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An idea whose time has not yet come: Government positions on Long Term Care funding in England since 1999

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Abstract
This article seeks to explore ideas in Government Green Papers, and the Government appointed Commissions on Long Term Care funding since 1997 through the lens of the agenda-setting model of the Multiple Streams Approach. In particular, we examine the roles of ideas in the five major concepts of the model: the problem stream; the politics stream; the policy stream; the policy window; and the policy entrepreneur, for three key ‘moments’: the 1999 Royal Commission on Long Term Care for the Elderly, the 2009-10 Green and White Papers proposing a ‘National Care Service’, and the 2010-14 Dilnot Commission, White Paper, and the Care Act (Part 2). It is found that most of the documents discuss similar problems, similar policy options (although with different favoured options), and the need for some measure of political cross-party agreement (which has been undermined by cross-party sniping). However, the main obstacle seems to be perceived affordability. The efforts of the policy entrepreneurs have not, as yet, resulted in the policy window, ajar for over twenty years, being fully opened. In short, Long Term Care funding represents an idea whose time has not yet come, with discussions dominated by cost, meaning that the ideas have been on the agenda – but not seriously on the agenda.

Keywords: Long Term Care, funding, England, agenda-setting, Multiple Streams Approach, ideas

Introduction
In his first speech as Conservative Prime Minister Boris Johnson clearly stated his aim to finally come up with a solution to one of the great policy failures of the last 20 years: ‘My job is to protect you or your parents or grandparents from the fear of having to sell your home to pay for the costs of care… And so I am announcing now… that we will fix the crisis in social care once and for all, and with a clear plan we have prepared to give every older person the dignity and security they deserve’ (Campbell, 2019).

This has a feeling of ‘Groundhog Day’, as over twenty years ago, Labour Prime Minister Tony Blair’s first speech to the Labour Party Conference stated that ‘I don’t want [our children] brought up in a country where the only way pensioners can get long term care is by selling their home’. The 1997 Labour Party Manifesto made a commitment to establish a Royal Commission on Long Term Care for the Elderly. However, the Labour government rejected the main recommendation of that Royal Commission, of free personal care, (although it was introduced in Scotland in 2001) (see e.g. HoCL, 2017). Humphries (2013) writes that there have been two independent Commissions, three Consultations, five White and Green Papers and innumerable reports from think tanks, charities and other organisations. However, despite all these documents, the essential features of the system remain unchanged (House of Commons Library [HoCL], 2017).

The most cited model of agenda-setting in academic literature is Kingdon’s (2011) Agendas, Alternatives and Public Policies, often termed the ‘Multiple Streams Approach’ (MSA) (see Jones et al., 2016). MSA is said to have five major concepts—three ‘streams’ of problem, politics and policy; policy window; and policy entrepreneur. The independent problem, political and policy streams at times are ‘coupled’ during fleeting opportune times called ‘policy
windows’ (Jones et al., 2016). Kingdon (2011, p.178) argues that the probability of an item rising on the decision agenda is dramatically increased if all three streams are joined. If one of the three elements is missing – if a solution is not available, a problem cannot be found important or is not sufficiently compelling, or support is not forthcoming from the political stream – then the subject’s place on the decision agenda is fleeting and fades from view. He goes on to argue that the policy entrepreneur provides the necessary dose of agency required to couple the streams and shape policy outputs. He writes that three qualities contribute to the success of policy entrepreneurs: some claim to a hearing (expertise, an ability to speak for others, and an authoritative position); political connections or negotiating skill; and ‘probably most important’, persistency (Kingdon, 2011, pp. 180-181).

A number of scholars have stressed the importance of ‘ideas’ in Kingdon. For example, Mehta (2011) argues that his work remains the touchstone for any theoretical discussion about the role of ideas in the policy process. According to Greer (2015), ideas are vitally important in Agendas, Alternatives and Public Policies, and have a much more stable and definable position than in many theories. Béland (2016) writes that although it is not primarily a book about ideas, it provides significant insight about their role in agenda-setting, with the term ‘idea’ appearing in the text 82 times in total.

This article seeks to explore ideas in Government Green Papers, and the Government appointed Commissions on Long Term Care (LTC) funding since 1997, through the lens of MSA. In particular, we examine the roles of ideas in the five major concepts of the model (above). While there have been several independent enquiries (notably the King’s Fund ‘Wanless’ Social Care Review), and related policy developments regarding eligibility, charging and marketisation (HoCL, 2017), for the sake of space and clarity, we have focused on understanding government produced or commissioned documents concerning the overall funding settlement. We also narrowed our investigation to English proposals, given the divergence of funding policy in the UK following the establishment of the Scottish, Welsh and Northern Irish assemblies and governments. This set of criteria leaves us with three key ‘moments’:

• The 1999 Royal Commission on Long Term Care (RCLTC) for the Elderly, chaired by Professor Sir (now Lord) Stewart Sutherland, which proposed ‘free personal care’.
• The 2009-10 Green and White Papers proposing a ‘National Care Service’.
• The 2010-14 Dilnot Commission, Green Paper, Care Bill and Care Act (Part 2) proposing a ‘cap and floor model’.

The framework of our approach

The structure of this paper is as follows. First, we discuss the role of ideas in MSA. This is followed by a brief chronology of recent Government Green Papers, and the UK Government appointed Commissions on LTC funding since 1997. The following sections explore ideas in relation to the five major concepts of MSA, before turning to a final section that sums up the paper’s argument and conclusions.

Kingdon and ideas

Ideas appear at a number of points in Kingdon’s text. He discusses how ideas float around in the ‘policy primeval soup’, arguing that within the policy communities, many ideas are considered at some stage and in some way, and that policy entrepreneurs are advocates for proposals or for the prominence of an idea (pp. 121-122). Policy entrepreneurs attempt to ‘soften up’ both policy communities and larger publics, getting them used to new ideas. The criteria that enhance the odds of an idea’s survival include technical feasibility and value acceptability, which are internal to the policy community; but others, such as tolerable cost, anticipated public acquiescence, and a reasonable chance for receptivity among elected decision makers, exist in the larger political arena (p.131). He claims that a policy community
produces a short list of ideas, but few ideas emerge as the leading candidates for further serious consideration (p.139). When the policy window opens, ideas must have gone through a ‘long process of consideration, floating up, discussion, revision, and trying out again’ (p.141).

Béland (2010, 2016) examines ideas which roughly correspond to Kingdon's problem, policy, and political streams. For example, Béland (2010) discusses respectively ideas as understanding of policy issues and problems; ideas as assumptions that guide the development and the selection of policy alternatives; and ideas as framing processes that help actors legitimate particular policy decisions. Similarly, Mehta (2011) considers ideas at three levels of generality: policy solutions, problem definitions, and public philosophies or zeitgeist.

**Long Term Care in the recent past**

The system for funding LTC inherited by the Blair government emerged from the post-war settlement and its separation of health and welfare services, with the former being delivered largely free at the point of use, on the basis of need, by the National Health Service (NHS); and the latter delivered (or commissioned) by local government, with access determined by means and needs testing. In 1997, individuals with more than £16,000 capital were ineligible for state support (which included the value of their homes if they entered residential or nursing care, but not if a partner was living there), those with between £10,000 and £16,000 were partially charged for services, and only those with under £10,000 received full, free, state care. In addition, local government was not compelled to support those whose needs they considered ineligible according to locally determined needs-tests. This section presents a timeline of key events (taking into account our criteria established above) since 1997 (e.g. Humphries, 2013; HoCL, 2017; Wenzel et al., 2018).

Following a manifesto commitment, the Labour Government established a Royal Commission on Long Term Care for the Elderly, chaired by Professor Sir (now Lord) Stewart Sutherland. The Secretary of State for Health announced the Royal Commission in December 1997, rejecting the ‘value acceptability’ of the current arrangements: ‘The present situation cannot go on much longer. People are entitled to security and dignity in their old age, so we must find a way in which to fund long term care which is fair and affordable both for the individual and for the taxpayer’ (Hansard, 4 December 1997, cols. 489-90, our italics). In a theme that shaped the path for the next twenty years, the terms of reference for the Royal Commission stressed tolerability of costs, using terms such as having regard for ‘constraints on public funds’, the ‘deliberations of the Government's comprehensive spending review’, and the need for ‘costed’ recommendations (RCLTC, 1999).

The Royal Commission reported in 1999, with a majority report advocating free personal care, but a note of dissent by two of the 11 Commissioners rejected the main tenets of the report on the basis of the intolerability of costs. It is also likely that political acquiescence and technical feasibility came into play: Sutherland, in an interview with The Guardian in 2009 described ‘a campaign that had this unholy alliance of special advisers, folks who always took the Treasury outlook – never take on any spending commitment you can avoid’ (Brindle, D., The Guardian, 25 February 2009).

The Government response (Secretary of State for Health, 2000, p.5) stated that a fairer and more sustainable balance between taxpayers and individuals must be found for the funding of long term care, that it be brought into line with ‘NHS principles’, and that people should not have to sell their homes to fund care. However, the Government did not accept Sutherland’s central recommendation of ‘free personal care’, believing that the funds necessary could be deployed more effectively in services. Stressing the ‘very substantial cost’ of free personal care, it cited the Note of Dissent to the Royal Commission’s report that this recommendation would not help the least well off, arguing that its ‘alternative proposals' were preferable (Secretary of State for Health, 2000, p.11).
In 2003, the nine Royal Commissioners who had signed the Majority Report issued a statement (Royal Commissioners, 2003), pointing out that nearly five years after the report, ‘little has been resolved. Governments in most of the United Kingdom still decline to act’. It argued that the lack of action with respect to the funding of free personal care was ‘regrettable’, which was ‘all the more so because governments appear to have rejected the Commission’s recommendation essentially on grounds of lack of affordability (tolerable cost) rather than lack of value acceptability’. Pointing to a ‘policy vacuum’, it continued that:

It is interesting to note that, while the Government’s 1997 Manifesto spoke of a ‘fair’ system of Long Term Care funding, the Government’s response to the Royal Commission Report claimed merely to be introducing a ‘fairer’ system. There is a world of difference between the two (pp. 5-6).

This change of framing relates to Mehta’s conceptualisation of ‘policy definition’ in Kingdon.

Under the new Labour Prime Minister Gordon Brown, a Green Paper Shaping the Future of Care Together (Secretary of State for Health, 2009) launched the ‘Big Care Debate’, a public consultation on how social care should be funded and organised. The Government proposed a ‘National Care Service’, with five options for funding, but favoured the partnership model where the state would cover a specific (to be determined) proportion of costs, with individuals and their families covering the remainder.

This was followed by a White Paper, Building the National Care Service (Secretary of State for Health, 2010). The Government proposed that, for England, there would be three steps towards creating a system of free social care: from 2011, ‘around 280,000 people with the highest needs will receive free personal care in their own home’; from 2014, ‘anyone staying in residential care for more than two years will receive free care after the second year’; and subsequently there would be the introduction of a National Care Service, free-at-the-point-of-use, for all adults in England (Secretary of State for Health, 2010, pp. 8-9).

The proposed two-year limit on paying for social care for care home residents was similar in nature (but of a shorter duration) to that considered (but not recommended) by the 1999 Royal Commission. Although under step three of the proposals, social care would be free at the point of use, the Government expected that ‘people will continue to pay for their accommodation costs in residential care if they are able to do so’. There would also be a deferred payment scheme, to enable people to retain their homes. This would be available to those whose capital fell below £23,000 (excluding the value of their home). The White Paper explained that, ‘after carefully considering the results of the Consultation, the Government has concluded the National Care Service should be based on the approach that received the greatest public and stakeholder support (public acquiescence and political feasibility) – the Comprehensive option’.

During the following 2010 election campaign, the Conservatives had produced a ‘Death Tax’ poster, alleging that during cross-party talks Labour had proposed a levy of £20,000 on all estates. The election produced a hung parliament and the formation of a Conservative/Liberal Democrat Coalition Government. Kingdon’s political stream was notably absent on this occasion.

The Coalition Government stated that it would establish a Commission on LTC, to report within a year, which would consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a ‘partnership’ approach. It appointed the Dilnot Commission in 2010, which recommended changes to the means test and a capped cost model (Commission on Funding of Care and Support, 2011). A White Paper, Caring for Our Future: Progress Report on Funding Reform (Secretary of State for Health, 2012) was followed by a draft Care and Support Bill.
The Government agreed that the principles of the Commission’s model would be the right basis for any new funding model – financial protection through capped costs and an extended means test. However, ‘due to costs, it was unable to commit to introducing the new system at this stage’ (Secretary of State for Health, 2012, p.6). Again, the political stream was missing, framed in terms of tolerable cost, with the Government’s commitment to reducing public expenditure taking priority.

