From the State to the Personalization of Social Policy

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The move to personalization in social policy in western society has been presented as part of consumerist agenda that is increasingly associated with western social policy (Powell 2009). Today, public services in modern society also face new demand side challenges in a global economic recession. At the same time, individuals and populations in western culture have expectations of the State to deliver to meet their health and care needs from resources to services to provide support. These increased expectations are strongly felt in public services and challenge the traditional relationship between the State and vulnerable groups in modern societies such as older people, disabled people and people with mental illness, and people who are frail and sick.

The traditional focus has been on the State providing for individuals. Part of a re-casting of that relationship has been on the entrenchment of personalization as a new language in western culture for the responsibility for social welfare (Dittrich 2009). To put simply, personalization is a means to focus more on the individual rather than the State. Using the UK as a case study, sheds light on wider contemporary trends on social policy in western society in general.

But is this too simplistic a conceptualization? Why and how is personalization relevant to social policy and modern society? How is it researched? How is personalization reconciled in a formidable structural climate of decreasing public resources? This is not just a global economic recession but one of which effects all nation states. Many of these questions can be connected to why personalization services are needed, what is provided and how it is coordinated. Last year, the Brown Government (2009) in Great Britain announced it would provide a Social Care Reform Grant over 3 years, worth £520 million as part of an adult care 'concordat', to support the 'transformation' of care systems (Dittrich 2009). The aim of the transformation is to move to personalization in local authority social care provision to enable the roll out of personal budgets. The personalization agenda offers an opportunity to make social care (and other services) more responsive and flexible so that it is actually doing what people who use budgets and services want and need, rather than being constrained in rigid task and time specifications (Samuel 2008; Dittrich 2009).

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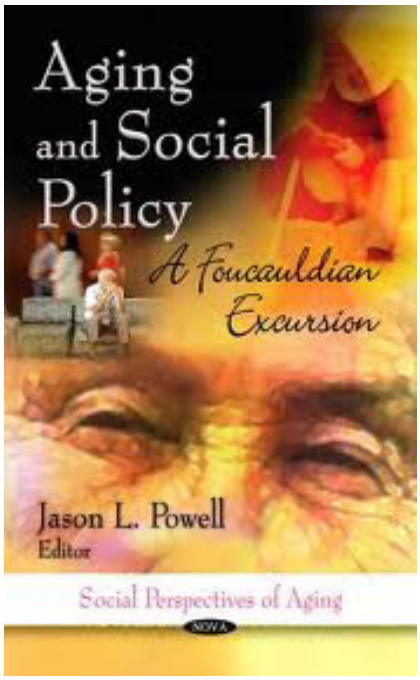
Personalization is inextricably linked to process that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings (Glendenning et al. 2008). Carr (2008) suggests its overall aim is for social care service users to have control over how money allocated to their care is spent. It includes within its remit direct payments, individual budgets, personal budgets, user-led services, self-directed support (Glendenning et al. 2008). Self-assessment is a cornerstone of personalization that gives service users the opportunity to assess their own care and support needs and decide how their individual budgets are spent, that is a process transforming social care (Carr 2008).

In order to explore the conceptual, policy and research literature on personalization, this working report focuses attempts to set out in more detail what personalization is, what it will mean, how it may work, and discusses to what extent it is likely to happen. It considers the opportunities these changes are presenting service users. The paper illuminates the key research findings from the IBSEN report (2008) that provides a series of research benchmarks to measure how pilots of personalization and individual budgets are being experienced.

A word of caution however: overall, it is fair to say that the evidence base in relation to the critical success factors of personalization is extremely scarce (Rabiee and Moran 2006; Moran 2006; Glendenning et al., 2008). This also means that it is very difficult to bring evidence together in any cumulative sense to gain an impression of the overall or aggregate impact of personalization. A key point to state is that the available literature is on what the implications would be rather than what the implications evidentially are. Samuel (2008) makes the cogent point that there has been such political enthusiasm for individual budgets from both New Labour and Conservative parties that they have run ahead of the evidence: a whole new personalization approach to social care policy and invested at least £500,000,000 in making it happen before even its own research findings were available to offer an adequate evidence base (Samuel 2008). Hence, greater use of methodological interrogation of experiences is required in tapping the narrative and experiential contours of personalization and Individual Budgets (IBs). There have been scarce longitudinal research designs (Glendenning et al. 2008), in which interventions and their beneficial/dystopian effects on IB can be studied over time (Carr 2008); or evaluation designs, for example where ostensibly similar interventions or the work of comparable agencies are undertaken in



different settings as the process is only starting to unfold (Moran 2006; Glendenning et al. 2008).

