

Resilience and the maximisation of achievement of policy potential: English service-outcome relationships & user control

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Paper theme: how conference title's concepts illustrated in recent English ltc policy history

- ***Ageing of Society***
Vital to mainstream ageing in policy & politics: eg UN policy
But also to acknowledge that challenges & opportunities & so policy depends on mediating factors: drivers endogenous, many, & all levels of generality
- ***Resilience: fast English response – partly by accident?***
Success in inventing policy principles gaining support
Working through to policy detail less advanced. Dangers: [a] hasty rollout of radical ideas before principles sufficiently worked through; [b] ignoring lessons of history
- ***Risks and/or opportunities***
Trade-off sharpened: citizen to be given more opportunity in return for more risk as user, family, citizen of neighbourhood, municipality & state
- ***Missing concept: sustainability***
Some interpretations of new policy ambitions doubtfully sustainable prior to crisis

The English situation on eve of mainstreaming - 1

- **Pre1989.** Substantial budget base. Vagueness re prioritising of outcomes & so targeting, service development policy. Fragmented & uncoordinated though commanding heights 2 holonic public monopolies: la ss departments & the NHS.
- **1970s&1980s.** Critiques from academe then eg from DH & (Value for Money) Audit Commission. Financially unsustainable, inequitable, ineffective, inefficient. Responses: KCCP 1974- user-sensitive integration & flexibility in means & ends via decentralisation & incentives; tapping & increasing community's caring capacity
- **1989- Reform principles.** 'Independence' & choice; more holistic & outcomes led. Support at home with targeted resources & user-responsive case management for bottom-up integration, greater efficiency by flexibility about tactics (Heineken: morale as means & ends) & means, protection of vulnerable, signals for market management & commissioning. Variety & choice (& cost containment) via competition in mixed economy
- But ...

The English situation on eve of mainstreaming – 2 BUT

- **Government prioritisation of growth of independent provision.** Big incentives & ferocious sanctions to overcome hostile local executives & politicians. Big local efforts to set up new institutions for commissioning & quality assurance.
- **Fiscal pressure on authorities** continued but growth in demand (diversion from NHS, demography, attractive)
- Therefore **care management implementation** without the retraining etc for cultural change for outcomes-led with greater flexibility of means
- Also attempt to specify roles **insufficiently integrated social, long-term, acute, & preventive health effort.** Major diversion of priorities 2000- unselective & so only slowly achieving environment for citizen outcomes

Mainstreaming proposals–DH policy response: the Green Paper *Independence Wellbeing and Choice* (2005) - 1

- Fundamental assumption: Unrealistic to continue in same direction without Green Paper changes. ‘Doing nothing is not an option’
 - *Expectations*: higher, ‘people want greater control over their own lives, including the management of risk’.
 - ‘*Increased demand for organised social care*’ and ‘*Changes to be made from existing funding*’.
Increased longevity, families less close-knit (partly due to greater geographical mobility). Greater diversity within and between communities.

Mainstreaming – the first DH policy response: the Green Paper *Independence Wellbeing and Choice* (2005) – 2

Key proposals

- Extension of concept of '**independence**' to giving people choice & control in the ways needs are met; but also increased responsibility of individual & family re State
- **Greater focus on preventative services** – 'early, targeted interventions and the use of the la wellbeing agenda to ensure greater social inclusion and improved QoL'. 'Strong strategic and leadership role for local government working in partnership with other agencies'; POPs, local, some communitarian, 3rd sector emphases
- **More use of Direct Payments**, piloting **Individual Budgets**
- **New and exciting models of service delivery and harnessing technology** – technological advance + substitutions: sources & nature of inputs & budget heads
- **10-15 years horizon** – no more money for social care budget than otherwise

Progress in implementing Elements of Mainstreaming:

1 Policy distorted by fiscal stringency

Fiscal pressures caused

Tighter floor eligible criteria. Increasing proportion of authorities restricting access to users from higher/highest of 4-level FACS priorities. This reality at variance with objective to provide less intense services for targeted prevention etc.

