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## Editorial

Welcome to the long delayed second edition of Volume 33 of *Research, Policy and Planning*, which contains three very different, but extremely interesting papers.

The first, by **Randall Smith and colleagues**, explores the origins and meaning of (adult) social care in England. The article reveals that though the term 'adult social care' is ubiquitous in English policy and academic literature, there has never been a definition of the term in legislation. The authors suggest that the term 'social care' is 'indeterminate'. Without clear definition, the term is mutable and unstable. The authors draw parallels between the indeterminacy of social care and other indeterminate concepts such as 'choice' (deconstructed in the work of Clarke *et al.* (2006), and health care, examined by Herlitz (2017). Smith and colleagues point out that this can have serious consequences, since false assumptions can be made, and competing definitions laid out which make it possible for the term to acquire different meanings over time which create acute problems when practitioners and managers attempt to translate policies into practice.

The second paper, by **Susan Lowe and Hashum Mahmood**, focuses on childhood health inequality and obesity. As the authors point out, obesity is an increasing problem throughout the UK and obese citizens are at greater risk of a range of serious and life-threatening diseases. The authors' particular focus is on deprivation and obesity among school-age children in Birmingham. Using National Child Measurement Programme data for Birmingham, and the Income Deprivation Affecting Children Index, the authors compare Reception and Year 6 school records. Their analysis suggests that obesity inequalities are widening and calls for local, practical, preventive public health measures to address the problem.

The third paper, by **Francesca Pozzoli**, offers a critical analysis of one aspect of the current NHS vision: the introduction of Personal Health Budgets (PHBs). Based on a considered, critical analysis of key policy documents, and on semi-structured interviews with members of the Personalised Care Group for England, the author challenges 'received wisdoms' about the benefits of PHBs, and the potential implications for the NHS of introducing personal budgets into a service in which clinically defined need rather than individual choice is the main arbiter of service provision.

In addition to these three original articles, this edition also presents some lively reviews of social work and social care literature. Books reviewed for this edition reflect the range of research and especially policy issues to be found in the social care debating chamber. Martin Powell reviews a very wide-ranging contribution by Peter Beresford and Sarah Carr, who follow up an earlier publication on a participatory approach to welfare with this collection of essays which purportedly represents a paradigm shift in analysis and discussion of social policy. The book is not without limits, flaws and inconsistencies in relation to its aspirations and its contents, in the view of our reviewer. However, it must be accounted stimulating, if cautiously so, and mindful of the slippery conceptual nature of 'knowledge' – a topic being investigated and debated from times even before books were invented.

Powell's own book on current social policy, in the form of the mixed economy of social welfare, is reviewed by Guy Daly. This is more overtly an updated student textbook, and not a polemic. There is a thesis, though, as our reviewer points out. The state arguably dominates less now than in the past but is far from absent from welfare provision. The distributional consequences of these changes are not easy to map, but the schematic framework provided by Powell represents a way to start the process.

A participatory passion even colours part of the *Short Guide to Health and Social Care* by Jon Glasby, reviewed by Paul Dolan. In offering guidance to a prospective student, who might well be from outside the UK, Glasby highlights the impact of events from his own social work training days, linking them with the revolutionary idea of a social model of disability, and its implications for adult social care services.

A social model is implicit in the final review by Emma Pinfield. These are of two books offering guidance in responding to eating disorders among adults. Neither of these books, intended for service users and possibly professionals, follows a medical or evidence-based model, and they both espouse self-help techniques. They would be valuable aids at a time of austerity in specialist professional services, and they are written from lived experiences: but are hardly enough on their own.

### **Postscript**

Finally, over the last few years, readers will have noticed that *Research, Policy and Planning* has experienced a significant fall in the number of submitted papers, which has seriously delayed our attempts to publish the anticipated three editions per year. This trend is one that the Editorial Team and Board have been unable to reverse, despite sometimes strenuous attempts to encourage the submission of papers. There are, of course, several reasons for this position, and two seem to predominate. First, the 2009 banking crisis led to a decade of public sector austerity and, along with other consequences, the stripping out of research capacity in local authority adult social care and children's services. As a result there are now far fewer researchers and planners working in these settings who might submit their work to us. Second, university researchers increasingly are encouraged or required to publish their work in 'high impact factor' academic journals, to enhance their portfolios for each Research Excellence Framework cycle. *Research, Policy and Planning* does not have an 'impact factor'; largely because it is independent, and it cannot draw on the resources and marketing expertise of established publishing companies.

At the time of writing, this edition of the journal is probably the penultimate one. We hope to produce a final themed, historical and policy-related issue. However, the Editors have decided, after serving in this role for over 8 years, to step down. No replacements have been identified. We will continue to explore all possible avenues so as to ensure that access to past editions of the journal is maintained, including seeking an institutional repository for all volumes and editions to ensure they remain publically accessible. We are immensely grateful to those who have published their work with us over these last few years, to our readership for their support, to our Editorial Board for their guidance, and to Shelley Nix for her enthusiasm and unflagging efforts to organise peer reviews and coordinate publication of each issue.

**John Woolham, Guy Daly and Paul Dolan**

## What is (Adult) Social Care in England? Its origins and meaning

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### Abstract

*The term 'social care' emerged in both official and academic publications in England in the 1990s but has not been defined in legislation. How the phrase has varied in usage over the last 20 plus years is outlined in this article. Whilst the element of 'personal care' has been present in the range of descriptions of 'social care', the policy context has changed dramatically, affecting the broader debate about priorities in public support for vulnerable adults. What 'social care' means as a policy rather than a practice has changed over time. The notion of indeterminacy provides a plausible explanation of changes in terminology and meaning in policies and practices.*

**Keywords:** Social care, adult social care, personal care, indeterminacy

### Introduction

In his book, *How Language Works in Politics*, published in 2018, Matthew Williams has analysed the wording, using machine readings, of all primary legislation passed at Westminster between 1900 and 2015. His broad conclusion is that in more recent times parliamentary legislation has become much more vague with major consequences for policy and its impact. This notion of indeterminacy and its consequences is not confined to the language of legislation (Williams, 2018). It can also be found in official publications such as White and Green Papers and other policy relevant documents such as Law Commission and Royal Commission reports. It could be argued that social care is a composite of indeterminate concepts. Clarke *et al.* (2006), for example, discuss service user 'choice' as an indeterminate concept while, in the context of health care, Herlitz (2017) point to the indeterminate nature of 'need'. A similar argument could be applied to 'care'. An important point to emphasise is that although concepts such as 'choice' and 'need' have significant purchase in policy formation, their indeterminate nature makes it extremely difficult to monitor and evaluate policies (Clarke, 2006). Indeterminacy describes the multifactorial nature of social care, its instability and tentative characteristics arising from the myriad ways in which services interact with political, economic and organisational contexts.

Social care has become a political hot potato as the political imperative to exert strict controls over public spending meets the equally important imperative of satisfying public expectations about support for people in need. Societal ageing is at the heart of social care policies, usually expressed in terms of the imperative to manage the 'rising tide' of demand for public services (National Audit Office, 2014, 2018; Phillips & Simpson, 2018). On the other hand, old age has been a central focus of welfare policies for over a century and remains so, with the emphasis being on quality and choice in services for older people. These conflicting imperatives are a source of particular difficulty for the current conservative government because of the older age profile of their voter base. The careful use of language in policies circumnavigates such conflict, thus highlighting the rhetorical value of social care policies to broader policy agendas. Indeterminacy also generates false assumptions that everyone involved in implementation shares a common understanding of the meaning of key terms, with adverse effects of differences in understanding emerging as policies are translated into practice.

A key area of difference is that between the abstract language of policy makers and the concrete reality of social care, which involves ‘personal’, bodily care for individuals, usually in their own homes (Andersson & Kalman, 2012). When community care legislation was implemented in the 1990s, the idea of a ‘social bath’ (as opposed to a ‘medical bath’) was the subject of some derision among practitioners and commentators but it exemplified a crucial delineation between those services that would be provided (free) by the NHS and those provided (subject to a financial assessment) by the local authority social services department. Julia Twigg (1997) argued that assistance with bathing is an aspect of service tension and ambiguity. It involves intimacy and body management, which are not normally a part of the more rationalistic and disembodied account of social policy. These observations highlight the importance of understanding differences in perspective between actors in different roles within the care system. In addition, as Andersson & Kalman (2012) argue, clarity in meaning is essential to the process of policy evaluation, especially at a time when the pressure is on to ensure that expenditure of precious resources must yield good outcomes. Gregory & Holloway (2005) argued that the context of individual policies must be taken into account in understanding how meanings change over time. For example, the meaning of the term ‘need’ changed in line with the introduction of an administrative model of community care to become narrower and more functional. This paper traces the use of the term ‘(adult) social care’ in official and other relevant publications over a twenty-year period and demonstrates that a wide range of issues can be covered under this umbrella term, although the theme of ‘personal care’ is common to all of them.

Throughout the period since the 1990 NHS and Community Care Act was introduced, the overarching imperative of controls over public spending on services organised by or through local authority social services departments has been not merely financial and organisational. The impact is also cultural, reflecting a significant shift in prevalent norms and values concerning the relationship between the individual and the state and the allocation of responsibility for individual wellbeing (Needham & Glasby, 2015).

## **(Adult) Social Care in England**

### *(i) 1980-2002: The Early Years*

The Royal Commission on Long Term Care was set up primarily to address the future of funding for long-term care but did in part go beyond its specific brief. Its report, published in 1999, listed a Glossary of Terms. Neither ‘social care’ nor ‘adult social care’ were listed but the text did state that ‘we deliberately do not use the term ‘health care’ or ‘social care’ because of the confusion that now surrounds these terms and their association with particular agencies or forms of funding’ (para 6.43). Instead it provided a definition of ‘personal care’ (p.68):

*Personal care would cover all direct care related to: personal toilet... eating and drinking... managing urinary and bowel functions... managing problems associated with mobility... management of prescribed treatment... behaviour management and ensuring personal safety.*

This definition makes no mention of categories of people, though the text preceding the definition refers to ‘the care needs which give rise to the major additional costs of frailty or disability associated with old age’ (para 6.43). The report also acknowledged that the definition cited above ‘could be regarded as on the tight side. It would, for example, exclude costs attributable to: cleaning and house work; laundry; shopping services; specialist transport services; sitting services when the purpose is company or companionship’ (para 6.45) on the grounds that ‘although they may contain an element of care, they are in principle ‘living costs’ (para 6.46).

Despite the comments by the Royal Commission, the term 'social care' began to appear towards the end of the 20<sup>th</sup> century in policy documents on the responsibilities of local authorities for the commissioning of social services and collaboration/joint working between health and social services. In the Labour Government's 1998 White Paper, *Modernising Social Services* (Department of Health, 1998b), it was only in the section on improving standards in the workforce that the term appeared, referring to the 'social care workforce'. 'Social care staff will have clearer standards and better training arrangements overseen by the General Social Care Council' (para 8.2). The General Social Care Council, as a regulatory body for the social care profession, in England, was formally established under the Care Standards Act 2000 and started work in October 2001, the same year that saw the incorporation of the Social Care Institute for Excellence, set up as a charity to promote quality in the planning and delivery of social care (Department of Health, 2000). In 2002, the Social Care Workforce Research Unit at King's College London was established with core funding from the Department of Health.

Meanwhile, longstanding central government concern for better links between the NHS and local authority social services departments led to a discussion document, called *Partnership in Action* (Department of Health, 1998a) which put forward specific proposals on collaboration which were embodied in the 1999 Health Act and led to the creation within the Department of Health of a Joint Health and Social Care Unit to coordinate local policies on joint working. Academic commentators (Hudson & Henwood, 2002) pointed out that the emphasis on collaboration rather than competition cut across the core developments from the 1990s onwards of social care markets (Wistow *et al.*, 1994; 1996), following the implementation of the NHS and Community Care Act 1990, which introduced 'a national strategy for reform that reflected the government's commitment to increasing choice and efficiency through the development of welfare markets' (Means, Richards & Smith, 2008, p.52).

One of the consequences of this policy shift was the appearance in the late 1980s and early 1990s of the term 'social care' in academic commentaries (e.g. Judge & Matthews, 1980; Payne, 1986; Davies, 1988; Qureshi, 1991; Hudson, 1992; Warren & Walker, 1992) and the first volume of the journal *Health and Social Care in the Community* appeared in 1993. However, in its early years, peer reviewed articles with 'social care' in the title were few in number (three out of 118 articles in the period 1993-1996). It was in 1996 that the title of the University of Kent's Personal Social Services Research Unit annual publication on unit costs changed from Unit Costs of Community Care to Unit Costs of Health and Social Care (Netten & Dennett, 1995; 1996). From that time on, references to social care became more common, whether linked to debates about the robustness of social care markets, concern about the consequences for joint working between health and social care, or reporting each year on the state of social care. The phrase 'social care services' rather than 'social care' was sometimes used in official publications but did not appear frequently in academic commentaries.

## (ii) 2003-2010: The Labour Government and the Review of Social Care

Early in 2004 SCIE launched a project, *Looking to the Future*, to examine the current and future role of social care in England, Wales and Northern Ireland. Following the publication of a Green Paper called *Independence, Wellbeing and Choice* in March 2005, SCIE drew on papers already in draft to produce in July 2005 a Position Paper, *Developing Social Care: The Past, the Present and the Future* (Wistow, 2005). One of the contributory papers, *Developing Social Care: Values and Principles* (Waine *et al.*, 2005, p.1) offered a definition of social care, namely:

*All interventions provided or funded by statutory and/or independent agencies which support older people, younger adults and children in their daily lives, and provide services which they are unable to provide for themselves, or which it is not possible for family members to provide without additional support.*



Waine *et al.*'s definition reflects a particular tension in social care, which is the recognition that families provide the bulk of care but that family carers also require support from the state or its agencies. They are therefore both providers and users of social care services.

The Position Paper itself (Wistow, 2005) took a rather different tack. In the first paragraph of the introduction, the term 'social care' was defined:

*As encompassing: social work and care management; all the responsibilities of local social services authorities for commissioning services, service provision, and direct payments in relation to children, adults, families and other carers; the management role underpinning these responsibilities; service provision in the private and voluntary sectors.*

This Position Paper was designed to influence the content of the subsequent White Paper, *Our Health, Our Care, Our Say: A New Direction for Community Services* (HM Government, 2006). These contrasting 'definitions' from SCIE indicated the ambiguity of use of the phrase 'social care' which suggests that 'description' might be a better word than 'definition' whenever the term is used.

But when did the word 'adult' begin to appear in front of 'social care'? In January 2003, the term was added in a guidance document called *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care* (Department of Health, 2003). In March 2005, a Green Paper focusing specifically on a vision of the future of adult social care appeared (Department of Health, 2005). However, it was an important legislative change to local authority social services departments under the Children Act 2004 that transformed the usage of the terms 'adult social care' and 'adult social services'. Schedule 2 of the Act referred to amendments to section 6 of the Local Authority Social Services Act 1970, including the following:

*A local authority in England shall appoint an officer, known as the director of adult social services, for the purposes of their social services functions other than those for which the authority's director of children's services is responsible under section 18 of the Children Act 2004.*

In May 2006 guidance was issued on the new Statutory Chief Officer Post of the Director of Adult Social Services (Department of Health, 2006b). Unsurprisingly, the Association of Directors of Social Services (ADSS) became the Association of Directors of Adult Social Services (ADASS). Other developments in 2006 included the creation of a Minimum Data Set for Social Care by Skills for Care and the foundation of the National Institute for Health Research (NIHR) under the government's health research strategy, *Best Research for Best Health* (Department of Health, 2006a).

