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Securing Good Care for Older People: Taking a Long-term View

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Abstract

The paper aims to explain and evaluate two key features of *Securing Good Care for Older People*, the Wanless Report on alternative mechanisms for funding long-term care of older people. One is the new elements of the methodology for evaluating the alternatives (section 1.1). The paper argues that more successfully than previously and analyses in other countries, these elements focus attention on what are really the core issues: the means and ends which are the unique foci of long-term care, and estimates of the consequences of alternatives for them. By doing so, the report faces the politicians and policy analysis and research communities with a formidable challenge, to master and contribute to the development of the new framework and evidence. Failure to meet the challenge will increase the risk that the policy system will reinforce rather than weaken causes of gross inequity and inefficiency caused by the under-funding of long-term care seemingly unanswerably demonstrated by the report. The second key feature is the type of funding model the Report recommends given expected changes in the balance between demands and public expenditure. Section 1.2 argues that the report's analysis as successfully transforms the state of the argument about this as much as about the framework, methodology and evidence for evaluating alternatives, demonstrating the relative weakness of models widely advocated a decade ago. Part 2 discusses how to build on the Report. Section 2.1 discusses the framing of issues and the analysis of evidence for each of the key foci of the report's main contribution to evaluation methodology. Section 2.2 discusses whether the recommended model would be the wisest choice given the environment likely during the next few decades.

Introduction

In every generation, a few reports redefine issues of current moment in a way which could set the framework for evidence-based discourse, often for a long period. This is so of the report of the Wanless team's review (hereafter WR) (Wanless *et al.*, 2006). It will have less impact than it should unless this is widely enough recognised not just in academe but far beyond. And its most important contributions are precisely those whose application in other countries could advance their discourse also.

In particular, it engages the means and ends which are really at the heart of long-term care debate. Starting with quantified descriptions of what levels, balance and incidence of outcomes are most valued by citizens (and are the declared aims of policy intervention), and how they can be most fairly and efficiently produced, it works back to

resources and costs and who would pay how much for what value of benefit given each of a set of exemplar funding models. It shows that some model types could not sufficiently satisfy enough of the general criteria to play anything more than a supporting role, if that. The patterns of benefit differ from one another and so confer varying ratios of benefits to costs to groups though much the same in effectiveness judged by the most general of the WR criteria, but likely to attract different advocates. As the models have been designed and parameterised by WR, the 'partnership model' has the edge, it argues.

It provides this key insight without neglecting the many criteria which recent analyses recognise should affect judgments about systems in policy and political processes, from the broadest principles to the most focussed analyses of costs and benefits by subgroups of the population. Analyses of the properties of model types, indeed of multiple exemplars of parameterised models of each of several types (as with the analysis of costs and the incidence of costs and benefits on groups defined in various ways), have been transformed in their sophistication and detail. But it is the WR which is the first internationally to fill the key gap: to provide a methodology for evaluating alternative funding mechanisms starting from quantitative evidence about citizen's valuations for the specific benefits which are the *raison d'être* of long term care policy and quantitative knowledge about how to produce them most efficiently. Think of the alternative: without this WR methodology, we are doomed to asking partially irrelevant questions and providing only partially relevant evidence to answer them, not the ones directly about the ends and means which the policy process has honed in its long learning experience. Without it, we should be able to compare funding models by their outcomes for the income, educational, cultural minority, gender, social class, and many other relevant distributions of costs to public and private funds and the monetary costs of services received. But we should be unable to compare their distributions of public and private costs and the value of the net benefits of care as these are perceived by potential beneficiaries for groups defined by the need criteria of long-term care in general, and the policy paradigm for social care in particular.

The application of this new methodology makes WR's case a formidable challenge. The WR framework assembles key new components, some the basis of publications only during the last decade or so. Although the argument it bases on them is itself sophisticated, and based on complex models and detailed analysis of large amounts of evidence, above

all it suggests the great practical benefits from strengthening the knowledge base. It is all the more a challenge to those seeking to create the knowledge it needs because crossing boundaries between intellectual communities is difficult, uncomfortable and risky, and it is dangerous to narrow readerships by using argument whose basis is analysis which many cannot follow: gurus chant KISS – Keep it Simple and Sequential. But in this field the public interest demands that we do the opposite. And requisite engagement of the complexity is a challenge not just to those advancing knowledge but also to the higher official with many other concerns than this, the policy analyst in a pressure group, the specialist journalist, and politicians.

It would greatly handicap policy development were insufficient policy leaders, analysts and others to learn to understand and use the new frameworks and methods. What would be tragic would be for people not to attempt to contribute to the new argument. Hence the form and content of the paper. It is to help the reader understand some essentials of the WR framework and argument and how to improve it and discuss how the momentum can be maintained.

1. Analytic framework and evaluation methodology

The Wanless team's key methodological contribution to the evaluation of alternative funding models has been to combine quantified knowledge about the levels and mixes of outcomes from mixes of services with citizen valuations of the levels of outcomes. WR did so in two stages of the analysis, each a breakthrough for the discussion of the WR topic. The first was to develop a methodology for setting a *threshold level for the outcomes obtained from an increment of cost to public funds above which subsidy should be made*. The second was to provide a methodology for comparing the *relative benefits given costs from alternative models* (weighting benefits by older people's valuations of them). That methodology was key to the final stage of the evaluation of funding mechanisms.

1.1 Threshold value above which subsidise

The threshold is based on the selection of a value of the increase in benefit obtained from the service obtained using an increment of subsidy; that is, an incremental benefit/cost ratio.¹ The selection is based on incremental benefit/cost ratios in competing policy areas, reflecting estimates of the threshold beyond citizens would not be willing to pay for additional gain.

ADLAY: a generic measure of the value of outcomes. The value of the benefit is a generic indicator of welfare of the kinds which social care is intended to produce. WR's generic indicator is the value of outcomes of services intended to compensate for limitations in activities of daily living due to disability, either physical or mental. The estimate of benefits is for the year. So the Report calls the generic indicator the ADLAY, the ADL-adjusted year.

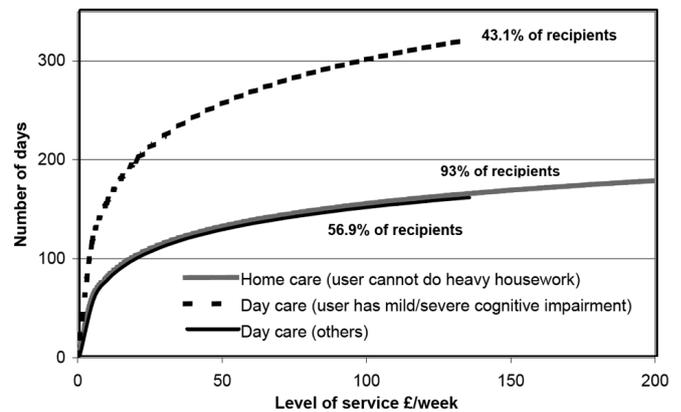


Figure 1: Effects of home care and day care on the extra time an older person remains in the community

The estimation of incremental benefit/cost ratios requires both a) knowledge about how outcomes differ given variation in the costs of inputs, other things being equal – what economists call the ‘production function’, and b) valuations of outcome levels to use as weights to compute the overall value of benefits.

