

Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom

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THE INTEGRATION OF ACUTE AND LONG-TERM CARE for persons with disabilities and chronic illnesses has received support in both the United States and the United Kingdom as a means to efficiency, user satisfaction, and better outcomes (Davies 1995; Social Services Inspectorate 1995b; Vladeck 1995). Integration could address cross-system care problems, including poor coordination of services and benefits, cost shifting, and frustration for users in accessing services.

The term “integration” has taken on a wide range of meanings, however, as it can signify anything from the closer coordination of clinical care for individuals to the formation of managed care organizations (MCOs) that either own or contract for a wide range of medical and social support services. Part of the debate, indeed, concerns the degree to which financial and organizational integration is needed to achieve clinical integration (Leutz, Greenlick, and Capitman 1994; Wiener and Skaggs 1995). Nor is there agreement about who should be in charge of integration, whom it should target, what supportive structures are needed, or what to call it (Harrington, Lynch, Newcomer, et al. 1993; Leutz, Greenlick, Ervin, et al. 1995). One purpose of this paper is to draw such distinctions more clearly.

Integration is defined, for the purposes of this paper, as the search to connect the health care system (acute, primary medical, and skilled)

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with other human service systems (e.g., long-term care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency). Populations that may benefit from integration have physical, developmental, or cognitive disabilities—often with related chronic illnesses or conditions. Integration can occur at the policy, finance, management, and clinical levels. The means of integration include joint planning, training, decision making, instrumentation, information systems, purchasing, screening and referral, care planning, benefit coverage, service delivery, monitoring, and feedback.

I will review integration efforts in both countries with these goals in mind:

1. demonstrating which approaches have worked and which have not
2. synthesizing important lessons for policy makers, professionals, and providers
3. recommending directions for the future

Although there is clearly much left to learn, innovators should build on the hard base of experience, rather than relearning what works and repeating past mistakes. To highlight the lessons, they are proposed as “laws of integration.” First, however, the structures of the US and UK health care systems are briefly reviewed, particularly the efforts in both countries to integrate acute and long-term care.

Health Care Systems and Integration in the United States and the United Kingdom

The two countries have very different systems of acute and long-term care. A half century ago, the United Kingdom created the National Health Service (NHS), a nationally funded, universal coverage system for acute, primary medical, and skilled care that is free to users at the point of delivery. The NHS is administered by the Department of Health, which works through regional and district health authorities. Hospital care and community nursing are delivered, respectively, through publicly owned hospital and community “trusts.” General practice (GP) physicians contract with district health authorities under terms that are set nationally. Its central authority for operating budgets, capital, and wages and salaries has allowed the United Kingdom more effective

control over total health care spending than is possible in the United States. A small, but growing, private insurance and provider sector specializes in services, like elective surgery, that may be difficult to obtain through the NHS.

The United States has multiple approaches to financing and delivering medical care. Most of the working-aged population and their families are insured through employers, who either contract with insurers and MCOs or purchase care directly from provider networks. Disabled workers and the elderly are covered by the national Medicare program, which purchases care from individual providers on a fee-for-service (FFS) plan and also contracts with a growing variety of MCOs. The very poor are covered through the federal–state Medicaid program, which in most states is moving rapidly toward an exclusively managed care contracting and delivery mode. More than 40 million persons (about one-sixth of the population) have no health insurance and must fall back on their own resources, local indigent care funds, or charity care. The majority of service providers are privately rather than publicly owned, and all types of providers (hospitals, nursing homes, home health agencies, and even physician practices) are increasingly being converted from nonprofit–individual ownership to for-profit–corporate chain ownership.

The two countries' long-term-care and other human service systems do not differ as markedly as their health care systems. The states and localities (counties and cities) that manage and finance such nonmedical care in the United States find their counterparts in British local authorities. Both countries' state and local systems receive partial national funding under flexible guidelines. Means testing for long-term care is also a hallmark of both countries, as is the private provision of many services (both private provision and means testing have increased during the last decade in the United Kingdom).

Although their health care systems differ, both countries face some of the same challenges: increasing numbers of persons with disabilities; the closure of public hospitals for persons with physical, mental, and developmental disabilities; increasing costs for acute and long-term care; shorter acute-care stays that shift care to the community; and fiscal pressures at national and local levels. Both countries also have had to struggle with parallel changes in social welfare paradigms, incorporating the sometimes conflicting ideologies of privatization, devolution, care management, markets in care, and user–carer rights. (The British term “carer” is used here, rather than the US term “caregiver,” to refer

to family and friends providing care.) The next two sections review how the two countries have experimented with new paradigms to integrate care for populations with special needs.

UK Systems and Initiatives

The UK health and social services systems traditionally have been characterized by organizational separation, like that, for example, between community and hospital physicians and between NHS medical services and local authority social services. There also are long-standing efforts, however, to bridge these divisions through joint consultation committees and community health councils, as well as through cooperative operational and purchasing mechanisms, like joint commissioning (Light 1994; Small 1989; Schulz and Harrison 1984; Klein 1979). Such efforts unite separate bodies (e.g., district health authorities, hospital trusts, community trusts, and local authorities) to better meet the needs of population subgroups that use multiple services.

The last decade saw major health and social services reforms in the United Kingdom. Beginning in the late 1980s and early 1990s, the Conservative government introduced internal markets in the NHS, privatization of long-term-care service delivery, and stronger means testing for long-term-care services offered by local authorities. Professional leadership was deemphasized in favor of managerialism in both sectors. Although it is unlikely that full-blown MCOs will be established in the United Kingdom, the ideas of demand management, medical management, and care delivery are popular (Smith 1997). Several major reforms were initiated with a bearing on integration:

- The Community Care Act (1990): strengthened care management in long-term care and directed health authorities and local authorities to cooperate in planning and purchasing services for certain population subgroups, like persons with learning disabilities (Greig 1997; Social Services Inspectorate 1995b; Waddington 1995).
- GP fundholding (1990): allowed private GP practices to finance and contract for more than their own services. Although it does not allow GPs to purchase long-term care from local authorities, they can purchase home health and nursing-home care (National Health Service Management Executive 1993; Weiner and Ferriss 1990).

