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Community Care in Scotland

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Introduction

This ethnological perspective of Community Care in Scotland will focus on historical, political, and social contexts and their influences on the community care arrangements for individuals within various types of communities in Scotland today. Community Care represents both a philosophical and policy approach to care.¹ The provision of care by Scottish communities since pre-industrial times evolved to its more formal and institutional culmination during the modernist thrust of the twentieth century. Since then, major changes have occurred within the delivery of health and social care, particularly over the last twenty years. The dismantling of the twentieth century institutional structures accompanied the post-war era and the consolidation of contemporary Scottish culture in the latter half of the last century. The enactment of the National Health Service and Community Care Act² (1990) in post-modern times was the beginning of a political endeavour to respond to economic, demographic and professional pressures about the welfare of its citizens within their own communities. An explicit aim of these community care reforms is to maintain people within their own homes whenever possible.³ Family members and the development of other community agencies are therefore important service providers in achieving this objective. This new framework of delivery with the creation of quasi-markets has redefined the boundaries of responsibility between state provision, family, voluntary and private sectors. The consequence of such radical reforms on those requiring care has provoked a vigorous debate. For example, critics of changes in health and social care delivery^{4 5} have questioned the congruency of policies which claim to advance the principles of choice and empowerment when family members are expected to play a central role in the delivery of care. The nectar to be drawn from these reforms was the apparent shift from a service-driven to a more needs-led social and health service within Scotland and Britain. The sting attached to such a vision of utopia was the shape of these reforms, which divided health and social needs and introduced a means-testing mechanism to assess peoples' ability to pay for specific services.

When considering Community Care in Scotland it is also necessary to have some understanding of the wider British perspective because of the historical links and the evolving administrative structures. However, changes within the Scottish political structure have provided opportunities to reconsider Scottish society as separate from the rest of the United Kingdom. Scottish welfare reforms previously determined by the Westminster parliament, who had to consider the needs of England, Scotland, Wales and Northern Ireland, are now addressed by the devolved Scottish parliament. The relevance of Scottish initiated political reforms, for example the response of the Sutherland report,⁶ to the welfare of the Scottish people is still unfolding.

The Scottish community and its political passage to self-determination

The choice of self-determination in 1999 may be seen by some as the culmination of a process dating from the Union of the Crowns in 1707. The alliance was seen in Scotland from the outset as being one of patronage rather than partnership.⁷ Politically impotent, Scotland had manifested its independence culturally, through force of symbolic identity, which had been honed and matured through economic expansion, military adventure, religious ferment and social improvement.⁸

Glasgow, so often the self-elected core of Scottish identity, can be taken as an example. In the eighteenth and nineteenth centuries, the second city of the empire saw rapid industrial growth, and subsequent decay accompanied by a number of social ills, which were never addressed with any degree of effectiveness through the 20th Century.⁹ It was only in the late 1980s that Glasgow began to emerge from the shadow of the industrial revolution and reposition itself as the City of Culture. This, however, was culture with a small c - the culture of the community, of sharing and, in principle, though frequently not in practice, one of inclusion.¹⁰ This was pride turned out and 'showing off': Scotland's bid to be part of a modern Europe; the same but different. That difference would be most marked in relation to its immediate southern neighbour and administrative partner. Indeed, Scotland has long preferred its administrative structures to be organised using a different system to its neighbours down South. For example, the unpopular local government reorganisation of 1993 from a two-tier to the weakened single regional

authority system, reduced state involvement in public services, whilst placing the onus on communities to maintain health and social services. Whether city scheme orcrofting town individuals would be expected to participate more fully in the administration of their communities.

Moreover, as Scotland moved towards the end of the twentieth century its preference for State intervention in relation to meeting the needs of the community was clearly differentiated from that of England. According to Harvie:¹¹

...the economy retained more of a state sector, which involved opposition politicians in consensual activities and public-private sector partnerships, while in England the municipal socialist ethos, if while not in abeyance, was subordinate to commercial pressure.

