In 1990, Great Britain enacted the National Health Service and Community Care Act to reduce unnecessary institutionalization, improve coordination of community-based long-term care, and stimulate private service provision. An overview of four major principles of the legislation is provided: the elevation of the assessor/care manager role, the emphasis on inter-agency collaboration across the health and social care divide, privatization of service, and support of carers (caregivers). Preliminary findings related to their implementation indicate incremental rather than sweeping change. The elements of the new policy that borrow from American models of community care — and may be difficult to transplant — are highlighted.

Key Words: Community care, Long-term care, Institutionalization, Nursing homes, Great Britain
The new law proposes to rectify these problems by the consolidation of long-term care services in single points of entry at the local level, through social service departments. By making SSDs responsible for authorization of both (social) community care (which has always been their domain) and institutional care, the new law aims to divert individuals from institutions, reduce fragmentation of service and augment community care provision. These goals are to be achieved by (a) transforming the role of social service workers at local authorities from chiefly one of provider to that of assessor/care manager; (b) arranging joint agreements between SSDs and health boards that produce a “seamless service” across the social/health care boundary of community care provision; (c) stimulating non-statutory community service development; and (d) assisting carers (the preferred word for caregiver) in keeping their dependent relatives out of institutions.

This article provides a survey of the four above principles as contained in the 1990 NHS and Community Care Act. Preliminary findings related to their subsequent implementation are summarized. The study concludes with a comparison of some elements of British and American policy on community care.

The Assessor Care Manager Role

The cornerstone of the new law is “care management,” the preferred term for case management. The choice of term, justified in a footnote of a Department of Health document (Huxley, 1993), reflects that care is to be managed, not people. The key characteristics of the proposed care management model transcend national boundaries. Like the demonstration projects that preceded the law (cf. Challis, Darton, Johnson, Stone, & Traske, 1995), the new system is expected to provide continuous and integrated home-based long-term care to clients with multiple service needs through a six-step process of screening, assessment, care planning, monitoring, review, and case closure.

The government manuals offering guidance on implementation stress several areas of innovation. First, assessment is not to be circumscribed by available service but is to be “needs-led,” expressing “the requirements of individuals to enable them to achieve, maintain, or restore an acceptable level of social independence or quality of life. . . .” (Department of Health Social Services Inspectorate; Scottish Office Social Services Group, 1991). Second, SSDs are expected to be evenhanded in their selection of services from those provided by their service units and those provided in the nonstatutory service sector. To increase the prospects for neutrality, SSDs are to “float off” their service provider branches into separate management units. To minimize conflicts of interest, departments are discouraged from delegating assessment and care management tasks to their specialist service provider staff, which includes occupational therapists and domiciliary care workers (Department of Health Social Services Inspectorate; Scottish Office Social Work Services Group, 1991). Third, care managers are required to take into account the cost effectiveness of the services selected in care plans, stimulating the development of alternative service providers if necessary. To foster creative and entrepreneurial care management, the devolution of some financial responsibility to front line workers is advocated. Departments are expected to devise ways in which other agencies might be participants in care management when their involvement was indicated. In particular, health boards, housing authorities, voluntary and private agencies might need to be represented on a care planning team. Finally, the departments are required to show how unmet needs could be documented, how this information could be channeled into future service planning, and how the feedback could be a catalyst for a mixed economy of ever more flexible services.

In the short time that has elapsed since the implementation of the Act, it would appear that the proposed care management model has not been enthusiastically embraced. Local authorities and their professional staff have been loath to split the purchasing and provider functions, to prohibit specialist staff from serving as care managers, to complete comprehensive assessment forms, and to document unmet need (cf. Department of Health, 1993; 1994; MacDonald & Myers, 1995). The concept of needs-led assessments has been difficult to operationalize because of service scarcity, costs, and eligibility criteria as well as the inability of clients themselves to articulate their preferences (McLean, 1996; Stalker, Taylor, & Petch, 1994). Some critics fear a holistic assessment using a life span approach, and requiring counseling skills is not possible in a system that emphasizes managed care over care management (Gearing & Coleman, 1996). In this brave new world, professional social work skills take a back seat to budgeting and coordinating services. Very few SSDs have “floated off” their service provision arms or devolved budgets to practitioners. What has emerged is instead concern for “territorial justice” considering the substantial variation in approaches across authorities in Scotland (Buglass, 1993; Petch, 1996), England, and Wales. Inequities in access to community care, rather than being leveled, may well have increased.