One of NIHR's five strategic goals was to commission research focused on improving health and social care (Department of Health, 2006a, p.19). In 2009 the social care dimension was reinforced by the establishment of the School for Social Care Research (SSCR), based at the London School of Economics. The NIHR described SSCR as a leading funder of social care research to develop the evidence base for adult social care practice in England.

It was also in 2006 that the King's Fund published the *Wanless Social Care Review on Securing Good Care for Older People*. It focused on the challenges for social care over the ensuing 20 years. What resources were needed and how would they be found? The conclusion was that a partnership model between the state and the individual was the best of four funding options. The costs of care would be shared for those needing care. Whilst there was no formal description of social care, the report describes the period after the passing of the 1990 NHS and Community Care Act as a revolution where local authorities scaled back in-house provision in favour of independent providers and as indicating greater emphasis on prevention and rehabilitation in order to reduce demand for high intensity services (despite the ageing of the population in England).

In 2007 a short protocol signed by central government ministers, local government and NHS representatives and social care, professional and regulatory organisations (HM Government, 2007) committed to a shared vision on the transformation of adult social care. Following up on this, 2009 saw the formal large scale consultation on the future of the social care system in England, *Shaping the Future of Care Together* (Secretary of State for Health, 2009). This led to a White Paper in March 2010, *Building the National Care Service* (Secretary of State for Health, 2010). This committed the then Labour Government to the creation during the second decade of the 21<sup>st</sup> century of a national care service ‘free when people need it, for generations to come’ (*op cit.*, p.4). The text of the White Paper used the term ‘social care’ throughout the 21 page Executive Summary but the phrase ‘adult social care’ occurred just once in a section on the plan to deliver ‘integrated adult social care services’ (*op cit.*, p.21). May 2010 saw the defeat of the Labour Government and the subsequent Conservative-Liberal Democrat Coalition Government published a new agenda for social care in England, called *A Vision for Adult Social Care: Capable Communities and Active Citizens* (Department of Health, 2010). The subtitle reflects the core values of the new government. ‘Social care is not solely the responsibility of the state. Communities and wider civil society must be set free to run innovative local schemes and build local networks of support’ (*op cit.*, p.4).

### (iii) 2011-2015: The Coalition Government and the Care Act

Whilst adult social care has become a standard term in official publications and elsewhere in recent years, it was not precisely defined in legislation. Indeed, there were growing concerns about the complexity and piecemeal nature of the laws underpinning local authority social services. In June 2008 the Law Commission announced a multi-stage inquiry into adult social care law. The first stage consisted of a scoping review which was published in November 2008 and the second stage involved consultation on proposals for reform between February and July 2010. During this period a general election saw the arrival of the Coalition Government. The final report with recommendations for reform to create a single modern statute for adult care and support appeared in May 2011 (Law Commission, 2011). The introduction to the report addressed the question: What is social care? The Commission's reply to its own question was that adult social care means the care and support provided by local social services authorities pursuant to their responsibilities towards adults who need extra support (para 1.5).

*This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Adult social care services include the provision by local authorities and others of traditional services such as care homes, day centres, equipment and adaptations, meals and home care. It can also extend to a range of so-called non-traditional services such as gym membership, art therapy, life coaching, personal assistants, emotional support, and classes or courses. Adult social care also includes services that are provided to carers – such as help with travel expenses, respite care, and career advice. Finally, adult social care also includes the mechanisms for delivering services, such as assessment, personal budgets and direct payments.*

The Queen's Speech on 9 May 2012 announced that a draft Bill would be published ‘to modernise adult care and support in England’ and a Draft Care and Support Bill was published in July 2012 together with a White Paper on reforming care and support (HM Government, 2012). This White paper, like the Law Commission, asked: What is care and support? The answer to the question was couched in plain English (HM Government, 2012, p.13):

*Care and support enables people to do the everyday things that most of us take for granted: things like getting out of bed, dressed and into work; cooking meals; caring for our families; and being part of our communities. It might include emotional support at a time of difficulty or stress, or helping people who are caring for a family member or friend. It can mean support from community groups and networks: for example, giving others a lift to a social event.*

*It might also include state-funded support, such as information and advice, support for carers, housing support, disability benefits and adult social care.*

On the same day as the White Paper was published, the government issued its official response to the Law Commission report (Department of Health, 2012). The first sentence of the official response asserted that ‘care and support law is opaque, complex and outdated’ (*op cit.*, para 1.1).

The Joint Parliamentary Committee examining the Draft Bill noted that ‘the words ‘care’ and ‘support’ are nowhere defined in the Bill – rightly in our view’ (Joint Committee on the Draft Care and Support Bill, 2013, para 47). The eventual outcome was the Care Act which received Royal Assent in 2014 with an implementation date of 1<sup>st</sup> April 2015 apart from the subsequent postponement of funding reforms.

*The Act does not talk of disabled, elderly or ill people; instead it uses the word ‘adult’ – but this is generally qualified as being an adult ‘needing care’... These terms are not defined... It is... almost certain that ‘adults needing care’ will be given a very wide interpretation.*

(Clements, 2017, p.4)

It is worth noting that the debates about this legislation took place against a background of the longer term domestic consequences of the global 2008 financial crisis. The 2010 Conservative-Liberal Democrat Coalition Government began a fiscal consolidation programme and implemented large scale spending cuts which have been sustained to the present day. The consequences for adult social care of this strategy were examined in a report published in March 2014 by the National Audit Office. It characterised social care as comprising ‘personal care and practical support for adults with physical disabilities, learning disabilities, or physical or mental illnesses, as well as support for their carers’ (National Audit Office, 2014, p.5). It concluded that ‘providing adequate adult social care poses a significant public service challenge and there are no easy answers’ (*op cit.*, p.11). This report influenced the views of the House of Commons Public Accounts Committee which highlighted the challenges faced by local authorities and other agencies in implementing the provisions of the 2014 Care Act (House of Commons Public Accounts Committee, 2014).

#### *(iv) 2016-2019: The Years of Crisis and the Promise of a Green Paper*

To repeat, there is no definition of adult social care in the Care Act. What can be found in the legislation and statutory guidance is a framework for determining when an adult with a physical or mental impairment or illness might be deemed to have ‘eligible’ care needs which a local authority is required to meet (Department of Health, 2016, para 6.111). The focus is on the inability of a person to look after her/himself on a daily basis and is separate from any eligibility for financial support to pay for care or support. The quality of initial and subsequent assessments by qualified social workers and/or experienced social care assistants is a crucial element in this eligibility process and can be affected by the reduction in resources in recent years. ‘We need to be able to harness the skill and aptitude of good care workers, so that we need fewer mediocre ones’ (Koehler, 2018, Section 5).

Prior to the June 2017 general election, the House of Commons Communities and Local Government Committee produced two reports on adult social care. The pre-budget report (HoC CLG Committee, 2017a) stated at the beginning of its Summary (p.3) that ‘adult social care provides care and support of a personal and practical nature to adults of all ages with care needs to enable them to lead independent and fulfilling lives’. The second report (HoC CLG Committee, 2017b) stated in its conclusions and recommendations (p.8 and para 49) that it welcomed the preliminary announcement of a Green Paper on the long-term funding of social care and recommended (*inter alia*) that:

*It takes into account the range of uses for which social care funding is required. Over the course of this inquiry, we have identified these as including: (i) care and support, including people's needs for care and support; preventative care and early intervention; and assessments for carers, leading to the provision of support for carers; (ii) payment of fees to providers, which contribute to the wages of the care workforce; as well as holiday, sickness, pension and travel costs; their training, qualifications and career development, including measures to enhance the status of the care workforce; and meeting providers' business costs and generating profit to invest in their capital assets and the workforce.*

At the time of writing (March 2019) social care was publicly acknowledged to be in crisis, indicated by (i) a rising need for care at the same time as public expenditure is falling; (ii) the lack of a strategic budgetary response by government to the acknowledged need for a substantial increase in funding for adult social care; (iii) unchanged views on the value placed on care work, seen as undertaken mainly by women, resulting in a low wage economy in this sector; (iv) increasing business failures on the part of care companies; (v) the dementia tax, an ill-informed strategy in the Conservative Party manifesto for the June 2017 General Election; (vi) a belated recognition of the crisis in the form of an official announcement in November 2017 of the publication in the summer of 2018 of a Green Paper on the future funding of social care for older people. (Earlier announcements had referred to a Green Paper on the long-term funding of social care, not restricted to older people. The situation of so-called working age adults would be reviewed by a programme of work parallel to that focusing on older people.)

Responsibility for the preparation of the Green Paper was initially placed in the Cabinet Office, but after the resignation of the Minister for the Cabinet Office (Damian Green) in December 2017, responsibility was transferred to the renamed Department for Health and Social Care (DHSC). The MP who became responsible in DHSC for the Green Paper, Caroline Dinenage, was appointed Minister of State for Care on 8<sup>th</sup> January 2018. Independent experts appointed to advise on the development of the Green Paper include Paul Burstow, former Minister of State for Community and Social Care (2010-2012) and current Chair of the Social Care Institute for Excellence and Sir Andrew Dilnot, former Chair of the Commission on the Funding of Care and Support. However, there was no direct representation from service users or care staff in the group.

At Westminster, the House of Commons Committees on Health and Communities and Local Government launched a joint inquiry in January 2018 on long-term funding and provision of adult social care to feed into the Green Paper. On 20<sup>th</sup> March 2018, the former Secretary of State for Health and Social Care, Jeremy Hunt, outlined at a British Association of Social Workers (BASW) conference seven principles on adult social care reform, including high quality services, a valued workforce and control by service users. Commentators have noted that the principles seemed relatively uncontroversial, though the reference to sustainable funding was not accompanied by any detailed reflections on how this might be accomplished.

The Secretary of State did recognise that the track record of governments was less than impressive (speech to delegates, BASW conference, 20<sup>th</sup> March 2018):

*No one could accuse this or any government of not talking about the issue. In the past 20 years there have been 5 Green and White Papers, numerous policy papers, and 4 independent reviews into social care. So it would not be unreasonable to expect scepticism about yet another one this year – and as the new [sic] Health and Social Care Secretary I do rather feel the weight of stalled reform programmes on my shoulders.*

This sentiment was echoed in a consultation paper on the proposed Green Paper produced by the Local Government Association in July 2018. In the Foreword to the document jointly signed by the Association's political leaders it was noted (Local Government Association, 2018, p.9) that:

*The approach of governments past and present in dealing with mounting pressures in social care has been to limp along with piecemeal measures from one year to the next... The need to resolve the long-term future of care and support is now urgent. We cannot duck the issue any longer.*

On 16<sup>th</sup> October 2018, the government announced that the forthcoming Green Paper would, after all, focus on all adults, not just older people and would be published 'before the end of the year' (Jarrett, 27 November 2018, pp.7-8). On the same day, the government minister, Lord O'Shaughnessy, informed the House of Lords that 'the intention is that the (NHS) Long Term Plan and the Green Paper will be published together around the same time' (HL Deb 16 October 2018, c392). The NHS Long Term Plan was published on 7<sup>th</sup> January 2019 ([www.longtermplan.nhs.uk](http://www.longtermplan.nhs.uk)) but the much delayed Green Paper on adult social care had not appeared by the time this article was drafted (12<sup>th</sup> March 2019). On 14<sup>th</sup> December 2018 the Department of Health and Social Care (DHSC) informed the *Local Government Chronicle* journal that the Green Paper would be published 'at the first opportunity in 2019' (Jarrett, 14 December 2018, pp.7-8). A DHSC spokesperson was quoted in *The Observer* on 5<sup>th</sup> March 2019 as stating 'we will shortly set out our plans to reform the social care system for adults of all ages to ensure it is sustainable' (Ryan, 2019).

## Reflections

The early focus of the term 'social care' was on those commissioning or providing social care. Thus, the language of markets and independent providers, the cost of services, the effectiveness of the workforce and the importance of collaborative working on grounds of efficiency predominated.

Despite the major changes and upheavals in the politico-financial context of social care policy over the last 20 years, including the split between children's and adult social services in 2006, the impact of the global financial crisis since 2008 and the passing of the 2014 Care Act, it seems that the language of descriptions of adult social care has changed little, apart from a more person-friendly vocabulary in documents aimed at the general public rather than for professional care service staff. This may be because there has been no legal definition of (adult) social care, varied descriptions of the term in official publications, leading to what Williams (2018) characterised as indeterminacy.

Clearly, early references to children's services disappeared after 2006 and the range of potential and actual service users and carers moved from a focus on elderly people to a broad range of adults until the announcement in 2017 of a Green Paper that would focus on the future funding of social care for older people with the vague promise of parallel work on social care for adults of 'working age'. Unlike NHS documents, the notions of person-centred care and the emphasis on personal responsibility seem not to have featured in the various descriptions of adult social care in official documents over the last 20 years. The word 'independence' is absent in the various descriptions though it does feature in other sections of official publications. The abiding concern for the funding of social care for older people from the 1999 Royal Commission to the promised Green Paper is absent from the formal descriptions of adult social care. The crisis in social care, so prominent in policy commentaries (e.g. Charlesworth, 2018), is hard to find in the various official descriptions of adult social care. In other words, the descriptions do not reflect the dramatically changing context for the planning and delivery of adult social care. The continuity in descriptions of social care belie its indeterminate nature, the unstable and shifting meanings of the terminology used in policy documents and the complex interactions that occur between social care policies and practices on the one hand and the political and economic contexts of social care policy on the other.

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## **Widening childhood obesity inequalities in Birmingham primary schools – A longitudinal analysis and multi-level linear regression of BMI changes between 2006-2015**

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### **Abstract**

*Background: childhood obesity is a major concern in England with prevalence in Birmingham significantly higher than the national average. Cross-sectional studies indicate there is a strong link between childhood obesity and deprivation; however, there is a paucity of longitudinal research examining weight status health inequalities in children.*

*Methods: longitudinal analysis of Birmingham primary school children using NCMP data (2006-2015) for three cohorts (26,728 children). Investigating the effect of gender, ethnicity and deprivation on mean BMI z-scores using a mixed effect multi-level linear model of the effect of BMI z-score at Reception on the BMI z-score at Year 6. Examination of weight status changes.*

*Results: mean BMI z-scores almost trebled between the start and end of primary school. More than half of the children who were obese in Year 6 had been overweight or obese at school entry. Increases were markedly higher for boys, those in deprived areas and Black and Asian children.*

*Conclusions: longitudinal evidence of health inequalities widening through the primary school years with the greatest increases found in the most deprived areas. Children who have a high BMI z-score in Reception are more likely to have a higher BMI z-score at the end of primary school.*

**Keywords:** Health inequality, child obesity, NCMP

### **Background**

Obesity prevalence in children and adolescents has increased globally and has been associated with short and long-term health sequela (Mead *et al.*, 2017). The issue has been a major concern in the UK for many years (Kimm & Obarzanek, 2002) and there is evidence that children who are overweight or obese have increased risk of asthma, type 2 diabetes, heart disease, certain types of cancer and are more likely to become obese adults (Reilly, 2007). In 2015 the House of Commons Health Committee called for ‘brave and bold action’ to tackle the issue. The publication of England’s childhood obesity action plan chapters in 2016 and 2018 have further signalled the intention and commitment of the government to use legislative action to reduce childhood obesity.

Within England, the heights and weights of primary school children are assessed at age 4-5 (Reception) and age 10-11 (Year 6) as part of the National Child Measurement Programme (NCMP). Data for 2017/18 shows that nationally within England the prevalence of overweight (including obesity in) Reception pupils has remained steady (22%) between 2006/07 and 2017/18, however, the prevalence amongst Year 6 pupils has significantly increased between 2006/07 (31.5%) and 2017/18 (34.3%) (NHS Digital, 2018). Within the same time period in Birmingham, the prevalence of overweight (including obese) children has been higher than the national average, equating to one in four (23.5%) children being overweight (including obese) when they start school to 40.3% of children by the last year of primary school in 2017/18.

