine self care with formal and even with some informal services. At the extreme, admission to residential care disables virtually all aspects of self care. The provision of formal domiciliary services may be less drastic but few health or social care employees have time to wait while elders do things at their own pace. Formal carers from the state sector are often forced to take over some activities of daily living for their clients if they are to get through their case loads. Privately paid or voluntary formal carers may be under less pressure but there is still the feeling that they are there to do a job and hence cannot wait about while parts of it are done very slowly or unconventionally. There is also the problem that many aspects of self care are private. They involve unconventional behaviour of some sort. It follows that they cannot easily be performed when others are present. This will apply to all paid staff but may also apply to relatives.

Many relatives strongly discourage unconventional behaviour of any kind. For example, one women who tried becoming a vegetarian, partly for health reasons and partly because it was cheaper and she needed money to pay for transport, was quickly told by her non-resident daughter that such behaviour was irresponsible. She felt she had to stop. Another who had devised a way of defrosting her freezer by sitting on the kitchen floor was found by her daughter and told to stop.

While it is relatively easy to define co-production, there are a number of difficulties in operationalising it as a management tool. The first is the lack of relevant theory on public human services management. Two common factors are identified in the literature on the management of service industries in the private sector. One is that these industries are distinguished by the personal demands they make upon staff and the second is that the customer has an important input to the production of services (see for example Sasser, Olsen and Wyck, 1978; Normann, 1991).

Staff in human services agencies are particularly liable to emotional wear and tear (or burn out) (Normann, 1991). In elder care a very high proportion of services go to people who have dementia or who are in the last stages of life. Such services make very high demands on staff who often have to deal with extremely difficult clients or patients and at the same time face up to their own fears of dependency and death (Wilkinson and Wilson, 1992). The nature of these agencies therefore poses human resource management problems which are at present

undertheorised. Normann (1991) offers a number of ways forward. For example he sees the management task as including ways of enabling users to increase the self esteem of front line staff. This will be difficult if the users are disgruntled because their services have been cut, but with better targeting (Davies et al 1990) it might be possible.

There is also a clear need for better human resource management with better training and conscious attempts to make work more rewarding for all grades of staff (Normann, 1991). As Flynn (forthcoming) has pointed out, staff development, and staff and user empowerment becomes difficult, if not impossible, when managers see their role as controlling the workforce and its tasks. Management by commitment on the other hand needs greater trust and allows staff more autonomy. It is more likely to produce high quality services but there is a danger that current trends in service contracting mean a shift towards management by control.

A second problem arises from multi-agency nature of elder care and the existence of a purchaser-provider split in health and social services. The input of service users and of informal carers is fragmented across a number of management systems (Dockrell and Wilson, forthcoming). In most cases service planning, assessment, provision, and monitoring or quality assurance are no longer part of the same hierarchy. The actual division of activities varies from place to place but there will be very few service users who deal with only one management system. The management of different relationships of co-production will therefore vary according to the activity being considered and the stage in service provision.

It follows that the ability to see the management task as one of managing users and carers as well as an agency and its interagency relations demands a cultural shift. This shift is not dissimilar to that needed for managing for quality (Wilding, 1994), nor is it in conflict with Sir Roy Griffiths' original intentions for community care. Each stage as set out in DoH guidelines (DoH, 1991; 1991b) is considered below. The processes are continuous and must take account of changes in the mix of self care and formal and informal care.

Service planning is the area where co-production is perhaps most advanced. The NHS and Community Care Act 1990 required local authorities to consult with users in the planning of community care services, though there has been no such demand placed on health authorities. Planners and managers, used to the old traditions of needs analysis have often found it hard to incorporate user views in any meaningful sense. McGrath and Grant (1992) give a detailed analysis of the difficulties taking the case of the All Wales Strategy, but Cormie (1992) and Barnes (1993) show that user input can be managed effectively and can have beneficial outcomes.

Assessment is a key stage in service delivery. If it is intended only as a rationing device (Rivlin and Wiener, 1988), a minimal input is all that is needed from the potential user. However if assessment is used as may have been intended (DoH SSI, 1991a; 1991b), to allocate scarce

resources to those most in need of support in the community, users should make as full an input as possible. Management procedures, such as multidisciplinary assessment forms which can recognise and value co-production, will be needed by staff doing assessments.

