Citizenship, choice and care: an examination of the promotion of choice in the provision of adult social care

Guy Daly

University of Derby

Abstract
Choice for service users in social care and public services more generally in the UK has been promoted by all Westminster governments over the last thirty years. However, there has been insufficient reflection on how this impacts on service users and citizens as a whole. When choice in social care is examined from economic, psychological and socio-political perspectives, doubts arise as to the extent it has empowered service users, promoted the rights of citizens and improved service delivery. Social care needs to be (re)constructed less as solely a market or civil right and more as a social right since markets can be ineffective in coordinating the production, distribution and governance of social care. In addition, the promotion of choice in social care can have deleterious socio-political, psychological and economic consequences. The paper argues, therefore, that rather than concentrating on choice, a more appropriate way forward in the provision of social care and in the meeting of citizens’ rights to care would be to conceptualise choice as a ‘second order’ concern at most and, instead, to concentrate on establishing adequately funded, high quality universal social care services across the whole of the UK.

Keywords: Choice, citizenship, social care, adult care, public services, rights, service users

Introduction
Over the last thirty years UK social policy has been shaped by the neo-liberal informed Conservative governments under Margaret Thatcher (1979-1990) and John Major (1990-1997), Tony Blair’s (1997-2007) and Gordon Brown’s (2007-2010) Third Way New Labour administrations and, since 2010, the Conservative and Liberal Democrat Coalition Government (see, for example, Ferguson et al., 2002; Clarke, 2004; Grimshaw & Rubery, 2011; in relation to social care, see Stevens et al., 2011). During this time, we have observed the championing of ‘choice’ in social care policy discourse and more widely, but arguably with insufficient reflection on how this impacts on service users and citizens as a whole. Choice has been promoted across the public services in health, housing, social care and education. Social care users have, similarly to other public service users, been reconstructed increasingly as ‘heroic citizen consumers’ making choices over their care arrangements within a mixed economy of public, private and third sector providers. However, when we examine choice in relation to social care and more widely from economic, psychological and socio-political perspectives, doubts arise as to the extent that its promotion has empowered service users, promoted the rights of citizens and improved service delivery. This paper therefore explores the phenomenon of choice as it relates to social care provision, firstly by drawing on T.H. Marshall’s work (1950) on citizenship and citizens’ social and market rights, followed by briefly examining current social care policy developments, and then by examining the promotion of choice in relation to economic, psychological and socio-political analyses. The paper then briefly examines some of the evidence on the effectiveness of the promotion of choice in social care before moving on to recommend that rather than concentrating on choice, a more appropriate way forward in the provision of social care and in the meeting of citizens’ rights to care would be to cease being distracted by a focus on choice and
instead to concentrate on establishing adequately funded, high quality universal social care services.

Citizenship

In trying to understand developments in UK social care policy and their relationship to citizenship, it is useful to refer to the work of T.H. Marshall (1950). Marshall’s analysis of citizenship is regarded by many as seminal (Roche, 1992). Marshall described the evolution of citizenship within modernity from the eighteenth to the twentieth century. He argued that citizenship had developed over these three centuries during which time citizens acquired civil or market rights (in the eighteenth century), then political rights (in the eighteenth and nineteenth century with the advent of modern parliamentary democracy) and latterly social rights (in the first half of the twentieth century, in which citizens acquired the right to social entitlements, institutionalised in the post war settlement and the creation of the modern British welfare state) (see Bulmer & Rees, 1996; Timmins, 1996; Gladstone, 1999). Whilst not part of Marshall’s analysis, one also needs to note that as part of the welfare state settlement, whilst some social rights would be met universally and would be free at the point of use (e.g. NHS provided health care; education), others would be either targeted and/or means tested (e.g. social housing, unemployment benefit and welfare benefits more generally). Social care was an interesting case in that, unlike health care – free at the point of use, irrespective of means – social care was to be means tested and non-universal. This was as a result of healthcare being constructed, via the NHS Act 1946, as free at the point of delivery whilst social care, via the National Assistance Act 1948, was to be the responsibility of local authorities and, as such, subject to means testing and local variance. This ‘anomalous’ position of social care entitlement has remained throughout the subsequent seventy years and is, therefore, still being grappled with by Government today, as can be seen with the Dilnot Commission of last year (Dilnot Commission, 2011).