The Brisbois *et al.* review (2012) on the early markers of adult obesity reported that a large number of studies reported a significant association between childhood obesity at <5 years of age and adult overweight and obesity. Internationally there is evidence to suggest a link between disadvantaged socio-economic status and increased prevalence of obesity in developed countries (Wang & Lim, 2012). However, there is mixed evidence on the relationship of weight status and socio-economic status from studies in England (Goisis *et al.*, 2015) (Pearce, A. *et al.*, 2015). There is evidence to suggest a relationship between deprivation and obesity differs by ethnicity and by gender (Ells *et al.*, 2015).

Within Birmingham, the relationship between childhood obesity and deprivation, as well as the widening inequalities, has been reported previously, utilising the local NCMP data to conduct cross-sectional data analysis (Mahmood & Lowe, 2017). In order to take a more preventative and upstream approach to tackling childhood obesity and assuage future increases, there is a need for longitudinal research to determine those children at greater risk. As the NCMP programme has now completed a child's journey throughout primary school, it is now possible to track children that have completed their primary school education and identify potential predictive factors, which can inform local public health and school strategies to devise appropriate services and interventions to reduce the prevalence of unhealthy weight.

The aim of the present study is to examine the longitudinal changes in weight status of children in Birmingham primary schools between the ages of 4 and 11 using individualised NCMP data. The study will also explore inequalities, in particular relating to socio-economic status, gender and ethnicity and whether weight status inequalities widen or narrow in children during primary school years.

## Aims

- Track changes in BMI z-scores and weight status among children from Reception to Year 6 between 2006-2015.
- Assess relationship between BMI z-scores in Reception and Year 6 in order to examine predictors of becoming overweight and obese.

## Methods

### *Ethics*

The study protocol was approved by Birmingham City Council's research governance process in December 2015. The Local Authority Regulations covering the NCMP allow for local authorities and those acting on their behalf to further process NCMP information for the purposes of research, monitoring, audit, the planning of services, or for any purpose connected with public health (Public Health England, 2019).

### *Data*

The main dataset used in the study was the NCMP for three cohorts of Birmingham primary pupils. Other data sources utilised were the UK90 growth reference (Cole *et al.*, 1995) to calculate BMI z-scores and the Income Deprivation Affecting Children Index (IDACI) 2010 to provide an area level socio-economic status measure representing the proportion of children who live in low income households (Ministry of Housing, Communities & Local Government, 2011).

### *Matching Reception and Year 6 Records*

NCMP data from three cohorts of children measured in Reception in 2006/07, 2007/08 and 2008/09 and their subsequent Year 6 cohorts; 2012/13, 2013/14 and 2014/15 were utilised. The linkage of records was carried out by auto-matching on a concatenation of gender, date of birth and first name variables. Any Reception records that were not matched through concatenation were matched via manual checking.

### *Statistical Analysis*

Statistical analyses were carried out using STATA v13.1. These comprised of an unadjusted linear regression and a mixed effect linear regression model of the association of Reception BMI z-score on Year 6 BMI z-score. This was adjusted for the fixed effect variables of gender, ethnicity and deprivation and for school as a random effect. In addition an investigation was undertaken of the effect of gender, ethnicity and deprivation on mean BMI z-score change (two-sample t-test) and weight status change ( $\chi^2$  test).

## **Results**

A total of 36,093 children were measured in Reception from 2006-2009. Auto matching via concatenation was able to match 24,042 (67%) records, with a further 3,715 records matched with manual checking. 1,029 records were excluded from the study due to missing or invalid measurements. A total of 26,728 (74%) records from 313 schools were matched and included in the study (**Table 1**).

Within the three cohorts boys accounted for a slightly higher percentage than girls, 52% compared to 48%. Cumulatively White and Asian ethnicities comprised of just less than three quarters of the children. Nearly a third of children resided within the most deprived IDACI quintile. Between 2006/07 and 2008/09 weight status classification (underweight, normal, overweight and obese) remained fairly constant whilst children were in Reception; however, matched Year 6 data showed increases in those with overweight and obese classifications between 2012/13 and 2014/15. Another striking feature was the increase in the unknown ethnicity category, which increased from 230 (2.7%) in cohort 1 to 1,155 (12.7%) in cohort 2 and 1,273 (13.9%) in cohort 3. This increase may have been due to changes in recording methods during this time. The unmatched records were analysed to test for significance of difference. A higher proportion of girls than boys were linked ( $\chi^2$  test  $p < 0.005$ ), and those with a healthy weight status at Reception were more likely to be lost to attrition.

### *Gender*

The mean BMI z-scores for boys and girls at the start of primary school were similar (0.23 for boys, 0.22 for girls), however, by Year 6 the mean z-scores for boys (0.69) were higher than for girls (0.54). Girls were slightly more likely than boys to remain at a healthy weight (71% girls, 68% boys). Whilst prevalence of obesity was similar at Reception, by Year 6, 26% of boys were obese compared to 24% of girls. 16% of boys moved from being a healthy weight to being obese, this is higher than for girls (12%) ( $p < 0.001$ ). The proportion of children remaining obese is the same for both girls and boys.

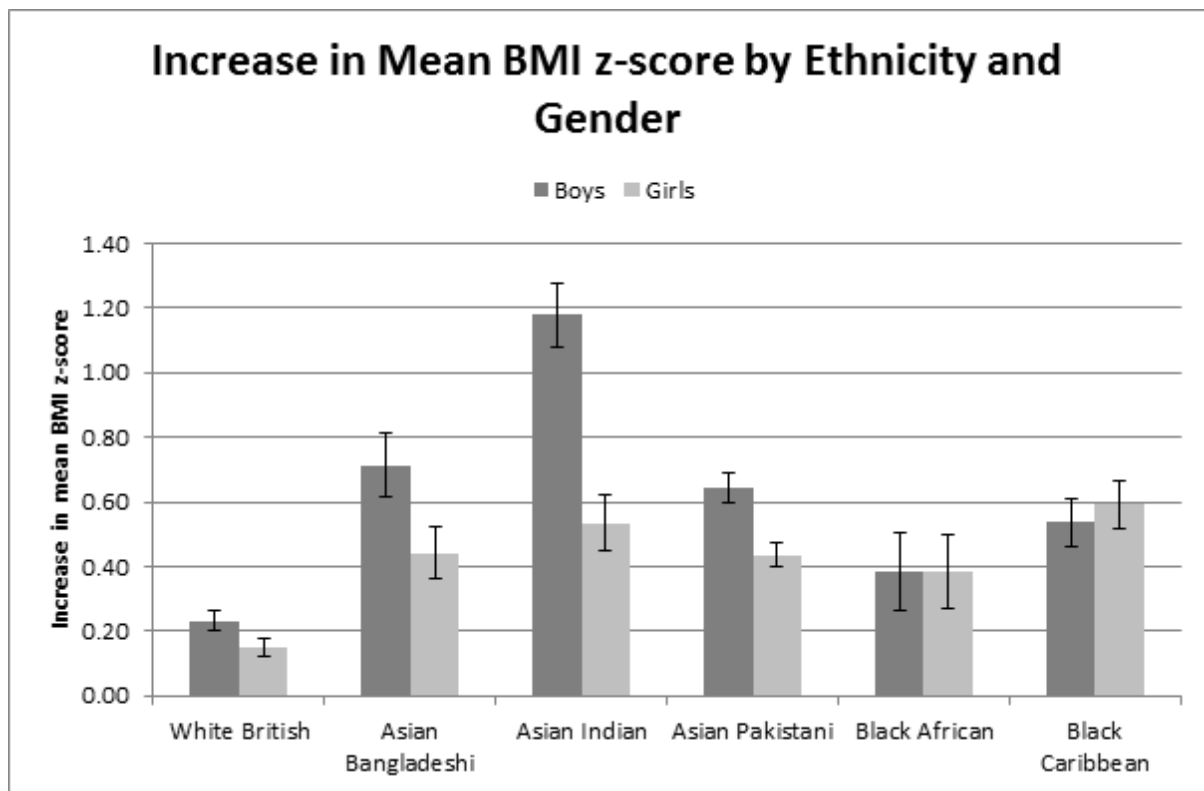
### *Ethnicity*

Boys' mean BMI z-scores were more diverse by ethnicity at Reception but less so in Year 6. White British boys had the highest mean z-score at Reception (0.38) but one of the lowest in Year 6 (0.62). The highest increase through primary school was seen in Asian boys (**Figure 1**); in particular Asian Indian boys, where this group increased to a mean z-score of -0.51 at baseline to 0.67 at follow up.

In stark contrast the mean BMI z-scores for girls were closer at Reception than they were at Year 6. White British girls have the highest mean scores at Reception but increase only slightly from 0.37 at Reception to 0.52 at Year 6 (**Figure 1**). Black African and Black Caribbean girls have significantly higher scores at Year 6 than girls of other ethnic groups. The sharpest increases in mean scores between Reception and Year 6 are for Black Caribbean (Year 6; 0.88) and Asian Indian girls (Year 6; 0.41).

**Table 1.** Descriptive Statistics of Matched Cohorts.

Participants	2006/07 - 2012/13		2007/08 - 2013/14		2008/09 - 2014/15	
	n	(%)	n	(%)	n	(%)
All	8,445		9,116		9,167	
Gender (female)	4,091	48.4	4,407	48.3	4,479	48.9
Ethnicity						
White	3,487	41.3	3,298	36.2	3,293	35.9
Asian	3,272	38.7	3,214	35.3	3,196	34.9
Black	755	8.9	823	9	820	9
Chinese	24	0.3	26	0.3	21	0.2
Mixed	516	6.1	340	3.7	375	4.1
Any other ethnic group	161	1.9	260	2.9	189	2.1
Unknown	230	2.7	1,155	12.7	1,273	13.9
IDACI 2010 local quintile						
(most deprived) 1	5,237	62	5,650	62	5,587	61
2	1,191	14.1	1,295	14.2	1,404	15.3
3	1,013	12	1,133	12.4	1,104	12
4	565	6.7	606	6.7	646	7.1
5	439	5.2	432	4.7	426	4.7
Reception Weight Status						
Underweight	276	3.3	264	2.9	219	2.4
Normal	6,271	74.3	6,924	76	6,895	75.2
Overweight	996	11.8	1,050	11.5	1,066	11.6
Obese	902	10.7	878	9.6	987	10.8
Year 6 Weight Status						
Underweight	207	2.5	160	1.8	177	1.9
Normal	4,871	57.7	5,404	59.3	5,365	58.5
Overweight	1,397	16.6	1,359	14.9	1,368	14.9
Obese	1,970	23.3	2,193	24.1	2,257	24.6
Reception BMI z-score	Mean	SD	Mean	SD	Mean	SD
	0.25	1.19	0.19	1.18	0.24	1.18
Year 6 BMI z-score	0.60	1.31	0.62	1.29	0.63	1.31

**Figure 1.** Increase in Mean BMI z-score by Ethnicity and Gender.

### Deprivation

The mean BMI z-scores were similar at Reception for children in all the deprivation quintiles. Whilst the mean scores increase for all groups by Year 6, the greatest increase and the highest scores were found in the most deprived areas (**Figure 2**). The increase being almost four times higher in the most deprived areas compared to the most affluent. There is a significant gap between both boys and girls in all but the most affluent quintile.

Differences in weight status by level of deprivation already exist at Reception, however, by Year 6 the prevalence of obesity in the most deprived has risen to 26.4% (25.7%, 27.1%) compared to a prevalence of 13.0% (11.3%, 15.0%) in the most affluent areas. Furthermore, those children in the most deprived areas are more likely to remain obese (79.5%, 95% CI 77.6%, 81.2%) than those in the most affluent (65.8%, 95% CI 54.6%, 75.5%).

### Regression

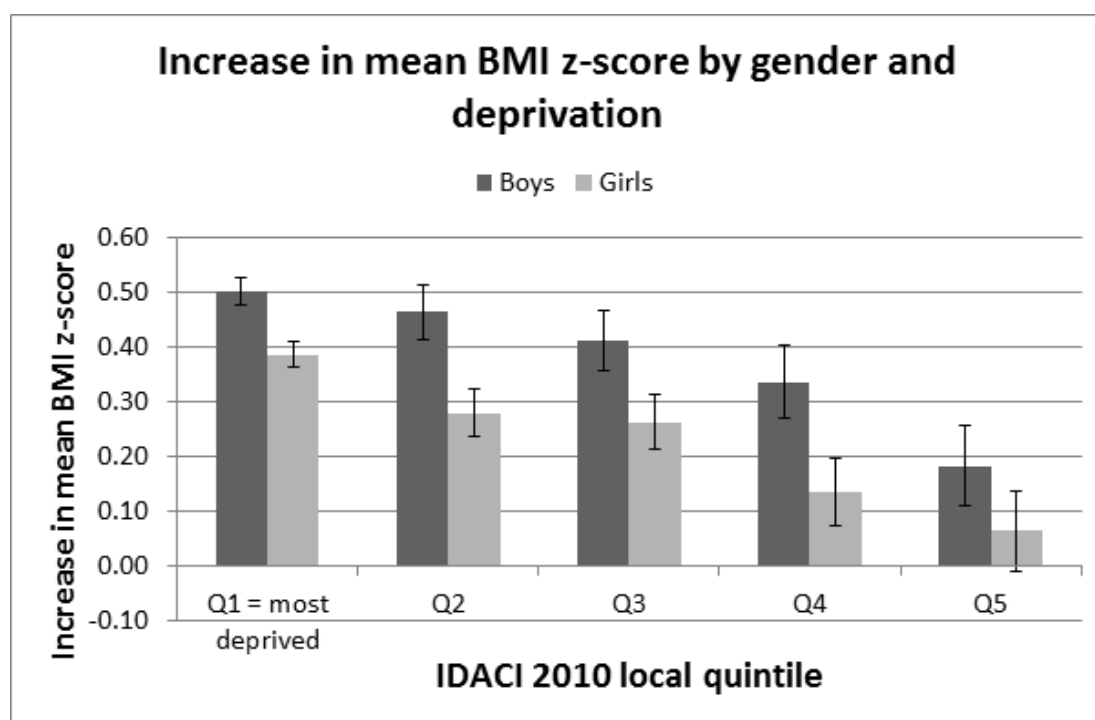
The unadjusted linear regression showed a statistically significant relationship between BMI z-score at Reception and Year 6 ( $p < 0.001$ ) with a co-efficient of 0.66. This relationship was maintained in the adjusted mixed effect linear regression model with the co-efficient being slightly larger (**Table 2**). The greatest effect on increasing BMI through primary school is BMI z-score at Reception. Although gender, ethnicity and deprivation level also have a significant effect.

## Discussion

Childhood obesity inequalities are widening in England. Latest data from 2017/18 shows an increase in the gap in obesity prevalence for children in both Reception and Year 6 between those living in the most deprived and those in the least deprived areas (NHS Digital, 2018). With the current study showing a doubling of the prevalence of obesity in children as they complete the journey through primary school between the ages of four and eleven, tackling childhood obesity remains one of the greatest public health challenges of the 21<sup>st</sup> century. Data and findings from this longitudinal investigation also indicate that there are significant differences in obesity prevalence between gender and ethnic groups. The need for urgent action on these widening inequalities was reinforced within a recent Health and Social Care Committee report that urged for stronger action on the disproportionate burden of childhood obesity on children from low income backgrounds (Health and Social Care Committee, 2018). The longitudinal tracking analysis has allowed the exploration of how the weight status of individual children changes over time and the impact of socio-demographic factors. This study found that 78% of children who are obese in Reception remain obese in Year 6. This is a higher proportion than that reported in other longitudinal studies (Pearce, M. *et al.*, 2015) (Bartle *et al.*, 2013). A greater proportion of children living in deprivation could explain the higher percentage in Birmingham. The effect of gender and ethnicity which has not been explored in the other work may also contribute to the high prevalence.