Tickbox risk/need assessment. Not outcomes-led equation of ratios of marginal increment to social care QoC & QoL to marginal cost – the theoretical criterion since *Matching*

Demoralising (probably inequitable) bureaucratic control over individual allocations

Costs over-emphasised in commissioning. Time-task contracting causing impersonal unresponsiveness to users

Disgruntled field professionals & proponents of new models blame logic & arrangements of post89 models without examining the evaluations

Progress Implementing Elements of Mainstreaming 2: Reinterpreting role of state while creating political support for sustainable reform taking into account welfare needs and production relations of welfare

- Changes with long lead times. So increased predictability provided by broad national consensus required to tackle; eg
 - Rights & responsibilities of citizens, expectations & behavioural responses re [a] funding policy (deferred from earlier stages of post1990 reforms) [b] informal care & support, [c] proactive citizen engagement
 - Infra-structural and technological change in provider & policy agencies, often small with 'oral cultures'
- Requires appealing & so simple philosophy & policy narrative. But also maximising welfare from public spending requires recognition of complexity of aims and patterns of technological relations in POW.
- Dangers of application of rhetoric for consensus without elaboration to take into account other principles and contextual modifiers

The key documents at the beginning of 2008: the Concordat & the Circular

- In contrast with 1989, consensus for enduring commitment carefully constructed. Evidence: 'The Concordat' *Putting People First: a Shared Vision & Commitment to the Transformation*. Signed by main agencies & pressure groups. Seeming cross-party acceptance of principles. Appeal of citizen control powerful element
- Policy essentials in circular to local authorities: *Transforming Social Care*. Apparent supremacy of principle of user control. Internal executive & political politics of authorities makes many susceptible to oversimplifying resolutions for their irresolvable dilemmas with weak analytical resources

The two foci of remainder of paper

- The Circular's key logic about User Control
 - The logic summarised
 - Comparison of Circular logic with post89 policy
- Empirical tests of propositions which must be valid for the exclusive application of the principle of maximising user control to improve welfare compared with allocations based on post89 practice during mid-late90s

TRANSFORMING'S KEY PROPOSAL & END-MEANS LOGIC: INTERPET AS DEFAULT OPTION & PRIMARY NOT EXCLUSIVE PRINCIPLE?

- Narrowly interpreted, Circular proposes application of models incorporating a personal budget mechanism accompanied by the policy-(etc)-reinforced principle of user control to achieve 'personalisation' and so maximum welfare
- Circular's logic uses three key concepts:
 - '*Personal Budget*': $PB = DP \text{ or } IB \text{ or mix}$
 - '*Personalisation*': P
 - *Should maximise user control subject to outcome acceptability*: UC
- Hypothesised causal mechanism: $(PB + UC)$ produces P and maximises welfare

Interpreting the Circular. User Control nearly always a principal consideration? Or almost always the only one?

- Issues are [a] policy for, and organisation of, assessment & resource allocation at individual level & [b] whether incentives etc they create bias against application of principles additional to the Circular principle for most users in most circumstances.
- One interpretation: (PB + maximising UC) the only principle for all but exceptional circumstances. This implicitly a mono-causal specification of means-end process, a sentence with only one main clause. Alternative interpretation: allow other main (& subordinate clauses) for many users, though (PB + maximising UC) generally a main clause. (PB + maximising UC) then generally the default option where defensible case for applying other principles can not be made in transparent systems of accountability, appeals mechanisms etc
- Examples of other principles: allow for impaired capacity unless unsupported; conflicting interests with unequal power in willing informal support network; ... Most DH policy papers 2005- recognise non-Circular principles

Circular's causal mechanism: comparison with the post89 narrative concepts: *'Personalisation'*

Compare logics of post89 narrative with that of the circular: first each concept in the logic in turn

[a] personalisation

- 'Cornerstone' in Circular & 89 White Paper ('keystone' in Griffiths)
- Circular's definition: 'the way in which services are tailored to the needs and preferences of citizens' (subject to priorities and eligibility) with overtones of end as well as means
- That is same as post89 narrative and Kent Community Care Project – the experiment with holistic user-responsive outcomes-focused with flexibility re means through budget devolution. Post89 policy advocated application of that and its replications & extensions to other groups.

