

Social care of older people: Personalisation and Personal Budgets, Choice and Control, Wellbeing and Integration in the emerging means-ends logic of the policy narrative of the 00ies: Implications of the past for improving the future?

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The paper discusses only policy for social care of frail older people and areas most clearly related thereto and relates only to England.

The aim of the paper is to suggest that concepts and logics using them are similar to the most important in today's narrative – particularly the Transformation Agenda, but also others important in the noughties – have been used in the past. (They have also been used in other countries, but that is outside the paper's focus.) If that is so, it can make past experience more directly useful for the present and future. The paper's treatment is narrow. It seeks merely to suggest some ideas to complement those of the true historians of the policy area and others who have seen and studied the area during the period, and so assumes that the reader will fill gaps for themselves and forgive imbalance in the foci of treatment.

The paper picks up themes from the periods post-War but pre-Seebohm, 'the Seebohm years' ending in the eighties, of the post-Griffiths reforms until the late nineties, and the noughties.

1. Pre-Seebohm

I suggest two key feature of the period: [a] absence of what Curtis provided for the development of children's services – common ground here with other writers, but so glaringly obvious to someone researching from 1960;¹ [b] given policy responsibility of what was for long more a ministry of hospitals than a ministry of health and an uncomfortable frontier between NHS and local authorities' responsibilities, the inevitable entry and continual return to the stage of issues of health-social care integration issues formulated about the more effective use of hospital beds; ie *the* integration issue in every post-War period.

Neither point can be sufficiently elaborated here.

With respect to [a]

- The Curtis Report provided a charter: well worked through values, service goals, evaluative criteria, a sense of vision to use as ammunition in the struggles against lack of imagination, sloth and turf defence. There was no equivalent legislatively

¹ There were the ideas around (eg in the NCCOP) from which a broad mission could have been constructed. But times were hard, government massively over-extended, and of course Nye Bevan was going to do no more than talk the talk of dignity and independence (at which he was a master) at a time when there was the NHS and the appalling shortfall in the supply of housing to deal with. See Hennessy, Foot and Dai Rees.

- legitimated definition of vision for care services for older people: not even a white paper for disposing of what many must have seen as some of the loose ends of the Poor Law: certainly no foundation for a policy of a degree of articulation of values, goals, priorities, performance criteria, resource and other inputs and process and structure policy which we expect for the introduction of a new policy narrative.
- The reforms were focused on institutional structures of governance: divisions of policy turf at central and local government levels, structures of accountability within it, and the like. The legislation did little more than create one (tiny) local authority department dominated by providing residential service (to replace the workhouse) and headed by a chief officer (with a high probability of having started his career as a workhouse clerk) with some seeds for the development of services for younger disabled people; and another local authority department supervising domestic help and home nursing services (which were to be joined by other home and community services through time), mostly ultimately accountable to chief officers, the Medical Officers of Health, of high status in the authorities (but not elsewhere), and to few of whom (despite exceptions like East Ham) the development of community services for older people were of little interest.^{2 i} Accountability was to different sections of the Ministry, where again policy interest and imagination was limited for an area of little political priority and without powerful interest group support inside and outside the executive, particularly during a long period of Conservative control and the ever-present spectre of big spending demands even after Guillebaud and Titmuss and Abel-Smith (Lewis).^{3 ii}

There were predictable consequences for organisations which so strongly reflected Beatrice Webb's belief in small paternalist bureaucracies with narrowly focused professions. They developed a powerful but mainly blinkered and boring bureaucratic cultures focused on delivery (and only marginally on development) of services. The spaces were also protected zones of low pressure; a classic example in public service agencies of an invitation to satisficing, Liebenstein x-inefficiency; and to some degree where dysfunctional criteria could influence the institutional structure, and once established, the preoccupations of policy-makers and managers within the organisational spaces. That is, the structures which were to be the locus of policy for social care of frail older people then emerging were neither established to make a reality of a vision and

² I and others established this in interviews in authorities two decades later. There were signs of greater interest in child health and welfare and proactive policy to promote it in some of the departments. For instance, an Assistant MOH for Newport showed me a paper she was writing on the nutritional consequences of non-uptake of free meals in 1961, years before this was recognised as a national issue at the publication of the Plowden Report and the stir caused by Tony Lynes' letter to the Times about what was revealed (Central Advisory Council 1967)..

³ John Griffith and his colleagues contrasted the cultures of the DHSS with, for instance the DES as they affected central-local relations. The DHSS he characterised as having a 'laissez-faire' attitude to authorities. He perceived the DES to be more capable of proactive policy development in partnerships with authorities, aided by central expertise developed in departmental sections like the Curriculum Study Group. (Griffith 196x; Kogan 1971).

proto-narrative about ends and means specifying outcomes of value in their own right for users and caregivers, nor were they spaces conducive to developing a vision and narrative, and once policy, for learning how to improve the narrative and its implementation.^{4 iii}

Seebohm's question. The odds were against systemic independence across the organisational boundaries caused by supply side coordination, at least until well into the period of bed ratios and ten-year planning and then joint finance. A minority of local authorities had established a single committee and/or a single department, allowing greater possibilities for the constructive exploitation of systemic independence in ways which would improve fairness and efficiency.⁵ Like John Griffith,⁶ the Seebohm Committee sought and failed to find evidence suggesting whether one form of organisation produced characteristics suggesting superior performance to the other, or at least spend more. Failing to find such evidence, it had research commissioned on its behalf. In summary, the results showed that [a] There was a strong positive correlation between having CWO as chief officer and the share of Council spending allocated to welfare services: having MOH in charge seemed to depress the expenditure share ('priority') substantially. [b] Either the CWO or expenditure share variable appeared to have an influence on other patterns. Having a CWO was associated with higher spending per resident and higher provision of residential care, a lower proportion of gross spending recouped from user charges, higher spending on persons with physical handicap, higher spending on services for those with impaired vision, higher spending on services for those with auditory problems, a (slightly) higher ratio of spending on social workers to spending on all welfare services. There was no association with the spending priority attached to local health services or indicators of standards for them. (Davies 1971)^{iv}