The Government proposed further consultation, with the policy to be set out in the next spending review. The White Paper did note that among stakeholders ‘there was discussion of the level of the cap, with some people suggesting that a cap could be set at the top of the Commission’s range – or even slightly higher (e.g. at £75,000) – without undermining the principles of the system’ (ibid., p.14).

The Care Act 2014 implemented a less generous version of the Dilnot proposals, setting a cap at a level of £72,000, an upper capital limit at £118,000 for care home residents and £27,000 for those receiving care at home. The lower capital limit would be raised from £14,250 to £17,000. However, this part of the Care Act was never implemented, trumped by ‘austerity’ (HoCL, 2017).

The May 2015 General Election saw a new Conservative Government in power, and the Conservative Party’s election manifesto had made a commitment to implement the cap from April 2016. However, in July 2015 the Government announced that it would delay reform of how people pay for social care from April 2016 to April 2020. Significant controversy surrounded the Conservative manifesto for the May 2017 General Election, with interpretations of the cap being dropped, and the proposals being labelled a ‘dementia tax’ much in the same way Brown’s plans were labelled a ‘death tax’, although the Prime Minister Theresa May insisted that ‘nothing has changed’. The fiasco over LTC reform apparently contributed to a significant reduction in electoral support for the Conservatives, and the subsequent minority government announced that it would no longer be taking forward plans to implement a capped cost care model by 2020. In short, little has changed since the Royal Commission of 1999, leading to the ‘Groundhog Day’ (above) of a new Prime Minister in 2019 promising to solve the problem of LTC.

**Ideas and the problem stream**

Kingdon (2011) is well aware that within the problem stream, not all ‘issues’ or ‘conditions’ become ‘problems’, and that indicators need to be interpreted. He argues that conditions come to be defined as problems due to values, comparisons and categories. For example, he discusses how conservatives and liberals may differ on whether a given income distribution might be regarded as a problem of poverty. He discusses how some conditions become problems through ‘indicators’, which are seen as providing quantitative and qualitative information on a condition, and through ‘focusing events’ which are jarring and sudden and become attached to particular problems. The reports discussed below produced many indicators, and focused attention (albeit temporarily) on the issue of LTC.

The Royal Commission (1999) was keen to stress the ‘opportunities and challenges’ rather than the ‘problem’ of ageing. However, it pointed out that society would be ageing, and outlined the five most important factors which affect the future demand for and costs of LTC: demography; health expectancy; the supply of unpaid care from families, relatives and friends; use of services; and care costs. It was ‘quite clear’ that ‘there is no such thing as a do-nothing option’ (para 10.4). The Government Response (Secretary of State for Health, 2000) noted too that we live in an ageing society, and that people were living longer.

The ‘Foreword by Secretaries of State’ to *Shaping the Future of Care Together* (Secretary of State for Health, 2009) pointed out that the current care and support system was designed in
the 1940s and we need to develop a system that fits our needs in the 21st century, arguing that a system that is fairer, simpler and more affordable for everyone was needed.

After the almost obligatory reference to Beveridge, the Secretary of State for Health (2010) noted that the current social care system was designed for a different era and cannot cope with the challenges of today. The current system, in which people are expected to pay for their care if they can afford to do so, simply cannot cope with anticipated pressures and presents an unacceptable uncertainty which private insurance markets cannot respond to. Without reform, the system will quickly become unsustainable and many more people will go without the care they need or risk losing their homes to pay for their care.

The document discussed ‘the case for change’ and ‘challenges with the current system’. It noted the current problems with the system, but also argued that over the next 20 years we will see new challenges on a scale that care and support has never had to grapple with: demographic changes; changes in technology; changing expectations; and economic conditions. It pointed to geographical inequalities: people with the same needs receive different levels of care depending on where they live. The system was confusing, and there is no way of predicting what a person’s care costs will be, leaving everyone at the potential risk of catastrophic care costs.

In his ‘Foreword’ (Commission on Funding of Care and Support, 2011, p.3), Dilnot stated that ‘our system of funding of care and support is not fit for purpose and has desperately needed reform for many years. ...Now is the time to act’. Dilnot also repeated the themes of growing demand due to ageing and identified LTC as an uninsured risk of modern life which exposes people to potentially massive costs. He too identified the complexity and confusion facing those who attempt to get state support. The Secretary of State for Health (2012) largely repeated the Dilnot Commission’s case for change, and its main arguments made in support of reform.

In short, most of the documents (and related political discourse) point to similar issues:

- demand due to an ageing population,
- the complexity and uncertainty faced by those with care needs and their families,
- the inadequacy of the current system to insure against huge costs,
- the unacceptability of the impact from a values perspective: having to lose savings, sell your home and forgo an inheritance for your children,
- the urgency of action to address the above.

If the system was outdated, with ‘no such thing as a do-nothing option’ (RCLTC, 1999, para 10.4) in 1999, the need for action must presumably be greater now some twenty years later. While these indicators have consistently jolted governments to consider LTC funding a problem, policy formation has been more difficult.

**Ideas and the policy stream**

The Royal Commission (1999) discussed three very broad options: voluntary private insurance; compulsory social insurance; and state collective provision, along the lines of the NHS (para 3.9). It favoured the third option, of universal risk pooling (para 3.16). In the chapter ‘Improving Public Provision’, it set out six options for change. One of these discussed, but not favoured, was essentially a ‘cap’ (although the term was not used) of ‘limiting liability to pay for four years’ as a way of alleviating the impact of the means test (para 6.21). Having rejected the first five options as ‘little more than tinkering with the means-testing system’ (para 6.27), it settled on the sixth option of ‘a major restructuring of the payment system for residential care’, which would make state financial support more universal than now. This meant that ‘the Commission's main recommendation is that personal care should be available for those individuals who need it, after an assessment’ (para 6.37). To finance this, it favoured a ‘pay as you go’ system based on general taxation, rather than a hypothecated (or ‘ear marked’) levy (paras 6.67, 6.71).
This is the specific policy element rejected by the minority commissioners. In their view, this represented an ‘alarming’ cost, which involves a ‘huge transfer of expenditure from the private to the public purse over a period when the public purse is likely to be severely stretched’ (Note of Dissent, Royal Commission on Long Term Care, 1999, paras 27, 28). Their objection takes in Kingdon’s categories of tolerable cost and technical feasibility on behalf of the state.

The Government Response (Secretary of State for Health, 2000) supported the position of both the majority and minority reports that nursing care should be available free under the NHS to everyone in a care home who needs it. Reflecting the minority view, it rejected making personal care free for everyone, as it ‘carries a very substantial cost, both now and in the future’, but:

Would not necessarily improve services, as the Note of Dissent to the Royal Commission’s report makes clear. It does not help the least well-off. We have not followed this recommendation because we believe our alternative proposals to improve standards of care and fair access to services will generate more important benefits of health and independence for all older people, now and in the future (p.11).

According to the Secretary of State for Health (2009), the policy solution was to ‘build the first National Care Service in England’. It outlined five ways in which the National Care Service (NCS) could be funded. First, a ‘Pay for Yourself’ model was ruled out as being ‘fundamentally unfair’. Second, the ‘Partnership’ model involved everyone who qualified for care and support from the state being entitled to have a set proportion – for example, a quarter or a third – of their basic care and support costs paid for by the state. People who were less well-off would have more care and support paid for – for example, two-thirds – while the least well-off people would continue to get all their care and support free of cost. Third, ‘Insurance’ sees everyone entitled to have a share of their care and support costs met, as in the Partnership model. However, if they wished, additional costs of their care and support would be covered through private or state insurance. Fourth, the ‘Comprehensive’ model would require everyone over retirement age with the resources to do so paying into a state insurance scheme. Everyone who was able to pay would pay their contribution, and then everyone whose needs meant that they qualified for care and support from the state would get all of their basic care and support free when they needed it. Fifth, a ‘Tax-funded’ model was ruled out because it places a heavy burden on people of working age. The government proposed that the Partnership model should be the foundation of the new system.

Turning to accommodation costs, the Government stated that it was fair to expect the majority of people to meet these costs themselves. It proposed a ‘universal deferred payment mechanism’, allowing residential care and accommodation costs to be charged upon a person’s estate when they die, rather than having to go through the process of selling their home when they need residential care.

Not for the first time, the ‘White’ Paper (Secretary of State for Health, 2010) seemed to be fairly ‘Green’, in that it kicked the can down the road. It stated that:

At the start of the next Parliament, we will establish a commission to help to reach consensus on the right way of financing this system. The Commission will consider all the options for payment put forward by charities and the public as part of the Big Care Debate and at the Care and Support Conference (p.4).

However, without using the term, it did suggest the idea of a ‘cap’: while it would take time to fully deliver the vision of a universal NCS, free when people need it, ‘from 2014, anyone staying in residential care for more than two years will receive free care after the second year’ (Secretary of State for Health, 2010, p.5). It stated that the Government was committed to a NCS in which everyone was protected against the costs of care, and in which no one needed to lose their home or their savings to meet these costs.
So while retaining individual contributions and a long term and iterative implementation process, the Government claimed the NCS would be based on the approach that received the greatest public and stakeholder support – the Comprehensive option:

*We think it is right that society takes collective responsibility for sharing care costs, in a way that will give people peace of mind and will allow them to plan properly for later life. For this to be affordable requires a care system in which everyone contributes, through a fair care contribution. Under a comprehensive NCS, the Government expects that people would continue to pay for their accommodation costs in residential care (p.24).*

The Dilnot Report (Commission on Funding of Care and Support, 2011) discussed a range of different approaches to pooling risks so that people have protection against high care costs, but rejected both private insurance and a full social insurance scheme, eschewing the universalist discourse of the NCS proposals. It proposed a ‘capped cost model’, with the cap between £25,000 and £50,000. It estimated that the recommended changes to the funding system would cost from around £1.3 billion for a cap of £50,000, to £2.2 billion for a cap of £25,000. It stated that a cap outside this range would not meet criteria of fairness or sustainability and suggested a cap of £35,000. After reaching the cap, people should continue to pay general living costs such as food, heating and accommodation. The Commission believed that a means-tested system should continue alongside the new capped cost element and recommended that the upper threshold within the residential care means test should be raised from £23,250 to £100,000.

According to the Secretary of State for Health (2012), the Government agreed that the principles of the Commission’s model would be the right basis for any new funding model – financial protection through capped costs and an extended means test. However, for reasons of cost, it was unable to commit to introducing the new system but would come to a final view in the next spending review. It would take forward some of Dilnot’s other recommendations. For example, it would introduce a right to a deferred payment scheme for residential care. It would also introduce for the first time a national eligibility threshold for adult care and support in England, as set out in the accompanying White Paper.

**Ideas and the politics stream**

In broad terms, the political right has favoured means-testing, while the political left has favoured universality, such as the risk pooling of the NHS. However, it is generally agreed that making changes to the financing of LTC requires some degree of cross-party agreement. Moreover, several documents, such as those cited above, have stressed the value of public debate and stakeholder engagement.

The Royal Commission (1999, para 11) stressed they were in search of a series of proposals which would give due weight to issues such as fairness, efficiency and effectiveness. Their ‘framework for evaluation’ included issues such as fairness; maximum choice, dignity and independence; security, sustainability, adaptability; quality and best value. The main proposal of free personal care was based on considerations of both equity and efficiency. First, it focused on the issue of ‘diagnostic equity’: ‘whereas the state, through the NHS, pays for all the care needs of sufferers from, for example cancer and heart disease, people who suffer from Alzheimer’s disease may get little or no help with the cost of comparable care needs’ (para 6.33). Free personal care ‘would go a long way to making services provided for long term care as valued and as jealously guarded as those provided by the National Health Service. The principle of equal care for equal needs would be properly recognised for the first time’ (para 6.35). Second, from the point of view of efficiency, the Royal Commission considered that the extension of universality, through the collective approach entailed by the proposal, was the most efficient way of covering the risks of having to meet LTC costs (para 6.36).
The Labour response to Sutherland (Secretary of State for Health, 2000), while stressing principles of ‘fair access’ and ‘fairer’ (p.20, rather than ‘fair’) funding, rejected free and universal personal care, in the name of making the best use of resources.

