Chapter 9
Long Term Care Reform in England: A Long and Unfinished Story

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9.1 Introduction

This chapter is not about a single reform, or series of reforms. It documents some major changes that have taken place in the organization and delivery of long term care in England over the past two decades—in particular the introduction and elaboration of quasi-markets, and what might be considered to reflect New Public Management ideas aimed at improving efficiency both within long term care and at the interfaces between long term care and acute health care. However, it also documents the *failure* over the same period to achieve reform in the critically important area of funding. It is widely agreed that the current budgets for long term care services are woefully inadequate and unsustainable in the longer-term; and that the ways in which these resources are allocated are neither fair nor transparent. It is difficult to interpret these contrasting developments as characterizing any one of the modes of transformative change proposed by Streeck and Thelen (2005). Indeed, it is striking that one series of policy preoccupations—quasi-markets and choice—has been pursued so consistently and assertively over two decades by Conservative, Labour and Conservative–Liberal Democrat coalition governments alike, when all have found more fundamental funding reforms much harder to achieve.

A range of political and policy interests—not all with equally high public profiles—are involved in debates about long term care reform in England. Given their statutory responsibilities (see the following section), local authorities and social care professional leaders are important players, as are the associations of private (for profit and charitable) residential and domiciliary care providers. Organizations representing older people, people with learning disabilities and articulate campaigning groups of younger physically disabled people are key actors; indeed the latter groups have exerted major influences over the shape of reforms, by arguing that cash-based arrangements offer greatest opportunities for choice, control and citizenship. England also has a long-established and highly effective organization promoting the

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C. Ranci, E. Pavolini (eds.), *Reforms in Long-Term Care Policies in Europe*,
DOI 10.1007/978-1-4614-4502-9_9,

interests of family carers. Because they do not contribute directly to the funding of long term care, neither employers nor trade unions have historically been involved in debates about reform, although since 2010 public sector trade unions have begun to campaign against the coalition government's public spending cuts by highlighting the damaging impacts on quality of care.

9.2 Structure and Scope of LTC in England

England is unusual among developed welfare states, not only in the fragmentation of responsibilities within the care sector, but also in the residual nature of state funding for long term care and in the variable local arrangements governing access and levels of provision. Arrangements for funding and delivering long term care are highly fragmented. There is no single policy, funding or service stream that is widely understood as 'long term care'. Resources contributing to long term care are embedded within the separate budgets of the National Health Service (NHS), local authorities and the Department for Work and Pensions (DWP). Each of these also determines its own macro-level policies and micro-level resource allocation processes.

- Residential care, help with personal care and domestic tasks at home, day care and other daytime activities are the responsibilities of local authority adult social care departments. They are funded through a mixture of national taxation, distributed by central government to local authorities but without ring-fencing for specific services; local property taxation; and user charges. People with assets above £ 23,250 (including the value of a family home) are generally unable to access any local authority-funded residential or domiciliary care and even poor people pay charges. Overall, income-related user charges make up around 17 % of the entire spending on social care. Local authorities also have statutory duties to assess the needs of family carers and provide help for carers, most commonly in the form of respite care (or funding to be spent on respite care). Local authorities are additionally responsible for some housing-based support services, particularly for people with learning disabilities or mental health problems. In relation to older people, there is currently interest in developing 'extra care' and supported housing (specially designed or adapted housing with high level support services on the premises) as a less costly alternative to residential care.
- The National Health Service (NHS) contributes around £ 3.0 billion to long term care through the funding and direct provision of nursing care and therapy services for people in their own homes or residential care. NHS services are funded from general taxation and are free of charge at the point of delivery. In addition, a small number of people—about 14 % of all nursing home residents in 2005—have healthcare needs that are so intensive or unstable that all their care is funded by the NHS (NHS continuing care), a funding regime equivalent to hospital in-patient status (Laing and Buisson 2005).

- Relevant social security benefits include the Attendance Allowance (AA), which is received by 1.4 million older people needing regular or substantial help with personal care or supervision; and Disability Living Allowance (DLA), which is claimed by 2.8 children and working age disabled people and includes an additional element covering extra transport costs for those with moderate to severe mobility difficulties. Both benefits are intended to meet the extra costs associated with disability. Benefit rates vary from £ 20 to £ 131 a week, depending on age, the level and frequency of help needed and whether the claimant has additional mobility difficulties. It is extremely difficult to calculate how many eligible people actually receive these benefits because of difficulties in estimating the size of the eligible population. Estimates range from 40 to 60 % (AA); 30 to 50 % (DLA care component) and 50 to 70 % (DLA mobility component; Kasparova et al. 2007).
- Family carers of AA and DLA recipients who have little or no income from other sources can also claim Carers Allowance, which is intended to replace earnings lost because care responsibilities prevent paid employment. These benefits are the responsibility of the Department of Work and Pensions and are administered nationally. However, because AA is usually included in means-tested calculations of user contributions for local authority social care, at least some of these benefits are effectively public expenditure transfers from one government department to another.

Total UK spending on long term care, as a percentage of GDP, is broadly comparable with other advanced welfare states such as Australia, Canada and Germany (OECD 2005). However, public expenditure accounts for only about 65 % of this total. The remainder is made up of user charges (around 17 %) and private purchase of services (Comas-Herrera et al. 2004). In addition, in 2007, the 6 million informal carers (about one in ten of the total UK population, according to the 2001 Census) contributed care equivalent to £ 87 billion (Carers UK 2007).