The Seebohm Committee described the evidence as inconclusive. Most authorities organisational patterns were created at the beginning of the period. So the low prioritisation of the policy area and local spending in relation to keeping the rates down may have caused the adoption of that organisation, not the reverse, though authorities could have changed it if they wished. Also the data was for activity and expenditure not outcomes of value in their own right. Applying John Griffith's criterion, the evidence would seem stronger, but still not conclusive of course

However interdependence could arise through demand side mechanisms impinging from below. Changes in allocations could affect changes in flows of demand through the system, initiated by the responses to demand and supply in their sector by field

⁴ General political histories, histories of the NHS during the forties and pre-Powellite fifties, and studies of early social care organisations illustrate why that was almost certain to have occurred in the circumstances of the time (Hennessy 1992; NHS histories, Means and Smith, Davies 1968; Sumner and Smith 19xx; Rodgers and Dixon xxx; Jefferies an anatomy.

⁵ Indeed, Coventry had in effect made the welfare department responsible for the relevant local health services – but Coventry was Coventry, perhaps the country's leader in corporate and inter-corporate policy and governance development and a seedbed cultivating the virtues of new public management, the home of Charles Barratt and Hedley Marshall, the site for Friend and Jessop experimentation.

⁶ John Griffith argued that 'the strongest case that can be made for a joint health and welfare committee is that this gives the best possible chance for the welfare services to prosper.'

personnel, 'referral agents', and users, and sometimes legitimated by formal policy change at a higher level. Undertaken with the interests of users and carers in mind with relevant information and skill, that mechanism is in effect the adaptation of cost-benefit need judgments by individual allocators through time to equate supply and demand (Davies 1975).^v In a sense, this was one way in which professional organisations without definition of key policies for practice and/or control over the compliance from informed and powerful management in street level contexts: a combination of Blau and Scott and Lipsky. It was not until the early sixties that service substitution and so these demand flows were investigated. However they suggested some patterns suggesting systemic interdependence of services whose supply side activity seemed to have largely independent dynamics. In particular, it seemed that there was clear evidence of the influence of the inheritance of only slowly adjustable stocks of physical and human capital on services dependent entirely on newly recruited resources: 'that in the short run at least, the stock of capital is not adjustable to demand, do that in the short run at least the demand is deflected to other components of the system, thus altering the roles of each service' (Davies 1972^{vi}; Davies et al 1971). For instance, although the supply of domiciliary service did not seem to affect the supply of residential homes, the supply of residential homes affected the supply of domiciliary services (Davies et al 1971). The analyses were later extended to cover the effect of hospital beds as capital stock (Gorbach and Sinclair 198x).

2 The Seebohm years

Narrow focus of reforms on structural merger and providing a single home for social workers in local government. One has a lot for which one should be grateful to the Seebohm reforms. The organisations and divisions of policy labour which followed it massively advanced the basis from which the social care paradigm could advance. Because of it, there were later important ways in which the English system became a contender for world leadership in what was then called 'community care' reform.

But with hindsight we can see how vague was the vision Seebohm created about the potential contribution of social care policy, how little that was worked through to a discussion of alternative priorities with respect to targeted outcomes for subgroups of those that might benefit, how narrow and again unspecific was the argument how to connect ends and means, even about organisational structures to achieve it.⁷ Despite the membership of Charles Barratt for most of the time, it was in some respects from an earlier intellectual tradition from what the Maud Report was helping to develop: a shift in concepts of local government management forward to an age of broad concepts of goals, clarity of goal specification, flexibility and innovativeness in means of achieving them, and so much else. There was little in it of John Stewart, the then new ideas about urban politics and planning, corporate and intercorporate vision and governance. The material in Phoebe Hall's *Reforming the Welfare* partly explains why. Peter Townsend's quotation from the Explanatory and Financial Memorandum to the Bill also helps: it was sold as something which would not inflate public expenditure (Townsend 1970). No doubt that

⁷ At the time and subsequently, Jerry Morris, a Seebohm member, pertinently asked from where were the supermen to undertake such a challenging and ill-defined task to be recruited.

was one reason why the pioneering work on the estimation of unmet need by Peter Townsend and others was not developed in the report. Perhaps discretion had to be the better part of valour in this respect too for the reform to happen.