Although this study did adjust for deprivation and ethnicity, these factors were still found to be independently associated with obesity risk. The findings of this research suggest that a child who is overweight at the beginning of primary school is more likely to remain overweight or to develop obesity than to achieve a healthy weight status. Within this Birmingham study 20,090 had a healthy weight status at Reception but only 69% of these had maintained this in Year 6. The doubling of the obesity prevalence is postulated to be the combination of children who have healthy or overweight weight status at Reception who move to an obese weight status in Year 6. These findings support the case for primary and secondary obesity prevention programmes for children within the healthy weight category alongside appropriate interventions for those children who are overweight or obese.

**Figure 2.** Increase in mean BMI z-score by Income Deprivation Affecting Children Index 2010 quintile and gender.



**Table 2.** Mixed effect linear regression.

Year 6 BMI z-score			
Fixed effects	Co-efficient	95% CI	P value
Reception BMI z-score	0.69	(0.68, 0.70)	<0.001
Gender female (reference = male)	-0.14	(-1.67, -0.12)	<0.001
Ethnicity (reference = White)			
Asian	0.24	(0.20, 0.28)	<0.001
Black	0.25	(0.20, 0.29)	<0.001
Chinese	0.12	(-0.12, 0.36)	0.320
Mixed	0.17	(0.11, 0.23)	<0.001
Any other	0.17	(0.09, 0.26)	<0.001
Unknown	0.14	(0.10, 0.19)	<0.001
Deprivation quintile (IDACI 2010)			
(Reference = 1 – most deprived)			
2	-0.34	(-0.04, 0.31)	0.726
3	-0.03	(-0.08, 0.01)	0.122
4	-0.09	(-0.15, -0.04)	0.001
5	-0.18	(-0.24, -0.11)	<0.001
<b>Random effect</b>			
School	0.102	(0.01, 0.015)	



The Government's Childhood Obesity Plan (COP1) published in 2016 aims within the next ten years to encourage industry to cut the amount of sugar in foods and drinks and for school children to consume healthy food and stay physically active. Chapter Two of the Childhood Obesity Plan (COP2) published in 2018 set a national ambition to halve childhood obesity and significantly reduce the gap in obesity prevalence between children from the most and least deprived areas by 2030. COP2 says little about diet or physical activity in the early years, with much of the focus on school age children (Knai *et al.*, 2018). The Chair of the Health and Social Care Committee's response found COP2 to be a substantial improvement on COP1, especially its ambition around the reduction of the inequality gap. The response was also complementary of the Government's pledge to develop a trailblazer programme with local authorities to understand 'what works' in different communities, especially the focus on ethnic disparities, but was discontented on the absence within COP2 of making health a licensing objective for local authorities.

Given the current significantly higher prevalence of childhood obesity of Year 6 pupils within Birmingham (25.6%) compared to the national average of 20.1%, this study provides timely evidence to parents, school staff and health professionals of the existing inequalities and the requirement to focus preventative efforts towards those at greatest risk, in order to prevent future health problems. Being one of the first tracking studies to have been undertaken within Birmingham, these findings provide an important benchmark for future analyses.

The existence of socio-demographic inequalities highlighted within this study underscores the need for assessing the predictors of child obesity in local areas. National policy drivers such as COP1 and 2 can empower local areas to influence and reduce childhood obesity rates through reducing or limiting harmful commercial influences such as advertising and marketing of unhealthy foods and drinks. A greater examination of the wider social, environmental and economic determinants of health such as fast food outlets, green space availability or fiscal policies such as the sugar tax is required (Evans, 2018) to understand the opportunities and obstacles to childhood weight management in local areas. These insights are likely to be achieved through qualitative studies and by understanding the social milieu 'whole system approach' to elucidate the best mechanisms, such as population segmentation (Mahmood & Lowe, 2017) that are able to engage effectively with those communities whose children are at greatest risk.

The findings here support national cross-sectional NCMP data that there is a strong link between childhood obesity and deprivation and that this widens by the end of primary school (Townsend *et al.*, 2011), South Gloucestershire study findings (Pearce, M. *et al.*, 2015) were similar but the sample was too small to show significant effect. The widening gradient fits with the results of the longitudinal studies with wider measures of deprivation (Goisis *et al.*, 2015) (Pearce, A., 2015). However none of these studies have also looked at the effect of gender and ethnicity.

Studies that have looked at gender and ethnicity have found associations for obesity and deprivation for girls and non-White children (Griffiths *et al.*, 2013) (Ells *et al.*, 2015). In this study it was found the effect of deprivation did not markedly differ between boys and girls but that increases in BMI z-scores were generally much higher in boys than girls and that there was far greater differences by gender and ethnicity. This conflicts with findings of a longitudinal study (Bartle *et al.*, 2013) that there was no significant difference between boys and girls. Reasons why boys have higher obesity in Birmingham are potentially associated with ethnicity. The increase in mean BMI z-scores in Asian boys is higher than boys in other ethnic groups and markedly higher to Asian girls. Possibly due to cultural and societal norms and behaviours, boys may have more risk factors relating to diet and physical activity.

Early identification and a focus on the prevention of obesity in children is paramount as the impact if left disregarded can have potentially detrimental effects in later life. The findings from this study endorse wide-scale multidisciplinary primary and secondary prevention programmes with pre-school and primary school children which engage and interact with local communities to abate the rising of obesity prevalence through primary school. In order to successfully influence and reduce childhood obesity prevalence, national and local government policy must do more to develop holistic 'whole systems approaches' to tackling childhood obesity (Bagnall *et al.*, 2019) as it corrals expertise across all sectors, such as health, schools, industry and academia.

### *Limitations of this Study*

This is a large longitudinal study of a representative sample of multi-ethnic population with a high rate of follow-up. It provides richer information than serial cross-sectional studies. Although the study population is representative of the ethnically diverse children in Birmingham, the data is based on children in a large city with more deprivation than there is in the England population as a whole. Therefore the trends and characteristics associated with increasing weight status may not necessarily apply to a wider population.

The data for the first years of the NCMP were of poorer quality compared to those collected in the most recent years. Particularly in the first year of collection where more data is missing than for other years. Nevertheless, the patterns observed were similar in the three cohorts of children, suggesting that the missing data was unlikely to have resulted in significant bias. No unique identifier was routinely collected until 2012/13 making it difficult to link children for a longitudinal study. Analysis of the loss to follow up found that children are not likely to drop out because they are recorded as obese at Reception, but did show that boys were less likely to be followed up than girls. As the findings of this study show that boys are more likely to increase weight it may be that these children have become obese and the parents are unwilling for them to be measured. However, it may also be because there are a higher number of boys in Birmingham schools than girls. The matched sample was representative of children within the city and obesity prevalence similar to the NCMP collection from 99% of the eligible population and therefore this study is unlikely to be adversely affected by attrition bias.

BMI is not an accurate measure of weight status (Davillas & Benzeval, 2016), however, it is a simple measure to collect and is commonly used and recommended for use in population studies and monitoring by national authorities (NICE and PHE). However, BMI does have the weakness of not being able to distinguish between excessive lean and fat mass (Must & Anderson, 2016) and this may impact on results for non-White children; overestimating obesity in Black ethnicities who are more likely to have high muscle mass and be taller for their age in comparison to White British children and underestimating prevalence for Asian children who have higher central adiposity (Nightingale *et al.*, 2013). The cut points are arbitrary and may skew results for tall children. Analysis of the heights of the Year 6 girls show that Black girls are taller than those of other ethnicities. The increase BMI z-score for girls is steepest in Black Caribbean ethnicity and this could be explained by their being taller than the other girls. Using another method than BMI would likely return a lower obesity prevalence for this group.

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## Personal Health Budgets: A critical analysis of the NHS vision

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### Abstract

*Personal Health Budgets (PHBs) could prove to be a radical policy initiative for the National Health Service (NHS) in the UK because they represent changes to the way services are organized and delivered that, if extended, potentially challenge existing funding, commissioning and delivery of health care service arrangements.*

*This paper aims to provide a critical analysis of the NHS vision for PHBs and a discussion of potential risks and negative effects should a wider roll-out of PHBs take place.*

*To do this the paper explores ways in which PHBs are claimed to offer choice and control through the combination of documentary analysis of policy documents and guidelines and semi-structured interviews conducted with PHBs specialists. The vision for PHBs emerging from these sources is discussed against the critical literature available on the topic.*

*The paper suggests that for the promises of PHBs (choice and control) to be delivered, the concomitant radical shift in the way services are financed, commissioned and delivered may lead to the further privatisation of NHS services and the individualisation of care interventions.*

**Keywords:** Personal health budgets, personalised care, choice

### Introduction

Personal Health Budgets (PHBs) are a new approach to service delivery in the UK National Health Service (NHS). They can be defined as follows:

*A Personal Health Budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG). It isn't new money, but a different way of spending health funding to meet the needs of an individual.*

(<https://www.england.nhs.uk/personal-health-budgets/what-are-personal-health-budgets-phbs/>)

Unpacking this definition, and complementing it with the requirements set by NHS England for PHBs (*Ibidem.*), their key features emerge together with the process that links them together: following an assessment of needs and outcomes for an individual, a support plan is developed by the individual and their CCG (or NHS team) on the basis of an indicative budget. This provides an indication of how much money is available in order for the assessed needs to be met. Minor adjustments of the budget are allowed provided they are justified by the support plan and, once the CCG (or NHS team) approves the plan, its overall cost becomes the PHB of the individual. People can then choose between direct and indirect management of a PHB. In the first case they will receive their PHB as a direct payment while in the second one a third party or the CCG will manage the budget. This last option is usually referred to as notional budget. A mix of these three options is also possible.

PHBs were first introduced in health care in England in 2014 – following a three year pilot programme which ended in 2012 – and they represent a key component of the NHS England personalised care model.

Personalisation is today a major driving principle of health care policy in England and the NHS commitment to personalisation in terms of choice, self-direction and the use of ‘budgets’ somehow mirrors that of social care policy in the country just over ten years ago. At that time, the third sector organisation ‘In Control’ had introduced a new model of service delivery known as self-directed-support (Hatton *et al.*, 2008). In Control’s work influenced government policy in social care, and the slogan of ‘choice and control’ originally coined by disability movements in the 1980s (Oliver, 1996) was incorporated into the then government ‘personalisation agenda’ (HM Government, 2007).

However, though arguably research on personalisation and personal budgets (PBs) in social care is now extensive and varied, that on personalised care and PHBs within the NHS is currently quite limited (Gadsby, 2013; Gadsby *et al.*, 2013). Most of the evidence regarding PHBs comes from two independent evaluations commissioned by the NHS (Forder *et al.*, 2012; Jones *et al.*, 2017). The recommendation in support of a wider roll out of PHBs beyond the pilot was based on these studies’ conclusion that PHBs were cost-effective – given certain assumptions – and that their use was associated with significant improvements in care related quality of life and psychological wellbeing for budget holders. I will argue below that partisan interpretations of these evaluations’ results have supported the wider roll out of PHBs and that the warnings of critical scholars regarding the risks PHBs might pose for NHS services have been overlooked or ignored. These risks include how PHBs might contribute to furthering the individualisation of health care practices and the privatisation of health care services.

This article contributes to research on PHBs by investigating the NHS vision for PHBs against more critical literature on the topic. In particular, it will focus on the way in which assumptions about PHBs have turned into a powerful narrative and how such narrative risks to overshadow potentially contested changes of current funding, commissioning and delivery arrangements of NHS services.

## Methods

This study is based upon critical analysis of policy documents and guidelines on PHBs together with interviews conducted with experts on PHBs. The analysis and discussion draw on the work of other scholars who have considered the rationale behind PHBs and the evidence so far produced in their support.

Searching for ‘personal health budgets’ on the NHS England homepage reveals a series of links providing information and guidance about PHBs (<https://www.england.nhs.uk/?s=personal+health+budgets>). The first link leads to a webpage detailing all the different areas in which PHBs have been applied (<https://www.england.nhs.uk/personal-health-budgets/>) and, through this, to a ‘questions and answers’ section addressing various matters on PHBs (<https://www.england.nhs.uk/personal-health-budgets/what-are-personal-health-budgets-phbs/frequently-asked-questions-about-phbs/>). These links, together with key documents identified via these links and references to PHBs from more generic policy documents setting out the NHS vision for *personalised care*<sup>1</sup> were used as data for my analysis. The focus was restricted to include only documents published after 2014 (the year of the introduction of PHBs in the NHS as a ‘right to have’) and containing information about the plans for expansion of PHBs within the NHS. The focus of the analysis was concerned with understanding the vision of the NHS with regard to PHBs.

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<sup>1</sup> The main documents setting out the NHS vision for personalised care are: the *Five Year Forward View* (5YFV) (2014), the *Next Steps on the Five Year Forward View (Next Steps)* (2017), the *NHS Long Term Plan* (NHS, 2019a) and the last government’s *Mandate to the NHS* (DHSC, 2018b).

This vision was then further explored through semi-structured interviews conducted with experts from both NHS England and Clinical Commissioning Groups (CCGs). A request was made to the Personalised Care Group at NHS England to interview PHB experts in both strategic and delivery roles. These experts provided details of PHB lead managers within CCGs. The Personalised Care Group is the team which, within NHS England, is in charge of embedding personalised care into NHS policy and processes while CCGs are bodies responsible for the translation and delivery of personalised care into local areas. Seven people were invited to participate. Six accepted and were interviewed: four experts from NHS England and two managers from CCGs. One person accepted but subsequently withdrew from the study. Four interviews were carried out in person while two were completed by telephone.

The interviews explored with participants the NHS vision for PHBs, focusing in particular on the changes required for the vision to be implemented. Three overarching research questions were asked: 1) What are the main changes PHBs demand at a service level?; 2) What is the scale of such changes?; 3) What could be the effects of a wider roll out of PHBs?

In line with these research questions, the interview topic guide focused on the role of PHBs within NHS policy and practice; the changes PHBs demand at a service level; and the scale of the implementation process of PHBs, including strategies and targets. Questions about positive and negative aspects of PHBs, relevant examples and similarities/differences between PHBs and Personal Budgets (PBs) were also included.

All interviews were scheduled to last a maximum of one hour. The shortest interview lasted 52 minutes while the longest 60 minutes. With the consent of the participants, all interviews were recorded.

Interviews were transcribed and thematic analysis applied to the transcripts. The topic guide was also used as the analytical framework for coding which was carried out using *Nvivo*.

The main findings emerging from my study were then compared and discussed against the work of critical scholars on PHBs. PHBs in the NHS are a fairly new policy and there is currently limited research literature on the topic. *Google Scholar* was used to identify relevant texts and hand searching of reference lists was also employed to select key studies. Most of the critical studies relied on experiences from other fields and countries – such as, respectively, social care (Slasberg *et al.*, 2015) and the US (Scott-Samuel, 2015) – or on the critical analysis of existing evidence (Slasberg *et al.*, 2013) to highlight potential risks and negative effects, as PHBs are mainstreamed in the NHS and current funding, commissioning and delivery arrangements of health care services might change. There appears to be currently limited research evidence about this topic.

## Findings

These are organised in three main sections: first, an outline of the current scenario and the NHS vision for PHBs as it emerged from policy documents and guidelines; second, a description of key findings from interviews and, third, an analysis that, drawing on the work of critical scholars, discusses findings in terms of the potential effects of a wider roll-out of PHBs for NHS services and implications for policy and practice.