Production functions. Figure 1 reproduces WR's illustration of a (‘reduced form’ of the) production function for one outcome and one service, for the contribution of home care to ‘producing’ extra time supported in the community, from the ECCEP study which estimated production relations for 19 outcomes of value in their own right (Davies, Fernandez and Nomer, 2000). The figure illustrates the shape of the mathematical form most commonly describing the effects of variations in service levels on outcomes.² The effects of increments of input are smaller as input levels increase.³ The figure also illustrates that the effects of the services depend greatly on circumstances of users and carers, a result consonant with the predictability of outcomes from risk factors. The patterns confirm the importance of using production function techniques, incorporating equation forms which allow theoretically likely complex forms to reveal themselves.⁴ Estimates for social care do indeed have several of these features, illustrating why attempts to estimate the relations between service levels and mixes (and costs) and outcomes often yield absurd results.⁵

Outcome dimensions. WR used OPUS as a tool for outcome measurement and the value weighting of outcomes (Netten *et al.*, 2005). The outcome domains used in the WR analysis were: personal care and comfort; social participation and involvement; control over daily life; meals and nutrition; safety; accommodation; employment and occupation; role support (as carer or parent), and being in their own home.⁶

The selection of OPUS was politically shrewd, because OPUS was originally influenced by the assumptive worlds of those faced with balancing needs and the allocation of public spending of a period which was more pessimistic

about the balance between needs and resources than that of earlier classifications of outcome and their indicators.⁷ What is key for avoiding biased estimates and a balanced description is that it should include all important outcomes. Some to which the attention of some in the policy world wavered as spending grew more slowly than demands was user morale, the probability and severity of the sub-clinical and clinical depression which between them are so prevalent in the population at risk (Davenand *et al.*, 1996; Livingston *et al.*, 1996, Saunders *et al.*, 1993, and their carers (Buck *et al.*, 2002). Improvements in them are outcomes valued in their own right.⁸ Some early British argument was that the production of morale effects for many (as means, ends or by-products) were hallmarks of high quality and efficient systems, with enhanced user influence on the prioritisation of ends and choice of means being important in the causal process (Davies and Challis, 1986; Davies and Missiakoulis, 1988). More recent research differentiates good from bad commissioning and service quality by referring to related causal processes (Patmore, 2006; Sinclair *et al.*, 2000). More directly, modelling research on substantial data from a variety of areas suggest that during the nineties, the reforms caused services to produce substantial outcomes for morale and depression-associated variables.⁹

The same (or co-produced and highly correlated) effects are once again highly valued in policy statements. Despite fiscal stringency¹⁰ whose effects at the local level has been well documented by user, professional and local government interest groups and others (Health and Care News, 2007; CSCI, 2006), the green paper of 2005 (DH, 2005) courageously made a political commitment to goals related to morale, wellbeing and associated concepts: courageously – because it thereby made the widening gap between aspirations and achievements the focus of public attention – including the consequences of the targeting consequences of stringency that the Commission for Social Care Inspection [CSCI] has promised to ‘focus on in its report for 2006–07’ (Carson, 2006; CSCI, 2006c, LGA, 2006, 2007). So these goals now have a higher policy priority during the mid00s than such goals had among hard-pressed managers at the end of the previous decade, giving them an importance closer to that in some other leading countries from the mid 1980s.¹¹

In this respect, the new policy statements of the mid-00s are closer to the articulation of the social care paradigm in 1989 and 1990 in *Caring for People*, the associated guidance papers (especially those for field managers and workers; DH, 1990a, b), and the literature which first included morale, wellbeing, and life satisfaction as outcome criteria.¹³ The green paper *Independence Wellbeing and Choice* (DH, 2005) made much of the wellbeing agenda and specified a key role for Directors of Adult Social Care. The outcome goals from the Green Paper were reflected in criteria of quality developed by the CSCI (2006). One of the outcome domains is ‘Quality of Life’, another ‘Improved Health and Emotional Wellbeing’. The latter was elaborated with, *inter alia*, the statement that that ‘emotional and

mental health needs are responded to and appropriately addressed’ (CSCI 2006, pp.7–10).

The WR methodology is being rapidly developed. Though OPUS does not have the equivalent of a morale dimension *per se*, its developers are ‘committed to seeking to cover all the consequences of the impairment disability or handicap due to all causes (physical, cognitive impairment, other mental health problem) for the performance of key personal care and ‘instrumental acts of daily living in the circumstances of users and carers.’ Therefore work is in progress to develop a morale dimension, and as far as statistically possible to map existing OPUS dimensions onto all CSCI domains. WR applied both the narrower ‘core business’ concept and a broader concept attempting to cover wellbeing. But by presenting estimates for stringently defined core business alone as well as the broader concept, WR could not be accused of Utopian optimism about the ease with which allocations of public spending to social care could be raised.

Valuation of outcome dimensions. The relative value of increments of each output must be weighted to derive the total value of outcomes required for broad allocation judgements. The valuations used by WR were derived for a sample of older citizens, only some of whom were users. A sample of older people was selected partly because it was assumed that they would be aware of the issues. Results showed that preferences were associated with user and carer circumstances; and in particular, with whether they had actually had experience of the services.

Selecting the threshold to equalise costs of values across policy votes. It would strengthen the basis for allocations across policy areas competing for a share of the same budget to be able to compare the benefit/cost ratios for each area’s marginal expenditures. The invention of the ADLAY does this. The QALY, an analogous generic indicator for health outcomes is widely applied. Most famously, it is used by NICE, the National Institute for Clinical Excellence, in the evaluation of new pharmaceuticals and treatments. WR set the threshold maximum cost per ADLAY at £20 thousand. The Chair of NICE recently commented that ‘anything around about £20,000 per QALY is likely to be regarded as cost-effective. Beyond about £30,000 per QALY, we wouldn’t necessarily say ‘no’, but you’ve got to have

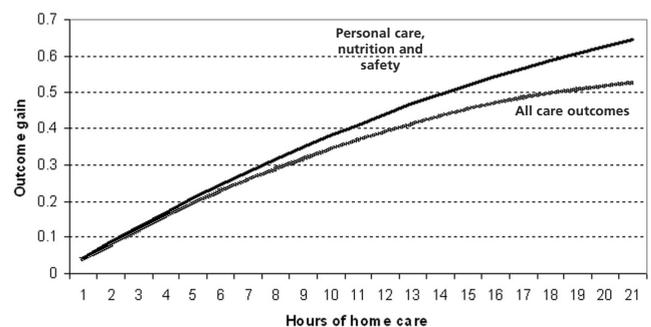


Figure 2: Outcome gains from home care services

better . . . reasons for saying “yes” (Rawlins, 2007). He related these thresholds to estimates of approximately £32,000 for the value of a lost life because of a road accident averted by public spending. He described how there were exceptional circumstances in which NICE had approved pharmaceuticals whose costs per QALY were much greater: for instance, Riluzol, which ‘avoids the need for tracheotomy for about six months for victims of Motor Neurone Disease... [because] people with tracheotomy say it’s almost worse than death’, and for which NICE’s estimate of the costs per QALY was approximately £38,000.¹³

WR was shrewd to base the threshold on an ADLAY concept and to choose £20,000 per ADLAY as the threshold. The subsidy to social care being paid from the vote of the DH, NHS heads are adult social care’s closest competitors in the budgeting process. The ADLAY is designed to be a close analogue of the QALY, and the QALY is the accepted generic indicator of the value of health care outcomes. Given that NICE would almost take for granted that additional public expenditures yielding a QALY for £20,000 would be cost-effective, it would seem difficult for government to deny special funding approval for forms of social care expenditure with a cost per ADLAY considerably exceeding £20,000 in circumstances in which it would relieve situations judged to be ‘almost worse than death’. What about some manifestations and stages of dementia about which *The Guardian* (2007) wrote ‘for those directly afflicted, the unremitting erosion of independence can resemble torture’?¹⁴

Of course, for this argument to hold, it has to be broadly accepted that an ADLAY is roughly equivalent in value to a QALY, and that estimates of costs per ADLAY and per QALY are valid and reliable enough to provide a useful if crude guide. Results of the research mapping QALY and other generic indicators for health on ADLAY will provide evidence. A more formidable obstacle to the comparison is that generic outcome indicators have not been applied systematically to health policy areas. Kind and Williams (2004, 1) wrote: ‘It is remarkable that we know so little about the health improvements brought about by the enormous array of activities provided by the NHS, but in recent years some piecemeal attempts have been made to rectify the situation’. They recommend the systematic application of EQ-5D to all areas of health services; a major step towards comprehensive and systematic QALY analysis. One of its five dimensions is Anxiety and Depression, possibly close enough to be mapped onto a social care morale and wellbeing dimension.

1.2 Comparing funding options

Selection of funding options. WR designed funding model types, and undertook a general evaluation of model exemplars of eight of the types chosen to provide variety.¹⁵ The types were ‘free personal care’, ‘social insurance’, ‘means-tested public funding’, ‘the partnership model’, ‘limited liability’ (a version of the American Connecticut Partnership

and its descendants, including the Conservative ‘partnership’ model: DHSS (1997), Care Savings Account, and private insurance.

