The health and social care divide: bridging the gap

It is nearly three years since the full introduction of the reforms advocated in the Caring for People White Paper (DoH 1989) and reports and articles are now being published which comment on the initial effects of these changes, particularly those which have arisen from the health and social care divide created by the reforms. This article examines the nature of this division of responsibility, its implications for patients and for nursing practice. Some positive developments and possible courses of action are also considered.

Date of acceptance: November 16 1995.

The Caring for People White Paper (DoH 1989) suggested that community care means: 'Providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives.' It is clear that not everyone will require assistance in order to achieve this aim and thus a number of priority groups were identified, that is, those affected by the problems of ageing, people with a mental illness, people with a mental handicap and those who have physical and sensory disabilities. People within all of the groups may require support on either a long term or a short term basis depending on the nature and extent of their individual needs which will vary over time.

There is, however, a further group of people who may require community-based support (albeit on a short term basis), for example, people who are discharged from hospital following medical or surgical interventions. While they would not normally fall into one of the categories identified within the White Paper they may have additional short term needs and thus require support in order to regain health (Ovretveit 1995).

Community nurses may be involved with all the client groups identified in the White Paper (DoH 1989) and also those who have additional short term needs on discharge from hospital.

THE HEALTH AND SOCIAL CARE DIVIDE

Central to the reforms proposed in Caring for People (DoH 1989) was the principle that the provision of community care services should be based on the assessment of individual care needs. This was to be achieved through the introduction of care management whereby needs would be identified and an individual package of care devised. It was stressed that a written plan should be produced detailing the services to be provided and that the views and preferences of clients should be taken into account. It was recognised, however, that people's needs can be complex, require intervention from more than one agency, and, hence, accountability for service provision and co-ordination between services is vital.

To promote accountability, it was stressed that local authorities would be responsible for ensuring that people's needs for social care were assessed and an individual package of support was arranged, while health authorities were charged with the responsibility for meeting health needs. Co-ordination was to be promoted at a strategic level through consultation between agencies in the production of community care plans. At an operational level, this was to be achieved through collaboration between professionals from health, social services and voluntary agencies in assessment and care planning. It was stressed that users and carers should experience a 'seamless service' (Audit Commission 1992).

Defining health and social care

The Audit Commission (1992) also highlighted the importance of agreement as to what constitutes health and social care, warning that failure to do so could lead to friction when individual packages of support were being devised. While in principle this seems logical, in practice it has proved extremely difficult to agree what constitutes health and social care (RCN 1995, Duggan 1995, Daphne Heald Research Unit 1995).

One attempt to distinguish between these two aspects of care provision has been offered by North (1995) who defined health care as being 'generally equated with actions designed to cure sickness or manage the symptoms of ill health or disability' while social care 'relates to the non-medical interventions focused on ensuring that a person is able to lead a full social life'. North (1995) also acknowledged that health and social care are interlinked, however, the definitions she offered are somewhat limited. For
example, the definition of health care made no reference to those aspects of care which are necessary to maintain or promote health, and promoted a predominantly medical model of care.

Henwood (1992) warned that the health and social care divide was 'always going to be the Achilles' heel of the community care reforms'. The basis for this assertion was that while some needs can be clearly identified as either health or social care, there is a 'hazy boundary and disputed no man's land' which falls between these two extremes. Indeed, it has been suggested elsewhere that the separation of health and social care divide was 'always going to be the Achilles heel'.

The needs of an individual for health and for social care may be charged for (Audit Commission 1995). As a direct result of this latter point, Ovretveit (1992) warned that the health and social care divide. Duggan (1995) in a recent report suggested that: 'The retreat of the NHS is straining local authorities' ability to provide community care to large numbers of people.'

Two main inter-related factors have, however, detracted from effective collaboration – first, the resource implications for whichever agency claims this disputed territory, and second, the fact that while health care is still predominantly free at the point of delivery, social care may be charged for (Audit Commission 1992). As a direct result of this latter point, Ovretveit (1995) suggested that: 'People are learning that it really does matter whether a service is provided by health or social services.' It is necessary, therefore, to examine each of these factors separately before considering the implications for nursing practice.