### *The NHS Vision*

In accordance with the NHS *Five Year Forward View* (2014), the *Next Steps on the Five Year Forward View* (2017) and the *NHS Mandate 2018/2019*, the focus of the wider agenda to which PHBs belong is on prevention and public health initiatives aimed at supporting users of NHS services to take an active role in their health and wellbeing. A strong emphasis on self-care is indeed at the heart of the many policy initiatives which fall under the umbrella of *Personalised Care*. Choice and control over a budget are just one way of encouraging NHS users to take an



active role in their care. *Patient activation, social prescribing, shared decision making and community capacity building* are other measures and programmes which are intended for the same purposes (NHS, 2014; NHS, 2017; DHSC, 2018b).

One factor which distinguishes PHBs from other initiatives is their target population. The Comprehensive Personalised Care Model (<https://www.england.nhs.uk/wp-content/uploads/2019/02/comprehensive-model-of-personalised-care.pdf>) shows how, out of the whole NHS population, PHBs (and integrated budgets) are deemed relevant for just the 5% of the population, comprising people with the most complex needs, including long-term health conditions and disabilities.

It is for this 5% of the NHS population that choice and control over a budget become relevant. To briefly summarise NHS policy and guidelines on PHBs, personalisation is claimed to allow users of health and social care services to have more choice and control over the way their needs are met and PHBs represent a key mechanism for personalisation (DHSC, 2018a). It is suggested that people are empowered to become more confident in managing their own health and wellbeing and that they are able to influence, through their choices, the development of more appropriate and tailored support solutions compared to those of traditional NHS services (NHS, 2019b). Finally, for those individuals with both health and social care needs, PHBs also mean the possibility of joining together their resources into an integrated budget, so needs can be met in a seamless and integrated way (DHSC, 2018a).

This logic is not dissimilar from that which underpinned the introduction of personalisation through PBs in adult social care. Here, personalisation was defined in terms of self-direction and choice through PBs and Direct Payments (Hatton *et al.*, 2008). These concepts informed social care policy in the same way as they are now influencing NHS policy. Arguably, the model of self-directed-support promoted in social care by 'In Control' (Duffy, 2006) and later endorsed, in many of its aspects, within government policy (HM Government, 2007) is similar in respect of how it links support and care planning to 'indicative budgets' (or upfront allocations) in the NHS. Moreover, the claim that PBs would deliver better and more efficient care together with greater empowerment (Hatton *et al.*, 2008; Leadbeater *et al.*, 2008) resonates with today's commitment from the NHS to expand PHBs as a means for personalised care.

This commitment is declared in the *NHS Long Term Plan* (NHS, 2019a), a key component of which are PHBs. Since March 2019, PHBs have become a *default option* for NHS Continuing Healthcare (CHC)<sup>2</sup> users. Action 12 of the *Universal Personalised Care* document requires steps to 'ensure all people receiving home-based NHS CHC have this provided as a PHB by default by 2019/2020' (NHS, 2019b, p.43). Adults eligible for NHS Continuing Healthcare (CHC) and children receiving continuing care packages have also been the first groups of users for whom the 'right to have' a PHB was introduced, in 2014. This means that, irrespective of where they live, since 2014, people with CHC arrangements have been able to request a PHB from their local CCG. For some other user groups, instead, the right to request a PHB depends on where they live and on whether there are plans to expand the use of PHBs by their local CCG. Accordingly, they may be available to people with mental health problems, learning disabilities, autism, people using end of life care, wheelchair services and, more recently, women using maternity services (NHS England, 2017). Also, as part of the Integrated Personal Commissioning (IPC) Programme launched in 2015, integrated budgets for people with a range of long-term conditions and disabilities and high level of needs across health and social care have been piloted and, following a recent consultation (DHSC, 2018a), work is underway to introduce new 'rights to have' for new groups of people with ongoing health needs.

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<sup>2</sup> Adults with long-term complex health needs might be eligible for NHS CHC. Eligibility for NHS CHC depends on the complexity, intensity and unpredictability of certain health needs. If eligible for CHC, both the social care and health elements of a person's package of support will solely be funded by the NHS: '*free social care arranged and funded solely by the NHS*' (<https://www.nhs.uk/conditions/social-care-and-support/nhs-continuing-care/>).

In terms of numbers, the *Universal Personalised Care* document (NHS, 2019b) reports that 32,000 people across the UK have a PHB, as opposed to just over 1,200 in 2012, and the commitment is to reach 40,000 by March 2019 (NHS, 2017), 100,000 by 2020/21 (DHSC, 2018b) and 200,000 by 2023/24 (NHS, 2019b).

## Key Findings from the Interviews

### *PHBs and Changes*

We have seen how the NHS vision emerging from policy documents and guidelines has emphasised the power of PHBs to lead to better self-care, more tailored support solutions and better integration between health and social care. The paper will now present key findings emerging from interviews with PHB experts. These enable a deeper understanding of what changes PHBs might imply at a services level and what could be the consequences of such changes.

The shift towards self-management and self-care was highlighted clearly in the interviews:

*... it's a thread really that runs through everything that comes out of the NHS now [...] That's all about taking care of yourself and your health... and that's the shift. [...] So, all that self-management, self-care stuff... I think that the language has changed slightly around our responsibility.*

(NHS England Expert 1)

However, within this agenda, PHBs were described as covering a double role. On the one hand, they were referred to as the “purest version of personalised care” (NHS England Expert 2) or “the ultimate in handing over of power and control to an individual” (NHS England Expert 4). On the other hand, their remit was described as going beyond the strict number of people using them. PHBs, in this sense, were described as a mechanism to introduce new care models within the NHS.

*So, the way that we think about it is that PHBs are a good top-down way of changing and introducing personalised care [...]. What you've got is two different ways of approaching it. So, one is PHBs which are for a smaller group of people but which are a very pure and very accelerated way of making change, and then you've got the bottom-up approach which is for a much bigger number of people. It's a lot less pure [...] So, if you do it from both directions that's what leads to change.*

(NHS England Expert 2)

PHBs can therefore be seen to represent a further step in the expansion of treatments which, within the NHS, are provided based on the model of ‘money following the patient’ which were previously introduced in order to create an internal market in the NHS (Timmins, 2005). What is specific about PHBs is the application of a demand-side strategy through a shift from population-based commissioning – based upon estimations of annual demand for services and on fixed-value contracts with providers – to individual commissioning based on cost-per-case contracts and linking funding to activity. The ‘unpicking’ of block contracts emerged from interviews as necessary for a full roll-out of PHBs. If this was achieved, it would represent a major change in the way services are commissioned within the NHS. From the interviews, however, unpicking block contracts was perceived to be not just necessary but also the biggest challenge to the expansion of PHBs: freeing up money from block contracts was extremely difficult and – despite the efforts of NHS England and CCGs in this direction – block contracts continued to underpin the provision of the majority of NHS services.

*The problem with a community contract is that it's just one block of money that goes to the provider, and it's very hard to take individual personal money out of that, so [...] it's very hard for me to take £2,000 out for one individual and give it to them as a PHB. This is one of the biggest challenges.*

(CCG Manager 1)

The fact that PHBs are a 'right to have' in CHC is indicative: CHC funding sits outside the NHS financial remit from which the majority of NHS services are funded. This means it is much easier for CHC packages to be provided in the form of PHBs, because the commissioning model for CHC services is not based around block contracts. For all other services though, unpicking block contracts remained a big challenge:

*... no one is doing that yet, so in many places they are double funding for PHBs...*

(CCG Manager 2)

An example which was repeated several times during interviews was that of integrated budgets offered as part of IPC programmes. IPC is based on a model of integration at the individual level but, at least in the geographical areas in which interviews were conducted, this was achieved so far through 'doubled' funding, rather than through the use of available resources from existing block contracts.

*No one has managed to take money out of the existing contracts yet. So that's the biggest hurdle they need to overcome. So, yes, it's good to do a lot of testing [...] but we need to work out how do we make it sustainable in the long term as well, which is a big challenge...*

(CCG Manager 1)

This suggests that – despite claims that PHBs do not require new money – the pilot sites where PHBs have so far been implemented did have a significant amount of new money. This allowed managers to get round the difficulties they would otherwise have had of finding ways to de-commission providers to release the money needed for PHBs. Beyond the injection of new money, however, PHBs have proven to be difficult to implement. Nevertheless, NHS England and CCGs remain committed to explore ways for unpicking block contracts. Reducing the size of some contracts is one way; and the embedding of PHBs into new contracts is another. The extract below from one interviewee describes the way this could be done but also potential reasons why this model might not work:

*... I went to a PHB masterclass from NHS England, that was for children's services, they had a big block community contract and they managed to change the commissioning of that contract. So, 80% of it was provided in block, so 80%, whatever happened, that was paid to the provider, 20% of it was paid on a cost and volume basis, and so of that 20%... if the body was a million pounds, every year we would give them £800,000 regardless, and then £200,000 is set aside based upon the activities in the contract, so, if for example twenty PHBs go through that service and they cost £50,000, that £50,000 will come out of that 200,000. That is based upon what actually happened in the service, and you can take some of that money out. It's really hard to do though [...] from a provider point of view, there is no real incentive for them, really getting involved in PHBs and promoting them...*

(CCG Manager 1)

Other difficulties, relating to cost per case commissioning models also emerged, including the problem of unreliable resource allocation systems (RAS) which aim to link needs to an amount of money; local markets which do not necessarily respond to the needs and wants of PHB holders and – related to this last point – the uncontrolled expansion of non-conventional and non-NHS providers, including some, for instance, providing new treatments such as aromatherapy, homeopathy, yoga or tai chi for which there is no clear clinical evidence of benefit and which are not 'approved' by the National Institute for Clinical Evidence (NICE).

These difficulties, however, were mainly treated as barriers yet to be overcome rather than risks to NHS services.

The RAS could be taken as an exemplar. Talking about RAS, NHS England Expert 1 said:

*We've learnt from social care that the areas that did the RAS in the IB pilots are probably on version 625 of their RAS, and some of them just abandoned them because it was so complex. [...] what we said right from the very beginning was 'you don't have to have a RAS', what you have to be able to do is to understand what you would normally spend on the service, so if you assess me and I need... I don't know... six sessions of physio, and some bath equipment and a ramp for my front door... you need to understand how much that would normally cost...*

(NHS England Expert 1)

Personalising the cost of services into allocations to single individuals, however, is problematic both at a technical and structural level. CCG managers provided examples of the complexities of 'costing' budgets and of the solutions different CCGs have adopted. These range from using average costs of different kinds of care packages within a certain CCG area – with margins of error of a few thousand pounds a week per package – to engaging in quite complex and uncertain calculations with the aim of turning different services' costs into single package monetary values. The excerpt below illustrates this last case:

*One of the tricky things is that... how do you calculate the size of someone's budget? ... it's quite difficult, and within the rehab service we looked at different ways [...]. If someone is referred to the rehab service, they get an assessment from the nurse, and they have 14 different types of packages of care they provide for people, so anything from mobility and transfers, communication therapy and... 14 different types of support they provide and each of those are tiered in complexities from 1 to 3. So, what we've tried to do is to look at each of those packages, associating a budget value to what's assessed in someone. [...] so what I looked at is for a package of care, say mobility and transfers, I sat down with the team and said so... for that, how many hours do you spend with the patient? So, if it's mobility and transfers tier 1, they might say we spend 5 hours with the patient face to face... so for the 5 hours face to face, how much time do you spend in preparation, travel time, non-face to face hours, ... so we got a total number of hours for that specific package and I looked at what professionals are involved in that care, so if it's a band 8 physio involved in that care for 5 hours, I then work out what is the hourly rate of the band 8 physio to the NHS, and then times that by the average number of hours in the package, if that makes sense... it gives you a monetary value. [...] it's not completely robust but it's the best way we could find to get to a budget for each of these packages.*

(CCG Manager 1)

'Technical' difficulties, however, are not the only problem. The unpicking of block contracts may affect the stability of existing NHS services and its underpinning value as a universal public service. Another extract from one interview clearly describes this issue. The example of physiotherapy is used to highlight what moving from block contracts to PHBs would imply:

*... we are working really hard with CCGs to understand how we can do without destabilising current services, but you know [...] ... to actually give someone a budget for physio would mean you have to start to unpick that block contract and individualise some of those services, so that's actually incredibly difficult to do, because what you have to understand enough about I think is what you need to hold on to, because everyone has a right to have a physio appointment within, for example, a physio rehab gym for people with a stroke. So, at what point have you put so much money out of your block contract that you make your rehab gym not viable? And I guess that's the thing that people are really struggling with, it's how possible is that to do, when actually some of these stuffs like the rehab gym needs to be there but it's actually quite expensive and requires everyone to pay into that... if you see*

*what I mean... it's a community resource that everybody uses, so actually by slicing off, you know, your £200 a week here and there for physio and pulling that out of the block contract... at what point do you jeopardise that free at the point of delivery and available to everyone? And it's a universal service... so it's really key that people understand the whole of how the NHS works and the whole universality and stuff...*

(NHS England Expert 4)

The risk of jeopardising the universal and public value of NHS services in the name of individuals' right to control a budget, however, did not generally lead interviewees to question the use of demand-side strategies for the provision of NHS services. The extract above represents in fact one of the very few instances of scepticism from interviewees.

### *PHBs and Scale*

The objective of reaching, with PHBs, the 5% of NHS patients might seem quite small, as the target, reported earlier, of 200,000 PHB users by 2023/24. To achieve such targets, however, NHS England is pressuring CCGs to 'sign up' more and more people to IPC and PHB programmes and it is also supporting them through incentives and dedicated resources.

*... now it has to be a priority because everyone has been managed around how many PHB numbers we do have, what we are doing with them etcetera [...] And so, each quarter we report back to NHS England on how many PHBs we have, what areas are they for, what are our challenges etcetera... and then they're pretty good, people like XXX come and provide training to individual areas [...]. That team [the Personalised Care Group] has been set up specifically to provide local support to each area.*

(CCG Manager 1)

'Notional' budgets<sup>3</sup> are key in enabling targets to be achieved. At present, only a small percentage of those with a 'right to have' a PHB have chosen to directly manage their budget. This has resulted in an increase of notional budgets. The claim of NHS England that notional budgets would still offer more choice and control was explored in interviews. Some responses confirmed this claim:

*I would say the difference [between notional budgets and traditional service delivery] would be the person knowing how much money is available... making sure that everybody has been provided with information about all the different types of PHBs [...] they have to have the choice, they have to choose to take a notional budget, they have to make sure that's what they want to do by knowing how much money [...] the idea of notional is that it does mainstream personalisation and that way of thinking within service provision, and then the step further is when you need the structural changes and the DP etcetera... but why not getting everybody thinking about personalisation?*

(CCG Manager 1)

Other responses introduced elements of doubt:

*I think there is a danger that people start calling things notional budgets that are not, so they just set it up... so they could set up an agency and say this is a notional budget. Even though they haven't had that conversation with the person to say – how would you like to manage? Is it really this agency that you want? And so that's kind of my worry about doing this at this speed.... [...] because people say they're doing personalisation and this term is banded around a lot... so we do person-centred planning but actually we don't when you*

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<sup>3</sup> Notional budgets represent one of the three management options for a PHB: managing the money as a direct payment, a third-party budget or a notional budget. In this last case, the CCG is responsible for managing the budget and the money is hence retained within the NHS.

