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Policy gaps and solutions: Strengthening community-based geriatric care in the U.K

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Abstract

The United Kingdom is undergoing a rapid demographic shift, with projections indicating that individuals aged 65 and over will comprise nearly a quarter of the population by 2045. This aging trend places increasing pressure on health and social care systems, particularly in the context of community-based geriatric care an approach widely recognized for its cost-effectiveness, person-centered philosophy, and alignment with older adults' preference to age in place. Despite policy efforts such as the Care Act 2014 and the NHS Long Term Plan, significant gaps persist in delivering coordinated, accessible, and sustainable community-based services for older adults. This study critically examines the current policy landscape, identifies key structural and operational deficiencies, and explores international best practices to inform reform. Employing a qualitative policy analysis approach, the research draws on government reports, academic literature, and comparative models from countries such as Sweden and Japan. Findings reveal fragmented governance between health and social care, underfunding of local services, workforce shortages, and inadequate caregiver support as central challenges undermining effective care delivery. The study advocates for a nationally coordinated strategy that integrates funding mechanisms, standardizes geriatric training, and strengthens support for informal caregivers. These recommendations aim to enhance service delivery, improve the quality of life for older adults, and prepare the U.K. for future demographic demands. Bridging these policy gaps is not only a strategic imperative but also a moral obligation to ensure dignity, autonomy, and well-being for the aging population.

Keywords: Geriatric Policy; Aging Population; U.K. Healthcare; Policy Reform; Long-Term Care

1. Introduction

The United Kingdom is currently undergoing a profound demographic shift characterized by an increasingly aging population. By 2045, it is projected that individuals aged 65 and over will constitute nearly 25% of the national population, marking a dramatic increase in the proportion of older adults and generating considerable pressure on the nation's health and social care infrastructure (Khan, Addo, and Findlay, 2024). This aging trend is accompanied by an increase in age-associated conditions, including chronic illnesses such as diabetes, arthritis, heart disease, multimorbidity, frailty syndromes, and neurocognitive disorders like dementia. These conditions necessitate a care model that extends beyond episodic treatment to one that is holistic, continuous, and individualized (Oliver, Foot, and Humphries, 2014).

Against this backdrop, the role of community-based geriatric care has become increasingly prominent. Unlike institutional or hospital-based services, community care is embedded in the everyday environments where older adults live, promoting autonomy, social participation, and functional ability. Community-based geriatric care integrates medical, social, psychological, and rehabilitative services delivered through domiciliary visits, primary care, community clinics, and volunteer networks. The approach seeks to prevent unnecessary hospitalizations, reduce institutional dependency, and improve the overall quality of life for aging individuals (Williams et al., 2009; Lee et al., 2022). Despite this recognized potential, real-world implementation has fallen short. National frameworks, including the NHS Long

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Term Plan and the Care Act 2014, have emphasized aging in place, yet operational barriers such as disjointed governance, financial constraints, and variable service quality remain prevalent (Bardsley et al., 2013; Jacobs et al., 2009).

Moreover, the gap between policy and practice is further exacerbated by a heavy reliance on informal caregivers, typically family members, who are often expected to shoulder care responsibilities with minimal training, support, or respite. This caregiver burden, if unaddressed, may have adverse effects not only on the well-being of carers but also on care recipients (Flaherty and Bartels, 2019; Burnett and Beauchamp, 2025).

1.1. Problem Statement

Despite extensive policy discourse promoting community-based geriatric care and aging in place, a significant disjunction persists between political intent and lived experience. The infrastructure necessary to support this model remains underdeveloped and inconsistently applied across the country. A major issue lies in the poor integration between healthcare services provided by the NHS and social support managed by local authorities. This fragmentation leads to duplicated efforts, service delays, and confusion among older adults navigating the system. Additionally, a growing shortage of trained professionals in geriatrics and community health services presents a serious challenge, particularly in underserved or rural regions.