An estimated £ 13 billion (Wanless 2006) is allocated to people aged 65+ in England through these different arrangements. However, responsibilities for funding, assessment and service delivery are profoundly fragmented between different central government departments and between national and local organizations. Thus macro-level policies and resource allocations for both social care and NHS services are the responsibility of (different sections of) the Department of Health. Social care budgets are determined by individual local authorities; individual local authorities also decide whether they can support people with only critical level, or less acute, support needs in the light of their local budgets. There is more uniformity across England in the allocation of NHS services, but these ultimately rely on local professional assessments of need and discretion and some local variations still exist. The DWP administers AA, DLA and Carers Allowance on a national level across the UK as a whole.

In summary, access to public funding for long term care involves assessments that use different combinations of several different criteria, including: income and assets/wealth tests; health needs and needs for medical treatment; capacity for self-care and risks of harm; and other individual circumstances, especially the availability of informal carers. These allocation arrangements lack strategic coherence; are not transparent or easily understood; may not be well-targeted on those with the highest level needs (Wanless 2006); and often involve costly duplicate assessments. In addition, policies and funding for NHS and local authority social care services are the responsibility of the individual countries of England, Scotland, Wales and Northern Ireland; only in relation to the DWP social security benefits are eligibility criteria and entitlements the same across all four countries of the UK (see Glendinning 2007 for further details). The following account relates only to England.

Partly because of this systemic fragmentation and partly because there are no national thresholds of eligibility for health or social care services, it is very difficult to estimate the coverage of English publicly-funded long term care services relative to need. In 2009, a Parliamentary Committee was told by senior civil servants in the Department of Health that about 6,000 older people had high support needs but received no social care services or informal care and around 1.5 million people (60 % of all disabled older people) had some shortfall in their care needs, if it is assumed they had no informal care to make up the deficit (House of Commons Health Committee 2010, p. 41). Reflecting policies to shift care from hospital and residential settings to community-based services, there has been a 1 % shift in expenditure from residential to community services over each of the five years from 2002–2003 to 2005–2007. During that time, the total number of older residents living in care homes with funding from local authorities fell by 13 %. Home care services are increasingly targeted at those with the highest levels of need; there was a 22 % reduction in the number of households receiving home care services of five or less hours per week during the same period. Meanwhile, the number of people using non-residential intermediate care services (see Sect. 9.5.2) following early hospital discharge rose from 98,000 to 225,000.

These structural arrangements have their origins in the institutions of the English post-war welfare state. In the late 1940s, responsibilities for ‘treatment’ and ‘cure’ were assigned to the newly established NHS, with local authorities responsible for longer-term personal and practical services for older people. Accordingly, while the NHS provided for the ‘ill’ and ‘sick’, the 1948 National Assistance Act made local authorities responsible for supporting people in need of ‘care and attention’ (Means and Smith 1998). In addition, policies and funding for both health and social care are entirely separate from cash benefits for maintaining income and living standards, including benefits to help meet the extra costs of disability and care. The funding and accountability mechanisms underpinning these divisions of responsibility have remained fundamentally unchanged ever since. However, the boundaries between NHS and local authority responsibilities have shifted markedly over time (Glendinning and Means 2004; Lewis 2001). Since the late 1940s, the NHS has withdrawn from virtually all responsibilities regarding non-medical care for people with long term support needs. Thus, during the 1970s, a series of central government circulars defined older people with ever higher levels of frailty and ill-health as ‘appropriate’ for local authority residential care, so that those considered to need ‘care and attention’ came to include people with severe cognitive impairments, those who were bed-bound and those in the final stages of terminal illness (Means and Smith 1998).

Similarly, since the mid-1990s, a series of legal test cases and government directives has restricted long term NHS services to only those with intensive or unpredictable health needs, as noted above (Glasby and Littlechild 2004; Glendinning and Lloyd 1998).

The following account will focus primarily on developments (and the lack of developments) within social care. These developments are characterized by the simultaneous co-existence of, and tensions between, institutional inertia and incremental innovation (particularly the extensive marketization that has been introduced into English long term care over the past two decades). Thus, long term care services have been transformed by two distinct waves of quasi-market development, and by the search for greater efficiency in service organization and delivery. At the same time, there have been repeated—and continuing (2011) failures to reform a system that is widely regarded as inadequate, inequitable and unsustainable; indeed, it is arguable that the twin pressures of marketization and efficiency have actually increased the difficulties of introducing more radical, transformative change. The following sections describe these contradictory developments and their consequences: the introduction and elaboration of quasi-markets within adult social care; the drive for improved efficiency; and the unresolved problems of funding and fairness.

9.3 The Development of Markets in LTC

The marketization of English social care has occurred in two main phases:

- The community care structural reforms of the 1990s.
- The development of consumerist initiatives from 2000 onwards.

9.3.1 The 1993 Community Care Reforms—Introducing Markets into Social Care

Until the 1980s, local authorities were both the funders and the providers of social care services, including home help (domiciliary care) services, residential homes and day centres. However, a series of reforms to means-tested social assistance benefits in 1980 made it easier for low income older people and those with disabilities to obtain social assistance funding for the fees for private residential and nursing home care. There is debate about how far the implications of these changes were anticipated or unexpected; however, their impact was dramatic. Both local authorities and NHS hospitals rapidly saw the opportunity to shift responsibilities for funding residential and nursing care to the social assistance budget and a private market in residential and nursing homes quickly developed in response to this new funding opportunity. Older people with low incomes and assets increasingly entered to institutional care solely on the basis of their low financial means, with no assessments of their actual needs for care, or consideration of whether alternative domiciliary based services might provide appropriate levels of support. At the same time, NHS policies aimed to close the remaining long-stay hospital provision for people with learning disabilities and long term mental health problems and move them to community-based accommodation. The NHS was also experiencing considerable pressures on its long term geriatric hospital facilities. Again, social security funding for new community-based residential care was an attractive option.

