

REPORT

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Developing social care: the current position



Chapter 2: Conceptual framework

Criteria for evaluation

In addressing needs, resources and outcomes in social care, it is useful to have some criteria for evaluating the allocation of resources, especially in the context of both high levels of need and resource scarcity. We start with a number of familiar criteria:

- economy
- effectiveness
- efficiency
- equity.

In addition, however, we propose some further criteria for this evaluation:

- (informed) user choice
- autonomy
- inclusion
- social solidarity.

These criteria need to be defined in the context of social care:

Economy is the saving of resources. The pursuit of economy obviously requires detailed and accurate cost information, but—in its strictest sense—pays no heed to the impact of lower spending on social care users, families or communities. Economy is closely linked to *cost*.

Improving *effectiveness* means enhancing user welfare and quality of life or moving a provider or commissioner closer to their chosen operational objectives (for example, increasing the number of clients supported, services delivered or referrals processed). Effectiveness is closely linked to *outputs* and *outcomes*.

It must be emphasised that many of the most important facets of effectiveness are hard to gauge. It was our expectation from the outset that we would find little robust evidence for the outcomes of most social care policies or services, for the following reasons:

- Changes in welfare or quality of life can take years to be achieved (indeed, some social care rightly aims to influence lifetime behaviour patterns).
- Effectiveness will sometimes be achieved by slowing down a deteriorative trend (e.g. physical or cognitive decline of elderly people), which is difficult to assess without a comparison group or some indication of what would be typical for the general population.
- Effectiveness in the social care context is partly subjective, with its measurement based partly on users' views and experiences. But users may be unable to express their views reliably because of their frailty or confusion, or because of the compulsory nature of their care.
- Many interventions have 'multiple clients' (e.g. an elderly woman and her carer), raising questions as to whose effectiveness should be assessed, whose perspectives are relevant, and what to do when perspectives and/or experiences are in apparent conflict.

Efficiency combines the resource and effectiveness sides of care. There are many definitions of the term, including allocative and productive. The pursuit of efficiency can mean reducing the cost of producing a given level of outcomes (or effectiveness), or improving the level of effectiveness or the volume and quality of outcomes achieved from a fixed budget.

Cost-effectiveness is a measure of efficiency in the transformation of resources (summarised in terms of their costs) into outcomes (often called effectiveness in economic evaluations). It is rare to find studies that look at both the cost and effectiveness sides of the production relationship, although a number claim to do so. Where such evidence exists, we have set it out in the relevant section under outcomes.

Equity refers to fairness, and two kinds can be distinguished. Horizontal equity refers to the equal treatment of equals (individuals with the same 'needs' should receive equivalent amounts of care or support), and vertical equity refers to the unequal treatment of unequals (differential allocation of treatments or outcomes to individuals with different needs). Targeting services on needs is the most common example of the pursuit of greater equity.

Choice can be seen to have three key elements. The first is the degree of variety within the care system in terms of available services or support systems. The second, and

equally important, is the extent to which service users (and, in some contexts, their carers) have accessible, intelligible information about service options (i.e. about the variety within the care system). The third is the power to be able to make or influence decisions from across that range of options. Indeed, it can be argued that choice requires adequate resources to back up preferences (i.e. control), as can be seen where systems for direct payments are employed. Of course, scarcity of resources means that the social care system cannot simultaneously meet the expressed demands of every individual with assessed social care needs. We therefore call attention to areas where individuals seem to be given *greater* choice in the services they use.

Autonomy is closely linked to some interpretations of choice within a care system. It conveys the extent to which people with social care needs are enabled to make independent decisions about their lives. It is necessarily restricted by efforts to prevent intended or unintended self-harm.

Inclusion has been given an increasingly high profile in social and health-care discourse recently, particularly in official documents. We can include under this criterion efforts to help people avoid moving into a congregate care setting, such as a residential home or hospital. This may or may not be appropriate for any one individual—there is considerable evidence of difficulties with institutional and community living—but it is nonetheless a useful criterion with which to address development.

Finally, and linked to inclusion, a criterion often suggested in social policy contexts is the promotion of *social solidarity* (Le Grand et al 1992). This means the promotion of a sense of fairness within society, such as between generations when considering options for the funding of long-term care. Another interpretation would be to avoid disincentives to providing informal care by family and friends.