Almost a decade later, Prime Minister Gordon Brown (Secretary of State for Health, 2009) stated that the way in which our society provides care and support for those who need it, whether in later life or because of disability, should reflect our values of compassion and fairness. The NCS, in his view, was fundamental to that vision, addressing the unfairness of postcode lotteries and providing greater security for all in their later years.

The following year, Brown (in Secretary of State for Health, 2010) explicitly compared the NCS to Labour’s achievement of the NHS. He pointed to a ‘bold, ambitious reform to create a system rooted firmly in the proudest traditions of our NHS’ (p.2). However, it can be seen that while the NCS would probably have increased ‘nationalness’, by reducing the ‘postcode lottery’, only the rejected option of tax funding and being free at the point of use would have approached a ‘bold’ NCS, similar to the NHS. For all the talk of ‘fundamental change’, ‘radical reform’, and ‘new chapter in the story of our welfare state’, the Bevan model had been ruled out the previous year.

In addition to reflecting ideological choices, the Secretary of State for Health (2010) was keen to root the reform in the ‘national mood’ as reflected in the ‘Big Care Debate’, which involved over 68,000 people taking part, making it the largest consultation ever on care and support: ‘people told us that the time for reform has come’ (p.4).

The Dilnot Report (Commission on Funding of Care and Support, 2011) stressed the importance of ‘shared responsibility’ (i.e. not like the NHS), pooling of risk, and ‘fairer funding’. The Secretary of State for Health (2012) reported stakeholder engagement which showed that the majority of those involved in the engagement supported the Dilnot Commission’s proposals for a cap. Turning to the level of the cap, it was generally felt that the cap could be set at the top of the Commission’s range. However, the financial services industry considered that a cap at the top end of the recommended range or higher would be appropriate, and other [unnamed] stakeholders had suggested that even higher levels of cap (e.g. £75,000) should be considered (p.20).

**Ideas and the policy window**

As noted above, Kingdon (2011) argues that the policy window opens when the three streams come together. In some ways, the policy window has been open, or at least ajar, for over twenty years. The problems have remained, and arguably intensified, and the windows are ‘political’, opened largely by elections or new governments. However, it seems that windows on a resolution of care and cost issues in adult social care have been closed, largely due to issues of cost. The Sutherland window was closed because of affordability. The issue reached the legislative stage in the form of a Labour draft Bill around 2010 and elements of the Coalition’s Care Act of 2014. However, neither were implemented, due to a change of government and backtracking respectively.

**Ideas and policy entrepreneurs**

The obvious policy entrepreneurs are the Sutherland and Dilnot Commission chairs, along with their fellow commissioners (including the Sutherland dissenters and the ‘unholy alliance’ briefing against them) (Brindle, 2009). As noted above, (most of) the Royal Commissioners of 1999 took the unusual step of issuing a statement nearly five years after the Commission’s Report. Dilnot has also maintained an interest in the topic. There is little reference in the White and Green Papers or Commissions to other policy entrepreneurs, which suggests a very limited degree of policy learning, and much discussion on ‘reinventing the wheel’.
Discussion and conclusions

It can be seen that most of the documents discuss similar problems (Figure 1), although as the population continues to age, they become more urgent. The documents have produced a broad discussion of similar policy options, although with different favoured options. Sometimes an option rejected in a previous document has been revived. Conversely, a favoured option in an earlier document has sometimes later been rejected. However, there appears to be little ‘organisational memory’ or policy feedback, in that there are few references to previous documents. The main problem appears to be cost.

Figure 1. Policy documents: contents and Kingdon’s policy schema.¹

<table>
<thead>
<tr>
<th>Problem Stream</th>
<th>Policy Stream</th>
<th>Political Stream</th>
<th>Policy Window</th>
<th>Policy Entrepreneurs</th>
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<tbody>
<tr>
<td>RCLTC (1999)</td>
<td>‘Opportunities and challenges’ rather than the ‘problem’ of ageing. However, in future society will be ageing, and the future demand for and costs of LTC will rise.</td>
<td>Free personal care, but continuing accommodation costs.</td>
<td>Manifesto commitment to set up Royal Commission.</td>
<td>‘Quite clear’ that ‘there is no such thing as a do-nothing option’. Majority and Minority Commissioners.</td>
</tr>
<tr>
<td>SSH (2009)</td>
<td>Outdated system; rising life expectancy and care costs; uncertainty; unfairness (post code lottery).</td>
<td>Discussed five options: ‘Pay for Yourself’ (rejected); ‘Partnership’; ‘Insurance’; ‘Comprehensive’; ‘Tax-funded’ (rejected). Favoured ‘Partnership’.</td>
<td>NCS intended to invoke NHS; reflects values of compassion and fairness.</td>
<td>NCS to be phased in over a number of years. ‘A White Paper will be published in 2010’.</td>
</tr>
<tr>
<td>SSH (2010)</td>
<td>Care system was designed for a different era. Problems of demographic changes; changes in technology; changing expectations; and economic conditions increasing over next 20 years.</td>
<td>Series of stages, including two year ‘cap’ from 2014. Favoured ‘comprehensive’ option (but with funding issues yet to be decided), and some to pay accommodation costs.</td>
<td>As 2009.</td>
<td>Due to be implemented after 2010 Election, so window closed.</td>
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</table>

¹ ‘SSH’ is ‘Secretary of State for Health’
### Government positions on Long Term Care funding in England since 1999

<table>
<thead>
<tr>
<th></th>
<th>Geographical inequalities; confusing system.</th>
<th>Rejected both private insurance and a full social insurance scheme. Proposed a ‘capped cost model’, with the cap between £25,000 and £50,000. Extended means test, with upper threshold raised from £23,250 to £100,000.</th>
<th>Cost-pooling.</th>
<th>Stressed urgency: ‘Now is the time to act’.</th>
<th>Dilnot has also subsequently urged action.</th>
</tr>
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<tbody>
<tr>
<td><strong>CFCS (2011)</strong></td>
<td>Current system is confusing, unfair and unsustainable, with a major problem that people are unable to protect themselves against very high care costs. System of 1948 is not fit for purpose in the 21st century and is in urgent need of reform. Geographical inequalities: 152 different systems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSH (2012)</strong></td>
<td>As 2011.</td>
<td>Broadly accepted Dilnot funding model – financial protection through capped costs and an extended means test. However, for reasons of cost, it was unable to commit to introducing the new system at present. Agreed the recommendation of a universal system of deferred payments for residential care.</td>
<td>Agreed principles of the Commission’s model would be the right basis for any new funding model.</td>
<td>Delayed due to cost.</td>
<td></td>
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</table>

Ideas in the politics stream contain a mix of ideology, public opinion and stakeholder engagement, and the need for some measure of cross-party agreement. However, any cross-party agreement was made difficult by accusations of imposing a ‘death’ or ‘dementia’ tax. Although Labour draws on broad ideological support for universality, and attempts to draw parallels with Bevan’s NHS, its ideas in the policy stream have not always matched these. Despite its suggested NCS clearly attempting to invoke comparisons with the NHS, the NCS does not appear to match the principles of the NHS as being largely tax-funded and free at the point of use. All Labour arguments against tax funding would have applied to the 1948 NHS, but similar arguments from opponents were overruled by Bevan, despite policy implementation being at a time of great austerity. Similarly, the traditional Conservative favouring of means-testing has been blurred by the electoral imperatives of not alienating supporters facing large care bills and selling assets such as houses. The efforts of policy entrepreneurs have not led to the opening of the policy window in the form of implemented legislation.
After the decisive Conservative victory in the General Election of December 2019, it appears that Prime Minister Boris Johnson will be in office long enough to implement his promise; but the statement of the Secretary of State for Health in 1997 that ‘the present situation cannot go on much longer’ has resonated for over 20 years; and thus the entitlement of older people ‘to security and dignity in their old age’ (Hansard, 4 December 1997, cols 489-90) represents an idea whose time has not yet come. In short, it seems that ideas on LTC over the last twenty years or so have been dominated by cost, meaning that the ideas have been on the agenda – but not seriously on the agenda.

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References


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“But can things only get better?” Older people’s social care before, during and after austerity

Andrew Kerslake
Emeritus Professor of Public Care, Oxford Brookes University

Abstract
In 2006 the then Labour Government published a significant, two hundred plus pages, White Paper, ‘Our Health, Our Care, Our Say’. Endorsed by Prime Minister Tony Blair and backed by the Secretary of State Patricia Hewitt, it was designed to outline a new and lasting approach to improving community-based health and social care services. In particular, it recognised the need to better manage the increased demand for care based on the anticipated growth in the numbers of older people within the UK population. Fourteen years later we still await that ‘new and lasting approach to community-based health and social care’. This paper explores why the aspirations of that original White Paper remain to be achieved and what strategic direction social care for older people should take in the future.

Keywords: social care, older people, health care, policy, prevention

Introduction
With its key themes of integration, prevention and consumerism, the 2006 White Paper, Our Health, Our Care, Our Say was designed to tackle long term issues in the health and social care system. As the Secretary of State argued in her Foreword to the White Paper, the need was for legislation that could address ‘years of under-investment, widening inequalities, soaring waiting lists, critical staff shortages, inflexible and unresponsive services’ (Department of Health, 2006, p.3).

If the problems sound familiar, then so do the solutions. Change was to be achieved through a series of interventions, such as practice-based commissioning, shifting resources into prevention, more care to be undertaken outside hospitals and in the home, better joined up services at a local level, encouraging innovation and allowing different providers to compete for services.

Since then there have been two further White Papers, four public Consultations, two policy papers, the Dilnot and Barker Commissions, a House of Lords review and the Care Act 2014. Yet despite this abundance of intent, social care remains trapped in a ‘Groundhog Day’ of immobility, where the same problems and solutions get endlessly repeated, whilst how to fund care stays locked in the ‘too difficult to solve’ box. As one civil servant was quoted:

I’ve had a ringside seat for every effort to reform social care funding in the past decade. I’ve drafted Green Papers and White Papers and even got legislation passed, but not one reform has ever been implemented.

(Warren, 2019)

This stagnation can be illustrated in Table 1 by putting the aspirations from the DH White Paper alongside the Care Quality Commission’s (CQC’s) 2018 report Beyond Barriers – How Older People move between Health and Social Care in England (Care Quality Commission, 2018a).

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1 https://www.kingsfund.org.uk/blog/2019/07/social-care-funding-reform
(Accessed: 06.02.2020)
Table 1. DH/CQC aspirations for improving community-based health and social care services.

<table>
<thead>
<tr>
<th></th>
<th>DH White Paper 2006</th>
<th>CQC Beyond Barriers 2018</th>
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<tbody>
<tr>
<td>Commissioning</td>
<td>‘At the moment too much primary care is commissioned without integrating with the social care being commissioned by the local authority. There will be much more joint commissioning between PCTs and local authorities’ (p.9).</td>
<td>‘Future system working will need to include aligned performance measures, aligned oversight and regulation, and funding to incentivise joint commissioning across health and social care’ (p.47).</td>
</tr>
<tr>
<td>Prevention</td>
<td>‘We must reorientate our health and social care services to focus together on prevention and health promotion. This means a shift in the centre of gravity of spending. We want our hospitals to excel at the services only they can provide, while more services and support are brought closer to where people need it most’ (p.9).</td>
<td>‘As a starting point, there should be greater emphasis on keeping people well at home. Investment in preventing health problems and keeping people out of hospital where possible will be better for people and for the health and care system. Bed occupancy in hospitals is higher than ever’ (p.4).</td>
</tr>
<tr>
<td>Integration</td>
<td>‘Access to high quality primary healthcare has a vital role in helping people to live longer and healthier lives. Integration of these services with other community and social care services helps to ensure better coordinated support and care for each individual, better management of chronic disease, and reduced need for costly and avoidable hospital care’ (p.57).</td>
<td>‘Health and social care organisations should work together to deliver positive outcomes for people and ensure that they receive the right care, in the right place and at the right time… Nationally, there is a need to create the right incentives for integration and joint working in local systems’ (p.4).</td>
</tr>
<tr>
<td>Consumer control</td>
<td>‘Individual budgets will put far more control in the hands of people who use social care services… Recent national surveys show that we still need to do more to empower people with long term health and social care needs through greater choice and more control over their care’ (p.110).</td>
<td>‘Personal budgets and direct payments are a mechanism to allow people to have choice and control over the support and services they receive… Nationally, personal budgets and direct payments for social care and health are not widely accessed’ (p.24).</td>
</tr>
</tbody>
</table>

So, if these four elements have remained the same over a twelve-year period, why might this be?