Thus Scotland, forever cautious about investment at home, would always look to the State for investment in infrastructure. Private Finance Initiatives for building, be it hospitals or whatever, is not liked by the Scottish people. Whatever New Labour's motivation for allowing the Scottish referendum on devolution, it is seen by many as being a halfway house in the transition to full independence, entailing total power over matters such as economy and defence. It was the economic and representational disparities between Edinburgh nobles and the court of James the Sixth and First that fermented the Union. It may be economic and social cross-border discrepancies that split it. The Scottish National Party has continually affirmed its commitment to Europe, in a way that is anathema to anti-European lobbyists. Whether Scotland goes on to be an equal partner in Europe, remains to be seen.

When considering communities and community care from a Scottish perspective, it is therefore important to consider that the understanding of perspectives of a community is influenced by historical, cultural, personal and or political factors.¹² This account of community care for Scotland therefore takes into account the ways in which these issues have shaped the development in Scotland.

Defining communities

When considering the provision of community care services, policy makers are faced with the difficulty of trying to define 'natural communities around which services should be organised'.¹³ Communities assemble for a diversity of reasons and the boundaries between them can be well defined or blurred with a keen sense of identity or a vague notion of belonging. Hence, there are geographical communities defined by location, or elective communities¹⁴ based on a common identity such as gay people, black people, deaf people, older people. Defining community care needs is further complicated by the fact that where people are associated with a particular community defined by geography, ethnicity or some other factor, this does not necessarily mean that people identify themselves with or have strong social networks within the larger parent community.

In the context of current Scottish community care policies it is recognised that there is a need to consider communities that are defined by geographical location such as cities, towns, villages or districts.¹⁵ There are also communities that are identified by needs, such as older people, people with mental health and learning difficulties.¹⁶ It is, however, acknowledged that tensions may arise when attempting to meet the needs of different communities. For example, as the number of older people aged 85 and over with health problems increases, meeting their needs has to be 'balanced against the needs of other community care groups including people with learning disabilities, mental health problems, alcohol, drug dependency and HIV/AIDS'.¹⁷ Other examples of these tensions can be illustrated by exploring the experiences of minority ethnic communities in relation to health and social care services.

Scotland itself, a net exporter of people for much of its history, many of them asylum seekers, has had the tarnish blown off the empty rhetoric that there is no racism in Scotland. Political refugees in Sighthill in Glasgow have been the focus of much unwanted attention, being accused, however erroneously, of attracting favourable attention from the social services. Certainly Scotland has an enviable record of integrating other nations successfully; Lithuanians, Indians, Poles, Italians and others have all merged into the fabric of Scottish life. However, one group that has been less successfully integrated, yet which has had the longest history of residency of any in Scotland is that of the travelling folk.

In terms of health care travellers, by far Scotland's largest minority culture, have been discriminated against in a way that would be unlawful against any other group. They have recently been refused registration and treatment at GP surgeries and women have been denied screening and children immunisation.¹⁸ Babies born to traveller families are approximately two times more likely to die in their first year than those born to the rest of the population.¹⁹ They are more likely to suffer from general poor health, including chest infections, heart disease, accidents, and conditions linked to poor sanitation.²⁰ It has also been reported that the life expectancy of a Scottish traveller male is 55, the equivalent of an African Third World Country.²¹

In order to address these inequalities, the Scottish Parliament's equal opportunities commission, in its report of June 2001, recommends that Scottish travellers be given ethnic minority status thus affording them equal rights under the law. The report notes how certain councils are being proactive by employing liaison officers, instigating traveller resource centres and experimenting with hand-held health records that are transferable between administrative regions. It recommends training in cultural sensitivity for health and social service staff, and greater consultation in designing partnership provision. It also recommended a review of funding schemes, taking into account the itinerant nature of the traveller in cash calculations, which has been a major drawback in full and effective service provision.²²

The debate offered so far has highlighted the complex nature of communities, revealing a diversity of needs within communities. Meeting them is far from straightforward. Moreover, as Hill²³ points out, modernisation and development in society have created complex 'sophisticated industrial processes'. These in turn have resulted in changes to employment patterns, which have increased the numbers of women in employment and separated extended families, as they have become more geographically mobile for work. These factors have made it difficult for many communities to meet everyone's needs. In these situations the State or Government have been willing to get involved when family, community and charitable care fail.²⁴ In order to make sense of State intervention it is therefore necessary to understand how community care policies for the United Kingdom and more specifically Scotland have been developed and their impact on the groups they were developed to serve.