Marshall’s work is not simply a helpful historical analysis but is also useful in explaining what has happened in the refashioning of citizenship over the last thirty years, that is since the advancement of the influence of neo-liberalism in UK social policy. Over this period, one has seen the promotion of notions of the citizen as a customer of public services (whereby there is an emphasis on ‘consumer citizens’ with civil or market rights). Whether it be in relation to choice (and personalisation) or just more generally, public service users, including social care users but also patients, housing tenants, pupils and students, are all constructed to a greater or lesser extent as customers and consumers. Public services have therefore been reshaped, rhetorically at least, as ones that promote the citizen customer or citizen consumer who is able to exercise choice. This promotion of choice in current social care policy is what will be explored next.

The continued promotion of choice within social care policy development

Under the Coalition Government there has been a continuation of the promotion of the choice discourse that was witnessed under previous governments over the last thirty years (DH, 1998, 2001, 2003, 2005, 2006, 2007, 2008; HMG, 2007, 2008). In both A Vision for Adult Social Care: Capable Communities and Active Citizens (DH, 2011) and the White Paper Caring for Our Future: Reforming Care and Support (HMG, 2012), the Coalition has expressed its commitment to social care services’ users having choice, not least through the ‘greater rollout of personal budgets to give people and their carers more control and purchasing power’ (DH, 2011, p.8). In addition, the Coalition established the Dilnot Commission in 2010 into the funding of social care and support in England. This reported its findings in July 2011 with a set of proposals that would cost just under £2 billion a year in order to implement a more universal care service. However, the Coalition has yet to respond fully to the Dilnot Commission’s proposals.
other than to publish its own social care White Paper (HMG, 2012) mentioned above.

When one examines the extent to which social care users have actually been provided with choice, an ambiguous picture emerges (see Netten, 2005; Scourfield, 2007; Beresford 2008, 2009; Daly & Roebuck, 2008; Glendinning et al., 2008; Ali, 2009; Institute of Public Care, 2009; Woolham, 2009; Orellana, 2010; Needham, 2011; ADASS, 2012; Beresford et al., 2012; Glasby, 2012; Woolham & Benton, 2012). On the one hand, over the last thirty years, a mixed economy of social care providers and social care markets has slowly developed. This has included a substantial shift to independent sector provision of services as well as a shift to domiciliary or home based care. Another change has been that it is increasingly only those social care users with the highest levels of need who are deemed eligible for state funded support. However, these ‘eligible’ service users are then, paradoxically, provided with more intensive care packages. Consequently, those with lower levels of need increasingly have to purchase care services independently (‘self-funders’), if they can afford to do so. If one is judged to be in need of social care support, one may be provided with both a greater voice and greater choice over provision. However, this is arguably at the expense of the numbers deemed not entitled to receive adult social care. It is as if those social care users who are provided with public support have seen their (Marshallian) civil or market rights increase, whilst the vast majority of citizens who may be viewed as in need of some sort of social care support have seen their (social) rights reduced. As a consequence, running alongside or even counter to the promotion of choice and personalisation in social care, there is a concern that the inequities or contradictions within current state supported care need to be resolved, whether that be in relation to the vagaries of the ‘postcode lottery’ of local authority eligibility criteria and charging policies or that increasingly it is only those individuals with the highest levels of need who are provided with social care and support (and then only if they meet increasingly strict means testing criteria). Within this context, a focus on choice is arguably a second order matter. And, whilst personalisation in social care does seem to have gained widespread support (Glasby & Littlechild, 2009; Needham, 2011) there has been some degree of critiquing, that is not accepting the supremacy of ‘choice’ at face value or unquestioningly (see, for example, Beresford 2008, 2009; Daly & Roebuck, 2008; Ali, 2009; Woolham, 2009; Beresford et al., 2012; Woolham & Benton, 2012). It is to this critiquing of the promotion of choice that the paper now turns.