*look at it. Just because we've asked the person how they are for instance, so how are you... well let's go... let's tick the plan...*

(CCG Manager 2)

The prospect that PHBs would bring just cosmetic changes to NHS services, without actually changing the experiences of NHS patients was raised. Nevertheless, 'success stories' about PHBs were also mentioned to counteract scepticism. One such, mentioned twice, was of a woman using her budget to buy a dog – who would help her at home and keep her company at night thus allowing her to keep living in her house and, as a by-product of that, to save money to the NHS. Other examples of positive stories can be found on the NHS England website (<https://www.england.nhs.uk/personal-health-budgets/phbs-in-action/patient-stories/>). These stories have a strong appeal and they tend to showcase the success of PHBs without showing, however, how the key features the NHS requires PHBs to have are preserved and respected.

Integrated budgets were also problematic. Responding to a question about how a PHB would support integration, NHS England Expert 1 replied:

*I think a PHB can help in the short term because you can actually make some quick wins if you do an integrated personal budget. So if you integrate around the level of the individual you haven't had to have all the really difficult conversation about pulling structures, pulling teams, collocating teams, and all of that structural stuff that takes forever... [...] so you do it around the person so that all the systems and processes are staying but you just join them up for when you talk to the individual... and so you could do some really good quick wins. [...] But I think from a long-term perspective you couldn't... this is my view [...] I would have thought that it's not a long-term sustainable solution to continue with two separate processes that then just meet at the individual, so at some point we are going to have to start merging... otherwise you double fund everything...*

(NHS England Expert 1)

The extract above suggests the possibility that cosmetic rather than structural changes might again be at work. However, in the case of integrated budgets, these have been supported through dedicated resources. As mentioned already, integrated budgets have been so far piloted through double funding. This suggests that the intention to introduce a shift towards demand-side funding of NHS services is real. Given this scenario, the changes PHBs might bring about within NHS services might be more than cosmetic, in the sense that they might reconfigure the funding and commissioning of NHS services on the basis of ideological assumptions which have so far proven to be problematic in their application. This will be discussed further in the next section.

## Discussion

The rest of this paper will critically discuss the findings presented above. In particular, the promises PHBs are trusted to deliver will be discussed against the potential risks and negative effects they might imply for the NHS. The discussion will intentionally focus more on risks and negative effects than opportunities and positive outcomes, drawing on the work of critical scholars to question the rationale behind PHBs and further exploring the implications of PHBs for the rest of NHS services. This last aspect has not received much attention, neither in the context of the evaluation studies (Forder *et al.*, 2012; Jones *et al.*, 2017) nor, to date, in the academic debate around PHBs. Within the discussion, an aim will be to highlight the need for debate about the changes PHBs might bring to the way NHS services are funded, commissioned and delivered and on the effects such changes might imply for the future of free and universal health care in the UK. The nature of this work is exploratory and both the small scale of the project and the purposive nature of the sampling of the interviewees are limitations to the study. Despite these, however, some suggestions for future research and some implications for policy and practice could be drawn from this work.

*Comparison of Findings with the Work of Critical Scholars*

We have seen how the commitment to introduce PHBs within the NHS is based on the premises that PHBs would allow individuals to be the best judges of their own health and wellbeing, the best compass for services in the market and the best integrators of their own care. We have also seen how such commitment is translating into practice through the combination of new commissioning mechanisms: the notion of ‘money following the patient’, the unpicking of block contracts and the development of new resource allocation systems. None of these mechanisms has proven to be free from controversial implementation processes. Nevertheless, such mechanisms continue to be promoted and trialled in the NHS. The changes PHBs are trusted to deliver rely then on a radical shift in the way NHS services are financed, commissioned and delivered. A few instances of scepticism were observed; such as the interviewee who questioned the possibility of further expanding PHBs without destabilising the universality of current healthcare arrangements, or another who expressed the view that PHBs might be more about cosmetic than structural change. Overall, though, interviewed managers and experts seemed more inclined to suggest that PHBs represent the purest version of choice and control and, as such, the best tool to introduce personalised care within the NHS.

The contention of this paper is that assumptions more than empirical evidence underpin this claim. The works of scholars critical of the rationales behind PBs and PHBs can help the understanding of these assumptions.

A central assumption is that knowing and controlling a pot of money allows users of care services to exercise choice and control (Slasberg *et al.*, 2015). Not only is this a very limited notion of choice and control – one which undermines social and civic rights in favour of ‘market’ rights (Daly, 2012) – but, it has also been argued that this notion subverts the original, emancipatory values of disability activism: choice is reconfigured to be less about day-to-day decisions regarding how to live one’s own life and more about shopping around and selecting support services. As Ferguson (2012) has argued, this exercise of choice through consumer power has been very powerful in translating a neo-liberal ideology around choice into public services. The mechanism of resource allocation systems capable of linking needs to a tariff provided the basis for upfront allocations. RAS systems, however, regardless of the different ways in which they have been tried in practice, have proved to be very poor predictors of what resources are required to meet people’s needs (Series & Clements, 2013) and – a few years after their launch – they have largely been abandoned in social care (Slasberg *et al.*, 2013). Nevertheless, RAS might be successful in respect of introducing an overtly resource-led culture in healthcare, where models which ensure spending is within a cash limit get greater support than models based on clinically defined need and which demand a stronger role for commissioners in planning around unmet needs, and a stronger focus on care planning (Slasberg & Beresford, 2015). In this respect, the critique offered by Slasberg *et al.* (2013) of the first PHBs evaluation report highlights how, on a closer reading of its results, having an upfront allocation did not seem to bear much relation with improved outcomes among PHB holders. However, the attempts to make upfront allocations, RAS and the ‘unpicking of block contracts’ work – as we have seen in the findings from the interviews – lead in the opposite direction, suggesting that the risk of introducing a resource-led-culture in the NHS is actually a possibility.

A second assumption is the ability of individuals to make choices as rational agents and, as such, to increase their agency and to inform the responses of a market, or quasi-market, of services capable to adapt to the different needs and wants of its users. This is an example of how rational choice theories (Le Grand, 2009) have been applied to the idea of PHBs. The traditional failures of such theories in the context of public services – represented by market externalities, information failures, behavioural failure and rising inequalities – have been discussed at length by researchers (Glennerster, 2009; 2013). Some references to these ‘failures’ have also emerged from interviews reported in this paper which suggested that NHS markets may both be unable to respond to basic individuals’ choices whilst also offering

choices of treatments such as reflexology or aromatherapy, the effectiveness of which is challenged by other NHS organisations, such as NICE, whose guidance around treatments healthcare professionals are expected to follow. Nevertheless, the trust in budgets, explored in the interviews, still appeared to prevail over practical difficulties and setbacks.

A final assumption is in relation to the power of PHBs to deliver integration. PHBs and integrated budgets are trusted to promote integration at the level of the individual. This is an alternative approach to integrated care focused at a system level (Exworthy *et al.*, 2017) where other kind of arrangements – such as for instance joint commissioning and joint funding – underpin the idea of integration. The risk, in the individual level approach, is that of transferring the responsibility to ‘integrate’ services onto service users while avoiding structural and ideological challenges to integration, such as the fact that the NHS is a free and universal service while social care is means tested. Again, we have seen this risk emerging in the findings from the interviews.

Doubts about the NHS vision and its assumptions around PHBs have emerged. Nevertheless, it is on these assumptions that the PHBs model continues to be promoted, regardless of evidence that, in practice, this has so far produced only small gains and has unveiled difficulties and controversial mechanisms. Moreover, problems and difficulties – as highlighted earlier – tend to be turned into barriers that have yet to be overcome rather than being addressed as potential risks for the future of NHS services. The ‘unpicking of block contract’ is a clear example of this.

Comparison with the introduction of PBs in social care may also be useful, because arguably, it highlights some of the consequences of promoting a model based on assumptions and little evidence that could act as a warning for NHS services.

#### *Parallels with Social Care*

Despite some differences<sup>4</sup>, it could be argued that there are close similarities between what happened in social care during and after the pilot study of PBs (Glendinning *et al.*, 2008) and current developments within the NHS.

As part of the personalisation agenda in social care, between 2005 and 2007, PBs were implemented in 13 pilot sites in the UK and an independent evaluation of the pilots was commissioned by the government. The aim was to test whether individual budgets would offer better care compared to conventional solutions and, if so, what model would work better for different groups of users (Glendinning *et al.*, 2008). The work of In Control, the charity which had already supported local authorities to pilot self-directed-support models, helped to create the climate for this large-scale trial of PHBs (Woolham *et al.*, 2015), which later became known as the IBSEN report. However, without even waiting for the results of the trial to be published, the Government announced its intention to extend personal budgets with the publication of *Putting People First* (HM Government, 2007) and the allocation of £500 million of funding to support local authorities to introduce, among other things, self-directed-support. Some misleading interpretation of the IBSEN report (Woolham *et al.*, *op cit.*) together with the use of powerful personal stories ‘framed in human, flesh-and-blood terms’ (Beresford, 2014) helped to ‘sell’ PBs in social care after 2008, in spite of the evidence-based policy commitment of the then government (*Ibid*). In 2014, with the publication of the *Care Act* (DH, 2014), all local authorities in the country have been required to provide a PB to all adults with eligible needs. This means that PBs are nowadays the default option for everyone accessing social care services.

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<sup>4</sup> The main differences between PBs and PHBs are the following: PHBs do not allow top-ups from users; PHBs need to satisfy the two tests of added value and cost effectiveness; no contribution can be requested to PHB holders; the NHS clearly indicates what are the services for which PHBs cannot be used.



Three observations can be made at this point. First, the evidence about the success of PBs in delivering choice, control and better quality care was far from conclusive at the time of the introduction of PBs in social care and, even today, such evidence is mixed and often questioned (Glasby & Littlechild, 2016). For example, evidence about the success of personal budgets in delivering better care outcomes for older people, by far the largest group of adult social care users, is weak (Woolham *et al.*, 2015). For PHBs, the scenario is not too different. On the one hand, the evidence for their expansion is again to be found in research commissioned by the Department of Health, confirming the position of Williams & Dickinson (2016) who contend that much of the personalisation evidence is produced mainly by those in favour of the concept. On the other hand, partisan interpretations of the findings from the evaluation took place (Slasberg *et al.*, 2013) and the cherry picking of some of the findings over others, together with the use of powerful personal stories, have also helped to make the case for PHBs. Support for a wider roll out of PHBs (beyond the pilot) was based on two independent evaluations, previously referred to (Forder *et al.*, 2012; Jones *et al.*, 2017). These were commissioned by the NHS and their findings were that PHBs were cost-effective – given certain assumptions – and that their use was associated with significant improvements in care related quality of life and psychological wellbeing for budget holders. However, other findings from these same studies received less attention. For example, on other outcomes indicators – such as health status and health related quality of life, having a PHB appeared to have no impact or, as highlighted strongly in the second report (2017), certain conditions were necessary for positive outcomes to be achieved for PHBs. Among these were: capability and willingness of the budget holders to receive a PHB; presence of a diverse providers' market; and ability of commissioners to create a fertile environment for PHBs, including assuming some financial risks in order to release further the benefits of PHBs.

A second observation concerns the development of PBs and PHBs once implemented as a 'default option'. The increase of notional budgets in health recalls the increase of council managed budgets in social care (Beresford, 2014), which we have seen some authors interpreting as the sign of a resource-led culture where budgets are allocated based on resource-led assessments, without necessarily leading to greater choice and control for users of care services (Slasberg & Beresford, 2015). Who guarantees then, similarly, that PHBs are not just a way to set a limit on the resources available to users and patients of NHS services, rather than a mechanism for choice and control? The developments around the use of notional budgets which emerged from the interviews lend support to this claim.

Finally, there is the question of how PBs and PHBs are used. The employment of Personal Assistants (PAs) is often portrayed in the context of powerful case stories as evidence for the success of PBs: people are allowed to continue living in their home with the flexible support from PAs of their choice (Slasberg, 2018). However, evidence shows that only 29% of Direct Payment (DP) recipients employed their own PAs (Skills for Care, 2018), and DP recipients are anyway far from being the majority of community care users (NAO, 2016). Slasberg also suggests that if the success of PBs is to be measured by the use of PAs to support independent living, there is not much that the PBs strategy would add, for PA users, to what the Direct Payment Act (1996) had already made possible. Applying this argument to the case of PHBs within the NHS raises doubts as to whether a massive transformation of NHS services' commissioning, such as in the case of the 'unpicking of block contracts' for NHS specialist services, is needed. Could there be other measures allowing NHS users to stay in control of their life and treatments?

## Conclusions and Implications

This paper has argued that the promises of choice and control PHBs are trusted to deliver rely on a radical shift in the way NHS services could be financed and delivered in future. The target, reported earlier, of 200,000 PHBs by 2023/24 is tiny in comparison with the numbers treated by the NHS. They do, though, appear to represent a significant shift within the NHS commissioning model. This shift becomes even more significant if the speed at which it has been – and still is

being – introduced is considered. In a time span of less than 10 years, PHBs moved from being considered a tool that would never apply to NHS services to being a growing reality (Glasby, 2009). As highlighted above, the CHC example is instructive. Introduced as a ‘right to have’ in 2014, since March 2019 PHBs have become a *default option* for NHS Continuing Healthcare (CHC) users. And work is also underway to extend the ‘right to have’ for PHBs, reaching the 5% of the NHS population made of people with the most complex needs and making high use of high cost specialist services.

The relevance of PHBs in the wider NHS agenda is, then, related less to the number of people who will benefit from them and more to the kind of changes they might imply in terms of support provision for an increasing number of people with complex needs and long-term conditions who depend on high cost NHS services. The introduction of a different commissioning model for this specific user group, however, represents a major change in terms of how NHS services could be funded, commissioned and delivered in future. And this change could be read as a further and covert process of privatisation of NHS services. In particular, the shift towards personal responsibility for self-management and self-care, the idea of dividing government tax revenues into single user entitlements and the attempt to free up money from contracts, which individuals can then spend freely among NHS and non-NHS providers suggest that a further step in the individualisation of care and in the privatisation of the NHS could be underway.

Given this scenario, it is possible to argue that the potential of PHBs to deliver choice and control is limited, but the likelihood that PHBs could be mainstreamed without being accompanied by a more personalised care system is credible. The experience of social care and PBs should act as a warning here as well as the worries of some critics (Scott-Samuel, 2015; Slasberg & Beresford, 2015; Alakeson *et al.*, 2016; Williams & Dickinson, 2016) which point to the risks PHBs might imply in terms of de-personalisation of care interventions in the context of resource-led systems of care, rising individualisation within public institutions and, finally, privatisation of a public healthcare system.

What is at stake, in this scenario, is the stability of a universal public healthcare system based on the principle of redistribution of resources and benefits for all (Williams & Dickinson, 2016). Some scholars push this reasoning further in claiming that PHBs would lead to the creation of a health insurance-based market on the US style, with only very limited cover for the very poor (Scott-Samuel, 2015).

Even if this last scenario was a distant possibility, the privileging of individuals’ right to choice through the control of a budget might act as the ‘trojan horse’ threat to a free and universal NHS. This is why a reflection on PHBs continues to be needed, their development deserves attention and further research is required in this area.

Some implications for policy and practice could be drawn from this paper. The mantra of choice and control is so powerful, and so widespread within both health and social care, that it is now very difficult, both at a policy and practice level, to challenge such concepts or to substitute them with others. Consumerist and individualistic notions of choice in the context of marketized healthcare services have been so powerful in subverting the original, emancipatory meaning of ‘choice and control’ as originally conceived by disability movements that there is currently little space for investigating and testing alternative frameworks. However, reflecting on some of the risks which the current model of choice and control might imply for the sustainability of NHS services could help to question some of the assumptions around choice and also to consider alternative meanings of the concept if not, possibly, even alternative concepts to inform a universal healthcare system. More research would be needed to examine what seem to be controversial and contestable mechanisms of PHBs, including the development of new resource allocation systems and the unpicking of block contracts. These represent in fact the core of the shift in the way NHS services are financed, commissioned and delivered under PHBs and which may lead to a further step in the privatisation of NHS services and the individualisation of care interventions.