At present care planning is often seen very much as an activity which is led by professionals (DoH SSI, 1991a; 1991b, Ellis,1993). The degree of user input varies but the fact that older people and/or their relatives and friends have in most cases been planning packages of care for some time before they come to the attention of health or social services (Wilson, forthcoming) is routinely ignored. Service management which is based on an understanding of co-production will be more likely to take account of take the work of users and informal carers when designing care support. They will be less likely to put in services which duplicate or conflict with existing care packages. The aim should be to move from the implicit or needs based recognition of co-production which occurs at present in the determination of support services (they must support something already there) to overt recognition. Such a change in service culture will need management support.

The same is true in managing service delivery. Since paid staff can offer only very limited amounts of support in most cases (Wilson, 1993) the main work of caring in terms of activities of daily living has to be done by the service recipients themselves or by their informal carers. As stated above, little is known about how best to link formal, informal and self care in ways that are efficient, effective and ethical, but there is clearly scope for improvement (Sinclair et al., 1988; Levin et al., 1989; Allen et al, 1992). The main burden at present falls on front line staff but managers who saw their role as managing user input as well as staff input would be able to take a more strategic view of the type of service development needed.

Managers of purchasing agencies have a different interest in co-production. They need, ideally, to enlist the users as monitors of service quality and effectiveness. At the stage of final service delivery only individual users and carers can assess the quality of services. Their views may differ from each other and from professionals, but they are undoubtedly important co-producers of quality assurance. Services which are judged by their recipients to be of low quality are not likely to be efficient in terms of maintaining people in the community or supporting carers, unless the nature of the residential sector is a very strong deterrent to entry.

Problems with the theory of co-production

As stated above much more work is needed on the theory of co-production in the public sector. Normann's (1991) work on the private sector raises a number of problems. In the first place there is the question of language. Is co-production any different from 'partnership' or any other currently fashionable item of jargon associated with user empowerment? At the level of front line service delivery the answer is probably no. Partnership between patient or client, informal carers,

private, voluntary and state service providers involves co-production at all stages from assessment to service monitoring. However service managers from first level upwards have relatively little direct contact with service users (Dockrell and Wilson, forthcoming) and cannot easily see themselves as partners in service delivery. It is at management level, therefore, that the concept of 'co-production' becomes more useful. Management systems and practices which recognise co-production at all stages from service planning onwards (Normann, 1991), could greatly improve the quality of services provided, in terms of effectiveness and acceptability, and should also enhance staff satisfaction and reduce burn out.

One problem which applies to any translation of theory from the private sector to a mainly publicly financed mixed economy of welfare is that service users are not customers in the same sense as they are in private industry. The customers of health and community elder care services are the purchasers and with few exceptions (Wilson forthcoming) these are state agencies rather than individuals. Users do not therefore have commercial power over their providers. They may exit from the service but they cannot close it down by shifting their custom elsewhere. Their 'custom' has been placed with the provider by an agency setting up a block contract, or by a professional who has built up their care package from a devolved budget. Another difficulty arises in defining the service user, even when it is recognised that users and customers are not synonymous. Clients or patients may have different needs and wishes from their informal carers or relatives. Professional social work staff have been trained to deal with value conflicts (CCETSW, 1990) of this type but not all find their learning easy to apply. Health service staff have usually been trained to concentrate on the patient and may find it hard to see their services in terms of support to informal carers as well (Atkin and Twigg, 1991). Front line staff may still find it possible to concentrate on individual users and carers, but managers must act with a wider range of service users in mind, ranging from service recipient to government ministers.

According to Normann (1991) successfully managed services will involve the customers in more than simple co-production. For example customers will help to define the ethos of the service and will enhance the self respect of front line service providers. It is not yet clear how far the NHS and Community Care Act 1990 has managed to move care provision away from professionally determined services towards needs led provision (which could be seen as a first step in the direction of co-production). Initial evidence is conflicting (Ells, 1993; Stevenson and Parsloe, 1993). However it is clear that if the management of co-production is to become a reality in community care, more research is needed and new strategies which will empower all the co-producers will have to be developed.

