영국의 사례관리와 공공과 독립 부문의 역할분담에 관한 연구

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국외훈련 개요

1. **훈 련 국**: 영국

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3. **훈련분야**: 복지여성 분야

4. **훈련기간**: 2018. 8. 1 ~ 2020. 7. 31.

훈련성과보고서 요약서

성 명	김현숙	파견연도	2018
훈련분야	복지여성		
훈련과제	선진 복지국가의 클라이언트 사례관리와 공공과 민간의 역할분담에 관한 실천연구		
훈 련 국	영국		
훈련기관	요크대학교 (University of York)		
보 고 내 용			
제 목	영국의 사례관리와 공공과 독립 부문의 역할분담에 관한 연구	보고서 매수	51
내용요약	서울시는 기존 복지전달체계의 한계를 극복하기 위해 공공 주도의 사례관리에 중점을 두고 있다. 사례관리 사업의 성공적인 추진을 위해서는 다양한 서비스 자원과 업무경험을 가진 민간부문의 협력이 필수적이지만, 공공·민간 부문의 역할 범위와 관계 설정에 대해 구체적인 기준이 제시되지 못하고 있다. 영국은 오랫동안 사례관리를 지역사회 돌봄의 주요 수단으로 시행해 왔고, 그 체계를 계속 보완 및 발전시켜 왔다. 영국의 사례관리는 공공부문인 지방 정부에 의해 수행된다는 점에서 서울시의 경우와 유사하다. 따라서, 본 보고서는 영국의 공공부문과 독립부문(서울시의 민간부문에 해당) 사이의 관계를 탐구하여 서울시 정책에 대한 시사점을 도출한다. 영국은 사례관리 시행의 오랜 역사가 있으므로, 사례관리가 도입되고 현재의 정책에 이르게된 배경을 이해하기 위해서는 이를 전반적으로 살펴볼 필요가 있었다. 따라서 사례관리 도입 이전부터 현재까지의 정책에 대해 시기별로 공공행정 패러다임인 '전통적 공공행정'과 '새로운 공공관리'와 '거버넌스'를 적용하여 공공과 독립 부문의 관계를 분석했다. 이를 토대로 서울시에 대해, 공공부문과 민간(독립)부문 간의 역할분담을 명확히 하기 위해 사례관리 구조를 일원화하고, 이용자 중심으로 관련 조직 구조를 정비하며, 단일 규제 기구의 설립 등의 방안을 제시한다.		

〔한글요약서〕

1. 서론

서울시는 기존 복지전달체계의 한계로 정작 필요로 하는 시민들에게 복지서비스가 제대로 전달되지 못하고 있다는 판단하에 전달체계 개편을 시도했다. 이 사업은 '찾아가는 동 주민센터' 사업으로 명명되었는데, 이 사업은 민·관 거버넌스형 '추진운영본부'를 구성해 민간의 노하우를 활용하고 협력을 이끌어내고자 하였다. 그중의 하나가 사례관리 사업이다. 서울시의 사례관리 사업은 민간의 다양한 서비스 자원과 사례관리 업무 경험을 활용하고자 사업 초기부터의 협력과 참여를 강조하였다. 그러나, 서울시의 사례관리사업은 공공 사회복지전달체계를 중심으로 설계되어 사례관리 경험이 많은 민간영역의 전문성이 충분히 발휘되지 못하는 한계가 있어 보인다.

공공은 개인정보에 대한 접근성과 행정 권한을 가지고 있으며 민간은 사례관리 실천을 위한 전문성 및 관계(rapport) 형성의 강점을 확보하고 있으므로, 사례관리 서비스의 질을 높이기 위해서는 상호보완적 두 체계의 소통과 협력이 필수적이다. 따라서 공공과 민간의 상호작용으로 이뤄지는 사례관리 전개과정과 각각의 강점에 대한 이해를 바탕으로 공공과 민간의 적절한 역할분담에 관한 연구가 필요하다.

영국은 대규모 사례관리 시범사업을 진행하였고, 현재 공공영역에서 사례관리를 직접 시행하고 있다. 시범사업(Kent and Gateshead, Darlington 프로젝트 등)을 실시한 결과 성공적인 평가를 받아 검증된 제도이다. 시범사업 이후에는 지역사회 보호의 주요 실행수단으로 공공부문에 사례관리를 본격 도입하여 현재까지 시행해 오고 있다. 영국은 또한 지방정부에서 사례관리 업무를 수행하고 있다. 이는 지방정부로서 공공주도로 사례관리 정책을 시행하고 있는 서울시의 경우와 유사하다. 공공부문인 지방정부는 조정자로서 서비스 연계에 중점을 두며, 민간부문은 서비스 공급자로서 지방정부와의 계약을 통해 서비스를 공급한다. 따라서, 공공과 민간의 역할과 관계를 중심으로 영국의 사례관리 정책을 연구하여 서울시 정책에 참고할 수 있는 시사점을 얻고자 한다.

2. 기존문헌 연구

2-1. 사례관리의 정의

Moxley(1989)는 사례관리를 대인 서비스 실천의 다양한 분야에서 복합적인 욕구를 가진 클라이언트들의 욕구를 사정한 후, 그 욕구를 충족시키기 위해 적절한 서비스, 기회 또는 급여를 확인하고 포괄적인 서비스계획을 개발하며, 각종 서비스에 대한 클라이언트의 접근이 용이하도록 옹호를 제공하고, 적절하고 효과적인 서비스의 전달을 점검하거나 평가하는 활동이라고 정의하였다. Woodside와 McClam(2006)은 사례관리는 복합적인 욕구를 가진 대상자들에게 다양한 서비스를 효과적으로 전달하기 위한 실천전략이라고 정의한다. 미국사회복지사협회(NASW: National Association of Social Workers)(1992)는 Moxley(1989)의 정의와 유사하게 사례관리를 전문사회복지사가 클라이언트와 가족의 욕구를 진단하고, 클라이언트의 다양한 욕구 맞는 서비스를 적절하게 준비, 조정, 모니터, 평가, 옹호하는 활동으로 본다.

사례관리는 다양하고 복합적인 욕구를 지닌 클라이언트와 가족의 사회적 기능과 삶의 질을 향상시키기 위해 통합적이며 지속적으로 서비스를 제공하는 전문적인 실천방법으로 볼 수 있다. 또한, 클라이언트의 욕구에 부합하는 서비스의 제공을 위해서는 체계적인 사정과 자원개발이 필요하며 욕구충족과 사회적 기능 회복을 위해 지속적으로 지역사회와의 협력체계 구축이 필요한 것을 알 수 있다.

처음에 미국의 'case management'가 영국에 소개되었지만, 영국에서는 미국과는 달리 주로 'care management'라는 용어를 사용하고 있다. 1990년에 'NHS and Community Care'법을 제정하면서 'case' 대신 care'라는 용어를 사용했다. 이는 'case'라는 개념이 돌봄을 받는 사람을 관리의 대상으로 여기게 하여 비하하는 느낌을 줄 수 있다고 판단했기 때문이었다(SSI/SWSG, 1991). 이 보고서에서는 사례관리를 지칭하는 데에 있어 영국에서 좀 더 포괄적인 의미로 사용되는 'care management'라는 용어를 사용한다.

2-2. 전통적 공공행정(Traditional Public Administration: TPA), 신공공관리론(New Public Management: NPM) 및 거버넌스(Governance)

영국의 사례관리 정책과 관련해서는 시대의 흐름에 따라 공공행정의 역할이 변화하는 과정에서 민간부문의 역할이 강화되는 모습을 보여주고 있다. 이는 영국 복지정책의 전반적인 흐름과도 연결되어 있다. 2차 세계대전 이후부터 1970년대 후반까지는 공공행정이 국민의 복지를 주도적으로 책임지고 있었다면, 경제위기 이후 보수당이 정권을 잡은 1970년대 후반부터는 신공공관리론의 영향으로 공공부문의 서비스 공급자의 역할이 민간으로 본격적으로 이전되기 시작했다. 그러다가 1997년에 신노동당이 집권하면서 거버넌스의 중요성을 인식하면서 공공

부문과 민간부문의 파트너십을 강조하기 시작하였다. 각 시기별 공공행정의 양상은 각기 다른 행정 패러다임의 특징을 지니고 있는데 각각 전통적 공공행정(TPA), 신공공관리론(NPM), 거버넌스(Governance)의 개념으로 설명할 수 있을 것으로 보인다.

먼저, 전통적 공공행정은 중앙 집중식 통제, 규칙 및 지침 설정, 정책 결정과 구현의 분리, 그리고 계층적 조직 구조의 특징을 지니고 있다(Osborne, 2006). 즉, 정부는 계층제적 구조를 통해 내부조직을 운영해왔으며, 중앙정부와 지방정부의 관계 및 정부와 시민사회와의 관계에서도 계층제적인 통제의 모습을 보였다(Pierre and Peters, 2000). 이러한 패러다임 안에서 1970년대까지 정부의 역할이 계속 커지면서 관료기구는 비대해졌고 민간부문은 상대적으로 위축되었다. 그러다가 1970년대 후반에 세계 경제가 석유 파동 등으로 침체하면서 '정부실패'가 주요 화두로 등장하였다. 관료제의 비유연성, 고객 서비스에 대한 대응성 부족, 비효율성 등의 문제들로 인해 정부 권한을 축소하고 공공부문에 민간부문의 관리기법을 도입하여 효율성을 추구하고자 하였다. 이러한 변화는 Hood(1991)에 의해 '신공공관리론(New Public Management)'으로 불리워졌는데, 이처럼 신공공관리론은 관료주의적이고 전통적인 행정 패러다임의 한계를 극복하기 위한 해결책으로서 등장하였다. 관료적 절차와 규칙보다 산출 및 성과 목표의 강조, 경영관리기술의 중시, 민간 기업의 관리기법 모방 등을 신공공관리론의 주요 내용으로 들 수 있다(Kamensky, 1996).

그러나, 신공공관리론은 많은 한계점으로 인해 비판을 받아 왔다. Entwistle과 Martin(2005)은 신공공관리론이 경쟁 체제를 전제로 하고 있지만 실제로 경쟁은 활성화하지 못하면서 비용은 많이 든다고 지적한다. Minogue(2001)는 계약, 민영화, 시장화로 인해 효율성이 향상되었다는 증거는 부족한 반면에, 공공부문의 축소로 인해 책임성이 감소되었다고 주장한다.

이러한 신공공관리론의 한계에 대한 대안으로서 '거버넌스' 개념이 주목받고 있다. 거버넌스라는 용어는 여러가지로 다양하게 정의되고 있지만, 기본적으로 공공부문과 민간부문간의 경계가 흐려진 통치 유형의 변화를 전제하고 있다(Stoker, 1998). Rhodes(1996)는 거버넌스와 관련하여 네트워크 개념을 강조하고 있는데, 네트워크를 이전의 계층제적 접근과 시장적 접근에 대한 대안으로 제시하고 있다. 거버넌스는 정부, 시장, 시민사회 등의 파트너십 및 네트워크 형성을 통한 새로운 공동체적 운영방식으로 볼 수 있다(March and Olsen, 1995; Rhodes, 1996). 이러한 거버넌스는 다양하고 새로운 사회문제들을 해결할 수 있는 방식으로 여겨진다.

이처럼 기존의 공공행정의 서비스 전달 방식으로 해결하기 힘든 문제들에 대처

하기 위해 새로운 행정 패러다임이 등장하였고 이는 세부적인 정책에 영향을 미쳐왔다. 따라서, 본문에서는 이 세 가지 행정 패러다임을 이용하여 영국 사례관리 정책의 변천과 세부내용을 분석한 후 시사점을 도출한다.

2-3. 복지혼합(welfare mix)과 시장화(marketisation)

1970년대 서구 국가들은 경제위기 속에서 국가의 재정부담을 줄이고자 복지국가의 역할을 축소하고 대신 시장의 역할을 강조하기 시작했다. 이와 관련하여 복지혼합의 개념이 강조되었는데, 이는 이념적으로 복지다원주의(welfare pluralism)에 뿌리를 두고 있다. 복지다원주의는 복지공급의 주체를 다원화하는 것을 의미한다. 1980년대 이후 서구의 복지국가들은 복지다원주의와 시장원리를 중심으로 복지서비스를 제공하는 경향이 강화됐다(Daly and Lewis, 1998). 영국의 경우에는 보수당인 대처 총리가 집권한 이후 복지다원주의를 내세우며 공공부문에 민영화와 시장경쟁원리의 도입을 정당화하고자 하였다.

이러한 복지혼합을 구성하는 서비스 공급주체는 크게 공공부문과 민간부문으로 나눌 수 있는데, 이 중에서 민간부문은 다시 영리부문, 비영리부문, 비공식부문으로 나눌 수 있다. Salamon과 Anheier(1998)에 따르면, 영리부문은 시장에서 이윤추구를 목적으로 활동하는 조직을 말한다. 자원부문(voluntary sector)으로도 불리는 비영리부문은 공식적으로 구성되어 자발적이고 자치적으로 활동하는 조직으로 공공 서비스에 관심을 갖고 정부 규제를 받지만 공공기관은 아닌 조직을 말한다(Kendall, 2004; Deacon, 1996). 비공식부문은 사적 관계에 기초한 가족, 친척, 이웃 등을 포함하는 개념이다(Johnson, 1987). 요약하자면, 서비스 공급주체들은 크게 비공식부문과 공식부문으로 나누어 볼 수 있으며, 공식부문은 공공부문, 비영리부문과 영리부문으로 다시 구별할 수 있음을 알 수 있다. 영국에서는 주로 이러한 비영리의 자원부문과 영리의 민간부문을 통칭하여 독립부문으로 부른다(Sharkey, 2007; Department of Health, 2001). 이 보고서에서도 비영리인 자원부문과 영리인 민간부문을 포괄하여 독립부문으로 지칭한다.

Brennan 등(2012)은 시장화를 정부가 민간의 영리와 비영리 부문의 돌봄 시장 참여를 촉진하여 시장의 원리인 경쟁과 선택을 활성화하는 조치라고 한다. 시장화의 추진방법에 있어서, 영국은 서비스 제공자로서의 국가의 역할을 축소하고 비영리기관과 영리기관의 역할을 강화시켰다(Means et al., 2008). 서비스 구매와 공급의 역할을 분리하여, 지방정부가 구매자의 역할을 맡고 민간에서 공급의 역할을 맡도록 했다. 이와 같은 시장화(marketisation) 정책으로 민간의

영리와 비영리기관이 복지서비스의 주요한 공급주체가 되었다. 이에 따라 공공부문은 복지서비스에 있어서 다양한 공급주체들에 대한 관리 및 규제자의 역할도 강조되고 있다.

