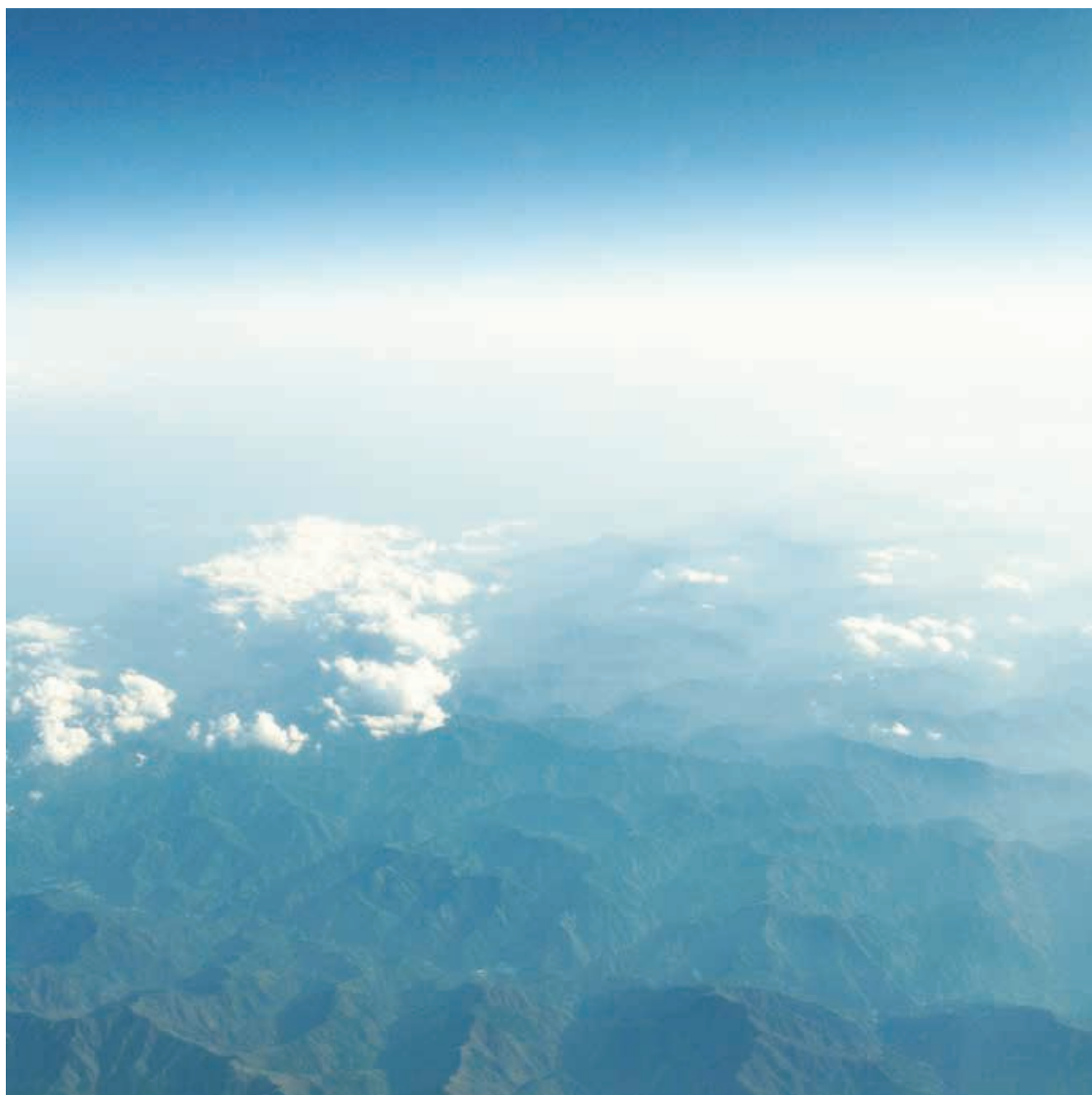


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ORIGINAL ARTICLE

# The Changing Characteristics of In-home Care Service Providers in the U.S. and in the UK: Implications for South Korea

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## ABSTRACT

Social service policies should be designed to guard the characteristics of the public interest while they enhance the possibilities for users to choose service providers. It might be crucial to establish a management system that enables to minimize the potential problems due to the enhancement of the right of choice among service users. As the number of social service users expands, the role of this management system would be more and more important. Taking into account that the volume of both demand and supply is continuously increasing, and that service users' right of choice and the role of for-profit providers are enlarging at the same time in South Korea, it might be meaningful to review how western countries have dealt with these problems. This study investigates the features of welfare pluralism and the responses of social policies focusing on in-home care services in the U.S. and in the UK, and attempts to draw social policy implications for South Korea.

### < Key-words >

In-home Care Service, For-profit Organizations, Not-for-profit Organizations

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## I . Introduction

The characteristics of social service providers have been increasingly diverse since 1980. This trend has been referred to as welfare mix or welfare pluralism, which has drawn fierce debates on its pros and cons. Some urge that multiple providers are needed in order to increase the service quality and efficiency in the social service field. However, others believe that private providers may damage both the equity and integrity of social service providers, which should be cherished in the social service policy.

Meanwhile, the proportion of for-profit organizations in the social service field continues to increase in many western countries. The phenomenon that both non-profit and for-profit organizations have a greater role in providing social services than the public organization is related with diverse factors. One of the major factors is the considerable increase of the elderly population and working married women, which multiplies the volume of social service needs. The trend that the increasing numbers of social service users demand their own decision power to select service providers is also one important factor.

The characteristics of the public interest and enhancing the right of choice among social service users are basically contradictory. The difference results mainly because it is meaningless for service users to have the right of choice without competition among service providers. In addition, it is due to the fact that substantial competitions among service providers may impede the stable provision of social services and weaken the public characteristics of social services. Therefore, these two conflict orientations should be deliberately considered in social service policy in order not to severely damage either orientation.

Specifically, social service policies should be designed to guard the characteristics of the public interest while they enhance the possibilities for users to choose service providers. It might be crucial to establish a management system that enables to minimize the potential problems due to the enhancement of the right of choice among service users. As the number of social service users expands, the role of this management system would be more and more important.