'Taking aim' at Personalization

In the UK, the Brown administration (2007-2010) has identified personalization to promote and use as a vehicle to transform the shape of adult social care services. Personalization is at the heart of the transformation agenda for adult social care. The relationship between the service user and the State is one where citizens should be able to take control of their needs through a range of provision from which they can choose (Leadbeater 2008). This will change social care from a system where people have had to accept what is offered, to one where people have greater control, not only over the type of support offered, but also how and when it is offered, how it is paid for and how it helps them achieve the outcomes that are important to them (Dowson and Grieg, 2009).

Service users participating to meet their own needs will achieve the transformation of social care. Indeed, Leadbeater (2004) suggests in order to understand personalization we must locate it in its broad context of 'participation' that changes the way in which social care services are delivered. It is about enabling the individual, alone or in groups, to participate in the delivery of a service (Leadbeater 2004). From being a recipient of services, service users can become actively involved in selecting and shaping the services they receive (Carr 2008).

According to Carr (2008), personalization has the potential to reorganize the way we create public goods and deliver public services. Leadbetter (2004) for a report for DEMOS suggests that personalization through participation makes the connection between the individual and the collective by allowing users a more direct, informed and creative say in 'rewriting the script' by which the service they use is designed, planned, delivered and evaluated. Leadbetter (2004) states a number of over-arching principles related to personalization and impingement on individual autonomy:

1. *Intimate consultation:* professionals working with clients to help unlock their needs, preferences and aspirations, through an extended dialogue – focusing on facilitating relationships between professionals and service users.

2. *Expanded choice:* giving users greater choice over the mix of ways in which their needs might be met; to assemble solutions around the needs of service users rather than limiting provision to social care and services department.

3. *Enhanced voice:* expanded choice should help to further unlock the service user's voice. Making comparisons between alternatives helps people to articulate their preferences. Leadbetter (2004) implies choice for service users simultaneously helps to listen and carry voice of users fused into partnerships with social care agencies.

4. *Partnership provision:* it is only possible to assemble solutions personalized to individual need if services work in partnership between user groups and social care agencies.

5. *Advocacy:* professional social workers should act as advocates for service users, helping them to navigate their way through the social care system. That means service users having a continuing relationship with professional social workers that take an interest in their case, rather than service users artificially engaging in a series of disconnected transactions, disconnected assessments with disconnected services.

6. *Co-production:* service users who are more involved in shaping the service they receive should be expected to become more active and responsible in helping to achieve and deliver the social care service from Local Authorities.

7. *Funding:* should follow the choices that users make and in some cases – direct payments to disabled people to assemble their own care packages – funding should be 'put in the hands' of service users themselves, to buy services with the advice of professionals.

Leadbetter (2004) makes the cogent point that service users should not be fully dependent upon the judgement of professionals; they should be able to question, challenge and deliberate with them. Nor are users merely consumers, choosing between different packages offered to them; they should be more intimately involved in shaping and "co-producing" the service they want. The question this raises: what does this actually mean? The answer is fivefold: (i) finding new collaborative ways of working and developing local partnerships, which (co) produce a range of services for people to choose from and opportunities for social inclusion; (ii) tailoring support to people's individual needs; (iii) recognising and supporting carers in their role, while enabling them to maintain a life beyond their caring responsibilities (HM Government, 2008); (iv) access to universal community services and resources – a 'total system' response; (v) and early intervention and prevention so that people are supported early on and in a way that's right for them.

Social Policy and Personalization

It can be argued that Individual Budgets (IBs) are the central to the aim of 'modernising' social care policy and practice in England (Glendenning et al. 2008). They build on the experiences of direct payments and *In Control* and are intended to offer new opportunities for personalized social care. Since the1980s there has been growing interest among policy makers and service users alike in England in developing ways that enable adults who need support and help with day-to-day activities to exercise choice and control over that help (Powell, 2005). Growing dissatisfaction has been

articulated, particularly by working disabled people, about the inflexibility and unreliability of directly provided social care services. These have been argued to create dependency rather than promoting independence and impede disabled people from enjoying full citizenship rights (Dowson and Grieg, 2009). Instead, disabled people have argued for the right to exercise choice and control over their lives by having control over the support they need to live independently. This, they have argued, can be achieved by giving them the resources with which to purchase and organize their own support in place of in-kind provided services (Samuel 2008).