Development of Community Care Policies

Community care has been defined as the availability of resources outside 'formal institutional structures', focusing on informal support and care provided by friends, families and neighbours.²⁵ This is an interesting definition as whilst community care in the twenty-first century is still largely provided by the family^{26 27} there have also been various policy initiatives since the 1950s that have aimed to formalise aspects of community care support and services. However, the major development of community care policies and services came about in the 1960s and 70s. This occurred for a number of reasons, one being the increased criticism of poor standards of care in institutions caring for older people, people with mental health problems and people with learning difficulties^{28 29}. Baggott³⁰ further suggests that it was not just criticism of care standards but also recognition that despite good intentions institutionalised care was more likely to make those needing care more dependent.

The major changes in community care occurred in the late 1980s as a result of the Conservative Governments reforms laid out in the White Papers Working for Patients³¹ and Caring for People³². The idea was that instead of community care services being directly provided by Local Authorities, funding should be redirected to purchase more services from a range of private and voluntary agencies.^{33 34} Local Authorities also received money from the social security budget and the responsibility for financing people seeking public support for their care in residential and nursing homes.³⁵ The basis of these changes to the funding of community care in the 1990s was based on the belief that the introduction of market elements into the provision of community care services would improve efficiency and ensure that services were more responsive to users needs.³⁶

The main users of health and social care services include older people, people with mental health problems, people with learning difficulties, people with physical disabilities and children, with older people and children being the apparent major source of expenditure.³⁷ When looking at where challenges to the future provision of community care will come from, one group likely to place increasing demands on community care services are older people.³⁸ Indeed the number of people aged 65 and over in Scotland is predicated to rise by just over nine per cent to nearly 858 000 by 2012 and the number of people aged 75 and over to 380 000, again a nine per cent increase

(Audit Scotland, 2000). The over-75 age group are the most likely group of older people to require some help or support as a survey showed that half of this age group reported 'a limiting illness, health problem or disability' (Audit Scotland, 2000: 1.1.2). Because older people are key users of community care services this group provide a useful example of how community care policy developments have impacted on one group within Scottish society. One major health problem is the growing number of people living in Scotland who have dementia. Dementia is not part of the ageing process but does occur more frequently within older age brackets. Recent projections for Scotland estimate that 60,000 people have dementia and this is likely to increase to almost 70,000 by the year 2005.³⁹ This group of people forms an increasing proportion of the group defined as 'incapable adults'. New legislation has been introduced by the recently devolved Scottish Parliament⁴⁰ that highlights individual autonomy and offers legal interventions for people living in Scotland who face diminished decision-making capacity.

It is, however important to recognise that whilst community care policies have been developed with the aim of supporting people in their own homes and maintaining quality of life, these policies have also aimed at reducing the overall costs of care to the State.⁴¹ ⁴²Brereton and Nolan argue that as a result of these financial constraints, in reality, Community Care is largely provided by the family both in the UK and across Europe.

Those commenting on the community care reforms of the late 1980s were particularly critical of the emphasis given to the funding of care. For example ⁴³Titterton was critical of the Scottish perspective within the white paper ⁴⁴ Caring for People (1989). He was principally concerned with the impact of these proposals within Scotland as he estimated that for every pound spent on community care, eight pounds are spent on hospital and residential care. Moreover, at that time, twice as many people were in mental hospitals and one and a half times as many in Mental Handicapped hospitals per 100,000 of the population compared with England. Thus, ⁴⁵Titterton cited one newspaper as saying that, 'Community Care has taken off at the rate of a senile tortoise'. At this time there was an apparent underdevelopment of Community Care within Scotland. Again the historical development of care services may in part explain the reluctance to embrace

new approaches to community care in Scotland, as the NHS had been prototyped on Clydeside in the early 1940s. The Scottish people therefore felt a great affinity towards the original organisation of care and services. Any changes to the founding principles were therefore difficult for Scotland to envisage.⁴⁶

Unfortunately the reforms of the late 1980s were not economically efficient and the budget could not support a needs-led philosophy. As a result social workers were advised through Government circulars to be sensitive to the needs of individuals and their carers but not raise expectations about the packages of care that could be offered. This resulted in care management being a process where resources were rationed rather than choice being extended.⁴⁷ Ironically, whilst the aim of community care policies was to help people stay in their own home, the numbers of older people who entered a long-term care facility such as a nursing or residential home increased in the 1990s.⁴⁸ Indeed, in Scotland over half the current expenditure on community care is on residential and nursing home care.⁴⁹ This Commission found that whilst approximately 34,000 older people in Scotland live in nursing or residential homes only just over 6,000 people receive 10 to 20 hours home care per week, and of these only 1,800 people receive more than 20 hours home care per week. These figures appear to justify current arguments that the result of the policy reforms in the 1990s, which led to the funding of expensive community care support was biased towards providing this in some form of institutional care as opposed to supporting people in their own homes⁴⁹(Audit Scotland, 2000).