Taking into account that the volume of both demand and supply is continuously increasing, and that service users' right of choice and the role of for-profit providers are enlarging at the same time in South Korea, it might be meaningful to review how western countries have dealt with these problems. This study investigates the features of welfare pluralism and the responses of social policies focusing on in-home care services in the U.S. and in the UK, and attempts to draw social policy implications for South Korea.

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## II . Social services in the U.S.<sup>2</sup>

### 1. Social Services Since 1960s

The number of social service providing organizations greatly increased during the 1960s and 1970s. The growth was mainly attributed to the federal expenditure on social services, which had been growing rapidly during this period. Therefore, the number of new organizations mostly funded from the federal government for social services was largely expanded at that time, and the purchase of services between these private (both for profit and not-for-profit) organizations and government became popular. As the Omnibus Budget Reconciliation Act (OBRA) was enacted in 1981, the size of the federal expenditure on social services incrementally decreased. On the other hand, delegating the financial responsibility on social services to the state government increased.

Nevertheless, the demand on new social services, particularly in the long-term care for the elderly and home health services, has continuously incremented. Also, the financial recession during the 1980s made the demand on existing social services to increase as well. As a result, the size of public expenditure on social services has been growing since the early 1990s. Since then, the number of for-profit organizations has rapidly increased as social service providers; furthermore, the proportion of for-profit organizations in long-term care facilities, home health and care centers, child care centers, and medical services have been much higher (Gilbert, 1993).

After the beginning of the 1990s, the federal government expanded the expenditure on social services through new financial sources, such as Medicaid and Medicare. Therefore, the state as well as the local government tried to increase social service expenditure through Medicaid funding. The existing recipients of child welfare services, home-care services, hospice-care services, counseling services, foster-care services, drug and alcohol services, and mental health services, which were mostly funded by the state government, have been qualified recipients for Medicaid in the area of social services. The number of people who have entitlement for social services continuously increased.

In sum, before the 1960s in the U.S., public financial support for social services had been only a small amount of subsidies on not-for-profit organizations. It was only after the 1960s that financial support of both the federal and state government for social services became a substantial amount. After the 1980s, the importance of performance management in the public service area considerably increased due to the stress of the New Public Management (NPM). This trend led to an increase in the number of purchase of services in the area of social services, which made for-profit organizations enter the social service market. In fact, due to the stress on the outcome performance in public policy, the characteristics of organizations, such as public or private and for-profit or not-for-profit, became of little importance. The major

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interest of governments became the outcome performance of organizations providing social services.

As the importance of the power of choice among service users has been stressed since the middle of the 1990s, the voucher mode among social services grew, leading the number of for-profit-organizations to increase. Since the 2000s, the amount of subsidies on service organizations and of expenditure on purchase of services has been diminished, while tax-credit on service users and reimbursement on service providing organizations have substantially increased. Furthermore, managed care on social services was much more utilized from then on (Smith, 2007).

The trend on the increased proportion of reimbursement on service organizations is closely related with the fact that the role of Medicaid and Medicare, as financial sources on social services, has continuously been growing. The mode of reimbursement on service organizations is similar to that of the voucher in terms that both modes provide service users with the power of choosing. The expansion of users' power in terms of service selection engenders the increase of for-profit-organizations.

The long-term care facility services and home health services are the representative services which are fully funded by Medicaid and Medicare (Klees et al, 2010). In 2009, the 41 percent of total finance for long-term care facility services are funded by Medicaid and 16 million people have entitlements for this service. Total expenditure on home health also has been continuously increased, and almost 12 million people of home health service users are funded by Medicaid (Klees et al., 2010).

## 2. Home Health Service

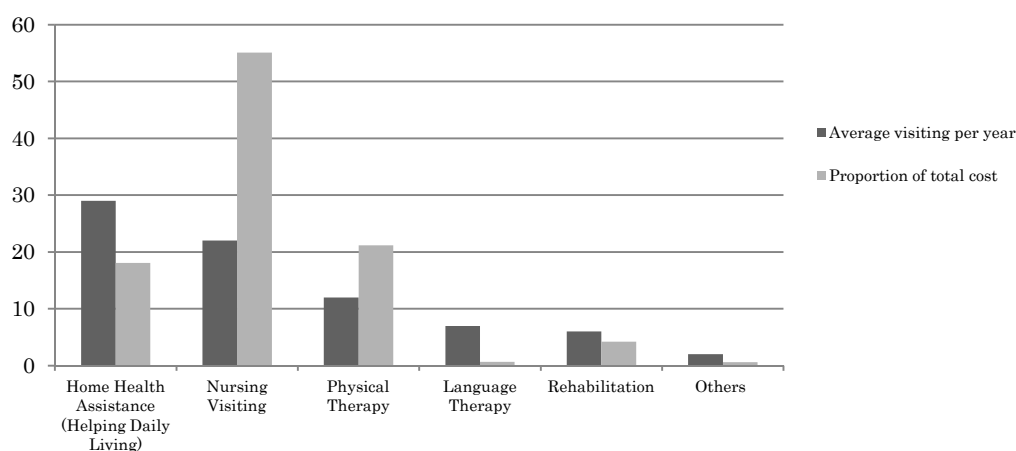
Home health care is generally defined as comprehensive health-related care services, which can be utilized in the service users' home. Home health care is considered more effective and convenient than that from hospitals or nursing facilities. Home health care services include professional services, such as part-time professional nursing services, physical therapy, rehabilitation, and language therapy. They also include routine care services supporting daily living, such as services done by a home health assistant.

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<Figure 1> Content, Average Visit, and Cost of Home Health (2009)



Source: CMS (2009, 2011).

<Figure 1> shows that home health assistance services are smaller than other services, such as nursing, visiting, or physical therapy, in terms of the proportion of the total cost. However, the average visiting numbers of home health assistants are the highest among other home health services. From fee-for-services to diagnosis-related-grouping, the proportion of home health assistance services dropped from 25 percent to 18 percent, whereas that of professional nursing services increased from 50 percent to 55 percent between 2001 and 2008 (CMS, 2010).