- Total Purchasing Pilots (TPPs) (1995): expanded the range of health services commissioned by GPs through 53 pilot projects. The expanded services are still paid for by district health authority budgets, but the program allows GPs to participate in planning for long-term-care populations (Mays 1997b; Myles, Popay, Wyke, et al. 1997).

In December, 1997, the Blair government released a blueprint for NHS reform that will abolish fundholding and the internal market and create 500 primary groups; each will have about 50 GPs and will serve 100,000 patients (Department of Health 1997). The groups will be responsible for more planning (e.g., for regional health improvement plans) and, by virtue of these increased responsibilities, could themselves eventually become free-standing primary care trusts. The reforms may reflect the fact that the market-based reforms envisioned in the creation of GP fundholding have not found fertile soil in the tradition-bound NHS (Klein 1995; Light 1997a). I will discuss below the ways in which planning and purchasing through new, larger groups of GPs will present its own set of opportunities and challenges.

US Systems and Initiatives

In contrast to the United Kingdom's public reorganization of largely public systems, US policy makers must achieve integration largely through private managed care models. Despite great variation in the details, three generic models are being developed: those that integrate acute care; those that integrate long-term care; and those that try to integrate both.

Acute-care initiatives include:

- *Medicare HMOs*: These organizations receive a capitation for beneficiaries who enroll voluntarily. About 10 percent of Medicare beneficiaries have joined to date (Welch 1996). The 1997 Balanced Budget Act contains provisions to expand sponsorship options and enrollment.
- *Medicaid HMOs*: Until recently, most states exempted the aged, blind, and disabled from mandates that other beneficiaries face to join HMOs. This is changing in many states, including some (Minnesota and Tennessee) that are stimulating providers by requiring

both state workers and Medicaid beneficiaries to join contracted plans (U.S. General Accounting Office 1996; Iglehart 1992).

Initiatives designed to consolidate long-term care include:

- Gatekeeping systems: A single agency—sometimes public and sometimes private—in each region manages entry to all important sources of long-term-care funding. At least two states (Oregon and Massachusetts) permit management agencies to assume some financial risk (Kane, Kane, Haye, et al. 1996; Leutz, Sadowsky, and Pendleton 1992).
- Managed long-term care: Arizona Medicaid contracts with one organization in each county (usually the county itself) to manage long-term care on a capitated basis (McCall and Korb 1994). Florida has a two-site demonstration, in which HMOs receive a capitation covering all long-term care for beneficiaries who enroll voluntarily.

The third category, initiatives that integrate the financing and delivery of both acute and long-term care on a capitation basis, covers both full-population and “carve-out” models. The former seek to enroll both frail and nonfrail persons. The latter enroll only persons with disabilities. Examples of full-population models include the following:

- Social HMOs: These demonstration MCOs were launched in 1985 and enroll a cross-section of Medicare beneficiaries over age 65. All enrollees receive Medicare benefits, while the frail subgroup is eligible to receive a finite long-term-care supplement that is controlled by a care management unit (Leutz, Greenlick, and Capitman 1994; Leutz, Greenberg, Abrahams, et al. 1985).
- Minnesota Senior Health Options (MSHO): a Medicaid demonstration project that allows dually eligible beneficiaries to choose among competing MCOs for all covered acute- and long-term care (Minnesota Department of Human Services 1997).

Examples of carve-out models include the following demonstration MCOs:

- On Lok/Program for All-inclusive Care for the Elderly (PACE) enrolls community residents over age 65 who meet nursing-home

entry requirements and who are eligible for both Medicare and Medicaid (dual eligibles). All the enrollees' acute and long-term care is managed by a multidisciplinary day center team (Ansak and Zawadski 1984; Branch, Coulam, and Zimmerman 1995; Kane, Illston, and Miller 1992).

- The Wisconsin Partnership enrolls either elders or working-aged adults with physical disabilities. All the enrollees' physicians' services, hospital care, and long-term care are coordinated by the MCO (Hamilton 1995).

This brief summary of the US and UK systems and integration initiatives reveals both common goals and significant contrasts in systems. In the remaining sections, I will analyze how these and other initiatives have worked, with an eye toward finding parallels and lessons for future policy and practice. It appears that the Labour party will lead the United Kingdom away from the Conservatives' plans to cede considerable control of health services delivery to powerful private organizations (Wilkin, Butler, and Coulter 1997); the new primary groups will face management, information, and contracting challenges analogous to those confronting large HMOs. As the United States advances toward more structured integration within and between managed care systems (Wiener and Skaggs 1995), it should consider the experiences of UK medical and long-term-care personnel who have been tackling the same issues in public managed systems. In the interest of provoking action and discussion, I have formulated the lessons and parallels as five "laws of integration." Following the presentation and discussion of these laws, I will conclude with lessons and recommendations.

Laws of Integration

1. You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people.

This paraphrase of Abraham Lincoln's insight about fooling the people addresses choices about narrow versus broad efforts to integrate. To date, the first part has received the most attention, and it is epitomized by the ideal of the interdisciplinary team that is empowered to cut across systems (e.g., being authorized to offer acute and long-term care and to provide housing services in On Lok/PACE). This strategy has raised one

question that has received much attention (who needs integration?) but has diverted attention from another (what should be done for everybody else?). A comprehensive approach to integration will shape whole systems to enable them to respond to the varied needs of all persons with disabilities.

Who needs what level of integration cannot be answered with empirical data, but some dimensions of need and the operational domains of service systems that may shape the answer can be suggested. First, need dimensions include the stability and severity of patients' conditions, duration (short, medium, long, end-of-life), urgency of the intervention (is it needed today, next week, next month?), scope (number and complexity of service and benefit systems), and the users' or carers' capacity for self-direction. It seems logical that, at the extreme, subgroups characterized by limited capacity for self-direction and by long-term, severe, unstable conditions that require urgent interventions from both acute and related systems may benefit from more integration. Groups that score on the other end of these dimensions might be candidates for less. Second, there are operational domains in which integration can be structured in service systems: systems to identify persons with disabilities; clinical practices that are responsive to the needs of these persons; management of transitions across settings; information gathering and exchange; case management; management of funds from multiple payment sources; and coordination of benefits.