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## Notes on Contributor

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## Reviews

### **Social Policy First Hand: An International Introduction to Participatory Social Welfare**

Beresford, P. & Carr, S. (eds.), *Bristol: Policy Press, 2018*

ISBN: 978-1447332367 (pbk), £24.99, pp.320

According to the editors, this book is the first exploration of participatory social policy internationally, critiquing its nature, origins and possibilities, as well as the issues and problems it faces. They point out that they have not sought to privilege any one perspective or set of knowledges, stressing the importance of an international and inclusive approach, and noting that chapters are of different styles and lengths (on average, just over 8 pages per chapter, with some very brief at about 2.5 pages).

The book covers a great variety of sectors and topics (e.g. health, housing, education, employment, poverty, citizenship, disability, equality, race, gender, ageing, and dying). It contains 50 chapters organised into eight parts. The first four parts focus on the need for and the knowledge base of participatory social policy: service users and social policy; critiquing and reconceiving Beveridge's 'five giant evils'; the contribution of service users' knowledges; an inclusive life course and developmental approach of social policy. The last four are on 'making it happen': transforming social policy; campaigning and change; breaking down barriers; and participatory research and evaluation. The book has some 80 contributors, including academics, activists and service users. While this cast is international, I estimate that about 52 of the 80 contributors are based in the UK, with a further 21 from Australia and New Zealand (including many linked to two universities there).

It is clearly impossible to cover these very diverse chapters in detail, so I will focus on a few main themes, and on some unanswered questions. At one level, it is possible to sum up the book's overall approach with reference to George Orwell's '1984' and Jonathan Bradshaw's (1972) 'Taxonomy of Social Need'. Orwell writes that 'If there is hope it lies in the proles' (cited by Beresford, 2016, p.333). Participatory social welfare would appear to favour Bradshaw's 'felt need' over expert-derived 'normative need'. However, at a deeper level, it seems to me that there are some unresolved issues.

The first such issue concerns who we should be listening to. The book mentions a large number of keywords or clues: 'participatory', 'people on the receiving end', 'subjects of social policy (especially of its more 'heavy end')', 'real say', 'new voices', 'first hand voices', 'first-hand experience', 'lived experience', 'marginalised perspectives', 'experiential knowledge', 'grassroots activists', 'service users' and 'voiceless' service users. However, as Ruth Lister points out in the book, 'users are not a separate group... We all experience social policy in various ways' (p. viii), albeit not all at the 'heavy end'. It is not clear whose of these voices should count most (especially in that they are sometimes in conflict). Should it be all voices, or 'vulnerable' or 'less heard' voices; individual voices (including through choice and voice mechanisms) or the voices of groups or collectives? A recent local example in Birmingham involved sincerely held but conflicting views about placing LGBT issues on the school curriculum – conflicts between school staff and some local, predominantly Muslim, parents, with others also taking part in demonstrations. To use a vast over-simplification, it is possible that each side could accuse the other of homophobia and Islamophobia. So, who decides whose views count on the issue in question?

According to the editors, this book is a response to growing calls for a different approach to social policy; one that is truly participatory and democratic, rather than paternalistic and controlling (p. 1). However, it could be said that some of the contributors can appear a little 'paternalistic and controlling' at times. Danny Dorling writes that in the UK '52% of those who voted in the (2016) EU Referendum decided to leave the EU because they were told it was the only way things could get better. They were fooled' he says (p.19), but later adds, without acknowledging the irony, that 'Social policy has to be the product of millions of minds' (p.20). One assumes that in the 1975 Referendum vote, those 'fooled' included Tony Benn, Michael Foot, Barbara Castle, and a young Jeremy Corbyn. Similarly, Peter Taylor-Gooby suggests that the 2016 UK referendum shows how an 'ostensibly participative and grassroots movement among the more vulnerable groups can have damaging consequences for the inclusiveness of the welfare state' (p.30). To adapt a notorious term used by the railway industry about autumn leaves, clearly this was the wrong sort of participation. To over-extend the point for effect, the EU Referendum analysis elsewhere saw some academics demonising and 'othering' working class communities, while in effect standing shoulder to shoulder with the 'establishment': CEOs, millionaires, high court judges and the political class.

The second unclear issue concerns what sort of evidence counts. Stressing, as the book does, the importance of 'experiential knowledge' sounds like a rejection of 'expert' or 'scientific' knowledge. However, Ruth Lister writes that it has become politically fashionable on the Right to dismiss 'traditional' experts (e.g. Conservative politician Michael Gove's claim that people have had enough of experts or Donald Trump rejecting the scientific evidence on climate change). She continues that 'while such attitudes have been justly castigated, participatory approaches to social policy do create a challenge for those of us considered 'experts' on the subjects it addresses' (p. viii). Gove was arguing against what he saw as flawed previous forecasts of economists, but nevertheless appeared to believe climate change experts in his role as Environment Secretary. Moreover, (to the present reviewer, as probably one of the few social policy academics who has lived in an ex-mining village), the climate change expert view argument seems to suggest that earlier politicians were correct (albeit for different reasons) to choose to close coal mines and so devastate working class communities.

The editors write that 'some first-hand voices are sometimes dismissed as testimonies, anecdotal or just 'bearing witness' (p.8). However, previously Peter Beresford (2008) has criticised 'cosy stories of a few people's gains from individual budgets (being)... used to sell one of the biggest, least evidenced, reforms to be introduced since the founding of the welfare state.' It is easy to support the argument for responding to free speech when we agree with the speaker. Similarly, the approach here seems to suggest that we should listen to the voices of those with whom we agree, but we should dismiss similar evidence from the 'wrong' sort of people when it suits. To adapt Orwell, 'If there is hope, it lies in the proles... so long as they agree with the Inner Party' (1984) and 'All service users are equal... but some are more equal than others' (Animal Farm).

The final unclear issue relates to the criticism made of traditional social policy, both the politics and the academic literature. The editors make trenchant criticisms of 'mainstream' or 'conventional' social policy. It is claimed that social policy is still largely characterised by being top-down, non-participatory and essentially economic (subordinating social issues to narrowly economic ones). Nevertheless, as Bradshaw pointed out in his 1972 article, 'the policy maker still has to make complex decisions about which categories of need should be given priority'. Moreover, they point out that a well-known social policy textbook (not by the present reviewer) contains chapters on service users (written by a non-service user) and on disabled people (written by a non-disabled person). I am not sure if similar charges might not be brought against this book, whether or not the general point is arguable. Certainly, there is a mix of 'first person' narratives, some co-produced work, and academics writing to represent the views of groups and users, with the latter being fairly close to some 'conventional' social policy contributions to textbooks. The editors, though, argue that the 'defining characteristic' of conventional social policy is that it has been non-participatory (p.4). It is stated that 'moving to participatory social policy represents a paradigm shift', involving a different set of values and principles, a radically different

approach to understanding, studying, analysing, and researching social policy (p.1). Accordingly, it is claimed that the book does not read like a 'traditional social policy text, and it cannot be judged in the same terms as conventional social policy, because 'a participatory approach generates new theoretical discussions and approaches' (p.9). It is perfectly reasonable, and familiar, to criticise 'traditional positivist research assumptions' about rigour, reliability and replicability in social policy. However, in my view, a significant proportion of social policy research is not in fact based on 'traditional positivist research assumptions', but rather, for example, on critical, narrative and interpretative approaches. Moreover, the editors would also need to offer clearer alternative criteria (authenticity, inclusion etc) and approaches (e.g. narrative policy theory, participatory action research, co-production, user-controlled research) to make their message more compelling. A stronger concluding chapter longer than the present seven pages could have attempted to pull together key messages from the very diverse styles and elements within. However, the book brings together a great number and variety of voices that have been too rarely heard, and it is thus at least a useful counter-balance to much 'traditional' social policy writing.

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## Martin Powell

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**Understanding the Mixed Economy of Welfare** Powell, M. (ed.), *Second Edition*, Bristol: Policy Press, 2019

ISBN: 978-1447333227 (pbk), £21.99, pp.250

This edited work is the second edition of a text originally written in 2007 by Martin Powell and colleagues. This second edition provides an update and, arguably, an even more prescient and relevant exploration of how welfare might now be provided increasingly by a mixture of welfare providers, not least within the private and/or voluntary/informal/independent sectors. This is as the state itself withdraws its involvement in a variety of ways, not least in the funding, direct provision and regulation of welfare. For those who have been brought up as recipients of, advocates for, providers of and ideological sympathisers with state funded, governed and delivered welfare, this is a timely reminder that there is no 'natural', preordained set of arrangements in the provision of welfare.

Powell explains in the introductory chapter that the mixed economy of welfare (MEW) can be broken down into its components of state, market, voluntary and informal. The book considers these components alongside and interacting with what he describes as the social division of welfare (SDW) which comprise statutory, occupational and fiscal dimensions, ultimately a breakdown derived from Richard Titmuss.



Powell and his contributors set about explaining and exploring the connections between the various components of both the MEW and the SDW, arguing that these are often neglected in academic texts and analyses, which have tended to focus 'on the individual trees rather than on the wood...; put another way, while the individual pieces of the jigsaw have been described, there has been little attempt to piece them together in order to see the whole picture' (p.3). Also, he argues that one needs to provide a three-dimensional analysis of welfare provision rather than the usual one-dimensional picture of the nature of provision (public, market, voluntary, informal). This is to be done by considering also the dimensions (and interconnectedness) of service finance (state funded or subsidised as opposed to personal funding or payment, and of regulation (where the state may choose to regulate or control prices and/or standards rather than provide directly).

This three-dimensional depiction allows Powell to create a tabulation of the various possible welfare arrangements, depending on whether:

- the provision is state, market, by voluntary provider, or informal,
- the financing of such provision is via state funding, the market (individual payment), voluntary (e.g. via charitable funding) or informal, and
- whether such provision is highly regulated, or the regulation level is low (though recognising that this binary construction of levels of regulation is somewhat stark).

From this, Powell suggests that there are some 32 i.e. 16 x 2 (*sic*) possible welfare arrangements:

Provision					
Finance		State	Market	Voluntary	Informal
	State	1a (high reg.) 1b (low reg.)	2a 2b	3a 3b	4a 4b
	Market	5a 5b	6a 6b	7a 7b	8a 8b
	Voluntary	9a 9b	10a 10b	11a 11b	12a 12b
	Informal	13a 13b	14a 14b	15a 15b	16a 16b

This table is applied in the concluding chapter by Powell and, variously, by other contributors where, following the introductory chapter, the book further explores the nature of the MEW and SDW. This is through chapters on: the mixed economy of welfare (John Stewart), the state (Brian Lund), market welfare (Robin Miller), voluntary and community welfare (Rob Macmillan and James Rees), informal welfare (Martin Powell), the benefits and inequalities of fiscal welfare (Adrian Sinfield), occupational welfare (Edward Brunsdon and Margaret May), the mixed economy of welfare: a comparative perspective (Michael Hill), before, as mentioned above, returning in the final chapter to an analysis of the mixed economy of welfare and the social division of welfare (Martin Powell). For me, the more interesting chapters are the latter ones that explore areas of welfare provision that are less frequently examined: fiscal welfare, occupational welfare, and a comparative analysis.

In 'The mixed economy of welfare in historical context', John Stewart explores the patterns of welfare provision historically, noting that we mistakenly often overemphasise the role of the state in the provision of welfare. He focuses, therefore, not only on the role of the state in providing welfare but also on the role of the family, the market and the 'third sector', arguing that the role and extent of each has changed over time, because the mixed economy of welfare is a dynamic and changing phenomenon dependent upon the prevailing context.

Brian Lund then explores the role and nature of the state in welfare provision, noting that this can be thought of in terms of state funding as well as provision, providing four possible sets of arrangements (public finance/public provision; public finance/private provision; private finance/public provision; and, private finance/private provision); and that for the major areas of welfare (housing, health, education, social care, social security) there has been an increasing emphasis on the state steering rather than providing, via quasi markets and the introduction of new managerialism, as well as a shift into the private domain. Nevertheless, with the impact of devolution in the UK, one is also witnessing greater welfare plurality within the four countries of the UK.

Robin Miller explores market welfare and, in some respects, continues to explore the configurations used by Lund when considering the role of the market, adapting Burchardt's (1997) *wheels of welfare* typology. In so doing, he does make the important distinction between 'marketisation' and privatisation. A major part of this chapter then looks at the increased influence of privatisation in the NHS. He concludes by saying that rather than simply focusing on the role of markets in funding and provision of welfare, one needs to consider the actual impact, which itself will be dependent upon the local and wider political and economic context.

In the following two chapters, Rob Macmillan and James Rees explore the role of voluntary organisations and community groups in the provision of welfare; and Martin Powell then discusses the role of families, particularly women, in providing informal care. He argues that for many people, including older and disabled people, the main source of care is their families, rather than the state or independent / third sector.

In the chapter on the benefits and inequalities of fiscal welfare, Adrian Sinfield focuses on the effects of fiscal welfare, including taxation and (particularly) tax credits and pensions tax relief. This is an area that is rarely examined, not least because the UK Treasury, which has responsibility for overseeing them, does not regard them as part of public spending even though there are estimated to be over 1,000 types of tax relief in the UK. Indeed, it is interesting that income tax and National Insurance benefits and pensions tax relief have rarely been scrutinised (benefiting, as they do, higher earners) whereas tax credits (for lower earners) have been the subject of quite detailed public (including parliamentary) scrutiny. Sinfield's conclusions are that fiscal welfare arrangements are, overall, regressive and thus widen inequalities, even though governments and the media often portray them within a narrative of fairness, along the lines of an 'individualistic calculus, where you get out what you put in' (p.151).

In their chapter on occupational welfare, Edward Brunsdon and Margaret May explore another often neglected focus of analysis, that is the benefits afforded to people in work (typically employees but also partners and employers). The main benefits, and those that Brunsdon and May use as case studies, are workplace pensions and health care. However, there are other occupational benefits, some due to mandatory/legislative direction, such as occupational pensions and sick/maternity/paternity pay. The other types of benefits are non-mandatory, that is at the discretion of the employer, and include private medical insurance, free or subsidised housing, car allowances and company cars.

In the penultimate chapter, Michael Hill provides a comparative approach to examining the mixed economy of welfare. This is something that is probably less familiar to readers than the earlier focus on history, state, market, voluntary and informal welfare arrangements (Chapters 2 to 6). Hill reminds us that it is difficult to make comparisons and to generate neat typologies of different countries' welfare arrangements, but that one can at least attempt to group welfare regimes into different broad types.

In his conclusion, Martin Powell reminds us that we need to move away from thinking of welfare as being purely or mostly a state affair. Whilst one might have been able to construct, describe and analyse the provision, funding and regulation of welfare in the UK in this 'statist' way when considering the 1945-1979 post-war welfare state period, this is inadequate when considering welfare arrangements in the UK, both historically (prior to the post-war welfare state) and contemporaneously. In addition, an emphasis on 'state welfare' is also inadequate when analysing and understanding welfare arrangements in many countries across the world.

Overall, I would suggest that the book might have benefited from a tighter, shared structure employed in each chapter and also from a more frequent reference to Powell's depiction of the 32 possible welfare regimes (Table 1). Otherwise, and as is the case in this book to an extent, each chapter author provides their own structure and lens to analyse the MEW of welfare as related to their chapter topic.

The book, mindful of its potential student audience one imagines, does helpfully contain within each chapter:

- a chapter overview,
- a chapter summary,
- questions for discussion,
- suggested further reading,
- suggested electronic resources, and
- references at the end of each chapter.

In summary, the book is a clear account of how one needs to apply a mixed economy of welfare perspective in order to analyse welfare provision historically and contemporaneously, whether in the UK or globally.