In the medical area, private for-profit insurance companies stopped providing insurance for home health due to the low profitability after the early 1920s. However, from the middle of the 20<sup>th</sup> century, home health services has been considered as an efficient alternative to facility services, which engendered for-profit organizations to become interested in providing services. Notwithstanding, for-profit insurance companies did not commercialize the services for home health mainly because of the difficulties in standardizing and recoding (CMS, 2010).

As both Medicare and Medicaid officially supported health-related care services in 1965, home health services were recognized as public services funded by the federal government. In the Medicare system, the officially funded area of home health was refined to acute care at the very beginning. The area had been expanded until 1981 when OBRA got rid of the necessary conditions for funding, such as co-payment, the visiting number limitation, and pre-hospitalization. Also, for-profit organizations were qualified as public funded providers of home health service organizations. In 1997, the total costs for home health increased 4 times more than that in 1990 because the number of service users doubled during this period and also due to the fact that the average visiting numbers increased rapidly (CMS, 2009).

In 1997, the Balanced Budget Act (BBA) was enacted. The act enabled the Department of Health and Social Services in the federal government to apply DRG to home health services. Moreover, the entitlement became more restrictive and the cost per visit and cost per person were also strictly limited. Until the early 2000s, the number of service providers for home

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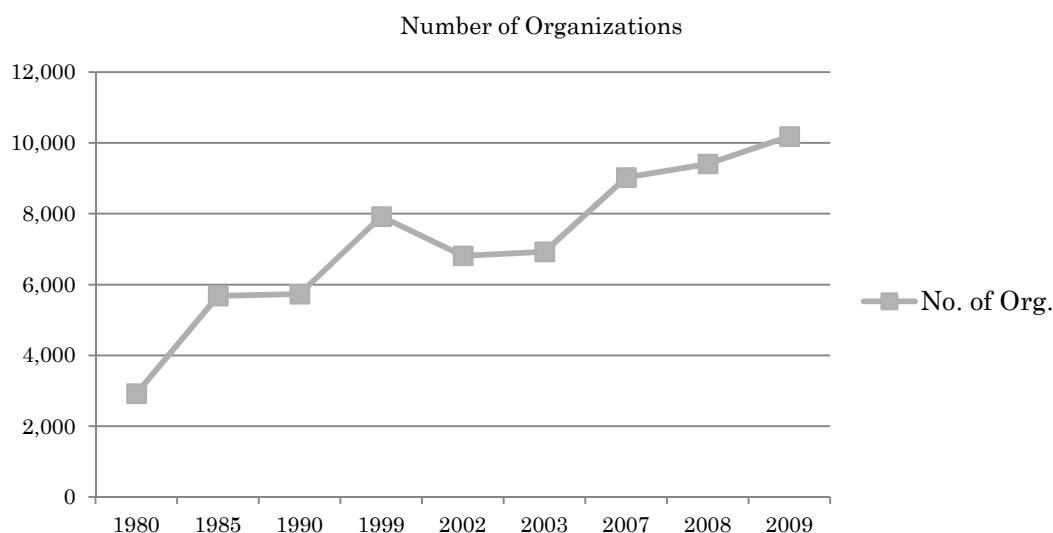
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health had been diminished because of these changes. These changes in the reimbursement policy much more affected for-profit organizations than not-for-profit or government organizations (CMS, 2010).

However, the number of home health service users has been continuously increasing since the 2000s. This is mainly because the number of people entitled as Medicare recipients rapidly increased. The total expenditures on Medicare in 2001 were similar to the expenditures in the middle of the 1990s, but the expenditure increased by more than double in 2009 (CMS, 2009). Furthermore, the number of service providing organizations was much faster than that of total expenditure. This was mainly due to the increases of for-profit organizations<Figure 2, Table 1>.

<Figure 2> Increase of Home Health Organizations: 1980~2009



Source: CMS/ORDI/OIS data

### 3. Characteristics of Organizations

The proportion of for-profit organizations among home health service organizations had been less than 50 percent until the early 2000s. The proportion increased to 69 percent in 2005, and 70 percent in 2009. This increase results from the fact that Medicaid expenditure has been continuously increasing and moreover, the contract mode also changed from a contract with service organizations to that with service users through a policy of reimbursing the cost to service organizations.

The service providers of home health care are composed of diverse professionals, such as nurse, nursing assistant, home helper, physical therapist, social worker, and rehabilitation therapist. Only qualified Medicare organization can provide social care services, and in order to be qualified, the organization should meet the minimum standard coded in the “Code of

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Federal Regulations (2009)". The minimum standard includes the certificate of service providers, users' rights, service plan, data management, medical record, and comprehensive assessment rules.

In 2009, 85 percent of qualified Medicare organizations are independent organizations, and the remaining percentages are the sub-centers of hospitals, rehabilitation facilities, or professional nursing institutions. Among independent organizations, approximately 70 percent are for-profit, and 30% are composed of not-for-profit and public organizations. In the U.S., the characteristics of service organizations in rural areas are very different from urban areas. In the South, about 45 percent of service organizations are for-profit, whereas in the North, only 22% are for-profit (CMS, 2010).

Generally, not-for-profit organizations are apt in taking care of acute care patients, while for-profit organizations have the tendency to take chronic care patients (CMS, 2010). Recently, the number of chronic care patients using home health care has rapidly increased, which led for-profit-organizations into the service market. In 2008, about 70% of home health service users are chronic care patients (CMS, 2008).

The interest in home health care services, as a promising industry, has been gradually increased. However, at the same time, the existing risks due to the change of regulations, the increase of costs, and the shortage of professional service providers are also regarded as substantial threat factors. Nevertheless, the fact that the number of the elderly are rapidly increasing and the need to use services at home is also increasing make the home health care field as a prospective industry (CMS, 2010).