Table 1 illustrates the first law by describing three levels of integration: linkage, coordination, and full integration. The table is designed to answer the question of how the acute care and the "other side" (e.g., long-term care, education) work together. The first seven entries compare the three levels with regard to the seven different operational domains for integration. The final entry lists the six dimensions of need and gives profiles that can be addressed by each level of integration.

"Linkage" allows individuals with mild to moderate or new disabilities to be cared for appropriately in systems that serve the whole population without having to rely on outside systems for special relationships. Linkage begins with population screening to identify emergent needs. This can be done through population surveys (like those performed in the Social HMOs) (Leutz, Abrahams, Greenlick, et al. 1988), analysis of clinical and administrative data, and in the course of clinical practice. Clinicians are taught to understand the basic special needs of different categories of persons with disabilities, for example, by knowing to check for sensory impairments in patients with Down syndrome (Valk, Akker,

Maskaant, et al. 1997). Personnel from nonmedical systems also establish links, for example, by noticing when clients are not taking medications and contacting medical personnel with the information. When more serious conditions are identified, professionals know where it is appropriate in other systems to send people and how to ensure that they get there. They are ready to provide more information about care when asked or to make inquiries for the benefit of patients who need to know more about topics that affect them. In systems with linkage, providers on both sides understand who is responsible for payments for each type of service and who is eligible for what benefits, and they follow the rules of coverage and payment rather than trying to shift costs and responsibility. Because systematic linkage has seldom been fully implemented in the current system, its pursuit promises to improve system performance (Kerr, Fraser, and Felce 1996).

At the second level, "coordination," explicit structures and individual managers are installed to coordinate benefits and care across acute and other systems. Coordination is a more structured form of integration than linkage, but it still operates largely through the separate structures of current systems. Coordination focuses on persons receiving benefits simultaneously or sequentially from two systems of care on either a short- or a long-term basis. The main tasks are coordinating benefits (where does health coverage end and long-term care begin?); coordinating use of services; sharing clinical information in a planned manner; managing transitions between settings; and assigning primary responsibility for coordinating care. It goes beyond linkage by developing and implementing policies in these areas. The Social HMO sites have generally operated at the linkage and coordination levels of integration. For example, when frail members are hospitalized, the care management unit is informed of admissions so that home care is terminated. Discharge planners are trained to identify current or potential clients for case management and to know the eligibility criteria for long-term-care services. After discharge, communications are established between skilled home health and long-term home care to share responsibilities and transition to long-term care (Leutz, Abrahams, Greenlick, et al. 1988). In summary, coordination identifies points of friction, confusion, or discontinuity between systems and establishes structures and processes to address problems (Social Services Inspectorate 1995b).

The third level, "full integration" creates new programs or units where resources from multiple systems are pooled. Examples include the interdisciplinary team at the PACE day center and joint commissioning

TABLE 1
Levels of Integration: How Do You Work with the “Other Side”?

Operations	Linkage	Coordination	Full integration
Screening	Screen or survey populations to identify emergent needs	Screen flow at key points (e.g., hospital discharge) to find those who need special attention (e.g., CM, MD consult)	Not important except to receive good referrals (changing needs identified and met through team members)
Clinical practice	Understand and respond to special needs of PWDs in primary care, LTC, education, etc.	Know about and use key workers (e.g., discharge planners) to link	Multidisciplinary teams manage all care
Transitions/service delivery	Refer and follow up	Smooth the transitions between settings, coverage, and responsibility	Control or directly provide care in all key settings
Information	Provide when asked; ask when needed	Define and provide items/ reports routinely in both directions	Use a common record as part of daily joint practice and management

Case management	None	Case managers and linkage staff (e.g., an MD rep on the CM team)	Teams or “super” case managers manage all care
Finance	Understand who pays for each service	Decide who pays for what in specific cases and by guidelines	Pool funds to purchase from both sides and new services
Benefits	Understand and follow eligibility and coverage rules	Manage benefits to maximize efficiency and coverage	Merge benefits; change and redefine eligibility
Need dimensions			
Severity	Mild/moderate	Moderate/severe	Moderate/severe
Stability	Stable	Stable	Unstable
Duration	Short to long term	Short to long term	Long term or terminal
Urgency	Routine/nonurgent	Mostly routine	Frequent urgency
Scope of services	Narrow–moderate	Moderate–broad	Broad
Self-direction	Self-directed or strong informal	Varied levels of self-direction and informal	May accommodate weak self-direction and informal

Abbreviations: CM, care management; LTC, long-term care; PWD, person with disabilities.

teams set up to facilitate deinstitutionalization of dually diagnosed patients (Waddington 1995) and other challenging populations (Cambridge 1997). Rather than better coordinating services and benefits of existing systems, the fully integrated program gains control of resources to define new benefits and services that it controls directly. Rather than sharing information across systems, its providers work from a common record.

The final entry of table 1 outlines the types of needs that might be served by linkage, coordination, and full integration. It posits that linkage is the most appropriate way to identify new needs and to begin integrating services for many persons with disabilities who have both mild or moderate impairments and stable medical and functional conditions that are unlikely to destabilize and thus to require urgent attention. Linkage candidates may receive services in both medical and long-term-care or other settings, but they require little in the way of ongoing communication or coordination, and these patients themselves or their families may be willing and able to manage. Coordination may be appropriate for a broad range of persons with moderate to severe conditions who receive short-term or long-term special services and whose care is usually, but not always, routine. A critical difference from linkage is that, when urgent or complex circumstances arise, there are systems and personal relationships in place to identify changes and to ensure coordination, particularly when the user's or family's capacity for self-direction is limited. Full integration probably is appropriate only for a small subset of each group of persons with disabilities. Full integration may need specialized types of interventions, expedited access to them, close collaboration between knowledgeable professionals, and the like. Defining the persons who belong in such programs, assembling the necessary services, and allocating appropriate resources (enough to do the job but not so much as to short-change other groups) are among the most pressing issues in integration policy and practice.