The absence of vision and narrow focus was immediately recognised by some academics. Peter Townsend wrote in *The Fifth Social Service* the 'broad conclusion illustrated in different ways by several authors in this book can be put briefly, the Report is constructive and its chief recommendation to merge ... is justified. But as an example of planning the report is lacking in analysis drive and vision and it gives an insufficient picture of the objectives that would be pursued.' He added: 'Partly as a consequence, the Government's proposed legislation and its policy statements also lack these qualities.' In the same collection, Adrian Sinfield's *tour de force* of analytic clarity and evidence showed how the assumptions about causality and foci of intervention held by social workers would make their practice fit only a small minority of users and then not without adaptation. The implications of the distinction between 'personal social services' and 'social work' for the patterns of relationships within the family and with other agencies, indeed, the whole pattern of the production of welfare, were insufficiently understood. The vagueness remained in the Barclay Report more than a decade later, ensuring that the report's contribution to adaptation to the new world was diminished at a key time in policy evolution.⁸

Other critiques based on Seebom's restricted vision and vagueness about ends and means: client self-determination, an outcomes fairness and efficiency perspective and the emergence of 'personalisation. Tilda Goldberg published the results of the first major experimental study of older people in the UK in 1970, evaluating the project using indicators of a wide variety of the criteria applied in social work and care. That contributed to a literature which sought to define mission, goals and outcomes and to measure them, to map the relationships between services, outcomes and the influences on them, and to show how these reflected supply side structure and processes and why these supply side influences existed. That sought greater specificity in the mapping of the relationships, and borrowed and adapted sharper theoretical and empirical analysis tools to estimate and test them. They built on the principle of self-determination as a value and heavily weighted user and carer perceptions and prioritisations of outcomes. It was hypothesised that some of the relationships found by sociologists of school education (eg the importance of Ostrom co-production and other forms) would apply in personal services. They used the increasingly informative body of concepts and argument from family sociology and delivery studies. The objective was a coherent body of meta-theory, theoretical generalisations of the middle range, analytic tools capable handling the variety of relationships suggested to be possible by the meta-theory, tools for empirical work like scales and a repertoire of research designs features. An experiment designed in 1974 in a

⁸ The Seebom discussion of other social services personnel was slight, and seems to treat them as ancillaries to social work, defining social work primarily in terms of casework and behavioural change. The 'family' was implicitly the main focus, the source of most inputs, and the target for most benefits. An option which had potential benefits for older people was rejected because 'it would separate social care of [children] from that of their parents and the rest of the family, interrupt the continuity of care, and militate against a comprehensive approach to family problems.' (para 128).

new research unit established to develop the new approach took on what had been invented and contributed massively to its development.

The foci of the experiment were

- a gap in the systemic arrangements for the achievement of what was coming beginning to emerge as the key mission of ssds in meeting the needs of older people: supporting them in their own homes, including in circumstances in which they had a high risk of admission to institutions for long term care. The gap was the absence of a mechanism for brokering arrangements for users unable to undertake the brokerage themselves either because of a specific vulnerability of some kind, or a high degree of complexity of the circumstances making it unlikely that anyone could cope without some help.
- unresponsiveness to the needs and wishes of carers in assessment and arrangements, in the content and flexibility and user-orientation of services available. Little attempt was made to increase or mobilise the caring capacity of the community by means of the methods then being developed. Carers were neglected and under strain, but 'interweaving' and the needs of carers neglected, creating what was later shown to be serious strain (eg Davies et al 1990). This inflexibility of response and resource mobilisation reflected the dominance of the bureaucratic top-down pressures in ssds, rather than the bottom-up pressures from user, carer and field workers potential for acquiring and analysing detailed knowledge of the variety and complexity of circumstances. This situation created perverse incentives throughout ssds, and reinforced the tendency to the pervasive lack of engagement with the clear analysis ends and means noted by Goldberg (Davies and Challis 1986). One symptom was that insufficient resources were allocated to persons with high potential benefits; the outcome of imbalanced incentives which encouraged what the French called '*saupoudrage*', the sprinkling of resources over as many recipients as possible (Branch and Jette 198x; Schopflin 1991). There was too great a gap between costs in institutions and what was spent on people of high risk in the form of home and community support (Davies and Challis 1986; Davies et al 1990). There was little evidence that much of the low level expenditure prevented outcomes rated important by policy makers.
- a lack of concern and of performance with respect to obtaining the most welfare given the resources. The agency did not the need-related circumstances of users and carers and how these related to services received and the outcomes of value in their own right. Information for managerial understanding far less control of 'equity' and 'efficiency' were unheard of - no information on the costs of services, costs of individual cases and their constituents, the proportions of the budget for the team or service for the accounting period already spent, on relative welfare gains and states of users and carers, were unavailable or grossly defective, unrelated to cost concepts appropriate for the decisions which they should be used to guide.⁹ It was important to create structures and cultures which would provide

⁹ Roy Griffiths was later to write: 'the present lack of refined information systems and management accounting within any of the authorities to whom one might look centrally or locally to be responsible for

- positive encouragement – in the new design mechanism theory and political science language of the time (eg , Schulz xxxx) ‘incentives’, to take into account benefits and costs to stakeholders, and continually search to tap new sources and find new ways of achieving goals which would improve outcomes and/or reduce costs.
- The incremental nature, small geographical coverage, failures to evaluate describe thoroughly and follow through innovations which had the potential of being fairness and efficiency-improving suggested that only a radical new vision worked through to detail of ends and means and implementation strategy would work (Davies 1981; Ferlie and Davies 1982, 1984 ; Ferlie Challis and Davies 1984, 1985, 1989)
 - As a consequence, *marginal* productivities of services for key outputs used to justify public subsidisation of care extremely or invisibly low. Such low productivities limited policy options. For instance, the Audit Commission was sceptical about the effects of home care on the probability of unwanted and inappropriate admission to homes (Audit Commission 1986) partly because a high proportion at the highest risk were likely to be service recipients. To raise productivities it would be necessary to operate targeting and allocation criteria finely, requiring personalisation by means of an arrangement of performing the care management tasks to the requisite degree, the care management arrangements adapted to the circumstances of users and local circumstances, and greater flexibility in the range and content of services. Achieving that would be much more difficult than simply to improve targeting because it required engagement in depth – including big investments in human resources and support structures like reliable up-to-date and accurate devolved financial information and service supply information to field teams. In addition to that was the escalation of unit costs without increases in real service resources in some years.¹⁰

The experiment (the Kent Community Care Project) and its replications and descendants had successful outcomes. More important, the ideas they integrated caught on here and abroad. The programme of experiments – aimed at a minority of users of ssd services – was joined by a programme developing and testing the same arguments for all ssd users. This post-Goldberg shift towards the outcome perspective reinforced more general changes in culture and expectations at every level and widely described in the social policy literature by many authors in the direction of making personalisation one of the concepts of the Transformation agenda. It provided much the context-specific technical know-how and rationale allowing the context-specific interpretation of general social and political change.