2-4. 공공부문과 독립부문의 파트너십

복지혼합에 따라 복지서비스 분야에서 영리와 비영리의 독립부문은 주요한 서비스 공급주체가 되었다. 그런데 공공부문과 독립부문은 각자 서비스 공급에 있어서 한계를 가지고 있다(Salamon, 1995). 따라서, 복지서비스 제공에서 실패를 보완하고 이점을 극대화하기 위해서는 각각 중앙 및 지방정부, 영리기관 및 비영리기관으로 대표되는 공공부문과 독립부문 간의 협력이 필요하다(Billis and Glennerster, 1998). 공공부문은 형평성 보장, 서비스의 지속성과 안정성 보장, 사회적 결속을 강화시킬 수 있는 장점을 가지고 있으나, 국가 주도의 복지서비스는 관료주의에 따른 경직성, 이용자의 욕구에 대한 유연성 부족, 자원과 권력에 대한 중앙집권화된 통제, 비효율성 등으로 비판을 받아 왔다. 반면에, 독립부문은 공공부문에 비해 서비스 전달에 있어서의 반응성, 소통능력이 높다는 평가를 받아 왔다. 독립부문 중 영리기관은 수익을 추구하기 때문에 정책성과에 대한 의욕이 강하며(Grover, 2009), 경영의 유연성을 통해 공적 행정체계가 접근할 수 없는 사각지대에 대한 접근이 용이하다(Finn, 2007). 비영리기관은 수익이 발생하면 다시 서비스에 투입하는 경향이 강하며(Giotis, 2011), 영리기관 보다 공공성을 지니고 있어 사회적 신뢰도가 높다(Davies, 2011).

공공부문과 독립부문의 협력의 필요성에 따라, 그 관계 구축에 대한 다양한 논의가 있었다. 이러한 논의의 핵심은 서비스 공급 및 재원조달의 주체, 서비스 품질관리 등에 대한 것이었다(Glennerster, 1997; Ascoli and Ranci, 2002). Gidron 등(1992)은 이 중에서 서비스 제공주체와 재원부담의 주체에 따라 정부와 비영리인 자원부문의 관계를 네 가지 유형으로 제시하고 있다. 이 중 정부가 재정을 부담하고 서비스 전달은 자원부문이 맡는 협조모형(collaborative model) 중에서도 파트너십(partnership) 모델은 두 영역 간에 협력관계가 형성되어 있고 자원부문의 자율성이 존재하는 유형이다.

파트너십의 개념에 대해서는 통일된 정의는 없지만, Powell and Glendinning(2002: 3)은 파트너십을 구성원들 또는 기관 간에 '약간의 공통관심사 또는 상호의존성을 바탕으로 '신뢰, 평등, 상호성이 요구되는 관계로 최소한으로 정의한다. Pierre(1997)에 따르면, 파트너십은 내부적 및 외부적으로 시너지 효과를 생성하여 공공부문과 민간부문 간의 소통을 촉진시키는 기능을 한다.

그러나 공공부문과 독립부문이 협력에서 기대하는 효과를 달성하기 위해서는 정부의 조정기능이 필수적이다(Bruttel, 2005). Bruttel(2005)은 정부가 민간부문에 대해 세 가지 조정기능을 가질 필요가 있음을 강조한다. 첫째, 민간의 자율성을 저해하지 않는 수준에서 '통제메커니즘 (control mechanisms)'이 마련되어야 하며, 둘째로 정부, 민간부문, 서비스 이용자 간에 투명한 '정보메커니즘(information mechanisms)'이 구축되어야 한다. 마지막으로 그는 민간부문이 지속해서 성과를 높일 수 있도록 하는 '인센티브메커니즘(incentive mechanisms)'이 존재해야 한다고 주장한다. 결과적으로 복지혼합 환경하에서 공공부문과 민간부문의 협조는 필수적이며, 정부가 제시한 기준 범위 내에서 민간의 자율성을 보장하면서도 실패를 방지하기 위해서는 정부의 규제자로서의 기능도 필요함을 보여준다.

3. 영국 사례관리 정책의 태동과 변천

이 보고서에서는 사례관리 정책의 도입 이전 시기부터 도입기 그리고 현재의 정책현황까지 각 참여주체의 역할과 관계를 중심으로 전반적으로 살펴본다. 시대의 변화에 따라 각각 다른 공공행정 서비스 전달의 특징을 지닌 세 가지 행정 패러다임의 틀에 기반하여 관련 내용과 특징을 분석한다.

3-1. 전통적 공공행정의 시기(전후~1970년대 말)

이 시기는 영국에서 사례관리 정책이 등장하기 이전에 해당한다. 따라서 사례관리가 등장하게 된 사회적, 정치적 배경을 이 부분에서 살펴볼 수 있다. 나중에 영국에서 사례관리가 커뮤니티 케어의 주요 실천장치로서 등장한 만큼, 이 시기의 커뮤니티 케어에 대해 살펴봄으로써 사례관리가 등장하게 된 사회적, 정치적 배경 또한 파악할 수 있을 것으로 본다.

3-1-1. 강한 책임성

2차 세계대전 이후에 영국은 전시 내각에서 작성된 베버리지 보고서(1942)에 기초하여 복지국가를 확립해 나갔다. 이에 따라 사회보장, 의료, 고용 등을 아우르는 정책이 추진되었고 이를 위해 각종 법과 제도가 마련되었다. 건강, 교육, 사회보장 등 다양한 영역에서 정부가 공공재의 공급을 책임졌다 (Hogwood, 1992). 1946년 국민보건서비스법(National Health Service Act)의 제정

으로 의료서비스가 모든 국민에게 무료로 제공되었고, 1948년에 국민부조법(National Assistance Act)이 제정되어 나이, 질환 등으로 인해 돌봄이 필요한 사람들에게 시설돌봄(residential care)을 제공할 것을 지방정부의 의무로써 규정하였다. 이러한 일련의 입법과정을 통해 노인, 장애인, 아동 등의 대상 집단별로 지방정부에 사회서비스에 대한 새로운 책임과 권한이 부여되었다(Lowe, 2005; Sullivan, 1996).

그러나, 사회서비스에 대한 지방정부의 권한과 책임은 확대되었지만, 지방정부 내에서 조직이 복지부, 아동부, 보건부 등의 여러 부서로 분산되어 있었다. 이러한 이용자 중심이 아닌 행정의 전문분야에 따라 분할되어 제공되는 서비스 구조는 복합적인 욕구를 가진 대상자에 대해 효과적인 접근을 어렵게 하는 요소로 지적되었다(Forder, 1975). 이로 인해 노인과 장애인의 정상적이고 자립적인 삶을 위한 대안으로 커뮤니티 케어가 제시되었다.

이러한 사회 분위기 속에서 1968년 시봄 보고서(The Seebohm Report)에 의해서 커다란 정책적 전환이 일어났다. 이 보고서는 지방정부 내에 사회서비스국을 신설하여 서비스를 직접 제공할 것과 지역사회 내의 욕구와 자원을 파악하여 계획 및 지원할 책임이 지방정부에 있다고 강조하였다. 이러한 시봄 보고서를 토대로 하여 1970년에 '지방정부 사회서비스법(Local Authority Social Care Act)'이 제정되었다. 지방정부 내에서 아동국과 복지국으로 분리되어 있던 조직을 통합하여 사회서비스국(Social Services Department, SSD)을 새로 설치하였다. 사회서비스국에서 사회복지사를 고용하여 지역의 대상자에게 서비스를 직접 제공하였다.

이처럼 이 시기에는 국가와 지방정부를 중심으로 한 공공부문의 역할이 확대되었지만, 독립부문도 일정 역할을 하고 있었다. 특히, 비영리 민간부문은 전체 보호 아동의 25% 정도를 수용하고 있을 만큼 적지 않은 비중을 차지하고 있었고(Griffith, 1966), 또한, 영리 민간부문도 요양시설을 운영할 경우에 지방정부로부터 재정적 지원을 받을 수 있었다(Eyden, 1973). 새로 설립된 지방정부의 사회서비스국은 지역사회 내의 다양한 민간자원을 활용하는 역할이 부여되었다. 독립부문이 일정 부분 서비스를 공급하고 있더라도 그들의 역할은 지방정부를 보조하는 것으로 제한되었고 지방정부의 대리기관으로까지는 인정되지는 않았다(Seebohm Committee, 1968; Griffith, 1966).

3-1-2. 복지부동 및 비유연성

그러나, 이러한 개혁은 한편으로 공공부문에 집중된 사회서비스 공급으로 인하여

이용자에 대한 공급자의 권력을 증대시켰다는 비판을 받았다(Brooke, 1969). 집중된 권한을 지닌 관료가 서비스 공급을 거부하면 이용자는 모든 서비스에 대해 접근이 박탈당하게 된다는 것이다. 이런 상황에서, 영국의 경제는 1970년대에 심각한 위기상황에 처하여 세수 감소와 실업 증가로 이어졌고, 반면에 복지 수요는 증가하여 복지국가 유지에 따른 재정 압박이 심화되었다(Ellison, 1998). 이러한 재정부담과 더불어, 1945년 이후부터 지속된 중앙집중적 독점적 공급구조에 따른 선택사항의 부족과 서비스 질에 대한 불만으로 인해 공공부문에 대한 개혁의 필요성이 제기되었다(Hadley and Hatch, 1981; Jacobs et al., 2009).

3-2. 신공공관리론 시기(1970년대 말~1996)

1970년대의 경제위기로 인해 사회보장 등 복지부문의 재정감축의 필요성에 따라 공공부문의 역할에도 변화가 요구되었다. 국가 중심의 복지 모델의 한계를 극복하기 위한 대안으로 복지서비스에 있어서 국가뿐만 아니라 다양한 공급주체들이 참여하는 다원주의 모델이 제시되었다. 또한, 보수당 정부는 비효율을 없애기 위해서 전통적인 상의하달식 계층제에서 벗어날 필요가 있다는 인식하에 '계층제에 의한 통제(control by hierarchy)'를 '계약에 의한 통제(control by contract)'로 변화시켰다(Hoggett, 1991: 250). 이는 복지서비스 전달에 있어서 시장화를 가속화시켰다.

3-2-1. 효율성 추구

1979년에 정권을 잡은 보수당의 대처 정부는 이러한 흐름 속에서 국가재정의 감축을 위해 시설보다 지역사회의 자원을 활용하기 위한 정책을 시행하였다. '지역사회에 의한 돌봄(care by the community)을 강조하며 국가재정이 다수 투입되는 시설보호보다는 대상자가 자신의 집에서 거주하는 형태인 재가복지를 강화하고자 하였다. 이러한 상황에서 1970년대 말부터 켄트 대학교(the University of Kent)의 PSSRU(the Personal Social Services Research Unit)에서 시행한 사례관리 시범사업이 주목을 받았다. 1970년대 미국에서 정신질환자를 대상으로 시행됐던 케이스 매니지먼트(case management)가 이 PSSRU 연구소의 'Kent Community Care Scheme'을 통해 처음으로 영국에 소개되었고, 이후 영국식 사례관리 모델을 개발하기 위한 시범사업이 동 연구소에 의해 Kent, Gateshead, Darlington 등에서 추진되었다(Payne, 1995). 시범사업을 통해 사례관리가 이용자들과 그들의 보호자

들에게 높은 만족도를 주고, 비용 측면에서도 재가서비스를 이용하는 것이 시설에 거주하는 것보다 비용 부담이 덜하거나 비슷한 것으로 평가되었다(Challis et al., 2007, 2004).

이러한 사례관리 시범사업의 긍정적인 결과는 이후 보수당 정부의 커뮤니티 케어의 개혁에도 반영되었다. 1988년 공개된 그리피스 보고서(The Griffiths Report)(Community care: an Agenda for Action)는 중앙정부에 의해 지급되던 개인 돌봄 관련된 사회보장급여를 중단하고 그 예산을 지방정부로 이전할 것을 권고하였다. 또한, 지방정부에서 서비스 신청자에 대해 경제력과 돌봄 욕구에 대한 별도의 사정을 거쳐 이 예산을 집행할 것을 제안하였다. 효과적인 자원 활용을 위해서 사례관리가 제안되었는데, 지방정부는 지역사회 욕구 사정, 커뮤니티 케어 계획 수립, 정보제공 등을 통해 사회서비스의 독점적 공급자가 아닌 가능자(enabler)로서 기능할 것을 권고하였다. 이것은 혼합경제 하에서는 경쟁을 통해 효율성이 향상되고 예전의 복지 관료제 체계에서보다는 비용 효과적일 것이라는 신념에 근거한 것이었다(Sharkey, 2007).

그리피스 보고서의 내용은 1989년 정부 백서인 'Caring for People: Community Care in the next decade and beyond'에 거의 반영이 되었다. 지방정부 사회서비스국의 책임과 역할을 욕구사정, 계획 수립, 서비스 구매, 서비스 질에 대한 관리 등으로 규정하였다. 지방정부로 하여금 비공식 부문의 돌봄 서비스를 최대한 활용하고 민간 서비스 성장을 위한 역할을 수행할 것을 제시했다. 또한, 백서에는 최초로 '사례관리(care management)'라는 용어가 등장하였고, 이는 적절한 욕구사정에 따른 사례관리를 통해 질적인 보호를 추구한 것이었다. 이러한 백서의 내용은 1990년 '국민보건서비스와 커뮤니티 케어법(National Health Service and Community Care Act)' 제정으로 구체화되었다. 이 법의 핵심은 지방정부 사회서비스국의 역할이 서비스 제공자에서 구매자로 변화한 것이었다. 공급자-구매자 분리(purchaser-provider split)에 의해 다양한 공급자가 경쟁을 통해 지방정부와의 계약을 맺고 서비스를 공급하게 되었다(Langan, 1998).

사례관리를 위해 지방정부 사회서비스국에 케어 매니저(care manager)를 두었는데, 이러한 케어 매니저의 등장이 유사시장(quasi-market)의 형성에 기여하였다(Glendinning and Means, 2006). 케어 매니저는 개별 이용자들의 욕구조사를 토대로 필요한 서비스로 케어 패키지(care package)를 구성하여 실행 및 정기적으로 점검하는 사례관리를 시행하였다. 즉, 그들은 케이스 발굴 및 이용자의 욕구 사정, 케어계획 작성, 모니터링 등의 역할을 수행했다(Challis, 2003). 예산에 대한 집행권한을 부여받아서 개인의 욕구 사정을

토대로 다양한 서비스 공급자를 파악하여 필요한 서비스를 구매할 수 있었다(Harris and Chou, 2001). 서비스 이용자의 욕구를 파악하여 적정한 돌봄 계획을 수립하여 필요한 서비스를 구매하는 방식으로 서비스 이용자의 선택권을 강조하였다. 이는 서비스 공급의 경쟁을 통해 비용의 효과성을 증진시킬 뿐만 아니라, 이용자의 선택권이 증진되고 서비스도 개선될 것이라는 기대가 포함되어 있었다(Knapp et al., 1994).