To develop integration priorities more systematically, the needs of various subgroups can be identified by analyzing utilization patterns, health conditions, and user concerns about the quality of health care, long-term care, and other important service systems. Depending on the population, the additional benefit systems might include long-term care, behavioral health, education, housing, or vocational rehabilitation. For example, persons with learning (developmental) disabilities often have more pressing concerns, like the need for housing (Prosser 1997)

and supports for vocational, educational (Social Services Inspectorate 1994; 1995c), and leisure services (Greig 1997; McGrother, Hauck, Bhaumik, et al. 1996). Each major group of persons with disabilities may contain one or more subgroups that are characterized by particular urgency (e.g., serious mental illness in addition to developmental disability; terminal and debilitating illness; or specific transitions, like those from school to work and hospital to home). The relative importance of health and various other service systems can be expected to change over the life cycle (Leutz 1999; Social Services Inspectorate 1995a).

2. Integration costs before it pays.

Saying that integration costs before it pays raises a caution sign when promises of cost offsets are used as a selling point. The second law posits that the savings from integration are hopes, whereas the costs cannot be avoided if success is to be achieved. Whether the former outweigh the latter to create net savings will depend on specific situations and must be subjected to careful analysis. There are at least three types of costs to integration: staff and support systems, services, and start-up.

Staff and Support Systems. Depending on the scope of integration, staff should be involved at the clinical, management, and policy levels. At each level it takes time to learn about the capabilities of the other system, to decide how to work together (including changing to improve the fit), and to communicate. There are up-front costs, ongoing operational costs, and future costs arising from evaluation and change. Complaints about drains on staff time are common in evaluations of the major UK integration efforts (Glendinning and Lloyd 1997; Mays 1997b); in the United States, On Lok/PACE staffing appears to increase with the complexity of administering larger sites (Branch, Coulam, Zimmerman, et al. 1995). Successful integration requires any of a variety of support systems, including consolidated assessment forms and clinical and management information systems. Failure to increase budgets to train staff in new operations has hampered many integration efforts (Leutz 1994; Leutz, Capitman, MacAdam, et al. 1992; Leutz, Greenlick, Ervin, et al. 1995; Social Services Inspectorate 1994).

Estimates of the magnitude of staff and support costs are difficult to obtain because they are usually embedded in other costs. Efforts to integrate medical care provide some guidance. As managerialist schemes were implemented in the NHS, management costs increased from £1.2

to £2.1 billion between 1989–90 and 1993–94 (Ham 1995). Administrative costs of Medicare HMOs commonly run from 10 to 15 percent of revenues (Wiener and Skaggs 1995). Larger TPP sites tended to have dedicated managers, but lower per capita management costs, than smaller sites, suggesting the addition of management tasks to clinical tasks for physicians in smaller practices (see the Third Law) (Mays 1997b). The most prominent ongoing administrative cost entailed in integrating acute and long-term care is care management, which typically ranges between \$100 and \$150 per month per client served in long-term-care demonstrations and state programs (Leutz, Greenlick, and Capitman 1994; Phillips, Kemper, and Applebaum 1988; Thornton, Dunstan, and Kemper 1988), and even higher in PACE (Branch, Coulam, and Zimmerman 1995).

Service Costs. Experience shows that new service funding helps to facilitate integration. These may be particularly difficult funds to obtain from payers because promises are often made that integration initiatives will self-fund new services through “savings” when an existing service (ideally, lower-cost long-term care) is substituted for another. The problem with this tactic is that it is rare for people to give up control of “their” services to substitute for someone else’s. In the United Kingdom, attempts to integrate, which generally rely on voluntary cooperation, provide numerous examples of turf guarding by health authorities (Glendinning and Lloyd 1997; Greig 1997), social services (Myles, Popay, Wyke, et al. 1997), and even housing and educational authorities (Jones 1996). The problem may even be worse at policy than at operational levels: at one TPP site, for example, even though line staff were participating as members of a multidisciplinary geriatric team, policy-level staff of the local authorities avoided planning meetings because they were afraid of being saddled with health system costs (Myles, Popay, Wyke, et al. 1997). This suggests that one ingredient of success in integration experiments is the allocation of new service money designated for that purpose. There are precedents for such funding: Social HMOs’ funds from member premiums and the “extra” money they receive from Medicare for frail beneficiaries (Leutz, Greenlick, Ervin, Feldman, et al. 1991); money restricted to community care to support deinstitutionalization of persons with learning disabilities (Waddington 1995); generous Medicaid capitations to PACE and a Medicare capitation concession to MSHO (Branch, Coulam, and Zimmerman 1995; Minnesota Department of Human Services 1997); Medicare dem-

onstration funds to the program, Channeling, and its predecessors (Weisert, Cready, and Pawelak 1988); and new service funds for community-care experiments in the county of Kent (Davies and Challis 1986).

Start-Up Costs. Successful integration projects generally have been helped by significant start-up grants. In the United States, these include the first round of Social HMOs (Leutz, Greenberg, Abrahams, et al. 1985), PACE (Kane, Kane, Haye, et al. 1996), Wisconsin Partnership (Hamilton 1995), and MSHO (Minnesota Department of Human Services 1997). In the United Kingdom they include special transitional grants to implement Caring for People (Social Services Inspectorate 1995b) and TPP (Mays 1997b). In contrast to the Conservatives' additions to administration for the purpose of creating an internal market in the NHS, the new Labour plan to form primary groups of GPs is accompanied by a proposal to shift £1 billion from NHS administration to services (Horton 1998), a policy that does not bode well for successful integration.

As integration moves beyond the demonstration stage, it is harder to find funds for replication. Failure to anticipate these costs, which could legitimately be considered long-term investments (Davies and Challis 1986), is a typical shortcoming of public initiatives, which are often strapped for cash and may not recognize the new management, training, and supervision models that are required (Davies 1994; Leutz, Altman, Capitman, et al. 1992).

In summary, unless these start-up and continuing costs are paid, integration may not occur—either within or between organizations. Staff may not participate in planning, smooth support systems will not be developed, and inadequate training will hamper operations. If they are not compelled by strong policy or financial controls or lured by new service funding, subunits will hold on to the control of their services, and thus, their jobs. Furthermore, if the deal is not attractive to private providers and MCOs, they simply may choose not to participate.