Another problem arises from differences in social status between users and many of those who provide their services (Stacey, 1984). It is easier to envisage co-production of services as a partnership between provider and user, or even as a new approach to enabling the consumer, when clients or users have same status as the providers. In the private

sector customers are often of superior status. They decide on their own eligibility and purchase the service if they like it. In catering, for example, customers choose the restaurant or fast food outlet which suits their needs at the time and eat their meals in the way they want. In health and social care users are assessed, usually by trained professionals who consider themselves experts in the service they are providing. The users are often socially disempowered - frail elders, people with learning difficulties and those with mental health problems. This disparity poses particular problems for the development of co-production. In private services the issue is one of managing customers (who can make or break the firm) and staff who are usually lower paid than their customers. In contrast, health and social services managers may be accorded lower social status than some of their professional staff (though this is rapidly declining with the professionalisation of management), but they and their front line staff are financially and socially more powerful than most of their service users. It is difficult to see those who are deemed socially inferior as equal partners let alone as superiors.

Ethical issues

Differences in social status between users and providers also gives rise to ethical problems in the management of co-production. Management theory, partly because it is based on private sector practice, has in the past tended to neglect ethical questions. Co-production of services for and with frail elders and other disadvantaged groups therefore raises a range of ethical issues which need to be investigated. In the first place ethical problems arise when older people are forced to carry greater burdens of care for longer periods. These may be more serious if the increased burden leads to physical or mental ill health. Secondly, there may be cases where professionals can only achieve an extension of self care and informal care inputs by an unacceptable degree of manipulation. If staff see themselves as providing a service not coercing the client, there will be a clash of professional ethics. Finally, the management of co-production involves the recognition of the contribution of service users and informal carers. However, there is no automatic reason why such recognition should increase professional respect for elders or give them more power. It might instead lead to more sophisticated ways of exploiting their labour.

Wilding (1994) identifies the tension between seeing users as consumers (and so as potentially having adversarial rights to good service) and seeing them as partners. Partnership in human services has always been a possible aim for providers, but equally there has always been the possibility of conflict. Teachers join with parents to encourage learning but also examine and may fail children. In health and social care professionals are backed by sanctions over wide areas of practice. They may refuse treatment, commit users to mental hospital or take children into care. The management of co-production should involve explicitly recognising and managing these areas of tension, whereas at present they may be fudged or ignored. In this area as in others, beneficial changes will only be possible if conscious efforts are made

to develop theory and practice which relate to the reality of managing services in a mixed economy of welfare.

Conclusion

Even without the 1990 NHS and Community Care Act there was a need to make support services for the growing population of frail older people more responsive as well as more effective (Smith, 1980). The presumption was that more responsive services would also be more efficient (Audit Commission, 1986). They would avoid duplication and older people would feel better supported. This paper has called for further research in two related areas of services provision for older people. The first is the understanding of self care and the second is the management of co-production of care, including self care.

The paper has called attention to the significant contribution that older people make to informal care in the community. Such care can be divided into two branches - elders as caregivers and elders as self carers. At present self care is wholly unrecognised whereas informal care by elders has at least been mentioned in the NHS and community Care Act 1990. Under the Act informal carers are to be supported by local authorities (within financial limits). This is to be welcomed but, as has been demonstrated, formal services are not well adapted to supporting or enabling informal care.

Bureaucratic and professional traditions in community services management make it difficult for professionals to see themselves as co-producers of care, even in an interagency context, let alone working with informal and self carers. However the application of management theory developed for the private services sector could go a long way to improving the ability of managers in human service agencies to deliver user-friendly services and to reduce staff burn out (Normann, 1991). Although co-production takes place on a day to day basis it is not defined as such and managers do not see the management of user inputs to services as part of their role.

The types of management theory which are grounded in the experience of the private sector are of limited use in human service agencies because the users are not paying customers in the great majority of cases. They are also usually of lower social status than the service providers. This difference increases the salience of ethical issues in the management of co-production because the risk of exploitation of disempowered users is greater than in the private sector. Research which can adapt and develop relevant theory to the needs of public, private and voluntary agencies that deal with vulnerable people is urgently needed. Managers will then have a more practical and enabling body of theory to assist them in coping with the conflicts built into community care policy. It will allow the expression of management objectives and service standards in terms which are not derived either from manufacturing industry or from the private sector.

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