Quite simply, these developments illustrated ‘cost-shunting’—the transfer of funding for long term care from constrained local authority and NHS budgets to the open-ended, needs-led social assistance budget. ‘The social security budget had inadvertently come to the rescue of families, local authorities and the NHS, all of them under tight budgetary limits and increasing demand. What the government had done was to create an effective voucher system’ (Lewis and Glennerster 1996, p. 4).

The result was an exponential increase in public spending on residential care; the rapid growth of a private market in residential and nursing home care, funded through the social assistance budget; and major disincentives to local authorities to develop domiciliary and community-based services to support people in their own homes. Between 1986 and 1991, social security spending on residential care rose from £ 10 m to over £ 2,000 m. For the first time in English social care, a substantial private care market had developed.

These trends were, however, contrary to the stated government policy of encouraging ‘community-based’ care—that is, care for older and disabled people in their own homes or at least non-institutional settings. The Audit Commission is an influential independent watchdog, responsible for ensuring that local authorities and the NHS secure good value for money through their use of public funding. In 1986, the Commission published a report (Audit Commission 1986), criticizing the ‘perverse effects of social security policies’ created by the social assistance rules and the consequent rapid increase in residential and nursing home provision, in contradiction to official policy. The Commission also criticized the fragmentation of responsibility between NHS and local authorities for community-based care and the lack of a single organization with clear lead responsibility.

Eventually, the then Conservative government appointed a Committee of Enquiry to review the resourcing of community care services and advise on changes. The report of this Enquiry (Department of Health and Social Security 1988) recommended that responsibility for funding and assessing social care needs should rest clearly with local authority social services departments. However, rather than recommending an expansion of the volume and range of directly-provided local authority social care services, the Enquiry argued that choice and efficiency should be stimulated through a ‘mixed economy’ approach, in which the public, private and voluntary sectors should compete on an equal footing to provide services: ‘The primary function of the public services is to design and arrange the provision of care and support in line with people’s needs’; a ‘mixed economy’ would encourage choice, flexibility and innovation, in a climate of competition (Department of Health and Social Security 1988, para 3.4). Information about the range of local needs that should shape local market development was to be generated through annual community care plans, created jointly with health and other local partners at the macro/strategic level (Lewis and Glennerster 1996; Means et al. 2002). At the level of individual care recipients (older people or those with disabilities), the assessment of eligibility and micro-purchasing of services was to be the responsibility of local social care 'care managers'. This was an important new 'gatekeeping' function, intended to cap the burgeoning social assistance expenditure on residential care by restricting eligibility to those with higher levels of need and encouraging the search for less costly and more appropriate alternative arrangements.

The proposed 'mixed economy' in social care reflected the dominant ideology of the Conservative Government, which was in a powerful position, having just won its third consecutive election. 'Mixed economies' were being imposed on other local government and National Health Services. The creation of a 'mixed economy' in social care was also a response to the then Prime Minster Thatcher's antipathy towards public sector services in general and local authorities in particular, and her concern to support the newly emergent private residential care sector that had developed with social assistance resources.

Simply to cut off the flow of social security money to new applicants would lead to the bankruptcy of many small private homes. Not only had they become an influential pressure group, but they were exactly the kind of small family businesses which Mrs Thatcher approved (Lewis and Glennerster 1996, p. 6).

Eventually, Mrs Thatcher was persuaded to agree to the transfer of the social assistance budget to local authorities on condition that it was used to purchase private sector provision. In summary, the reforms were a response to a funding crisis—the haemorrhaging social assistance budget being spent on long-term residential care—with additional elements designed to minimize political outcry, appeal to groups representing service users and carers, and avoid awarding additional resources to local authorities (Lewis and Glennerster 1996).

Nevertheless, it was in 1993, another five years, before these recommendations were implemented. At that point, the social assistance funding that had been supporting people in residential care was capped and transferred to local authorities, who were encouraged increasingly to purchase services from independent, charitable and for-profit providers. In-house services were to compete with these alternative service providers. Social workers became care managers, responsible for assessing needs and for purchasing 'packages' of support to suit individual needs from those providers with whom the local authority had or was able to negotiate contracts (Means et al. 2003). In effect, market and consumer choices were exercised by care managers, on behalf of service users.

In summary, this stage of marketization reforms involved:

- Introducing 'gatekeeping' assessments of individual needs and separating these from the planning and procurement of services to meet those needs.
- Separating purchaser/commissioner and provider functions within the local authority.
- The gradual transfer of provision from local authorities' own in-house services to the charitable and for-profit sectors.
- Business development, licensing and regulatory activities to support the development of new services and providers.

These reforms were successful. In 1992, the year before the reforms, the private sector was supplying only 2 % of all home care contact hours; by 2001 this had increased to 60 %. By 2001, 85 % of all residential care places for adults were provided by private organizations, although this was no longer an expanding market as increasing demand for domiciliary services, falling occupancy rates and other economic pressures squeezed the sector (Means et al. 2003). Some residential care providers diversified into new service areas such as respite care. Others closed, with associated insecurities for their residents. Subsequently the sector has been described as displaying 'traditional tendencies to monopoly and standardization' (Drakeford 2006, p. 936), as corporate and global healthcare organizations have acquired significant market shares and considerable policy influence at national and local levels (Schofield 2007). Thus the number of homes, and the number of places in them have both dropped, in line with policies of supporting people in their own homes for as long as possible, although the average size of homes has increased (CSCI 2009).