I would add that the book is nicely written, which is not always something that one can say about academic texts, whether they be research-focused or written more for a student audience; and this is even more difficult to achieve in edited books, comprising chapters from a number of different contributors, however tight the brief given to them. One particularly nice metaphor is in the introductory chapter, where Powell suggests that the shift from state to informal welfare arrangements 'is more than a 'mere rearranging of the furniture in the drawing room'' (p.6); a very fine turn of phrase and depiction.

Overall, therefore, I recommend this helpful update to a very useful text on how to understand and analyse the contemporary provision of welfare, where the state arguably now dominates less than in the past, and is being replaced or supplemented: both in provision, by markets, voluntary organisations and charities as well as by informal provision; and also financially, by market, charitable and informal (personal/self) funding.

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**The Short Guide to Health and Social Care** Glasby, J., *Bristol: Policy Press, 2019*  
*ISBN: 978-1447350583 (pbk), £14.99, pp. xvi, 202*

It took a bold author in late 2017 to write a 215 page guide to health and social care, aimed at those who might be thinking of a career in the formal services and those interested in learning about the NHS and adult social care services as voters, taxpayers and citizens. Professionals could be part of the latter group, as well as LARIA members wanting to keep up to date.

Step forward Jon Glasby, helped no doubt by having grown up in Devon and having trained as a social worker – facts he draws on in the relaxed style of the book, with occasional pointed anecdotes. He also refers to his own earlier publications frequently, though not exclusively. This is not a dry guide, though the style can be bland – and it results in an easier read than most textbooks would provide. At the same time the references are well informed, to websites such as that of the King's Fund, which are frequently updated. These in themselves reflect the skew implicit in the title of the book.

Adult social care is an adjunct to NHS formal health care – and children's social care is totally excluded as it is the subject of another book in the same series. So although global and specific figures on staff numbers in the NHS can be referred to by Glasby, data provided and trends identified, the equivalent in social care is only at a general level – no numbers of social workers, for example working in adult social care, only the broad statistics can be cited from Skills for Care sources. This is not a criticism of the book, though more could have been drawn from the limited sources available – notably the Care Quality Commission, whose (annual) State of Social Care report is the only citation from this source.

The book's strengths are manifold. There is an explicit England focus, but acknowledgement is given to intra-UK differences, and sources are cited for Wales, Scotland and Northern Ireland, with specific discussion of the Scottish policy on free personal care to people in residential and nursing homes. Indeed, the reluctance of English policy makers to learn from experience elsewhere in the UK is mentioned, though not explored, in contrast to the readiness to look to the USA, Australia and New Zealand. Another strength is the array of text boxes: Concepts and debates, Facts and figures, Key sources and, most numerous and vivid, Voices of experience. These boxes are usefully listed on pages v-vi.

Weaknesses are few. The NHS Confederation is quoted, but is absent from the Index, as is Skills for Care – though the latter makes it into the references. The Commonwealth Fund comparative international rating overall of the NHS as best is quoted from, but not the rating of tenth in outcomes (out of 10 countries) from the same source. The Local Government Ombudsman is absent, despite receiving 3106 adult social care complaints and enquiries in 2017-8 and upholding 62% of them – both trends being upwards since 2010. The views of the regulator, the Care Quality Commission, on Adult Social Care are given in two paragraphs, compared with four quoting its view on the NHS and a further four paragraphs on the experience of a GP practice being inspected.

The Introduction provides basic statistics on both the NHS and adult social care, in four pages. The first chapter covers the history and structure of both, in 22 pages. Social services departments receive two sentences, compared with two pages describing the UK political system as if for an uninformed foreign visitor.

Chapter 2, the longest in the book, covers the differences in funding approaches to the NHS and adult social care, the split between purchasing and providing services, the implications of commissioning and a mixed economy of care, the impact of austerity (9 pages) plus the financial aspects of controversies over paying for long-term care and over the use of personal budgets. The references are wide-ranging but have minimal annotation. Checks on the personalisation references indicate they can be very dated – 2015 is a future date on In Control's website in a glossary, and there is only one item of news so far in 2019 on the same website; but the Sheffield-

based Centre for Welfare Reform, also referenced, has a very up to date website and frequent publications available.

Chapter 3, on organising health and social care is shorter, offers a critique of structural reorganisations as solutions to service tensions, explores mental health as distinct from physical health, health care, social care and partnership working and integration. The latter is both a policy objective and has not been achieved in full anywhere. (The text does not contain the word chimera.)

The second and shorter part of the book is also of three chapters, headed People and Practice, and has an emphasis on health professions and culture. Chapter 4 discusses concepts of health and wellbeing, contrasting well-meaning legislation, such as the 2014 Care Act, with the reality at ground level of financially constrained local government. This is the chapter that also discusses health inequalities, social construction in everyday life, and a social model of disability (as contrasted with a medical model). Drawing on his personal experiences while training as a social worker Glasby presents six examples of services being offered inappropriately, based on false or outdated assumptions about those the services were intended for. While these resonate, there is no comment on whether the services changed if the assumptions were challenged, or whether such services might just have ceased. User involvement and independent living are discussed in the chapter, but references are minimal. None is evaluative and only one is to a publication of Glasby's.

Being a Professional (Chapter 5) is explicitly for those thinking of a career in health and social care, primarily in the NHS, in nursing, or where ethical issues of principle are likely to arise. Chapter 6, on delivering care, addresses realities in management, the different perspectives of patients and managers, and new 'vanguard' models of health care. The adult social care element is a promotional page from Skills for Care. On job satisfaction and stress, Glasby points out that though there are data on turnover, vacancies and sickness rates, the social care system is essentially local and there are less systematic data on morale – compared with the findings of a regular Workforce survey of NHS staff. A short section on Brexit and the international make-up of health and social care staff now appears flawed because of large differences between the quoted estimated numbers provided by Independent Age and the analyses of Skills for Care, the ostensible source of the same data on the national origins of members of the social care workforce. Who said analysts were unnecessary? Certainly not Jon Glasby, whose boldness and personal commitment outweigh the limits of his brief, and results in a stimulating and useful short guide.

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*Review of Adult Social Care Complaints 2017-8 Local Government and Social Care Ombudsman*, November 2018.

**Paul Dolan**

Reviews Editor

**Honest Dialogue: Presence, Common Sense and Boundaries when You Want to Help Someone** Falk, B., *London: Jessica Kingsley Publishers, 2017*  
*ISBN: 978-1785923531 (pbk), £9.99, pp. 120*

**I Can Beat Anorexia: Finding the Motivation, Confidence and Skills to Recover and Avoid Relapse** Davies, N., *London: Jessica Kingsley Publishers, 2017*  
*ISBN: 978-1785921872 (pbk), £13.99, pp. 160*

Pity the practitioner professional seeking to guide someone with eating disorders. Literature varies from the preachy to the drily clinical, with self-help the current order of the day. Perhaps this approach is now realistic, for the times we are in, reflecting being target-focussed, time-managed and cost-driven; but it must also be confusing for the person concerned; and it reflects a lack of critical consensus. NICE guidance tries to fill the gap, is written both for professionals and for 'people with suspected or diagnosed eating disorders and their families and carers', but it is itself limited by what evidence is available.

The approach in the book by the Danish counsellor Bent Falk relates to the individual reflecting on their behaviours and experiences, and then allowing and encouraging them to make choices in moving forward if they decide to. The author uses his background experience in counselling to guide the practitioner in various possible ways of approaching complex topics in work with individuals in therapy. He outlines issues of resilience, burn-out, and of the personal life of the therapist as having a negative impact on therapy if shared in too much detail. His approach also allows the individual a way of acknowledging past events: not dismissing them, but also not continuing to battle with the pain and constant misery that they cause. This choice is offered to the person: if they want to continue in the past or to move forward with change, as in Chapter 15, headed 'Forgiving does not undo the done'.

The approach is often open or extremely non-judgmental: for example, 'Explanation is no comfort'. For the client or the patient to reach this "acceptance", or for a helping "lay individual" to achieve this, can take a possibly significant period of time and of work. The approach of this book thus comes emphatically from a stance that does not judge our own or others' situations. Following this approach requires practice and a set of skills. Falk appears to have a grounded set of skills based, as he believes, on his background life experiences and his own faith in religion, which is evident throughout. Not all patients, clients or therapists will hold these beliefs or have the same set of skills.

In my own practice, and often working with complex individuals, it is important to set clear goals and boundaries, allowing each person (therapist and client) to know that there are treatment expectations and limitations. It is an expectation that we *both* do not judge each other: being non-judgmental is therefore a two-way process (within acknowledged risk or safeguarding boundaries) within types of therapy. Falk seems to take a non-judgmental stance to its extreme limits, as with 'helping is not always giving advice'. He implements change via a questioning style rather than sharing his own opinions. This therefore may beg the question: when does a person learn or implement meaningful changes, cope with others having opinions, and gain an understanding of other people's limitations?

Dialogue is clearly important in clinical practice, in gaining and maintaining the engagement of the people we work with. Falk offers advice on parameters in dialogue and overall grounded advice that is thoughtful, reflective and appropriate. Part of the detail does become over-attentive towards certain words and details, and it can appear that everything needs to be discussed. The impression is given of focussing on interrogating certain words, so as to promote reflection on communication, rather than on the quality of engagement or the relationship of the patient/client with the therapist. In theory this could be a good way of getting someone to reflect on how they communicate. However, there is still a need for them to air their feelings even if they can't express themselves in words they are wanting to use and know before they learn how to rephrase them. Consequently, they might hold back completely in sessions, and not engage at all.

In summary, Falk's approach to counselling may be thought somewhat context-specific, and no evidence is offered in the book about any general results achieved, nor indeed any failures.

The overall theme of Dr Nicola Davies's book is of a shared experience of a personalised recovery journey, focusing on anorexia. It is written from a professional's own experience, aiming to relate personally to individuals who might choose to read it, and not feel they are being patronised by someone who doesn't "really understand". Often for those working in practice this can be the feedback received: patients state that professionals do not truly know what it feels like to have anorexia, understand the battles to overcome it, and don't have the "lived experience". This book provides both a personal and professional account which offers a strong sense of realism.

The author uses a style of writing that is non-judgemental, valuing people, particularly those suffering an eating disorder. This engagement might not be something that they have experienced or often come across. It is a style that is compassionate and offers a sense of reassurance that their current experiences of what they are going through are not unusual, nor are they behaving this way to gain attention. The author continues in the same compassionate style to address very succinctly the high risks of continuing to engage in behaviours related to anorexia and their longer-term consequences, what types of eating disorder there are and how they can damage the person's short and longer term physical and mental wellbeing. Continuing with a non-judgemental approach, Davies offers a statement on what might cause anorexia: biological, psychological and social factors. This again anticipates, and rejects, the sometimes overwhelming sense that an individual might be behaving this way on purpose, associated with a sense of blame; and she suggests that there is not just one reason or issue, but a series of complex events and factors that lead to anorexia.

Highlighting signs, symptoms and behaviours does allow a person to identify what might be going on for them, understanding the reasons why they are thinking certain things or following a certain set of behaviours. For example, there is an ('over to you') exercise in identifying a problem or relating to a set of issues, put in a way that allows someone to feel a sense of understanding and validation. This is conveyed in a way that does not put demands, and so allows them to make choices. Furthermore, when exploring the types of treatment options, a grid box is used, with clear explanations and rationales for the types of treatments available, and why they might be helpful for different presentations, including the advantages and disadvantages of the different therapeutic approaches. Davies doesn't really favour one approach over another, but allows the person to consider what might be available to them; though she suggests that Cognitive Behavioural Therapy tends to be widely used. Specialist support from clinical management, in my experience, highlights the importance of weight gain alongside psychological intervention.

The author then goes on to ask the person reading the book to do an exercise about what they might require. This envisages several approaches and then gets the reader to address some of their own issues, such as eating, weight gain, purging, exercise, mood, family dynamics and moving on. The approaches and interventions that are described during these chapters are in current practice. They are thus in line with current NICE guidance: this is a CBT style, allowing people to identify and challenge behaviours, and to change them, with self-help exercises to support this. There are also elements of dialectical behaviour therapy (DBT) within the book that would help address emotional regulation for individuals in distress. DBT treatment is usually used in treatment for personality disorders; but to develop an understanding of emotional regulation and to be able to tolerate distress is used in clinical practice, and it would often be essential for the patient group to have access to these practical skills. Furthermore, there is also a close link between personality disorders and disordered eating.

This book too envisages for individuals a choice of whether they are ready to consider a recovery journey. Including many self-help questions and exercises makes it very interactive, with more detail than you first realise. This would therefore be a useful stepping-stone for an individual waiting for assessment or treatment, or unsure whether they are ready to start their response to anorexia along with a professional, and thus require further practical information before they envisage a long-term treatment programme.

However, I would also recommend professional colleagues to advise prospective clients to study what they can, especially if they may be waiting for an initial appointment.

This author, like Falk, explicitly puts the responsibility for actions and exercises on the person engaging with the book. For this reviewer such self-help can be a useful mechanism for the person using the service or for someone who might be suspected of having an eating disorder. It can also allow the professional to assess engagement and motivation to explore future interventions, such as CBT, and/or psychological treatment. If activities are worked on in self-help self-guided work this can allow both the professional and the person using the service to build on a clinical formulation, and to implement this in relation to goals for further treatment when this is required.

However, this is something of an aspiration. There can be successful reflective practice: for the person to identify that changes might need to be made in how they are currently living, and to limit harm they are causing themselves – gaining insight but also requiring some insight. This does mean that they will need to agree, consent and work to complete the process, which is often problematic, especially if motivation or insight is limited or transient, and whether or not they have used these useful books as aids.

## References

*NICE Guideline [NG 69] Eating Disorders: Recognition and Treatment*, May 2017.

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### **What are SSRG's objectives?**

- To provide a network of mutual support and a forum for the exchange of ideas and information on social and healthcare services.
- To promote high standards in social and healthcare services research, information, planning and evaluation.
- Encourage collaboration in social, housing and health services activities.
- To develop an informed body of opinion on social and healthcare services activities.
- To provide a channel of communication for the collective views of the Group to central and local government, other professional bodies and the public.
- To sponsor relevant research and identify neglected areas of research.
- To encourage and, where appropriate, sponsor high quality training in research techniques.

### **Who belongs?**

SSRG is open to anyone who subscribes to the objectives of the Group. Members are drawn from a wide range of professional groups and organisations sharing a common interest in the work of the caring services.

### **How is it organised?**

SSRG is run by an 'Executive Committee' (EC) which comprises elected and selected officers, elected members, co-opted members and representatives from SSRG Scotland, whose principal tasks are to promote the objectives of the group and to coordinate its activities.

### **What does it do?**

SSRG publishes a Journal and a Newsletter which are distributed free to all members. It maintains working links with central government departments, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Children's Services (ADCS) and other professional bodies and organises an annual workshop on a topical theme in social and health care services research, and occasional day conferences, for which members receive generous discounts on fees. It also coordinates the work of Special Interest Groups which provide members with an opportunity to contribute to the formulation of SSRG responses to national policy initiatives and current issues in the social and health care services.

### **Equal Opportunities Policy Aims**

- To ensure that every SSRG member, user, job applicant, employee or any person working with, or in contact with, the organisation receives fair treatment irrespective of their age, colour, disability, gender, ethnic origin, marital status, nationality, race, religion, sexual orientation, responsibility for dependents, political affiliation or membership of a trade union.
- To ensure that the contribution of research, information, planning and evaluation work in social care and health is sensitive to this issue.
- To ensure that SSRG promotes the equalities agenda in all its activities.

## **Research, Policy and Planning is the Journal of SSRG**