Circular's causal mechanism: comparison with the post89 narrative: *Personal Budget*

Incentive/enabling effects postulated

1. Users' wider mobilisation/choice of means – Circular, post89 narrative like KCCP
2. Users' choice of weighting of outcomes – Circular, post89 narrative like KCCP
3. Balance marginal benefits of additional resources between users – post89 narrative and KCCP, but not by same process in Circular & post89 practice

Circular's causal mechanism: comparison with the post89 narrative: *User Control*

Apparently biggest departure from post89 narrative. But close to default option and principle in In Control etc demonstrations; eg 6 degrees & mixes of user control in Glasby & Duffy 2007; 'much greater onus on human services identifying people at risk & authorizing named individuals to take responsibility for their services'. Similarly In Control Pilots (Glendinning et al 2008). 'Default determinant' metaphor also supported by Beresford (2008) for mental health services.

Cf post89 narrative – SSI guidance: 'instead of users and carers being subordinate to the wishes of service providers ... users and carers will be enabled to exercise the same power as consumers of other services.' But swamped by fiscal stress, professional paternalism, absence of managerial & training focus

KCCP designed as IB model but with care manager budget holder to avoid *ultra vires* objection to KCC voucher idea – basis of Rotterdam 'Individuele Zorgsubsidie' & descendant national system, individual care budgets

Circular's causal mechanism: comparison with the post89 narrative: *Conclusions*

- Biggest difference – greater priority to user control, less ambiguity & ambivalence
 - But caveats entered in In Control writing & acceptance of 'default option' metaphor; cf Peter Beresford (re mh context where also anxieties about complex cases)
 - So opposition of old & new logics exaggerated – more matter of contingency-determined balances – contingency theoretic approach more productive
- What reforms are trying to replace is bad features of current arrangements & practice, not post89 narrative, certainly not its experimental precursor. In effect aim is a more firmly user-dominating version of the KCCP

How far necessary to balance Circular & other principles?

5 prerequisites for unqualified application of Circular principles to most users to improve welfare given resources

1. Older citizens' must value increased control highly compared with other benefits
2. System after the post89 reforms failed to contribute substantially to enhancing users' control
3. Post89 services failed to contribute to support of carers and/or their sense of influence over the care plan
4. What the post89 system produced fitted wishes and interests badly
5. What the post89 system produced fitted wishes and interests worse than would maximising users' felt control

Test each in turn

P1. Older citizens' value increased control highly compared with other benefits

- Marginal valuations from discrete choice experiments with general older populations show increased control lower value than personal comfort or social participation & involvement (Netten et al.)
- But anyhow, Valuation an insufficient condition: Patient Activation Measure – scores for only 9.3 per cent of those aged 85 and 12.6 per cent of those between 75 and 84 over predicted capacity to stay a self-care course under stress (Picker)
- Etc

Proposition not supported

P2 Post89 system did not contribute substantially to enhancing users' control

- Relevant because greater potential benefits if post89 system did *not much enhance* users' sense of control
- *Equity and Efficiency Policy* 'Risk Offset 'Proportion from Productivity' effects, ie % predicted adverse change offset by services (Davies Fernandez Nomer 2000)
 - Sense of control over own lives: ROPP 24%
 - Felt influence during SetUp stage of cm: ROPP 14%
 - Many powerful risk factors to a high degree irremovable & irresistible, so ROPPs substantial
- Proposition not supported

P3 Post89 services failed to contribute to support of carers and/or sense of influence over the care plan

- ROPP for principal informal carers felt influence during the set-up stage: 9% cf 14% for users
- ‘The whole agenda has moved on a huge amount since the first carers' strategy’ (Policy Officer, Carers UK)