9.3.2 Consumerism, Disability Rights and Personal Budgets—Making Users the Purchasers

Since the 1980s, organizations of working-age physically disabled people had campaigned to receive their support in the form of a cash payment instead of services in kind. They argued that this would enable them to employ personal assistants and other carers to provide help with the tasks of their choosing, at the times and in the ways that best suited them. Exercising choice and control over their support arrangements through cash payments instead of services in kind constituted essential steps in achieving human rights and full, active citizenship (Morris 2006).

Legislation allowing local authority adult services departments to make cash direct payments instead of services in kind was implemented in 1997,[1] first to working age disabled people and from 2000 to people aged 65+, parents of disabled children, carers and disabled 16- and 17-year olds. This marked a clear break with the traditional post-war welfare state structure, in which cash payments were restricted to the social security and income maintenance functions of the Department for Social Security (later DWP), while local authorities provided (and, increasingly commissioned and purchased) services in kind (Glasby and Littlechild 2006). Commentators were quick to point to the uncomfortable alignment between disability and civil rights discourses and the neo-liberal discourses of the then Conservative Government that emphasized the rolling back of state responsibilities and a greater role for individual consumer choice:

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[1] The 1996 Community Care (Direct Payments) Act was passed before constitutional devolution in the UK; it therefore covered, and was implemented in, the four countries that make up the UK.

> When we talk about the introduction and expansion of direct payments, we are really talking about two different processes—on the one hand a victory for disabled campaigners . . . on the other, an attempt by a Conservative government to introduce the values of the market into social care (Pearson 2006, p. 28).

However, relatively few people chose the direct payments alternative to receiving services. Take-up remained stubbornly low and characterized by major variations between the countries of the UK; between local authorities within those countries; and between different groups of service users within those authorities (Davey et al. 2007). Take-up rates were highest in England and lowest in Northern Ireland. People with physical and/or sensory impairments consistently had higher rates of take-up. Older people, people with learning disabilities and, particularly, people with mental health problems were much less likely to opt for direct payments (Davey et al. 2007). Direct payments appeared more popular among those with the most severe disabilities and among younger age groups.

Local authorities themselves identified a range of factors considered to promote take-up of direct payments (Davey et al. 2007). These included effective support services to help people recruit personal assistants and manage direct payments; leadership, training and support for the care managers who introduced older and working age disabled people to the option of direct payments instead of directly provided services; and demand from service users themselves. Conversely, anxieties among older and disabled people about managing direct payments and shortages of people willing to work as personal assistants were considered to hinder take-up. Local political and policy factors appeared to play a significant role (Fernández et al. 2007), as did professional resistance by front-line care managers anxious about the threats to traditional social care practice (Ellis 2007).

By 2009, only 6.5 % of all people using adult care services were using direct payments, ranging from 9.5 % of adults aged 18–64 to 3.6 % of those aged 65 and over (Care Quality Commission [CQC] 2010). Consequently, in 2001, legislation was introduced *requiring* local authorities to offer direct payments as an alternative to direct service provision; and direct payment take-up rates were introduced into the indicators on which local authority performance was judged. In 2003, the then Labour Government introduced a £ 9 million Direct Payment Development Fund in England, to fund local organizations (often run by people with disabilities themselves) who could provide information and help with managing payments, recruiting and employing personal assistants. Despite these measures, take-up remained low. While central government legislation and additional funding to promote take-up were undoubtedly important, local culture and practice among front-line staff and workload pressures restricting the time available for the more demanding tasks of encouraging people to use direct payment use were also influential in restricting take-up (Davey et al. 2007). To these barriers could be added resistance by social care service users to taking on responsibility for planning, organizing and the ongoing management of their own care services, particularly if they were experiencing illness, pain, cognitive impairments or fluctuating conditions.

From 1997, the Labour Governments built on these quasi-market foundations as part of a wider consumerist approach to public sector reform. Consumerism was heralded as further increasing user control, continuing the earlier trajectory of squeezing provider and professional interests; and, by creating new opportunities for entrepreneurialism, enhancing efficiency in public sector markets. Consumerism of course also involves transfers of risk—not just from the state to the private sector but also to individual service users themselves. 'The rhetoric of user choice . . . can be seen as a form of individual risk transfer. Choice has been put forward in a wider range of different services and processes . . . many of which are potentially liberating for service users but some of which raise concerns about risk, capacity and equity' (Needham 2007, pp. 74–75).

Commentators have pointed out that the Labour administrations from 1997 to 2010 pursued the marketization of public services to a much greater extent than the previous Conservative governments—albeit tempered by frequent references to community, equality, responsibility and the social sphere (Needham 2007). These themes came together in discourses of co-production—the active involvement of users in the creation and delivery of the services they use:

> By putting users at the heart of services, enabling them to become participants in the design and delivery, services will be more effective by mobilizing millions of people as the co-producers of the public goods they value . . . (Leadbeater 2004, pp. 19–20).

It was argued that co-production introduced new incentives for service users to optimize how the resources placed under their control were used and for providers to respond to individual demands, thus increasing cost-effectiveness. Addressing critiques of the individualism underpinning consumerism in welfare sectors, co-production was claimed to:

> . . . create a new way to link the individual and the collective good; people who participate in creating solutions that meet their needs make public services work harder and help deliver public policy goals. Self-directed services work because they mobilize a democratic intelligence; the ideas, know-how and energy of thousands of people to devise solutions rather than relying on a few policy-makers . . . (Leadbeater et al. 2008, p. 81)

Social care has been at the forefront of implementing these ideas, extending the marketization of social care by devolving purchasing power—command over the public resources available for any individual to spend on social care—to individual service users themselves. As noted, this also involves devolving associated responsibilities and risks. Although, like direct payments, the following developments were initially promoted by and for disabled people of working age, they have subsequently been extended to all social care service users.