<Table 1> Proportion of Home Health Organizations (Under Medicaid): 1999~2009

|      | Home Health Organizations |            |            |                |
|------|---------------------------|------------|------------|----------------|
|      | Not-for-profit            | For-profit | Government | Total          |
| 1999 | 34.6                      | 49.9       | 15.4       | 7,924 (100.0)  |
| 2002 | 35.4                      | 49.0       | 15.5       | 6,813 (100.0)  |
| 2005 | 26.8                      | 62.0       | 11.2       | 8,090 (100.0)  |
| 2008 | 21.5                      | 69.5       | 9.0        | 9,407 (100.0)  |
| 2009 | 19.6                      | 72.5       | 7.8        | 10,184 (100.0) |

Sources: CMS/ORDI; Choi & Davitt (2009)

#### 4. Policy Responses to Welfare Pluralism

The research on differences between for-profit organizations and not-for-profit organizations, in terms of service quality and outcome performance, did not produce consistent results. In fact, the level of performance is also affected by other factors, such as the size of organization or the characteristics of the local area. Considering cost-efficiency as one of the most important criteria, for-profit organizations seem to produce better outcomes than not-for-profit organizations, particularly in the area of long-term care facilities and child care

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institution. However, better performance of for-profit organizations, in terms of cost-efficiency, would mostly be from the reduction of the number of service providers or service coordinators (Gilbert, 1993).

Even though the proportion of for-profit organizations in social services has been increased, which might have produced the quality issues related to profit seeking strategies, public regulations were reduced during the 1980s. In the 1980s, the power of markets in raising service quality and efficiency was strongly emphasized (Gilbert, 1993). However, the reduction of public regulations developed a public concern as to the quality of social services. From the middle of the 1990s, public regulations on social services have been rather increasing (DHHS, 2004; NCQA, 2010). Public policies in the social service realm are stressing the establishment of quality management. Utilizing the NPI (National Provider Identifier) system and assuring service qualities through the NCQA (National Commission for Quality Assurance) are some of the strategies taken by the U.S. government.

### **1) National Provider Identifier (NPI)**

The U.S. federal government planned to establish a quality assuring system through managing service providers funded by Medicaid and Medicare in 1993. As a result, the NPI (National Provider Identifier) number was conferred upon the service providing organizations, and this was legally obligated. The Center for Medicare and Medicaid Services (CMS) in the federal government mandated that all organizations funded by Medicare or Medicaid should obtain the NPI.

CMS established the National Provider System (NPS) based on NPI in order to manage the nationwide social service organizations. The data gathered by NPS include not only the organizations funded by Medicare or Medicaid, but also diverse organizations providing health-related services. This system plays a vital role in providing comprehensive information needed for services users to choose the services that they want. Although the information of service providers in health and care services had been gathered and managed before the NPS was established, the information was also gathered by the local government. For the first time, the current NPI systems are mandated and protected by the federal law.

### **2) National Commission for Quality Assurance (NCQA)**

The NCQA was established in 1990, and is currently the representative not-for profit organization assuring quality of health related care services. The information provided by the NCQA is comprehensively utilized when recognizing and judging the level of service quality among service organizations mostly funded by Medicare or Medicaid. Also, nationwide health insurance companies are registered on the committee in quality assurance. The committee is equipped with quality management systems, including the official procedure of accreditation and certification.

The NCQA is consolidating the association with federal and state governments. The federal government increasingly emphasizes the importance of the accreditation from the NCQA in

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order to become Medicare providers. In particular, the CMS in the federal government obligated the authorizing power to the NCQA in order to acknowledge the qualification of service providers, such as the Medicare Advantage (MA) program. Therefore, service organizations accredited by the NCQA do not need to be assessed in terms of quality control for participating MA programs.

In addition, 40 state governments utilize the quality accreditation results of the NCQA when they make plans for their health related service providing scheme through Medicaid. 25 state governments utilize the NCQA data as the main criteria for selecting official providers, and 10 state governments mandate NCQA certifications for official Medicaid providers. The Code of Federal Regulation (CFR) codifies that the data from a nationwide quality assurance organization can be utilized on behalf of the External Quality Review Organization (EQRO) of state or local governments (NCQA, 2009).

Currently, the quality rating results among service organizations are open to the public in terms of the Medicaid program performance. Thus, not only state governments but also the public can make use of the information (see <http://reportcard.ncqa.org>). The information provided by the NCQA is often utilized as an importance source for diverse magazines of “consumer guide”, and also as the criteria for selection of organizations performing “best practice.”

### III. The Social Care Services in the UK

#### 1. Changes in the Social Service Policy

Social services in the UK are comprehended through a system of community care. It is difficult to define a community care system because the concept of community care has been used very extensively in the UK. Since 1948 (or prior to that year), almost every ruling party has tried to reform the social welfare system, known as community care (Lewis and Glennerster, 1996). In effect, the concept of community care before 1990 was understood as the orientation of social welfare services. The National Health Service and Community Care Act (NHSCCA) acted in 1990 changed the concept of community care to an implementation system as well as a major content of social welfare services. The NHSCCA was conducted in 1993 after three years of preparation period. Community care, as an institution in the 1990s, can be summarized as adopting market principles, decentralizing government power, establishing the care management system, and welfare pluralism in terms of the characteristics of service providers. Community care institution comprehends the implementation systems and contents for the vulnerable adult groups, mainly for disabled, old, or mentally defective people.

There have been a lot of controversies on the fundamental reason as to why the NHSCCA in was legislated in 1990. A large amount of literature argues that the core objective of the legislation was to cutback the government expenditure on social services. Other people

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empathize that in the course of legislation, the ways of applying rational and systematic mechanism to the process of designing and delivering social services were seriously considered, even though reducing the public expenditure on social services is also one of its objectives. It might be difficult to deny the fact that the NHSCCA took into account the practical ways to enhance service users' power, although the key objective of the act was to adopt strategies that strengthen the market mechanism to the social service area (Harris and Chou, 2001).

Lewis and Glennerster explained the background reasons of the NHSCCA in 1990 as follows (Lewis and Glennerster, 1996). First, the public expenditure on institutional services had been rapidly increased since the 1980s. Before the year of 1980, the expenditure on institutional (residential) services was solely from the local government, and the board of experts determined who could receive those benefits. From 1980, the institutional service was transformed to the benefit that should be given to people who have legal entitlement, and moreover, the federal government had the responsibility to financially provide such benefit.