Care-managed community care and the fruits of health/social care coordination. The KCCP also produced evidence that in care-managed community care, an advance to a superior technology could be achieved in which social care inputs could more than compensate for their costs by reducing utilisation of acute beds. That theme is still investigated during the 00ies, the DH becoming more willing to acknowledge that such

community care would plunge most organisations in the private sector to a quick and merciful liquidation’ (Griffiths 1988, para 29).

¹⁰ That phenomenon was to be repeated in the early 90s (Bebbington and Kelly 1995)

an effect might exist other than due to community matron and other Intermediate Care types of project than previously.

3 Post-Griffiths Reforms to the 1990s

We recall with ambivalences the ways in which broad changes in the philosophical basis of policy-making – not just arguments and assumptions about the potential virtues of using competition, market and quasi-market mechanisms etc, the potential virtues of importing some of the culture and techniques of commercial management, and the greater emphasis on consumer choice introduced by the Conservative administration changed the nature of policy discourse of care policy for older people in particular after the post-Falklands election. The interest here are the bits of history which affected the use of concepts and logics which are present still, though differently described. Important were

[a] Shift from local authorities as local policy coordinator, principal source of public subsidy, provider and quality assurer of most services, to authorities as ‘enabling’. The concentration of responsibilities for financing, goal-setting, quality monitoring and provision were thought to cause the producer – ie the worker and manager given the local polity and politics in many authorities – to dominate. There were speeches by Ridley and by Norman Fowler at Buxton speech. Out of this flowed the concept of the ‘enabling authority’, vaguely recalling the fashionable Osborne and Gaebler nostrum about governance in public policy: distinguish between ‘steering’ and ‘rowing’ and concentrate the effort of the key policy agencies on the former not the latter (Osborne and Gaebler 1992)^{vii} The administration’s belief that public sector management was weak, and that accountability was impaired by local councils protected by their status as monopoly providers. It was reflected in the undeniable escalation in unit costs, for instance in a paper by Bebbington and Kelly alluded to in the 1998 white paper and speeches of a Cabinet minister.^{11 viii} Widespread inefficiency was assumed.

[b] Ineffective coordination of health and social care in particular at management and field levels. After much hesitation, the government eventually accepted Roy Griffiths’ view that ‘to make restructuring mandatory would be enormously disruptive and would create turmoil under a semblance of action’ with the likelihood of only slow improvement in performance, that warts and all, local government would be sufficiently of alternatives to up its game in ways consonant with the new policy and could deliver arrangements adapted to local contexts, so that for the time being the best way to achieve improvement would be to ‘clarify the responsibility of agencies [and] hold them to account for their performance’ (DH 1989).^{12 13 ix}

¹¹ Analysis by the Department of Health and others, including the PSSRU at the University of Kent, has shown falling efficiency in social series over several years ... The Government has therefore decided to set targets for improvement in the efficiency with which social services are delivered (DH 2008, para 7.16)

¹² Not all this was stated in the report, though he stated the basic argument with the flourish of the barrister of Celtic descent: ‘Nothing could be more radical in the public sector that to spell out responsibilities, insist on performance and accountability, and to evidence that action is being taken.; and even more radical, to match policy with appropriate resources and agreed timescales Griffiths 1988, para 20).

[c] Criticisms of the pattern of outcomes, utilisation patterns and productivities accumulated during the eighties. This was demonstrated by independent research, some of which was echoed by the influential Audit Commission and the new Social Services Inspectorate, created by the DH to meet the requirements of the Financial Management Initiative (Davies and Challis 1986).^x The Audit Commission (1983, 1986) repeated the argument that too high a proportion of resources were allocated to people of low dependency and that the criteria for allocations were inexplicit, inconsistent, and in important ways biased, and stressed the importance of providing cost-effective alternatives for care in institutions. The white paper included among its objective a ‘high priority’ for practical support to carers, albeit implying the main motive to be instrumental, to encourage them to provide service. Research showed that *marginal* productivities for outcomes central to policy priorities were few and small. Improvement in marginal productivities were essential to a policy which rated main aims of community care policy to be ‘to enable people to live as normal life as possible in their own homes...’ ‘.. to help people achieve maximum possible independence ...’, and give people a greater individual say in how they live their lives ...’, particularly to the degree that this would be achieved by more purposive targeting of service by quantity and nature; that is, personalisation. (Davies et al 1990).^{xi}

Interpretation of the 1989 white paper’s objectives and the means of achieving them during the nineties