THE NEED FOR COLLABORATION BETWEEN SERVICES

Caring for People (DoH 1989) recognised the potential lack of clarity which may arise in some 'individual cases' where it is 'difficult to draw a distinction between the needs of an individual for health and for social care'. It can be seen that this could present particular difficulties for some client groups such as those who have multiple disabilities whereby a client may be assessed as requiring social care support to meet personal care needs. However, if the client does not receive this care to a high standard then his or her health may suffer when, for example, pressure sores develop due to poor positioning and inadequate skin care. Such an example reinforces the need for effective collaboration at both strategic and operational levels (DoH 1989, Means and Smith 1994).

Two main inter-related factors have, however, detracted from effective collaboration – first, the resource implications for whichever agency claims this disputed territory, and second, the fact that while health care is still predominantly free at the point of delivery, social care may be charged for (Audit Commission 1992). As a direct result of this latter point, Ovretveit (1995) suggested that: 'People are learning that it really does matter whether a service is provided by health or social services.' It is necessary, therefore, to examine each of these factors separately before considering the implications for nursing practice.

Protecting budgets While it would appear difficult to dispute the necessity of effective collaboration between health and local authorities, it can be seen that, given the potential resource implications at a time of economic constraint, disincentives currently exist. There would appear to be a greater potential for disputes regarding responsibility (and hence funding) of provision as it is clearly to the advantage of both health and social services to attempt to 'redraw' the dividing line so that the demands placed on their limited resources are reduced. The potential for such a situation to arise was recognised by a social services committee as far back as 1990 when it was acknowledged that incentives would seem to remain for each authority to 'cost shunt' across their boundaries rather than co-operate (Lewis 1994).

Such fears have been realised and while examples of good practice exist there are also areas where difficulties have arisen (RCN 1995, Duggan 1995). Moreover, strain which arises from financial considerations can be seen on both sides of the health and social care divide. Duggan (1995) in a recent report suggested that: 'The retreat of the NHS is straining local authorities' ability to provide community care to large numbers of people.' From a health perspective, the RCN (1995) noted that district nurses report working overtime in order to 'carry out non-nursing work because of the lack of services offered by other agencies'. A failure to agree about responsibilities of agencies at a strategic level thus has direct results at an operational level.

A further difficulty arises because as well as local authorities and district health authorities, GP fundholders would also appear to be well placed to promote the seamless community care service which is advocated. However, while many GPs perceive themselves to be important in the provision of community care, they are often reluctant to adopt the role of care manager (Means and Smith 1994) and many, particularly fundholders, remain 'on the periphery' of community care (Daphne Heald Research Unit 1995). It is also suggested that GPs are 'preoccupied' by the need to deliver clinical services and often do not appear to appreciate the extent to which social care can impact on health (Duggan 1995).

One possible solution to this problem is that community care could become a funded activity for GPs (Means and Smith 1994), although it must be recognised that this would impose additional pressures on GPs who may already feel overwhelmed by the existing pressures of fundholding. An alternative approach would be to locate care managers within health centres (McIntosh and Bennett-Emslie 1993). In the meantime, however, the situation described above exists whereby community nurses work additional hours to cover gaps in social care provision (RCN 1995), but GPs who purchase their services may not perceive this as a legitimate use of their time.
The net result of such difficulties is inevitably that clients suffer. Indeed, it is suggested that in some areas, 'essential services' are not being provided to people who have a high level of dependency because of a lack of co-ordination between services at strategic and operational levels (RCN 1995). It has also been reported that one in four people identified as needing community care receive no formal services (Pennington 1994).

The extent to which this results from a lack of consensus regarding responsibility for provision or from 'targeting' and 'prioritisation' is unclear, but the finding is, in itself, significant. Rather than assuring accountability for service provision, it would appear that further division may have been created; and far from being a 'seamless service', it would seem that there is danger it may be being torn apart by financial concerns. The views and wishes of patients and clients would also appear to be lost in the debate regarding problems of funding.