These changes caused the rapid increase of public expenditure on institutional social services. Second, there was a large amount of criticism on "the perverse effects of" social policy. Even though government policies had continuously stressed community-based services, the perverse effect that the larger number of social service users selected institutional services was larger. Therefore, the government urgently required to implement reformative strategies on the social service policy (Glendinning, 1991). The audit committee of the government strongly criticized this perverse effect by the report named "perverse effect against the goal of social security policy" (Audit Commission, 1986).

In relations to this issue, Griffiths argued that social security expenditures on personal care should be suspended by his report "Community care: an agenda for action" (Griffiths, 1988). The federal budget used in this category should be transferred to local governments. He also recommended that local governments implement this budget based on their own criterion of selecting beneficiaries, which might be a means-test, care need assessment, and so forth. The segmented characteristics among health services, social security benefits, and social services provided by the government and private organizations were also criticized. To alleviate this segmentation, it was recommended that the social service department (SSD) of the local government had full responsibility to design, conciliate, and pay social welfare and personal care services (Glendinning, 1991).

These arguments ended up with establishing 'the mixed economy' on care services. Along this orientation, a care management system was adopted and through this system, care managers were bestowed to appoint a social service budget to each user. Care managers also had responsibilities to assess the level of care need, to figure out service providers, and to assign the budget to service providers competing with each other (Harris and Chou, 2001).

The gist factors inherent in the community care system in the UK are as follows. First, the market mechanism is utilized in order to enhance the users' right of choice and efficiency. Based on this mechanism, service purchasers and service providers were divided. Second, both the responsibility and the authority of the local government were strengthened. The

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main role of the local government changed from a direct provision of social services to need assessment, service purchase, and cost payment. Third, it is noteworthy that the privatization of social services has been widely progressed. The privatization of social services lessened the amount of services provided by the government, while increasing those provided by private organizations or individual businesses. Fourth, the systems of universal assessment and care management were established on local unit. Adults who need social services can apply their demands to the one-stop window of SSD where it manages social services integrally.

## **2. Home Care Service**

In 2006-07, the gross expenditure of local governments on adult care increased by 1.2% point compared to the increase in 2005-06(CSCI, 2009). This increasing rate is relatively lower compared to the 4% point in 2004-05, and to the 8% point in 2005-06. Among this cost, 59% of it were spent on services for the elderly (61% in 2005-2006), and 22% were spent on those who are mentally handicapped from the age of eighteen to sixty four (21% in 2005-06). From 2003-04 to 2006-07, the public expenditure on the disabled have been increased by 17% points, which is a relatively higher point. In 2006-07, half of the net expenditure of local governments to purchase social services was spent on care home services. However, the total amount of expenditure on care home services has been reduced by 1% point each year during the 5 years after 2001-02. On the contrary, the expenditure on community care services has been increased by 1% point during the same period.

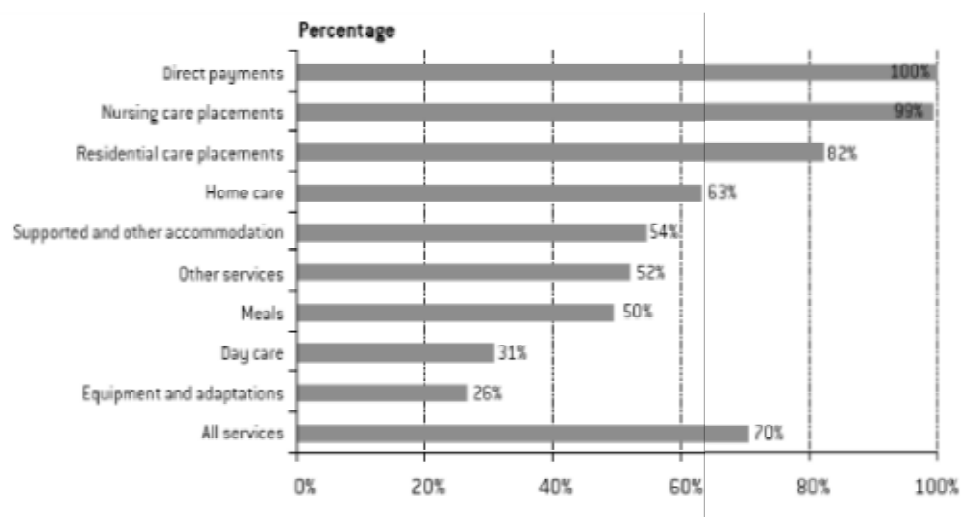
The proportion of purchasing services from private organizations of both for-profit and not-for-profit has continuously increased compared to that of providing services by the government. In 2001-02, the proportion of purchasing services from private organizations was 59%, which increased to 70% in 2006-07. Figure 1 shows the proportion of purchasing services from private organizations (both for-profit and not-for-profit) among the total expenditure of local government on adult social services in 2006-07.

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<Figure 3> Proportion of Purchasing Adult Social Services from Private Organizations  
(both For-profit and Not-for-profit Organizations) (2006-2007)



Source: CSCI. 2009. The state of social care in England 2007-2008.

Home care service is a major service of community care in the UK. Different from the U.S., home care service is managed separately from health care. The major trend of community care services, including home care, day services, equipment, and adaptations in the UK is as follows (CSCI, 2009). The net expenditure of local governments on home care service in 2006-07 increased by 2% compared to 2005-06. Taking into account that the expenditure has been increased by 10% points every year since 2002-03, the increasing rate was slowing down. The proportion of expenditure on home care service among total community care services was 47.6% in 2006-07, which is relatively lower than 48.5% in 2005-06.