[a] Promote the ‘development of a flourishing independent sector alongside good quality public services’. The white paper claimed only to be endorsing Griffiths’ recommendation, but its formulation suggested a more hawkish pursuit of the development – ‘it will be their responsibility to maximise possible use of private and voluntary providers’ – no mention of an economic best value criterion there. It mentioned price and quality competition but also with a slightly Austrian accent talked about extending the range of services. The government upped the ante in the pursuit of increasing the market share of the independent providers, the STG (specific grant) providing a strong incentive, particularly in urban authorities subject to rate capping and adverse redistributions of the general grant. The SSI inspections reinforced the pressure. This was the first period in which the tenure of Directors of Social Services was compared to football managers. The diversion of the efforts of management and councillors to the implementation of a policy which in many areas ran entirely against the grain of the local political culture and raised great anxieties among managers and field personnel must be remembered when one remembers the under-investment in other key elements of the reforms. The gain from the shift was given fixed and stretched budgets, a larger quantity of service provided for the expenditure. The losses included were a risk of reduced quality improvement in the long run and in areas with high degrees of market concentration both a danger of price escalation and quality-endangering cost shaving; the shift of risks to employees in secondary labour markets, thirdly the additional costs of

¹³ Roy Griffiths described to me a plane journey from Edinburgh to London seated by Margaret Thatcher in which he eventually convinced her that his proposals were as far as she should be going at that time. I think that I later saw this mentioned in one of his articles.

navigating the more fragmented system, and fourthly the opportunity costs in the worse implementation of important reform elements.

[b] ‘Proper assessment of need and good care management’. Griffiths had described care management as the keystone of his proposals; the white paper as ‘the cornerstone of good quality care’. The issues were complex and the history more so. The white paper and supporting documents bolstered the case with reference to results of the KCCP and its replicatory and descendant experiments. They were very favourable compared with most policy experiments before or since and the KCCP was imitated in experiments in other countries with favourable results^{14 xii} But in the process of reconciling the KCCP with other features which the intellectual context and new policy arrangements seemed to make desirable some of the key principles were seriously diluted if not altogether forgotten.

The historical context and what was put in place

[a] Care managers for all or requisite performance of care management tasks for all? The KCCP and its ‘replications’ and descendants were targeted highly selectively at those for whom it was judged that it would be most welfare-assisting. *Matching Resources to Needs* quoted a Wisconsin programme director with approval: most users need case management – ie the full inputs of a Medicaid waiver case manager – ‘like they need an ‘ole in the ‘ead’. *Matching* guesstimated – more accurately perhaps, hazarded a guess - that perhaps up to a fifth of all then users of home and community services might benefit to a substantial degree. The programme of PSSRU experiments of which the KCCP was a first was primarily to explore how care management arrangements should differ in ‘arrangements and parameters’¹⁵ and other ways between subgroups of users recruitable in the social and health care systems. It was about furthering the personalisation of care management within what would almost certainly have been a minority of users, in the circumstances of the age. It paralleled a main focus of the analysis of the evaluation data: what patterns of utilisation and outcomes characterise a highly personalised system. It was the antecedent of work in the eighties and nineties scaling up the question to all users in the DCP and its ‘replication’ more than a decade later in the ECCEP, the studies of patterns of outcomes, utilisation, productivity and efficiency patterns.

That focus produced a body of generalised logic; a body of theory about care-managed support in the community care of older people. So for, instance, there was argument (used by the Audit Commission) about the dependence of aspects of efficiency on the performance of individual care management tasks (Davies and Challis 1986). Of

¹⁴ For instance the RWJ-financed project in Rochester NY whose results were among the most favourable among American demonstrations, and the Community Options projects in Australia (whose evaluations were unfortunately not comparable. The project was referred to in a succession of French official reports leading to the PED, PSD and the brilliantly named *allocation personnalisée d'autonomie* (APA); Davies, Fernandez and Saunders 1998. See *Case Management, Equity and Efficiency: the International Experience* Davies (1993) and the OECD paper related to it (Davies 1992) for a comparison of logics of projects and programmes influenced by the KCCP and of other care management programmes in various countries.

¹⁵ The inadequate concept used in *Case Management Equity and Efficiency*.

relevance as we now consider how to provide arrangements for navigation, brokerage and other variants on performing care management tasks was the attempt to construct a body of 'contingency theory' intended to distil evidence from projects and programmes in various countries into a body of generalised argument about differences in aspects of case management, their combination and contextual fit to produce good outcomes by various criteria. The argument varies in generality. For instance, argument about the dangers of distorting incentives of different arrangement for full or partial budget devolution is a narrow but important subject. So is the way arrangements etc have been show either to complement one another or reduce one another's influence in producing effects. There is a substantial literature reviewing the evaluations of care management experiments. , and the potential effects of context and arrangements on outcomes or people in different circumstances with respect to need-related circumstances, policy priorities, features of the supply context and the like (Davies et al., 1990; Davies 1993). Examples are reviews of evidence suggesting features which commonly and reduce its effectiveness; reviews of potentially useful tested instruments; discussions of systems support for case management; reviews of influences which commonly distract during a care management process ; reviews of literature suggesting broad features likely to raise the productivities of care management; to provide generalised argument about matching care management arrangements for subgroups of uses to user circumstances, policy priorities, supply system characteristics, and the like; model for balancing inputs into care management and other care inputs in a context with known productivity patterns; a mode for considering the influence of a change in demand with constant resources and productivities given the triaging arrangements which seemed most prevalent in care management of the mid-90s (Davies et al 1990).