Space does not permit a description of the first stage of the evaluation at which model types were systematically scored by the general criteria developed in the literature. The first stage dismissed some runners which had been thought potential winners a decade ago, indeed later (Brodsky *et al.*, 2003; Gibson *et al.*, 2003; OECD, 2005); and are still promoted in some countries. Some of the types offering more universal cover like German long term care (social) insurance, and by implication treated by some as if important elements (if not the entire model) could well be applied in England, did not score highly when all the criteria were taken into account. That the UK’s social care paradigm uses a much wider and more subtle range of criteria for the evaluation of policy success in long-term care than those for which evidence is available for countries which have adopted the social insurance route is relevant because policy-makers tend to look for models elsewhere which work better by their paradigm’s criteria (Rose, 1991). Perhaps also some recent history of the schemes contributed to their lower ratings: crude reliance on risk factors not welfare shortfalls in the implicit definition of eligibility and allocations; inefficiencies in the production of welfare outcomes; inflexibilities in response to worsening balances of demands and income flows in two of the best known long-term care insurance systems; the replacement of the well established Dutch arrangements by some more like those in Sweden and England.¹⁶

WR concluded that two exemplars of the eight families best met the general criteria. These were ‘free personal care’ of which a variant had been implemented in Scotland, and ‘the partnership model’, in which the state would finance ‘a basic, minimum level of care’, and would match private payments above that up to a maximum package cost ‘set in line with available resources’ (WR 2006, p.231). The partnership model satisfied the WR effectiveness-equity-efficiency criteria somewhat better: ‘a more sophisticated and less costly mechanism’ WR commented. They were compared with a re-parameterised version of the existing means-testing model. Although a means-testing model with substantially different values set for all its parameters could yield greatly improved performance compared with the present, its basic features interferes with equalizing the incremental benefit/cost ratios of what users would actually consume, a prerequisite for optimal achievement of the goal implicit in the policy goals. Some distortions would be basically similar to those of the present system, re-parameterisation reducing but not removing them. There is no escaping the fundamental truth. Poor Law mechanisms were designed for another age. Perhaps only argument based on the slow adaptation of cultures behaviours and supply systems or a value shift more thoroughly subordinating social policy to the requirements of an age of ferocious global competition could make them acceptable; and in the former case, only temporarily. We return to the theme below.

2. Discussion

2.1. Issue framing and evidence analysis

WR has shifted the discourse enough to make some comfortable intellectual habits more difficult to square with the public interest. That is illustrated in three areas where by the use of new (and more technically demanding) methodologies, WR has shifted the framework for discourse.

Advancing knowledge about how resource inputs affect valued outcomes. This is the most formidable challenge – to understand how and in what way through time events and circumstances affect the impact of resource: user and carer circumstances, values and cultures underlying expectations, behaviour and preferences; supply-side cultures, policies, processes and practice, endowments, circumstances affecting the pattern of productivities of service. So easy to write, so difficult for the research world to achieve, it requires the use of a wide enough range of social science in designing collections and their analysis, recognition of the connection between what they are finding and the broad framework of policy discourse. For what proportion of the time of what proportion of our working lives are we researchers happily hacking our way through the wood without understanding the importance of those twigs and leaves for understanding a world of great and subtle variations in what counts and what affects its individuals?

Valuing outcomes. The history has been too short for there to have been time to explore the forms of interrelatedness of preferences and their dependence on circumstances and characteristics: the equivalent in utility analysis of data collection designs and the equation forms which allow complicated joint supply, non-linearities and non-monotonicities, substitution and complementarity effects (many already themes of utility theory) to show themselves – the interdependence of utilities of persons within a network, the dependence of the marginal valuation for one outcome on the level of another achieved, circumstances in which mechanisms which distort perceptions and expressions of preference work in what way. Already there is evidence that preferences are associated with users', carers' and other citizens' circumstances; and in particular, and predictably, whether they have actually experienced of services.¹⁷ There are other issues which are tricky in other ways also.^{18 19} Whose valuations should be sought? The Pareto principle on which much normative economics is based might suggest the most relevant preferences would be the user and carer populations and those most at risk, though sensitivity of valuations to the degree of unmet seem often to be reduced by psychological adaptation to their position. However the general citizen would be expected to foot the subsidy bill. Should their preferences should be altogether discounted if they do not agree to it? The issue has long been recognized. Alan Williams wrote in 1974 that at 'the heart of the matter ... is a societal judgment as to who shall play what role according to what rules' (p.71), clearly still one factor underlying differences in arguments about policy and funding models today.

Projecting costs, outcome values and their incidence.

Like all reports since the Royal Commission on Long-Term Care, WR uses more elaborate simulation modelling methodologies to project consequences over its time horizon to 2026. Indeed, continuity in the discourse has been helped by them all using the same model and its descendants and elaborations. Again, the challenge is the same: to cross subject and topic boundaries, to recognise the development of the knowledge base for projecting the consequences of alternative funding mechanism as something to which an apparently unrelated analysis of data base can contribute. Because some societies have potential for suggesting trends in structures and cultures in others and anticipation of scenario evolution is the key, add the information for the imaginative basis for the models from other societies. Again, there are the same obstacles: those who have investigated the right areas have not thought it useful to ask the questions the answers to which would best develop the WR-type framework. Perhaps it will help that more states will come to develop WR-type argument. When they do so, we can expect a greater variety in assumptions and so in the architecture of projection models: a great stimulus to intellectual progress.

The mushroom growth of climate change theory illustrates why. Projection of demand and supply of long-term care has some characteristics in common with the projection of climate change and its consequences – a relatively new area with a rapid increase in understanding, great sensitivity in estimates to assumptions about trends²⁰, the potential for differences in the fundamental architecture of the causal models implicit in the projections models, deep uncertainty and so the need to attempt to attach probabilities to scenarios, differences in perspectives and interest in what should be a transparent and pluralist discourse about alternative policies and so a preference for different position on the probability distributions of greatest interest to the participant.

The Stern Report suggests how the subject might develop. Projections are summarised in Figure 3. As in long-term care projections – for instance the plotting of the funnel of doubt in Wittenberg *et al.* (1998) and Hancock, Wittenberg *et al.* (2006, Figure 26) - the differences between low and high base case projections for each type of model are much greater than the differences in projections between models. (The large number of independent models is not of relevance for long-term care: it would be fanciful to imagine more than one or a few for each country.) Such figures help to focus discussion. Finance ministries would no doubt have a concern for the costs to public funds and press for a solution with a probability of 90 per cent that it would not exceed a certain proportion of the GDP, while consumer interest groups would be interested *inter alia* in the threshold benefit: cost ratio, and would press for parameterisation of a model yielding not less than a 90 per cent probability that those whose interests they promote would actually receive benefits of at least a particular threshold level.

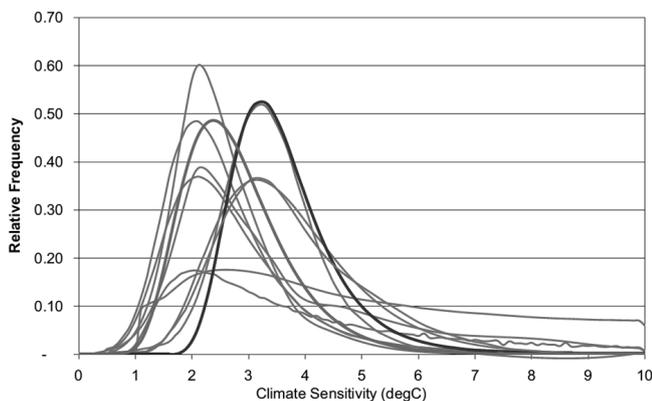


Figure 3: Probability distributions of an outcome given probability-weighted scenario variations in each of a variety of projection models; source: Meinshausen (2006) in Stern (2007)²¹

To conclude: great though the contributions of the WR analysis are, it and others on which it draws rely too much on early cost/time-limited evidence analysed. There are implications

- Social science sometimes needs ‘bigger’ (if certainly anything but ‘big’) research by natural science standards. Bigger research is risky and with long collection periods and vast collection effort, of apparently low productivity. Too often, it has paid better to keep clear of it save as hitch-hiker. But it can produce uniquely important evidence.
- There should be more research collaborations across disciplines and groups *as long as* much of the work is integrated rather than in parallel. Disciplinary associations can provide the frameworks for working groups seeking to establish such work. The flexibility demanded in such working should be better reflected in education and training of researchers and the courses and professional settings from which they are recruited. Many would agree that the principles are mainly honoured in the breach, suggesting that the challenges to actual performance are not trivial.
- Research funders can helpfully remember that one quality that makes applied research reliable enough to use is its theoretical strength, barely visible though that may be to the research user.
- The pressure group, manager or politician can helpfully remind themselves that the useful generalities are only likely to have the validity their plausibility suggests when based on hard detailed work often requiring technical skill and repeated and costly collection and analysis of evidence. Academe must assert the importance of time horizons and the time and resources to think around issues and others must not be so foolish as to denigrate it for doing so.