More recently the election of a Labour Government in 1997 has led to changes in the way that both health and social care community services have been organised and delivered. The major changes to services were outlined in the White Paper the New NHS Modern, Dependable⁵⁰ and the NHS Plan.⁵¹ Moreover, anticipating impending devolution in Scotland and Wales additional White papers for Scotland - Designed to Care⁵² and Wales - Putting Patients First⁵³ were published.⁵⁴ Amongst the core principles of these policies the Government aimed to end the NHS internal market and improve the ability of the NHS to respond to individual and different populations' needs.⁵⁵ Strategic measures to meet these objectives were outlined in plans to organise community health care services into local Primary Care Groups (PCGs). These have the option to take more responsibility for commissioning and providing community health services thus

becoming Primary Care Trusts (PCTs).⁵⁶ There have also been a number of policy initiatives aimed at improving the interface between health and social care services. These include National Service Frameworks for Mental Health and Older People Care Trusts and Modernising health and social services.⁵⁷ More importantly in the context of this study, decision-making powers over the funding of health and social care services were devolved to the Scottish parliament.

Whether these reforms will result in more people receiving more person-centred care in their place of choice is still to be seen. Some of these issues and their impact to the Scottish population are revisited within the section on 'the emergence of Scottish approaches to community care'. However, having explored the impact of community care policies on the development of care services it is important to understand what some of these specific community care services are and what the issues are for those reliant upon them for support and care.

Community Care Services

Community care services have been defined as a system of service provided by statutory and voluntary organisations developed by a number of unrelated organisational patterns.⁵⁸ For example the Audit Commission⁵⁹ described how Health Authorities, Family Practitioner Committees, Social Services, Housing Authorities, Housing Associations, Education, Voluntary and Charitable Organisations and Private/Independent Sector all provide some form of care or service for community-dwelling individuals. Drawing on the report from the Audit Commission⁶⁰ and our personal knowledge the following description gives some idea of the range of community care services available. For example, professional care services provided by these agencies includes care and assessment by nurses, doctors, therapists, chiropodists, dentists, ophthalmologists and social workers. Other forms of support include respite care, home care, sitting services, day care, luncheon clubs, drop in centres, befriending services, meals on wheels, community transport and much more. Alternative forms of housing such as sheltered housing, supervised and unsupervised group homes, residential homes, nursing homes, flats and specialist housing are also ways in which some

individuals may be able to stay in some form of 'home' as opposed to institutional environment.

In the context of providing community care within Scotland the church has had a significant role to play in the provision of community care services. One example to be drawn on here is the Presbyterian Church community within Scotland. The Church of Scotland has an unusual position in Scottish society:

Areas of collective responsibility which the English State contracted out to the aristocracy or forgot about, in Scotland passed into the hands of the Kirk: notably education and poor relief, where Calvinist values were expressed at their most emphatic⁶¹

'On the parish' became a euphemism for poverty, and its consequent health problems. Yet the Church of Scotland to this day harasses and nips at the Governments Health and social policy record. There are exhortations from the General Assembly, such as:

Inequalities in health cannot be adequately addressed without the wealth of the nation being more equitably distributed⁶²

Meanwhile, the Church of Scotland Board of Social Responsibility appears to concentrate on both health and social problems. It runs...

35 residential homes, including 4 specialist senile dementia (sic) units and more than 40 other centres dealing with alcohol and drug dependency, counselling and support, epilepsy, learning disabilities, mental illness, single homeless and offenders.⁶³

The Church of Scotland also addresses poverty issues at root through its poverty policy committee, thus continuing its historical role of agency for the poor in Scotland.