Examining the general consequences of promoting choice

In this section of the paper, a number of critiques are presented of choice as a mechanism for delivering goods and services, not least public services, including social care. These include economic, psychological and socio-political critiques of the consequences of choice.

‘Economic choices’

For liberal economists, sovereign and rational individuals exercising their freedom of choice results in the most efficient production and distribution of society’s goods. Adam Smith’s (1776) ‘invisible hand’ ensures that supply will meet demand in the market and that price will keep this in balance. However, some of the problems with the market include: the need for perfect information; how to resolve the challenges of distributing scarce goods and merit and public goods; and, thirdly, problems of inelasticity of supply. Each of these will now be explored briefly with reference to social care where appropriate.

Rational economic men and women are supposed to be able to make appropriate choices because they have perfect information and are likely to behave rationally. This is, obviously, problematic when an individual does not have sufficient information, is unable to interpret it, and/or
chooses to make ‘irrational’ choices. Decisions over the provision of social care helps to illustrate these difficulties (Daly, 2008). Even in the Wikipedia and Google-age, we are not necessarily sufficiently well placed as social care users or carers to exercise choice; notwithstanding that one needs to recognise the expertise of service users or experts by experience. Do social care users or carers have all the information they require about their social care needs, the care options available, the competence of the social care providers, the efficacy of the various options available to them? Evidence from research on individual budgets (Glendinning et al., 2008) and self directed support (Woolham, 2009; Woolham & Benton, 2012) would suggest that older social care users for one are not necessarily wanting to take on the role of rational economic decision makers in the social care market place.

Second, there is the problem of how to distribute scarce items. Obviously, where supply cannot meet demand, or those in need cannot afford the cost of supply, the price mechanism might not be the most appropriate mechanism for distributing such goods and services. This leads us on to considering whether certain goods or services are, therefore, too important to be left to the market to provide, that is ‘public’ goods or services, because the appropriate distribution and consumption of them is in the interest of wider society. Public health and education would be examples of this as would, arguably, social care services for vulnerable individuals and groups. Where ‘social care goods’ are too expensive for most individuals, other than the most wealthy of ‘self-funders’, we may collectively decide to choose to ‘pool the risk’ and to distribute social care via means other than the market.

**The psychology of choice**

Choice is also not entirely helpful as a mechanism for distributing goods and services, including social care, when one considers it from a more psychological standpoint. In this section, choice will be considered in terms of: quantities and quality of choice; the ‘tyranny’ of individual decisions; opportunity costs and choice; whether having less choice is more effective; whether choice promotes anxiety; notions of satisficing rather than maximising; and, whether choice can make us unhappy. In exploring each of these in relation to social care, reference is made to the ‘paradoxes of choice’ as presented by Schwartz (2004). Schwartz argues that more choice does not necessarily equate to greater choice, let alone greater liberty. For social care users and carers when faced with the possible choices open to them (similarly to when one visits a supermarket to be confronted by the array of different types and brands of baked beans), may feel disempowered by the choices they have to make. The use of a broker or care manager is often required to support a user and/or carer to design an appropriate care package.

Also, our individual decisions about our care arrangements may have unintended long term consequences (sometimes described as the tyranny of small decisions). As individual social care users or carers, we may make our own individual (sic.) decisions, believing them to be in our best interest. However, the aggregate consequence of these may not be what we would have wanted in the longer term. For example, as more and more social care users set up their own, individualised care arrangements, they and society as a whole may not appreciate that their withdrawal from supporting the collective provision results in that provision being withdrawn altogether (even though these same social care users might have thought it would be there for them to fall back on when they needed it). Examples of this can be seen in the withdrawing or closing of day care provision as it becomes unviable due to insufficient ‘demand’; what Ali (2009) has described as the withering away of ‘bog standard’ provision.

The opportunity costs associated with weighing up different choices is also something worthy of consideration and reflection. Schwartz argues that spending
time researching for the best product or service creates opportunity costs, for example in reducing the time we spend on other important activities. This may partly explain why older people, for example, have been reluctant to take up the option of Individual Budgets or Personal Budgets (Glendinning et al., 2008). Indeed, making choices can simply result in disappointment. When presented with an array of choices, and having made one’s decision, one may often feel regret (‘what if’) over missed opportunities, raised expectations, awareness of inadequacy in comparison to other options available. Social care users and carers are often faced with these anxieties when deciding whether or not to enter residential care. Is going into residential care the right choice; is the chosen care home the best one available; what if it is the ‘wrong choice’, will it be possible to switch to another provider or an alternative type of care arrangement?