**Charging for services**

The second key aspect of the health and social care divide referred to above was that while health care is still largely free at the point of delivery, social care may be charged for. As a result of this, local authorities have, since the introduction of the community care reforms, been encouraged to introduce a financial assessment as part of the care management process, whereby people who require social care services are assessed as to their ability to contribute to the costs of such services (DoH 1989). This reinforces the problems of definition discussed above because for services to be chargeable they have to be clearly identified as social care. Some local authorities have refused to introduce a charging policy and the rates charged by others vary a great deal, making it somewhat of a lottery, dependent on where you live.

A recent report by Scope (Lamb and Layzell 1994) suggested that access to services is directly affected by the limited financial resources of clients and that 18 per cent of the disabled people who responded to its survey have had to refuse a service because they could not afford to pay for it. It concluded that: 'Charging for services can force disabled people to choose between meeting some needs and not others.'

While charging relates specifically to social care services, it is evident that if some of these services are not accessible to clients and their families then it is likely that their health may suffer which in turn has implications for the health service. For example, respite care used to be provided free of charge within NHS long stay hospitals, but now it is often provided by local authorities or voluntary agencies who levy a charge. Respite care in community-based units may be far more appropriate and would, in some situations, appear to be a social rather than a healthcare service. However, some carers may feel that they cannot afford to pay, refuse the service and their health may then suffer.

**IMPLICATIONS FOR NURSING PRACTICE**

There are clearly a number of areas of concern which have implications for nursing practice. Firstly, the disputes at a strategic level regarding the boundaries between health and social care make it difficult for individual practitioners to collaborate effectively at an operational level. They are often unclear about their responsibilities and confusion arises regarding the roles of the various professionals working in community care (George 1994). Therefore, a situation can arise where there is 'mutual distrust' at the field level between nurses and social workers regarding each other's assessments (Johnstone 1993) which often leads to inappropriate duplication of work.

It is acknowledged (Daphne Heald Research Unit 1995) that the history of collaboration between health and social services is one which has been fraught with difficulties and that the present climate would appear to be posing additional problems rather than offering easy solutions. It has been suggested that 'optimal conditions' for co-operation between the two agencies only exist in exceptional circumstances and that, even then, aspects such as structural, cultural and policy differences can present obstacles (Duggan 1995). Examples of such differences might include differing geographical boundaries and different perspectives regarding need and priorities.

However, if there is not effective collaboration at the strategic level then work at an operational level can be reduced simply to a question of 'who' is able to do 'what' task. Using the example of bathing, it becomes a question of who should provide the bathing service rather than focusing on the needs of the client. This is a long way from the integrated flexible service to which clients should have access and it is 'indefensible' to suggest to an elderly, frail person that he or she cannot receive assistance with bathing because it is a 'grey area' (RCN 1995).

The RCN Powerhouse for Change document noted that patients and clients will not receive care which is high quality, comprehensive and co-ordinated unless community nurses work well with their colleagues (RCN 1992). It would, then, seem imperative that nurses seek to establish positive working relationships with colleagues in the community while at the same time communicating to their managers the effects of strategic disputes on their day-to-day work. Moreover, nurses working at a strategic level should endeavour to promote collaborative service provision which ensures that client need is met effectively.

It is disturbing, although increasingly common, to hear colleagues talk of patients being discharged into community settings from acute hospitals without appropriate community nursing care being arranged. One of the main reasons for this appears to be a lack of agreement between health and social services regarding the contribution which community nurses could, and should, make. As a result, care manage-
ment assessments carried out by social services prior to discharge may not reflect the need for community nursing input. An example of this is where someone is discharged from hospital following a stroke with a social care package, but community nursing support is not included until that person has been at home for some time and has developed a pressure sore. Had nursing support been available earlier, then it might have been possible to prevent the pressure sore from developing.

One of the key roles of community nurses is, therefore, to make their particular contribution to community care explicit. This must involve discussion with both local authorities and GPs as it is important to communicate their specific contribution while listening to the contribution of others. If there is to be a seamless service, it is essential that the services offered by nurses are co-ordinated with those offered by other professionals and agencies.

