

## DEBATE: A Beveridge report for the 21st century? The implications of self-directed support for future welfare reform

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In the early 21st century, elements of the English welfare state are in the middle of a 'transformation' process based on the concepts of personalisation and self-directed support (HM Government, 2007; Glasby and Littlechild, 2009; Carr, 2010; Needham, 2010). Beginning in adult social care, these approaches seek to recast users of state welfare away from being passive recipients of pre-purchased services towards a situation where they are active citizens with a right to control and shape their own support. Central to this agenda has been the concept of direct payments (pioneered by disabled people's organisations and developing in the United Kingdom from the mid-1980s onwards) and personal budgets (developed from 2003 onwards by a national social innovation network known as In Control). Beginning with 60 people in six local authority pilots in late 2003, there are now over 200,000 people receiving a personal budget and the government has stated that all adult social care will be delivered by this mechanism in future (HM Government, 2007). This approach is now also being piloted in children's services (Carlin et al, 2006; DfES, 2007; Crosby, 2010) and in healthcare (Alakeson, 2007; Darzi, 2008), with several leading think tanks and commentators exploring its scope to extend to other areas of state welfare (such as the tax and benefits system, housing, education, rehabilitation for ex-offenders, substance misuse services and support for young people not in education, employment or training – see Needham, 2010, for an overview of the spread of personalisation). Underpinning much of this is a broader sense that the values, frameworks and ethos of much current statutory welfare remains too dominated by 1940s thinking and assumptions – and that some of the concepts inherent in debates about personalisation and self-directed support could help to shape ongoing debates about the future of welfare reform. If the Beveridge Report (1942) is widely credited with establishing the thinking behind the post-war welfare state, is a similar document or process needed to clarify thinking and options around the relationship between the state and the individual in the 21st century?

Against this background, this paper is the product of a two-day think tank organised by the University of Birmingham's Health Services Management Centre (HSMC) and The Centre for Welfare Reform (CWR) to explore these issues in more detail. With a small invited audience of leading policy makers, managers, practitioners, policy analysts and researchers, the think tank was based around detailed policy and practice papers on topics such as partnerships and personalisation, the spread of personalisation, children's services, healthcare, community development, criminal justice and the tax and benefit system. While

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detailed policy and practice summaries will be available via the HSMC and the CWR (see [www.hsmc.bham.ac.uk](http://www.hsmc.bham.ac.uk) or [www.centreforwelfarereform.org](http://www.centreforwelfarereform.org)), the current paper explores the potential of personalisation to become more of a general organising feature for future welfare services.

## **New frontiers**

Although self-directed approaches are increasingly influential in social care, they have started to spread to other areas of the welfare state.

### ***Healthcare***

The case for increased personalisation in healthcare largely relies on the fact that the successful delivery of some aspects of healthcare delivery are critically dependent on the unique preferences, skills, needs and capacities of the person receiving healthcare. Thus:

- Improvements in mental health are hard to achieve without engaging the motivation and aspirations of the person experiencing poor mental health.
- Managing pain, improving mobility, coping with impairments and long-term health conditions require clinical or supportive interventions to be integrated into the life of the person, sensitive to their goals and wider community and social existence.
- Preparing to die, with dignity, making the best use of any remaining months, weeks or days, must be shaped by the person's values and requirements.

Against these examples can be set some examples of healthcare provision that may be done 'to someone' who is unconscious, or uncooperative or whose active involvement is not required in any way (for example the work carried out in Accident & Emergency departments for individuals experiencing a heart attack). However, what these examples make clear is that effective healthcare operates along a continuum and that many forms of healthcare do require high levels of personalisation in order to be successful. The case for increased personalisation in health, which includes the potential use of personal health budgets (currently being piloted; DH, 2009), will therefore vary in proportion to the degree to which the person's involvement, knowledge or leadership adds value to the quality of healthcare decisions and the outcomes achieved.

### ***Children and families with disabilities***

The case for the extension of personalisation into children's services seems particularly strong for children with disabilities and their families. This is for at least two distinct reasons. First, impairments often have a complex and lifelong impact on the life of the person and their family, requiring highly sensitive support to enable the individual to find the most effective adaptations to their environment. Any adaptations cannot be generalised, they need to be specific to the needs and aspirations of the child and, in time, the young adult. However, the second reason for extending personalisation into services for children and families is that the complexity of the individual is reflected in a multiplicity of

service responses. This complexity creates a paradox. It is often the experience of the disabled child and their family that, despite the high level of support they are entitled to in aggregate, the complexity and the frequent system conflicts that are thereby revealed lead to the child and their family being unsupported (Murray and Penman, 1996; Murray, 2004).