A rather different set of policies have reflected the attempts of successive governments to reduce the control of social care service providers over the composition, timing and flexibility of services and make providers more responsive to the circumstances of individual service users. Thus the 1993 community care reforms made front-line care managers responsible for purchasing individualized 'packages' of services from a range of different providers, tailored to meet individual needs and preferences (Powell, 2005). At that time, the position of monopolistic authority service providers was challenged by the active encouragement of a 'mixed economy' of social care services, funded by local authorities (and increasingly also by individuals funding their own care entirely from their own private resources), but provided by a range of charitable and for-profit organizations (Powell, 2009; Gilbert and Powell, 2010). More recently, policy commentators have argued for the active involvement of users in the co-production of services. Co-production is argued to introduce new incentives for providers to respond to individual demands; and new incentives for service users to optimize how the resources under their control are used in order to increase cost-effectiveness. This has been repeatedly stated in key policy documents including Improving the Life Chances of Disabled People (published by the Prime Minister's Strategy Unit in 2005), and the 2006 Community Services White Paper, Our Health, Our Care, Our Say which announced the piloting of IBs. Personalization had its early beginnings in Direct Payments introduced in 1997 under the Blair administration, whereby people who are eligible for social care can choose to receive a cash sum or service. The model for IBs was largely derived from work developed by In Control that pioneered self-directed support for people with learning disabilities and is engaged in supporting personalization developments in more than 90 local authorities (Glendenning et al. 2008).

Individual budgets (IBs) are central to Labour Government's ambitions for 'modernizing' social care in England, and lie at the heart of the 'personalization' agenda. IBs were first proposed in the Cabinet Office Strategy Unit (2005) report, *Improving the Life Chances of Disabled People* and this commitment was repeated in the Government strategy planning for an aging population and impact on public resources. In the same year, a Green Paper on adult social care called for more opportunities for older and disabled people to exercise choice and control over how their support needs are met as well as for the focus of support arrangements to shift from service inputs to user-defined outcomes. The intention was to build on experiences with two pre-existing schemes: direct payments (where individuals eligible for social care support receive cash payments in lieu of direct service provision) and the pioneering. The move towards self-directed support involves comprehensive change: self-directed support is to become the core way of delivering care and support to service users. Implementing self-directed support is as much about changing cultures as it is about changing systems (Gilbert and Powell, 2010).

Personalization and research themes

In order to trace the research themes that emanate from initial experiences of personalization, there is a need to trace the key findings. The research is not meant to be an exhaustive list but rather an overview of some emerging themes. Moran (2006) suggests that plans to use IBs mainly focus on the employment of Personal Assistants; but they also include the purchase of equipment, transport, respite, and leisure services. Interviews in participating sites (Moran, 2006) suggest that Individual Budgets facilitate a move towards more holistic, user centered assessment. However there were concerns that service users engaging in self-assessment may under-assess their needs. Service users are, consequently, turning to the voluntary sector to act as advocates for users – helping them to complete the self-assessment forms. In some areas there is also a dual system of care manager assessment alongside self-assessment. Staff at most sites expected the introduction of Individual Budgets to be easier among certain user groups (as was the case with Direct Payments).

Moran (2006) made the point that people with physical or sensory impairments are most commonly viewed as 'most suited' to IB. Professionals, using the experience of Direct Payments, perceived these people as

better able to plan their own support and manage their own budgets. The inclusion of people with learning disabilities was also expected to be successful, partly because of the cultural shifts that had taken place among staff working with this user group and the experience of the In Control approach to person-centred planning and individualised approach to meeting needs. At the same time, Moran (2006) cautioned that the inclusion of older people, however, was considered more difficult. There was also an expectation that health service staff would be reluctant to offer Individual Budgets to mental health service users (Moran, 2006).

Following on from this, research from Rabiee and Moran (2006) suggest that, as with Direct Payments, pre-existing block contracts can undermine implementation. Rabiee and Moran (2006) suggest both the potential of a successful IB scheme, and suggest obstacles that have to be addressed.

Rabiee and Moran (2006) claim that service users had positive views of IB benefits:

- greater choice and control;
- flexibility;
- self esteem;
- a more transparent process of assessment;
- easier to manage than Direct Payments.

Rabiee and Moran (2006) also suggest that service users had realistic views of IB costs:

- difficult to understand which funding streams are accessible;
- difficult to understand which services IB can be used for;
- need for help in form-filling;
- lengthy application process;
- fear about responsibilities shifted to under-supported carers and families.
- A number of the sites suggested that the budgetary pressures associated with money tied up in block contracts would take 3-5 years to resolve (Rabiee and Moran 2006).

These two studies by Moran (2006) and Rabiee and Moran (2006) were the first research evaluations of the implementation of this form of personalised approaches to social care and its impact on the individuals involved, the workforce and providers, as well as the support and commissioning processes. This was influential to the design and implementation of the research frames of The Individual Budgets Evaluation Network (IBSEN) report (Glendenning et al. 2008).

The IBSEN research report (2008) provided a national evaluation of individual budget pilots that have implications for service users, professionals and policy makers. People receiving an IB were significantly more likely to report feeling in control of their daily lives, welcoming the support obtained and how it was delivered, compared to those receiving conventional social care services. However, there were differences between groups.