It is also important to remember that in discharging patients from acute hospitals, nurses must collaborate on both an intra- as well as inter-professional basis. Work has been undertaken regarding good practice on hospital discharge and it is stressed that discharge planning should start at the point of admission, or before in the case of elective admissions (Henwood 1994). It is also advocated that hospital staff should be aware of community care arrangements so that accurate information can be provided for patients and carers, mechanisms should exist for social services departments to make cash payments to disabled people in lieu of providing community care services (DoH 1994). While such payments would be for the purpose of purchasing social care services, it could promote a situation whereby clients can purchase services which more closely reflect their individual needs and may reduce some of the problems regarding service co-ordination. It should be remembered, however, that such an approach may not be welcomed by all disabled people and that a wide range of service provision may not be readily available to purchase. It is also important that the level of funding provided is adequate and protected.

**POSITIVE DEVELOPMENTS**

Despite the difficulties identified with the community care reforms so far, there have also been some positive developments. It is, therefore, important to examine some of these and to consider the contribution which they may make to resolving some of the problems.

**Joint commissioning** The RCN (1995) suggested that if joint planning, multidisciplinary co-operation and support services are in place, then community nurses will be in a position to contribute 'fully' to community care. Joint commissioning is one development which has sought to address some of these issues through the creation of joint arrangements and agreements between agencies for commissioning services for a client group (Ovretveit 1995).

Ovretveit (1995) suggested that such an approach makes the sharing of assessments of need from differing perspectives easier, promotes the alignment of plans (or creation of a common plan), identifies and agrees shared and separate responsibilities, and thus seeks to avoid the duplication of services or gaps in service provision. It can be seen that this would appear to offer some solutions to the problems of co-ordination discussed above.

However, it is suggested that joint commissioning at present only takes place where local conditions allow and that practice varies between client groups and localities, with pilot projects being launched mainly in learning disability services (Waddington 1995). Ironically, given previous comments regarding GP fundholders, Waddington (1995) suggested that the debate regarding the expansion of fundholders' powers is creating a cultural climate which favours the expansion of joint commissioning.

**Locality purchasing** A further development which may offer some solutions is locality purchasing. This is described as a way of organising commissioning work to ensure that the purchasing of healthcare services is sensitive to the needs and views of a given geographical locality (Ovretveit 1995). It has been suggested that some district health authorities have adopted this approach to promote co-ordination of purchasing and planning with that of local authorities and GP fundholders (Ovretveit 1995). Given that collaboration with these two groups has already been identified as necessary for effective community care, then this approach would also appear to offer some hope.

**Cash payments** A further development which may have a positive impact on community care provision is the proposal by the government to allow social services departments to make cash payments to disabled people in lieu of providing community care services (DoH 1994). While such payments would be for the purpose of purchasing social care services, it could promote a situation whereby clients can purchase services which more closely reflect their individual needs and may reduce some of the problems regarding service co-ordination. It should be remembered, however, that such an approach may not be welcomed by all disabled people and that a wide range of service provision may not be readily available to purchase. It is also important that the level of funding provided is adequate and protected.

**THE WAY FORWARD FOR NURSES**

From the evidence presented in this article a number of questions emerge which appear central both to current and future delivery of community nursing care (Box 1). Work has already begun on attempting to provide answers to these questions as discussed in this article, however, it is evident that these areas demand ongoing attention and further work is required. In conclusion then it is necessary to consider what actions nurses should be taking.

First, it is suggested that nurses should undertake a monitoring function in respect of the care provided to their patients and clients. Difficulties in securing appropriate services, whether these arise from a lack of agreement regarding responsibility for service provision or from the effects of charging policies, must be noted and made known to the appropriate persons and agen-
Box 1. Key questions regarding community care.

- How are health and social care being defined across the UK?
- What impact is this having on the role of community nurses?
- To what extent are there gaps in service provision evident?
- Are vulnerable groups of patients/clients refusing or being refused services because of the charging policies?
- What effect is this having on their health?
- To what extent are gaps in service provision evident?
- What impact is this having on the role of community nurses?
- How are nurses working in partnership with patients/clients and their carers?
- To what extent are nurses working in effective collaboration with other service providers?

REFERENCES
Department of Health (1989) Caring for People: Community Care in the Next Decade and Beyond. London, HMSO.

This article is based on a paper presented to the Health and Social Policy Committee of the RCN.