Further compounding these challenges are structural gaps in addressing the non-clinical dimensions of aging. Mental health services for older adults are often underprioritized, despite the prevalence of depression, anxiety, and cognitive disorders in this population. Social isolation and loneliness, exacerbated by urban planning, digital exclusion, and changing family structures, remain largely invisible in many care strategies (Kim, 2025; Robison et al., 2012). These barriers do not only impede efficient service delivery but also undermine the dignity, autonomy, and holistic well-being of the older population.

Objectives

This article is guided by the following key objectives

- To identify and critically examine the primary policy gaps that impede the effective delivery of community-based geriatric care in the United Kingdom.
- To explore and evaluate international best practices and care models that may serve as adaptable solutions within the U.K. context.
- To propose actionable and targeted policy recommendations for the enhancement of community care systems that are capable of responding to current and future geriatric health demands.

Significance of the Study

The rising geriatric demographic presents both a policy challenge and an opportunity to reshape the future of health and social care in the U.K. Beyond administrative logistics, this issue raises fundamental questions about how society values and supports its older citizens. This study is significant in its effort to bridge policy discourse with practical, evidence-based solutions. By identifying systemic weaknesses and leveraging lessons from other countries, it contributes to a growing body of research aimed at developing a more integrated, equitable, and sustainable eldercare framework. The findings of this article are intended to inform health policymakers, social care commissioners, community health organizations, and other stakeholders invested in designing a more resilient and compassionate community-based care system.

Table 1 Key Demographic and Systemic Challenges in U.K. Geriatric Care

Challenge	Details	Sources
Aging population	25% of the U.K. population projected to be 65+ by 2045	Khan et al., 2024
Rise in chronic conditions	Increased demand for continuous, coordinated community care	Oliver et al., 2014
Fragmented health and social care	Disjointed funding and delivery between the NHS and local authorities	Bardsley et al., 2013; Jacobs et al., 2009
Workforce shortages	Lack of trained geriatric and community care professionals	Flaherty and Bartels, 2019
Informal caregiver burden	Families provide the majority of care with little financial or institutional support	Burnett and Beauchamp, 2025
Inequity in access and outcomes	Regional disparities in service availability and quality	Robison et al., 2012
Mental health and social isolation	Underserved areas of community health and well-being among older adults	Lee et al., 2022; Kim, 2025

2. Literature review

2.1. Conceptualizing Community-Based Geriatric Care

Community-based geriatric care refers to the delivery of integrated health, social, and psychological services in non-institutional settings such as homes, day centers, or local clinics targeted at older adults, particularly those with chronic illnesses, frailty, or cognitive decline (Williams et al., 2009). The model aims to promote aging in place, preserve autonomy, and prevent costly hospitalizations. According to Bulmer (2015), the social foundation of community care lies in collective responsibility, decentralization, and the right of older adults to live with dignity in familiar environments.

The growing interest in community-based models aligns with global demographic trends and policy priorities. Jeste et al. (2016) argue that age-friendly communities should integrate public health, urban planning, and social infrastructure to support successful aging. The concept also intersects with mental health promotion, as seen in Lee et al. (2022), who emphasize that preventive interventions in local settings are more effective in tackling loneliness, depression, and early-stage cognitive decline among older adults.

2.2. The Current Policy Landscape in the U.K.

The U.K.'s health and social care system has undergone several waves of reform, including the Care Act 2014, which sought to unify adult social care standards across England, and the NHS Long Term Plan, which emphasized prevention, community services, and integrated care. Despite these intentions, the practical execution remains inconsistent across local authorities, resulting in a postcode lottery of care (Jacobs et al., 2009).

Oliver, Foot, and Humphries (2014) highlight that while national-level strategies acknowledge the importance of community-based care, real-world implementation suffers due to fragmented governance, disjointed funding models, and the lack of statutory mandates for collaboration between the NHS and local councils. Similarly, Bardsley et al. (2013) report that most local authorities struggle to shift resources from acute to preventive care, primarily due to rigid budgeting cycles and short-term political priorities.