**Commissioning**

In the same year as the White Paper (2006) I wrote an article for *Research, Policy and Planning* (Kerslake, 2007) exploring how the Government’s aims might be implemented. The article proposed a different approach to commissioning and, in particular, that the procurement of social care, as the original diagram (Figure 1) illustrated, whether by individuals or organisations, needed to be intelligence driven. Underpinning the White Paper was the assumption that purchasing would not be dominated by local authorities but by individuals who, if state funded, would be allocated an individual budget (later called a personal budget) to spend on the care of their choice. With a growing older people’s population and more self-funders, the market would expand and reflect the diversity of demand that people presented. Individuals or local authority commissioners would use the best knowledge available to achieve a set of desired outcomes through flexible and responsive service provision. However, for these
objectives to be fulfilled required one final assumption, that funding would continue to increase as it always had done in the past. What of course happened was that whilst demand increased, funding did not. In 2016 there were nearly 12 million people aged 65 years and over in the UK; 25 years’ before that there were just over 9 million, and in 25 years’ time it is estimated there will be 17 million, with the fastest growth being in the oldest population aged 85 or more (ONS, August 2018). Yet currently nearly half of that post 65 life span is spent in ill-health (Swerling, 2019), with around two-fifths of NHS spending being on that age group (Obineau, 2016). For those aged 85 and over the numbers of people with high dependency needs will have doubled between 2015 and 2035, and the number with comorbidities will similarly increase substantially (Kingston et al., 2018).

Interestingly, in 2006 expenditure was not perceived as an issue, as social care spending consistently rose year on year. Since the recession that has not been the case, as the Institute of Fiscal Studies chart (Simpson, 2017) shows in Figure 2. In the nine years from 2001 spending grew by £6.3 billion, as compared to a drop of £1.5 billion over the following seven. The impact of this drop is then even greater if inflation and the overall growth in the older people’s population is taken into account.

Figure 1.

Source: Kerslake, 2007, p.106.

Figure 2.

One effect of this has been to distort the care market. In a normal market, if demand outstrips supply, prices will rise until new suppliers find it advantageous to enter the market. The increased supply will then cause prices to fall. In this way markets maintain equilibrium. However, the social care market does not function in this way. In those areas where it is the dominant purchaser then the local authority in effect becomes monopsonistic, controlling the market through the price it chooses, or can afford, to pay. If it is not sufficient, then providers who wish to continue to operate their business will have to find alternative finance to survive by gaining greater economies of scale, increasing debt, finding cheaper labour, or reducing the quality of the service they provide. The consequences of this have been extensively reviewed by the Competition and Markets Authority, who point out that:

... About a quarter of care homes have more than 75% of their residents LA-funded, and that these are the ones most at risk of failure or exit because of a funding shortfall. We estimate that LA-fees are currently, on average, as much as 10% below total cost for these homes, equivalent to around a £200 to £300 million shortfall in funding across the UK.  
(Competition & Markets Authority, 2017, p.13)

The conclusion they draw from this is that:

The current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority (LA)-funded residents are unlikely to be sustainable at the current rates LAs pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs.  
(Competition & Markets Authority, 2017, p.6)

Prevention

Central to the DH White Paper was the role of prevention.

Finally, throughout this White Paper we have been clear that the focus on greater prevention, and on greater activity in primary and community settings, is crucial to delivering an NHS that is high quality, that focuses on health and wellbeing, and that is cost-effective in the medium term. Unless this White Paper strategy is pursued – and the consequent service reconfigurations take place – some local financial imbalances may never be corrected.  
(Department of Health, 2006, p.150)

Despite two major national funding initiatives, the Partnership for Older People Projects (POPP) and the Better Care Fund (BCF), neither can be said to have delivered the aspirations of 2006 (Steventon et al., 2011; National Audit Office, 2014) though both offered some benefits. For example, in the case of the Better Care Fund, although gains occurred in relation to delayed transfers of care (DETOC), they have been subject to the law of diminishing returns, i.e. the more money you put in, so the marginal impact on delayed transfers declines (Forder et al., 2018). So, why has prevention been so difficult to achieve, given that financial limitations might have been expected to drive alternatives?

A lack of focus

Prevention can cover a myriad of interventions: from broad based community programmes, to recovery and rehabilitation from conditions, to avoiding readmission to hospital.

- **Low level preventative interventions** As the Kings Fund (Curry, 2006) pointed out, these may well be valued by older people, but there is a lack of evidence about their long term preventative or diversionary benefit, and hence whether they are cost-effective.

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2 The opposite of monopoly, i.e. one or few buyers to many sellers.
• **Preventing hospital admission** Reducing hospital admissions and preventing readmissions has been a key aspiration of prevention, yet despite many initiatives and a pressing demand for bed spaces, older people still experience over-extended stays and unnecessary admissions. The consequences, as the NHS reports, are serious:

35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%. Extensive use of audit tools has shown 20% to 25% of admissions and 50% of bed days do not require an ‘acute’ hospital bed. (NHS Improvement, 2018, p.2)

• **Avoiding inappropriately induced conditions** Many older people have a number of co-morbidities, yet in hospital enter a world mainly focused on single treatment modalities, e.g. orthopaedics, cardiology, etc. As a consequence, a poor intervention in one area may increase demand in another, e.g. the over-use of catheterisation post fracture could lead to an older person being readmitted for a urinary tract infection (UTI) (NHS, 2018; Ramanathan & Duane, 2014).

• **Care not seeing its role as ill-health prevention** A recent study from The Heath Foundation (Walters et al., 2019) showed that not only are there high levels of hospital admissions from care homes for preventable conditions, but also that those from residential homes were higher than those from nursing homes. Therefore, it might not be the type or severity of condition that prompts admission but the ability of staff to cope with or manage it.

**A failure to mainstream**

Many preventative initiatives have been small-scale, seen as temporary, rather than from the outset being designed to scale-up. Although the social care literature on organisational inertia is limited, the question has to be asked: why, even where success has been achieved, have preventative interventions not been universally adopted? Possible answers:

• **Restrictive practices** The National Audit Office (NAO) suggested that ‘differences in working culture, professional entrenchment and different terms and conditions across the health and local government sectors remained barriers to integrating and developing the workforce’ (National Audit Office, 2017, p.47). This was in a report that only mentioned prevention four times within its 52 pages, despite this being an area where the need for integration is probably at its greatest.

• **Inertia** Most managers at some time will have encountered staff or colleagues for whom stopping change seems to be their primary goal. As Coiera states:

> Humans apparently favoured culturally static organisations—perhaps, because they were believed to be more reliable or accountable. Unfortunately, static organisations become increasingly out of step as the surrounding environment changes.

( Coiera, 2011, p.27)

• **Lack of permanence** Many preventative initiatives are set up as experiments, projects or pilots. Whilst the intention may be to test whether something works, it often means that funding is time-limited and such projects can seem artificial, divorced from the day-to-day realities of practice. Equally, if the only route to funding is via one-off bids, then the temptation is to move to the next new idea rather than consolidate the old.
A failure to incentivise providers

Given their large workforce and community base, the main providers that should be central to prevention are home care agencies. Yet as Opus Restructuring and Company Watch reported in 2017, the sector loses £11.66 per client per year, with total losses of £10.5m, prior to the implementation of the National Living Wage; and 27% of domiciliary care providers accordingly fell within the Company Watch Warning Area (Opus Restructuring and Company Watch, 2017). Even large providers are in difficulties. Mears, for example, was losing £3m a year on its home care business, saw its share price halve over the last two years (London Stock Exchange, 2019) and in the end has sold the business (Homecare.co.uk, 2020). As CQC confirmed:

The adult social care market remains fragile, with providers continuing to close or cease to trade and with contracts being handed back to local authorities.

(Care Quality Commission, 2018b, p.4)

In such an environment it is little surprise that providers have often been reluctant risk-takers in developing preventative approaches. Within the author’s work for CQC on market stability (Institute of Public Care, 2014) the following were all advanced by providers as reasons why investing in prevention was problematic.

- ‘Preventative initiatives involve risk. Why take them if your business is already vulnerable?’
- ‘Nobody is going to invest in prevention, unless there is some guarantee of funding continuance and a belief it is possible to get a return on that investment?’
- ‘If you spend time and money developing an innovative approach then why would you share that with your competitors if that is a requirement of the contracting process. After all, they have taken none of the risk?’

A failure to invest in measurement

There are two key elements to measuring the impact of preventative interventions. The first is establishing a clear link between cause and effect, i.e. ‘is the anticipated or actual outcome a result of the intervention?’ Secondly, moving away from measuring success by input or take-up to measuring the outcomes the intervention is intended to achieve.

In understanding the relationship between cause and effect, social care has long had measurement difficulties. Its interventions do not lend themselves to control groups and double-blind testing, given that it would be hard to deliberately leave someone without care in the interests of good measurement. Equally, effective outcome measurement takes time and skill to develop, requires shared aspirations between commissioners, providers and service users (Allcock, 2015), with a willingness to change practice if interim results are not as expected. This lack of a focus on outcomes can be illustrated by the quality of some reporting on the Better Care Fund (Ministry of Housing, Communities and Local Government, 2019). It either measures process (the allocation of funding to x or y) or in its local metrics self-reported anecdotes of success.

These problems with measurement tie into organisational inertia. I recently spent time working with an information team that straddled health and social care. Over and above compiling statutory returns and answering members’ queries, most of the data captured remained unanalysed. A lack of time or managerial motivation were described as the reasons for this. When the data were reviewed it became apparent that some people were being admitted to hospital from care homes for preventable conditions. Yet from both health and social care perspectives, there was an inevitability about such admissions. Despite the potential for resource saving, it seemed too difficult to alter people’s practice, roles and functions so that this outcome could be avoided.
Integration

If prevention was seen as important in 2006, then integration of services was one of the mechanisms by which it might be delivered cost-effectively. Yet, like prevention, there has frequently been confusion about what integration means: a single budget, shared commissioning, common management, staff transferability, or a single health and social care body that combines all of the above? The Nuffield Trust (2018) explored the potential of different arrangements:

Organisational integration requires a lot of time and dedicated resources to create the necessary infrastructure. Progress towards integrated working on the ground can be made more quickly via service level integration, but organisational integration can bring other benefits, such as helping all members of staff to understand the entire health and social care pathway. It is important to be very clear about exactly what it is hoped will be gained from integration.

(Holder et al., 2018, p.4)

What should be inside or outside an integrative model for older people’s care is open to question.

- Should it include housing (Buck & Gregory, 2018) or learning disability (currently part of social care, but a sector that spent decades trying to move away from a health-based model of provision) (Brend, 2008)?
- Should public health and social care, both part of local government, become single departmental entities?
- What are the accountability structures, given that social care is enmeshed in the funding, governance and management systems of local authorities, whereas health is not (and after all, health care provision can run at a deficit whereas social care cannot)?
- How do we manage the difference between private and state funded provision, bearing in mind the vast majority of social care provision is delivered by the private and voluntary sectors?

Therefore, it is of little surprise the National Audit Office concluded that:

Nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services… The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients… There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity.

(National Audit Office, 2017, p.7)

Consumerism

The 2006 White Paper was intended to create a new breed of care consumer. Individuals would either be self-funders or personal budget holders, with the market responding to their diversity of demand with an equal diversity of supply.

Choice means people will increasingly determine what services they want, and where. Providers that offer these services will thrive; those that do not won’t.

(Department of Health, 2006, p.157)

Some of the original assumptions about the way consumers would behave were flawed. Care is not a ‘good’, unlike many consumer goods, that can be easily returned to the vendor. For example, once a care home ‘purchase’ has been made it is hard for an older person to return home, move to another establishment or find an alternative provider. Equally, whilst there was
an initial growth in the use of direct payments and personal budgets, as finance diminished, older people who were more likely to buy traditional services (National Audit Office, 2016) were disadvantaged; because if they were only funded to purchase at the same price as the LA, a provider was always likely to prefer purchasing from a bulk purchaser with contractual security. That of course assumed in a market with limited choice that the personal budget holder could even find a service they wished to purchase.