3-2-2. 책임성 약화

보수당의 대처 정부가 들어선 후인 1980년대부터 돌봄에 대한 가족의 도덕적인 책임을 강조하기 시작했다. 이런 정책 방향 하에서 장기적인 돌봄이 특히 필요한 노인을 부양하는 가족과 친지의 부담은 가중되었다(Dalley, 2000). 전후에 '요람에서 무덤까지'라는 국가책임을 강조하던 복지국가의 시대보다 사회서비스에 대한 국가의 책임성이 약화되었음을 알 수 있다.

또한, 1990년 커뮤니티 케어법에 의해 장려된 서비스 공급에서의 시장화는 공공부문에 비해 독립부문의 비중을 확대시켰다. 커뮤니티 케어법 제정으로 중앙정부로부터 지방정부로 이전된 사회보장 이전금(Special Transition Grant)의 85% 이상을 독립부문이라고 불리는 민간부문에 사용하도록 하여 유사시장의 형성을 촉진시켰다(Player and Pollock, 2001). 시설서비스와 재가 복지서비스(domiciliary care)에서 공공부문의 직접 공급에 비해 독립부문의 공급 비중이 크게 증가하였다. 1992년 지방정부가 재가서비스의 98%를 제공했으나, 2002년에는 재가서비스의 60% 이상이 독립부문에서 제공되었다(Pollock, 2004). 그러나, 민간의 영리부문의 증가는 이용자의 경제력에 따라 서비스 접근에 있어서 격차를 심화시킬 수 있다. 공공부문이 보다 책임성 있고 시민의 요구에 부응하고 권리를 충족시키는 장점이 있는 반면에, 영리부문은 개인의 욕구 충족보다는 이익 창출에 관심을 두기 때문이다(Cooper, 1988). 따라서, 이러한 영리부문의 성장은 사회서비스 공급에 있어서 이용자에 대한 책임성 약화로 이어질 수 있다.

3-2-3. 규제

Grant(2002)에 따르면, 영국에서는 신자유주의 정책의 확산으로 국가의 역할이 규제를 보다 강화하는 방향으로 변화하여 왔다. 사회서비스 공급에 있어서 독립부문의 참여가 확대되고 정부의 통제력은 약화되면서, 보수당 정부는 엄격한

규제와 서비스 질 관리 체계를 도입하고자 했다. 1984년 등록시설법(1984 Registered Home Act)에 따라 일반 요양시설은 지방정부에 등록하도록 하고 의료시설은 보건당국(district health authority)에 등록하도록 하였다. 1985년에 사회서비스조사원(Social Service Inspectorate)의 설립으로 사회서비스 제공기관에 대한 운영 및 재정구조, 공급과정 등에 대한 체계적인 평가제도가 도입되었다. 1990년 커뮤니티 케어법에 의해서는 지방정부의 사회복지서비스에 대한 모니터링 기능이 이 조사원에 부여되었다.

1980년대 초부터 이러한 감사기구들이 증가한 사회현상은 Power(1997)에 의해 'audit society'로 묘사되었다. 이처럼 규제가 강화된 것은 공공부문의 역할이 직접적인 서비스 공급보다는 제삼자인 민간부문에 의해 제공되는 서비스에 대한 감독으로 방향이 바뀐 것과 관련이 있다(Scott, 2000). 사회서비스가 정보 비대칭성의 특징을 수반하고 있어서 규제없이 시장원리만을 가지고는 기대했던 효율성 또는 형평성을 달성하기가 어렵기 때문이다(Steuerle, 2000). 이 과정에서 규제의 대상이 주로 독립부문과 지방정부였기때문에 중앙정부의 통제자로서의 영향력은 더 커졌다고 할 수 있다.

3-3. 거버넌스 시기(1997~현재)

약 20여 년 간의 보수당 집권을 끝내면서 1997년에 토니 블레어의 신노동당이 새롭게 집권하였다. 블레어 정부는 이전의 보수당 정부가 구축해 놓은 사회서비스에 있어서 유사시장은 유지하면서도 새로운 정책적 변화를 시도하였다. Balloch과 Taylor(2001)는 이러한 신노동당의 새로운 개혁방향을 계약문화(contract culture)에서 파트너십 문화(partnership culture)로의 변화라고 설명한다. 이러한 개혁의 내용은 1998년에 정부에서 발표한 사회서비스 현대화에 관한 정책백서(White Paper)(Department of Health, 1998)에 잘 나타나 있다. 백서는 보건, 복지, 교육 등을 담당하는 공공기관 간 뿐만 아니라 공공부문과 독립부문의 협력과 파트너십(partnership)을 증진시키는 것을 주요과제로 내세웠다. 이러한 파트너십을 형성 및 증진하는 데에 있어 지방정부의 구심점으로서의 역할을 강조하였다. 모든 사회서비스에 대해 'Best Value'를 기치로 내세워 질적 강화를 추진하였으며, 취약계층이 독립적인 삶을 누릴 수 있도록 하는 정책 방향을 제시하였다.

3-3-1. 파트너십의 강조

신노동당의 현대화 프로그램은 네트워크를 통한 협력을 강조하는 면에서 계층제나 시장기제보다는 거버넌스의 면모를 보여주고 있다(Rhodes, 1997; Pierre and Peters). 블레어 총리는 지방정부에 대한 비전을 제시하는 연설에서 지방정부의 미래가 공공기관들, 민간회사들, 지역사회집단들, 자발적 조직들과의 파트너십에 있다고 강조하였다(Blair, 1998: 13). 신노동당 정부는 비영리인 자원부문의 역할에 주목하면서, 사회서비스에 있어서 그들과의 협력을 강조하였다. 지방정부가 지역 내의 자원부문을 잘 파악하여 그들이 지역민의 욕구를 충족시키기 위해 충분한 역량을 발휘할 수 있도록 지원해야 한다고 하였다 (Department of Health, 1998). 이처럼 신노동당 정부가 공공부문과 비영리인 자원부문 간의 파트너십 체계 구축을 강조한 이유는 시민들에게 가장 합리적인 비용으로 좋은 품질의 서비스를 제공하기 위해서였고 이를 제공하는 데에 있어서 공사의 구별이 중요하지 않다는 데에 있었다(Cabinet Office, 1998; Butcher 2002: 189).

사례관리 측면에서도, 이러한 파트너십이 적용되고 있다. 2004년 아동법(Children Act)의 개정으로 기관 간 협력이 강조되었고, 이에 따라 서비스의 통합적인 전달을 위해 공통사정틀(CAF: Common Assessment Framework)이 개발되어 보급되었다. 공통사정틀을 통해 파악된 아동의 복합적인 욕구를 충족시키기 위해 관련된 기관들이 협력하여 통합된 서비스를 제공하고자 하는 데 목적이 있었다. 이러한 과정에는 담당 사회복지사뿐만 아니라 교육, 보건, 청소년, 아동보육, 범죄예방 등의 다양한 분야의 전문가가 함께 참여하여 협력하고 있다. 또한, 지방정부는 다양한 분야의 전문가들이 협력을 잘 할 수 있도록 공통으로 필요한 지식과 기술에 대해서도 정기적인 교육기회를 제공하고 있다. 이와 관련하여, 중앙정부는 지침을 만들어 제공하고 지방정부는 지침의 범위 내에서 구체적인 재량권을 행사한다. 구체적인 예로 아동보호와 관련하여 중앙정부는 'Working Together to Safeguard Children'이라는 지침을 마련하여 관련 기관 간의 협력 의무를 강조하고 있다(HM Government, 2018). 이 지침은 공공부문뿐만 아니라 독립부문을 위한 내용으로 구성되어 있다. 아동법, 교육법 등의 관련 법령에 대한 설명과 기관 간의 네트워크의 필요성을 강조하고 있으며, 아동학대 예방과 보호를 위한 정책 및 실천방안 등을 담고 있다.

3-3-2. 이용자 선택권 강화

영국에서는 노인, 장애인 등을 주요대상으로 하는 성인 사회서비스 분야는

서비스 공급의 시장화가 가속화되어 그러한 특징이 사례관리에도 반영되고 있다. 과거에는 일률적으로 지방정부에 소속된 케어 매니저나 임상실천가(practitioner)가 욕구를 사정한 후 알맞은 서비스를 연결해 주는 형태로 사례관리가 진행되었다. 노인과 장애인 등의 많은 이용자들이 선택권한이 매우 제한적이라는 것을 알게 된다(Parry-Jones and Soulsby, 2001). 서비스 공급주체가 다양화되어 선택의 여건은 확대되었으나 실제적인 선택권한이 이용자에게 주어지지 못한 것이었다. 서비스 공급주체의 다양화는 대표적으로 홈케어 분야에서 확인해 볼 수 있다. 커뮤니티 케어법이 시행된 1993년도의 홈케어 서비스를 살펴보면, 지방정부 소속 공공기관들은 이용가구수 기준으로 홈케어 서비스의 96.3%를 제공한 반면 독립부문은 단지 3.7%를 제공했다. 그러나, 1993년에 96.3%였던 공공부문의 이용 가구수 기준 서비스 제공비율은 2008년에는 22.5%로 급격히 감소했지만 독립부문의 서비스 제공비율은 3.7%에서 77.5%로 증가하여 독립부문의 서비스 공급이 다수를 이루고 있음을 알 수 있다(표 1 참조).

〈표 1〉 커뮤니티 케어법 시행 이후 홈케어 서비스 공급주체별 이용 가구의 변화

*반올림 수치임

조사연도	가구		
	합계	지방정부	독립부문
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

* 출처: NHS (2006; 2009)
* 9월 중 조사(Survey week during September)
* 지방정부: 성인 사회서비스를 맡은 지방정부
* 누락된 데이터에 대한 추정치를 포함. 반올림으로 인해 합계가 각각의 합과 불일치 할 수 있음

이처럼 독립부문의 서비스 공급이 증가하며 시장화가 가속화되는 상황에서 이용자의 선택권 보장에 대한 요구가 커졌고, 이에 영국 정부는 직접지불(direct payment)제도를 발전시켰다. 이 제도는 원래 보수당 정부 시절인 1996년에 'Community Care(Direct Payments) Act'에 의해 도입되어 1997년에 시행되었다. 장애인들의 요구로 도입됐던 이 제도는 신노동당 정부 하에서 지속적으로 확대되어 장애인 뿐만 아니라 노인 등을 대상으로 한 사회서비스 영역에도 적용되었다. 이 제도는 기존의 케어매니저 등의 제삼자를 통해 서비스 구매가 이뤄지던 것에서 서비스 이용자가 직접 구매 당사자가 되는 변화를 의미했다. 직접지불 제도는 이용자가 스스로 서비스 제공기관을 찾아야 하고 지불한 비용에 대해 지방정부에 정산 보고를 할 책임을 지고 있었기 때문에 이용자의 입장에서 어려움이 있었다(Glasby and Littlechild, 2016).

이러한 직접지불 제도의 한계를 보완하기 위해 개인예산제(personal budget)가 2006년부터 도입되었다. 이 제도는 서비스 설계에서부터 집행에 이르는 전 과정에서 이용자의 자기주도성(self-direction)을 강조하였다. 이용자가 직접 현금을 수령하여 집행하는 방식, 개인예산을 지방정부 케어 매니저에게 위탁하여 서비스를 구매하는 방식, 서비스 기관에 개인예산을 위탁하고 그 기관으로부터 서비스를 받는 방식 등이 있다(Carr and Robbins, 2009). 이처럼 서비스 이용에 있어서 선택권과 개인의 삶에 대한 스스로의 통제권에 대한 강조는 신노동당 정부의 뒤를 이은 보수당과 자민당의 연립정부인 캐머런 정부에서도 계속되었다. 이런 기조 속에서 2014년의 돌봄법(The Care Act)은 직접지불과 개인예산제를 모두 법에 규정하였다. 직접지불을 선택한 이용자는 전체 성인 및 65세 이상 노인층 모두에서 꾸준히 증가해 왔다(표 2 참조). 이는 직접지불 제도에 대한 이용자의 선호가 증가하고 있음을 보여준다.

〈표 2〉 직접지불 이용자수 변화

(단위: 천명)

Age	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
18세 이상	49	67	86	107	125	139	148	155
65세 이상	18	27	37	45	52	61	63	63

* 출처: HSCIC 'Community Care Statistics', 2008-09, 2010-11, 2013-14.

3-3-3. 규제의 증가

영국은 자유주의적 복지국가 중에서도 민간 영리부문의 역할이 강조되고 시장화의

정도가 높으면서도 강력한 규제제도를 마련해왔다(Taylor-Gooby, 2004). 시장화로 민간 영리부문의 시장진입이 증가하면서 규제의 필요성도 커졌기 때문으로 보인다. 공공부문 대비 독립부문의 급속한 성장은 홈케어 분야에서 연도별로 각 공급주체의 서비스 제공기관 수의 변화를 통해 확인할 수 있다. 특히, 영리부문의 증가가 비약적임을 알 수 있다(표 3 참조). 2004년에 민간 영리부문이 전체 홈케어 서비스 제공기관 중 70.2%를 차지하여 이미 대다수의 서비스 제공기관이 영리부문임을 알 수 있는데, 2008년도에도 민간 영리부문이 75.2%를 차지하고 있어 영리부문의 활발한 참여가 계속해서 증가하고 있음을 알 수 있다.

〈표 3〉 서비스 공급주체별 제공기관 수의 변화

(단위: 기관수)

연도	계	지방정부	자원	민간영리	NHS	기타
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

* 출처: The Commission for Social Care Inspection (CSCI), 2009.

이에 신노동당 정부는 사회서비스의 공급 주체보다는 서비스 이용자 및 그 보호자와 가족들이 경험하는 서비스 질에 정책의 초점을 두었다. 이를 위해, 보수당 정부에서부터 시행해 왔던 의무경쟁입찰제(CCT)를 폐지하고 최고의 가치(Best Value) 제도를 도입하였다. 지방정부는 가격과 품질 모두에서 최상의 가치를 제공하는 서비스 공급자를 선택해야 할 의무를 부여받았다. 또한, 지방정부는 이용자, 시민, 지역사회를 참여시켜 만든 수행 목표(performance target)와 사용자 만족도 같은 지표에 의해 중앙정부의 통제를 받았다(Scourfield, 2007; Boyne, 1998).