A critical weakness in the current system is the undervaluation of informal caregiving and the chronic underfunding of social services. Flaherty and Bartels (2019) point to structural issues in the community-based workforce, particularly the lack of geriatric specialists and interprofessional care teams trained in home-based service delivery.

2.3. Identified Gaps in the Literature and Practice

The literature identifies multiple intersecting gaps that undermine the potential of community-based geriatric care in the U.K.

2.3.1. Integration Deficit

Health and social care services are often siloed, leading to service duplication or neglect (Leutz, 1999). Despite efforts to integrate primary care, mental health, and social services, most reforms have not been sustained beyond the pilot phase (Greenhalgh et al., 2016).

2.3.2. Economic and Resource Constraints

Community-based interventions often lack robust cost-effectiveness evaluations, making them vulnerable during budget reallocations. Kwon, Squires, and Young (2023) highlight the difficulty in justifying investment in falls prevention and other upstream interventions due to methodological challenges in demonstrating efficiency and equity.

2.3.3. Geographic and Social Inequity

Access to quality community services varies significantly across regions and socioeconomic groups. Robison et al. (2012) found that older adults transitioning from home to institutional care often experienced unmet needs due to service gaps in community programs.

2.3.4. Mental Health and Social Isolation

While physical health services are moderately well represented, mental health support for older adults in community settings remains fragmented. Lee et al. (2022) found a lack of consistency in interventions targeting loneliness, anxiety, and depression issues increasingly recognized as risk factors for hospital readmission and early institutionalization.

2.3.5. Workforce Shortages and Burnout

The community geriatric workforce is aging, underpaid, and inadequately trained. Flaherty and Bartels (2019) emphasize the need for interprofessional education and expanded recruitment to meet future demand.

2.4. International Best Practices and Lessons

Several international models provide valuable insights into structuring resilient, community-focused eldercare systems:

- Japan's Community-Based Integrated Care System provides 24-hour health, welfare, and medical services through regional centers, enabling seamless care coordination and reducing hospital dependency (Feng et al., 2020). Their approach integrates professional services with voluntary sector and neighbor-based support, addressing both clinical and social determinants of health.
- China's Tiered Elder Care System (Chen and Han, 2016) focuses on home-based care as the foundation, supported by community centers and institutional options as backup. Shanghai's citywide deployment of "community eldercare stations" demonstrates the feasibility of scaling up care infrastructure while maintaining neighborhood familiarity.
- Canada's Aging at Home Strategy has been lauded for its intersectoral collaboration and focus on preventive care, caregiver training, and community navigation programs (Williams et al., 2009).
- Comparative UK–Korea analysis by Kim (2025) identifies the U.K.'s relative strength in universal coverage but exposes its weakness in program continuity and caregiver inclusion, particularly in mental health domains.
- Co-creation models described by Greenhalgh et al. (2016) show that involving service users, caregivers, and professionals in designing interventions enhances their relevance and sustainability.

2.5. Summary of Literature Gaps

Although the existing literature affirms the value of community-based geriatric care, it reveals major gaps in the integration, funding, workforce capacity, and equity of service delivery. These weaknesses reflect not only design flaws but also implementation challenges tied to political, economic, and institutional inertia.

3. Methodology

3.1. Research Design

This study adopts a qualitative, exploratory design using a policy review and thematic analysis approach to identify systemic gaps and propose policy solutions for strengthening community-based geriatric care in the U.K. Given the complex and interdisciplinary nature of geriatric care spanning health, social, and public sectors qualitative inquiry

allows for deep interpretation of context-specific policy frameworks, institutional practices, and international benchmarks (Greenhalgh et al., 2016; Valaitis et al., 2017).