### ***Community development***

It may seem surprising that community development is seen as relevant to the future of personalisation, yet a plausible case can be made for seeing these as mutually supportive strategies (Keohane, 2009). Although direct payments, personal budgets and self-directed support are often seen as approaches based on an individual consumer model, they have actually emerged from the collective struggles of disabled people involved in the independent living movement and of people with learning difficulties and their families involved in what might be described as an 'inclusion' movement (Duffy, 1996, 2005; Glasby and Littlechild, 2009). Although there are fears that personalisation will promote isolation and atomisation, it can be hypothesised that it will do the opposite. Three examples suggest themselves.

First, people who take increased control over their support report increased community involvement, increased friendships and improvements in family life. This may well occur because collective provision – despite its title – struggles to enable people to build community in ways that are consistent with individual interest, aspiration or exiting networks (Poll et al, 2006; Poll and Duffy, 2008). The term 'collective' may suggest an attractive image of mutuality and community, but it can also mean sharing vital time with people you don't like [Comma here? Currently a little unclear] doing things you don't want to do or doing nothing at all. Second, personalisation offers people opportunities for collective action, as part of the self-direction process. Often people are best supported to take increased levels of control by accessing peer support or by working in groups (Cowen, 2010). Third, when people take increased control of funding there is no evidence that they only purchase individual forms of provision. In fact, funding may move to more inclusive forms of collective activity, such as leisure services, as opposed to more segregated forms, such as day centres (Duffy, 2010a).

### ***Criminal justice***

Self-directed principles can also be expanded into the field of criminal justice. This may mean applying personalisation to people who are deemed as 'undeserving' (or worse) and to people who have had some specific rights and freedoms removed as a punishment or in order to safeguard the person or others in their lives. The value of personalised approaches here may not seem as self-evident as in health and social care, where the dignity and autonomy of the service user are generally uncontested. However, it can be argued that greater self-direction has the scope to reduce reoffending and improve the effectiveness of support programmes.

One area where this approach is already being tested is within the work of the WomenCentre in Halifax, which is working with women to help them both avoid

prison and rebuild life after prison. The central methodology of the work of the WomenCentre is a commitment to help women identify the problems and issues that are important to them and to strengthen them in all aspects of their lives. It involves coordinating multiple funding streams around a woman, creating a de facto individual budget. This holistic approach is proving highly effective at helping women move away from criminality and to build self-esteem and a safer life for themselves and others (Hyde et al, 2010).

### **Tax and benefits**

Finally, it has been argued that personalisation can be extended into the reform of the tax and benefit system (Duffy, 2010b). The principles used to identify personal budgets could be used to create one benefit, focused on a socially agreed definition of need and balancing different factors to deliver one cash figure. In addition, it may also be possible to integrate the tax and benefit system so that contributions and entitlements of citizens could be clarified in one calculation. This may also create opportunities to re-engineer the current benefit system to dampen some of the poverty traps created by the current system. It is possible to argue that in fact the extension of personalisation into the reform of the tax and benefit system is only a practical consequence of shifting increasing levels of funding away from services and increasing the resources under the control of the citizen. While early innovations are happening without reference to tax or benefits, once personalised approaches take hold in social care, health, children's services and the criminal justice system, it will inevitably have implications for the broader framework of the tax and benefit system.

### **Conclusion**

Personalisation and self-directed support are approaches to welfare reform that have the scope to reorder not only social care, but also health, children's services, criminal justice and the tax and benefit system. Given their potential transferability across the range of services that the state provides, it is possible that such approaches can be the underpinning for a radical reshaping of the welfare state, as ambitious as that achieved by the 1942 Beveridge Report.

It is not yet clear, however, what a welfare state based on self-directed principles would look like, and broader ambiguity remains a feature of the personalisation agenda. Some see personalisation as insufficiently robust in articulating the rights of disadvantaged groups, leaving issues of equity inadequately addressed. For others, personalisation has an ambivalent impact on expertise, championing the citizen expert while also prizing the distinctiveness and integrity of professional practice. Self-directed support also generates new opportunities and risks with respect to the broader social contract and the balance of citizen rights and responsibilities.

It may be that it is precisely this ambiguity that has enabled personalisation to thrive. It offers new patterns of behaviour and engagement, which can meet the aspirations of groups who are not satisfied with older patterns of service provision,

but it also offers a positive and dignified role to professionals, working with service users in more co-productive ways. The discussion in this article suggests that self-direction and personalisation could be the basis of a reconfigured welfare state, which draws on a more expansive view of capacities, and fosters their deployment within supportive communities. However, careful policy design and a robust political debate are required to ensure that social justice is placed at the heart of such a new welfare settlement.

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*Sarah Carr<sup>1</sup> replies to Glasby et al, 'A Beveridge report for the 21st century?'*

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## Introduction

Glasby, Duffy and Needham's call for a new way of thinking about and delivering public services is an extremely timely one. As they argue, structures, systems and services are rapidly becoming outmoded and personalisation and self-direction are potentially fundamental for this reconceptualisation of welfare in England. This reply suggests exploring two implied principles further to strengthen the authors' proposals: understanding empowerment and using evidence. It draws on some of the lessons and debates from implementing personalisation in adult social care.