But then came the 'enabling authority' policy; maximising the share of the independent sector. That made the supply system more fragmented, more difficult for the user to navigate and manage. All needed a greater performance of the core tasks of care management than had previously been necessary. A new director at Kent, Norman (Lord) Warner led a change to care managers for all, as distinct for care managers for some with requisite performance of core tasks of care management for those for whom its productivity would be high: the distinction between care management as 'process' and as structure made later by Huber???.¹⁶ At about the same time, the extremely impressive team which produced the SSI report *From Home Help to Home Care*, accepting the argument about the logical connections between performance of care management tasks and aspects of efficiency put forward in *Matching*, argued that rather than have the careful development of KCCP-like selective specialist care management teams in what in the medium term would be 'a parallel services' model, the system should grasp the nettle and aim quickly for a universal 'radical change' model – oddly for a report so well versed in organisation theory and so, one would have thought with a tendency to perceive rapid

¹⁶ Nick Stacey's successor as Director of Social Services at Kent, Norman (later influential Minister of State Lord Warner) supported that development, and was anxious not to skew development excessively towards services for older people and away, particularly from child care. In 1997, the score of KCCP look-alikes were replaced by a new variety of care manager; all former care managers, home care organisers, social workers etc working with older people who shared equally the total number of home care and other home and community service caseloads. Worker caseloads were greatly increased. Skills were arguably diluted. The culture was changed. Intensive care management inputs were made less likely.

universal radical change to a model with clear principles and logics which would not work without skill and cultural development (SSI 1987).^{xiii}

In the guidance on care management, the DH compromised.¹⁷ It was less that they set out to match alternative arrangements and parameters to user circumstances and subgroups, more that they proposed what amounted to 'triaging' to one of six levels of assessment. In the event, SSI reported in the later 90s, authorities chose an extraordinary variety of arrangement and parameters, but a high proportion could be crudely described as triaging to three levels, the lowest of which was minimal and unrelated to long-term care. The triaging occurred largely within teams, often without an elaborate body of formal policy even at the team level. It was a triaging to workers of different levels of training, associated with caseloads smaller for the most highly trained and so to more or less time on average for users. David Challis and Manchester PSSRU colleagues argued throughout the late nineties and later that the result was a failure to provide intensive care management for older people with the result that inappropriate admissions to institutions were greater than they should have been (eg Challis et al 2001; Weiner et al 2002;).^{xiv} The amendments in SAP are best considered in the final era considered in the next section.

[b] *Budget devolution to care management team with information etc support and authority to use with maximum flexibility.* The White Paper was unambiguous by implication that this was a core part of the policy, contrasting the flows of funds in the then practice and the KCCP-patterned flow in the reformed system. But it was not so worded as to suggest that this KCCP feature was a mandatory feature of what the authorities were to put into place. The guide agonised too much about balancing economies of centralised purchasing and care manager purchasing – a problem faced by the KCCP satisfactorily. It argued that the closer the purchasing decisions and so the budget could be taken to the users, 'the more relevant they would be to their needs'; and by extension, we may argue them to suggest, the more personalised in today's meanings they would be likely to be. The Audit Commission commented: 'Sometimes older people and their carers do not appear to have as much influence over their care as they should. In practice, care managers have limited choice to offer older people. Social services departments should ensure that care managers have greater influence over services buy reducing restrictions on choice, introducing service level agreements with in-house provider and delegating budgets': a conclusion reinforced in the analysis of care management in the ECCEP productivities equity and efficiency study (Audit Commission 1998; Davies 1992).^{xv} The text suggested that the authors misunderstood a central principle of the KCCP. It was not that a discretionary budget which could be used to supplement centrally purchased services was devolved to the team: it was that the team/worker was responsible for deploying a total budget for its caseload and was guided

¹⁷ The two guidance documents were broad stimulating and excellent imaginative essays to whose composition a wide range of people from inside the DH and elsewhere contributed their expertise of various kind for the whole range of user groups. Perhaps they raised too many possibilities and rejected too few in the context of a policy that was to allow authorities great autonomy in the nature of the arrangements they were to introduce – but a committee of authors the expertises and perspectives of whose members were so diverse might have found authoritative evidence-based rejection and ratification difficult. Within a few years, leading officials in the area were privately apologetic about some features of the argument.

by a budget cap and had the authority to prescribe the centrally commissioned services (charged against the devolved budget) and also purchase or otherwise procure services and support from other sources and of other kinds. That was key for the incentive to be flexible in meeting users' preferences and in seeking out the most cost-effective ways of achieving goals. The guide talked about the lack of cost, financial control and other related information. The authors had clearly not taken to heart Roy Griffiths' sharp comment: 'the present lack of refined information systems and management accounting within any of the authorities to whom one might look centrally or locally to be responsible for community care would plunge most organisations in the private sector to a quick and merciful liquidation' (Griffiths 1988, para 29). The guide ensured that authorities would not act precipitately by discussing transition periods of indeterminate length.

[d] *Prioritisation of user wishes and other influences.* The DH documentation talked about the 'profound cultural changes' required before user wishes perceptions expectations and the like could have the needed influence. Some described the social services as primarily an 'oral' culture; and the additional difficulties in securing desired cultural changes that that implied. Care management was one of the chapter heads of the reviews of individual authorities undertaken jointly by the Audit Commission and the SSI, and the SSI undertook occasionally undertook topic 'inspections' (ie analytic reviews of the national state of play) but their methodologies did not allow depth in the collection of evidence and its analysis: the SSI had rejected the more challenging methodology of *From Home Help to Home Care*, with its use of the then theoretical state of the art. Care management may have been described as a 'cornerstone' of the reform policy, but one would not have guessed it from the list of priorities for authorities identified in the annual letters to authorities from the Chief Inspector. Authorities did not generally develop policies and mechanisms to encourage the enhancement of user influence, or mechanisms to monitor its degree, such mechanisms and policies being directed at raising users expectations of enhanced influence and recourse to systems when they felt that their interests were being inadequately taken into account, and also at the personnel of the authority and its agents. Investment in individuals was needed in field personnel undertaking care management tasks, and their managers. Unsurprisingly authorities' investments were inadequate in scale and nature. CCETSW took no training initiatives; indeed showed little interest. The central government did not set frameworks for authorities for making these investments and making them effective. It was not a major focus of its quality assurance.