3.2. Data Sources

The analysis draws on three primary data sources

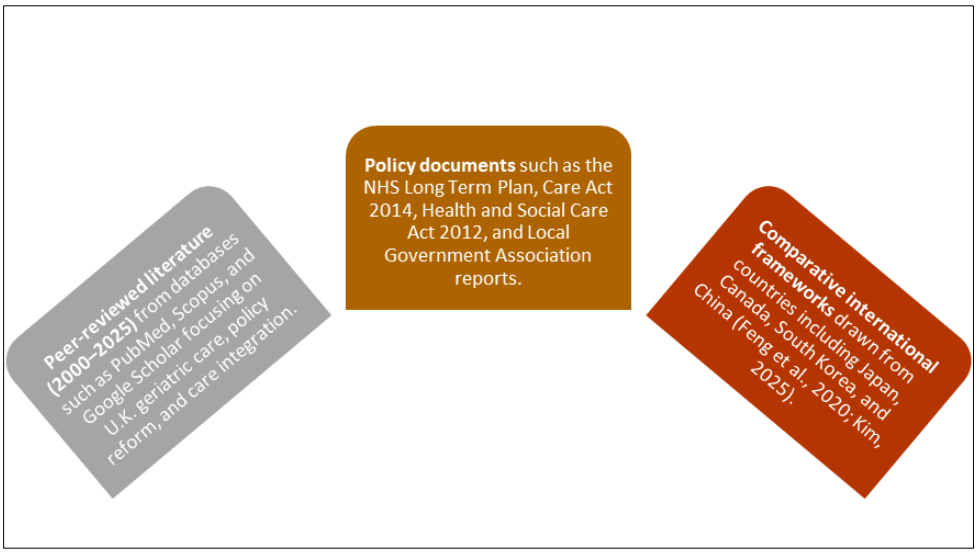

Figure 1 Primary data sources for policy analysis, including peer-reviewed literature, key UK policy documents, and comparative international frameworks

All literature was screened for relevance using inclusion criteria (English language, community-based care focus, older adults) and exclusion criteria (hospital-based care only, non-age-specific interventions).

3.3. Analytical Approach

A thematic content analysis was conducted to extract dominant policy themes. Coding categories were created based on

- Care integration frameworks (Leutz, 1999)
- Workforce capacity and training models (Flaherty and Bartels, 2019)
- Mental health inclusion and social support systems (Burnett and Beauchamp, 2025)
- Caregiver policy and funding mechanisms (Challis, 1992; Oliver et al., 2014)

Themes were reviewed iteratively and triangulated across national and international sources to ensure robustness (Greenhalgh et al., 2016).

3.4. Comparative Framework

The study utilizes a multi-level comparative policy framework to assess

- Vertical alignment of national and local policies
- Horizontal integration of health and social services
- Cross-national benchmarking for alternative policy pathways (e.g., Japan's long-term care insurance, Canada's geriatric outreach teams) (Chen and Han, 2016; Jeste et al., 2016)

This allowed for identifying both structural gaps and operational innovations applicable to the U.K. context.

Table 2 Methodological Framework for Policy Gap Analysis

Component	Details
Design	Qualitative, exploratory policy review
Data Sources	Peer-reviewed studies, U.K. policy documents, international best practices
Analysis Method	Thematic content analysis and comparative policy synthesis
Analytical Themes	Integration, workforce, funding, mental health, social care, caregiver needs
Comparative Countries	Japan, China, South Korea, Canada
Justification	Addresses complexity of geriatric policy, emphasizes multi-sector insights

3.5. Ethical Considerations

This study does not involve human subjects or primary data collection. All sources were secondary and publicly accessible. Nonetheless, academic integrity was maintained by accurately referencing all works and ensuring proper citation of institutional documents.

4. Discussion

4.1. Overview of Key Findings

The analysis reveals a constellation of systemic barriers and fragmented strategies undermining effective community-based geriatric care in the U.K. Despite the Care Act 2014 and NHS Long Term Plan committing to integrated care, implementation remains inconsistent across localities due to workforce shortages, inadequate funding, and insufficient coordination between health and social care sectors (Jacobs et al., 2017; Oliver et al., 2014). This mismatch between policy intent and practical execution continues to hinder the realization of age-friendly and inclusive community care systems (Greenhalgh et al., 2016).