Some diversity did arise through the development of personal assistants, although it is not clear how much that created new jobs as compared to diverting home care staff or paying previously unfunded carers. Yet even this trend seems to be slowing. As Skills for Care reports (Skills for Care, 2019), the personal assistant workforce of around 140,000 has remained fairly static in recent years, with over half of those employed being people who were already known as either family or friends of the care recipient. Therefore, the consumer driven market has never really developed as envisaged for older people. Instead they have ended up with a system more akin to the Soviet economy of the late 1980s: money to buy but little choice, queues for what there is, which when purchased isn’t really what you would have desired, but you buy it because that is all that is available. Even older self-funders, the group that might have been expected to use their financial muscle to drive diversity, have ended up being the very people who have kept traditional residential care afloat. As the Competition and Markets Authority states:

Many care homes are relying on higher prices charged to self-funders to remain viable, even when providing the same services... Our assessment based on larger providers is that self-pay fees are now, on average, 41% higher than those paid by LAs in the same homes. This represents an average differential of £236 a week (over £12,000 a year).

(Competition and Markets Authority, 2017, p.14)

The way ahead for funding

So, as austerity eases, are the unfulfilled aspirations of 2006 likely to be delivered? It is interesting to consider the two main political parties’ 2019 election manifestos as a policy benchmark for social care. At least between them there is consensus: it’s all about the money. For one party (Conservative and Unionist Party Manifesto, 2019) it’s about how much they have spent and how much more they will spend in the future (2 out of 3 text references). For the other (Labour Party Manifesto, 2019) it’s about how much finance has been cut and how much of that will be reversed (8 out of 9 text references). The implicit assumptions of both are that funding can keep pace with demand, that demand is irreducible, and that the current configuration of services must be worthy of continuance, given that they wish to spend more on them.

Funding is of course a matter for political will; and hence it is questionable whether a more youthful, poorer population will in the future wish to increase spending on their more affluent but dependent seniors. That pessimism may also be detected in the ‘coded’ cautions from the Office for Budget Responsibility (OBR). As their chart shows in Figure 3 (Office for Budget Responsibility, 2018, p.73), older age drives a rapid increase in state spending per individual, whilst revenue from the same population diminishes.

In the short term, the Government has responded to the pressures on the sector by increasing funding directly and giving local authorities the ability to increase council tax further. But ASC (Adult Social Care) spending remains well below pre-crisis levels in real per capita terms. Current policies could return spending to previous levels and our long-term projections assume that these short-term fixes persist, but further pressure for the Government to increase publicly funded provision of ASC and to enhance integration of health and social care appears likely.

(Office for Budget Responsibility, 2018, p.155)
The Competition and Markets Authority is more pessimistic when it looks at provider-side financing:

*Our assessment, however, is that the sector is not able to attract the investment required to meet the future increase in demand to serve LA-funded residents.*

(Competition and Markets Authority, 2017, p.15)

Therefore, given the likelihood of increasing demand from more people, with less funding per head, surely the logical policy is to focus on demand; in the case of older people, how can the period of ill-health or morbidity experienced prior to death be reduced? To explore this, it is worth returning to the four themes proposed by the original 2006 White Paper, i.e. commissioning, prevention, integration and consumerism.

**The way ahead for commissioning**

Kerslake (2007) suggested that commissioning needed to be more knowledge-driven, a statement that feels as relevant today as it did then. However, this is not just about the acquisition of knowledge but about how it is used, which to have impact calls into question where the commissioning function sits in health and social care and what power it exercises. Joint commissioning, striving to achieve shared outcomes, should mean commissioners being able to cut across health and social care boundaries, not that one or another is a ‘no go area’, or that one function is subservient to the other. Commissioning must be a strategic function, able to go beyond the role of purchasing, because whilst this might be one element of commissioning, in straightened financial times there is a tendency for it to be seen as the only element.

Consequently, commissioners need to be able to undertake three activities:

- to quantify demand over time without being limited in their thinking by the services currently on offer,
- to be able to evaluate existing supply in terms of how well it is able to meet that demand now and in the future, and
• finally, where there are gaps in supply, or where current supply does not meet what older people say they want or need, then to explore how such provision can be developed at what cost and from whom.

Even if evaluating demand and supply in this way is not possible, then at the very least there should be some explicit assumptions made about the minimum volume and range of service provision for any given population, e.g. across 10,000 older people, what volume of care home beds, home care provision, extra care housing, carer support, community dementia services, physiotherapy, occupational therapy, handyman and housing move services should be available.

Following such an evaluation, ‘selling’ the results to managers, providers, Government and, critically, the public, is then required: which in turn demands leadership. Scott et al. (2003) see this as one of the key elements in delivering change, both through reward and cognitive change in behaviour. Whilst improving people’s status or giving higher pay or more holidays may act as incentives, people also need to integrate change into their behaviour, to ‘buy into’ the vision. For example, they argue that if you wish to deliver a patient-centred model of care then this:

...is not just about modifying familiar behaviour, it is also about radically redefining participants’ interpretations and experiences of health care.

(Scott et al., 2003, p.116)

Although the funding and legislative intent needs to come from central government, the impetus for change must be led by local health and care communities (Ham, 2012), including convincing the public that change is essential and desirable.

The way ahead for prevention

Whilst ill-health and its aftermath are the major drivers for care, as a number of authors (Institute of Public Care, 2010; Taylor et al., 2010; Gawande, 2014) have pointed out, decline in older age is not a smooth path. Instead it is more a series of steps, where critical incidents such as the death of a partner, a fall, or a stroke, can produce a sudden loss of functionality. At each step, restorative or rehabilitative interventions may take an individual back to a pre-critical state, yet as CQC points out, access to such services is limited:

Access to reablement and rehabilitation services can make a significant positive difference for people – there is wide variation in access to these services. Of those older people who received these services following discharge from hospital in 2016/17, 82.5% were still at home 91 days later. However, only 2.7% of older people discharged from hospital received these services in the first place.

(Care Quality Commission, 2018b, p.28)

Yet the issue is not just about access, but about how we target interventions at those key moments of decline. There are three elements to this: what do we know, when is the optimum point of intervention, and with what?

In terms of the first of these elements, joint commissioners need to understand what their data are telling them is happening and why. At a minimum there must be the capacity to interrogate and align health and social care information (perhaps with assistance from Public Health). For example, are there patterns in who goes into hospital for preventable conditions? Who is getting readmitted post hip fracture, and why? Which populations look to be most vulnerable to UTIs?
If, as stated above, decline is not constant but occurs through a series of critical incidents or events, then there is a need to focus resources at the point where they are most likely to have maximum impact. Intervene too early and it is hard to prove that the benefit arises from the intervention, intervene too late and it may become impossible to restore a person's functionality. Whether it is falls prevention or carer support, or any other of the myriad of preventative initiatives, the question should always be: what is the optimum intervention point in order to achieve maximum cost benefit? That determination should also include when the recipient is most likely to be motivated to change and be receptive to the intervention.

If defining ‘when to intervene’ is important, then so is ‘with what’? If in the past prevention has developed on a basis of let a ‘hundred flowers bloom’, then now is ‘harvest’ time; for bringing together the best of what is known, ensuring it is routinely available and implemented across the country, maybe with some kind of cost / benefit scoring. At least there is no shortage of information about what works and what doesn’t, either in terms of routine clinical data, as the Nuffield Trust points out (Neuburger, 2016), or from the reports on the many pilots and experiments that have been conducted. For example, just a quick review shows there is good information about how to lessen A&E admissions from care homes (Lloyd et al., 2017), reduce the level of UTI based hospital admissions (NHS, 2018), improve recovery from stroke (Clark, 2019; Dragert & Zehr, 2013), lessen the likelihood of falls (Public Health England, 2016), improve frailty (Holland et al., 2015), and increase food intake through better oral health care (Public Health England, 2018).

The way ahead for integration

As the NAO argued (National Audit Office, 2017) there is a need to understand which models of integration work best and/or achieve most and put people at its heart, not systems or organisations. If integration is simply seen as a process for bringing health and social care together then, as stated before, it is unlikely to deliver the desired benefits (Georghiou & Keeble, 2019). If, as suggested above, the focus of intervention shifts towards reducing demand and onto those optimum points when poor outcomes might be diverted, then that will almost always require integration. For example, if it is recognised that there are sound predictors of falls amongst older people (Todd & Skelton, 2004), then lessening risk might require structured exercise programmes, housing adaptations, dietary change, sight checks, and changes to drug regimes, not forgetting someone encouraging the older person to change their own behaviour. This does not require a single service, but it does require integration across planning and delivery, not least in the end user’s experience of what is on offer.

The NAO established that there are some important hurdles to overcome in pursuing integration (National Audit Office, 2017). Firstly, establish the evidence base, then address the following three barriers:

- **Misaligned financial incentives** Changing a tariff system that incentivises hospitals to recruit patients,
- **Workforce challenges** Overcoming issues such as differing working cultures, professional restrictive practices, employment terms and conditions, and recruitment,
- **Reticence over information sharing** Ensuring there is clarity over the sharing of patient information at a national and local level.

There are also other obstacles, such as how to align services that are free with those that are means tested / charged for, or, in terms of information-sharing, how to overcome problems not only between organisations but within health and social care, given the plethora of systems they use. Finally, as others emphasise, the primary beneficiary of integration needs to be the service user.
The way ahead for consumerism

As self-funders indicate, social care consumerism is not about who holds the money, because if there is little choice, limited availability and services are not desirable, then you are forced into being a recipient rather than a consumer.

Choice

Most older people say they want to remain in their own home, including specialist housing, until death (NatCen, 2013). Yet only 20% of the population aged 75 and over achieve this, whilst nearly half die in hospital and 30% in residential care (Public Health England, 2019, Section 4, Table 2: Proportion of deaths by place of death for people aged 75 years and older in England in 2017). In the case of the latter, it is often a decision which many older people feel they have little choice over, and one which is made at a time of crisis or ill-health. Few of us know what outcomes we expect residential care to deliver, what constitutes good care or even whether one care home really differs from another. Even the information that is available via the CQC, as the Kings Fund points out, is often not well used.

Providers and patient and public groups told us that awareness of CQC and use of CQC information in the context of choice still seems quite low among the general public and service users when compared with, for example, sectors such as education.

(Smithson et al., 2018, p.24)

Although choice is often couched in terms of choice of services, as funding has fallen, the very things that people say they want to have a choice over are more likely to become restricted. Which person delivers my care? How much time do they have for me? What choices do I have over what they do? Do they know who I actually am? These are all issues frequently raised by older people. After all, there can be few things less desirable than being washed or dressed by someone you don’t like.

Overall, there is a need for a much wider discussion about how we ensure choice, not only between services but also within them. Some of this is about enhancing the role of the regulator to genuinely inspect against a higher standard, and some is about paying for services to spend more time with older people. As the ICDC stated eight years ago, a lack of choice often starts from assumptions that people make about older age and what older people need (Independent Commission on Dignity in Care, 2012, p.5). This is not helped by a public perception that older people can only be a problem, never an asset.

Availability

As discussed earlier, there has to be unused capacity in the market for choice to work, so equally there needs to be a funding mechanism which allows home care services and care homes to have spare capacity, as well as the funding to expand the scope of their provision. Even though this might seem impossible, farmers have been paid for years to leave land fallow! Equally, given that older people incur higher health costs, use services more, and stay in hospital longer, there is a need for them and their carers to be able to fast-track health care. Although older people are the group most satisfied with health services, overall satisfaction with primary care, such as GPs, is in decline.

Public satisfaction with general practice dropped by 7 percentage points in 2017 to 65 per cent, the lowest level since the survey began in 1983… patients (are) finding it harder to get through to the surgery on the phone, harder to see their GP of choice (which affects continuity of care, something that we know is key to keeping patients healthy and out of hospital) and rating their overall experience of the surgery more negatively.

(Robertson, 2018)
However, ‘availability’ cuts both ways. Government wishes to develop more family housing, yet in 2011 nearly 40% of all three, four and five or more bedded properties owned outright were occupied by those aged 65 and over (ONS: CT 0802_2011 Census, May 2018). Some older people will of course wish to remain in their family home as they age, yet it is estimated that up to a third of older people want to move but many feel unable to do so (Wood & Vibert, 2017; Nationwide Building Society, 2019). Some of the reasons for staying put are poor health, the physical exertion of sorting, packing and unpacking possessions, and the difficulties of buying and selling. Government could do more to offer incentives to older people to move, such as lowering stamp duty, better mortgage systems for older people, providing a national help-to-move service and through stimulating self-help, such as encouraging developments like cohousing:

_There are fewer than 10 existing cohousing developments designed specifically for older people... The Netherlands record approximately 230 senior cohousing communities._

(Quinio & Burgess, 2018, p.10)

**Desire**

Regardless of how many people might need care, few of us actively want it; yet that shouldn’t mean it has to be undesirable. My father, when in his late eighties, was asked if he might like to consider moving into an extremely well-funded almshouse in his hometown, he scornfully replied that they were for old people, not him. Anyone with parents of a similar age might well have experienced similar responses. It is hardly surprising, given the negative attitudes to old age (Royal Society for Public Health, 2018).