For Schwartz, we need to decide when we need to behave as choice perfectionists (maximizers) and when we should be content with being pragmatic choosers (satisficers). He argues that for most choices in life, we are probably better off being a satisficer. However, one could go even further with this argument and suggest that on the occasions when a choice is so important one needs to behave as a maximizer (for example, whether to have a particular medical treatment or whether to sell one’s property in order to go into residential care), one would probably be better off finding someone else to help you make the choice (in the manner of co-production) or even to ‘abdicate’ the decision to them if they are the expert.

One final aspect of the consideration of the psychology of choice is that choice can actually make us unhappy. Myers (2000) and Lane (2001) both suggest too much choice may lead to feelings of unhappiness or even depression and feelings of isolation. They argue that consumption can make us unhappy and the commodification of social interactions and exchanges may lead to isolation and a breakdown in communal or social connectivity. When one considers examples of the commodification of social care in which home care workers are only permitted to undertake pre-prescribed tasks, often within a particular timeframe, one can see the possibilities of marketisation of social care potentially creating feelings of alienation of social care users from their organised care providers. The consumption of care becomes increasingly a marketised or commodified transaction rather than a professional or social interaction. This latter point relates to some of the insights gained from socio-political analysis to which the paper turns next.

Before that, it is hopefully useful to draw some conclusions from this admittedly brief and limited exploration of the psychology of choice: having more choices does not necessarily mean better choice(s); sometimes less choice is better; our own individual choices may, alongside others’ choices, aggregate into something we had not thought would happen and we would rather did not happen; our agonising over choices can sometimes be at the cost of pursuing other opportunities and/or result in feelings of anxiety, inadequacy and alienation; and, overall, one needs to think about which aspects of our lives we wish to choose such that, for other parts of our lives, we should be pragmatic choosers or (if it is a significant decision) get advice or ask someone else to (help to) make the decision. Overall, therefore, social care users’ and carers’ psychological well-being is not necessarily best served by the pursuit of choice.

**Socio-political analyses of choice**

Socio-political analyses of choice also offer some helpful insights into the problematic nature of the promotion or reification of choice. In examining social care and choice, the work of Le Grand and Clarke are particularly relevant, in my view, not least in relation to: the development of quasi-markets in public services; the impact of privatisation and ‘individualisation’; the need to consider choice in terms of who, what, where, when, how and whether; and, finally, the extent to which choice may exacerbate inequality.
Over the last thirty years we have seen the development and incorporation of quasi-markets (with the split between the supplier and the purchaser) in the provision of public services. However, quasi-markets are problematic not least because, unlike in a ‘pure’ market, the purchaser is not the direct consumer or user. For example, the social care user may ‘consume’ publicly funded social care, but does not necessarily directly purchase it (unless they are a self-funder or are in receipt of an individual or personal budget). Rather, the care manager purchases or puts together the package of care on the user’s behalf. With the advent of individual and personal budgets, the service user may choose how to have their needs met, but it is still typically the case that the care manager or social worker will have assessed what the service user’s needs are and then played a significant part in determining from whom to purchase the social care provision. What is also interesting about the advent of quasi-markets is that this purchaser-provider split has arguably changed the behaviour of welfare purchasers and providers. Le Grand (1998) described this in terms of ‘knight’ and ‘knaves’, whereby before the development of quasi-markets, both purchasers and providers arguably behaved in more benign (or ‘knightly’) ways, constructing welfare (including social care) recipients as people to serve and to have their needs met (however naïve this may sound, today). With the advent of markets and quasi-markets, purchasers and providers behave more ‘knaively’, for example taking great care (as a purchaser or provider) when determining the level of social care support users are entitled to and what the budgetary implications of this are.