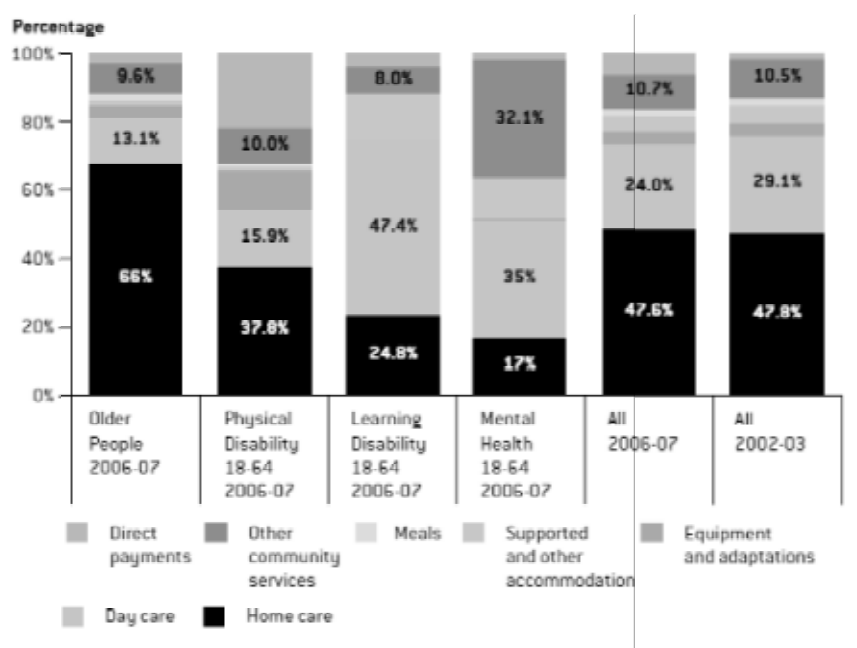
This is not because the amount of home care service was reduced, but because the proportion assigned to direct-payment was increased by 2.5% in 2002-03, 5.8% in 2005-06, and 7% in 2006-07. On the other hand, day services have been decreased every year so that only 24% of community care was day services in 2006-07. In particular, almost half of the expenditure (47.4%) on the mentally handicapped was spent on day services in 2006-07; yet, the percentage was considerably lower than 63% in 2002-03. The proportion of the expenditure on equipment and adaptations has been nearly 4% during the recent 5 years. <Figure 2> shows the proportions of expenditures on community social services on major populations.

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<Figure 4> Proportions of Expenditures on Community Social Services by Populations (2006-2007)



Source: CSCI. 2009. The state of social care in England 2007-2008.

### 3. Home Care by the Types of Providers

<Table 4>~<Table 7> show the proportion of home care provided by the government and those purchased from private organizations (for-profit and not-for-profit) separately by the major index (the total amount of service hours, service hours per week, the number of users and providers). The yearly trend of total home care service hours indicates that the total time increased by 150% from 1993 to 1999, by 200% from 1993 to 2005, and by 230% from 1993 to 2008. Specifically, the total home care time has continuously increased since the 1990s.

The change rates in total home care time according to the characteristics of service providers show that the proportion of service hours provided by local governments was over 95% in 1993, which was the year the NHSCCA was first enacted. During that year, the proportion of time provided by private organizations was less than 5%. However, the proportion provided by private organizations increased to over 50% in 1999. In 2005, the proportion of home care provided by local governments was 26.6% and that by private organizations was 73.4%. By 2008, the proportion by private organizations increased to 81.3% and that by the local government decreased to 18.7%. It can be said that by the end of the 2000s, most home care services were provided by private organizations.

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&lt;Table 2&gt; Change in home care time by the characteristics of providers (1993-2008)

| YEAR | TOTAL     | LOCAL GOV. | PRIVATE ORG. |
|------|-----------|------------|--------------|
| 1993 | 1,780,800 | 1,696,000  | 86,600       |
| 1994 | 2,215,100 | 1,787,000  | 428,200      |
| 1995 | 2,395,700 | 1,688,900  | 706,800      |
| 1996 | 2,486,700 | 1,581,200  | 900,900      |
| 1997 | 2,607,500 | 1,506,500  | 1,101,000    |
| 1998 | 2,607,400 | 1,410,500  | 1,197,000    |
| 1999 | 2,684,200 | 1,324,200  | 1,360,100    |
| 2000 | 2,791,300 | 1,241,100  | 1,550,200    |
| 2001 | 2,881,700 | 1,161,900  | 1,719,800    |
| 2002 | 2,983,200 | 1,078,600  | 1,904,600    |
| 2003 | 3,174,800 | 1,043,700  | 2,131,100    |
| 2004 | 3,359,000 | 1,022,400  | 2,336,600    |
| 2005 | 3,576,800 | 952,100    | 2,624,700    |
| 2006 | 3,726,000 | 920,000    | 2,806,000    |
| 2007 | 3,874,300 | 843,100    | 3,031,200    |
| 2008 | 4,082,900 | 764,100    | 3,318,800    |

\* excluded the services by direct payment

Source: The Information Center for Health and Social Care, 2008. Community Care Statistics 2008: home care services for adults, England.

The number of home care users was 514, 600 in 1993; 421,000 in 1999; 370,000 in 2005; and 338,500 in 2008. These results indicate that the number of home care users have continuously decreased since the early 1990s. The main reason of this decrease, even though total home care time increased to 230% from 1993 to 2008, is that home care has been concentrated to those with high demand for care and also to the poor. It has been more and more difficult to obtain an entitlement for home care. Related to this trend, the problem of overly strict service entitlement, territorial deviation, and lack of prevention intervention became the main policy issues (Hwang, 2008).

The proportion of users utilizing services provided by the local government among all social service users in 1993 was 96%; only 4% of the users were utilizing services provided by private organizations during that year. However, the numbers of users utilizing private organizations rapidly grew during the 1990s ending at nearly 40% in 1999. The proportion of service users from the local government was 32.4%, and that of users from private organizations was 67.6% in 2005, and 22.5% and 77.5%, respectively, in 2008. It is no exaggeration to conclude that most service users came to utilize services provided by private organizations by 2008.