In the 21st century, any report proposing radical welfare reform should not solely be conceived and written by people with little or no experience of Beveridge's original 'five evils': squalor, ignorance, want, idleness and disease. For decades, people who use or work at the front line of Beveridge's welfare state services have been trying to reform it from within because its culture, structures and service provision can often be restrictive rather than supportive. Therefore, service users, carers and practitioners have an essential contribution to make to any thinking about the relationship between the state and the individual as they have direct lived experience of the system and its flaws.

## Empowerment

The authors propose that personalisation can empower service users as they move from being 'passive recipients of pre-purchased services towards a situation where they are active citizens with a right to control and shape their own support'. The terms 'citizen' and 'citizenship' are often used in policy discourse relating to empowerment and personalisation, which rightly indicates that personalisation has a distinct value base. However, the fact that 'citizenship' can be a problematic

or contested concept for people who use social care and support is seldom fully accounted for by policy makers. Therefore, citizenship should be considered from the different perspectives of service users and carers, some of whom find certain models of citizenship exclusionary (Morris, 2005; Rummery, 2006). There appears to be an internal tension within a social care and health reform agenda, which tries to combine or even conflate certain concepts of user citizenship with consumerism: 'Service users may have a dual identity as consumers of services, and as citizens to whom such services are accountable. ... The user movement calls for a more robust range of citizenship rights than those found in the customer relation' (Rose et al, 2002: 12). It could be argued that this difficulty has its origins in the construction of New Labour's public sector modernisation programme, which focused on empowerment through consumerist choice as well as user and patient participation, as exemplified by personalisation (Cutler et al, 2007). For some critics there is an inherent political incompatibility between the service user movement's understanding of citizenship and empowerment and that of the state and service system: 'for service user movements, getting involved has meant the redistribution of power, democratization and achieving change in line with their rights and needs. For the state and service system there has more often been a managerialist/consumerist model, framed in market terms' (Beresford, 2009: 4). Other observers of New Labour's reforms argue that the combination of user empowerment, citizenship and consumerism does not necessarily result in a fundamental shift in power or rights, but the reconstruction of the 'role' of the service user as a particular sort of citizen to operate within a consumerist social care system (Scourfield, 2007). Finally, some argue that the problem is about the degree to which disabled people have the same autonomy, power and agency to exercise choice as non-disabled or non-service user citizens: 'the consumerist model of user empowerment in community care policy has failed largely because disabled people themselves are not the consumers with powers of voice, choice and exit' (Rummery, 2006: 640).

## Evidence

Another aspect of New Labour's public sector reform legacy is the use of research evidence about 'what works and why' in the formulation of policy and practice (Wells, 2007). Service user and carer research is now seen as having a distinct contribution to make to that evidence base (Pawson et al, 2003). Personal budgets are one of the most discussed and promoted mechanisms for implementing personalisation in adult social care and were first piloted for people with learning disabilities by In Control (Poll et al, 2006). The IBSEN study of 'individual budgets' used a controlled trial methodology to evaluate how a budget that combined all the different support funding streams added to the evidence base (Glendinning et al, 2008). It found that because of regulation, procedure and administration processes any funding streams from outside social care were very difficult to incorporate. As an aside, this finding might be important for thinking about the challenges of transferring personal budget and self-directed support approaches into the tax-benefit system. Even though the National Health Service is being primed to reform using the principles of personalisation and self-direction and

personal health budgets are being piloted, early indications are that '[a] major constraint on professionals' enthusiasm is the lack of empirical evidence that service user choice as practiced through personal health budgets will deliver improved health outcomes' (NHS Confederation, 2011: 13). The lack of evidence about the immediate and long-term cost effectiveness of approaches such as self-directed support and personal budgets is also of concern at a time of drastic financial cuts in the public sector (Carr, 2010; Jones et al, 2011). Because of the practitioner perspective on evidence, the relationship of evidence (research and practice) and principles (values and ideology) need to be considered when constructing radical welfare policy based on personalisation, something that Glasby, Needham and colleagues in fact explore elsewhere (Glasby, 2011).

## Conclusion

Any far-reaching welfare reform programme based on personalisation and self-direction will need to acknowledge and address the complexities around empowerment, consumerism, choice and citizenship. It will need to be authentically 'co-produced' with services users, carers and frontline workers who have the expertise necessary to offer practical solutions to old and new problems. Their knowledge and expertise should be added to the robust evidence base required by those tasked with implementing policy reforms and transforming public services. There may then be a question about the need for a 21st-century Beveridge report to extend to a radical rethink of the way social policy itself is made in England.

## Note

<sup>1</sup> This article is written in a personal capacity and does not necessarily represent the views of the Social Care Institute for Excellence.

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