Ageism not only discriminates against older people but acts as a powerful disincentive to receiving age specific help or services. It is noticeable that adverts for aids and adaptations, such as stair lifts or continence products, typically feature younger people who don’t look to be suffering from any of the conditions for which the advertised product is intended. Equally, products ranging from alarms to raised toilet seats do little in terms of their design to lessen discrimination.

Finally, it is important to make recovery and rehabilitative interventions desirable. Bennett & Winters-Stone describe a range of behavioural interventions to encourage older people to engage in exercise programmes, rather than simply having them on offer (Bennett & Winters-Stone, 2011). Recovery from hip fracture (Sims-Gould _et al._, 2017) and stroke (Rapoliené _et al._, 2018) often requires considerable motivation, particularly where, in the case of stroke, the effect on the brain may in itself be to lessen motivation.

**Conclusion**

The argument in this paper is that little has changed in terms of policy towards older people’s social care over the last fourteen years, from the 2006 White Paper to the present day. A number of reasons can be advanced as to why this is true.

- Whilst finance has undoubtedly played a part in limiting social care innovation, it is not the sole reason why change has not occurred.

- The increased focus on how to finance social care over this time period has moved attention away from whether what is being purchased is appropriate or desirable.

- There needs to be a refocusing of the social care debate onto how demand for both care and health provision can be reduced.
• The commissioning function across health and social care needs to use research and local data analysis better in order to understand and predict demand, fuel evidence-based prevention and to target interventions. Public Health should be encouraged to support this activity.

• At a national and a local level there needs to be a greater emphasis on how good prevention outcomes are then mainstreamed.

• Given that the bulk of social care is provided by the private sector, if better and greater preventative provision is to be available, then that sector has to be better engaged, supported and incentivised.

• It should not be supposed that all integration is good; but it should be judged on whether it delivers replicable cost benefits and will lead to better provision for care consumers.

Overall, there has to be a significant shift from how we can fund greater supply, based on an increasingly ageing population, to how we reduce demand. Failure to achieve this will inevitably mean a deterioration in services as less money per head will be available. Politically, it may also become untenable to ask a poorer, younger, working population to fund such provision.

Instead the aim should be to reduce the period of ill-health that older people experience prior to death, through enhanced rehabilitative and recovery services that can target the optimum points in older age when maximum benefit may be achieved. Alongside this should be a much greater emphasis on provision that encourages and supports individual older people’s own health and wellbeing. Currently we spend far too much, far too late, on health and care services that escort us to the grave, without making sure that the journey is as good as it could be.

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Toward a new start and a sustainable future for adult social care

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Abstract

The social care system in England is widely seen to be suffering from a sustained period of underfunding as a result of a decade of austerity. Less well observed is that it is also suffering from a chronic lack of direction. The evidence leaves little room for debate that the high transformative ambitions of the personalisation strategy have failed. The ambitions remain ones that have universal support – a service that responds to each individual, enables wellbeing and good quality of life and makes best use of public resources. The question, therefore, is how to achieve this? This paper explores the predominant thinking of the sector’s leadership, highlighting its inability to fill the present intellectual vacuum. It goes on to explore how the thinking from the service user movement, notably the idea of independent living, holds the promise of authentic and sustainable change.

Keywords: independent living, social care strategy, funding, eligibility, rights

Context

It is now over a decade since the UK Government’s personalisation strategy was launched (Department of Health, 2007). The evidence is that it has not achieved its mission of transforming social care into a system that is fair, where people are in control of their care and support, which enables them to lead fulfilling lives. A survey of over 1,000 service users and carers (Think Local Act Personal, 2017) asked if their views were listened to, and found 70% thought their own views were either not listened to at all, or rarely, or at best only sometimes. The reduction in government grants to local authorities has resulted in an even greater postcode lottery. In 2017/18, after allowing for regional price differences, the highest spending councils spent £21,400 per service user and the lowest £11,400 (Slasberg, 2018).

Think Local Act Personal (TLAP), the body charged by Government to promote delivery of the agenda, is now into its second iteration of a programme they have called Making it Real (Think Local Act Personal, 2019). The title is a tacit recognition that the original policy, built on the foundations of the personal budget strategy, has not delivered as it was intended to. The TLAP strategy is based on a series of statements of good intent and invites organisations to sign up to them. At the time of writing, from the TLAP website only 5 of the 152 English local authorities appear to have signed up.

Although the phrase ‘personal budget’ is now embedded in the adult care sector’s vocabulary, its meaning is now taken from the Care Act itself rather than the policy definition. It is thus nothing more than a financial costing exercise that takes place following all the key decisions, not an upfront sum of money for the service user to directly plan their own support (Slasberg, 2017). The sector is encouraged to promote ‘strengths-based practice’ (Baron et al., 2019) in a recognition that the system is failing, given its focus on deficits thus creating dependency.

Much like the Community Care reforms of the 1990s which had similar ambitions, the personalisation strategy has come and gone, leaving the service largely unreformed and with little more than different language to describe it. A vacuum has been created. If the ambition of creating a system that is fair, empowering and makes the best use of public money still burns bright, to where should it turn next?
The following analysis is divided into two parts. The first identifies the key ideas being pursued by sector leaders. This focuses on two approaches – more money as the solution, and individual behavioural change in the form of ‘strengths-based practice’. The second part identifies strategies that originate from service users themselves. This focuses on the philosophy of independent living, with one approach making it a legal right, and the other as the driving vision within a budgeted system.

Ideas from the sector's perspective

More money

The Local Government Association, which represents the interests of local authorities, produced a report in preparation for the long delayed Green Paper on the future of social care (Local Government Association, 2018) which it followed up in a further report in 2019 (Local Government Association, 2019). Its basic premise is that the social care service is in good shape, but it needs greater financial backing. The report claims funding levels threaten ‘the great progress that has been made in challenging circumstances’ (p.42), and people working in local government ‘take pride in the role it plays in supporting people’s lives’ (p.12). Maintaining the message, against all the evidence (Slasberg & Beresford, 2016), contesting that the personalisation strategy has worked, the report proposes that the Care Act 2014 ‘promotes personal budgets and direct payments in order to give people choice and control over their care’ (p.47). Nevertheless ‘councils are increasingly struggling to even meet the ‘letter’ of the law’ (p.48).

The report identifies underfunding as the outstanding issue. In addition to £1.4 billion required to pay a fair price to providers, the Local Government Association says £5 billion is required to meet both unmet and under-met need. Unmet need is when people are excluded by the system altogether, and under-met need is where people are in the system but have insufficient support to lead the lives they want, and which the system might be expected to provide.

A system that denies there is a funding gap

This analysis runs into serious difficulties. The first is that the eligibility mechanism means the system denies any needs are unmet. Once a council deems a need ‘eligible’ it becomes a legal duty for the council to meet it. Councils have to square this reality with the equally powerful fiduciary duty to spend within budget. The conundrum is resolved by flexing the eligibility criteria locally to control the flow of eligible need to that which can be afforded. Any need which is not affordable is reduced to a want, or preference or wish, which the council has no responsibility to meet.

A recent case in Barnet (Disability News Service, 2019) exemplifies the process and the problem. The council sought to save £425,000 by placing people who required support at home in residential care if this would cost less. It was able to do so by declaring that residential care meets the ‘need’ while remaining at home is merely a ‘preference’. This is a view of ‘need’ that flies in the face of what most people are likely to view as needs for dignity, independence, identity and control. It also flies in the face of needs for wellbeing, as set out in section one of the Care Act (HM Government, 2014), which identifies nine core elements of wellbeing. These include emotional wellbeing, being in control of one’s life, being in control of one’s support, dignity and living in a place that is suitable. Most people are likely to agree these elements of wellbeing are better served living in one’s own home rather than an institution, thus making living in one’s own home a need that can be countermanded only in circumstances when wellbeing would demonstrably be better served by living in an institution.

The eligibility system’s circular definition of ‘need’ means that the system cannot recognise either unmet or under-met needs. In 2012, Paul Burstow, as Minister for Care, challenged over the funding gap in social care – which some members believed was as much as £7 billion –
denied there was any funding gap (Health Select Committee, Response to Q.544, Health Select Committee, Ev.108, 17 January 2012). In 2018, the same Committee nevertheless indicated:

*Authoritative sources in the social care sector say that, despite the additional funding, there will be a funding gap of £2.2–£2.5 billion in 2019–20.* (Housing, Communities & Local Government and Health & Social Care Committees, 2018, para 20)

A little later in 2018, Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care, repeated the official message (Oral Evidence: The Interface between Health and Social Care, HC 1376, 18 July 2018, Public Accounts Committee, 2018). He told the Committee that:

*With the exception of the one local authority (Northamptonshire) in which we have intervened, we do not have any evidence that any local authority is not meeting the floor that Parliament set* (i.e. to meet their statutory responsibilities under the Care Act). (Public Accounts Committee, op cit., Q.82)

**Why should Government heed the message?**

How will sector leaders persuade Government to heed their message that more money is needed to meet what they have hitherto decreed not to be ‘need’? The current government has acknowledged the need for more money, but only to prop up the current system. It has referred any debate about the long-term future to cross-party talks (Hancock, 2019). The sector's problem in getting Government to listen to the need for money over and above this is particularly problematic when the current political priority is the balance of public and private funding, with public and media concern about some people having to sell their homes to pay for their care.

**Will more money work anyway, without system change?**

But perhaps an even more damning indictment of the ‘more money’ solution is what the ‘postcode lottery’ tells us. Its existence was highlighted in 2011 by the Dilnot Commission (Commission on Funding of Care and Support, 2011, p.16) which found councils providing ‘very different’ levels of support for people with similar needs. Phillips & Simpson, in 2017, suggested that disparities had grown under austerity, given that the large cuts to government grants to local authorities had very different impacts on local councils, depending on demographics and the extent to which the council relied on central government grants for a higher proportion of their overall budget. The tenth of LAs making the biggest cuts to adult social care spending per adult saw an average cut of 31%, whilst the tenth making the biggest increases saw spending increase by 7% per adult, on average (Phillips & Simpson, 2017, p.28).

Data published by NHS Digital ([https://digital.nhs.uk/data-and-information/areas-of-interest/social-care](https://digital.nhs.uk/data-and-information/areas-of-interest/social-care)) include data on populations served, number of service users receiving continuing support during the year, and gross spend on people with continuing support, and unit costs of care in the various regions in England. This provides the information for the following analysis.

Equity is usually measured by spend per head of population. However, this is not a good test as populations vary hugely in the demand they make on social care. This is particularly the case in relation to older people. Services in more deprived communities serve significantly more people per head of population. The most significant factor is likely to be the means test effectively excluding more people in less deprived areas. Better health levels in such areas may be another factor. The different levels of demand would mean that two councils with identical budgets per head of population would provide potentially very different levels of support on average to their service users, if the populations they serve have different deprivation levels.
Figure 1 is a scattergram that shows the relationship of deprivation levels to demand from older service users in 2018. Deprivation is measured by the Index of Multiple Deprivation (IMD), which is the average deprivation score for each upper tier council’s small areas (https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019). The specific source is File 11 of English Indices of Deprivation, published 26 September 2019.

The numbers of service users are taken from the NHS Digital Activity and Finance Report (https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19). The specific source is Table 36 of SALT & ASCFR Reference Tables. The IMD scale is from 5.8 as the most affluent upper tier authority (Wokingham) to 42 as the most deprived (Blackpool).

A more reliable measure of geographical equity than spend per head of population is, it is suggested, the average spend per service user. This shows the level of support people with similar needs can expect from different councils.

NHS Digital Activity and Finance Report (Tables T34, T41 and T42) shows the number of long-term service users and the gross spend on them (Figure 2). It also reports on the unit costs for each service area for each region (Tables T49, T51 and T52). Dividing each council’s gross spend in each service area by the relevant unit cost for their region and multiplying by the national average unit cost for that service area enables all spend to be adjusted to the national average.