The production of welfare framework

A useful organising framework is the *production of welfare* approach (Davies and Knapp 1981; Knapp 1984). Summarised diagrammatically in Figure 2.1, the framework distinguishes seven key elements in the provision of services:

- *needs* for support, defined as the potential for improving the well-being of an individual along one or more of the dimensions relevant to social care. Need is generally a normative concept; in other words, if a person is seen to have a 'need', it is argued that not only is there a shortfall but that for whatever reason (moral, ethical, religious, political) it should be removed. We comment on the approach to defining need below.
- the *funding* base for social care spending, i.e. whether it is derived from taxes or user charges
- *resource inputs* to social care, mainly staff, capital and consumables
- *costs* of those resource inputs expressed in monetary terms (alternatively, this might be an agency budget, used to purchase resource inputs, plus recognition of opportunity costs)
- *non-resource inputs* to the care process, i.e. the influences on outcomes which do not have an identifiable price or are not marketed (such as the social environment of a care setting or staff attitudes)
- *intermediate outputs*, which are the volumes of service output, probably with a quality of care requirement, and perhaps weighted for user characteristics, produced from combinations of the resource and non-resource inputs
- *final outcomes*, the changes over time in the welfare and quality of life of users and their carers. User and carer satisfaction should feature here.

The final outcomes of a social care intervention—sometimes defined in terms of changes in *user needs*—are assumed to be influenced ('produced') by the nature of the services provided, the types, levels and mixes of resources employed, the 'social environment' of the care setting and other non-resource factors. This core theme of the production of welfare model is consistent with the basic assumptions of social work delivery and social care provision more generally. It emphasises the links between user/carer aims and achievements on the one hand, and the services provided and their costs on the other.

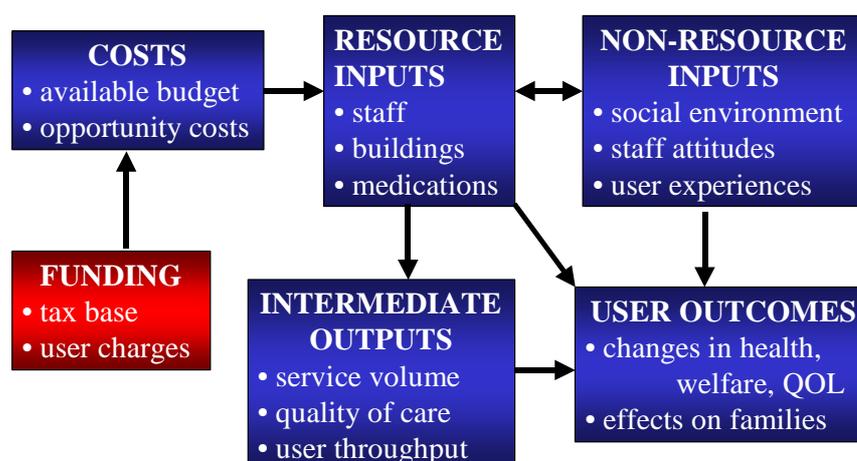
The production of welfare approach thus offers a framework for analysing the complex links between services and achievements and the resource and non-resource inputs that make them possible. It is a useful framework on which we hang much of the evidence on the organisation, funding, delivery and achievements of services.

Although the terminology associated with the production of welfare framework may be unfamiliar, there is nothing peculiar about the approach. It is simply an ordered collection of likely causal connections between factors within the control of decision-makers, staff and carers (and increasingly also of users, given the growth of direct payments and other choice-enhancing arrangements in social care).

Our interpretation of ‘need’

We should say a little about our interpretation of need. Most discussions of the concept tend to be couched in terms of compensating for disability, tackling isolation or addressing problem behaviour. These are all important aims of social care, but to focus exclusively on these dimensions is to employ a very negative conceptualisation of need. At various stages in the report we will discuss the developing, more positive (‘opportunities’) approach to need in policy discussion. To give just one example here, in his speech to the ADSS/LGA conference in October 2003, the Secretary of State for Health described social care as starting from ‘treating everyone as a whole individual—taking account of all their needs and their social context [in order to build] a service of care which is fair to all of us and as personal as possible to each of us’ (quoted in Robbins 2004).