신노동당 정부는 기존 보수당 정부의 획일적이고 정량적인 규제 시스템을 비판하며, 서비스의 안정성을 높이고 이용자의 안전한 서비스 선택을 보증하기 위해서 서비스 품질관리제도를 입법 및 기준설정 등을 통해 강화하였다. 2000년에 '돌봄기준법(Care Standards Act)'을 제정하여 사회적 돌봄서비스의 기존 규제체계를 개혁하고자 하였고, 감독기관인 국가돌봄표준위원회(National Care Standards Commission)와 국가최저기준(National Minimum Standards)을 규정하였다.

2003년에는 국가돌봄표준위원회(National Care Standards Commission)를 폐지하고 새로운 감독기구인 사회적돌봄감독위원회(Commission for Social Care Inspection, CSCI)를 설립토록 하였다. 아동서비스 평가가 Ofsted로 이관되면서, 결과적으로 CSCI는 성인 사회서비스만을 평가하는 조직이 되었다. 이 위원회는 지방정부와 사회서비스를 제공하는 기관들을 대상으로 등급을 부여하고 그 결과를 공표하였다. 2009년에는 보건과 사회서비스를 아우르는 새 감독기구인 CQC(Care Quality Commission)가 창설되었다.

Bode(2010)는 사회서비스 분야의 일반적인 규제장치로 공식화된 서비스 질의 표준(formalized quality standards), 감독 체계(inspection regimes), 계약 템플릿(contracting templates)을 제시한다. 영국은 서비스 질의 표준은 국가최저기준(National Minimum Standards)에 의해 제시되고 있고, CQC는 그 기준에 따라 각 서비스 제공시설들이 기준을 준수하고 있는지를 평가하는 감독 기능을 수행하고 있다. 그리고 중앙정부는 지방 당국이 지역사회 기관들과 서비스 계약체결 시 활용할 수 있는 Public Health Services Contract(Department of Health, 2015) 같은 계약 템플릿을 제공하여 서비스 질을 담보할 수 있도록 기준을 제시하고 있다. CQC(2019)에 따르면, 이전에 부적합 등급을 받아서 2018/19에 재검사를 받은 서비스의 74%가 개선된 것으로 나와, 2017/18년도에 비해 거의 모든 부문과 등급에서 서비스 품질이 개선된 결과를 보여주고 있다(CQC, 2019)(표 4 참조).

〈표 4〉 등급 개요(2018년 및 2019년 각 3.31일 기준)

구 분		성인 사회적 돌봄 기관 (Adult Social Care directorate)		의료 기관 (Hospitals directorate)		1차 의료서비스 기관 (Primary Medical Services directorate)	
연 도		2018	2019	2018	2019	2018	2019
등급	우수 (Outstanding)	513 (2%)	792 (3%)	46 (7%)	69 (8%)	326 (5%)	327 (5%)
	양호 (Good)	17,106 (79%)	18,159 (80%)	410 (62%)	599 (66%)	6,363 (91%)	6,196 (90%)
	개선 필요 (Requires improvement)	3,802 (17%)	3,485 (15%)	186 (28%)	215 (24%)	261 (4%)	264 (4%)
	부적합 (Inadequate)	349 (2%)	264 (1%)	15 (2%)	19 (2%)	75 (1%)	86 (1%)

* Source: CQC (2018, 2019)

4. 논의 및 정책 제안

영국은 공공재정의 비용통제와 이용자의 선택권을 보장하려는 방편으로

커뮤니티 케어를 시행했고, 사례관리는 커뮤니티 케어의 주요 실천 장치로서 기능해왔다. 이러한 사례관리는 지방정부를 통해 이뤄지고 있으며, 주요 대상자는 노인, 장애인, 아동 등이다. 이에 따라 영국의 복지 전달체계에 있어서 독립부문의 비중과 역할의 확대로 인해 공공부문과 독립부문과의 협력관계가 더욱 중요해졌다고 볼 수 있다. 따라서, Bruttel(2005)이 양자의 협력에서 기대하는 효과의 달성을 위해 제시했던 세 가지 거버넌스 메커니즘이 영국의 사례관리 정책에서 제 역할을 하고 있는지 살펴보는 것은 의미가 있을 것 같다.

거버넌스 메커니즘은 계약관계에 기반한 주인-대리인 관계에서 나타나는 도덕적 해이, 정보 비대칭성의 문제를 극복하기 위해 제안되었다. 공공서비스의 시장화 측면에서 공공부문이 주인(principals)이며 공공부문과의 계약을 통해 서비스를 제공하는 민간부문은 대리인(agents)이라 할 수 있다. 계약시스템의 주요한 문제 중의 하나가 대리인이 주인보다 자신의 이익을 추구하면서 생기는 도덕적 해이이다. 사회서비스를 공급하는 독립부문은 영리와 비영리 부문이 혼재되어 있는데, 계약의 문화가 영리와 비영리 부문 모두에 영향을 미치므로 이러한 메커니즘을 적용해 볼 수 있을 것으로 보인다.

우선, 정보메커니즘은 정보의 투명성을 높여 정보의 비대칭성을 극복하는 데에 초점을 두고 있다. 영국은 아동보호와 관련된 업무의 세부내용을 기술한 'Working Together to Safeguard Children'(HM Government, 2018) 등의 지침을 통해 공공기관 종사자뿐만 아니라 서비스를 제공하는 관련 민간기관 종사자들이 업무수행에 참고할 수 있도록 하고 있다. 또한, 정기적인 교육기회를 제공하여 다양한 분야의 전문가들이 공통된 지식과 기술을 바탕으로 협조를 원활히 할 수 있도록 지원하고 있다. 특히, 아동사례관리에 있어서는 공공뿐만 아니라 민간의 전문가도 공통사정 과정에 참여하여 사례관리의 초기 단계에서부터 공공부문과 독립부문의 정보교류가 잘 이뤄지고 있음을 알 수 있다. 이용자의 측면에서는, 사례관리의 행정체계가 비교적 명확한 점이 서비스 이용을 돕고 있다고 보인다. 사회서비스 이용을 위한 서비스 신청창구가 지방정부로 일원화되어 있고, 특히 지방정부 내에 아동과 성인이라는 대상별로 조직이 분화되어 있어 서비스 이용자가 신청창구를 찾는 데에 어려움이 없어 보인다. 즉, 서비스 신청은 지방정부에서 하므로 이용자 입장에서 전달체계가 비교적 쉽게 설계되어 있다고 할 수 있다. 이처럼 공공부문과 독립부문의 역할분담이 확실한 점이 영국 사례관리의 큰 특징이라고 할 수 있다.

둘째, 통제메커니즘의 관점에서 보면 영국은 다양한 규제 장치를 사용하여 사례관리를 통해 독립부문에 의해 공급되는 사회서비스의 질을 관리하고 있다. 영국은 공식화된 서비스 질의 표준(formalized quality standards), 감독

체계(inspection regimes), 계약 템플릿(contracting templates) 등의 다양한 규제장치를 사용한다. 중앙정부는 재정과 지침 등을 통해 지방정부를 감독하고, 지방정부는 서비스 계약체결시에 서비스 기간과 방식 등의 내용을 정하여 민간의 서비스 공급자들이 제공하는 서비스를 간접적으로 관리한다. 그리고 보건 및 사회서비스를 감독하는 독립기관인 CQC와 같은 단일 감독기구를 통해 규제의 일관성이 보장되고 CQC가 매년 발행하는 정기보고서를 서비스 종사자들이 활용하여 서비스 개선에 대한 인식을 높이고 있고 실제 서비스가 개선된 결과를 보여주고 있다(CQC, 2019).

마지막으로, 인센티브메커니즘은 서비스 공급자로 하여금 성과를 낼 수 있도록 유도하는 것으로 민간의 공급자들의 이익이 결국 공공부문 구매자들의 이익으로 이어질 수 있도록 하는 장치라고 할 수 있다. 영국에서는 이용자의 선택권을 보장하기 위해 현재 직접지불과 개인예산제를 법으로 규정하여 운영 중이다. 이는 보다 시장기제의 특성에 맞게 사회서비스 전달체계가 변화된 것으로 민간의 공급자들 입장에서는 보다 다양해진 소비자를 대상으로 선택받기 위해 경쟁해야 하는 것을 의미한다고 볼 수 있다. 자기주도적인 사회서비스 소비자의 선택을 받기 위해 대리인인 민간 공급자들이 서비스 품질에 보다 초점을 둘 가능성이 높아질 수 있고, 이는 주인인 공공부문이 추구하는 이익에도 부합하는 것이라고 할 수 있다.

이와 같은 영국의 사례관리 정책과 관련된 전달체계와 이에 따른 공공부문과 독립부문의 관계는 한국에 시사하는 바가 있다. 한국도 현재 공공부문에서 사례관리를 주도적으로 추진하고 있고, 특히 지방정부를 중심으로 이뤄지고 있기 때문이다. 그리고 2007년 사회서비스 전자바우처 제도와 2008년 노인장기요양보험 제도가 시행되면서 사회서비스 시장화가 이뤄지고 민간 영리부문의 시장 진입이 본격화되었다(Jon and Lee, 2018; Kim, 2016). 주로 비영리 기관들이 공공기관으로부터 보조금을 지원받아 서비스 공급을 해왔으나, 바우처 제도의 도입 이후에는 이용자가 서비스를 직접 선택하게 되었다. 한국의 공공부문 사례관리와 사회서비스 시장화는 영국에 비해서는 역사가 짧고 비교적 최근에 본격적으로 시행되기 시작하였다. 따라서 오랜 기간동안 그런 제도를 발전시켜온 영국의 사례를 참고하여 한국의 중앙정부와 서울시에 동시에 다음과 같은 정책 제안을 한다. 공공사례관리가 전국적으로 추진되고 있는 시점에서 중앙정부의 협조가 필수적이기 때문이다.

첫째, 공공부문과 독립부문의 역할수행에 있어서 중첩을 방지하기 위해 사례관리에 있어서 신청창구는 공공부문으로 단일화하는 방안이다. 영국처럼 사례관리에 있어서 공공부문과 독립부문의 역할 구분을 명확하게 할 필요가 있다. 영국은 공공부문은 욕구사정과 계획수립 등의 역할을 하고, 독립부문은 주요 서비스

공급자로서 기능을 한다. 반면에, 한국은 공공부문과 민간의 비영리 부문에서 사례관리가 중첩되어 시행되고 있다. 공공사례관리가 도입되면서 비영리인 자원부문에서 축적한 사례관리 기능이 위축되고 있다. 양 부문간에 사례관리 대상자가 중복되어 역할 충돌의 문제가 있기 때문이다(Min, 2015). 사례관리 시행의 주체는 공공부문이 맡고, 독립부문은 서비스 공급자로서 양질의 서비스를 제공하는 명확한 구조로 전환하여 역할분담이 이뤄질 필요가 있다. 단, 장기간의 사례관리가 필요한 대상(만성질환자 등)에 한해서는 독립부문에 사례관리를 맡기더라도 최초 신청창구는 공공부문으로 하여 역할의 혼선을 방지할 필요가 있다.

둘째, 업무별로 파편화되어 있는 지방정부의 사례관리 조직을 보다 단순화하여 사례관리 업무를 이용자 중심으로 전환할 필요가 있어 보인다. 영국은 지방정부의 사례관리 조직이 대부분 아동과 성인의 2가지 대상그룹군으로 구분되어 있다. 한국은 아동사례관리(드림스타트), 의료급여사례관리, 자활사례관리 등의 다양한 사례관리 업무가 존재하며, 이 업무들은 서울시와 같은 지방정부의 광역단위 조직 내에서도 관련 부서별로 파편화된 형태로 수행되고 있다. 아동사례관리의 경우에는 드림스타트 사업에서 전담하고는 있으나, 아동의 가족 내 구성원에 대해서는 드림스타트 사업에서 직접적으로 다루지 않고 통합사례관리 사업에 별도로 의뢰하는 형태로 이뤄져 있다(보건복지부, 2019). 영국은 아동을 중심으로 필요한 경우에 그 가족구성원까지 포함하여 사례관리가 한꺼번에 이뤄지고 서비스가 제공된다. 따라서, 영국처럼 이용자를 중심으로 조직을 운영하고 서비스를 제공할 필요가 있어 보인다. 지방정부의 광역과 기초자치단위 조직에서도 특히 파편화가 심한 성인대상 사례관리 업무의 경우 총괄 전담팀을 신설하는 방안을 고려해 볼 수 있다. 서울시의 경우 서울시청과 각 자치구 내에 각각 사례관리 총괄팀을 둘 수 있다. 또한, 동 주민센터의 사례관리 업무담당 팀 내에서 아동과 성인 또는 아동, 성인, 장애인 등의 이용자 중심으로 업무를 분장하여 종합적인 욕구사정과 서비스 연계를 할 것을 제안한다.

셋째, 단일한 규제기구를 설립하여 독립부문에서 제공하는 사회서비스에 대한 체계적인 질 관리가 필요하다. 2008년 장기요양서비스 제도 도입 이후에 영리목적의 서비스 공급자들이 증가하였고, 이러한 공급주체의 다원화로 인해 서비스 질에 대한 정부규제의 필요성도 커져왔다. 현재 한국의 경우 사회서비스 기관에 대한 감독 업무는 업무내용별로 지방정부의 소관 부서에 분산되어 있다. 전문성 부족과 과도한 업무량으로 인해 효과적인 서비스 질 관리가 필요한 상황이다(Choi and Lee, 2014). 영국의 CQC처럼 단일한 규제기구를 설립하여 일관성 있게 체계적으로 감독하고 전문화된 규제를 할 필요가 있어 보인다.

5. Conclusion

현재 한국은 공공부문에 사례관리가 도입되어 주요 서비스 자원을 보유하고 공급하는 민간기관들과의 관계의 중요성이 더욱 커지고 있다. 영국은 사례관리 시범사업을 거쳐 이미 1990년대에 사례관리를 공공부문에 도입하여 시행해왔기 때문에 관련된 정책 노하우를 가지고 있을 것으로 판단되었다. 그런 측면에서, 영국의 사례관리 정책을 살펴보고 한국의 정책에 참고할 수 있는 시사점과 대안을 제시해 보았다. 영국은 이미 30여 년에 달하는 사례관리 시행의 역사가 있어서 공공행정 전달체계에서 공공부문과 독립부문의 역할이 변화해가는 과정을 각 시기별 특성에 맞춰 세 가지 행정 패러다임을 기준으로 분석해 보았다. 이를 통해 영국에서 사례관리를 통해 전달되는 공공서비스와 관련하여 독립부문의 역할이 커져왔음을 알 수 있었다.