4.2. Integration Failures and Local Disparities

While statutory reforms emphasize person-centered care and service integration, siloed governance structures and fragmented funding streams have perpetuated service delivery gaps. Local authorities vary in their capacity to implement integration, often constrained by reduced budgets and rising service demands (Bardsley et al., 2018). As Leutz (1999) argued, "you can integrate some of the services for all of the people, or all of the services for some of the people," but full integration across systems has rarely been achieved in the U.K.

International models offer valuable lessons: Japan's long-term care insurance system and Canada's community outreach teams show how financial pooling and case coordination can facilitate equitable access and continuity of care (Chen and Han, 2016; Jeste et al., 2016). These approaches contrast with the U.K.'s fragmented pathways, where older adults frequently experience delayed discharges and uncoordinated transitions between hospital and home (Feng et al., 2020).

4.3. Workforce Constraints and Service Quality

One of the most critical challenges is the aging and under-resourced workforce supporting community geriatric care. Burnett and Beauchamp (2025) highlighted that over 30% of social care workers in the U.K. are aged 50 and above, and recruitment into the sector continues to fall below replacement levels. Workforce shortages lead to high caseloads, burnout, and declining service quality, particularly in rural and underfunded areas (Flaherty and Bartels, 2019).

Moreover, the workforce is often inadequately trained to address the complex needs of older adults with multiple comorbidities and mental health issues. The lack of gerontological training in both health and social care curricula contributes to reactive, rather than preventive, service delivery (Oliver et al., 2014). In contrast, Korea's community mental health centers emphasize specialized geriatric competencies and interprofessional collaboration, which may serve as a benchmark for U.K. reforms (Kim, 2025).

4.4. Social Isolation, Mental Health, and Informal Carers

Community-based care must also address non-clinical determinants of wellbeing, including social isolation and caregiver stress. Older adults often live alone or with limited mobility, exacerbating risks of depression, cognitive

decline, and hospitalization (Burnett and Beauchamp, 2025). Current U.K. policies inadequately incorporate mental health services and social inclusion programs into community frameworks (Williams et al., 2019).

Furthermore, informal carers mostly women and family members bear a disproportionate burden without adequate financial, psychological, or respite support (Challis, 1992). As Robison et al. (2007) noted, sustainable geriatric systems must embed caregiver wellbeing into planning, recognizing their role as a cornerstone of continuity of care.

4.5. Future Directions and Policy Recommendations

There is a pressing need for integrated policy solutions that are flexible, locally adaptive, and adequately resourced. These include