Inter-Agency Collaboration

An inequity that the 1990 law hopes to redress is the 3-prong system of institutional care, which allowed some individuals to receive institutional care free of charge from the NHS and others to use public social security funds for private residential care and nursing home facilities, while the remainder had to provide self-financing. The law effectively closes the social security pipeline of funds but still
retains the option of placement by the NHS, albeit with a dwindling supply of long-term care beds available. The dual system is not seen as duplicative or inconsistent — rather, the distinction is made that NHS placements demand continuing specialist medical and nursing supervision while others need institutional care for social reasons and are tracked to local authorities. Nevertheless, the definition of health care need is perceived as arbitrary and has been shifting, and NHS long-term care patients are not predictably distinguishable by their impairments from others in long-term care.

The new law does not merge the three-prong access to community care service, which features some differences in service type across the triple access points. Health boards, some general practitioners, and local authorities are all “fundholders” for community care. Typically, general practitioners and health boards would refer patients to community nursing care rather than to other types of service, but the government recognized there would be several areas of overlap in services, such as bathing services, provision of disability equipment, medicine application, bereavement counseling, etc. (Department of Health Social Services Inspectorate, Scottish Office Social Work Services Group, 1991). Again, the coexistence of more than one entry point to care is significant because community care provided under the auspices of physicians or health boards is free, while community care from local authorities often is not.

The new law is not meant to substitute NHS-provided long-term care with local authority service provision, but the concomitant trend of deinstitutionalization by the health service has made the shifting of responsibility to local government tempting. A number of successful demonstration projects established a precedence and indicated the feasibility of dehospitalizing long-term care patients and resettling them to the community with the collaboration of local authority SSDs (cf. Hallam, 1996; Knapp et al., 1992). These projects, however, moved patients from hospitals to residential accommodation using social security benefits, or transferred “dowries” with each to cover community service costs or waived the cost of services to the client, and their success is consequently not relevant to the current changes. Under the present law, long-term care clients are to be diverted from residential accommodation, social security benefits have been voided for institutional care (claimed by individuals), dowries are not applicable, and costs for care are to be shared with the client. A likely scenario is that the NHS will try to offload more of its long-term care patients onto SSDs, pressured in part by “bed blocking,” which has been caused by patients being unwilling to rehabilitate in a nursing home at their own expense (now that social security benefits have evaporated). In other words, local authorities appear overwhelmed by responsibilities for three groups — income benefit recipients who before the law would have independently sought long-term care in residential facilities, the long-term care population the NHS is trying to dehospitalize, and the acute-care NHS population being discharged for rehabilitation.

Although the boundary between social and health care remains blurry, there have been some positive developments. Cooperation between the local authorities and health authorities is evident in the development of joint community care plans (Stalker, Taylor, & Petch, 1994), multidisciplinary care teams (cf. Bland, 1994), and hybrid occupations, combining community nursing and home help functions (cf. Challis et al., 1995; Curtice, 1996). The record of collaboration between SSDs and private or voluntary agencies, general practitioners, and consumers has been more erratic (Beresford & Trevillion, 1995; Lewis, 1993; Thornton & Tozer, 1994). Consultation with other agencies has been seen as tokenism and general practitioners themselves do not seem to have fully appreciated the integral role they play in referral and monitoring. Efforts to involve consumers (collectively) in community care planning have floundered on several obstacles, including the unwieldy number of potential participants, issues of the representativeness and credibility of self-selected participants, and the uncompensated burden (in time and resources) that participation poses for consumers (Hoyes, Jeffers, Lart, Means, & Taylor, 1993).

Privatization of Service

The case for the effectiveness of care management was most persuasively made in the U.K. by the Personal Social Services Research Unit in Kent, which evaluated a project involving frail elderly people (Davies & Challis, 1986). Flexible and inexpensive services for care-managed clients in the study were largely supplied by recruiting workers from the private sector. These findings supported the views that services provided by government monopoly were not adaptable enough for personalized care plans, that voluntary or commercial agencies might be better suited to provide care and that increased competition in a quasi-market could make public agencies more responsive. Hence the 1990 law set targets in England and Wales for 85% of community care funds to be spent on private sector services (GAO, 1994).