Proposition not supported

P4 What the post89 system produced fitted wishes and interests badly

- Post89 system impacted 18 dimensions of wellbeing spanning social care paradigm
- Most powerful effects on interpretation of independence most fitting 1989 policy and interpretations of priorities by managers in authorities: making possible to avoid unwanted admissions to institutions for Itc – ROPP 32%
- ROPPs for Felt Burden of Caregiving 25%, User Satisfaction 18%
- Relative effects of limitations to flexibility identified by care managers accounted for little variation in outcomes given costs

P5 What post89 system produced fitted wishes & interests worse than maximising users' felt control would have done

- Simulation of alternative optimisations
- Serious collateral damage would have occurred if users' felt degree of control over their own lives maximised.
Diminished outcomes highly valued: days supported at home, user satisfaction, felt burden of caregiving

Proposition not supported

Caveats to tests of propositions

- Composition of samples:
 - reflected post89 targeting not broader targeting of subsidy aimed at in principle - average package subsidy lower with extended packaging. See EEPOL estimates of effects
 - Sample cohort followed until 2000: perhaps worsening balance of subsidy and demand and rising eligibility floor, resources, field organisation etc increasingly diverted to meet health policy objectives, belief in top-down (targetry) managerialism with diminished field discretion (with unknown productivity effects)
 - Trends in generational habitus – but effects not immediate & future living standards of low income people now in question
- Policy proposals radical: aimed to change POW parameters on which simulations based

Presumption nevertheless that invalidity of propositions imply that better outcomes depends on balancing Circular's maxi User Control principle with other goals and user and carer circumstances

Why are the propositions unsupported? Implication: make [a] policy elaborations & [b] research foundations more contingency-theoretically based?

- Variety (and frequently with intensity and complexity) of need-related circumstances
- High productivities of care management inputs during Set-Up stage; ratios of mps:prices ratios show cm under-inputted
- Dependence of marginal effects on outcomes of support inputs on condition-challenging factors must be taken into account in formulating simple generalisations about causality – eg KCCP Heineken Hypothesis. The dependence of mpies on mediating factors reflect the better explored caveats about (PB + maximising UC) logic discussed by others; eg capacity & risk, conflicting interests, other professions' assumptions in integrated systems.

Implication is that should base policy development & elaboration more on contingency theory, less on opposition of models

What do the newly-published results of the Individual Budgets Pilots imply?

- **Evaluation carefully avoided over-generalisation:** flagship policy. 'User after-only random assignment +' design for IB/Control comparison
- **Despite technical assistance based on earlier prototypes experience made available & pilot authorities untypically keen to implement, results show difficulties in locally adapting & working through designs;** eg long delays from consent to scheme membership to service (55% not in place 3 months later); also systems delays
- **Not actually universally applied but selection by capacity,** Big effect?
- **'Care management' & utilisation:** [a] increased cm inputs (cf *EEPOL* mp:pces above) [b] 'cms' helped to set priorities & explore alternatives, [c] only 56% op managed IB as DP; [d] greater outcome focus though also risk & needs; [e] less use of home care (partly mp:pces?); [f] RAS applied in most sites but validity & incentives anxieties;
- **Outcomes:** [a] IBs probably > effective & < costly for IB users as whole but no difference for op; for GHQ12 (malaise), [b] IBs similar cost but clearly < effective for op (anxieties about budget management) [c] great within-group outcomes variance
- **As usual, general features of model specification account for low proportion of evaluatively important outcome variations**
- **Mixed results for older people. Evaluation to be repeated later**

CONCLUSIONS

- Widespread consensus to put into place arrangements which will always put user influence and desired control into a main clause & make the default option good.
- Historically incorrect to suggest that the models altogether different from what gone before. Certainly early English experiments in holistic outcomes-focused budget-devolved case management with commitment to maximising user influence similar in ends & means, and clearly successful. Also IBSEN evaluation illustrates continuity of issues & logics
- IBs, DPs, PBs (IBs but only ssd funding) themselves heterogeneous, at clearest, some of a family of models aiming at user-responsiveness. New models still vague. Intellectual foundation needed is contingency theory: logical framework for flexible combinations matched to circumstances not few simple models
- For copy of presentation, email **B.Davies@lse.ac.uk**