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&lt;Table 3&gt; Numbers of Users by the Characteristics of Providers (1993-2008)

| YEAR | TOTAL   | LOCAL GOV. | PRIVATE ORG. |
|------|---------|------------|--------------|
| 1993 | 514,600 | 495,800    | 18,900       |
| 1994 | 538,900 | 479,300    | 59,600       |
| 1995 | 513,600 | 419,600    | 93,900       |
| 1996 | 491,100 | 370,200    | 121,000      |
| 1997 | 479,100 | 335,100    | 144,000      |
| 1998 | 447,200 | 284,500    | 152,700      |
| 1999 | 421,000 | 253,100    | 167,900      |
| 2000 | 415,800 | 225,800    | 190,000      |
| 2001 | 399,900 | 194,100    | 205,800      |
| 2002 | 383,100 | 167,600    | 215,600      |
| 2003 | 376,300 | 149,500    | 226,700      |
| 2004 | 370,900 | 134,100    | 236,800      |
| 2005 | 370,000 | 119,800    | 250,300      |
| 2006 | 358,100 | 104,900    | 253,200      |
| 2007 | 345,300 | 88,900     | 256,400      |
| 2008 | 338,500 | 76,000     | 262,500      |

\* excluded the services by direct payment

Source: The Information Center for Health and Social Care, 2008. Community Care Statistics 2008: home care services for adults, England.

The number of home care service hours per week was 3.5 in 1993; it increased to 6.3 in 1999, 10.1 in 2005, and 12.4 in 2008. The number of hours per week in 2008 was 3.5 times more than that in 1993. The trend of service hours analyzed, according to the characteristics of service providers, is as follows. In 1993, home care service hours per week provided by the local government were 3.4, whereas that by private organizations was 4.6. Home care service hours per week provided by the local government was 5.2, and that by private organizations was 8.1 in 1999, 7.9 and 10.5, respectively, in 2005, and 10.0 and 12.6, respectively, in 2008.

This trend shows that home care service hours per week by private organizations are much more than those by the local government. This is because the cases demanding intensive care tend to use services by private organizations rather than those by the local government. Intensive cares are often accompanied with holiday care and night care, which private organizations can much easily provide than the local government. In general, local governments should obtain an agreement from the Labor Union or change the agreement conditions for public officials in order to change the fixed working schedules (Woo, 2006).

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<Table 4> Home care service hour per week by service providers (1993-2008)

| YEAR | TOTAL | LOCAL GOV. | PRIVATE ORG. |
|------|-------|------------|--------------|
| 1993 | 3.5   | 3.4        | 4.6          |
| 1994 | 4.1   | 3.7        | 7.2          |
| 1995 | 4.7   | 4.0        | 7.5          |
| 1996 | 5.1   | 4.3        | 7.4          |
| 1997 | 5.4   | 4.5        | 7.6          |
| 1998 | 5.8   | 5.0        | 7.8          |
| 1999 | 6.3   | 5.2        | 8.1          |
| 2000 | 7.0   | 5.5        | 8.2          |
| 2001 | 7.5   | 6.0        | 8.4          |
| 2002 | 8.1   | 6.4        | 8.8          |
| 2003 | 8.7   | 7.0        | 9.4          |
| 2004 | 9.1   | 7.6        | 9.9          |
| 2005 | 10.1  | 7.9        | 10.5         |
| 2006 | 10.8  | 8.8        | 11.1         |
| 2007 | 11.6  | 9.5        | 11.8         |
| 2008 | 12.4  | 10.0       | 12.6         |

\* excluded the services by direct payment

Source: The Information Center for Health and Social Care, 2008. Community Care Statistics 2008: home care services for adults, England.

The number of service providers, according to their characteristics, shows that private organizations are much larger than that of the local government. The proportion of private organizations is increasing every year. In 2004, the proportion was 70%, and it increased to 75% by 2008.

<Table 5> Number of Home Care Providers by Characteristics (2004-2008)

| YEAR<br>(REF. MARCH 31) | TOTAL | GOV. | NOT-<br>FOR-<br>PROFIT | FOR-<br>PROFIT | NHS | OTHERS |
|-------------------------|-------|------|------------------------|----------------|-----|--------|
| 2004                    | 1,881 | 340  | 173                    | 1,320          | 7   | 41     |
| 2005                    | 4,111 | 731  | 364                    | 2,910          | 32  | 74     |
| 2006                    | 4,632 | 794  | 409                    | 3,286          | 41  | 102    |
| 2007                    | 4,729 | 717  | 390                    | 3,473          | 48  | 101    |
| 2008                    | 4,897 | 680  | 388                    | 3,687          | 47  | 95     |

Source: CSCI. 2009. The state of social care in England 2007-2008.

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#### 4. Policy Responses to Welfare Pluralism

The number of total service hours (<Table 4>) and that of service providers (<Table 7>) shows the changes in the characteristics of service providers. The proportion of total home care hours in 2008 indicates that the service hours provided by the local government was 19.7%, whereas that provided by private organizations was 81.3%. Meanwhile, in 2008, the proportion of governmental providers in terms of numbers was 11.8%, whereas that of private organizations was 83.2%. This means that the average size of private organizations would be smaller than government agencies. In effect, in the realm of home care services, most private organizations are small sized, holding less than 100 service users, which might be the most vulnerable characteristics (CSCI, 2009). This type of vulnerability might be connected to the problems of service quality. In order to lessen the problems owing to this vulnerability, the UK has tried to establish a proper quality management mechanism.

The Labor Party, as a ruling party in 1997, did not considerably change the policy framework of marketization and privatization of community care, which had been established by the Conservative Party. However, the Labor Party accepted the criticism that marketization strategies of the Conservative Party excessively emphasized the competitions among service providers, and that those strategies did not fully service the users' right of choice. The Labor Party, therefore, tried to construct a powerful service quality management institution in order to increase service stability and to ensure the safe choice of service users. This policy was implemented under the slogan of "Modernizing Strategy". Service quality mechanism was integrated based on the Care Standard Act (2000).

The major changes due to the Care Standard Act are as follows. First, the National Care Standards Commission (NCSC) was established. The mission of this organization was to register and monitor health and care service providers in order to enhance the quality of social care services. In 2004, this organization was separated to the CSCI (Commission for Social Care Inspection), and took full charge of the quality management of social care services. In 2009, the function of quality management for both health and social care services was integrated into the CQC (Care Quality Commission). Nevertheless, the changes occurred frequently and the basic principles and criteria were kept consistently.

Second, the National Minimum Standards for institutional and domiciliary services for the elderly and the disabled were established; this was used for registering and evaluating the regular inspection. Third, the Criminal Records Bureau was also constructed. This organization took charge of reviewing the criminal records of social service providers, which had been previously conducted by the policy department. Forth, the General Social Care Council was established in order to enact the code of ethics for the social care service field, and to manage the social service labor force.