And there first there were the massive distraction of reform elements like maximising the market share of independent sector providers and its consequences. Secondly, there was the steady pressure to keep down expenditure, exacerbated by the volatility of the annual general grant from central government, and in some places rate capping and the manipulation of the financing structure to create for some authorities a tax cost well in excess of a pound for every pound of additional expenditure undertaken. Related, but almost an independent factor, it was a period of increasing management control over the field – the growth of a form of new managerialism which was not balanced by enhanced

influence from the field up to which devolved budget care management was intended to contribute. Thirdly, there was the diversion of demand from the NHS.

So to what degree did the post89 reforms have beneficial impacts by means of the key logical mechanisms postulated by those reforms?

In the circumstances, big improvements enabled by the reform's main causal logics might seem surprising.

First, were some of the reform elements argued to generate the causal processes put in place? Consider the list at the beginning of the section.

- **[a] Shift to enabling authority and the maximisation of market share by independent providers.** The market share first in the care home and then in home and community services markets were increased.¹⁸ The benefits were quantitatively more service assuming the same quantum of funds spent by authorities, perhaps some greater variety of service in some respects, perhaps some greater potential for choice again in some respects. The cost was perhaps the danger of lower quality in the long run, and the transfer of financial and other risks to individual workers in the new secondary labour markets created.
- **[b] Care management and targeting: effects on outcomes and productivities.** It has been argued above that the policy which emerged at the end of the eighties produced a body of argument linking improvement in levels and mixes of outcomes, productivities (and so efficiency and fairness) to targeting. Were there improvements in these respects and did targeting and the increased focus on the performance of care management tasks contribute to the improvements.
 - ***Was there substantial improvement in outcomes?***
 - It will be remembered that ECCEP failed to find positive marginal productivities for most of the outcomes central to the criteria suggested by policy discourse and the evaluations of social care

¹⁸ By the end of the period, new dangers were arising. One arose from the monopsonist position of the purchasing of services for the poor. The pressure of demand on resources were providing incentives to commissioners to bully providers into lowering prices to secure custom, leading to lowering and elimination of providers' profits for providers, closures of capacity, quality chiselling, selection bias favouring less dependent privately financed residents. Paradoxically the same mechanism could create a situation in which in some areas market concentration could thus be increased – or arise for other reasons, creating the danger local monopolies and oligopolies, which in the long run could result in excessive profits and capital gains. *Resources Needs and Outcomes* described how something closer to the first changed to the second over time. The additional Texan ingredient was the political organisation and networks of the provider associations at the State level. That is more likely at the local authority than the national level – something to guard against given a policy of radical devolution of responsibility to lower levels of government.

projects (Davies et al 1990).¹⁹ It attributed that to lack of purposive targeting policy and practice, exacerbated by weakness in the performance of core care management tasks.

- A replication in the same areas in the mid-late nineties showed outcomes and productivities to have been transformed. In Figure 1, outcomes are defined as the degree to which the deleterious consequences on a dimension of welfare are offset by the effects of the publicly-subsidised care management support. This I called the Risk Offset from Productivity Proportion [ROPP].²⁰
 - The ROPP score for the additional number of days supported at home rather than in homes or other institutions suggests that the service support offset 32 per cent of the effect of the risk factors. That this had the highest ROPP score among the seventeen outcomes for which positive productivities were found reflects the great emphasis on this outcome in the statement of white paper priorities. That national priority was reflected in the high degree of consensus found among a sample drawn from the same authorities of 133 managers at all levels and in all sections that in their authority this had been the highest in the list of priorities during the relevant period.
 - The second highest score was the reduction of felt burden by informal carers (26 per cent)
 - Outcomes related to independence, empowerment, and sense of personalisation of the care plan also had substantial scores: degree to which users felt control over their lives; and users' felt empowerment during the set-up stage of care management. Principal informal carers' sense of empowerment had a lower ROPP score of 9 per cent. These no doubt contribute to the substantial score for users level of satisfaction with the level of services received.
- **These improved outcomes were associated with more purposive targeting.** Much higher proportions of users had higher scores on various characteristics predicting high risks and welfare shortfall. Simulation analyses based on the KCCP and its three closest replications had illustrated the consequences of different priorities: minimising unmet need in this population of recipients (and so disregarding differences in potential for gain created by the productivities associated with their circumstances: a need criterion without the cost-benefit component)

¹⁹ ECCEP was a twelve-area POW study of utilisation, productivities and outcomes and influences on them for a cohort of new users recruited in 1984

²⁰ The ROPP and COPP concepts are described in *Equity and Efficiency Policy* (Davies Fernandez and Nomer 2000, 170-1), where comments on the attributes of the indicator helpful to its interpretation are made. The COPP measures the proportion of the total sample affected by the productivity effects determining the ROPP score.