이렇게 독립부문의 비중이 커지는 상황에서 영국이 사례관리 정책에 있어서 기대하는 효과를 달성하기 위해서 공공부문과 독립부문의 협력를 어떻게 구축하고 있는지를 정보, 통제, 인센티브라는 세 가지 거버넌스 메커니즘을 통해 분석해 보았다. 영국은 사례관리에 있어서 지침과 교육 등을 통해 공공부문과 독립부문의 정보교류가 이뤄지고 있으며, 공공부문과 독립부문의 역할분담이 비교적 명확하게 이뤄져 있다. 또한, 입법 및 기준 제시, 단일의 독립감독기관 설립 등의 여러가지 규제방법을 활용하여 다양한 공급주체의 참여로 인해 시장화된 사회서비스의 질의 개선을 이끌어내고 있다. 그리고 직접지불과 개인예산제 시행으로 소비자로서의 서비스 이용자의 선택권을 강화해왔다. 이러한 영국의 정책사례를 토대로 한국의 중앙정부와 서울시의 사례관리 정책에 있어서 고려할 부분들을 제시하였다. 첫째, 사례관리 신청창구를 공공부문으로 단일화하고 장기간의 사례관리가 필요한 경우에만 민간으로 사례관리를 이첩하는 구조로 하여, 공공부문과 독립부문의 역할 분담을 명확히 하는 것이다. 둘째, 업무별로 파편화되어 있는 지방정부의 사례관리 조직을 영국의 경우처럼 이용자 특성 중심으로 개편할 필요가 있다. 마지막으로, 단일한 규제기구를 설립하여 규제업무에 대한 전문성을 확보하고 서비스 질 관리를 체계적으로 할 필요가 있다.

이 보고서는 사례관리 수행에 있어서 공공부문과 독립부문의 관계설정에 초점을 두고 연구하였다. 그런데, 사례관리가 공공부문뿐만 아니라 지역사회의 다양한 자원을 활용하는 정책이라는 측면에서 공공부문에서 독립부문과 협력하여 새로운 자원들을 발굴하여 이용자에게 서비스로서 연계하는 부분도 중요하다고 할 수 있다. 따라서, 향후 지역사회 독립부문의 다양한 자원을 발굴하는 방법과 이 부분에 있어서 공공부문과 독립부문의 협력방향에 대해 고찰하는 연구가 필요할 것으로 보인다.

〔훈련성과보고서 영문본〕

A Study on the care management in the UK and the role-sharing between the public and independent sectors

MPA

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Abstract

The Seoul Metropolitan Government (SMG) in South Korea, has been focusing on public-led care management to overcome the limitations of the existing welfare delivery system. For the successful implementation of the care management project, although the cooperation of the independent sector (voluntary and private sectors) with various service resources and work experience is essential, and specific criteria are not provided in the scope and relationship setting of the public and private sector roles. The UK has long been implementing care management as a major means of community care, complementing and developing the system. It is similar to the case of the SMG in that care management is carried out by the local authorities, a public sector. Therefore, in care management policy, this report examines the relationship between the public and independent sectors in the UK and derives implications for the policy of the SMG.

The UK has a long history of implementing care management, so it is necessary to look at it in general to understand the context behind the introduction of care management and its current policy. Therefore, from the period before the introduction of care management to the present, the relationship between the public and independent sectors have been analysed by applying the traditional public administration paradigms which are Traditional Public Administration, New Public Management, and Governance, respectively. Based on this, in case of the SMG, it is presented to unify the care management structure to clarify the role-sharing between the public and independent sectors, to reorganize the related organization structure centered on users, and to establish a single regulatory body.

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1. Introduction

The Seoul Metropolitan Government (SMG) in South Korea tried to reorganize its delivery system based on the belief that welfare services are not being delivered to the citizens who need it because of the limitation of the existing welfare delivery system. Therefore, in order to find out the citizens who are in the blind spot, the welfare service paradigm has been turned into a welfare system that visits directly from the way of receiving the application of the residents (SMG, 2015). This project was named as the "Visiting Community Service Center" project. This project intended to utilize the private's know-how and to induce the private's cooperation by composing civil and administrative governance type 'promotion and operation headquarters' in all processes preparing for the full implementation from the policy development stage. There are a number of detailed projects in this business, one of which is care management.

Hutt et al (2004) describe care management as a process of ‘planning, coordinating, and reviewing the care of an individual’. The care management project in the SMG is also linking services tailored to the person with multiple needs according to certain procedures. In order to utilize various private service resources and care management experience, it is emphasized the cooperation and participation of the independent sector from the beginning of the project. However, the care management project of the SMG is designed around the public social welfare delivery system, and there seems to be a limitation that the expertise of the independent sector with experience of care management cannot be sufficiently exerted. The standard of linkage cooperation between various fields of public, private and community is vague, and specific criteria for scope and role-sharing of care management beneficiaries are not presented (Kim, 2015; Min, 2015).

To appropriately link private services to care management target groups, the cooperation of private and voluntary institutions is essential. The public sector has accessibility and administrative authority to personal information, and the independent sector, especially voluntary sector, has the strength of expertise and rapport formation for care management practices. In order to improve the

quality of care management services, two complementary systems need to be communicated and cooperated. Accordingly, it is significant to study the proper role standard of the public and independent sectors based on the developmental process of public and private care management and understanding of each strength. To this end, it seems necessary to refer to the policy of the advanced welfare state, which has a long history of care management administration and various experiences. It is essential to present the future of SMG's care management policy by studying foreign applicable policies such as care management system and public-private partnership.

In particular, the UK has undertaken a large-scale care management pilot project and is currently conducting care management directly in the public domain. In the past, care management has been successfully tested and proven as pilot projects (Kent and Gateshead, Darlington Project, etc.) by adopting an integrated health and social service approach to revitalize community care in various parts of the UK. This has contributed to the provision of services centering on the beneficiaries and has been successfully evaluated in terms of cost competitiveness compared to the conventional facility protection methods (Challis et al, 2004; Challis et al, 1995). On the regional level, health and social services have developed innovations in the field of integrated management for many years (Ross et al, 2011). Since the pilot projects, care management introduced to the public sector and has implemented as a major means of community care.

The UK also conducts care management in local authorities. This is similar to the case of the SMG, which is implementing care management policies as a local government. In the UK, as budget authority is handed over to care managers of local authorities, they act as service buyers to induce competition in services in the independent sector, to reduce costs and provide quality services. Local authorities focuses on linking services as coordinators, while the independent sector provides services through contracts with local authorities as service providers.

According to Benington and Geddes (2001), the establishment of a cooperative system between local authorities and the local private organisations in relation

to the welfare service delivery system has become the main focus of discussion. Therefore, it will be examined the care management policies in the UK, focusing on the roles and relations of the public and independent sectors, to identify implications for the policies of Seoul. The care management policy in the UK is a project that has been in operation for decades, so the study focuses on the existing literature methodologically.

2. Literature Review

2-1. Definitions of care management

Before examining the care management policy in the UK, it is necessary to examine the concept of care management. The definition of care management or case management of major scholars is as follows. Moxley (1989) defines case management that it is an activity assessing the needs of clients with multiple needs in various areas of interpersonal service practice, then identifying appropriate services, opportunities or benefits to meet those needs, developing a comprehensive service plan, providing advocacy to facilitate clients' access to various services, and checking and evaluating the delivery of appropriate and effective services. There are also definitions that emphasize the practical nature of case management. Woodside and McClam (2006) define case management as a practical strategy for effectively delivering diversified services to people with multiple needs. And Moore (1990) emphasizes that case management is a new area of social work practice where clinical therapists' clinical skills and advocacy skills of community organizers are required. According to him, case management helps clients maximize their potential by integrating the activities of the informal protection system and the formal system, including the family, to meet the client's desires, and to enable them to interact effectively within the surrounding social environment.

There is also the definition of a professional organization related to case management. The National Association of Social Workers (NASW, 2013) in USA, similarly to Moxley's definition (1989), defines case management as "It is an activity that a professional social worker diagnoses the needs of clients and families, monitor, evaluate, and advocate services that suit a variety of

needs. The Case Management Society of America (CMSA) and the Case Management Society UK (CMSUK) provide the same definition of case management, which is used to assess the complex needs of clients and their families. They describe it 'a collaborative process' that plans, executes, adjusts, evaluates, and checks, and also argue that this process improves the quality of life of clients by using communication and resources and promotes cost-effective performance.

In this way, care management can be defined from a general approach to clinical and advanced practice. Taken together, this can be viewed as a professional practice that provides integrated and ongoing service to improve the social function and quality of life of clients and families with diverse and complex needs. In addition, systematic assessment and resource development are needed to provide services that meet the needs of clients, and it is necessary to establish a cooperative system with the local community continuously in order to satisfy needs and restore social functioning.

It was first introduced 'case management' from the US to the UK, but the term ‘care management’ is used in the UK. In 1990, the NHS and Community Care Act was enacted, using the term 'care' instead of 'case'. This was because the concept of 'case' could be perceived as a disrespect for the people who are looked after (SSI / SWSG, 1991). Later, in 2005, the Department of Health, the UK central department, began to use the term 'case management', suggesting that the target group was 'a long-term health care subject at risk of repeated hospitalisation'. (Department of Health, 2005). This can be seen as a special type of care management (Jacobs et al, 2006). Therefore, this report uses the term 'care management', which is used in the UK in a more comprehensive sense.

2-2. Traditional Public Administration, New Public Management and Governance

In the UK care management policy, the role of the independent sector is strengthening as the role of public administration changes over time. This is also linked to the overall flow of the UK welfare policy. From the end of the Second World War to the late 1970s, the public administration was

responsible for the welfare of the people. However, from the late 1970s, when the Conservative Party took power after the economic crisis, the role of the service provider by public administration began to transfer to the private in earnest under the influence of New Public Management (NPM). Then in 1997, the New Labour Party came to power, recognizing the importance of governance and emphasizing the partnership between the public and voluntary sectors. This shows that the type of service delivery is changing as the public administrative environment changes. Lynn Jr. (2001) discussed the change of public administration using the concept of paradigm, and the aspect of public administration at each time is characterized by different administrative paradigms. Therefore, the flow of policy related to care management in the UK can be explored within the framework of each administrative paradigm characterized by different types of service delivery. These paradigms can be identified as Traditional Public Administration(TPA), NPM and Governance, respectively. Colebatch and Larmour (1993) propose three models that focus on organisational processes: 'bureaucratic model' that focus on authority and rules, 'market model' where incentives and prices are key, and 'community model' which has norms, value and network as core elements. In a similar context, Thompson et al. (1991) present hierarchy, market and network as models of social coordination. These are consistent with the key elements of TPA, NPM and Governance respectively.

First, TPA is characterized by centralized control, setting rules and guidelines, separating policy decisions and implementations, and hierarchical organizational structures (Osborne, 2006). In other words, the government has operated an internal organization through a hierarchical structure and has shown hierarchical control in relations between central and local governments and also between the government and civil society (Pierre and Peters, 2000). The administration is also considered to be predictable and governed by rules, and administrators are recognized as trained professionals (McCourt and Minogue, 2001). Within this paradigm, the role of government continued to grow until the 1970s, bureaucratic bodies expanded and the independent sector contracted relatively. Then, in the late 1970s, as the world economy slumped due to oil shocks, 'government failure' emerged as the main topic. Accordingly, reforms

of traditional public administration were called for due to problems such as the inflexibility of bureaucracy and the bureaucratic welfare, lack of responsiveness to customer service, and inefficiencies that result from focusing on processes rather than consequences. Governments have tried to reduce the public finance deficit by reducing the role of the public sector. The government tried to reduce their own authority and introduce efficiency management techniques in the public sector. This points to a novel approach to administration seen in many OECD countries in the 1980s (Robinson, 2015). This change was called 'New Public Management' (NPM) by Hood (1991), which emerged as a solution to overcome the limitations of bureaucratic and traditional administrative paradigm.

In this context, Osborne and Gaebler (1992) stress that the public sector will have an entrepreneurial spirit that considers the people as customers by introducing competitive market mechanisms beyond the traditional bureaucratic framework. And they argue that the role of government is in steering rather than rowing. Steering is policy decisions and rowing is service delivery (Osborne and Gaebler, 1992: 35). Thus, the main contents of the NPM are the emphasis of output and performance objectives, the preference on management skills, and the imitation of management practices of private companies rather than bureaucratic procedures and rules (Kamensky, 1996). The NPM has also sought to make public services efficient management and financial principle (Osborne and Brown, 2005). Thus, Osborne (2006) explains that NPM presents the main features increased use of markets, competition and contracts for resource allocation and service delivery while focusing on cost management in public services. As such, the market emerged as an alternative mechanism for service delivery by NPM. However, NPM has been criticized for its many limitations. Entwistle and Martin (2005) point out that NPM presupposes a competitive regime, but in reality it is costly without activating competition. Minogue (2001) argues that accountability has been reduced due to contraction, privatisation, and marketisation while lacking evidence of improved efficiency. The OECD also negatively assessed NPM in its 2003 report (Matheson and Kwon, 2003). The OECD pointed out that the reform of NPM failed to recognise that the role of public management is to

deliver governance values as well as deliver public services.

As an alternative to the constraints of NPM, the concept of 'governance' is drawing attention. The term governance is defined in many different ways, but basically presupposes a change in the form one governs that blurs the boundaries between the public and private sectors (Stoker, 1998). Rhodes (1997: 15) explains that this is a new process of governing, which implies a change in the meaning of the concept of government. This is a network between organizations, characterized by interdependence, exchange of resources and autonomy from the state (Rhodes, 1997). He (1996) also emphasizes the concept of networks in terms of governance, suggesting them as an alternative to previous hierarchical and market approaches. Jessop (1999) regards the form of self-organization represented by networks as a narrow meaning of governance. A broad meaning of governance is a comprehensive concept that includes a variety of ways of solving problems related to organization, social systems, or the whole nation (Stoker, 1998). Pierre and Peters (2000) also present that governance involves various types of countries, markets, network communities and associations. In other words, governance can be seen as a new mode of community operation through partnerships and networks of governments, markets and civil society (Rhodes, 1996; March and Olsen, 1995).

Therefore, governance is considered as a way to solve a variety of new social problems. Rhodes (1997) notes the possibility that governance will solve social problems without hierarchical control or direct government intervention. Rosenau (1992) sees governance as a way of solving social problems on the basis of a shared purpose, and Scharpf (1997) says that in a similar context, addressing social problems by negotiation-based agreements is at the core of governance. As above, in order to cope with the issues that cannot be addressed by the existing public administration service delivery method, a new administrative paradigm has emerged and this has influenced the delivery of policy. Thus, these three administrative paradigms are used to analyse the changes and details of UK care management policy and draw implications.