The new quality management system, which unified the management practice separately, was applied to 150 local governments, respectively. Moreover, it encompassed home care services, which were not officially managed before. It also unified the rules applied to the private and public area differently. Newly introduced national minimum standards were first

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established to be applied to all organizations nationwide. The NCSC (changed to CSCI, and currently CQC) has endeavored to manage service providers and also produced concrete guidelines to be kept to the national minimum. The NCSC also has the authority to enforce strong sanctions on service providers who do not meet the minimum standards or to those who violate the rules.

In 2003, the proportion of service providers meeting the national minimum shows that the proportion was the highest among not-for-profit organizations, whereas that of for-profit organizations was the lowest. The proportion of government agencies were in the middle. Overall, the proportion of service providers over the national minimum standards has been growing higher since 2005, which applies to all the characteristics of the service providers. Since the proportion of for-profit organizations is overwhelmingly large, the proportion of for-profit organizations meeting the national minimum standards is similar to that of the whole social service providers. Therefore, the quality control mechanism of home care came to focus on the quality of services from for-profit organizations.

<Table 6> Proportions of meeting the national minimum standards by the characteristics of providers (2005-2008)

| YEAR<br>(REF. MARCH 31) | TOTAL | GOV. | NOT-FOR-<br>PROFIT | FOR- PROFIT |
|-------------------------|-------|------|--------------------|-------------|
| 2005                    | 66%   | 63%  | 75%                | 65%         |
| 2006                    | 72%   | 72%  | 76%                | 72%         |
| 2007                    | 78%   | 78%  | 83%                | 77%         |
| 2008                    | 82%   | 83%  | 87%                | 81%         |

Source: CSCI. 2009. The state of social care in England 2007-2008.

## IV. Conclusion

Since the 1960s, the proportion of cash benefit has decreased, whereas the number of beneficiaries of social services as an in-kind benefit has increased in the U.S. In particular, it has been emphasized in constructing a policy environment that service users as consumers in order to have a power to select service providers in the U.S. It is essential that a certain number of service providers should be secured in order to assure the right of choice among service users and to establish the stable base of service provision. In the U.S., a large number of for-profit organizations have entered the social service field since public budgets on social service rapidly grew in the 1960s.

As a result, the proportion of for-profit organizations in the social service field has continuously increased, while those of not-for-profit organizations or government agencies have decreased. The changes in proportions of service providers, in terms of their

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characteristics, as shown above, are closely related with those in the way of reimbursing social service costs to service providing organizations. Also, there are differences in service contents according to the types of service providers. For instance, chronic daily care in home health services tend to be provided by for-profit organizations, whereas not-for profit organizations have the tendency to provide services such as post-hospitalization.

Moreover, it is quite different in the number of service providers between urban and rural area. A rural area has a different condition in terms of accessibility to service users, the possibility of securing volunteers, and referring the cases from an urban area. Due to such differences, it can be stated that not-for-profit organizations are more appropriate than for-profit organizations as social service providers in a rural area (Skinner & Rosenberg, 2006).

Along with the continuous increase of for-profit organizations, the necessities of managing the quality of social services have been emphasized. In 1996, the NPI institution was established as a unified quality control mechanism, which should be applied to all service organizations on a nationwide level. Both the federal government and the state government utilize the NCQA, which is a private quality assuring organization for the social care field, established in 1990.

In the UK, local governments have kept deducing their direct providing role in social services and increasing their service purchasing role, since the NHSCCA was enacted in 1990. 20 years after, the community care provided brought changes in decreasing institutional services and increasing the community-based care. In the realm of home care services, the total number of service hours considerably increased, whereas the number of service users relatively decreased. The number of service organizations consistently and largely increased every year. Primarily, the number of for-profit organizations grew very rapidly, so that the proportion of for-profit organizations was 75% in 2008. This trend was intentionally designed since 1990 when NHSCCA was legislated (Filinson, 1998), and this intention was fulfilled by the government's consistent interventions.

It was found that for-profit organizations are relatively smaller and more vulnerable than other types of service providing organizations. Dealing with this problem, the UK government systematically established a quality management framework in order to prevent the deterioration of service quality related to the increase of for-profit organizations. In 2000, the Care Standard Act was conducted in order to implement a nationwide quality management system. According to this act, the independent institution took full charge of the quality management (currently CQC), and the institution of national minimum standard for social care was established. By standards, service organizations should registered and be inspected. Owing to this effort, the level of fulfillment meeting the national minimum standards has consistently increased; nevertheless, social care services are highly dependent on for-profit organizations.

In South Korea, the proportion of for-profit organizations is already very high in long-term care insurance. Among 4,174 care homes in April 2012, the number of local government

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agencies is 109 and the number of not-for profit organizations is 1,412. Further, for-profit organizations are 2,608, the proportion of which is up to 63%. Among 8,656 organizations providing in-home care services, 30 organizations are run by the local government and 1,594 are run by not-for-profit organizations. 6,978 organizations are for-profit organizations, the proportion of which is 81%.

Since the proportion of for-profit organizations is very high and furthermore, growing more and more, the proper policy responses are crucial issues for the success of social care policy. The increase of for-profit organizations is a common phenomenon for countries to emphasize the right of choice among social service users. This trend can be understood as one of a neo-liberalistic policy approach, which lessens the role of the government as a service provider and refers the service providing role to private organizations.

However, in the U.S. and in the UK, for-profit organizations have developed their own roles, such as providing services needed for chronic or serious disease need, rather than for mild cases. Also, they are likely to provide irregular care services, such as weekend or night care. In South Korea, heavy care needs are increasing as the number of the elderly are growing and growing. This trend is apt to encompass the increasing need for night or weekend care. Responding to these needs, small sized for-profit organizations would increase in the near future, which in turn may increase the importance of establishing a quality management system. Similar to the U.S. and the UK, South Korea also has to establish a systematic quality management institution, which would take full charge of setting up management standards and implementing those rules to providers on a nationwide level.

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