As this example of a non-statutory state provider shows, this complex myriad of services partly demonstrates why it is often difficult for people to find out what is available and how to access appropriate services prior to a crisis occurring. One group particularly affected by this issue is family carers. Audit Scotland point out that:

Carers, whether they are family, friends or neighbours, play a key role in supporting many older people in the community. Current estimates suggest that around 360 000 people in Scotland are caring for someone over 65, nearly a third of whom are caring for someone who is over 85. An estimated 96 000 carers are over 65 themselves⁶⁴

Audit Scotland further point out that in Scotland around 45 000 carers of older people provide more than 20 hours care per week and that some provide in excess of 50 hours care per week. What this demonstrates is that family carers often provide more community care to support someone at home than the state is prepared to provide. Indeed, a recent audit of community care services found that only 1800 clients receive more than 20 hours of local authority commissioned home care services (Audit Scotland, 2000). Moreover, Audit Scotland suggest that 'dependent people with a carer living in the same household are less likely to receive support from social care services than people who live elsewhere'.⁶⁵

Whilst the bulk of community care does appear to be provided by families, it is important to consider access to community care services. A guide for Local Authority Social Work departments within Scotland outlines how to provide information for older people and those who care for them about community care services.⁶⁶ The guidelines are based on UK wide research where four of the focus groups were based within Scotland. Recent reviews of community services have indicated that people do not know what is available or how to make contact with appropriate community care services.⁶⁷ Recent Scottish research also suggests that people with dementia and their carers living in Scotland have difficulty accessing and utilising the legal system and these barriers can be

detrimental to the quality of life of the person and their family. Fiscal problems with private property, domestic finances, housing, essential services and strains within family relationships have been reported when there has been a dearth of appropriate legal advice.⁶⁸

The health and social care divide

When considering the diverse nature of community care, it is important to recognise that people's opportunity to exercise their rights to care and services will vary depending upon whether their needs are assessed as health or social needs. If someone is assessed as having health care needs these are met free of charge by the National Health Service. However, if a person or their carer's needs are assessed as social needs the cost of services is offset against a process of means testing against individual assets. The division of responsibilities for services between health and social care services has been an issue of concern since the inception of the NHS in 1948 and the development of the National Assistance Act in 1948. Whilst the National Assistance Act made the provision of residential care the responsibility of Local Authorities, responsibility for welfare services was limited and in the main domiciliary services were left to voluntary organisations.⁶⁹ The services provided by voluntary organisations were developed in a patchy and rather haphazard manner.⁷⁰ Whilst subsequent legislation gave Local Authorities the power to provide a whole range of home care and domiciliary services directly themselves, in the twenty-first century, access and availability of such services can be inconsistent, ad hoc and inequitable.

This incremental development of community care services has led to a situation where people now find themselves means tested for services that they might have once expected the State to provide. The division of health and social care services was complicated further by reforms in the early 1970s when social and health care services were divided. Personal social services became the responsibility of local governments who also had major responsibilities for developing community-based services for older people, people with mental health problems and those with learning difficulties.⁷¹ The result of all this was that policy for Community Care became hampered by the health and

social care divide.⁷² Thus services such as home helps and day-care centres became the responsibility of local authority social services departments but community nursing and day hospitals remained the responsibility of the NHS.⁷³ This fragmentation is an important issue for users of community care services. This division, in conjunction with changes to the type of care provided by some services over the last decade constructs additional barriers to accessing appropriate community care services; for example, the symbiotic home-care and district-nursing services.

During the Conservative Governments reforms to Community Care in the mid 1990s, community nursing was also redefined and much of what was once considered nursing care was reclassified as social care in an attempt to reduce costs.⁷⁴ In response the nature of homecare services changed. Home-care has been defined as 'the bedrock of community care both by virtue of its coverage and cost'.⁷⁵ Traditionally home-care workers provided a housework service, but over the last decade there have been attempts to move away from this, and home helps have been encouraged to provide personal care instead of housework.⁷⁶ This shift away from domestic tasks to personal care came about because of attempts to ration homecare.⁷⁷ Thus home care has become a more intensive service that aims to meet individuals' personal care needs but one which serves fewer people.⁷⁸ Unfortunately meeting personal care needs does not seem to cover such things as bathing. The reduction in community nursing services which focus on meeting personal care needs has led to a situation where it is now difficult for many older people to receive help with having a bath at home from formal care services. The burden of providing this type of personal care and more has therefore fallen to family carers.⁷⁹

The division of responsibility between health and social provision and the question of eligibility for means testing or use of individual assets continues to be a contentious issue as we move into the twenty-first century.⁸⁰ Later we explore the continuing impact of this health and social care divide on Scottish citizens in light of current and ongoing developments in Community Care post the devolution.