2-3. Welfare mix and marketisation

In the 1970s, western countries began to emphasize the role of the market instead of reducing the role of the welfare state in order to reduce the national financial burden due to the economic crisis. Under the influence of neoliberalism, in the late 1980s, it was argued that welfare service providers should be replaced by the market, the family, and the community from the state. In this regard, the concept of the welfare mix has been emphasized, which is ideologically rooted in welfare pluralism. Welfare pluralism means diversifying the subject of welfare supply. According to Johnson (1987), this means decentralization, devolution, and empowerment in terms of providing welfare services. Therefore, since the 1980s, welfare states in the West had been increasingly inclined to provide welfare services centering on welfare pluralism and market principles (Daly and Lewis, 1998). In the UK, after the prime minister Thatcher took power, he tried to justify the introduction of the privatisation and market competition principles to the public sector, suggesting welfare pluralism. The Thatcher government has introduced a market mechanism in the field of welfare services to spread the culture of market and contract (Means et al., 2002).

The service providers that make up this kind of welfare mix can be broadly divided into the public domain and the private domain. The private domain can be divided into the commercial sector, the nonprofit sector, and the informal sector. Johnson (1987) divides the service supply sector that constitutes the welfare mix into the national, commercial, informal sector and voluntary sectors. Similarly, Kendall et al. (2006) also divide the constituents into the public sector, the nonprofit sector, the commercial sector, and the informal sector. The public sector includes central, local, and public institutions. According to Salamon and Anheier (1998), the commercial sector is an organization that operates in the market for profit. The not-for-profit sector, also called the voluntary sector, is an organization that is formally formed, voluntary and autonomous and that is concerned with public services and regulated by government, but not public sector (Kendall, 2004; Deacon, 1996). The informal sector is a concept that includes family, relatives, and neighbors based on personal relationships (Johnson, 1987). In summary,

service providers can be broadly divided into the informal and official sectors, and the formal sector can be further divided into the public, non-profit and for-profit sectors. The non-profit sector is called the voluntary sector while the for-profit sector refers to the private sector. In the UK, these voluntary and private sectors are collectively called the independent sector (Sharkey, 2007; Department of Health, 2001). Likewise, this report collectively refers to the voluntary sector and the private sector as the independent sector.

In the welfare mix, the public sector subsidizes funding, plays a role in regulating the market, and service provision is mainly in the independent sector, the community, and the market. Ascoli and Ranci (2002) argue that shifting the responsibility of providing services from the public domain to the private domain is referred to as privatisation, and Savas (2000) also says that privatisation is the adjustment of production from the government to the private. Barr (2003) argues that by expanding the concept of privatisation further, it is a strategy to transfer the public sector's role to the market sector in two aspects, production and financing. In the concept of marketisation, it is essential to introduce the market mechanism of competition on the basis of privatisation of welfare services. Brennan et al. (2012) argue that marketisation is a measure that encourages competition and choice, which is the principle of the market, by encouraging the government to engage in the caring market in the private commercial and nonprofit sectors. In the context of marketisation, the UK has reduced the role of the state as a service provider and strengthened the role of nonprofit and for-profit organizations (Means et al., 2008). Separating the role of service purchasing and supply, local governments took the role of the buyer while the independent sector took the role of the supplier. As a result of such marketisation policies, private commercial and nonprofit organizations became major suppliers of welfare services. However, the marketisation of such welfare services differs from the concept of a complete market. This can be explained by the concept of quasi-market. While quasi-market theory recognizes the positive aspects of the market, it emphasizes that the public sector should make efforts to prevent market failure by regulating price policy and service quality management (Propper, 1993). Therefore, it is emphasized that the public sector takes the

role of regulators and the managers of various suppliers in welfare services.

2-4. The partnership between the public and private sectors

With the welfare mix, the commercial and non-profit private sector in the field of welfare services has become a major service provider. Public and independent sectors, however, have their limitations in providing their services (Salamon, 1995). Thus, in order to complement the failures in providing welfare services and maximize the benefits, cooperation between the public and independent sectors, represented by central and local governments, commercial and nonprofit organizations, is required (Billis and Glennerster, 1998). The public sector has the advantages of ensuring equity, guaranteeing the continuity and stability of services, and strengthening social cohesion (Osborne and Gaebler, 1992: 2425). However, state-led welfare services have been criticized for their rigidity due to bureaucracy, lack of flexibility for users' needs, centralized control over resources and power, and inefficiency. On the other hand, the independent sector has been evaluated as having high responsiveness and communication ability in service delivery compared to the public sector. In the independent sector, for-profit organizations are more motivated by policy performance (Grover, 2009), because they seek revenue, and access to blind spots where the public administrative system is inaccessible through management flexibility is easy (Finn, 2007). Nonprofit organizations tend to put them back into service when they generate profits (Giotis, 2011), and get higher reliability with more publicness than commercial organisations (Davies, 2011).

According to the need for cooperation between the public and independent sectors, there have been various discussions on the relationship. The key to this discussion is on the subject of service provision and financing, and on service quality management (Glennester, 2003; Ascoli and Ranci, 2002). Gidron et al. (1992) suggest four types of relationships between government and the voluntary sector, depending on the subject of the service provider and the financial burden. One of the models is the collaborative model that the government is financially responsible and the nonprofit sector takes charge of

the service delivery. The partnership model is a type of collaborative model and is characterised the cooperative relationship between the two sectors, and there is the autonomy of the voluntary sector.

There is no unified definition of the concept of partnership, but Powell and Glendinning (2002: 3) believes that partnership is based on 'some common interests or interdependencies' between members or institutions. It is defined as a relationship that requires 'trust, equality or reciprocity' to the minimum. Waddock (1989) uses the concept of 'social partnership' and says the partnership is an action by several organizations working together to achieve a common goal. According to Pierre (1997), partnerships create synergy effects internally and externally, facilitating communication between the public and private sectors. In addition, partnerships can prevent duplication and omission of services among social service providers (Huxham and Macdonald, 1992) and strengthen community cohesion (Timms, 1990).

However, in order for the public and independent sectors to achieve the expected effects of cooperation, it is essential to have government coordinating functions (Bruttel, 2005). Bruttel (2005) emphasizes the need for governments to have three coordination functions for the private sector. First, 'control mechanisms' should be established at a level that does not hinder the autonomy of the private sector. Second, 'information mechanisms' that are transparent between the government, private sector and service users should be established. Finally, he argues that there must be 'incentive mechanisms' that enable the private sector to continue to improve performance. As a result, cooperation between the public sector and the private sector is essential under the mixed welfare environment, and it is necessary to ensure the autonomy of the private sector within the framework of the government's standards, but also to function as a government regulator in order to prevent failures.

3. Transition in the UK's Care Management Policy: Analysis based on administration paradigms

Care management was introduced to the UK in earnest under the National Health Service and Community Care Act (the NHS & CC Act) in 1990. To

understand the background of the introduction of a new policy, it is necessary to understand the policy environment surrounding previous related policies. Therefore, it is examined the policy focusing on the role and relationship of each participant, from the pre-introduction of the care management policy to the introduction period and the current policy status. To this end, as mentioned above, relevant contents and characteristics are analyzed on the basis of three administrative paradigms with different characteristics of the delivery of public administrative services according to the changes of the times.

3-1. The age of Traditional Public Administration (post-war – late of 1970s)

This was before the advent of care management policy in the UK. Thus, the social and political backgrounds of care management emerged can be explored. As care management later emerged as a major practice for community care in the UK, a look at community care during this period also reveals the social and political background of care management. Sharkey (2007) describes community care as providing social care and support within the community. He says care for most of these communities also includes the provision of health care. As the representative users of community care are the elderly and the disabled, care and medical support are essential for them to live independently in the community.

3-1-1. Strong accountability

After World War II, the UK established a welfare state based on the Beveridge Report (1942) produced by the Cabinet. As a result, policies covering social security, medical care, and employment were promoted, and various laws and systems were established for this purpose. The Beveridge Report regarded minimum living security as the state's responsibility, a breakthrough from the idea of the Poor Law, which provided welfare services only to the poor selected by strict qualifications. In other words, the government was responsible for the supply of public goods in various areas such as health, education and social security (Hogwood, 1992). With the enactment of the National Health Service Act of 1946, medical services were

provided free of charge to all citizens. Subsequently, in 1948, the National Assistance Act was enacted, and it was prescribed as the duty of local authorities to provide residential care to those in need of care due to age and illness. Medical services provided by the National Health Service (NHS) were provided free of charge, but social care services provided by local authorities were paid according to an asset level (Jones, 2000). This series of legislative processes had given local authorities new responsibilities and authority for social services for target groups of elderly, disabled and children (Lowe, 2005; Sullivan, 1996).

However, although the authority and responsibilities of local governments for social services had been expanded, the organizational structure within local authorities had been divided into various departments according to the areas of work such as welfare, education, children and health. The service structure, which is dispersed according to the administrative specialty rather than the user-centered, has been pointed out as a factor that makes it difficult for target users, who had complex needs, to effectively access services (Forder, 1975). In the process of expanding the service centered on the public sector, the issue that the user had to visit various institutions to receive the service was revealed, and it was argued that the structure of the service should be reorganized based on the user's needs (Wistrich, 1970). In addition, while the provision of welfare services centered on facilities continued, poor conditions of care for the main users such as the elderly, the disabled of the facilities revealed. As a result, community care was proposed as an alternative to the normal and independent living of the elderly and the disabled. Since the late 1960s, community care was recognized as a desirable goal for service users (Means et al, 2008).

In this social atmosphere, the Seebohm Report, published in 1968, brought about a major policy shift. The Seebohm Report focused on the development of community-based social services and the role of the community as well as the public sector as service providers. The report proposed the establishment of social services departments within local authorities to provide services directly. It also stressed that local authorities were responsible for identifying, planning and supporting the needs and resources in their communities. To this

end, it was proposed to reorganise the organisation by integrating welfare services distributed in local authorities. Additionally, the report emphasized the linkage between the public sector and the community, and the training of social workers for improving the quality of social work and fostering systematic workforce. Based on these, the Local Authority Social Care Act was enacted in 1970. In the local authority, social services departments (SSDs) were newly established by integrating organizations separated into children and welfare departments according to beneficiaries of children and adults. This reorganization can be seen as an emphasis on the role of local authorities in providing integrated social services based on community. Accordingly, the SSDs hired social workers to provide services directly to local users.

As such, the role of the public sector centered around the state and local authorities was expanded, but the independent sector also played a part. In particular, the voluntary sector, the non-profit sector, cared for 25% of the total protected children (Griffith, 1966) and historically was recognized charitable roles as social service pioneers (Holgate and Keidan, 1975). In addition, the private sector, the for-profit sector, was able to receive financial support from local authorities when operating nursing facilities (Eyden, 1973). The newly established social services departments in local authorities had given the role of utilizing various private resources in the community. In the Seebohm report, however, guarded against both local authorities' neglect of their obligations as providers of social services and the loss of voluntary sector's role as a pioneer (Seebohm Committee, 1968). Thus, even though the independent sector provided some services, their role was limited to assist local authorities and was not recognized as a proxy for local authorities (Seebohm Committee, 1968; Griffith, 1966).

3-1-2. Unresponsiveness and inflexibility

These reforms, on the one hand, were criticized in terms of increasing the provider's power over users due to the concentration of social services in the public sector (Brooke, 1969). According to the decision of a bureaucrat with centralized authority, the user may be denied access to all services. Hadley

(1981) states that this concentration of authority means service control as social services resources are always scarce. In this situation, Britain's economy began to be difficult in the 1960s and was in serious crisis in the 1970s. This economic hardship has led to lower tax revenues and increased unemployment, while the demand for welfare has increased and the fiscal pressure on maintaining a welfare state has intensified (Ellison, 1998). Besides these financial burdens, as the centralized monopolistic supply structure continued since 1945, the reform was required in the public sector due to the lack of choice options and the dissatisfaction with the quality of service (Hadley and Hatch, 1981; Jacobs et. al., 2009).

3-2. The age of New Public Management (late of 1970s - late of 1990)

In the post-war era, the welfare state emphasized the role of the public sector in providing welfare services, but after the economic crisis in the 1970s, a change in the role of the public sector was required for fiscal reductions in the welfare sector. In conjunction with this, the necessity of restructuring the welfare system was raised, and the concept of welfare pluralism came into full swing. As an alternative to overcoming the limitations of the state-centered welfare model, the pluralism model was proposed in which not only the state but also a variety of providers participated in welfare services. In other words, the focus was on the role of the private sector, the voluntary sector, and the informal sector such as family and relatives. Also, the Conservative government changed its 'control by hierarchy' to 'control by contract' in recognition of the need to move away from traditional top-down hierarchies to eliminate inefficiency (Hoggett, 1991: 250). This has accelerated the marketisation in welfare services delivery.

3-2-1. Pursuit of efficiency

The Conservative Party, which took power in 1979, implemented a policy to use the resources of the community rather than facilities to reduce national finances. The government emphasized 'care by the community' and tried to reinforce domiciliary care, in which the users lives in their own home, rather than care provided in state-subsidised facilities. Since the increase in social

welfare budgets due to aging has put a heavy burden on national finances, the Conservative government realised the need to reform the welfare system that makes older people use facilities services (Challis et al., 2007). At the time, not only were the governments under financial pressure due to soaring elderly populations and the cost of nursing homes, but the issue of unresponsiveness to the needs of service users continued to be raised (Glendinning and Means, 2006). In this context, care management pilot projects from the Personal Social Services Research Unit (PSSRU) at the University of Kent had attracted attention since the late 1970s. Care management, which was implemented in the United States in the 1970s, was first introduced to the UK through the 'Kent Community Care Scheme' of PSSRU and pilot projects were implemented to develop a British care management model in several regions such as Kent, Gateshead and Darlington (Payne, 1995). These projects sought to identify the effects of care management for severely inmates who are likely to enter the facility or who need long-term care. As a result, the pilot projects showed that care management provided high satisfaction to users and their carers, and that in terms of cost, using domiciliary services was less expensive or similar to living in a facility (Challis et al., 2007; 2004). In other words, it showed that the possibility of improving the lives of service users and their families at a lesser cost compared to the existing facility protection method was confirmed.

The positive results of this care management pilot project were later reflected in the reform of the conservative government's community care. As the burden on the central government's budget for social services grew, the Conservative government in 1986 commissioned Griffith, a well-known economist of the time, to reform social services. Accordingly, the Griffiths Report, 'Community Care: an Agenda for Action', published in 1988, recommended discontinuing the social care benefits paid by the central government and transferring the budget to local authorities. Besides, local authorities were advised to implement this budget for service applicants after a separate assessment of economic strength and care needs. The main feature of the report was that the SSDs of local authorities were not responsible for providing all services, and the SSDs should focus on the role of planning,

organizing and purchasing services rather than providing them directly. Furthermore, care management was proposed for effective resource utilisation. In relation to this, local authorities were recommended that they acted as enablers and not exclusive suppliers of social services through the community's needs assessment, community care planning, and information provision. In other words, the report advised the SSDs of local authorities to play a role in encouraging mixed economy of care. This was based on the belief that in a mixed economy, competition would improve efficiency and be more cost-effective than in the old welfare bureaucracy (Sharkey, 2007).