2.2. WR policy alternatives

WR logic depended on analysis of the properties of types at least as much as on the more detailed quantitative analy-

sis of exemplars. Would each possible member of a type share the properties of evaluative significance to a greater degree with other members of the type than with almost any member of other types? Could it be that the properties for types running in tandem – or hybrids – could be greatly different? Would the partnership type be the best of those so far considered whatever economic weather the changing climate throws at us? Since the immediate future will be a difficult time to commit to a radical change – a low maximum achievable allocation for public expenditure at least in the near future; as always, a slower rate of change in the capacity to cope of the kind of vulnerable people who would be losers by the changes than optimists trying to pursue new visions in the policy world assume; and likewise a slower and more geographically unequal pace of adaptability of service commissioning and supply systems – can we expect a better time later? If so, should we now choose a second best solution, but one which will ease the adoption of the partnership model later?

Within- and between-type variations in model properties. No doubt, the Treasury-led committee to develop alternatives are examining more variants within families, though there is not yet a comparison and synthesis of the pattern of outcomes from even from the published work. There are questions galore to ask of the quantitative analysis of the patterns. What WR-found patterns can be most relied upon? There might be more sensitivity at the second than at the first stage in the WR analyses, even of costs and outcomes and their incidence. But it is difficult to imagine that some key differences between the serious contenders would be removed if the comparison was with some new variant of a rival; other than a variant which is so exotic as to resemble nothing seen in real life if only because some of its special features would conflict too much with the national values for that type to be chosen.²²

Definitely the partnership model come what may? The partnership model could work well for balance of ideas about ends and means within the range of mainstream British discourse, given time to adjust and some minimum of public spending. A high enough level for the unmatched element of the state contribution would virtually avoid losers. So what the minimum would be would depend on the design of the implementation plan, about which no clues are available. What factors would affect the minimum? Could the policy system deliver that minimum?

The capacity to cope of vulnerable people likely to lose by model change is a factor suggesting that there exists a minimum. Changes in expectations and capacities of successive cohorts to manage change are easy to over-estimate. Circumstances making it more difficult to cope are well established: many least affected by transformed life chances and roles as proactive consumers; many with a lifetime trapped by the absence of opportunities and skills, and have family members who are similarly constrained; most at high risk too old to be baby-boomers;²³ many hit by health accidents which at least for a considerable period greatly

limits their capacities to self-manage, often causing a gestalt switch in assumption and morale to an expectation of decline and death; many with debilitating clinical and sub-clinical depression and cognitive impairment (Pavlou and Lachs, 2006). DH initiatives and CSCI policies developing more detailed policy attempting to combine choice and empowerment with avoiding excessive danger and risk reflect dilemmas more clearly than the policy papers stating policy argument and proposals at their most general level (CSCI, 2006a, 2006b; DH, 2006²⁴).²⁵

A slow and geographically uneven rate of adaptation and effectiveness/efficiency improvement of local commissioning and care systems would be a second factor suggesting a minimum. The performance of the social care system in England and Wales was in important respects transformed during the decade between the late eighties and nineties. Can the system respond as greatly to the requirements of the policies in the green and white papers? During the nineties there was in one respect a happy coincidence of wants. Prioritising user independence in the sense of enabling more users to be supported longer in their own homes was something which managers at all levels and field professionals could and did accept as the highest priority (Davies and Challis, 2000) because it fitted long-term aspirations and values of the social care paradigm, and was mainly (not wholly) strengthened by incentives from the financing arrangements after 1993.²⁶

National priorities then changed. Coordination with health services at various levels in Leutz's (1999) typology became the top priority. Rewards and sharp sanctions for adult social care were made more dependent on performance indicators of the social care contribution to achieving health system priorities. Health care received large funding increases while social care authorities continued to suffer severe fiscal stress, though it was widely believed that social care (home and community services as well as care homes) was substantially reducing the demand for acute beds.²⁷ Unsurprisingly, the gap between some national policy goals and the reality has seemed increasingly widen as a result (McNally *et al.*, 2003).²⁸ For instance, the proportion of areas in which only the two highest Fair Access to Care Services (FACS) (DH, 2001) priority classification of cases actually received services was increasing well before the most recent cuts (CSCI, 2006; Jones, 2006).

The green paper (DH, 2005) reasserted and reworked retainable values and policy principles of the social care paradigm while redefining it as part of a broader health and well being paradigm. But it redefined the issues in a way which made tackling them more complex at the same time as proclaiming a context of changing expectations and – most directly tackled by WR – a worsening resource balance. Re-engineering and substitution were major themes, but its argument was that to cope with the changed balance of demands and public budgets, many of the substitutions would replace resources financed from the adult social care budgets of 'councils with responsibilities for social services' [CSSRs]

by others; for instance by substituting universal services not financed from the social care budget for mainstream social care services, leveraging effort from the Voluntary and Community Sector, and other sources of care in the community. Directors of Adult Services were to play a leading role in promoting 'local wellbeing agenda': a task whose precise aims and form would vary greatly from place to place and from time to time, including the quantitative precision of links between means and ends. There were exhortations to develop new forms of governance to match the need to negotiate ends and means in the context of multiple interests and uncertainty. That is the Green Paper stressed the development of interventions whose contexts would necessarily make their creation and management generate more 'wicked' issues than the mainstream services (Rittel and Webber, 1973) more than, for instance, the white paper of 1998, and to recommend governance arrangements accordingly.²⁹ The complexity and uncertainty of the contexts and processes in which they would be established and the novel elements in their inputs, logics, cultures and prioritisation of effects, would create a low degree of technological determinacy at least until relationships and understandings had been fully established and trust in their continuation created. Experience has shown that when these preconditions for achieving a practically useful degree of technological determinacy are established at all, it usually takes much longer than optimistic managers expect and implicitly promise.

Paradoxically, the Green Paper argued that the system should also continue to cultivate the virtuous consequences of using tools of which some assume a practically useful degree of technological determinacy (Davies *et al.*, 2000), including what white papers called consistency (mentioned in 1989 and a main theme in 1998). The reforms of the period during which technological determinacy was most emphasised certainly delivered the then prioritised goals much more effectively by the later nineties. The proportions of losses of some prioritised dimensions of welfare predicted from risk factors were by then being offset by up to a remarkable 25 per cent on average among users and principal carers, and there were effects for a wide range of the dimensions of evaluative importance in the social care paradigm.

The greater consistency in the relations between means and ends by the late nineties sharpens the dilemmas of simultaneously pressing the exploitation of the benefits of technological determinacy and increased reliance on new 'wicked' ways of producing welfare for which the uncertainty of outcomes is great. The opportunity costs of relying more on wicked ways have been increased by the greater clarity and consensus about the prioritisation of goals, high risk offset proportions, clearer patterns of service substitution and complementarity, and the dependence of these on user and carer circumstances. Greater losses of other valued benefits than before would be caused by changing the prioritisation of goals, particularly by giving the highest priority to outcomes for which the relations between means

and the end are unclear to the key field and lower management actors.³⁰ A more determinate technology and greater consistency in its application imply less reducible inefficiency, and so larger opportunity costs if priorities are changed or efficiency savings are imposed. That would be still more powerfully the case if demand were diverted from health to social care as the NHS is put under increasing pressure during the coming CSR period, if more social care resources were absorbed by NHS-led schemes with different targeting priorities and objectives, and if the resource balance in social care worsened.

The dangers are obvious. Putting great effort and resources into developing those new ways of tapping resources to produce welfare which create the uncertainties and complexities of policy areas which are wicked may distract councils from achieving highly valued outcomes which have been increasingly effectively delivered with policies based largely on assuming a practically useful degree of technological determinacy. It may be more difficult for CSCI's successor to monitor commissioners and providers to the best effect. Perhaps it would be safer to err towards minimising the reliance on wicked ways of producing welfare than *vice versa*.