A 2001 policy statement on services for adults with learning disabilities, *Valuing People* (Department of Health 2001b) led to the development of an alternative approach to direct payments that also aimed to promote choice and control over social care. Supported by a social enterprise organization *In Control*, this approach gave service users a bigger role in assessing the level of social care support they needed (and correspondingly reduced the role of professionals in assessing levels and types of needs). Resources—personal budgets—were then allocated to individuals according to relative levels of need (rather than according to the value of in-kind services, as with direct payments). Individuals and their families were given information and support in planning how to use these resources in line with their specific priorities and preferences. Whereas direct payments were generally used to employ personal assistants to help with personal and domestic care, *In Control* encouraged much greater flexibility in how personal budgets were used, including the purchase of a range of ordinary community-based services. For example, personal budgets could be spent on art classes or gym membership rather than attending a special day centre. *In Control* connected closely with the principles underpinning direct payments, but had a broader aim of 'redesigning' social care systems towards 'self-directed support' (Duffy 2004). The *In Control* organization was extraordinarily successful in promoting this approach to supporting adults with learning disabilities in many English local authorities.

This experience was picked up in a major policy statement published by the Prime Minister's Strategy Unit in 2005. *Improving the Life Chances of Disabled People* contained a range of proposals designed to promote the social inclusion of disabled people, including the piloting of individual budgets (IBs). Unlike the *In Control* initiative, IBs were to bring together resources from a number of funding streams to which the individual was entitled—not just social care, but also housing-related support, equipment and adaptations and a special fund for people with very expensive support needs. The intention was to reduce duplicate assessments and increase choice and control for the service user, who would have more flexibility to use the full range of resources to which s/he was entitled according to her/his priorities and preferences. IBs could be managed in different ways—given back to a local authority care manager to purchase services on the user's behalf; managed by the service user as a cash direct payment; managed by a third party such as a relative; or managed by a service provider. A standardized resource allocation system, based on the one developed by *In Control*, was recommended. Like *In Control,* individuals were to know how much money was available to them before planning how to meet their needs (and be responsible for managing that resource); and like *In Control,* IBs could be used to purchase conventional social care services, employ personal assistants, pay relatives and friends or buy mainstream goods or services. Individuals' plans for using their IB were to be approved by a local authority care manager to ensure no undue risks were involved.

IBs were piloted in 13 English local authorities between 2005 and 2007 and an extensive multi-method evaluation of the pilots was undertaken (Glendinning et al. 2008). IBs were generally welcomed by their users because they offered more choice and control over daily life, but there were variations in outcomes between user groups. In particular, older people with IBs reported lower psychological well-being, compared to those receiving conventional services. Older IB users also reported lower levels of satisfaction compared to younger IB holders. There was no evidence, therefore, that IBs were cost-effective for older people. In addition, staff involved in piloting IBs encountered many challenges, including devising resource allocation processes and establishing legitimate boundaries for what IBs could be spent on. Despite the efforts of local service managers, efforts to integrate resources from different funding streams were largely unsuccessful; managers cited numerous legal, regulatory and accountability barriers that could only be reduced by central government action. For a variety of reasons (Moran et al. 2011), central government departments failed to take the necessary steps to facilitate integration of funding streams.

Moreover, before the IB pilots and associated evaluation were finished, the Department of Health announced a three-year 'transformation' program in adult social care that involved the extension of personal budgets (PBs) to everyone receiving adult social care (Department of Health 2008). Significantly, PBs involve *only* social care resources—the ambitions of integrating funding streams and reducing multiple assessments had been abandoned. Like IBs, PBs can be deployed in different ways—as a cash direct payment; managed by a service provider organization and drawn on to pay for services as and when they are used; managed by a carer or other 'third party'; or held by, and used to pay for services purchased by, the local authority.

Local authorities were given a specific grant to fund the necessary organizational changes to implement personal budgets and a target introduced to move all adults onto personal budgets within three years. However, progress has been slower. By March 2010, 18 % of adults (all ages) receiving social care had a personal budget; in-depth research in four local authorities found that between 13 and 59 % of older people had a personal budget (average 34 %), compared with an average 50 % of working age adults with physical disabilities (Audit Commission 2010). To support the wholescale implementation of personal budgets, local authorities have also had to transform methods for allocating funding to individuals and for managing financial and other risks; help local provider markets adapt to demands from personal budget holders for new services; and make available appropriate information and support for people to plan and manage their budgets.

Both the IB pilots and the PB program now being extended across all English adult social care involve the allocation of only local authority social care resources. Despite extensive collaboration between local health and social care organizations since 1997, leading to the creation of many joint local services for older people (see below), NHS resources were not included in the funding to be allocated through IBs and PBs (Glendinning et al. 2011). Instead, an experimental pilot program of personal health budgets (PHBs) was launched in 2009, supported by an extensive evaluation program. PHBs do not replace clinical treatments, but offer opportunities for more personalized and innovative ways of managing long term health problems that are not possible with conventional NHS services. Although the Coalition Government is committed to the long term future of PHBs, the extensiveness of the PHB program and the patient groups who are offered PHBs is likely to depend in part on the results of the pilot evaluation.