The Griffiths report was mostly reflected in the government white paper 'Caring for People: Community Care in the next decade and beyond'. This white paper defines community care as providing and supporting services for older people or people with disabilities to live as independently as possible in a comfortable environment within their community. For this purpose, the responsibilities and roles of SSDs in local authorities were defined as needs assessment, planning, service purchase, and service quality management. It suggested that local authorities should make full use of informal care services and play a role in growing private services. Also, for the first time, the term 'care management' appeared in the White Paper and it showed pursued qualitative care through care management based on appropriate needs. Care management can be seen as a policy tool for local authorities to properly grasp individual needs and provide quality services. In conclusion, both the Griffith Report and the White Paper emphasized the use of the independent sector, suggesting that social service marketisation was presented as a key method of reform.

The content of this White Paper was embodied in 1990 by the National Health Service and Community Care Act (NHS and Community Care Act). In line with the Griffith report and white paper, the core of the law was the shift of the role of the local authority's SSDs from service providers to buyers. It meant that local authorities purchase services from the public, for-profit and non-profit private sectors. The purchaser-provider split resulted in various providers signing contracts with local authorities and supplying services through competition (Langan, 1998). Since the 1980s, the

Conservative government had introduced Compulsory Competitive Tendering (CCT), which allowed local authorities to compulsorily bid for their services at the end of their contracts. Since the enactment of the NHS and Community Care Act 1990, independent sector's participation was encouraged, facilitated contracts with the independent sector. The main function of local authorities under this Act was to perform service purchase, contracting and management rather than service provision. The market in which these social services are traded is not a pure market and can be viewed as a quasi-market because the public sector plays a part in managing.

Care managers were set up in SSDs of local authorities for care management. The emergence of such care managers also contributed to the formation of this quasi-market (Glendinning and Means, 2006). The Care Manager implemented care management by constructing a care package with the necessary services based on the desires of individual users. In detail, they played a role in case discovery, users' needs assessment, care planning, and monitoring (Challis, 2003). Given the authority to execute the budget, it is possible to identify various service providers and purchase the necessary services based on individual needs (Harris and Chou, 2001). As purchasers, they control costs by contracts with service providers (Challis, 2003). As a result, in this care manager-driven management system, public and private service providers provided services through mutual competition, which formed a quasi-market. It can be seen that the principle goal of the NHS and Community Care Act 1990 was to improve efficiency based on market principles. In addition, the service users' choice was emphasized by identifying the needs of the service users, establishing an appropriate care plan, and purchasing the necessary services. This included the expectation that competition in service provision would not only increase cost-effectiveness, but also enhance user choice and improve services (Knapp et al.,1994).

3-2-2. Weakness of accountability

The Conservative government began to highlight the family's moral responsibility for care in the 1980s, after taking power. This was in line with focusing on community care through legislative activities in the late 1980s as

part of reducing the financial burden associated with the central government's social security budget. The government considered that care is the responsibility of the individual, and the state's responsibility is merely to play a minimal role in supporting the individual. Under this policy direction, the burden was placed on the family and relatives who support the elderly, who in particular needed long-term care (Dalley, 2000). It can be seen that the state's accountability for social services weakened than in the era of the welfare state as the government emphasized on the individual's responsibility for care and the state's secondary role.

In addition, marketisation in the provision of services promoted by the NHS and Community Care Act 1990 increased the share of the independent sector compared to the public sector. This is embodied through an implementation mechanism called buyer-supplier separation. Johnson (1999) states that buyer-supplier separation is a system for reducing the proportion of services provided directly by local governments and providing services primarily in the non-profit and for-profit private sector. This was also facilitated by the central government's financial control over local authorities. The enactment of the NHS and Community Care Act 1990 transferred the central government's budget for personal social services to local authorities (Glennerster, 1997). The Act encouraged the formation of a quasi-market by allowing more than 85 percent of the Special Transition Grants transferred from the central government to local authorities to be used by the independent sector (Player and Pollock, 2001). Local authorities still played a leading role, but were more involved in commissioning services in the independent sector than in direct service provision (Sharkey, 2007). The role of the public sector decreased and the role of the independent sector greatly expanded in the provision of services. Especially, the proportion of supply in the independent sector increased significantly compared to the direct supply in the public sector in facility services and domiciliary care. In 1992, local authorities provided 98% of domiciliary care services, but in 2002 more than 60% of domiciliary care services were provided by the independent sector (Pollock, 2004). However, the increase in the private sector, called the for-profit sector, can deepen the gap in accessing services, depending on the economic power

of the user. While the public sector has the advantage of being more accountable, meeting the needs of citizens, and fulfilling rights, the for-profit sector is concerned with profit generation rather than individual needs (Cooper, 1988). Therefore, the growth of the private sector can lead to weaker accountability to users in the provision of social services.

3-2-3. Regulation

According to Grant (2002), the spread of neoliberal policies in the UK has changed the role of the state to tighten in terms of regulations. Under this neoliberal keynote, the independent sector's involvement in the provision of social services expanded and the government had a difficulty in controlling their services. As a result, the Conservative government sought to introduce a strict regulatory and service quality management system. The Audit Commission was established in 1983 by the Thatcher's Conservative government to promote local authority's economy, efficiency and effectiveness (Humphrey, 2003). In addition, all nursing agencies were managed through registration under the Registered Home Act of 1984. General care facilities should be registered with local authorities while health care facilities should be registered with district health authorities. In 1985, the establishment of the Social Service Inspectorate introduced a systematic evaluation of the operation and financial structure of the social service providers, the workforce and the supply process. Under the NHS and Community Care Act 1990, the investigator was given the ability to monitor local government social services. The organisation was also assigned to publish a report every five years jointly with the Audit Commission (Hill, 2000).

The social phenomena, in which these audit bodies have increased since the early 1980s, was described as “audit society” by Power (1997). This heightened regulation is related to the shift in the role of the public sector to oversight of services provided by the private sector, rather than direct supply of services (Scott, 2000). This is because social services involve information asymmetry, making it difficult to achieve the expected efficiency and equity without regulation (Steuerle, 2000). In other words, there seems to be an aspect to manage the service quality through appropriate regulation in the

situation where the proportion of private suppliers in service provision is increasing. In this process, the targets of regulation were mainly the independent sector and local authorities. It can be seen that the influence as a controller of the central government increased.

3-3. The age of Governance (late of 1990s – the present)

In 1997, Tony Blair's New Labour Party came to power after over 20 years of conservative power. The Blair government attempted new policy changes in the social services established by the former Conservative government while maintaining a quasi-market. Balloch and Taylor (2001) describe this new reform of the Labour Party as a change from 'contract culture' to 'partnership culture'. The content of these reforms is illustrated by the government's 1998 White Paper on the Modernization of Social Services (Department of Health, 1998). The White Paper presented a major challenge to promote partnerships between the public and independent sectors as well as the public sectors responsible for health, welfare and education. Emphasis was placed on the central role of local authorities in shaping and promoting these partnerships. It also promoted qualitative reinforcement based on the 'Best Value' for all social services provided by the public and independent sectors, and suggested policy directions for vulnerable groups to enjoy independent lives. In summary, the main characteristics of the New Labor Party's policy in terms of social service delivery were the promotion of partnerships with each sector, strong service quality management, and strengthening the role of local governments. Since care management is a major means of delivering social services within the framework of community care, it is necessary to look more closely at the main features of the New Labour Party's social services policy.

3-3-1. Emphasis on partnership

The New Labour Party's modernization program shows governance, in its emphasis on cooperation through networks, rather than hierarchies or market mechanisms (Rhodes, 1997; Pierre and Peters). Blair stressed that the future of local authorities depends on in partnership with public institutions, private companies, community groups and voluntary organizations (Blair, 1998: 13).

The white paper of Social Services (Department of Health, 1998) also addressed the improvement of this partnership. These partnerships included not only public institutions as statutory bodies, but also voluntary organizations, independent providers of profits and informal sectors such as users and their carers. In particular, the New Labour government highlighted the importance of working with them in social services, noting the role of the nonprofit voluntary sector. Through the recognition of the voluntary sector's contribution to social welfare, the government tried to maintain a good relationship with the voluntary sector in order to understand the users' point of view (Evers and Laville, 2004). Therefore, the government presented that local authorities should be well aware of the voluntary sectors within the region and support them to be able to meet locals' needs (Department of Health, 1998). The government recognised the diversity and independence of the voluntary sector and tried to improve their working conditions, which led to 'Labour Government's Compact with the voluntary and community sector' in November 1998. The reason why the New Labor Party emphasized the establishment of a partnership system between the public and voluntary sectors was to provide good quality services to the citizens at the most reasonable cost, and that the distinction of public or non-public was not important in providing services (Cabinet Office, 1998; Butcher 2002: 189).

In terms of care management, this partnership has also applied. Emphasis is placed on partnerships between organizations for children to provide integrated services for children in need. By amendments to the Children Act in 2004 highlighted the interagency cooperation, and the Common Assessment Framework (CAF) was developed and distributed for the integrated delivery of services. The CAF covers the entire process of identifying and assessing needs, providing services and reviewing and evaluating them. The aim was to provide integrated services in collaboration with relevant agencies to meet the complex needs of children identified through the CAF. In this process, not only the social worker but also experts in various fields such as education, health care, adolescents, childcare and crime prevention are working together. Social workers in local authorities coordinate the roles of the experts and support their involvement. In addition, local authorities provide regular

educational opportunities for knowledge and skills that are common to professionals in various fields. In this regard, the central government formulates and provides guidelines, and local authorities exercise discretion within the scope of the guidelines. Private agencies in the community work with the public sector to provide services for children and their families. As a concrete example, with regard to child protection, the central government has set up a guideline, "Working Together to Safeguard Children," emphasizing the obligations of cooperation among related agencies. (HM Government, 2018). This guideline is intended for the independent sector as well as the public sector. It explains the related laws such as the Children's Law and the Education Law and emphasizes the necessity of the network between institutions. It also contains policies and measures to prevent and protect child abuse.

3-3-2. Strengthening Service User's Rights

In the UK, however, the marketisation in terms of service provision has accelerated in the field of adult social services, and such characteristics are also reflected in care management. In the case of the elderly and the disabled who are the main targets of adult social services, in the past, care management was conducted in the form of linking appropriate services after assessing users' needs by a care manager or clinical practitioner belonging to local authorities. As a result, the choice of services rests with local authorities' experts, not users. It did not meet the expectation that it would strengthen the user's choice as a consumer. Many users, including the elderly and the disabled, realised that options are very limited (Parry-Jones and Soulsby, 2001). The diversification of service providers expanded the choice, but the actual choice was not given to the user. The diversification of service providers can be seen in the home care sector. According to NHS (2009; 2006), home care is a service that enables users to function as independently as possible and to live in their own homes, including routine household services and personal care. Table 1 presents the estimated number of service households receiving home help or home. The number of households receiving home care from the CASSRs, the public sector, had fallen from 370,200 in

1996 to 76,000 in 2008 (a decrease of 98%). The number of households receiving home care from the independent sector had risen from 121,000 in 1996 to 262,500 in 2008 (an increase of 116%). This table shows the rapid growth of the independent sector as a service provider in the home care sector.

Table 1. Estimated number of service households receiving home help or home care by sector

Rounded Numbers

Year of survey	Households		
	Total (including double counting)	CASSR	Independent
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

* Source: NHS (2006; 2009)
* Survey week during September
* CASSR: Council with Adult Social Service Responsibilities
* Contains estimates for missing data. Components may not add to totals due to rounding.

As the supply of services in the independent sector increases and the market is accelerating, voices for demanding users' choices have increased. Accordingly, the UK government developed a direct payment system. This system was originally introduced by the Community Care (Direct Payments)

Act in 1996, during the Conservative government, and was implemented in 1997. The system, which was introduced at the request of the handicapped, continued to expand under the New Labour Party government and applied to the social service area for the elderly as well as the disabled. This system meant a change from the purchase of services through a third party such as a care manager to the direct purchase of a service user. Users who chose direct payment could use the cash they received to pay for carers in private sector agencies or to hire a 'personal assistant' as an employer for assistance (Arksey and Baxter, 2011).

However, the direct payment system was difficult for the users because they had to find the service provider themselves and was responsible for reporting the settlement to local authorities for the costs paid (Glasby and Littlechild, 2016). ‘Personal budget’ have been introduced since 2006 to address the limitations of this direct payment system. The system emphasized the user's self-direction in the entire process from service design to execution. There are various ways to purchase services by personal budget, so users can choose the way they want. There are ways of receiving and executing cash directly, entrusting personal budget to local authorities' care managers to purchase services, and entrusting individual budgets to service agencies and receiving services from such agencies (Carr and Robbins, 2009). This system can be called a system that strengthens the self-directedness of users and widens the choice of consumers as a direct payment system. This emphasis on choice in service and their control over individual life continued in the Cameron government, the coalition government of the Conservative and Liberal Democrats, following the New Labour party. In this light, the Care Act of 2014 stipulates both direct payments and personal budgets. It can be seen that the emphasis was placed on strengthening the individual's capabilities to control care and support by the user. Under these circumstances, the number of users who choose to pay directly has risen steadily in both adults and the elderly aged 65 and over (see Table 2).

Table 2. Number of adult clients receiving direct payments

Thousands

Age	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
All ages (18 and over)	67	86	107	125	139	148	155
65 and over	27	37	45	52	61	63	63

* Source: HSCIC 'Community Care Statistics', 2008-09; 2010-11; 2013-14.

This shows that users' preference for the direct payment system is increasing. Therefore, it seems that the marketisation of social services is intensifying not only through the increase in the supply of services in the independent sector, but also through the fact that these users' rights as consumers are reinforced. It also shows that since the introduction of the NHS and Community Care Act 1990 there has been a shift in care management to the direction of 'self-assessment and management' from what was commonly done by frontline practitioners who are experts (Sharkey, 2007).

3-3-3. Rise of regulation

The UK has established a strong regulatory system despite a high degree of marketisation and emphasis on the role of the for-profit sector among liberal welfare states (Taylor-Gooby, 2004). It appears that the need for regulation has increased as the market entry of the private sector increased due to marketisation. The rapid growth of the private sector relative to the public sector can be confirmed through the change in the number of service providers of each provider in the home care section. Particularly, the increase in the private sector is phenomenal (see Table 3). Participation in the independent sector as a service provider continues to increase year by year, especially in the private sector's service market. In 2004, the private sector accounted for 70.2% of all home care service providers, indicating that the majority of service providers were already for profit. In 2008, the private sector accounted for 75.2%, therefore, it shows that the active participation of the for-profit organisations continues to increase.