Fortunately, most of the most important new ways need not be wicked indefinitely, though conversion will require time, effort and resources. The analyses which were the basis of the concept of the 'wicked problem' distinguished between contexts in which the wicked characteristics could be temporary from those in which wickedness was irredeemably permanent (Rittel and Webber, 1973; Wood, 1944).³¹ But conversion from wickedness will require the skilful, gradual, committed, continuing and well-focused management of change, supported by sufficient, well-grounded and continuing investment in human, organisational and physical capital and investment to create stability and trust, preconditions for cooperation and collaboration between people and organisations.³² Perhaps then in the longer run the forms of intervention which are by nature irredeemably wicked will consume too low a proportion of the resources for their opportunity costs massively to reduce welfare. It is in that longer run that the demands for public financing will be greatest.

Could it be that making this optimistic scenario a reality could be helped by processes parallel to those observed in the urban regeneration programme (Whitehead, 2007)? The WR findings are key for putting the issues into perspective. The Green Paper developed the substitution and innovation argument substantially because without such substitutions and innovation, likely public funding would be insufficient to meet the demands with the then policies. A systematic shift in resources substantially reducing the vast underfunding shown by the WR in time to contribute when the innovations are at their most technologically indeterminate could transform the degree to which ambitions could be achieved in the long run.

What then is the lowest WR threshold which would keep

down the collateral damage of the most vulnerable losers to an acceptable degree? WR estimates suggest under-spending on social care compared with the NHS by approximately one fifth if the threshold is set in terms of core personal care business alone, two fifths including well-being. And budgeting makes no allowance for transitional costs. Only modelling of costs and the value of outcomes with allowance for transitional costs given realistic assumptions about the kinds of difficulty discussed above could give a quantitative feel for the answer. Presumably this is a focus of the activity of the Treasury-led team.

How likely is it that the government will deliver the minimum in the medium term? The room for manoeuvre in the triennium of the CSR08 (Comprehensive Spending Review) is presumably strictly limited, whatever the marginal rates of return on different forms of spending. What effort should government make in the longer run? The focus should be on the health vote and on the transfer of Attendance and Disability Living allowances from the social security budget.

The latter is easier to discuss partly for the bad reason that we have less knowledge on which to base estimates of the opportunity costs in terms of lost welfare of reducing these benefits. Would it be fair to apply to those British benefits the same scepticism about their impacts on our prioritised subtle but well-defined British social care outcomes as we apply to the German benefit in cash because government until recently has not demanded to know? The evidence is old and slight. Davies, Fernandez and Saunders (1998) did not find that Attendance Allowance receipt reduced the probability of admission to institutions for long-term care during the eighties. They estimated that the French ACTP was more successful. WR reasonably bases its suggestions on what is known. In several OECD countries disability and related policy areas are in question. And some of these are not traditionally tied in level and eligibility to the other elements in the wider social security system. It is difficult to deny the WR argument that substantial redistribution to the social care budget would add to the sum of human welfare, as indeed was suggested thirty years ago (Davies and Challis, 1986). But there should surely be transitional compensation for the losers, and the many who will be unable to adjust without great loss of welfare because of the nature of their disabilities – many more than the most obvious examples like socially isolated victims of autism with personality difficulties and substantial learning difficulties, for instance. Those transitional arrangements should continue over an indefinite period in the absence of a more efficient and welfare-improving alternative.

WR creates an extremely strong case about the direction, and order of magnitude for the redistribution from health votes that would maximise welfare. Highly respected experts suspect there to be little evidence that there is anything like the same marginal rate of return being achieved in many areas of the NHS. However, NICE recommendations have so far affected only a very small

percentage of the total NHS spend. Appleby (2007, p.50) argues that such evaluation should be carried out 'at another level' than NICE precisely in order to contribute to setting limits on NHS budgets, a theme parallel with that of the paper by Kind and Williams (2004). Appleby suggests that 'from the limited data that does exist, it is hard to demonstrate that the NHS is on the steepest part of the curve where the health returns from additional spending are high. In no area among those reviewed are there major identifiable health gains that can be attributed to extra health spending alone. This is even true of the diseases such as cancer and coronary heart disease (CHD) on which the government has focused extra resources . . . Gains are being achieved in such areas as convenience and process benefits (for example, the changes that have led to shorter waiting times within hospital accident and emergency departments). Some of these may lead to better health outcomes, but the main argument used by the government for setting targets such as these derives from the perception that 'expectations' of service performance are rising and that people want choice of when and where to be treated and easier access to whatever services they choose . . . While this is intuitively convincing, in fact there is very little hard evidence about the *value* placed on benefits of these kinds, nor indeed of the costs of providing these benefits' (Appleby, 2007, p.53). That is, the gains are more comparable with the wellbeing and morale gains from social care quality of life, but unlike the gains from additional social care, at the margin they are probably are likely to be at much higher cost than the NICE threshold.

So in a rational and just world, the minimum would be provided, even if not immediately. But it is one thing to speak truth to power, another for power so much as to acknowledge it, and yet another for government to act to remedy the inequity and inefficiency. The low expected increase in the adult social care budget for the CSR08 triennium has been repeatedly proclaimed. With a low CSR settlement not just for this but for subsequent triennia, the partnership model would have to be designed to incorporate an extremely high incremental benefit/cost ratio, a very low proportions of that set as the limit for the state entitlement, and/or a low state match to consumer payments. Given the threshold, the lower the state entitlement, and the lower the State match, the bigger the gap left to be covered by co-payments.

As a contingency plan, should we envisage garnering whatever additional budget is available for less costly attempts to soften the edges of the means-tested system during the medium term? There is a historical precedent. After all, except for shifting skilled nursing care to the NHS, making incremental changes to the system was how the government acted in response to the Royal Commission report of 1999 (DH, 2000). The literature has already explored various combinations of changing upper and lower limits of capital disregards and of income for either or both

residential or home care, reducing the tariff rate, or abolishing the assets element (JRF, 2006; Hirsch, 2005; Hancock, Wittenberg *et al.*, 2006; Royal Commission, 1999, pp.58–62).

How long would the medium run last? Certainly longer than one or two CSR triennia. Space does not allow an analysis of factors influencing its duration. Since the key constraint is surely what level of public spending will be forthcoming, the key precondition for a successful bid will be what growth in per capita GDP will follow from our performance in the global economy. For what it is worth, not until between 2035 and 2040 are the total and old age dependency ratios projected to stabilise.³³ Hancock, Wittenberg *et al.* (2006, Table 6) projections until 2051 of the demands and supply of long-term care of older people (with current policies) suggest diminishing rates of growth of public spending decade on decade after 2012, with a decline in the percentage increase by 20 per cent during the decade beginning in 2041. The pattern may not be very different for several model types. Radical change would still be an expensive undertaking, slightly less to the degree that the means-testing model were upgraded in the interim. Perhaps the conclusion is that there will not be an ideal period for a change to a model shifting responsibilities to the state unless the long run is defined so as to satisfy Keynes' observation that it is the period in which we are all dead.³⁴

The focus of WR was selecting main funding mechanisms. Whatever is chosen will create opportunities for 'niche' models to make a contribution when policy is sufficiently in place to create a more stable policy environment. It will then be important for the State to identify and publicise market failures, by that means helping to spot niches for which supplementary models would be useful. Government should publish its appraisal of proposals like that reported in WR by Kent County Council to continue work on the BRITSMO model (Davies and Challis, 1986) for which support in experimental implementation was first recommended in the Griffiths Report in 1987 (Griffiths, 1987; Wanless *et al.*, 2006, pp. 246–250).

3. Conclusions

WR has provided England with a clear direction for policy development based on evidence about what could most equitably and efficiently produce the benefits sought by means of long-term care policy. In the new real economy of care produced in the nineties, attempts to cope with additional demand and to increase quality will require higher spending because much of the system's inefficiency has been squeezed out by years of lower rates of increase in social care spending in relation to demands and relative price effects. Without the higher spending, even arguably efficiency-improving innovations would be financed largely by robbing Peter to pay Paul.