3. Your integration is my fragmentation.

The driving interest in integration comes from providers, managers, and researchers who are intimately—perhaps exclusively—involved with a particular group that “needs” integrated services: poor and frail elders with chronic illnesses; infants with severe developmental disabilities; teens with physical or developmental disabilities who are making the

transition from school to work; adults with physical disabilities who are seeking control and autonomy. The would-be integrator's focus for change is on how quality, efficiency, access, user control, and the like break down as a person needs help from multiple professionals and benefit systems.

However, asking professionals and managers to integrate their services—or even simply to cooperate—not only creates costs (as covered in the Second Law), but also requires them to expand their knowledge, perspectives, and interests. My job as a manager, provider, or professional is much simpler if all I need to worry about is my own service. The more special groups and procedures I must work with, the more I need to learn and to accommodate. Even if I appreciate the potential of integration to improve the quality of my service or to create savings to the system and the service user, I may nevertheless still have a sense that my job is being fragmented.

The situation of primary care physicians is the most critical case in point. They have demanding, complex, and unique tasks. They already deal with the needs of varied patients while experiencing increased productivity demands. Asking them to add special information or actions for small subgroups of patients simply increases the already considerable pressure of their practice routines.

Evaluators of integration efforts frequently seem disappointed with the level and quality of physician participation or understanding (Myles, Popay, Wyke, et al. 1997; Plant 1997; Social Services Inspectorate 1994; Harrington, Lynch, Newcomer, et al. 1993). Whereas evaluators may or may not be correct in their characterizations, a closer look at a few examples of GP involvement in integration raises questions about the reasonableness of expecting more from GPs in small practices. One total purchasing site with seven physicians serving 16,000 patients added continuing and community care to its agenda for total purchasing discussions. However, they also added emergency–accident, mental health, maternity, and early discharge provisions. Not surprisingly, the most frequent complaint about TPP concerned the demands it placed on professionals' time (Mays 1997b). Similarly, when the implementation of Department of Health guidelines was evaluated, one finding was that physicians were reacting to their experience of “consultation fatigue” by seeking to limit the scope of discussions through categorizing continuing care policy as a health authority rather than as a physician issue (Glendinning and Lloyd 1997). Finally, in implementing the Social HMO demonstration, one large HMO site decided not to train its

several hundred physicians to handle the new program features because it had just trained them for a new Medicare HMO demonstration a few years earlier (Leutz, Greenberg, Abrahams, et al. 1985). Instead, training focused on clinic nurses as coordinating points. The site was later criticized by evaluators as not having integrated primary care and long-term-care case management (Harrington, Lynch, Newcomer, et al. 1993). The new Labour proposal to create primary groups of 50 GPs will mean a larger base to support administrators in the handling of integration issues, but delegating responsibilities to administrators will remove planners from the everyday, operational issues that smaller, cross-discipline teams have been able to address more successfully (Coulter 1996).

In summary, would-be integrators need to be sensitive to other demands on providers and to consider carefully what level of integration is appropriate to expect. Even providing information about how to identify and care for a special needs group and how to make appropriate referrals (the basic linkage level of integration) requires time and effort both to implement and to absorb. Coordination requires more attention, training, and cooperation from more people. Full integration reduces demands on the sections of the larger systems that are transferred to the integrated team, but coordination, and even linkage (for referrals), are required for functions that the team does not carry out.

4. You can't integrate a square peg and a round hole.

Logical though integration seems as a concept, there are underlying differences between acute and long-term care that have frustrated integration efforts. The sources of this square-round problem may derive from the different entitlement bases for the two types of benefits. First, in both the United States and the United Kingdom, health care benefits (at least for elders) are universal national entitlements, and even in the United States most persons under 65 have health insurance. In contrast, long-term-care benefits are individuals' out-of-pocket responsibility up to the point when they have "spent down" their means to a level where they are entitled to state or local authority service benefits. Second, access to health care is based on medical need as determined by physicians, whereas access to publicly funded long-term-care benefits is based on functional status, which is usually determined by nurses or social workers. Parallel clashes can occur between medical care and other systems; one example would be the

developmental focus of early childhood educators working with children who have learning disabilities. In summary, both long-term-care and health funding systems pay for similar and overlapping nursing-home, community, and home care services (the source of potential savings from integration), but the conditions under which they do so differ. Each of these differences creates targeting conflicts, management challenges, and cultural clashes that frustrate integration.

First, differences between functional and health status approaches are epitomized by the frequent conflicts between the front-line, community-based staff in the two worlds: home health (community) nurses and home care (home help) case managers. One government evaluation of the UK program, *Caring for People*, diplomatically observed that the program's professionals lacked a "shared hypothesis for integrated action" (Social Services Inspectorate 1995b, 45). Social services assessments were characterized by description, eligibility criteria, negotiation, social support systems, and long-term goals, whereas health assessments were characterized by diagnosis, clinical judgment, expert advice, individual health, and short-term goals. Social service staff tended to see case management as a way to "drive organizational change," whereas health authority staff tended to see it as a "distraction from purely health provision."

Second, long-term-care benefits are granted only to those who are financially eligible. This requires an integrated system to offer universal access based on need for one set of its services while denying access to many who need another set of services. This not only creates conflict and frustration among professionals; it also can be confusing and time consuming when, to take one example, tracking financial eligibility. Such a problem occurred in the United Kingdom when the NHS reduced the number of its geriatric units and turned patients over to local authorities (*Lancet* 1994). Most US demonstrations of integration have "solved" this problem by designing the system for Medicaid eligibles only (as in PACE, MSHO, and the Wisconsin Partnership), but even these segregated systems have problems collecting and recording share of cost for the many long-term-care users who "spend down": that is, users who become financially eligible for Medicaid because they use more health and long-term-care services than they can afford. Difficulties also arise when a system confronts differing Medicare and Medicaid regulations, particularly the requirement to offer Medicare beneficiaries freedom of choice among providers.