UK governments over the last thirty years have also sought to privatise welfare not just in terms of handing provision over to private or quasi-private organisations, but also in terms of relocating parts of it (including social care) back into the private realm, that is with individuals, families and communities. Therefore, responsibility has been privatised, by making individuals, families and communities responsible for meeting their own welfare needs (Clarke & Newman, 1997).

Another complication in the promotion of choice in welfare provision is the need to be clear over what aspects of choice are being considered. In their text, The Consumer in Public Services, Simmons et al. (2009) adapted the work of Le Grand to depict the types of choices a public service consumer might make, including social care users. Social care users are increasingly faced with choices about who should provide their care, where to have that care provided, what care tasks should be provided, when that care should be provided and how the care should be provided. Over the last thirty years we have seen developments in choices over who provides (for example, with the promotion of private and voluntary sector providers of social care), what is provided (for example, IBs and PBs in social care), when it is provided (again, IBs and PBs are examples of this), and how it is provided. However, social care users are, arguably, more concerned with being provided with good care services and less concerned by the ‘who’ and, possibly, the ‘where’. The ‘what’, ‘when’ and ‘how’ are worries in that social care users do want to be able to determine, for example, what the care assistant might provide as well as when and how. One that is not identified by Simmons et al. (2009) but that needs considering is the whether, that is whether to take up the option of choice (and whether there is an option to opt out of making choices) (Daly & Woolham, 2010). Again, the results from the IBSEN review (Glendinning et al., 2008) of IBs suggest that some service users were less interested in taking up the choice option.

If markets are about suppliers responding to the demands of consumers, then not only do we have to contend with the limitations of rational economic humans, explored earlier, but also with the fact that some people are in a better position to demand or choose than others. For Clarke et al. (2005), choice may, therefore, exacerbate inequalities rather than reduce them; not least because access to
Citizenship, choice and care

welfare services is shaped by economic and social capital and social inequalities more generally. It is, perhaps, partly because of some of these uncertainties that social policy analysts of choice, as well as social care advocates, have suggested that rather than focusing on choice, we should be promoting co-production, personalisation, voice and so forth. Indeed, Simmons et al. (2009) suggest that choice is not the only fruit and that co-production might be a better fruit to cultivate. Through co-production, social care and other public services ‘can be brought under user control in very different ways: the key questions concern putting which consumers in what driving seat’ (Simmons et al., 2009, p.265). To paraphrase Clarke, consuming welfare and public services ‘is not [straightforwardly] like shopping’.

To conclude this section, socio-political analyses have identified a number of problems with the reification of choice. These encompass: the imperfections of quasi-markets and how their promotion of choice can lead to purchasers and providers being knaves rather than knights; that privatisation has led to shifting the responsibility back to families and individuals (which some would see as regressive); that when one contemplates the promotion of choice, one needs clarity over which aspect(s) one is promoting (choice over where, who, what, when, how and whether); and, finally, that the promotion of choice may add to existing inequalities.

What of choice and social care?

Having explored the implications and consequences economically, psychologically and socio-politically of promoting choice, the paper will now turn briefly to some of the evidence of how effective the promotion of choice in social care has actually been, by reference to research into the development of individual budgets (IBs) and personal budgets (PBs) as well as self directed support (SDS), the main vehicles through which choice in adult social care have been promoted. Indeed, these remain central to government social care policy (DH, 2011; HMG, 2012). Whilst some researchers have remained generally positive of PBs/IBs/SDS (see for example, Glasby, 2012), others have questioned their efficacy (see, for example, Beresford, 2008, 2009; Ali, 2009; Beresford et al., 2012; Woolham & Benton, 2012). Research findings suggest that: whilst aspects of choice have been developed via IBs, PBs and SDS, older people have found their promotion less beneficial (Glendinning et al., 2008; Orellana, 2010), psychological well-being is not necessarily improved for some groups (Glendinning et al., 2008), and that for people with mental health problems, while experiencing potentially significant benefits, there are still major barriers to increased take up (Glendinning et al., 2008). In addition, social care markets remain insufficiently flexible and responsive and still need to be developed fully (Institute of Public Care, 2009; DH, 2012), the supply of good care staff is still not adequate, social care users are still insufficiently skilled to take on the responsibilities of being IB or PD holders, and that there remains a need for effective advocacy services to be developed (Daly & Roebuck, 2008; Orellana, 2010; DH, 2012). As well as this, doubts have been raised as to whether PBs/IBs/SDS are really being implemented or whether councils with social care responsibilities (CSSRs) are simply labelling care arrangements as personalisation by attaching a notional cost to those care arrangements, whether PBs/IBs/SDS are more expensive because of the transactional costs associated with them, that there is a concern we might see a withering away of collective provision, and that one should be less occupied about who provides and more occupied about the what and when of social care provision (see Beresford 2008, 2009; Ali, 2009; Woolham, 2009; ADASS, 2012; Beresford et al., 2012; Woolham & Benton, 2012). Indeed, vis-à-vis older people, the ADASS (2012) has recognised this last point:

"For many older people the choices they want are not so much about who provides, but what is available [and] when [as well as]... whether they feel they have a rapport and relationship with that"
In the meantime, recipients of publicly funded adult social care remain some of the most vulnerable and most in need. Most people who might benefit from public social care support are deemed either to be not in sufficient need and/or as having sufficient means to support themselves. Therefore, the choices (or market rights) afforded to some citizens are in sharp relief to the lack of the social right to care for the majority of citizens. Rather than Government fetishising or reifying choice in social care, perhaps what is required is an adjustment to the social contract such that older people can be provided with the care that they need. The Dilnot Commission (2011) maps out a way to do that and, whilst it may cost £1.7 billion, that is 0.25 per cent of GDP. We can concentrate on ensuring care is personalised once we have the funding sorted. However, this doesn’t mean continuing to reify choice. Rather it means we will need to ensure social care is right ‘first time’, provided by well run and regulated providers, with the expertise to know what is required and the skills to facilitate the assessment of an individual’s care needs and then meeting those needs in a timely, personalised and effective manner (the what and when of choice).

Conclusions

The purpose of this paper has been to demonstrate that the promotion of choice is problematic. One of the consequences of the reification of choice is that over the last three decades there has been a shift in the balance of citizen rights, with an emphasis on market or civil rights sometimes, to the detriment of citizens’ social rights, not least in the provision of social care. However, when one examines choice from an economic, psychological or social-political perspective, doubts are raised as to the benefits of its promotion. Therefore, in the provision of welfare and public services, choice in and of itself is either not sufficient or, at times, not appropriate. It may be better to consider choice a ‘second order’ concern in that it is useful at a micro level, for example in the provision of adult social care where some (but only some) service user groups have found it empowering, not least disabled people and people with long term conditions. It is also useful at the macro level in terms of providing opportunities to service users and carers to shape provision. However, one should be mindful that the promotion of choice can also be counter-productive, not least in destabilising provision (Ali, 2009) and exacerbating inequalities (Clarke et al., 2005; Stevens et al., 2011).

One needs to recognise that social care is as much a social right as it is a market or civil right and that markets can be ineffective in coordinating the production, distribution and governance of social care (and other welfare and public service) provision. The promotion of choice in social care can have deleterious socio-political, psychological and economic consequences. In addition, the promotion of choice distracts from the need for appropriately funded social care (Dilnott, 2011) in order that adequate levels of care can be made available for all who need it, and not just to those with the highest need for social care support. Choice over ‘what’, ‘where’, ‘when’, ‘how’ and even, for some, ‘by whom’ and ‘whether’ are important considerations in the provision of social care but they are, arguably, only second order ones when considering how to meet citizens’ social rights to care.

References


**Notes on Contributor**

**Guy Daly** is Professor and Dean of the Faculty of Education, Health and Sciences at the University of Derby. His research interests include UK social care policy, local governance and government, housing and health policy. He has researched the relationship between citizenship and social care provision and is currently involved in an NIHR funded research project investigating older people and personal budgets being led by Dr John Woolham.

**Address for Correspondence**

Professor Guy Daly  
Dean of the Faculty of Education, Health and Sciences  
University of Derby  
Kedleston Road  
Derby  
DE22 1GB  
Email: g.daly@derby.ac.uk  
Tel: +44 (0)1332 591850