Figure 1. Older service users per 100,000 population for each council, against deprivation levels 2018/19. (Sources: NHS Digital Activity & Finance Report, op cit. and English Indices of Deprivation, op cit.).
Using this adjusted gross spend figure in 2018/19, it can be seen that the highest spending 15 councils spent about £1.8 billion on people with long-term support needs, on 77,630 people, spending an average of £22,600 per service user. The lowest spending 15 councils spent about £1.1 billion on 84,895 people, which is an average of £12,900. The highest spending 15 councils had an average IMD score of 15.9 and the lowest spending 15 councils an average of 24.7. To spell it out, the highest spending councils spent approaching double the lowest spending – 75% more – on people with equivalent needs.

**Characteristics of the councils**

One factor at play is population density. A review of the evidence of the cost of providing social care in rural communities (Hindle et al., 2004) concluded there was a cost premium in delivering domiciliary care compared to urban areas. The 15 highest spenders in 2018 included large shire counties such as Hertfordshire, Wiltshire and Surrey, and they served an aggregate population of 6.7 million. The 15 lowest spending councils included smaller urban authorities such as St. Helens, Southend and Salford. The NHS Digital Activity and Finance Report shows the unit costs of home care (Table T49). After adjusting for the impact of regional price differences using the same methodology as above, the unit costs of home care for the highest 15 spenders was £18.40 per hour and for the lowest 15 spenders £15.90, a difference of 15.7%. (Rurality would not be expected to affect residential and nursing provision as there are no travel requirements.)

This cost influences both home care and direct payments expenditure, given that direct payments mostly pay for domiciliary support. These two service areas account for 28% of gross spend nationally on long-term support. 15.7% of 28% means that about 5% of the 75% difference in spend per service user, between the highest and lowest, can be attributed to the rural-urban divide.
The 15 highest spending councils spent £366 per head of population against £314 spent by the 15 lowest spending councils, about 16% more. This points to higher budget levels, more than enough to compensate for the extra costs of rurality. However, by far the largest factor at play in the large spending differences per service user is the number of service users. Dividing the number of service users by the population served (https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19) shows the 15 highest spending councils served just 16 people per 1,000 population, while the lowest spending 15 councils served 24.7 per 1,000, 55% more.

This in turn relates to differences in levels of deprivation. The average IMD score for the highest spending 15 councils was 15.9 and for the lowest spending 15 councils it was 24.7. Thus, not only is the scale of inequity very large, it is weighted against the more deprived authorities.

**Impact on outcomes**

The starkness of this inequity is uncomfortable, but it does provide the opportunity for an acid test of the ‘more money’ argument for social care spending. Do the councils that spend more on service users achieve better outcomes? Against existing measures, the answer seems to be they do not.

The national returns from NHS Digital include surveys of service users about their experience of services (Measures from Adult Social Care Outcomes Framework, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/upcoming). A particularly telling one is the extent to which the services they are receiving are improving the person’s quality of life (Indicator 1J). The scale runs from 0 to 1, with the best individual council score in 2017-18 recorded as 0.46 and the lowest as 0.28.

The average score for 1J for both the highest and lowest spending 15 councils was identical at 0.4.

Another measure from the survey is the extent to which people say they are satisfied with the service (Indicator 3A). The 15 highest spending councils averaged 65.5% satisfaction rates and the 15 lowest spending councils achieved 63.9%. Although satisfaction levels are higher for councils who spent more, the difference is not of the order expected as a result of such great differences in spending. It is, at the same time, important to treat satisfaction surveys with caution because of generally low levels of expectations among social care service users.

In a hypothetical situation, if all councils were to spend the same per service user as the 15 highest spenders as shown above, this would cost an extra £8bn, nearly a 50% increase in national funding. However, the evidence above also points to any increase in funding within the current unreformed system as resulting in ‘more of the same’, without any real increase in better outcomes, whether such funding is used to provide more support to existing service users or increases the number of service users.

**Why more of the same is not the answer**

This is a counterintuitive suggestion. However, there is evidence to support a narrative that seeks to makes sense of it.

When need is defined by what people cannot do rather than what they aspire to, the resulting support depresses expectations. Research by Ipsos MORI (Blake et al., 2017) reported a small-scale qualitative study of the impact of unmet need on wellbeing and produced surprising findings.
The report found that getting help with practical daily living tasks of the kind the eligibility process favours was far from being welcomed unreservedly by study respondents. Participants in the study said help could undermine their ‘sense of resilience and independence’ that Ipsos MORI found was ‘associated with positive wellbeing, even in the face of unmet need for support with particular tasks’ (Blake et al., 2017, p.6). On the other side of the coin, people (overwhelmingly living alone) placed greater emphasis on the type of social interaction and companionship needs councils tend to say there is no public responsibility to meet under the eligibility process.

**Strengths-based practice and Wigan**

Building on sector-wide work (Local Government Association, 2014), and with vigorous support by the Social Care Institute for Excellence (https://www.scie.org.uk/strengths-based-approaches), the sector has been committed to the promotion of ‘strengths-based practice’. This is described as promoting ‘individual wellbeing by encouraging independence, self-care, support and learning opportunities for informal carers, before specific service solutions are sourced’ (Think Local Act Personal, 2018, p.5). This is seen as the route not only to free the system from its tendency to promote dependence, but to ensure the delivery of good value for money through better demand management.

The present authors have highlighted (Slasberg & Beresford, 2017a) how the promotional claims of success do not stand up to scrutiny, based on evidence in the public domain. While a process of assessment that builds on people’s strengths is universally accepted as the right approach, this is not possible within a system that allocates resources using deficits as the currency for decision making, and that is designed to deny the existence of a funding gap.

Nonetheless, promoting strengths-based practice remains sector policy. Wigan Council, perhaps above others, has been seen to champion the approach. It has created the ‘Wigan Deal’. The ‘Deal’ is a whole council movement that originated in adult social care. It sought a radical redefinition of the relationship between state and citizen, reversing the dependency that has developed in the wake of the 1948 welfare state settlement. Wigan was inspired by the work of Hilary Cottam, a social entrepreneur with a background in international banking, whose work has been described in The Guardian as capable of ‘transforming Britain’ (Freedland, 2019). The approach is based on the belief that the welfare state was built for ‘a world that no longer exists’. It has created a ‘transactional, pass the parcel’ bureaucracy. The future lies, it is said, in citizens taking control over their lives, building on their own assets.

The Kings Fund carried out an independent investigation into the ‘Deal’ (Naylor & Wellings, 2019). It came to a very positive conclusion. It claimed Wigan has shown that achieving ‘substantial savings while protecting or improving outcomes’ is possible, ‘but only if services are genuinely transformed and upfront investment is available to help bring about new ways of working’ (Naylor & Wellings, 2019, p.1).

Certainly, Wigan has reduced spending on social care. Using information available from NHS Digital, in 2010/11 (https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-expenditure-and-unit-costs/personal-social-services-expenditure-and-unit-costs-2010-11-final-release), and therefore taking into account the Council’s own money plus the increasingly important cash transfers from the NHS to fund social care, Wigan spent £111.9 million, which is £125.4 million adjusted to 2017/18 prices. In 2017/18, it spent £119.5 million. Thus, Wigan reduced its spending by 4.8% in real terms.

At the same time Wigan was not exceptional during this period of austerity. Although the cut was above average, 57 councils cut deeper.
There has also been a dramatic fall in numbers of people supported during the same period of time. Nationally they have dropped from 1.7 million to 860,000, a fall of 49%. For Wigan, the fall was even greater at 54%, from 10,875 to 4,950 (NHS Digital, op cit.).

Other authorities have made cuts with a sense of regret, forced upon them by austerity, with sector leaders believing cuts have ‘gone too far’ (Garrod, 2018). The key question is whether the claim is justified that Wigan has made its reductions through consent and the win-win of building on people’s strengths.

The Kings Fund report relies on two sources of evidence for its confidence – qualitative, in the form of what people in Wigan said to the researchers, and quantitative. Both leave much room to question the researchers’ conclusion.

What people told the researchers in Wigan

The researchers found a wave of enthusiasm for the ‘Deal’ amongst staff from top to bottom. This included political leaders of both main parties, senior managers, operational managers and frontline staff. One social care professional told them “It doesn’t feel like a job, it feels like a movement” (Naylor & Wellings, 2019, p.26).

The enthusiasm may authentically reflect what current staff have seen and experienced of the ‘Deal’. However, the Council’s strategy included requiring all staff to reapply for their jobs. Those who succeeded persuaded the Council they supported the ‘Deal’. Those who failed were not appointed and given compulsory redundancy. Staff ‘positivity’ might be a reflection of shared zeal, or a condition of employment.

Staff enthusiasm was not matched by the residents of Wigan whom the researchers spoke to in focus groups. They found predominantly distrust and cynicism, with concern that the ‘Deal’ was a ‘fig leaf for cuts’. Residents ‘wanted much greater reassurance that the council and indeed other people in their community are meeting their part of the bargain before committing to making the changes being asked of them’ (Naylor & Wellings, 2019, p.72).

Quantitative measures in Wigan

The researchers looked at overall satisfaction levels. They were a little perplexed to find that overall satisfaction levels were only ‘around the average’. This led them to wonder if the ‘metrics or methodology of the national survey do not capture the kinds of changes that have taken place’ (Naylor & Wellings, 2019, p.63).

The researchers overlooked the specific measure discussed above – The extent to which social care services have improved quality of life (NHS Digital, Adult Social Care Outcomes Framework, Indicator 1J). If the ‘Deal’ is achieving what it claims, building on people’s strengths to give them the life they want, it would be reasonable to expect Wigan to achieve well above average here. Wigan’s score, however, was exactly the same as the national average at 0.4.

They noted that Wigan’s service providers had improved their Care Quality Commission rating. However, that has only brought Wigan up to the standard of the national average (Naylor & Wellings, 2019, p.62).

The researchers went on to give pre-eminence to Wigan’s good performance in relation to hospital discharge and rate of emergency readmissions to hospital. Efficiency at the health-social care interface is certainly a valued performance measure. However, the researchers do not make clear why they believe this to be a measure of a radical new contract between the council and residents.
The researchers also refer to one of the Deal’s objectives being to ‘reduce the need for institutionalised care’ (Naylor & Wellings, 2019, p.61). In discussion, they refer to the number of people after reablement still ‘at home 91 days after discharge from hospital’, with proportions ‘significantly higher in Wigan than in England as a whole’. This may be another good measure of joint work between health and social care, but it is not evidence of fewer people going into institutional care.

The obvious measure here is the percentage of service users in long-term residential and nursing care. In fact, in 2017/18 in Wigan, 43.8% of older service users were in institutional care, significantly more than the national average of 38.4% (NHS Digital, Finance and Activity Report data on people in residential and nursing care and all receiving long-term support, undated).

**The real deal?**

The Kings Fund researchers ask: ‘Is the Wigan ‘Deal’ real?’ (Naylor & Wellings, 2019, p.59). The evidence does not support their belief that it is. The quantitative evidence points toward Wigan having responded to austerity little differently from other councils, by raising the eligibility threshold and excluding more people.

The quantitative data discussed here resonate more closely with the caution and cynicism of the residents the researchers spoke to than with the optimism of Wigan’s staff.

There is no question that greater funding in the short term is required to shore up a faltering social care system. However, this will not of itself create a progressive or sustainable system. The evidence above suggests that whether more money is used to buy more care for those already in the system, or to increase the numbers admitted to the system, the wellbeing of the recipients will not necessarily be improved. Social care, in its current state, by depressing expectations and failing to build on aspirations, is not the good it is assumed to be, but can actually be bad for people. The attempt to impose strengths-based practice on a deficit-led system appears to be the latest of numerous wild goose chases. A consultation document by the British Association of Social Workers (BASW, 2019) on the future of social care sets out a view that to be effective strengths-based practice should be located within person-centred practice. Strengths-based practice located within the eligibility regime is a potentially toxic mix. This might well explain why so much of the success claimed for strengths-based practice by the sector relates to work at the ‘front door’, prior to people needing council funded support on a continuing basis.

Strategies led from the top by the sector itself have signally failed. The present authors believe it is time to take a lead from service users themselves, and we go on to discuss their ideas.

**Ideas from the service user perspective**

Of the numerous national strategies over the past 30 years designed to create a person-centred care system that works for the individual, only one can claim evidence that has shown it to be consistently successful – independent living delivered through a direct payment to enable the person to manage their own support system.