The insistence on independent sector services reflects a general trend towards privatization and the dismantling of the welfare state in the U.K. since 1979. Hospitals and other parts of the NHS have been spun off into trusts, referred to as “arms-length” management units. Private health insurance and private pensions have become more popular and are encouraged by the government. After half a century of socialized benefits, British citizens are being weaned from services they had come to expect and told to seek private solutions. The Griffiths (1988) report that prompted the law’s development specifically set a goal of more private saving and planning. Hence, the tenor of the new law is in concert with the tone of recent policy — residential and nursing home care, as previously stated, are already
means-tested and community care already involves cost-sharing. Yet the reality of policy in practice gives a different picture. Bland and coworkers (Bland, Bland, Cheetham, Lapsley, & Llewellyn, 1992) in their study of the costs and quality of residential homes for elderly people, note that most residents in private and voluntary sectors were dependent on public funding either entirely or in part before 1990. Local authorities often suspend charges to appease voters and Thomas (1993) discovered that few paid the maximum charges for home care before enactment of the law.

Since the law’s passage, pursued of the mixed economy by local authorities has been tentative (Henwood, 1995), mirroring the government’s admission that the approach to implementation would be incremental and long-term (Wistow, Knapp, Hardy, & Allen, 1994). Wistow and coworkers argue that by requiring local authorities to be enablers rather than providers of care, the law is asking them to abandon an area of relative managerial strength. Moreover, local authorities are expected to restrain expenditure in the only area where private sector growth had been greatest, i.e., in residential accommodation. Leat (1993) points out that although there were public benefits available to fund domiciliary service in the 1980s, the response of the independent sector to these incentives was muted and thus there may be no reason to anticipate stimulated private service provision for community care under the new law. Thomas (1994) confirms that (in Scotland) there has been little evidence of an increase in domiciliary services; whatever growth has occurred in personal care services has been at the expense of homemaker care services, and there have been overall increases in charges.

Skeptics of the mixed economy in the U.K. assert that the nonstatutory sector in general lacks the experience, the professionalization and the administrative infrastructure to enter into competitive bidding for contracts with local authorities since they have been accustomed to grants that neither specified service provision nor detailed accountability measures (Reading, 1994). Others argue that the voluntary sector — whose services the local authorities prefer over commercial ones — abhor the prospects of charging clients, having their mission defined by an external agency, and relinquishing their assessment and care management roles to local authorities (Maxwell & Titterton, 1996). Consumers have been found to be no more enthusiastic about privatization than local authorities, preferring a basic safety net of services provided free of charge to a wider menu of cost-effective independent alternatives for which they need to pay (Hoyes et al., 1993).

Support of Caregivers

Government documents published prior to implementation of the law stressed the support of caregivers. Griffiths (1988), quoting an official statement to the House of Commons Committee on Social Services, identified “support and relief for informal carers (family, friends, and neighbors) coping with the stress of caring for a dependent person” as a major objective of community care. The importance of carer support resurfaced as the second of six objectives in the White Paper to Parliament that followed Griffith’s report. Specifically, it proposed to “ensure that service providers make practical support for carers a high priority” (Secretaries of State for Health, Social Security, Wales, and Scotland, 1989). The theme recurs in the practice guide rewritten to assist local authorities to prepare for the new law, in which community care is described as a partnership with users and carers. The guide advises that separate assessment of the carer’s needs should be offered when necessary (Department of Health Social Services Inspectorate; Scottish Office Social Services Group, 1991).

Since the introduction of the law, focus groups of carers (cf. Henwood, 1995) have been convened, and both telephone and postal surveys have been conducted with large samples of members of the U.K.’s National Carers Association (Warner, 1994; 1995). Despite carers’ initial low expectations about the Community Care Act, the findings suggest that users were still disappointed with their experiences under the new system. They indicate that a sizable minority of dependent persons and most of the carers had never been assessed and never received a copy of the written assessment, which could then be challenged. The levels of unmet need, particularly for carers themselves, were substantial, and the likelihood of obtaining respite care was no better since the law’s introduction. It is interesting to note that SSD staff themselves concur with this appraisal, admitting their uncertainty about assessment of carer needs; ambivalence about written documentation of assessment, and the lack of resources to provide a guaranteed level of support to carers (Warner, 1995).

U.K./U.S. Comparisons

Both the U.S. and the U.K. have witnessed the following trends in long-term care: the dehospitalization of chronically ill patients; the expansion of residential community-based care (particularly for older adults); the development of care management demonstration projects to improve delivery of community care and prevent unnecessary institutionalization; and the push toward home-based varieties of community care. Despite vast differences in their health care systems and in their commitments to the advancement of a welfare state, both countries have frequently taken into account the experience of the other before embarking on their own experiments. Recently, for instance, the American government consulted the British law on community care when long-term care reform was under consideration (General Accounting Office, 1994). Given the different health and social care institutional frameworks in which long-term care is embedded, how feasible is the mutual and liberal borrowing of ideas...
and practices concerning long-term care? In this last section, major differences between the two countries and their implications for cross-transplantation of community care service models are discussed.