Accessing Community Care in Scotland

Access to Community Care services is often difficult for those who may benefit from additional support or help. For example, the first port of call for help with a problem may

be through consultation with a General Practitioner (GP). What it is important to recognise is the role of the health-care professional as gatekeeper to other community care services.⁸¹ If the GP does not recognise the situation as one amenable to support from other health and social care providers the person or their carer could find themselves continuing to struggle in difficult circumstances. Indeed a survey of family carers reported in the current labour Government's strategy for family carers revealed that 71 per cent of carers believed that their GP's were unaware of their needs.⁸² A Scottish based study by Mason and Wilkinson⁸³ report that a bias toward a disease-orientated model of care can act as a barrier to accessing information about community and legal services for people with dementia and their carers. It is not, however, only General Practitioners who act as gatekeepers, for any community care worker's ability to accurately assess and support people in the community is affected by their knowledge of the whole range of community care support services. This situation could improve or worsen with the development of intermediate care services. Under Government reforms outlined in the NHS Plan⁸⁴ there is a clear expectation that health and social care services will work constructively together to develop more flexible imaginative community care services. These services have been called intermediate care and have been defined as a range of services that can:

Facilitate the transition from hospital to home, and from medical dependence to functional independence... Additionally, intermediate care covers those services which help to avoid admission to acute settings through timely therapeutic interventions and also those which aim to avert a physiological crisis, and offer recuperative services at or near a person's home⁸⁵

Whilst the growth of these services is encouraging in terms of developing Community Care there is also a recognition that for these new services to work there must be assessment tools that accurately identify needs and potential for rehabilitation.⁸⁶ However, as the range of community care services expands there is a danger that referral to appropriate community care services will become too complex for care workers to grasp. Existing patterns of working which tend to be focused on crisis management, rather than proactive care and support, might well prevail.

An essential feature to the development of community care and support that meets individual and collective community needs is the process of assessment. The major policy reform that influenced the assessment of individuals in terms of access to Community Care was the 1990 Community Care Act.⁸⁷ In terms of assessing people for community care services, social service departments were given lead responsibility of assessing individuals social care needs, working in conjunction with other care professionals. Within these assessments there was supposed to be an identification of individual need and service provision but the end result was likely to be that consumer interest was met rather than service provider.⁸⁸

There has, however, been criticism as to whether these policies resulted in users of health and social care services being truly consulted or offered any real choice. Again, older people as a group can provide a useful illustration of these criticisms. For example, one study of continuing health care policies in England revealed that many carers and older people were unaware that they had been consulted about future care plans. Nazarko⁸⁹ further 'concluded that for older people contemplating their long-term care options choices were often made by others on behalf of the older person and, in many cases, choice was dictated by the financial resources of individuals or authorities'.⁹⁰ Whilst these findings relate specifically to England, as the same policies were applied throughout Britain it is likely that the same issues affected older people and their carers in Scotland.

The Labour Government elected in 1997 has recognised the apparent failings of these early attempts to improve the assessment of individual users needs and provide appropriate community care and support. Some attempts at improving assessment of individual (and community) needs in the context of community care services are the:

- Improved implementation of The Carers (Recognition and Services) Act 1995 in Caring about Carers.⁹¹ It is recognised that implementation of this Act was patchy and that there needs to be an improvement in the numbers of carers whose needs are assessed on an annual basis.
- Single assessment. For older people, who are the major users of community care services, it is recognised that there is a need for a single rather than multiple assessment process in which 'the older person's views and wishes are central to the

assessment process'.⁹² The use of single assessment should, in theory, enable care agencies to make more effective use of their resources.