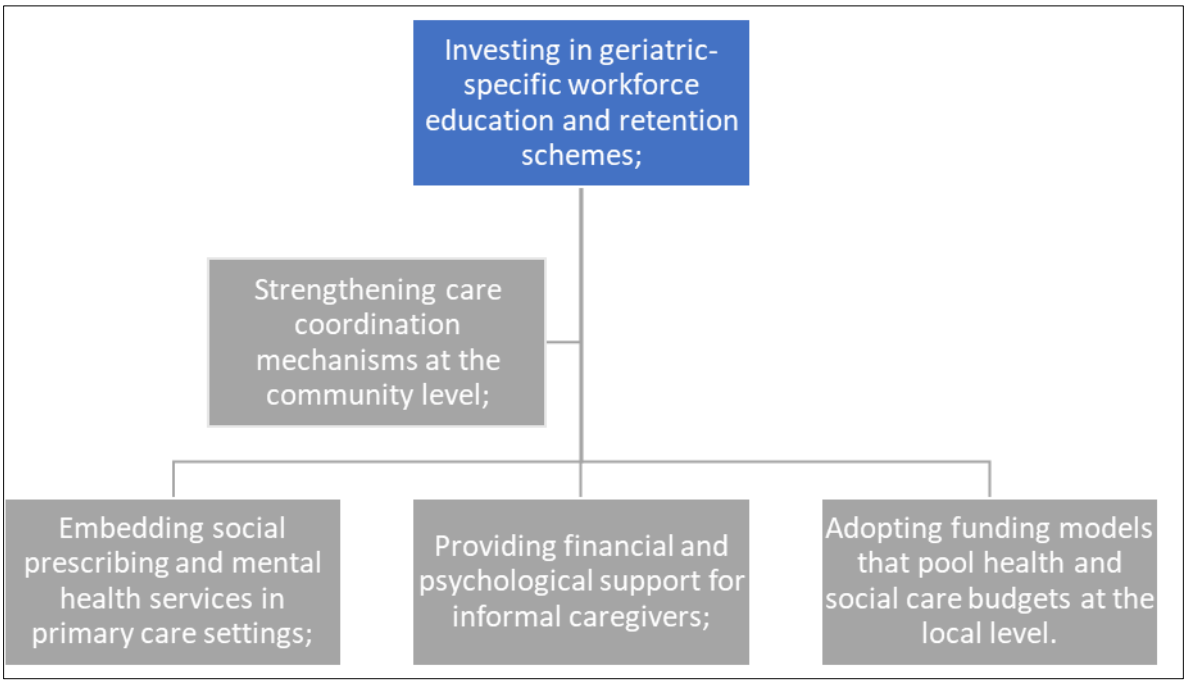

Figure 2 Key policy recommendations for strengthening integrated geriatric care, including workforce development, community coordination, caregiver support, and funding reforms

A robust, equity-driven geriatric policy must shift from episodic service delivery to proactive community engagement, supported by digital tools, community navigators, and multi-agency partnerships (Valaitis et al., 2017; Greenhalgh et al., 2016).

Table 3 Policy Implications and Strategic Recommendations

Policy Gap	Observed Consequence	Recommended Intervention
Siloed health and social services	Delayed discharges, fragmented care	Local budget pooling; integrated case management teams
Workforce shortage and aging staff	Reduced service quality, long waiting times	Targeted geriatric training; retention incentives
Inadequate caregiver support	Burnout and care breakdown	Respite care, financial support, mental health services for carers
Poor inclusion of mental health	Unaddressed isolation, cognitive decline	Embed mental health professionals in community care pathways
Local disparities in policy execution	Geographic inequality in access and outcomes	National oversight with localized implementation funding

Lack of prevention and continuity	Emergency-based service use, high system costs	Community-based outreach, social prescribing, digital engagement tools

5. Conclusion

This article has critically examined the multifaceted policy gaps undermining community-based geriatric care in the U.K., offering strategic solutions aimed at improving equity, access, and sustainability. Despite the presence of progressive legislative frameworks and healthcare strategies, older adults continue to face systemic barriers, ranging from service fragmentation and workforce shortages to mental health neglect and inadequate support for informal caregivers.

A recurring theme is the disconnect between policy rhetoric and real-world implementation. While integration and person-centered care are widely endorsed, they remain inconsistently applied across local authorities, particularly in under-resourced or rural areas. Similarly, the growing complexity of geriatric health needs is not sufficiently matched by workforce capacity, training, or funding.

International best practices demonstrate that community-based geriatric care can be both efficient and compassionate when supported by coordinated governance, preventive outreach, and cross-sector collaboration. The U.K. must move beyond reactive, crisis-driven models and invest in long-term, locally adaptable systems that value both clinical and social determinants of aging.

Strengthening community-based care requires a holistic approach one that not only aligns health and social services, but also places older adults and their caregivers at the heart of care planning. Future efforts must prioritize workforce development, equitable resource distribution, integrated mental health services, and robust support for informal carers. Only then can the U.K. develop a truly inclusive, sustainable, and age-friendly health and social care system.

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