WR results confirm large under-funding of this Cinderella

of the DH family. The WR estimates carry all the more conviction because they applied conservative assumptions: the low ceiling spend per ADLAY compared with actual NICE practice as described by its chair, the calculation of under-funding by approximately one fifth for a narrow 'core business' concept of outcomes, much larger assuming a concept including wellbeing effects. This underfunding has been long and often argued from other evidence. The underfunding worsened during most of the reform period. It distorted the implementation of key policies, particularly in care management and service commissioning and development, seriously weakening the outcome-affecting processes on whose outcome effects the logic of the reforms was argued. The continuation of gross underfunding would similarly distort and weaken the outcome-producing process and practice of the new models promoted in current policy – particularly for the outcomes prioritised throughout the period, because the earlier models were designed exclusively for their production, the new models being little different in their values and arrangements for producing those outcomes but adding new and often conflicting objectives.

Several things would help the policy process to correct the under-funding.

One is to continue and involve more people and groups in policy debate making use of the Wanless framework and the type of evidence it uses. It requires that more of the interested parties should tool themselves to participate in its deepening and development. That would help to create a coincidence between spending allocations which would best improve human welfare and those which would most gain electoral support. It would substantially reduce the

undue influence of established but partially erroneous assumptions, unbalanced formulations of issues and arguments, and so in effect the interests of some actors and groups.

A second is to ensure the continuing influence of the social care paradigm with field reorganisations and the amalgamation of the agencies for quality assurance and improvement for health and social care. The national quality improvement body has a degree of constitutional independence of the day to day pressures on the politicians and the executive. The danger most discussed in the international literature is 'capture': excessively frequent surrender to external interests in the effort to contribute to consensus.³⁵ Reorganisation at the field level has tended to place those most influenced by the social care paradigm into the organisational authority structures of paradigms dominated by other ends and means. When circumstances are difficult, outright confrontation with the strong may not seem to them to be the most effective way to make what limited progress may be possible.

A third is to ensure that the policy of devolution to lower level governments and independent agencies, and extending citizen empowerment in return for risk and responsibility, is accompanied by increasingly extensive and rigorous evaluation. WR illustrates how powerful can be the evidence produced from it. But again there is a danger of capture when such a high proportion of the money for big and continuing research collections and analysis on long-term care is provided by such few sources. If so, can we envisage creating institutional arrangements which would reduce it? The question has been put many times before and will no doubt be put many times in the future.

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Notes

¹ It reflects the development of the interpretation of one use of the concept 'need' as equitable and efficient allocation. Feldstein (1963) wrote that the many advocated 'meeting needs' when 'it would make for clearer analysis if they talked about "optimising the use of resources"'. During the seventies, York economists led and others followed in developing the cost-benefit concept of need (Culyer, Lavers, and Williams, 1971), a step in the development of what Culyer (2006) identifies as a theme in the development of 'extra-welfarist' theory better fitted to inform policy-makers than the more reductionist approaches in theoretical welfare economics (Culyer, 2006). A stream of papers followed using the cost-benefit concept to analyse policy argument, the rationale of methodologies for developing social indicators, and structures and processes by which resources were allocated using concepts like the policy paradigm. For instance, Williams (1974, p.65) used it to dismiss its then common use as what he called 'need as quasi-supply concept' where 'need' was defined as existing over the whole range of marginal productivities between the current level of welfare and the point at which they ceased add to the value of outputs because, first, that led to an overstatement of under-funding – and, secondly, not there argued, for different outcomes, the ratio of areas under the productivity curves in the range between the actual level and the optimal need threshold on the one hand to the area in the range from the optimal threshold to the top of the curve on the other, is likely to differ greatly between commodities, thus biasing estimation if the quasi-supply concept were the basis of indicators in models; Davies (1974) applied the cost-benefit need concept in conditions

of technical determinacy to the design of indicators in the context of the theory of standards-setting and to the measurement of need as welfare shortfall defined in relation to the cost-benefit need threshold, the range which Netten *et al.* (2005) define as measuring a concept akin to Sen's capability; Davies (1975a; 1977a) applied it to the discussion of needs indicators implicit in policy paradigms as one element in the theory of variations in local policy outputs; Davies (1976a, b) to the rationale for a new design for need-compensating central government grants to local authorities; Davies (1977b) to the discussion of its relevance to the empirical measurement and valuation of outcomes and production function studies using techniques applied in transport studies and studies using a human capital theory framework; and Davies (1985) the different weighting of dimensions for aggregating data into an indicator of supply-side non-resource inputs (weightings to leave outputs unchanged) and into an indicator of outcomes (valuation weights for the range between the observed and threshold cost-benefit need level).

² The analysis depends on a classification of 'services' assumed to have the same balance of content across local systems save to the degree that differences are controlled for by other variables in the estimation models. For practical purposes of interpretation and application, the assumption is that differences in content between systems in each 'service' are small compared with differences between services. Of course, as such studies have long emphasised and as national policy has increasingly pressed, it is important to engineer services around local system contexts. Models for areas whose services have different contents would of course have different classifications of services, and yield at least

slightly different patterns of substitution, complementarity, economies of scale, etc.; that is models must be interpreted in the context of their purpose and geographical scope.

³ Situations with linear relationships were often characterised by a scarcity of the service in question: less of the service with constrained supply was consumed than would have been desired or would have been efficient.

⁴ See Davies, Fernandez, and Nomer (2000) for such equation forms. To estimate the substitution and complementarity effects, it is necessary for the outcome indicators to be general to all inputs. If the raw information ties the outcome to each individual indicator separately – frequently done in all countries, the sum of the effects will exceed the true overall effect. Also the outcome variables for each domain must include questions worded to make it clear to users, carers and other respondents that what is being asked about are the overall effects of services, as well as questions about achieving service goals and process quality narrowly defined.

⁵ Particularly

– The ‘productivities’ of services are highly contingent on risk factors and other circumstances. We discuss the effects of low morale and its correlates below. Low morale is associated with greater disability, so that failure to allow adequately for it can yield what are oxymoronic negative estimates of marginal productivities or costs in conditions of tight service rationing.

– Most services affect several outcome dimensions but to different degrees, with the impacts depending on the mix of inputs and outcomes and supply side factors. Therefore it is key for efficiency and effectiveness to mix services in a way which best exploits the relationship between service productivities and service prices (or marginal costs) given the other factors.

– Levels of one outcome affect the ‘marginal productivities’ of services in the production of other outcomes. For instance, morale and depression at sub-clinical as well as clinical levels affect the costs of improving other care outcomes by whomsoever rated. In part, this is because users and carers themselves necessarily ‘co-produce’ some outcomes and can contribute to the co-production of others, and do so less if paralysed by low morale or clinical depression. Also some outcomes are user or carer perceptions, and the effects of low morale should be included.

⁶ The WR production function for it, estimated from ECCEP data, predicted the service inputs required to bring the perceived burden of caring of principal informal caregivers down to a threshold level established by mapping onto the ECCEP’s main indicator of carer burden a threshold from another ECCEP indicator for which an appropriate threshold had been established in the American literature. The ECCEP project included triadic design elements for the collection of data for users, principal informal caregivers and care managers, thus permitting analysis of the interdependence of utility functions and of differences in perception of situations and outcomes.

⁷ OPUS was the product of government-sponsored research. It worked to, and was helped by a reference group who usefully reflected the dilemmas of policy and practice affecting resource allocation at the time. Central government officials and local managers were powerfully represented on the reference group. Their experience and views were powerfully reflected in the domain structure and the wording of instruments.

⁸ Morale change (and associated indicators) were used as an outcome in some streams of the British literature since Mattilda Goldberg’s path-breaking experiment (1970), and indicators for much the same domain were used in major American experiments like channelling (Wooldridge *et al* 1986).

⁹ Examples are the influence of reduced carer stress on reducing the marginal cost of extending user stays at home and improving user satisfaction with services, and substantial levels of ROPPs (Risk Offset Proportion from Productivity effects, measuring the proportion of the predicted effects of risk factors offset by service inputs; Davies *et al.*, 2000, p.170) for indicators of reduced felt burden of caregiving and improved locus of control among users of 25 per cent and affecting 90 per cent of carers, improved satisfaction with life development (18 per cent affecting 40 per cent of users), and the general Philadelphia

Geriatric Center morale scale (Lawton, 1975), 12 per cent and 72 per cent (Davies, Fernandez, and Nomer, 2000, Figures 11.2 and 12.1). Social care inputs clearly increased morale and related variables for substantial proportions of users – just as they improved users’ feelings of empowerment over their own life, ‘locus of control’ (24 and 54 per cent).