- Assessment of people in their own homes. In a Northern English city it is recognised that for people to receive the correct community care services, assessment of need must, wherever possible, take place in their own home.⁹³
- Surveys have attempted to assess local Community Care needs and services available to meet these needs.⁹⁴ Participants in Building Better Communities recommend a new balance of power and responsibility within communities in order to strengthen local capacity of communities.⁹⁵

Whether these reforms to the assessment process will result in people receiving Community Care services that meet their needs is questionable and worthy of further research. Community Care in Scotland⁹⁶ (Scottish Office, 1996) is an example of a research programme. This aimed at evaluating the early implementation of Community Care provision of the NHS Community Care Act including care management and the process of assessment. Patterns of service delivery were found to have considerable variation. A particular influence was the extent of budgetary devolution and range of resources to be accessed. What is now becoming clear is that recent reform to the Governing bodies of England, Scotland and Wales means that community care will no longer be the same for all British citizens. Further research will be needed on patterns and outcomes of care delivery⁹⁷ (Scottish Office, 1996) and comparisons need to be made as to the health outcomes for people experiencing different patterns across countries within Britain.

The emergence of Scottish approaches to Community Care

The effects of the proposed changes to Community Care in Scotland have emerged quickly post-devolution. Responses to recommendations of the Royal Commission for Long Term Care, to meet the cost of nursing care and personal care needs by the State is one such example.⁹⁸ The Scottish government has decided to fund both long term and health and social care services for older people needing nursing home care. This is very

different to the situation in England where the decision has been taken to fund nursing care only and in a limited capacity where the highest level of nursing care funding available will be £110 per month.⁹⁹

At the forefront of the proposed changes implemented by the new Scottish Parliament, is the policy giving free health care to all long-term residents of care homes. It was no small source of discomfort for the departing Conservative administration that they should incur the displeasure of their middle-class home-owning voter base, by the issues surrounding long term-care for the elderly. Older folk, lifelong tax and National Insurance payers would have to pay again, for their residential care, often by selling their house. Sir, now Lord, Stewart Sutherland, Principal of Edinburgh University was commissioned to head up an official enquiry, in late 1997. His report was published on Tuesday, November 28, 2000 by the Parliament's Health and Community Care Committee.¹⁰⁰

The Scottish Executive, unlike the Westminster government, adopted the measures with a great deal less reserve, embracing, in particular the recommendation that all long-term care for the elderly should be funded out of the public purse. The division, between medical and personal care, so crucial in the Westminster debate was transcended in Scotland in the interests of 'fairness and equity'.

The declaration by Henry McLeish, the First Minister that he would be 'embracing the principles of Sutherland in full' was roundly jeered by his labour colleagues in Westminster. They responded that this would benefit only the wealthiest 30 per cent of pensioners, whilst costing up to £100m a year.¹⁰¹ Nevertheless, these measures are to be implemented by 2002, this will now be left to his successors to ensure that this is the case.

Whatever the political future for Scotland, whether independence or devolution, it seems that its citizens will enjoy certain differences in their rights and responsibilities from their neighbours in the rest of the UK. Whether these are viewed as a chastisement to Westminster or as an incentive to move North will depend upon the nature of those changes. Subsequently, whether the disparity of provision is taken as a wedge into the unity of the United Kingdom also waits to be written.

Conclusion

The development and delivery of community care in Scotland has been influenced by a diversity of historical, social, health and political forces. These include specific historical events such as the World Wars, government rulings, devolution, economic and demographic profiles, professional ideologies, lobbying powers within communities and contemporary cultural changes.

Caring for individuals has historically been present within Scottish communities. However, it was formalised as a specific political responsibility with the arrival of the NHS and Community Care Act, 1990. This economic reform changed the face of health and social-care delivery. Two main budgetary transfers increased the responsibility of Local Authority's obligation to provide community care. The transfer of the DSS budget was to cover private and voluntary residential and nursing care. Health Board transfer monies allowed Local Authorities to fund social care for people who would have lived in long-stay hospitals. Assessing whether a need was a social or health one was paramount to these reforms.

The Scottish perspective is not, however, always clearly identified within government reforms.¹⁰² This may be because many of the community care policies were created to cover England, Scotland and Wales and it is only now that the specific needs of the Scottish community are beginning to be identified and met. However, protecting Scotland as a country separate to its counterparts within Britain is part of its unique identity and one that the Scottish people have taken pride in. Its recent devolved parliament is a step toward administering its own affairs. Already there is evidence that its collective value system can produce health and social community care arrangements for its citizens that differ from other British countries. Political independence is a possible opportunity to symbolise the Scottish aspiration, protect its welfare and create an infrastructure that supports a diversity of communities and individuals with fairness and equity.

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