9.4 The Implications for the Social Care Workforce

Whether employed by local authorities or private organisations, care workers who provide direct 'hands on' care are predominantly low paid, low skilled and part-time women. Foreign-born people and those from black and ethnic minority communities and foreign-born workers are over-represented in the social care workforce, particularly in London. However, many are long term residents in England; temporary migrant workers tend to be concentrated in the residential care home sector and in the relatively small market for live-in domiciliary carers.

Low pay is endemic in social care, even though front-line care staff were one of the groups to benefit most from the introduction of a National Minimum Wage in 1999 (Grimshaw 2002; Grimshaw and Caroll 2006). Skill levels are also relatively low, although these are slowly improving through workplace-based training and assessment programs. However, the introduction of direct payments and the extension of personal budgets may slowly lead to a more diverse, flexible and less regulated workforce in the domiciliary and community sectors. There are an estimated 200,000 personal assistants employed by older people using personal budgets (Skills for Care 2010). Personal budget-holders may recruit their care staff from among their own informal social networks, which may lead to an overall increase in the size of the home care workforce, albeit under much less formal or regulated arrangements.

Surveys of personal budget-holders report improvements in reliability and flexibility and lower levels of abuse from directly employed personal assistants than from agency home care staff. Personal assistants also report high levels of job satisfaction, although some complain about long hours or low pay. There are no requirements for personal budget holders to provide contracts or formal conditions of employment for their personal assistant employees, nor for personal assistants to have minimum qualifications. Indeed, personal budget holders tend to give low priority to formal qualifications, preferring to provide their own personalized, on-the-job training (Skills for Care 2008). Local authorities are beginning to develop systems to help personal budget-holders manage their employment responsibilities, but these are highly variable across the country (CSCI 2008).

9.5 The 'Modernization' of Social Care

Arguably, the drive first to create quasi-markets in social care, and subsequently to transform those markets into consumer-driven entities responsive to individual preferences and outcomes, have been the dominant features of reform over the past two decades. However, other goals and levers for reform are also apparent, particularly those aimed at improving the organization, delivery, efficiency and accountability of services themselves.

A discourse of 'modernizing' public services permeated the Labour government's policies, particularly during its first term of office from 1997. The concept of 'modernization ' is contested: some argue that it extends the imperatives of New Public Management beyond the marketisation reforms of the Thatcher era; others argue that 'modernization' is as much about transforming citizens in line with the requirements of neo-liberalism as with changing institutions. In practice, it is difficult to identify a distinctive and coherent 'modernization' reform program, not least because the features of social care services render simple managerial reform levers (economic incentives and penalties, performance targets) ineffective or inappropriate (Newman et al. 2008). Three 'modernizing' initiatives will be described here: improving inter-sectoral collaboration ; intermediate care; and home care reablement. All aim to improve the efficiency and cost-effectiveness of services (as well, of course, as improving the quality of users' experiences).

9.5.1 Improving Collaboration Between Services

Barriers between health and social care services have long been identified as problematic, particularly in the prompt discharge of older people from acute hospital care and in de-medicalizing support for people with learning disabilities or mental health problems. A 1998 policy paper *Modernising Social Services* (Department of Health 1998) identified a number of areas for improvement, including better coordination between local social care, health and housing services. Subsequently, a plethora of measures was introduced to promote, incentivize and require collaboration between health and social care, including statutory obligations on NHS organizations and local authorities to work in partnership; 'ring-fenced' funding to support joint local services; national service frameworks that set benchmarks across both sectors; and the relaxation of legal barriers to closer organizational collaboration (see Glendinning et al. 2005). The latter allows pooling health and social care budgets for specific services; joint or lead commissioning by one sector on behalf of both; and/or the integration of health and social care staff and service delivery within a single management structure.

Many local collaborative developments have resulted, particularly in relation to services for older people. Individual assessments increasingly cover both health and social care needs (Department of Health 2001a). Joint strategic needs assessments and joint commissioning between local authorities and NHS Primary Care Trusts (PCTs) became widespread across many areas of adult services; collaboration and partnership are now mainstream activities for many managers and practitioners in both sectors.

Despite a lack of evidence of the benefits of collaboration for older people using services (Dowling et al. 2004), there is still an apparently strong belief in the potential efficiency gains. A Green Paper (consultation document) on the future of adult social care published in 2009 (HMG 2009) gave considerable attention to 'joined-up working' between different services and benefits.

> … services that are not joined up can be very wasteful of tax-payers' money. For example, different organizations may provide duplicate services, and services that do not work well together can increase costs (HMG 2009, p. 68).

Meanwhile, other policy initiatives, such as the piloting of individual budgets (Glendinning et al. 2011), have served to undermine collaboration between health and social care. Moreover, a focus on this particular service intersection may itself undermine collaboration across a much wider range of services (Newman et al. 2008).

9.5.2 Intermediate Care

One area in which considerable joint developments between health and social care organizations have occurred is at the margins of hospital admission and discharge. These developments have aimed to improve the efficiency of the acute hospital sector by facilitating prompt discharge as soon as clinical treatment has finished; and to expand rehabilitation services to help reduce longer-term dependence on health and social care (Department of Health 2000). 'Intermediate care' is a generic term covering a wide range of short-term services aimed at preventing admission to hospital, supporting early discharge, and reducing or delaying needs for long term residential care. Since 2000, intensive pressures from central government on local authorities and NHS organizations, supported by additional targeted funding and financial penalties, have led to the widespread establishment of intermediate care services to support early hospital discharge (Godfrey et al. 2005), jointly commissioned and funded by NHS and local authority partners and employing a range of nursing, therapist and care staff. In some localities, joint-funded rapid response teams provide intensive domiciliary care to support an older person through a health-related crisis and avoid admission to hospital. In other localities intermediate care services are entirely hospital-based. Many are funded and delivered jointly by local NHS and social services organizations. They are generally free of charge at the point of delivery and offered for up to six weeks.