Third, long-term-care benefits, particularly for home-based and community-based (HCB) services, are chronically underfunded in both the United States and the United Kingdom. This is reflected in waiting lists, individual spending caps, geographic differences, and service exclusions for Medicaid and local authority HCB care (Bennet 1996; Baldwin and Lund 1996; Kassner 1995; Liu, Hanson, and Coughlin 1995; Wiener and Skaggs 1995). If these funding shortfalls are carried over into the integrated program, it is then forced to adopt its own system of rationing, which is contrary to standard medical practice and may or may not be consistent with public policy on rationing. Also, most local long-term-care systems have additional HCB services outside mainline funding streams (e.g., Older Americans Act, social services block grants, voluntary and self-help services, and, of course, informal care). The basis for substitutability of these services with integrated system services needs to be worked out to ensure that system members receive fair, but not special, access to them.

On the surface, the integrated Social HMO and PACE models seem to belie the Fourth Law. On closer examination, they do not. The first, and more straightforward, factor is that Social HMOs' greatest achievement in integration has been with the 90 to 95 percent of their members who are private pay. Financing is integrated by adding a finite, universal, privately funded long-term-care benefit to an HMO—thus avoiding means testing. In contrast, Social HMO arrangements for enrollment of Medicaid eligibles, for transition of private-pay members to Medicaid once they qualify by spending their assets, and for access to Medicaid long-term-care benefits have been cumbersome at all sites (Leutz and Hallfors 1993; Leutz, Greenberg, Abrahams, et al. 1985).

The PACE program does fully integrate Medicaid and Medicare funding and integrate management and clinical decisions in the interdisciplinary team operating in the day care setting, and its performance in reducing hospital and nursing-home utilization (and perhaps morbidity and mortality) is impressive (Gruenberg and Kaganova 1997; Burstein, White, and Kidder 1996). However, PACE has supports and exclusions that open the way for waste from a poor round-square fit (Branch, Coulam, and Zimmerman 1995; Kane, Illston, and Miller 1992). First, unlike Social HMOs, payment rates have not been adjusted downward when the functional status of PACE members improves. (Rates will be so adjusted under 1997 Balanced Budget Act provisions, granting PACE permanent status.) Second, even though PACE enrollees reside in the

community on application, the Medicaid payment rates are based on Medicaid's higher average institutional spending—not on its HCB spending (reflecting the underfunding of HCB services). If these features lead to payments that are higher than would have been the case had enrollees stayed with the regular system, it means that scarce resources are being taken away from beneficiaries who do not join PACE. A final shortcoming is that few non-Medicaid members can pay the Medicaid rate (\$2,000 to \$4,000 per month, or more). Low-income elders can spend down to Medicaid eligibility levels, but this requires them to give up nearly all assets and income.

Several states are pushing the integration envelope even further than Social HMO and PACE by seeking contracts with mega-MCOs to deliver both acute and long-term care on a prepaid basis. Like Ronald Reagan's Strategic Defense Initiative antimissile system, these integrated systems may work out on paper, but in reality the chances for malfunction are many. Voluntary enrollment and capitated financing increase the likelihood of low enrollment, biased selection, and inaccurate payment. Full risk raises the stakes, increasing the likelihood that the bottom line will be a major factor for providers in choosing when to participate, whom to target for enrollment, and when to quit if the experience turns bad. During the first six months of Minnesota's SHO, for example, the largest HMO was not participating, and the next largest was waiting to see if payment rates favored its strategy of enrolling nursing-home patients only.

In contrast to American private initiatives, the United Kingdom has taken largely administrative and joint planning approaches to these issues, promoting TPP sites and encouraging joint commissioning efforts to bridge the gap between acute and long-term care with joint planning, purchasing, and care management strategies. Where these initiatives have overcome the simple avoidance that originated from turf guarding, there have been reports of culture clashes between medical and social service personnel (Glendinning and Lloyd 1997; Myles, Popay, Wyke, et al. 1997; Rummery and Glendinning, 1997). Operational, case-by-case solutions to problems have been easier to find than resolution at the policy financing levels, where clashes arise over more fundamental issues. Integration also has worked better with populations for which there is a longer tradition of joint commissioning; persons with learning disabilities would form one example (Social Services Inspectorate 1995b).

In summary, "successful" US integration models make compromises on full integration in three ways:

1. by focusing on either private or welfare populations
2. by coordinating rather than integrating management and clinical care
3. by filling gaps in long-term care through adding money rather than (or perhaps in addition to) saving it

UK integration models, which spurn strong financial and enrollment incentives to create integrated programs, are weaker, but perhaps more practical. Although GP fundholder and joint commissioning initiatives appear seldom to have made changes at the policy level, the value added from linking and coordinating the systems operations so that they work better for both employees and users on a daily basis should be recognized. Until we dismantle the barriers between social insurance and means testing and between national and local funding, perhaps we cannot expect more.

5. The one who integrates calls the tune.

The first question about the Fifth Law will be, Why doesn't it read as follows?: "The one who *pays the integrator* calls the tune." The answer is that integration to date largely has been a provider–professional rather than a payer–public initiative. For a number of reasons, which might include the wish to foster innovation, a lack of consensus on policy, or insufficient resources to direct and monitor implementation, payers generally have left the choice of tunes to the pipers. Some questions remain: What tunes have been called, who has requested them, who has been left out, and what impact have the characteristics of the payers had on the nature of integrated programs?

The initiators of the major US demonstrations of integration (e.g., Social HMO, PACE, MSHO, Wisconsin Partnership) were long-term-care providers, researchers, and bureaucrats, rather than physicians (Ansak and Zawadski 1984; Leutz Greenberg, Abrahams, et al. 1985; Minnesota Department of Human Services 1997; Hamilton 1995, respectively). The priorities of these organizations are social and long-term-care benefits, and they sought to bring the medical system around to a social care orientation. In addition to their part in development, nonphysicians also take the lead in day-to-day integration in some models. In the first-round Social HMOs, integration has been led by the care management unit, staffed by a mix of social workers and nurses, and

supported by medical directors with a geriatric orientation. The involvement of primary care physicians with long-term care at the first-round Social HMO sites has been primarily reactive (Abrahams, Macko, and Grais 1992; Abrahams, VonStenberg, Zeps, et al. 1992). PACE physicians are part of the team leadership, but PACE has had a difficult time finding physicians who want to work in the multidisciplinary team (Branch, Coulam, and Zimmerman 1995; Kane, Illston, and Miler 1992). The government chose a design for second-generation Social HMOs that emphasizes geriatric care. A geriatrician has been in charge of their development, and, true to the tenets of the Fifth Law, benefit priority has been given to geriatric teams following geriatric protocols (Finch, Kane, Kane, et al. 1992).