¹⁰ It will be remembered that the rate of diversion of more disabled users to social from health care accelerated from the end of the decade. National government set performance targets in ways which focused social care more on a narrower (and different) clientele in seeking to prioritise the reduction of demands on acute beds and aspects of need traditionally the foci of health care: not the imposition of the ‘medical model’, but an important refocusing away from some core elements of the social care paradigm and its outcome and targeting priorities nonetheless. Fiscal pressure continues. One reason is that the new health-orientated priorities for the social care services, including servicing new branches of NHS-led community activities for health policy purposes, have to be financed from social service budgets which are only modestly growing. Local authorities have been complaining about the difference in growth rates between social care and NHS expenditures. ‘Support for services such as social care through the general grant has increased by just 14 per cent in real terms since 1997/98. This is in stark contrast to the NHS, which has seen a 90 per cent rise over the same period. Half of local authorities with social care responsibilities received a government grant increase below inflation this year’ (LGA, 2006). The LGA survey of February 2007 again raised the consequences of NHS resource pressures for cost-shunting to social care, though suggesting that a lower proportion of authorities were intending (or contemplating) a step change between FACS levels in the minimum eligibility criterion, though substantial proportions suggesting other effects which would reduce the effectiveness and efficiency of service, including diminished preventive effects (LGA, 2007).

¹¹ In response to the LGA finance survey in March 2006, 77 per cent of the respondents suggested that they would raise the eligibility floor during the coming year. Carson (2006) reported that one third of the councils responding to a Counsel and Care survey had tightened eligibility criteria in the past year and two-thirds now only offer care to older people with ‘critical’ and ‘substantial’ risk levels. It was reported that Hampshire planned to raise the threshold to the topmost (‘critical’ risk) level of the fourfold FACS classification.

¹² Central government promoted a new priority to wellbeing as an outcome in Modernising Local Government (1998), which proposed a duty ‘to promote economic social and environmental wellbeing (para. 8.8) to be supported by a ‘discretionary power to enable councils to take steps which will promote the wellbeing of their area and those who live in it . . . provided that’ their policies would not prejudice the performance of other functions and those of other statutory agencies (para. 8.11). The logic was reflected in the Better Government for Older People initiative, and later in the 2005 green paper.

¹³ For Interferon, it was estimated to be ‘up to £900,000’ per QALY.

¹⁴ The issue arises irrespective of how the eligibility for NHS continuing care funding is defined, because there can be conditions in which the victim consumes no health resources.

¹⁵ Variety was sought with respect to eight characteristics, two in particular: the degree of risk pooling (and so risk reduction and cost), and the balance of State and individual responsibility. Other characteristics were the balance between entitlement and budget dominance; degree of redistribution; indemnity benefit versus needs-meeting; national or local determination of benefit levels and eligibility criteria; citizen choice of contribution and benefit levels; reliance on informal care.

¹⁶ One feature which at first sight seemed attractive was the national standardisation, simplicity, transparency, and so greater comprehensibility to citizens and beneficiaries/users of eligibility criteria and their relationship to levels of benefit in cash or kind. However, the subsequent development of some of the models seems to be weakening precisely these elements to some degree in the pursuit of new effectiveness and efficiency goals. For instance, Dutch legislation in 1986 signals the abandonment of

the AWBZ insurance mechanism, creating municipally subsidised and managed models. Reacting to dissatisfaction with the way the new system was working, and in particular to inadequate case management and the supply side unresponsiveness to users' wishes to which some partly attributed the fact that a high proportion of users chose cash not services, the Germans launched a major multi-site demonstration of a model in which the entitlement is viewed as a 'person-bound' (individual) budget with a professional case manager to help beneficiaries make their choices of provision, and also coordinate with medical care, increasing the likelihood of producing more welfare with the resources by taking into account a wider and more subtle range of circumstances and preferences, so lessening the clumsiness of the social insurance arrangement by which benefits based on crude individual and straightforward criteria are used in a user-unresponsive system of provision. Whereas, early French discourse had been substantially in the language of insurance - 'fourth social risk' and other metaphors, building on a standard national evaluation instrument, with almost complete reliance (for needs assessment) on the standard national tool, the AGGIR, in the second and third stages of development from the use of the disability benefit, the *Allocation Compensatrice pour Tierce Personne*, to a benefit for older people culminating with the introduction of the *Allocation Personnalisée d'Autonomie* likewise introduced assessment and care management by multi-disciplinary teams (Davies, Fernandez, and Saunders' 1988; le Bihan and Martin, 2006). What was interesting about German long-term care insurance was that it introduced benefits in kind into an insurance framework with its assumptions that benefits would be in cash. (Appropriate for their argument, some Anglo-Saxon observers instead treated payment of the benefit in cash as being what was interesting.) France too shifted some way from the focus on cash benefits. The influential sociologist Claudine Attias-Donfut had criticized the system thus: '*il y une conception très individualiste de la protection sociale. On aide des individus isolés, indépendamment de leurs contextes*'. Indeed, a French historian of the process (writing for French readers) summed up the French development as a shift from benefits in cash to services in kind matching resources to needs; 'The abandonment of *prêt-à-porter* for tailored benefits' (Frinault, 2005). Secondly, as experience has accumulated, it became evident that transparency carried with it the disadvantages accompanying simplicity and inflexibility of contributions and benefit structures and inflexibility of the regulatory structure. That made it more difficult to maintain effectiveness efficiency and equity by other criteria as the balance of pressures of demands and resources worsened. The political difficulties in raising more contributions (particularly from employers) in Germany caused benefits to lag increasingly behind costs, causing increasing recourse to the means-tested social assistance again, the escape from which for users and for the sub-national funding bodies alike was a major impetus for the introduction of long term care insurance. In Japan, a similar situation was responded to by changes in eligibility rules removing a substantial proportion of those who would previously have been eligible, and by the introduction of user co-payments for hotel costs in care homes (Ikegami, 2007). A priori, it seems more difficult to achieve effectiveness, equity and efficiency by the key outcome criteria of the social care paradigm, as reflected for instance in the new WR criterion, with a social insurance philosophy aimed to provide a contingency benefit to cover crude risk factors than with some of the alternative models.

¹⁷ For instance, already Ryan *et al.* (2006) have shown that there are associations with routine variables like age, living circumstances, and reporting both some impairment and currently receiving services. People aged 85 and over were more concerned about food and nutrition and less concerned about social contact than younger recipients. Disabled people in receipt of services ranked food and nutrition highest, followed by social participation. (See Table 5.7) As they stand, these patterns are Rorschach tests. The literature on valuation illustrates many interpretations with quite different practical implications for the analysis. Progress depends on teasing them out.

¹⁸ More work is needed to investigate the most appropriate ways to investigate differences in perceptions, to incorporate objective

risks and sense of safety and to identify utility weights with nationally representative samples. Specific investigations into groups of interest, such as ethnic minorities, would also both potentially provide alternative utility indexes reflecting the perspectives of these groups.

¹⁹ That creates problems of interpretation. For some it is because of the probability of cognitive dissonance among people responding to great distress, adjustment of their reference group to those with similar need-related circumstances, or other forms of psychological adaptation to cope with their situation. For others, it is that they are being asked to evaluate purely hypothetical situations whose effects they cannot easily envisage. Opinion differs whether valuation compression (by which those with experience give responses which distinguish between levels of unmet need less - in this study case, to a degree sufficient to remove statistical significance in some analyses) makes the valuations of the experienced more or less valid than the weightings of others. Perhaps the judgment must depend on whether it is the users' own psychological interpretation which should count the most. If so, there is a double danger that the estimates may exaggerate the value of meeting unmet needs: first the estimates are based on willingness to spend rather than willingness to pay, and secondly, because the value weights are more heavily weighted with the perceptions of the general population than of service recipients. These influences from all levels of illumination and irrationality down to the sub-conscious influence individuals to differing degrees. Most perhaps are to some degree potentially predictable from other data, so eventually allowing the correction of the resulting biases in estimates to a practically useful degree. They usefully warn the reductive modeller against the hubris of imagining that all the precise calculations provide are crude orders of magnitude and monochrome sketches of complex polychrome patterns.