9.5.3 Home Care Re-ablement

Since 2000, most English local authorities have developed short-term, specialist re-ablement services within home care. Re-ablement has been described as an 'approach' or 'philosophy' within home care that aims to help people 'do things for themselves' rather than 'having things done for them', thus developing both confidence and practical skills to help them live independently.

Home care re-ablement services take different organizational forms. Some are funded and operated jointly with NHS partners. In other localities adult social care departments' in-house home care staff are retrained in re-ablement approaches and teams are often strengthened by the appointment of occupational therapists (OTs), OT aides and other specialist staff. Easy access to equipment and assistive technology by re-ablement services is important.

There is widespread belief in the preventive benefits of home care re-ablement. A recent large scale, quasi-experimental study (Glendinning et al. 2010) found that re-ablement was indeed associated with a significant decrease in subsequent social care service use, compared to people using conventional home care services. However, these lower costs were almost entirely offset by the higher cost of the re-ablement intervention; after a year there was no significant difference in the costs of the social care services used by each group. Nevertheless, home care re-ablement was almost certainly cost-effective, because it was associated with marked improvements in outcomes for users.

9.5.4 The Effectiveness of Modernization Initiatives

These examples illustrate different attempts to improve the efficiency of long term care services, in particular by reducing barriers between health and social care sectors and by investing in new services at the interfaces between these sectors. However, there have been concerns that these developments—particularly the growth of intermediate care services—have been primarily driven by the imperative of improving throughput and efficiency in the acute hospital sector, rather than improving social care. Certainly the English Department of Health has claimed a 'dramatic fall' in the number of hospital discharges that were delayed because of previously inadequate post-discharge support services (Department of Health 2004). A review of evidence indicates that hospital-at-home schemes, providing intensive, specialist nursing and rehabilitation care in patients' own homes, are flexible across a range of conditions and functions (Young 2009).

Yet, the effectiveness of these new service developments is itself influenced by wider external factors—particularly the extensive under-funding of social care services relative to need. Thus the evaluation of home care re-ablement services found their effectiveness was reduced when, as commonly happened, it was not possible to discharge users promptly at the end of a re-ablement episode because there was insufficient funding and capacity in the standard home care services that could provide longer-term support (Glendinning et al. 2010). Moreover, focused, intensive, short-term intermediate care and re-ablement services both demonstrate the most dramatic impacts on people with primarily physical disabilities or who are recovering from acute illness or surgery. Neither type of service is likely to generate significant improvements in outcomes for the growing numbers of older people with dementia and other cognitive impairments. More broadly, a wide range of other extrinsic factors—including labor market supply and demand, changes in local governance, reforms in other welfare sectors and 'even changes to the accounting rules' (Newman et al. 2008, p. 553) contribute to the overall effectiveness of modernization initiatives.

Meanwhile, since the mid-1990s, there has been growing concern about the increasingly high levels of need (on top of the assets and income tests) required to qualify for local authority-funded social care and the lack of investment in services for people with lower level needs—help with shopping, social activities outside the home, gardening and cleaning. The association of English local authorities has argued strongly it is inefficient for older people requiring only a small amount of support to remain independent to be denied access to assistance until a crisis occurs and they become eligible for very expensive services (ADASS/LGA 2003); this was endorsed by the Audit Commission (1997, 2000). An experimental Partnership for Older People Projects (POPPs) program ran from 2006 to 2008, involving some 470 local projects aimed at developing preventive approaches and shifting resources from acute to community and domiciliary settings. The POPPs program showed that every £ 1 spent led to an average saving of £ 0.73 on the per month cost of emergency hospital care (Windle et al. 2008). However, as time-limited local projects heavily reliant on charitable and voluntary sector contributions, the impact of the POPPs program was necessarily limited, particularly with respect to redirecting resources from acute hospital budgets.

9.6 Funding and Fairness

Section 9.2 outlined the fragmentation of policy and funding responsibilities for long term care for older people in England. Underlying this fragmentation are long-standing—and still unfinished—attempts to devise a fairer and sustainable approach to funding and provision. These attempts focus primarily on social care (and to a lesser extent the social security Attendance Allowance benefit); consistent with the institutional fragmentation described in the first section of this chapter, they largely exclude both the NHS role in long term care and the substantial contributions of informal carers.

There is widespread dissatisfaction with current funding arrangements, although public understanding and awareness is low:

> It often comes as an unwelcome surprise to older people to discover that social care is means-tested and they are expected to rely on their own savings and income until their assets have fallen to the threshold set for state-funded care. It is a common complaint that the existing system penalizes those who have saved for their own old age (Wanless 2006, p. xxi).

Even without any reforms and based on current levels of support, demographic pressures are anticipated to lead to a near-doubling of costs by 2026. Without reform, access to publicly-funded care will become even more restricted to only the very poorest, who have the highest needs for care and are without any family support (Humphries and Forder 2010).

Over the past 15 years, numerous proposals, both from within and outside government, have proposed reforms to extend eligibility for state funded long term care and also to reduce some of the local variations in access and levels of provision. Longer-term sustainability, in the face of current high levels of unmet need, is an additional imperative.