Figure 2.1: The production of welfare framework



Chapters 4–8 are structured around the main elements of the production of welfare framework.

Social care processes

We can suggest four interpretations of, or perspectives on, social care:

- *Social care as a productive process*: This is the process described in section 2.2 as the ‘production of welfare’ framework. Social care is seen as the means by which budgets are allocated to the purchase, hiring or construction of particular inputs, such as staff or buildings, to enable services to be delivered; such services are intended to affect the well-being of individuals and communities.
- *Social care as a coordination–integration process*: Because the full panoply of services comprising social care extends far beyond social services departments and related private and voluntary organisations, the provision of social care necessarily requires joint working with many disparate bodies and professional groups. Such work can take various forms and the processes involved bring attendant difficulties.
- *Social care as a political process*: The management and delivery of social care necessarily entails complex negotiations between those undertaking these activities as well as the taking of controversial decisions, especially in the light of constrained resources. Such political activities include negotiations between central and local government, as well as discussions with users of social care.
- *Social care as a learning process*: Those engaged in managing and providing the many aspects of social care must keep themselves informed. This means not only drawing on the growing body of research but also learning from their own experiences, preferably in comparison with those of others. There has been much recent attention to improving local research and dissemination as well as extending training opportunities for these professionals. Such arguments also apply at the level of national policy-making.

The first of these interpretations—social care as a productive process—is used to organise and interpret the evidence within the client group-specific sections of this report (Chapters 4–8). The other perspectives are used to structure and interpret the more generic evidence on the operations and achievements of social care viewed in the aggregate (Chapter 3).

The mixed economy

Social care services for all client groups are delivered in increasingly complex ways. In analysing what has become known as the 'mixed economy of care', we find it helpful to distinguish two main dimensions of activity providing and financing. Cross-classification of the major types of purchaser and provider produces a simple representation of the relationships between funding and provision (see Figure 2.2).

Providers of social care

The providers of social care can be seen to fall into four main sectors, each with a distinct legal form (or set of forms) and covering a number of organisational types, driven by a mix of motivational forces. The *NHS and Community Care Act 1990* brought about a number of changes to the balance *between* and *within* provider sectors.

The *public sector* includes local authorities, NHS trusts and primary care trusts (PCTs). Local authority provision—quantitatively dominant for so long—has waned over the past two decades across almost all social care areas. On the other hand, the commissioning roles of local authorities have waxed. Strategic shaping of local social care markets has become a major responsibility.

The *voluntary sector* comprises formal organisations independent of government, but bound by a 'non-distribution constraint' which means that any surpluses earned cannot be distributed to owners. Historically, the voluntary sector has played many roles in health and social care, including provider of specialist services, supporter of marginalised population groups, innovator and advocate for change; sometimes, services provided by the voluntary sector are direct substitutes for public provision (Kendall and Knapp 1996). Most voluntary organisations in the social and health care fields in Britain have charitable status, conferring certain tax and reputation advantages.

Figure 2.2: Relationships between funding and providing: examples of governance arrangements

Funding mode	Provider sector			
	Public	Voluntary	Private	Informal
Coerced collective funding (tax)	Hierarchical structures; 'internal' quasi-markets	Public contracting-out, i.e. 'external' quasi-markets		Public support for carers; direct payments to users
Voluntary collective funding		Foundation support for voluntary efforts	Trust funding to 'top up' care-home fees	
Corporate funding		Support to formal voluntary organisations providing services		Paid leave or other support to carers from employers
Individual funding	User charges for public services	Fee-for-service delivery by charities	Traditional market	
Individual transfers and non-monetary support	Voluntary work within NHS	Formally organised volunteering in day-care settings		Help from family, friends and neighbours

The *private sector* is also constitutionally separate from government, but not bound by any non-distribution constraint: profits earned may be distributed to owners. Private-sector care provision for all social-care user groups has long been dominated by small family businesses, many running single residential or nursing homes. Recently the corporate sector has begun to acquire a bigger slice of these markets. In this report, we use the term *independent sector* to mean the (formal) voluntary and private provider sectors.