The concept of independent living developed in the UK, as in other countries, in the 1970s and 1980s (Beresford, 2016). It arose from within the disabled people’s movement. Disabled people rebelled against their patriarchal and institutionalising experience of the system of state funded care. They believed they were capable of living lives greatly more fulfilling, whilst contributing more to society than the system made possible. The 1996 Direct Payments Act gave authority to councils to offer cash rather than services, thus making the idea deliverable.
The problem is that few are able to use this model of service. It requires levels of skill, time, energy, assertiveness and confidence beyond the great majority of people in need of care and support. Despite strong encouragement by successive governments to increase numbers, only some 75,000 service users are estimated to employ their own staff (Skills for Care, 2019). This is 31% of the total of 237,000 direct payment recipients. The 69% majority are using their direct payment simply to pay the invoices of the services they would have received anyway. 75,000 is 9% of the total of 860,000 recipients of social care.

**Independent living as a principle**

The United Nations’ Convention on the Rights of Persons with Disabilities (United Nations, 2019) has created the key to making independent living accessible for all. It has extracted from ‘independent living’ as a service model a core generic principle that can be applied to all in need of care and support. Article 19 says:

> Disabled people should have equal rights to live in the community, with choices equal to others, and be fully included and able to participate in the community.

Article 19 goes on to make clear this should apply in the ‘range of in-home, residential and other community support services’ (Article 19b). The UN definition of disability includes all forms of impairment and covers all ages; therefore, the ‘principle of independent living’ can and should be taken to apply to all who need care and support as a result of physical or mental impairment or difficulty, in whatever setting they find themselves.

If the principle of independent living is to become integral to the social care system, the challenge is how to bring it about. The most certain route is to make it a legal right. Although Article 19 speaks of it as a right, the Convention acknowledges it is for each state to decide how the principle should fit within domestic legislation.

**Independent living as a right**

A number of disabled people’s organisations have formed an alliance to promote independent living (Reclaiming Our Futures Alliance, 2019). They have launched a campaign to create a National Independent Living Service. Their ‘core demand’ is:

> A new universal right to independent living, enshrined in law and delivered through a new national independent living service co-created between government and disabled people, funded through general taxation, managed by central government, led by disabled people, and delivered locally in co-production with disabled people.

(Reclaiming Our Futures Alliance, 2019, p.9)

The document notes that the ‘right’ to independent living has yet to be enshrined in domestic law. The authors note the Davey v Oxfordshire case as a landmark in the delivery of the Care Act 2014, which now provides the legislative context for social care in England. The same document quotes from the judgement ‘provisions which are aspirational cannot qualify the clear language of primary legislation’ (p.9).

The Reclaiming Our Futures Alliance (ROFA) therefore sees the Care Act 2014 as having failed, believing its duty to promote wellbeing to offer ‘insufficient protection against retrogression of our rights’ (p.9). ROFA sees the solution as new primary legislation. While independent living requires action across a range of public responsibilities, the campaign believes the social care element should be delivered ‘through a new national independent living service managed by central government but delivered locally. The service should be funded on the same terms as the NHS – through general taxation and free at the point of delivery’ (p.9). Disabled people should ‘have a meaningful say at all levels of decision making with a governing body that is made up of a majority of disabled people’ (p.13).
A key political challenge

The right to independent living can be understood as having two core elements – the right to ‘needs’ being understood in the context of independent living, and then the right to all the resources required to meet those needs. The second of these creates a significant challenge for the campaign. A right to independent living is incompatible with delivering social care within a budget, however generous.

Needs for social care are unique to the individual. They arise from the complex interplay of a large number of factors, each of which is highly variable – the nature and severity of the impairment, its longevity, the personal resourcefulness of the person, the resourcefulness within their network of support, the resourcefulness of their local community, the accessibility of local services, the physical living accommodation, and so on. Further, the cost of meeting needs can vary enormously.

These realities mean it is not possible to predict the cost of meeting needs for social care in advance, individually or collectively. Social care would have to deliver on an open cheque basis if there were a legal right to all the resource required for independent living. The challenge for the campaign will be that they are seeking a unique position for social care amongst non-financial public services. All others are expected to deliver within a budget, including the NHS. This would move social care from the back of the queue for public funds to the front. Whilst service users and their advocates would like nothing more, it is difficult to envisage the scenario when this will have sufficient support across the community for it to happen.

A right to an assessment of needs for independent living within a budgeted system

By using key provisions in the Care Act that have lain dormant hitherto, and with a change to government policy, Slasberg & Beresford, 2019, argue it will be possible to secure a right for all needs for independent living to be assessed and costed. The key is the failure hitherto of councils to deliver Section 9 of the Care Act as intended. This section requires councils to assess needs for wellbeing without regard to affordability. A recent (September 2019) High Court judgement (https://www.localgovernmentlawyer.co.uk/housing-law/397-housing-news/42339-judge-rules-against-council-on-meaning-of-needs-for-care-act-assessment) included the following clarification:

The needs of adults are assessed in accordance with those principles under s.9. Eligible needs are then identified under s.13, by reference to the regulations. A Care and Support Plan then has to be prepared and kept under review. The local authority must then act on the plan in accordance with the duties imposed by s.18, and may provide further assistance under s.19, in ways that it considers effective.

(R (Antoniak) v Westminster City Council [2019] EWHC 3465 (Admin))

The delivery of affordability, necessary to follow the fiduciary duty to spend within budget, can only be attained by limiting needs met under section 18 – the legal duty to meet need – to a safety floor, with quality of life needs met under section 19. It is not unlawful for councils to fail to meet needs under section 19, whereas it is so for needs under section 18.

Adopting the suggested changes will mean the extent to which those needs are then met will be a matter of transparent political priorities and choice. The gap that now exists between needs and resources will be exposed in the form of costed, unmet need.
Table 1 compares such a system of a right to assessment with the current system and with independent living as a right. It compares this in relation to 6 factors key to the management of the tension between needs and resources in delivering independent living:

- **Needs identified without regard to available resources** It is axiomatic that even if the extent to which needs for independent living are met is compromised by resources, 'need' itself need not, or should not be compromised. The prevailing eligibility system routinely compromises need in order to ensure spend matches budget (Slasberg & Beresford, 2017b).

- **Person able to define own needs and support requirements, subject only to enabling independent living and in the most cost effective way** Once the requirement has been removed to control the assessment in order to deliver spending control, councils will be able to make manifest the often repeated clarion call that people are experts in their own needs. The person's view cannot, however, be a simple wish list. Service users should be required, with support as necessary, to frame their views into a responsible assessment and plan that makes the best, most appropriate, use of all resources to deliver independent living.

- **Resources allocated to ensure the greatest extent of independent living for the greatest number of people** Under the eligibility system, service users compete to prove how bad things are, so as to secure support under the concept of 'greatest need'. If all needs for wellbeing are identified and costed, with the section 18 duty to meet need restricted to a safety floor, councils can make decisions about which needs to meet under section 18 on the basis of the most positive outcomes.

- **Resources allocated fairly and equitably** Controlling spending by controlling the flow of needs which there is deemed a legal duty to meet has resulted in gross inequity. This is because 'need' is necessarily defined by resources, thus concealing any inequity in resources relative to need being distributed inequitably. If the comparative extent of unmet need is known, it will be possible to redistribute funding in an intelligence led way as appropriate.

- **Levels of resources for all to have independent living will be known** The democratic process that determines public spending priorities will, for the first time, have information about the level of funding required to enable all to have an appropriate level of wellbeing, defined as independent living. It will fall to the democratic process to transparently determine the extent to which people are appropriately supported. Advocates for service users will need to be vigilant.

- **All resources for independent living provided** It is self-evident that to independent living all the resources are made available to meet all the individual's needs for support.

The current system fails to score against any of these 6 factors, while independent living as a right scores against all of them. The middle position, a right to needs for independent living within a budgeted system, scores against 5 of the 6. The 5 factors, however, can be expected to deliver the cultural, practice, managerial and political changes that will be required of the system if independent living is to be the driving vision for social care. This will only leave the right to all resources to be secured. This will arguably be more likely once the system is effectively designed to deliver independent living, and the funding implications are better understood.
Toward a new start and sustainable future for adult social care

Table 1. Comparing systems’ capacity to deliver independent living (IL).

<table>
<thead>
<tr>
<th>THE KEY ELEMENTS OF MANAGING NEEDS AND RESOURCES IN A PERSON CENTRED WAY TO SECURE INDEPENDENT LIVING</th>
<th>CURRENT SYSTEM</th>
<th>RIGHT TO ASSESSMENT OF NEEDS FOR IL</th>
<th>RIGHT TO INDEPENDENT LIVING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs identified without regard to available resources</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Person able to define own needs and support requirements, subject only to enabling IL, and in the most cost effective way</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Resources allocated to ensure the greatest extent of Independent Living for the greatest number of people</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Resources allocated fairly and equitably</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Level of resources for all to have Independent Living is known</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>All resource for Independent Living provided</td>
<td>X</td>
<td>X</td>
<td>✓</td>
</tr>
</tbody>
</table>

General conclusion: toward a transformed and sustainable future

In the wake of the failure of the personal budget strategy to bring about transformative change, sector leaders do not have a strategy to deliver the transformative changes that have been long sought. There is an intellectual vacuum. Independent living is a concept rooted in the experience and thinking of service users. If the right conditions can be found, it can fill the vacuum. It is tried, tested and proven to be successful. Developed into a principle, the UN definition of independent living can and should be applied to all.

The surest way to move for all to experience independent living is to make it a domestic UK legal right. However, the political challenges to achieve that may be too great, at least in the foreseeable future. In the meantime, the legislation, properly applied, has created the conditions for the assessment of needs for independent living to be a legal right, with the extent to which the resources are available to meet them becoming a transparent political responsibility. This will deliver the UN notion of ‘progressive realization’ of independent living (United Nations, 2017). This acknowledges states will not have all the resources required in place immediately, but they will need to commit to securing them over time. ‘The immediate obligation’ is to ‘design and adopt concrete strategies’ which set states on the road (UN, 2017, para 39). Establishing the legal right for all needs for independent living to be acknowledged and costed will require the transformation of what is currently a largely administrative service that distributes whatever resource is available, against arcane criteria. The transformation would be to a service driven by a vision of how life should be for older and disabled people. This would be a stepping-stone to independent living as of right. It might well be an essential stepping-stone, without which the ultimate vision may never be achieved.
References


Toward a new start and sustainable future for adult social care


**Notes on Contributors**

**Colin Slasberg** is a qualified social worker, worked in local authorities in children's services for the first part of his career and in adults' services for the second part. Subsequently, he has undertaken analysis and written on policy and its implications, in relation especially to adults and personalisation.

**Peter Beresford, OBE**, is Professor of Citizen Participation at Essex University and Emeritus Professor of Social Policy at Brunel University. He is also Co-Chair of *Shaping Our Lives*, a national service user organisation. He has written on social policy in the UK and internationally, recently most extensively in *All Our Welfare: Towards Participatory Social Policy* (2016).

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What are SSRG’s objectives?

- To provide a network of mutual support and a forum for the exchange of ideas and information on social and healthcare services.
- To promote high standards in social and healthcare services research, information, planning and evaluation.
- Encourage collaboration in social, housing and health services activities.
- To develop an informed body of opinion on social and healthcare services activities.
- To provide a channel of communication for the collective views of the Group to central and local government, other professional bodies and the public.
- To sponsor relevant research and identify neglected areas of research.
- To encourage and, where appropriate, sponsor high quality training in research techniques.

Who belongs?

SSRG is open to anyone who subscribes to the objectives of the Group. Members are drawn from a wide range of professional groups and organisations sharing a common interest in the work of the caring services.

How is it organised?

SSRG is run by an ‘Executive Committee’ (EC) which comprises elected and selected officers, elected members, co-opted members and representatives from SSRG Scotland, whose principal tasks are to promote the objectives of the group and to coordinate its activities.

What does it do?

SSRG publishes a Journal and a Newsletter which are distributed free to all members. It maintains working links with central government departments, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Children’s Services (ADCS) and other professional bodies and organises an annual workshop on a topical theme in social and health care services research, and occasional day conferences, for which members receive generous discounts on fees. It also coordinates the work of Special Interest Groups which provide members with an opportunity to contribute to the formulation of SSRG responses to national policy initiatives and current issues in the social and health care services.

Equal Opportunities Policy Aims

- To ensure that every SSRG member, user, job applicant, employee or any person working with, or in contact with, the organisation receives fair treatment irrespective of their age, colour, disability, gender, ethnic origin, marital status, nationality, race, religion, sexual orientation, responsibility for dependents, political affiliation or membership of a trade union.
- To ensure that the contribution of research, information, planning and evaluation work in social care and health is sensitive to this issue.
- To ensure that SSRG promotes the equalities agenda in all its activities.

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