Care management is the linchpin of the NHS and Community Care Act; it is regarded as a panacea that will provide a coherent, cost-effective means of offering flexible and tailor-made community-based alternatives to institutional care. It is viewed as a practice most definitely borrowed from the United States (cf. Twigg & Atkin, 1994), although its elements of triage and gatekeeping have always been practiced within the NHS. Huxley (1993) contends that care management has been a buzzword espoused in Britain with disregard of the empirical data evincing its limitations and of the features that would not translate. The Community Care Act juxtaposes care management with expansion of home-based care services and diversion from institutionalization, as if the first leads to the second and assures the third. The large series of American care management demonstration projects showed that on the contrary, care management did not reduce institutionalization and that the expansion of home-based services attracted users who would not have been institutionalized anyway (Challis et al., 1995). Sturges (1996) differentiates care management between the two countries by describing the U.S. as moving through piecemeal trial and error toward a practice-based clinical model, while the U.K. is swiftly adopting an administrative model that separates assessment, purchasing, and provision. In the latter approach, the weak link in care management is believed to be professional judgment, which it seeks to harness by tinkering with the technicalities of the process (Huxley, 1993).

In the U.S., care management has been the logical solution to the fragmentation of community care service created by a multiplicity of service providers (Huxley, 1993). The vast majority of these providers are nonstatutory and have experience in metamorphosing themselves in response to the fluctuations in the marketplace or in government policy. Since service development gravitates toward funding, rather than being rooted in a lucid, underlying rationale, care management has been imperative to restrain the resulting imbalances in service provision. The U.K., in contrast, has its community care services provided by local government with fewer independent alternatives. Its direct control of services would be viewed by some researchers on community care as advantageous because of its power to enforce quality standards (cf. Arnold, 1987; Knapp et al., 1992). The NHS and Community Care Act residualizes public sector service delivery (Walker, 1993), but it does so in an environment in which independent service delivery, especially by commercial organizations, is alien. According to Lewis (1993), the British nonstatutory sector is not well versed in moving into market niches created by available funding, nor are there the formal mechanisms, such as bidder conferences and technical assistance workshops, to stimulate suppliers (Wis-

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kept separate through the existence of a national web of Area Agencies on Aging. Spawned from the AAAs and the Older Americans Act has been a vast network of service delivery providers specifically geared to elderly persons — information and referral, legal counsel, senior centers, day care centers, nutrition sites, etc. While some services do accommodate younger, disabled persons, in general, the clientele is older. The U.K. has no discrete age-based service provision; social services are comprehensively aimed at all age groups, as is its health service. Therefore, the 1990 Act requires care managers to have the knowledge and skills necessary to maintain not only older adults, but also younger mentally ill and mentally or physically handicapped persons in the community. Consequently, the generic care management role is far more complex. The response by the larger community to the deinstitutionalization of mentally ill patients for instance, is different (and frequently more negative) than the reaction to efforts that keep older individuals in their homes. Likewise, the conventional care plan goal for the carer of a young adult differs from that of an elderly person, tending towards increased self-reliance and separation of the disabled persons from their carer in the former, but not the latter case. The Community Care Act earmarks funds for the mentally ill but not for other groups. Thus, British older persons are in the circumstances that block granting will likely create — perpetual competition with other client groups for a shrinking pool of resources. Furthermore, the presence of younger persons under the umbrella of service delivery exacerbates the shrinkage of resources because each cohort of the young disabled population ties up resources over a prolonged period of time, due to their greater life expectancy.

The inclusion of all age groups in British community care provision reflects that, unlike the U.S., the U.K. is a mature welfare state that has an array of social policies to support families across the life cycle. A consequence of the exclusivity of social programs for the aged is that the debate over generational equity has been a uniquely American phenomenon (Quadagno, 1989). Efforts to downsize government in the U.S. necessarily revolve around efforts to reduce expenditure on elderly persons; however, attempts at cost reductions have so far been unsuccessful because older persons are typically perceived as deserving recipients of public funds. British endeavors at retrenchment are less likely to be seen as singling out older adults and thus resources for service provision can be more vulnerable to unfavorable political winds.