(without regard to productivities maximising an indicator of welfare gain (and so basing allocations among recipients on marginal productivities: again a criterion taking account of only one element in a cost-benefit criterion of need); and the ratio of Gain to Cost (Davies et al 1995).^{xvi} *Equity and Efficiency Policy* used the ECCEP 12-area study of the nineties to simulate the consequences of maximising different outcomes: days supported at home rather than in institutions, reducing principal carers felt burden of caregiving, and user satisfaction with services. Those simulations explored the difference in the benefit structures, the incidence of benefits, and the ‘collateral effects’ of maximising each outcome; and also the effects of different price elasticities of supply of services. The simulations not only confirmed that allocations reflected the priority structures reflected in the 1989 white paper, but also that some of the alternatives postulated would have caused serious diswelfares to some users. They illustrated that with the more predictable relations between resources and outcomes created in the system of the 1990s, it was important that policy-makers should face up to the dilemmas of prioritisation as shown by the opportunity costs described by the collateral effects. This new degree of ‘technological determinacy’ on the supply side sharpened the difference between the high level of generality and emphasis on principles of political narratives and the more complicated discourse and conceptions of ends, means and process which good outcomes demand from the policy narrative.

- **Role of care management productivities.** The evidence from ECCEP is no more compatible with the wilder denigration of care management in the nineties than it is the wilder statements implying the uselessness of services. It showed that at the margin, the ratio of the marginal productivity of care management to prices was higher than the same ration for services. That is, too little care management was inputted during the set-up stage compared with services during the setup and continuing care stages of users careers.
- **Integration and partnerships.** The 1990s did indeed leave unfinished business in the integration with health. The 1998 white paper laid the foundations for change while reinforcing the importance of the reform of the nineties, particularly the greater attention to targeting and care management. By the early noughties, progress had been made with integration. The effort, and the distraction from pursuing social care goals rather than the dominant health interest in the more economic use of acute beds, must have had opportunity costs not yet properly documented. It was complained that the effects at the level of users were slow to come, most of the effort being directed at change at a higher level – with the notable exception of collocating social with primary and community health field personnel. It may be difficult to maintain the momentum in the context of cuts, prevention, and the Transformation agenda. There was an element missing from the often indecisive and incoherent integration policies of the later

nineties and later: putting enough emphasis on the circumstances in which there is good 'clinical' reason to think that re-engineering which integrates jobs and roles at the highest Leutz level or secures close coordination around common ends will allow a new and 'technically superior'²¹ patterns of productivities and with them greater ability to fit process and outcomes around user/patients. It was surprising that this was left to emerge by chance during the nineties and later. at the cost of enormous effort.

4. The noughties

Space does not allow me to take further the discussion of integration/partnerships

The Green Paper of 2005 announced that demographic change would make the system non-viable and would (presumably in the longer run) be incompatible with social change in other ways. The paper was innocent of quantitative argument.

A main effort by government has since been to create the new political narrative compatible with green paper ideas. The Concordat was a tangible and important political achievement. The nub of the argument was stated in the *Transforming ...* circular of January 2008. It proposed the application of a personal budget mechanism – individual budgets but with a narrow range of sources of finance than was aimed for with IBs – accompanied by the policy-(etc) reinforced principle of use control to achieve 'personalisation' and so maximum welfare for the budget. There are three concepts, the personal budget (IB or DP), personalisation and the maximisation of user control subject to outcome acceptability. The causal mechanism hypothesised is that the personal budget *plus* the user control produces the personalisation and personalisation maximises welfare given the budget. More recent documents are perhaps less stark

The Individual Budgets model postulates all the substitution aims of the KCCP form of care management except one: the IB model if fully applied replaces care manager arbitrage in the allocation of the devolved budget for the worker/team with the preliminary estimation of the IB value for a person by formula based on a self-completion questionnaire with revision by the agency if inequitable. Which is superior will no doubt vary between and within user groups. The reviews of formula allocations around the world over many years support this supposition. There are potentially perverse incentives which could be cost-escalating and biasing, and it is an empirical matter whether they could be countervailed.

However policy documents continue to qualify these with other principles and caveats. The question is to what degree will the core logic of the circular have to be balanced or sacrificed for outcomes to be maximised. Light can be thrown on that by existing evidence, because the greater the validity of *Transforming's* proposition and so the less accommodation there would have to be with other principles, the more valid would have to be the following propositions

²¹ That is improved total productivities; a technically superior production function.

1. Older citizens' value increased control highly compared with other benefits
2. System after the post89 reforms did not contribute substantially to enhancing users' control
3. Post89 services did not contribute to support of carers and/or their sense of influence over the care plan
4. What the post89 system produced fitted wishes and interests badly
5. What the post89 system produced fitted wishes and interests worse than would maximising users' felt control

Ann Netten's discrete choice experiments and ECCEP simulations suggest that none of the proposition receive strong support (Davies and Fernandez 2000)^{xvii}.

So care should be taken not to compromise the other principles in working out the more detailed policy narrative.

6 Conclusions

Some of the concepts and arguments important in today's narrative – particularly the Transformation Agenda – have clear predecessors in earlier narratives. Their application sometimes worked well, considering that the concepts logics and models were (as always – and the most recent experience is no exception) not implemented with sufficient thoroughness to fulfil their potential

It would be a mistake to see the new and old models built on an outcomes focus and personalisation as competing. They mix much of the same ideas in different proportions and given the variety between and within user groups different mixes of the elements may work best depending on circumstances. And the handful of main model features are only some of the influences which complement or compete with one another in the production of desired results. What would be most useful would be an attempt to create empirically tested body of 'contingency theory', able to suggest what would fit circumstances of various kinds. It would have to be based on a great deal of analysis of experience of all kinds from the econometric to the detailed micro-analysis of the politics of projects and the influences that change them. That is a much more challenging undertaking than promoting one or two simple models. We should resist the temptation to do otherwise.

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