One of the early measures of the 1997 Labour government was the establishment of a Royal Commission on Long Term Care (Royal Commission on Long Term Care 1999). Its main recommendation was that free personal care should be funded from general taxation on the basis of need only (as, indeed, was subsequently introduced in Scotland). However Commission members were divided over the affordability of this measure and this allowed the government to reject the recommendation and invest in intermediate care (see Sect. 9.3.2) instead.

Dismayed by this, a range of voluntary organizations, pressure groups and think tanks—not just restricted to those representing older people's interests—continued to lobby for more extensive reforms (Joseph Rowntree Foundation 2006; Churchill 2008). Their activities were underpinned by extensive research, particularly into the costs of alternative reform options. Thus in 2006, the Kings Fund, an independent health charity, commissioned research into the funding and outcomes of current English arrangements, alternative funding models and the costs of these. This study (Wanless 2006) proposed a 'partnership' model, in which anyone assessed as needing care above a given level would be entitled to a minimum level of publicly-funded care; above the minimum, additional state funding would match private contributions. The main arguments for this approach were that it would provide a basic level of state funding and encourage the contribution of private resources to the overall costs of care, but without the disincentive for personal savings that characterize means-tested eligibility systems.

These recommendations were not taken up by the English government. By this time, new evidence on the disparities of wealth enjoyed by the current and rising ‘baby-boomer’ cohorts, compared with younger generations, had appeared. Some £ 932 billion assets are estimated to be held by older people as a result of increases in home ownership and property values over the previous 20 years. Debates within and outside government shifted the emphasis from working age people as the main funders of long term care through general taxation to considering how to tap into the assets held by current and rising older generations (Lloyd 2010).

However by now two external factors seriously constrained scope for policy Manoeuvre: the growing international fiscal and economic crisis and the UK’s own financial deficit; and the anticipation of a general election in May 2010.

The Conservative-Liberal Democrat Coalition government elected in 2010 established a new Commission of Enquiry on the funding of care and support, chaired by a leading academic economist. The Commission’s remit was to consider the full range of possible funding models, including the respective financial contributions of individuals, the private sector and the state; and the implementation of different models, including the implications for local government and the NHS. The Commission reported in July 2011 (Department of Health 2011). It recommended a significant increase in the wealth threshold at which individuals become responsible for funding their own care, from £ 23,250 to £ 100,000; and that no individual should have to pay more than £ 35,000 for her/his care. These proposals covered older people only (care for younger people would remain largely free of charge), specifically for residential care. They effectively limited individual liabilities, thus creating an attractive market for the development of private insurance products, with the state being responsible for the highest risks and costs. The Coalition Government is committed to introducing new legislation on long term care in 2012. However, given the Government’s commitments to radical and rapid reductions in public expenditure and the consequent cutbacks in both public sector funding and services, it is very likely that the Commission’s proposals may be seriously modified. The prospects of radical reform—particularly any increase in public expenditure that might underpin a universal, tax-funded scheme—remains remote.

9.7 Conclusions

Over the period examined within this chapter, the coverage of publicly-funded adult social care has contracted significantly. Intensive home care services are provided only to those with the highest levels of need; many people are excluded altogether from publicly funded residential or domiciliary care because of modest levels of assets and/or income. With the introduction of quasi-markets, care services have become more fragmented; personal budgets shift responsibilities for managing resources and risks onto individual older people and their families.

At the heart of this failure is the challenge of finding a politically acceptable way of driving more money into the social care system.

> The problems, and the options, for solving funding reform, have long been known; and prime opportunities to initiate reform … have been squandered. The failure to grasp this nettle is sadly indicative of the low priority given to social care by successive administrations (House of Commons Health Committee 2010, p. 67).

Current and rising cohorts of older people certainly do have substantial assets, mainly from property ownership. However, increased taxation, whether levied on current assets or inheritance, is widely regarded as political anathema. This option is even less acceptable, publicly and politically, in the context of the major cuts in public expenditure, and the anticipated widespread job losses and reductions in public services, resulting from the Coalition Government's rapid deficit reduction strategy.

Underpinning this political challenge is a highly complex and fragmented system of long term care, with separate central government responsibilities, funding streams and local service delivery organizations for health, social care and other services. Further instabilities arise from the division of responsibility between central government and local authorities for social care. Social security benefits for disabled and older people and carers are further separated—and these cover the UK as a whole, raising further challenges for any care-related reforms that are restricted just to England. In short, radical reforms to long term care raise challenging constitutional issues for the English and the UK state. Nevertheless, unless more funding is made available, fewer and fewer people will benefit from publicly-funded social care; more people will be exposed to catastrophic costs as they spend down their assets on privately-purchased residential or intensive domiciliary care; and family carers will carry increasingly unsupportable burdens. Given overall public spending cuts of 25 % or more over the next few years, these scenarios are very likely.

Against this background, the extensive quasi-market reforms and their extension to individualized funding through personal budgets is remarkable—but also, some might argue, a relatively low priority. These reforms have not been introduced in order to exercise tighter control over public spending on social care, but simply to alter the ways in which existing limited resources are allocated and used. However, as with earlier experiences of direct payments, the recent 'transformation' of personal budgets may not be wholly successful in delivering improved outcomes for service users. Both initiatives have taken a method of deploying social care resources that appears to work well for some social care service users (working age physically disabled people and those with learning disabilities respectively) and universalized this to all users, including frail and cognitively impaired older people. Moreover, there remain significant questions over how well the largely private market of home care and other service providers can adapt to meeting requests from newly empowered personal budget-holding users without incurring new transaction costs or being exposed to destabilizing financial risks.

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