²⁰ One reason for the insistence of the designers of the projection models from their earliest publications that it should be focused primarily on examining the sensitivity of outcomes to scenario variations, however inevitable the reliance of the policy world on its best guess case projections. See Wittenberg *et al.* (1998).

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²² For instance, Hancock and Wittenberg (2006, tables 8 and 15) illustrate how the incidence on public and private expenditure can vary almost as greatly between current and the alternative reforms of asset means tests investigated as between current means tests and three variants of free personal care. But with the free personal care options, the share of public spending is in all versions lower, and the differences established early are projected to be continued in the long run to 2051. Another example: tipping the balance towards more formulaically weighted allocation judgments based on general risk factor into broad levels of care (as with social insurance) between now and mid-century rather than towards allocation by a wide range of factors, some complex and subjective, evaluated and weighted in a context-sensitive judgment within broad guidelines (closer to the Single Assessment Process philosophy) is likely to have more certain effects on the distribution of welfare than projections for 2051 from alternative variants of our current funding model.

²³ Someone borne in 1946 will not reach eighty until the end of the WR time horizon, almost twenty years hence.

²⁴ For instance, with respect to self-assessment and the allocation of a provisional budget for self-administration, a key aspect of one model of the commendable individual budgets model: 'Enabling individuals to self-assess the threats to their own independence/health is a complicated issue as there are potential risks around inappropriate service delivery and failure to identify some needs. . . . However, we believe that there are probably areas where self-assessment could be used, for example in assessments for some items of low-level, community equipment and for other low-level services' (DH 2006, p.38).

²⁵ Response to risk of diswelfares of various kinds is core to the language and logic of the Fair Access policy for eligibility determination and prioritisation: allocations to the four bands being based on the 'seriousness of the risk to independence or other consequences if needs are not addressed' (DH, 2003a, 2003b), and establishing this risk can require professional interpretation of the situation: 'needs assessment and risk

- evaluation rely for their quality on person-centred conversations with individuals seeking help carried out by competent professionals prepared to exercise their judgment . . . Frameworks, case examples and the like can only ever support the exercise of person-centred, competent judgment (DH, 2003b). Although some documents for models which require self-management and risk tend to contain little discussion about how hard it is to handle the dilemmas, scoring systems in self-assessment forms give heavy weights to safety and risk domains (Duffy and Waters, 2005; In Control, 2005), and some leading the implementation of the models have argued the importance of adapting policy and practice to recognise the dilemmas: ‘there is a risk that a focus on enabling disabled people will lead to services failing to identify those individuals where it is genuinely too risky to hand over leadership to the person. There will need to be a much greater onus on human services identifying people at risk and authorising named individuals to take responsibility for their services. At the moment the presumption of provider control masks the possible options available, but there will be no room for uncertainty in systems that seek to minimise central control’ (Duffy, 2004).
- ²⁶ The remarkable correspondence of rankings by workers at all levels in authorities and this top national priority was described in Davies and Fernandez (2000). Restoring the bulk of the costs of the public subsidisation of care home costs to the social care budget created the conditions for the generalisation of what were becoming the policies of leading authorities before the budgetary responsibility was in effect transferred by the creation of the Board and Lodging Allowance in 1980. So the development of alternatives to residential care in the new policy logic of 1989 fitted the dominant values at all levels and in most groups in social services departments. After a first year of relative plenty in 1993, the growth of demand in excess of public budgets sharpened the incentives both to find less costly home care alternatives, and also to strike hard bargains with home care providers – leading eventually to under-supply and pressure on quality, as the theory of the nursing home market of the eighties predicted (Davies, 1986, 1989; Davies and Knapp, 1988).
- ²⁷ The evaluation of a vaunted NHS nursing-led model, Evercare, the model from which the community matron stream of NHS schemes was to descend, had little if any effect on what it was designed to produce, diversion of demand from acute beds (Boaden *et al.*, 2005; 2006). In contrast, estimates of the effects of inter-personal variations in utilisation of home and community services suggested that home care had large effects on the utilisation of acute beds over a period of two years (Fernandez and Davies, 2004). Perhaps the excess demand for acute beds have been reduced more had the money been spent by the social services departments on the users they would anyhow have targeted (Fernandez and Forder, 2007 forthcoming).
- ²⁸ That is illustrated by their account of pressure at the front line: ‘our research [in three areas] points to a Catch 22 situation . . . [there is] so much incoming work that social services practitioners (as lead agents . . .) have often struggled to take any single referral beyond the initial stages of assessment and care planning. On the other hand, the inability first to integrate the monitoring and review stages and second to provide a comprehensive, multi-disciplinary approach (where appropriate) almost certainly helps explain the very high re-referral rates and subsequent work overload. This suggests that focusing on procedures for joint working and honing the existing system, as advocated in the single assessment guidance, will not address the root cause of the problem. This lies in case loads which demand the processing of clients and patients as quickly and efficiently as possible and overstretched practitioners who simply do not have time to act as ‘care managers’ coordinating care and the various ‘specialist assessments’ of other agencies and professionals. As noted earlier, social services departments are often expected to operate increasingly close to breaking point.’ Of course, there has always been great variation – and volatility, for instance in response to budget changes in related agencies and changes in grant settlements – in the balance between needs and resources at the local level, but it is likely that this has been and remains a fair picture of the situation of a substantial proportion of field areas at any time (McNally *et al.*, 2003, pp.21–2). See also Sinclair *et al.*, 1998.
- ²⁹ Ritter and Webber argued that the planning context in which they invented the concept of wickedness was characterised by extreme technological indeterminacy – social heterogeneity is incompatible great precision of goals, causality is unclear and so therefore are the means to achieve goals,
- ³⁰ The most highly prioritised goals have been shifted from some which are well culturally embedded and so pursued with little prompting by all participants and structurally embedded in field organisations dominated by them, to goals which are less directly open to social care influence increasingly in field settings requiring accommodation to culturally alien values and assumptions about ends and means. That is likely to weaken consistency in the relations between resources and outcomes.
- ³¹ Indeed, there seems to have been a tendency among both policy-makers and academics to have a preoccupation with ‘wickedness’ that would do justice to the devout Massachusetts colonists: to perceive and pursue it in policy contexts whose symptoms of wickedness and its causes pale into insignificance compared with the policy areas for which the wickedness argument was originally developed. That may have both led to misleading policy judgment and to the unintended creation of alibis for under-performance. For instance, more welfare may be produced if the context is acted upon as if it is substantially technologically determinate than technologically indeterminate when there is the evidence that it is the former to a practically useful degree.
- ³² The great diversion of resources and attention to improving the integration of health and social care had only mixed success partly because assumptions about time and other preconditions were too optimistic, the literature suggests. In some cases, like some of the NHS-led models seeking to reduce acute bed use among those at high risk using considerable amounts of spending on social services for older people by CSSRs, it will also require more effective learning from the experience from CSSR experience of care management.
- ³³ The older population is projected to be much more evenly distributed across the age range. Therefore there will be higher proportions in the older age group in 2051, with an increase of two thirds or more in the number of persons aged 85 and over during the previous two decades (DWP, 2004; Turner, 2004).
- ³⁴ Funding reforms were among those advocated for the period when the window of opportunity was last open, the nineties. The OECD projected that continuation of the whole range of current public policies would actually reduce public spending by 2 per cent over the decade. An academic suggested: ‘failure to find the resources to make the investment could be . . . an opportunity to improve the quality of our national life permanently lost’ (Davies *et al.*, 1990, pp.399; OECD, 1988). Policy makers had an alibi: as in several other countries, they were too busy developing and managing reforms to tackle issues with which the policy world is most familiar and for which it can most readily put tools in place, only later engaging other issues, often by modifying the newly created mechanisms: in the British case, supply side reforms; in the German and Japanese, a social insurance funding mechanism. It can be debated whether an important opportunity was lost by not also experimenting with models incorporating innovations in financing mechanisms with feature to improve equity, effectiveness and efficiency in the publicly subsidized real economy of care.
- ³⁵ In its official response to the DH consultation on its plans to merge the quality assurance regulators for health and social care, the CSCI suggested that the new remit was so broad that care would have to be taken to ensure health issues did not dominate official focus (Care and Health News, 2007). The announcement was made by Gordon Brown ahead of the 2005 election in the context of his battle to reduce red tape.

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