The TPP initiative in the United Kingdom sheds some light on community physicians' priorities for integration. The physicians who were in charge of the most sites focused only on one or two areas for total purchasing (Mays 1997b), and physicians showed no interest in broader areas like housing, targeting policy, or medical–social care cultures (Myles, Popay, Wyke, et al. 1997). No TPP prioritized at-risk children, physically disabled adults, or patients with learning disabilities (Mays 1997b).

Joint commissioning appears to be a more successful approach to integration in the United Kingdom than GP fundholding, perhaps because it relies on professional cooperation rather than on physician leadership in managing the internal market. Donald Light contends that cooperative planning soon won out over competition when the NHS internal market was being created in the early 1990s:

Within the first two years of the reforms, the British started using the term “commissioning” to connote the notion that purchasing authorities should do more than purchase existing services “off the shelf.” Rather, they should seek new, more cost-effective configurations of services across specialty and organizational lines and move upstream to prevention, health education, self-management of chronic problems, and reduction in illnesses whose source lies in local environments. (Light 1997a, 305)

A key to the success of joint commissioning is to recruit commissioners for whom integrated services for a population group is a preeminent issue. We should expect different views from district health authorities, community trusts, GPs, and social and educational service staff (Social Services Inspectorate 1995c; Light 1997b). Although physicians occa-

sionally take the lead in joint commissioning (Mays 1997a), Greig's (1997) finding that GPs were "almost totally absent" from joint commissioning for learning disabilities services should not be surprising.

It would be comforting to think that these local shortcomings could be fixed by a dose of national policy guidelines. Apparently it is not so simple. For example, studies of how localities carried out national mandates to promote better integrated care for those with learning disabilities (Hatton and Emerson 1995), to define the limits of NHS coverage of continuing and community care (Glendinning and Lloyd 1997), to coordinate services for persons with physical disabilities, and to ensure that TPPs implement continuing and community care policies (Myles, Popay, Wyke, et al. 1997) revealed that knowledge of national policies was limited (particularly among GPs), that there was not enough information on which to base decisions, and that compliance was poor. Labour's new primary groups of GPs should have better administrative support than was provided to the smaller fundholding practices to implement integration mandates, but they will still need planning models that include other providers, guidance on priorities for different groups of persons with disabilities, and resources to plan and implement change.

Before leaving the Fifth Law, it is worth considering its implications for one of the most pressing issues in long-term care: autonomy and control for users and carers. One hope for integration is that it will transform complex and confusing systems of health and human services so that they are more "user friendly." Integration can do this by creating single access points for multiple services, by empowering care managers to control more services, and by strengthening their access to other services they do not control directly. However, the more we integrate the system in these ways, the more users must rely on professionals to shape, maintain, and use it.

Of course professionals should take steps to empower users and carers, but they will still be sharing their power not ceding it. Light (1997b) contends that community and user involvement in planning is fundamentally threatening to professional values. Their professional and organizational perspectives cause them to value their own services more highly than those the users or the community may perceive as important. Nor is there much encouragement to be gained from the records of other professionals and health service systems of their dealings with service users and whether they provide good information about how to use the system, ask about user preferences, give users and carers mean-

ingful control over care plan decisions, or involve users in planning and policy (Clark, Dyer, and Hartman 1996; Leutz, Sciegaj, Capitman, et al. 1995; Myles, Popay, Wyke, et al. 1997; Rummery and Glendinning 1997; Social Services Inspectorate 1996). When user perspectives are ignored, the priority assigned to special needs issues is also reduced (Social Services Inspectorate 1996), often leading to other adverse consequences. For example, in the rush to implement *Caring for People*, service modalities that were comfortable to persons with learning disabilities were eliminated without their consultation (Social Services Inspectorate 1994).

One promising individual-level approach to empowerment in resource-strained long-term-care systems is “contextual autonomy,” whereby care managers clearly lay out the choices and limits for users (Capitman and Sciegaj 1995). More systemic approaches bring users, carers, and advocates into planning and commissioning efforts (Light 1997b; Morris 1995). Inclusion of service users and community-based providers allows for a range of views to be expressed in planning as a counter to medical views, leading to more resources for nonmedical service modalities, leadership from other sectors (e.g., social service, education) (Ruta, Donaldson, and Gilray 1996; Social Services Inspectorate 1995a; 1995c). Unless users and carers become strategically involved, it is less likely that individuals will find autonomy within the system (Social Services Inspectorate 1996).

Lessons and Recommendations

The laws of integration perhaps have no scientific justification. Social science lacks the tools to reveal and predict processes and outcomes in complex areas like health, long-term care, education, and other related systems. My intent in proposing laws is to draw attention to the fact that a great deal of experience and knowledge about integration still remains to be digested and applied. There is still plenty of room for research and experimentation, but there is enough accumulated experience that policy makers, managers, and clinical leaders can now call some of the tunes rather than having to encourage ad hoc initiatives indefinitely. The three recommendations offered below are relevant, with adaptations for the different system environments, both to the United States and the United Kingdom.

1. Involve service users, carers, and community service providers in planning and oversight.

Successful integration of medical and long-term-care services will occur only if all parties participate in planning and implementation. This review has made it clear that GP physicians or other mainstream acute care providers will focus on their own issues, which understandably do not single out relatively small, special-needs groups for attention. Planners and providers from all sectors must go out of their way to involve users and carers. There are various ways to accomplish this: changing the times, places, and formats of meetings to accommodate these groups; organizing separate users' and carers' groups, which would hold their own meetings and send empowered representatives to professional meetings; including advocates and specialized community providers in planning and activities (Barnes and Walker 1996; Gerry and Mirsky 1992; Tyne 1994).