Table 3. Number of home care agencies by type of ownership

Year	All Sectors	Council	Voluntary	Private	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: The Commission for Social Care Inspection (CSCI), 2009.

* Numbers of agencies

Under these circumstances, the New Labour government focused on the quality of service experienced by service users, their carers and their families rather than the providers of social services. As the private sector's for-profit sector grew rapidly as a service provider in social services, the core of the policy was to manage the quality of service to minimize the side effects caused by accelerated marketisation. For this purpose, Compulsory Competitive Tendering (CCT), which had been implemented by the Conservative government, was abolished and the 'Best Value' system was introduced. Local authorities had an obligation to choose service providers that provide the best value in both price and quality. In addition, local authorities were controlled by central government by indicators such as performance targets and user satisfaction created by engaging users, citizens and communities (Scourfield, 2007; Boyne, 1998). Local authorities, through contracts with service providers, oversee the quality of the services they provide in a variety of ways, including the length and manner of service delivery.

The policy of regulation and supervision initiated by the Thatcher government was further strengthened by the New Labour Government. This is because the need for supervisory functions has increased as the market speed of service delivery accelerates. The New Labour government criticised and tried to improve the Conservative Government's uniform and quantitative regulatory system. Ultimately, the service quality system was strengthened through legislation and standard setting in order to enhance the stability of services

and ensure the safe selection of users. In 2000, the Care Standards Act was enacted to reform the existing regulatory framework for social care services, and to define the National Care Standards Commission and the National Minimum Standards. The National Standards Care Committee, with registration and supervisory authority, had the aim of improving the level of service of registered health and social care service providers. In 2003, the National Care Standards Commission was abolished through the Health and Social Care Act and a new oversight body, the Commission for Social Care Inspection (CSCI), was established. With the establishment of the CSCI, health services were separated by the Commission for Healthcare Audit and Inspection (CHAI), and the management of child service quality was transferred to Ofsted (Office for Standards in Education, Children's Services and Skills) in 2007. This change stemmed from the Children Act 2004, which highlighted the importance of integrating and early intervention of children's services. As child services assessments moved to Ofsted, CSCI eventually became an organization that only assessed adult social services. The committee has given ratings to local authorities and agencies providing social services and published the results. In 2009, the Care Quality Commission (CQC) was created, a new oversight body covering health and social services.

Bode (2010) proposes 'formalized quality standards, inspection regimes and contracting templates', formulated as general regulatory mechanisms in the field of social services. In the United Kingdom, current standards of service quality are proposed by National Minimum Standards, and the CQC performs a supervisory function to assess whether each service provider complies with the criteria. CQC reserves the right to suspend, cancel registration, or close a facility. Service providers receive warnings, penalties and suspensions if they fail to meet the criteria set by the CQC. Besides, the central government can provide contract templates, such as 'the Public Health Services Contract' (Department of Health, 2015) for guaranteeing the quality of service, which local authorities can use to enter into service contracts with community agencies. As such, the UK has a variety of regulatory mechanisms aimed at preventing the decline in service quality that can be caused by marketisation. According to CQC (2019), 74% of services previously rated as inadequate

have been improved in 2018/19 whereas 72% of services had improved in 2017/18. The 2018/2019 report also shows improved service quality in almost all sectors and grades compared to 2017/18 (CQC, 2019) (see Table 4).

Table 4. Ratings profile as at 31 March 2018 and 31 March 2019

Category		Adult Social Care directorate		Hospitals directorate		Primary Medical Services directorate	
Year		2018	2019	2018	2019	2018	2019
Ratings	Outstanding	513 (2%)	792 (3%)	46 (7%)	69 (8%)	326 (5%)	327 (5%)
	Good	17,106 (79%)	18,159 (80%)	410 (62%)	599 (66%)	6,363 (91%)	6,196 (90%)
	Requires improvement	3,802 (17%)	3,485 (15%)	186 (28%)	215 (24%)	261 (4%)	264 (4%)
	Inadequate	349 (2%)	264 (1%)	15 (2%)	19 (2%)	75 (1%)	86 (1%)

* Source: CQC, 2018; 2019.

4. Discussion and Policy Recommendations

The UK has implemented community care as a means of controlling cost of public finances and ensuring user choice, and care management has served as a major practical device for community care. Care management is carried out through local authorities, and the main targets are the elderly, the disabled and children. These target users can be divided into two groups, one for children and the other for adults such as the elderly and the disabled. Among them, the provision of social services to adults seems to be more affected by marketisation as adult social services include living in nursing homes, which appears to have been managed by mainly the for-profit private sector. Accordingly, the expansion of the independent sector's role, in the UK's welfare delivery system, has made it more important for the public and independent sectors to cooperate. How the relationship between these two sectors is established can affect the effect that can be achieved by the provision of services. Therefore, it may be meaningful to see if the three governance mechanisms that Bruttel (2005) has proposed to achieve the expected effects of bilateral cooperation play a role in the UK's care

management policy. Through this, implications for establishing the relationship between the public and independent sectors in the SMG's care management policy are drawn.

Governance mechanisms have been proposed to overcome the problems of moral hazard and information asymmetry in contract-based principal-agent relationships. In terms of marketisation of public services, the public sector is the principal, and the independent sector that provides services through contracts with the public sector is agents. Pict and Wolff (1994) point out that one of the major problems with contract systems is the moral hazard of agents seeking their own interests over principals, and argues that principals have difficulty monitoring agents because of the separation of principals and agents. The independent sector that provides social services is a mix of for-profit and non-profit sectors, all of which are also under the influence of this contract culture. This is supported by the fact that income sources in non-profit sectors have increased income from service sales and contracts rather than voluntary income such as donations (Kong, 2017). As such, the culture of contracts affects both the private and voluntary sectors, so this mechanism could be applied.

First, information mechanisms focus on overcoming information asymmetry by increasing the transparency of information. This is because information asymmetry is considered one of the causes of moral risk (Bruttel, 2005). The UK provides guidance for the work of public authorities as well as those involved in the provision of services through guidance like 'Working Together to Safeguard Children' (HM Government, 2018), which details the work related to child protection. Additionally, regular educational opportunities are provided to assist experts in various fields to facilitate cooperation based on common knowledge and skills. Especially, in the care management of children, not only the public social workers but also the private experts participate in the common assessment process, and it can be seen that information exchange between the public and private sectors is well performed from the initial stage of care management.

From the user's perspective, the relatively clear administrative system of care

management in the UK is seen as helping the use of services. The service application for the use of social services has been unified to local authorities. In particular, the organisational structure for care management is simply divided into children and adults in the local authority, so it is not difficult for service users to find the place of application. This is related to the clear distinction between the public and independent sectors' role in care management. Local authorities serve as needs assessment, planning, and primarily service buyers, while the independent sector is a service provider that supplies services under contracts with the public sector. In other words, it is relatively easy to understand the delivery system from the user's point of view. The clear distinction of roles between the public and independent sectors is a feature of the UK's care management, and this aspect serves as an advantage that users can use the service based on the information and understanding of the service design structure.

Second, from the control mechanisms' point of view, the UK uses a variety of regulatory instruments to manage the quality of social services provided by the private sector through care management. The control mechanism is the use of rules and regulations, traditional tools of bureaucracy, to ensure quality standards of service (Bruttel, 2005). The UK uses a variety of regulatory instruments, including formalized quality standards, inspection regimes, and contracting templates. The central government supervises local authorities through finance and guidance, and local authorities indirectly manage the services provided by independent service providers by deciding the period and method of service when signing the service contract. In addition, CQC, an independent body that oversees health and social services, directly monitors and periodically evaluates services provided by local authorities and private agencies. A single supervisory body, such as CQC, ensures regulatory consistency, and service workers use the annual report issued by CQC to raise awareness of service improvements and show real improvements in service (CQC, 2019). As such, the UK is using the control of regulation to reduce decline in service quality due to the introduction of various providers after the market for social services was introduced.

Finally, the incentive mechanism is not only to induce service providers to

make a profit but also function as a device that allows private sector providers' profits to eventually lead to public purchasers'. This is mainly related to the optimal design of the payment structure (Bruttel, 2005). In the UK, direct payments and personal budgets are now prescribed by law to ensure users' choice. Prior to the introduction of these schemes, care managers in the public sector purchased the services directly and provided them to users, but after the introduction of the schemes, users had the authority to choose services as consumers. This means that the social service delivery system has changed in line with the characteristics of the market mechanism, which presents that independent providers must compete to be selected for more diverse consumers. Independent providers, who are agents, are more likely to focus on the quality of service in order to meet self-directed users, as a result, this can fulfill the interests pursued by the public sector as principals.

The delivery system related to the UK's care management policy and the relationship between the public and independent sectors has implications for the SMG. This is because South Korea is currently leading the care management in the public sector, especially in local authorities. After the social service electronic voucher system in 2007 and the long-term care insurance system in 2008 were implemented, the marketisation of social services progressed and the private providers entered the market in earnest (Jon and Lee, 2018; Kim, 2016). Although most of the social services were previously provided by the voluntary sector, called the non-profit sector, after the participation of the private sector, called the for-profit sector, a competitive quasi-market was formed. Nonprofit organizations have been provided with subsidies from public institutions, but since the introduction of the voucher system, users have chosen the services themselves. As a result, for-profit and not-for-profit organizations participating in the service competition are financed according to the amount of service benefits selected and used by users (Jon and Lee, 2018). The public sector care management and social service marketisation in South Korea has a short history compared to the UK and has begun to be implemented in recent years. Therefore, referring to the example of the UK which has developed such a system for a

long time, the following policy proposals are presented for the central government of South Korea and the SMG. This is because the care management of local government is affected by the central government's policy directions and guidelines.

First, in order to prevent overlap in the role of public and independent sectors, the application route in care management is unified to the public sector. As in the UK, there is a need to clarify the distinction between the public and independent sectors in care management. In the UK, the public sector acts as needs assessment and planning, while the independent sector functions as a major service provider. In South Korea, on the other hand, care management is being implemented in both the public and non-profit private sectors. In the voluntary sector, care management has been implemented through family welfare and home welfare projects, especially in community welfare centers. However, with the introduction of public care management, the function of care management accumulated in the voluntary sector is shrinking. This is because there is a problem of role conflict due to overlapping care management users between the two sectors (Min, 2015). Therefore, in the public care management system, the voluntary sector needs to focus more on its role as a service provider. However, considering the fact that one of the three functions of the community welfare center in Korea is care management and the accumulated private knowledge and experience, the voluntary sector is necessary to focus on those who need long-term care management due to chronic diseases. However, even in this case, the first application for care management should be made in the public sector, and afterwards, it can be transferred the matter to the private sector. This can also be seen as an alternative to avoid confusion of roles.

Second, it seems necessary to simplify the care management organization of local authorities, which are fragmented by tasks, to shift the care management work to the user-centered one. In the UK, care management organizations in local authorities are largely divided according to two target groups: children and adults. In Korea, there are various care management tasks such as children care management (Dream start), mental health case management and integrated care management. It is carried out in fragmented form by the

relevant departments. Although the Ministry of Health and Welfare has established guidelines for linking these care management projects to distribute guidelines 'public sector care management linkage, cooperation work guidance', it is difficult to understand because various projects are intricately intertwined like a net. In case of children care management, the dream start project is dedicated, but the members of the child's family are referred to the integrated care management project separately, not directly in the dream start project (Ministry of Health and Welfare, 2019). In the UK, care management, including family members, is carried out at one time and services are provided when necessary, centered on children. As a result, in South Korea, the care management organization is divided by types according to the project contents, not user-centered. Therefore, it seems necessary to operate the organization and provide services centered on users, as in the UK. In the case of the SMG, it is necessary to consider creating the care management team which covers all of the care management projects within its organisation. Hope Welfare Support Group is established in the autonomous district, but it is an organisation dedicated to the integrated care management project, which is just one of various care management projects, and other care management tasks such as children care management are performed by their respective departments. In addition, it is proposed to perform care management by dividing the work focusing on users such as children, adults, and the disabled within the care management team in community center, the lowest organization of public administration delivery system.

Third, it is necessary to establish a single regulatory body and to systematically manage the quality of social services provided by the independent sector. Since the introduction of the long-term care service system in 2008, for-profit service providers have increased, and the diversification of these providers has also increased the need for government regulation of service quality. In Korea, oversight of social service agencies is conducted by the departments of local authorities. Due to lack of expertise and excessive workload, effective service quality management is required (Choi and Lee, 2014). There seems to be a need for establishing a single regulatory body, such as the UK's CQC, for consistent, systematic oversight and specialized regulation.

5. Conclusion

At present, care management has been introduced into the public sector, and the importance of its relationship with private institutions that possess and supply key service resources is growing. The UK has relevant policy know-how since the care management pilot projects was performed and has been implemented in the public sector since the 1990s. In that regard, this report has examined the UK care management policies and has suggested alternatives for reference in Korea. The UK already has a history of more than 30 years of care management implementation, so it is necessary to look at the whole context to understand the context behind the current policy. Specifically, the process of changing the role of the public and independent sectors in the public administration delivery system was analyzed based on three administrative paradigms according to the characteristics of each period. This shows that the role of the independent sector has increased in relation to public services delivered through care management in the UK.

In the face of growing of the independent sector, the three governance mechanisms, information, control and incentives, have been used to analyse how the UK is building public-private relationship to achieve the expected effects in care management policies. An exchange of Information between the public and independent sectors is carried out through guidance and education, and the role-sharing between the public and private sectors is relatively clear. In addition, various regulatory measures, such as legislative and standards provisions and the establishment of a single independent oversight body, are used to induce improvements in the quality of marketed social services through the participation of various providers. In addition, direct payments and the implementation of personal budgets have strengthened the choice of service users as consumers.

Based on these UK policy case, some considerations for the care management policy of the SMG. First, the care management application routes are necessary to be unified to the public sector except in special cases, thus clarifying the role-sharing between the public and independent sectors. Second, it is necessary to reorganize the care management organization of local

governments, which are fragmented by task, with a focus on user characteristics as in the case of the UK. Finally, a single regulatory body needs to be established to ensure expertise in regulatory work and to systematically manage service quality in social services.

This report focuses on the relationship between the public and independent sectors in care management. However, it is also important to identify new resources to be linked to service users as care management is a policy that utilizes various resources of the community as well as the public sector. Therefore, it seems necessary to study further how to discover various resources in the independent sector of the community and the direction of cooperation between the public and private sectors in this area.

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