The vast differences between the U.S. and U.K. in social service delivery parallel the vast differences in their health care systems. The U.K. has a national health care system that provides long-term care free of charge based on medical need. Care is rationed covertly by general practitioners, the only health care providers whom patients can directly access, as well as the referral agents to secondary and tertiary care. Only the most difficult cases would reach the attention of the geriatrician or other medical specialist. The U.S. is a partial national insurance system in which long-term care is not a benefit typically provided by private insurance or by Medicare but in which high-tech, specialist, and hospital-based care are by comparison, easily reimbursable through private or public insurers. Whereas free long-term care has never been expected as a health care benefit in the U.S., in Britain there has been the precedence of free long-term care, although not as a universal entitlement. As long as some geriatric wards and nursing homes remain in the NHS, available regardless of financial need, there will be patients scrambling to access them. Hence, besides the practical problems of diverting patients from NHS institutional care, there is the ideological opposition with which to contend. At the same time, a socialized medical system is able to radically reduce and manipulate access at will, in contrast to the market-driven system in the U.S. The withdrawal of long-term care from the NHS has arguably been swifter than the dehospitalization in the U.S., but the pricetag for efficiency has been the immediate need to rapidly redeploy and enlarge resources. Moreover, widespread closure of geriatric wards may save costs over the long run, but not in the short run because funds are needed to sustain them during the transition and hospitals are left with the most dependent patients for whom to care.

In both the U.S. and the U.K., the growth in nursing home care was the serendipitous outcome of policy that never intended to promote its expansion. In the U.K., an oversight of the Department of Health in 1982 allowed anyone of pensionable age, eligible for income support, to have all or most of the cost of long-term private residential or nursing care paid for by central government (Wilson, 1993). In the U.S., Medicaid, a program initially intended to provide health care for poor women and their children, has been the back door through which many have obtained free long-term care (Kent, 1992). In contrast to Medicaid, the British benefit was administered by the income maintenance system, not the NHS, so that many recipients were relatively healthy and selected residential care facilities (like U.S. assisted living or board and care homes) over nursing homes. Medicaid never funded the growth of comparable facilities in the U.S., focusing instead on skilled nursing home care. Britain therefore has a potentially much larger population — that is, the relatively healthy and independent group that gravitated towards residential care homes — who must be diverted from institutions and accustomed to support in the community.

The U.S. has tried to reduce unnecessary institutionalization through Medicaid community care waivers and nursing home admission screenings. The British law mirrors these strategies, which proved ineffective in reducing overall Medicaid expenditure once Medicaid became a benefit for large segments of the middle class (Moses, 1994). Until the British middle class manages to beat the system like their American counterparts, by transferring or shielding their assets, to legally impoverish them-

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selves, the U.K. may be more successful in curbing growth in public spending on long-term care. It would be ironic if the U.S. — a reluctant welfare state — were providing through public funds long-term care to a larger proportion of the elderly population than the more welfare-minded U.K. The organization of the British system — with SSDs acting as both gatekeepers to and purchasers of service — may assure that institutional care spending is contained more than it can be in the U.S.

A curious paradox is that the more mature welfare state — Great Britain — has been able to expand the role of means testing to limit the universality of benefits (Pierson, 1994). Old-age pensions in Britain, for instance, are very low by international standards, so that a substantial number of older adults are dependent on a means-tested supplement while the more prosperous can opt out of the state system and rely on a private pension. Moreover, many components of community care in the U.K. have had cost-sharing (at least formally) which in the U.S. has been prohibited under the Older Americans Act. Recent Conservative governments in Britain have been credited with enlarging the means-tested portion of social programs more than Reaganism was able to accomplish in the U.S. What remains to be seen is whether the U.K. can quickly create a feasible home-based alternative care system to substitute for institutional care and whether it can at the same time recover the expenses from its users.

The ambitious goals of improved quality, access, choice, and cost control, embodied in the NHS and Community Care Act, have been pursued on both sides of the Atlantic but adapted within different health care and social service frameworks and with welfare states at different levels of maturity. Certain features indigenous to the U.K. and lacking in the U.S. will facilitate achievement of its policy agenda. These include its centralized health care and social services planning and administrative structures, its strategic amalgamation of gatekeeping and purchasing functions in SSDs, and the precedence of cost-sharing and means-testing in service delivery. The impediments to reaching the goals are equally impressive and stem from Britain’s traditions of NHS long-term care delivery, easily accessible residential care accommodation for the relatively independent and healthy, age-blind service sectors, and community care service provision by local governments. Thus, the success of the new law rests on repealing decades of publicly funded service expansion, a trend that it is far more daunting to reverse than to set in motion.

References
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Ronald J. Angel
and Jacqueline L. Angel

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