- Mental health service users reported significantly higher quality of life;

- Physically disabled adults reported receiving higher quality care and were more satisfied with the help they received;

- People with learning disabilities were more likely to feel they had control over their daily lives;

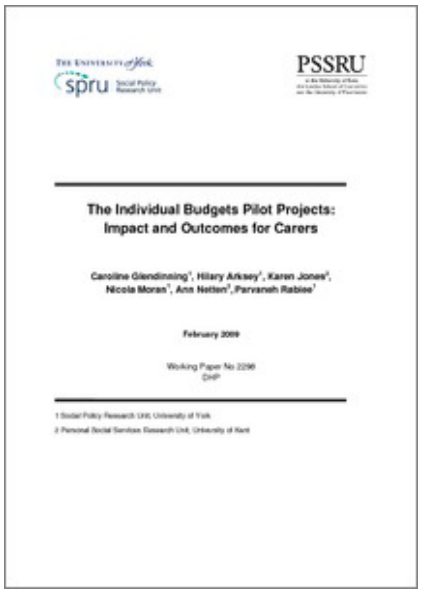
- Older people reported lower psychological well-being with IBs, perhaps because they felt the processes of planning and managing their own support were burdens.

- People who had higher value IBs had better social care outcomes – but so did people receiving higher value conventional services. Overall, holding an IB was associated with better social care outcomes, including higher perceived levels of control, but not with overall psychological well-being in all groups.

(i) Costs and cost effectiveness

IBSENs (2008) main findings were:

- The average weekly cost of an IB was £280, compared to £300 for people receiving conventional social care.
- Costs were lowest for mental health service users (average £150 per week); middling for older people (£230) and physically disabled people (£310); and highest for people with learning disabilities (£360).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The Individual Budgets Pilot Projects: Impact and Outcomes for Carers

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- The costs of IBs were higher for people with greater needs, whether because of problems with daily living activities or cognitive impairments.
- Costs were lower for people living with a family carer and those in paid work. IB holders also reported higher use of health services; and more contact with a social worker/care coordinator, reflecting the demands of support planning
- IBs were cost effective for mental health service users and physically disabled people with respect to both social care and psychological well-being outcomes.
- For people with learning disabilities, IBs were cost-effective with respect only to social care. For older people, there was no difference in social care outcomes, but standard care arrangements remained slightly more cost-effective and people receiving these felt happier.

(ii) Eligibility, assessment and resource allocation

- Formal eligibility criteria for social care support remained unchanged in the pilots, but care coordinators took other factors into account when offering IBs such as an individual's ability and willingness to make changes, manage money or understand new processes.
- Assessment processes did not necessarily change greatly, although there were greater emphases on self-assessment and outcomes.
- In most pilot sites, the sum of money allocated was determined through a

Resource Allocation System (RAS). This itemised the help needed by an individual and resulted in a score that translated into a sum of money which equated with the Individual Budget.

(iii) Planning support arrangements with the IB

 Deciding how to use an IB was challenging for service users.
 Care managers helped individuals to set priorities and identify potential ways of meeting them. Support planning was often judged to be person-focused and accessible.
 However, some concerns were raised over the amount and complexity of paperwork and the general slowness of the support planning process. External support planning organisations or advocates were sometimes involved.
 Social care staff experienced major shifts in their roles and responsibilities. Some welcomed these, though others felt their skills were being eroded. Supervision and training in implementing the new IB approach were considered essential.

(iv) Integrating funding streams

 IBs were expected to include money from several funding streams to enhance flexibility and choice. Pilot site senior managers were enthusiastic about this, but gains were very limited. Barriers included incompatible eligibility criteria; legal and other restrictions on how resources could be used; and poor engagement between central and local government agencies.
 Integrating into IBs the assessment, resource allocation and review processes for other funding streams was thought by IB managers to have been most successful in respect of Supporting People.

The IBSEN report also highlighted some difficulties. It was noted that implementation had been easiest for people with physical and/or sensory impairment, whilst extending the pilot to older people had been slightly more problematic. There were difficulties for people with learning disabilities and widespread difficulties were reported in relation to people with mental health problems. Examples were also cited of financial abuse and deception regarding levels of need. Other concerns were expressed around the costs and complexities of implementing IBs alongside traditional resource allocation systems and that meeting the demand for short-notice and unplanned care in a larger IB system would require a considerable change in the organization of staffing.

Conclusion

The personalization agenda means a major shift in the way social care and individual support providers approach service. This article has covered the conceptual and policy underpinnings of personalization and its relation to substantive issues in self-directed care. Importantly, this paper has located personalization through research studies and thematic areas that are crucial as a baseline for measuring the critical success factors of Individual Budgets. In particular, the themes that emanate from IBSEN report (2008) can be used as benchmarks to measure the effectiveness of the pilots of personalization, social care and IB in UK and other western societies moving towards personalization processes in social welfare for their populations. This challenge has only just started…

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