2. Develop systems to integrate, coordinate, and link services for persons with disabilities.

Integration of health care, long-term-care, and other human service systems is needed, not just for the most severely ill and impaired, but also for the moderately and newly impaired. In conjunction with developing fully integrated systems for the most frail and medically at risk (the main focus of current policy and demonstration), we should be reconsidering how mainline health care systems provide care for those persons with disabilities who do not choose or do not qualify for separate programs. Some possible approaches would be screening populations for risk of disability, providing primary care for all types of persons with disabilities, making appropriate referrals, and coordinating services with closely related systems through case management.

We can begin to design these systems for various populations by learning from tested models, by analyzing health and functional status data and utilization patterns, and by inviting users and carers to participate in design and evaluation. Two questions deserve special attention. First, what areas does each subgroup consider most critical for integration? What systems should be linked and at what levels? Second, who should oversee the integration effort? Who is most interested in these areas, and whose clinical or management approach is oriented

most strongly toward cooperation and understanding rather than domination and conflict?

In the United States, both opportunities and risks increase as more long-term-care system users join MCOs. HMOs have shown that they can establish screening systems and specialty care units, and even that they can coordinate continuing and community care benefits, but they have not produced many examples of linkage and coordination with public social care systems (Fama and Fox 1993; Kramer, Fox, and Morgenstern 1992; Wiener and Skaggs 1995). Even if some social care funds (e.g., for long-term care) follow beneficiaries into MCOs in new integrated models, other funds for the remaining members will stay in the current systems.

The British situation is different, but it has some of the same elements. Labour's plan to replace the Conservatives' fragmented NHS initiatives to empower primary care practices (fundholding, total fundholding, and total purchasing pilots alongside purchasing by district health authorities for nonparticipating GPs) with single, large primary care practices in each locality should lead to better integrated medical care delivery. However, social, educational, and long-term-care services lie outside the scope of the new practices. As in the United States, unless all levels of integration for all types of persons with disabilities are coordinated in all service organization approaches, the result may be new types of fragmentation, frustration, and waste.

3. Clarify borders between medical and other systems.

One definition of the long-term-care system is that it picks up all the pieces that the health care system does not cover (Leutz, Capitman, MacAdam, et al. 1992). Only when we have clearly and consistently defined the limits of medical care benefits (particularly skilled home nursing, therapies, and nursing homes) can long-term-care and other human service systems define where they begin. In both the United States and the United Kingdom, national guidelines can become lost in regional, local, and even private interpretations of coverage borders. In the United States, private intermediaries interpret the boundaries for Medicare fee-for-service beneficiaries, and private insurers and HMOs perform this exercise for others. In the United Kingdom, when local health authorities have been asked to define these borders, they have found it difficult to assign workloads and are not oriented to think in

this way about the divisions (Glendinning and Lloyd 1997; Social Services Inspectorate 1995c). It is naive to expect competing US providers to cooperate in working out local agreements (Brown and McLaughlin 1990).

Instead, clear national guidance should set the standards and criteria to be implemented locally. Clearer information, monitoring of within-plan benefits, and stronger appeal paths for service users are also needed. Opening up the debate over health benefit exclusions and limitations would make it more difficult to cut health coverage, or at least would strengthen the ability of social, educational, and other services to obtain resources to pick up the pieces. The debate also would clarify for long-term-care planners the exact point at which their coverage would begin and would help to inform beneficiaries about what to expect from each system.

Although clearer definitions of borders would help, the square-round fit problem can be solved only by redrawing the borders for a better fit. One approach would be to expand Medicare and the NHS to cover more long-term care; proposals have been made in both countries to add home care and short-term nursing-home care (Joseph Rowntree Foundation 1996; Pepper Commission 1990). Another would be to expand Medicaid and local authority care by applying less stringent means testing for long-term-care services. Means testing is seldom used for educational services, which may be one reason that joint commissioning has often achieved integration for the learning disabled (Greig 1997). Both entitlement expansions, however, quickly run up against cost constraints: Medicare and the NHS at the national level, Medicaid and local authorities at the state and local level.

In the absence of public action, private insurers and MCOs could commit themselves more aggressively to solving the square-round problem on their own. One way to expand borders would be to support private long-term-care benefits financed in conjunction with acute care, as occurs in the Social HMO and in the British Social Maintenance Organization proposal for the United Kingdom (Davies and Challis 1986). The 1997 Balanced Budget Act contains language that could make Social HMOs a permanent part of Medicare. Another example is the Manifesto 2005 initiative by Kaiser Permanente, which is the largest HMO in the United States. Based on its experience with the Social HMO it has operated in Oregon since 1985, the entire Kaiser Permanente system is conducting population screening and risk profiling, and

its Interregional Committee on Aging has adopted the following vision statement:

By the year 2005 Kaiser Permanente will have expanded its scope of services to include a LTC system consisting of a broad range of home- and community-based services that would be easily accessible to persons with functional disabilities. This will be a multi-disciplinary system, with providers and consumers of care working in collaboration to maximize the independent function of persons with disabilities of any age. (Nonnenkamp 1996)

Kaiser and other forward-looking MCOs will face limits in what they can do without corresponding support from public payments, and they could face competitive disadvantages if they overextend their benefits and reputation for serving persons with disabilities (Schlesinger 1997). There also are differences between what a group-model HMO like Kaiser (or a forward-looking local authority) can do compared with the possible achievements of a network-model MCO or an independent practice association.

Conclusion

I have recommended both more policy structure and more benefit coverage than are politically popular—particularly in the United States. My recommendations also may be interpreted as throwing cold water on the popular movement that advocates full integration of acute and long-term care for persons with severe disabilities. My intent is to place full integration into the larger context of good human service practices by integrating through linkage and coordination. The problem is that, without specification, support, and enforcement, it cannot be assumed that good human service practice will occur, particularly in the turbulent worlds of emerging managed care in the United States and reorganization in the United Kingdom. Full integration may be very effective, and even efficient, for a few. The caution I have offered herein is that while we are trying to identify who those few are, what they need, and how to provide and pay for their care, we should ensure that the needs of the many receive commensurate attention.

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