The *informal sector* principally comprises the huge number of individual unpaid family and other carers. Most carers provide support to older people (Rowlands 1998), often at a low level of intensity and on a reciprocal basis; nearly one million carers provide co-residential care to an older person (Pickard 2000). A small proportion of this support entails highly intensive care to dependent older people. Some carers are involved in mutual support groups, and thus shade into the 'self help' limb of the voluntary sector, to the extent that they organise formally (although many remain essentially ad hoc). The 1990 Act and subsequent legislation have sought to provide more support for family and other unpaid carers.

Purchasing

For the purposes of this report, five main routes of purchasing, funding or demand should be distinguished.

Coerced collective funding describes the arrangement whereby the public sector acts as purchaser on behalf of individuals, funded predominantly from taxation and mandated by democratic processes. This has been the largest source of funding for most formal social care services in the UK since the late 1940s. Tax-based funding may be routed directly to providers through central government (for example, by the DHSS/DSS prior to 1993 to independent care homes to support lower-income residents); or through local government as the direct service provider or to purchase private and voluntary sector services under contract; or through PCTs that commission some social care services.

Voluntary organisations (and occasionally other bodies) may use voluntarily donated funds to finance their own or other agencies' services. This can be called *uncoerced or voluntary collective support*. The choice as to what goods or services to purchase, and for whom, is controlled by the funding organisation and not usually by individual donors. Voluntary health and social care organisations have come to depend less on this source, and more on public (coerced collective) funding (Kendall 2003).

Corporate funding is purchasing by private-sector corporations or other businesses. Since the late 1940s, purchasing/funding has been dominated by tax-based, universal health and social care systems, greatly reducing the need for employer-funded private or social insurance payments. Nonetheless, employer-subsidised private health insurance is growing (slowly) in coverage, although employer-funded long-term care insurance is extremely rare.

The other two main purchasing routes are via individuals. *Individual funding* is payment for goods or services consumed by the payer, with or without subsidies from social security or other transfer payments. *Individual transfers and non-monetary support* are payments for goods and services to be used by someone else: payments are made

directly to suppliers and not to intermediary voluntary organisations. This final 'purchasing' or resourcing category also includes volunteering, which is a significant if perhaps under-recognised input to social care in the UK (Davis Smith 1998; Knapp et al 1996; Pickard et al 2001).

Governance

While systems for purchasing and providing are regularly discussed, the governance dimension which interconnects them—fashioning the transactions represented in the matrix—is equally important and too often overlooked. Understanding these relationships is essential to understanding how health and social care systems function. By *governance* we mean institutions, rules, regulations and protocols that govern stakeholders in undertaking transactions. Governance structures set the way in which stakeholders plan, exchange and pay for goods and services. The concept therefore covers an array of associations, from the hierarchical management-by-fiat structures found in public-sector organisations directly funding their own services, to voluntary market-based exchange mechanisms, such as contracting-out to independent providers or state support for family carers. A range of governance types can be located in the mixed economy matrix (Figure 2.2).

The nature of governance of social care transactions is affected by legally or politically authorised public sector decisions. Examples include the tax treatment of corporations, publicly sanctioned codes of practice for provider self-regulation, judicial review by the courts, and the establishment of training curricula and professional standards. Regulatory influences stem more directly from law-making and other central government policy prescriptions, including powers under the 1990 Act to call for reports and issue directives to social services departments. Central government's regulatory function is also exercised through Commission for Social Care Inspection. Arm's-length inspection units were introduced by the 1990 Act, located within the local authority and charged with responsibility for inspecting all provider sectors, whether private, voluntary or public.

Reviewing the regulatory system they inherited, the Labour Government identified deficiencies in three areas (Secretary of State for Health 1998):

- *Independence*: inspection units were part of the local or health authority.
- *Coherence*: there was a rather arbitrary distinction between health and social care and their respective inspection units.
- *Consistency*: the large number of local units operated independently of one another.

To address these problems, the 1998 White Paper proposed eight regional Commissions for Care Standards operating regionally to structure local regulation.